

WHAT HAPPENED TO NO-FAULT? THE ROLE OF ERROR REPORTING IN HEALTHCARE REFORM

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I. INTRODUCTION

Doctors amputating incorrect limbs, prescribing the wrong drugs, or simply misdiagnosing coughs—medical errors still occur too often. This is an unfortunate truth in both the United States as well as countries with no-fault systems for compensating victims of iatrogenic injuries. In response to persistent medical errors, many proposals for improving and implementing no-fault systems focus on costs and administrability, trying to shoehorn a system that must compensate many patients into a culture accustomed to lengthy litigation.

This Article takes a slightly different approach, looking instead to the patient safety movement and its focus on medical error reporting, to suggest improvements to no-fault proposals. The Article looks specifically at Dr. Farzad Soleimani's surveys of doctors'

attitudes toward reporting in both the United States and New Zealand¹—providing a contrast between tort and no-fault approaches. These surveys provide direct evidence about how practicing physicians feel about reporting, when and why they feel reluctant to report adverse events, and how they feel reporting affects the chances of disciplinary action.² Soleimani's data suggests that, more than costs or efficiency, error reporting should be the centerpiece of a no-fault system.³

In the United States, the academic push for no-fault liability for medical errors peaked in the early 1990s, when the Harvard Medical Practice Study published key results about medical malpractice litigation and recommended its own no-fault model.⁴ The push for quality reforms and error reporting, however, surfaced near the turn of the millennium.⁵ It is perhaps this temporal mismatch between these mini-movements that resulted in error reporting taking only a nominal role in no-fault proposals. Soleimani's studies show that error reporting is not just an important factor in an ideal no-fault system, but perhaps its most essential feature.⁶ Error reporting is essential not only for dispassionate data-gathering and risk analysis, but also for aggressive quality improvement, cost reduction, and greater trust in the doctor-patient relationship.

This Article proposes that no-fault medical compensation schemes refocus on error reporting, in addition to the more common worries about cost and administrability. After a substantial (but

¹ Farzad Soleimani, *Physicians' Attitudes Towards Reporting Different Types of Medical Errors and Their Perceived Possibility of Lawsuits if They Report* [hereinafter Soleimani US]. Poster presented at 23rd Annual Stanford Medical Student Research Symposium; 2006 May; Stanford, California (publication forthcoming; on file with journal); Farzad Soleimani, *Learning from Mistakes in New Zealand Hospitals: What Else Do We Need Besides "No-Fault"?* 119 JOURNAL OF NEW ZEALAND MED. ASSOC. 1239 (2006) available at <http://www.nzma.org.nz/journal/119-1239/2099/> [hereinafter Soleimani NZ].

² Soleimani NZ; Soleimani US.

³ *Id.*

⁴ Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York*, The Report of the Harvard Medical Practice Study To the State of New York (1990) [hereinafter HMPs].

⁵ *Id.*

⁶ *Id.*

necessary) introduction to no-fault and current reform proposals in Part I, the Article turns to Soleimani's survey data in Part II. Finally, Part III argues specifically that error reporting take a stronger role in two ways: (1) error reports should help injured patients by creating a legal presumption of compensability, and (2) doctors who fail to report an injury that results in compensation should receive feedback. Important associated reforms, such as dedicated patient advocates and confidential national databases for medical error reports, are also discussed.

II. NO-FAULT SYSTEMS AND MEDICAL ERROR REPORTING: WHY A DIVERGENCE?

Modern healthcare faces a critical and continuing problem: medical error is underreported, and too few medical injuries are compensated. This appears to be the case both in the United States, where a tort-based system of medical malpractice litigation handles patient compensation, and in countries like New Zealand, where a no-fault system (NFS) compensates the injured without assigning legal blame to doctors.⁷

This problem is particularly puzzling for health reformers proposing that tort-based systems like the United States' switch to no-fault compensation. In a basic no-fault system, administrators create a predetermined set of compensable medical events that result in injuries (often called designated compensable events, or DCEs⁸) along with a fixed schedule of damages, both economic and noneconomic.⁹ An administrative system then handles patient claims and resolves factual disputes, without officially penalizing physicians.¹⁰ In theory, no-fault systems should promote error

⁷ Peter Davis et al., *Compensation for Medical Injury in New Zealand*, 27 J. HEALTH POL. POL'Y L. 833, 833 (2002). Studies show that despite having a no-fault system, New Zealand compensates roughly the same proportion of injured patients as the United States. Soleimani NZ, *supra* note 1, at 2.

⁸ Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 933 (1993).

⁹ Soleimani NZ, *supra* note 1, at 2.

¹⁰ Mark A. Hall, et al., HEALTHCARE LAW & ETHICS 379, (7th ed. 2007).

reporting because they remove the negative consequences of litigation. The American Workers' Compensation and automobile insurance systems are examples of no-fault compensation programs,¹¹ though defining accidents and errors in those systems is probably less complicated than in medicine.

However, experts cannot be sure that no-fault *alone* encourages more reporting or compensates more victims than tort-based systems. This issue is critical because many reform efforts, including the World Health Organization's "World Alliance on Patient Safety" advocate no-fault systems and the general importance of "reporting and learning" but fail to connect the two.¹² Before the United States or other countries adopt the no-fault model, they must design a system that meets both goals of increased reporting and better compensation.

A. Criticisms of Existing Compensation Systems

There are two central questions related to existing compensation systems: (1) why are reporting and compensation too infrequent, and (2) what can be done to reverse this? Many health and legal scholars criticize both the American tort model and other no-fault schemes for how they compensate people injured in the hospital: this Section summarizes these critiques.

1. Tort

Criticism of the negligence-based tort system abounds. Observers claim that tort systems are inefficient: while 90% of first-party health insurance dollars reach the insured, only 40% of medical malpractice insurance dollars go to the victims.¹³ Not only does litigation under-compensate victims as a class, but lawsuits also

¹¹ Randall R. Bovbjerg & Frank A. Sloan, *No Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 66 (1998).

¹² See I. Ralph Edwards, *The WHO World Alliance for Patient Safety*, 28 DRUG SAFETY 379, 382 (2005).

¹³ Patricia Danzon, *Tort Reform: The Case of Medical Malpractice*, 10 OXFORD REV. EC. POL'Y 84, 85 (1994).

consume time and delay awards to legitimate claimants.¹⁴ For injured patients, the litigation expense also deters small but legitimate claims, although some see this as a benefit.¹⁵ For physicians, litigation expenses lead to extremely high malpractice liability insurance premiums for certain specialties, such as obstetrics and gynecology. Such premiums sparked insurance “crises” in the mid-1970s and 1980s and, in some states, in the 2000s.¹⁶ Moreover, doctors have argued that steep litigation costs cause doctors to practice defensive medicine—unnecessary and potentially harmful treatments used to avoid litigation.¹⁷ While health policy analysts dispute the true cost of defensive medicine (a questionable 2003 American Medical Association study estimated that 30% of doctors pass on complex cases¹⁸), it remains a strong argument against the medical tort system. Other research has shown that malpractice litigation only minimally deters negligent or substandard care.¹⁹

David Studdert and Troyen Brennan cite a less tangible harm from litigation: loss of trust in the doctor-patient relationship.²⁰ Because it is so adversarial, “[m]alpractice litigation induces silence and bitterness.”²¹ This loss of trust is especially troublesome because most Americans may be willing to forgo blame for their medical

¹⁴ *Id.*

¹⁵ *Id.* at 86-87.

¹⁶ David Dobbs, *Malpractice Mess*, SLATE, <http://www.slate.com/id/2113103> (last visited Feb. 22, 2005).

¹⁷ Frank Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. 1058, 1060 (1986).

¹⁸ Jordyn McAfee, *Medical Malpractice Crisis Factional or Fictional?: An Overview of the Gao Report as Interpreted by the Proponents and Opponents of Tort Reform*, 9 MICH. ST. J. MED. & L. 161, 169 (2005); but see Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1606-07 (2002) (observing that “[m]ost defensive-medicine studies have failed to demonstrate any real impacts on medical practice arising from higher malpractice premiums,” and that any defensive medicine “has diminished over time in response to the growing presence of managed care”).

¹⁹ Mello & Brennan, *supra* note 18, at 1606-07.

²⁰ David Studdert & Troyen Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 218 (2001) [hereinafter Studdert & Brennan: *No Fault Compensation*].

²¹ *Id.* at 218.

injuries if they can get fair compensation.²² Malpractice suits also divert doctors' professional attention from the hospital to the courtroom.²³

Under the rubric of "tort reform," legislators have tried to tame the malpractice insurance problem by introducing damage caps on litigation awards, creating state patient compensation funds, and regulating insurance costs.²⁴ However, critics say that tort reforms are only stopgap tweaks to the system that do not address the underlying goal of improving patient safety.²⁵

2. No-Fault

Despite these harsh criticisms of tort, the no-fault alternative has ample detractors. One of its biggest sticking points is cost. Many critics worry that: "full compensation for all medical injuries will be much more expensive in total than the present system because so many injuries now are entirely uncompensated."²⁶ Even no-fault supporters like Studdert and Brennan acknowledge that costs will increase significantly with broader compensation, and that special deductibles or injury thresholds must be used to reduce them.²⁷ For example, New Zealand redefined its list of compensable events, previously known as "medical misadventures," in 1992 to reduce compensation costs.²⁸ For these reasons, most no-fault advocates target the cost problem in their research.

Critics also argue that no-fault systems produce the wrong incentives for doctors and victims.²⁹ Simply put, without fault in the

²² Walter Gellhorn, *Medical Malpractice Litigation (U.S.) – Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 177 (1988).

²³ Grad, *supra* note 17, at 1066.

²⁴ *Id.* at 1076-77; Bovbjerg & Sloan, *supra* note 11, at 62.

²⁵ See Larry Palmer, *Patient Safety, Risk Reduction, and the Law*, 36 HOUS. L. REV. 1609, 1621-22 (1999).

²⁶ Hall, et al., *supra* note 10, at 381.

²⁷ See David Studdert, et al., *Can the United States Afford a "No-Fault" System for Compensation of Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1, 30-31 (1997).

²⁸ Davis et al., *supra* note 7, at 836.

²⁹ Bovbjerg & Sloan, *supra* note 11, at 73

compensation process, there is no (or at least less) stigma associated with fault, and therefore less incentive to prevent mistakes.³⁰ Examining the Swedish no-fault program, Patricia Danzon observed that neither the physician nor the patient has strong incentives to appeal compensation decisions; doctors have no financial stake in the process, and Swedish patients are uninformed about the appellate procedure.³¹ On the surface, Sweden's system has low overhead costs, but only because it "forgo[es] all links between compensation and injury prevention."³² Danzon also criticizes the New Zealand system because it eliminates "all links between compensation and deterrence," resulting in many unnecessary injuries and inappropriately compensated claims.³³

So, despite the increased cost, no-fault might not really improve health care quality. New Zealand's health care system might produce a larger proportion of compensable adverse events than the American system.³⁴ Furthermore, no-fault countries might not rigorously pursue negligent or incompetent doctors.³⁵ For all these reasons, some countries, like Canada, have not rigorously pursued a change to no-fault.³⁶

³⁰ *Id.* But it is not clear that no-fault eliminates all stigma attached to medical mistakes. Doctors in New Zealand still avoid reporting errors because of media reprisals, despite immunity from legal blame. Soleimani *NZ*, *supra* note 1, at 8-9.

³¹ Danzon, *supra* note 13, at 86.

³² *Id.*

³³ *Id.* at 91. But injured New Zealand patients may still file complaints, which might provide some deterrent effect. *See infra* note 85.

³⁴ Davis et al., *supra* note 7, at 849. Comparing national systems is clearly difficult, due to differences in economy, technology, and culture. However, if one of the benefits of no-fault is a much greater quality of care, no-fault countries should arguably perform better. And the New Zealand and tort systems produce comparable numbers of claims. *See* Soleimani *NZ*, *supra* note 1, at 2.

³⁵ Gellhorn, *supra* note 22, at 207-08.

³⁶ *See* Ann Silversides, *Fault/No Fault: Bearing the Brunt of Medical Mishaps*, 179 *CANADIAN MED. ASS'N J.* 309-10 (2008); Ann Silversides, *Fault/No Fault Part 2: Uneasy Bedfellows*, 179 *CANADIAN MED. ASS'N J.* 407, 407 (2008).

B. Existing No-Fault Models and Critiques

No-fault compensation schemes already exist in several countries, and in limited state and federal programs in the United States.³⁷ This Section briefly discusses these programs and respective critiques. The following table summarizes these plans' key features:

³⁷ *Id.*

Table: Comparison of No-Fault Systems

	VA/FL NICA	NVICP³⁸	NZ³⁹	Sweden⁴⁰
Compensable events	Defined by BIF/NICA statutes	Vaccine Injury Table	"Treatment injuries"	SCE – uniform set of criteria based on "avoidability"
Disability threshold?	Yes: babies must have grievous birth-related neurological injuries; weight requirement (FL)	Yes: defined by Vaccine Injury Table	Yes: 10% injury and 13-week threshold 14 hospital days or 28 disability days	Yes: 10 hospital days or 30 sick days; deductible for injuries at 1/20th of a "base sum" ⁴¹
End of payments?	No: ongoing for child's lifetime, with flexibility for changing expenses	No?	Yes: at 85% recovery	N/A
Reporting – voluntary or involuntary?	Workers' Comp. Commissions receive claims	Voluntary: through VAERS	Voluntary?	Involuntary: physician must file report if patient alleges

³⁸ See generally Lisa J. Steel, *National Childhood Vaccine Injury Compensation Program: Is This the Best We Can Do for Our Children?*, 63 GEO. WASH. L. REV. 144 (1994).

³⁹ See generally Gellhorn, *supra* note 22; see also Bovbjerg & Sloan, *supra* note 11.

⁴⁰ David Studdert & Troyen Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J. L. & MED. 225, 232 (2001) [hereinafter Studdert & Brennan: *Toward a Workable Model*].

⁴¹ Studdert, et al., *supra* note 27, at 8, 12.

⁴² *Id.* at 6.

				injury. ⁴²
Payment caps?	Yes: economics only (VA); \$100k for noneconomics (FL)	Yes: \$250k economics \$30k cap for noneconomics	Yes: schedule	Yes: capped at 200 times a "base sum"
Discipline for bad doctors	?	NA	Handled by Accident Compensation Corporation ⁴³	Patients can always file malpractice suits
Appeals possible?	Yes	Yes	Yes	Yes
Appeal procedure	To courts under tort, if denied compensation	1. Court of Federal Claims (CFC) 2. Federal Circuit	1. Review by ACC 2. Court	1. Panel 2. Arbitration 3. Malpractice suit

⁴³ See Gellhorn, *supra* note 22, at 197.

1. American "Bad Baby" Systems

In the late 1980s, Virginia and Florida enacted the first no-fault compensation programs for children suffering severe neurological injuries during childbirth.⁴⁴ The actual no-fault programs—the Birth Injury Fund (BIF, Virginia) and the Neurological Injury Compensation Association (NICA, Florida)—originally relied on the Workers' Compensation administrative model.⁴⁵ Both systems provide damages to the families of children suffering severe brain injuries from birth. Beneficiaries, however, are limited by strict eligibility rules: Virginia limits recovery to patients in need of assistance for daily living activities, while Florida imposes a minimum weight requirement to preclude premature births, yet excludes genetic conditions.⁴⁶

While NICA may be "the most significant experiment with compensation for medical injury yet undertaken in the United States,"⁴⁷ the results of these compensation experiments are mixed. In Virginia and Florida, no-fault programs have reduced malpractice insurance premiums for obstetrics and gynecology specialists. Over 90% of obstetrics and gynecology specialists in these states choose to participate in the program, and participation by Medicaid physicians is increasing.⁴⁸ However, detractors point out that the program is very narrow and provides little actual compensation.⁴⁹ From 1989 through 1997, only 86 of 225 filing families received payments.⁵⁰ If the no-fault review process denies them money, they can file malpractice

⁴⁴ See Bovbjerg & Sloan, *supra* note 11, at 56; see generally Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. § 38.2-5000 (2005); Birth-Related Neurological Injury Compensation Act, FLA. STAT. § 766.301-.316 (2001).

⁴⁵ Bovbjerg & Sloan, *supra* note 11, at 82, n.122. Peter Davis notes that the New Zealand no-fault system originated with reforms to workers' compensation as well. See Davis et al., *supra* note 7, at 835.

⁴⁶ Bovbjerg & Sloan, *supra* note 11, at 90.

⁴⁷ Lori A. Fritz & Troyen A. Brennan, *The Jury Is Still in: Florida's Birth-Related Neurological Injury Compensation Plan After a Decade*, 25 J. HEALTH POL. POL'Y & L. 499, 499 (2000).

⁴⁸ Bovbjerg & Sloan, *supra* note 11, at 99-101.

⁴⁹ See *id.*; Fritz & Brennan, *supra* note 47, at 500.

⁵⁰ Fritz & Brennan, *supra* note 47, at 500.

claims as an additional remedy,⁵¹ and many qualifying parents file both tort and no-fault claims.⁵² Moreover, state courts determine whether a child's injuries qualify under the no-fault eligibility rules, so they can remove potential no-fault cases to the regular litigation domain.⁵³ As Bovbjerg and Sloan note, "[c]ourts hearing tort cases may determine for themselves whether a case before them meets the statutory criteria of eligibility for NICA or whether the case may instead proceed in court."⁵⁴ Finally, many parents lack knowledge of how BIF and NICA operate and must hire attorneys,⁵⁵ which defeats a central purpose of no-fault – allowing victims to avoid legal fees.

2. The American National Vaccine Injury Compensation Program (NVICP)

With the rise of widespread childhood vaccination to combat public illness, vaccine companies feared product liability litigation.⁵⁶ These fears threatened the entire vaccination program because, with millions of distributed vaccines, the chance of some prohibitively expensive (and legitimate) lawsuits was quite high.⁵⁷ In response, the National Childhood Vaccine Injury Act of 1986 created a federal no-fault compensation scheme for children suffering any of a list of predetermined injuries from vaccines.⁵⁸ The law reflected a public consensus that neither the children nor the drug companies should pay for the costs of adverse reactions to vaccines.⁵⁹

The program's predefined compensation events appear in the Vaccine Injury Table, a list of vaccines, injuries, and elapsed times between vaccination and injury that establish which injuries are

⁵¹ Bovbjerg & Sloan, *supra* note 11, at 89.

⁵² Fritz & Brennan, *supra* note 47, at 499.

⁵³ Bovbjerg & Sloan, *supra* note 11, at 84.

⁵⁴ *Id.*

⁵⁵ *Id.* at 88.

⁵⁶ See generally Steel, *supra* note 38, at 146.

⁵⁷ *Id.*

⁵⁸ 42 U.S.C. § 300(aa)-10.

⁵⁹ Steel, *supra* note 38, at 146.

presumptively compensable.⁶⁰ If the injury falls outside the Table, the claimant must produce scientific evidence or expert medical testimony to a court-appointed special master to prove causation.⁶¹ Losing claimants can appeal to the Court of Federal Claims, and then to the Federal Circuit.⁶²

On the one hand, since the creation of NVICP, vaccination rates have improved while wholesale vaccine costs have decreased, without any major manufacturers going out of business.⁶³ However, NVICP's procedural requirements are daunting. Some criticize the Vaccine Injury Table for being too restrictive because it excludes victims whose injuries occur outside the rigid criteria.⁶⁴ Bringing a claim requires both legal and technical expertise, neither of which is cheap. Moreover, NVICP caps attorney fees at \$30,000 and pays no costs for expert witnesses if the claimant loses.⁶⁵ Following a survey of 786 NVICP cases, Derry Ridgway concluded that the program suffers from problems common to all no-fault cases: the need for expensive counsel and experts, costly causation disputes, and resistance from the plaintiffs' bar.⁶⁶

3. The "European" No-Fault Plans

In contrast to the piecemeal American approach towards no-fault, some European countries, including Sweden, Finland, Denmark, as well as non-European countries, such as New Zealand, have adopted nationwide fault-free approaches to rectifying all medical injuries.⁶⁷

Most of the available scholarship is about the Swedish and New

⁶⁰ *Id.*

⁶¹ *Id.* at 156-57.

⁶² *Id.* at 158.

⁶³ Derry Ridgway, *No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Fund*, 24 J. HEALTH POL. POL'Y & L. 59, 76 (1999).

⁶⁴ Steel, *supra* note 38, at 170.

⁶⁵ *Id.* at 165-66.

⁶⁶ Ridgway, *supra* note 63, at 85.

⁶⁷ Studdert, et al., *supra* note 27, at 229.

Zealand models,⁶⁸ summarized in the table above. Sweden started its system in the 1970s in collaboration with insurance companies.⁶⁹ A central administrative body, the Federation of County Councils, decides all claims, usually within six months.⁷⁰ Hospitals distribute information packets, and social workers explain how to file.⁷¹ Claimants denied compensation can appeal to a special panel, and then enter arbitration.⁷² The system does not preclude malpractice lawsuits.⁷³ Furthermore, Sweden applies a minimum injury threshold for compensation: the victim must suffer ten days in a hospital or thirty sick days from work.⁷⁴ Sweden controls costs by adjusting the predefined compensable injuries—Swedish Compensation Events (SCEs)—payments, and allowable claims.⁷⁵

New Zealand initiated its system in 1972 with the Accident Compensation Act, abolishing tort liability for medical mishap.⁷⁶ The Accident Compensation Corporation handles all claims based on designated compensable events (DCEs),⁷⁷ which are revised periodically—most recently in 1993.⁷⁸ In 2005, New Zealand introduced the new term “treatment injury” to include all injuries suffered during treatment received from health professionals.⁷⁹ New Zealand also uses a disability threshold—fourteen hospital days or

⁶⁸ Studdert and Brennan generally support the basic Swedish model, applying it in their costs estimates for implementing no-fault in Colorado and Utah. Studdert, et al., *supra* note 27, at 3. Most comparisons of American tort and foreign no-fault seem to center around New Zealand. *Id.*; see, e.g., Gellhorn *supra* note 22; see also Davis et al., *supra* note 7.

⁶⁹ Studdert, et al., *supra* note 27, at 5-6.

⁷⁰ *Id.* at 6.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.* at 8.

⁷⁵ *Id.*

⁷⁶ Davis et al., *supra* note 7, at 835-36.

⁷⁷ *Id.* at 836; Weiler, *supra* note 8, at 933.

⁷⁸ Davis et al., *supra* note 7, at 836, n.4.

⁷⁹ Marie Bismark & Ron Paterson, *No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety*, 25 HEALTH AFFAIRS 278, 280 (2006).

twenty-eight “days of significant disability”⁸⁰ – and ends payments to patients once they reach 85% of their capacity to work.⁸¹

Critiques of these systems come from all quarters. Some focus on unmanageable system costs and under-deterrence of substandard service, as Section I(A)(2) discussed.⁸² Other scholars claim that no-fault simply fails to compensate more people than a traditional tort approach.⁸³ Based on empirical studies of New Zealand no-fault medical claims, Peter Davis concludes that New Zealanders do not bring significantly more claims than Americans bring lawsuits, that many no-fault filings do not result from substandard medical care (although arguably they might be preventable and should still be compensated), and that overall, “a move to a no-fault system does not necessarily of itself address issues of low and selective claims making and receipt.”⁸⁴ Additionally, the New Zealand system still permits patient complaints with the Health and Disability Commissioner that are independent of any claims for compensation.⁸⁵

C. Summary: Flaws in All Systems

While existing no-fault programs differ substantially in the types of injuries they cover, some common themes emerge from their critiques. First, critics of every program argue that each excludes too many injured patients. In the American bad-baby systems, few people pursue no-fault, instead choosing to sue in court, especially as courts can readily decide whether a particular injury falls within BIF or NICA eligibility. The NVICP system also poses significant barriers to potential claimants because of attorney and expert witness fee caps. And as Davis’s work tends to show, even New Zealand’s

⁸⁰ Studdert & Brennan: *Toward a Workable Model*, *supra* note 40, at 232.

⁸¹ Studdert et al., *supra* note 27, at 15.

⁸² Refer to text accompanying *supra* notes 16-25.

⁸³ Davis et al., *supra* note 7, at 851.

⁸⁴ Davis et al., *supra* note 7, at 851-52; Peter Davis et al., *Preventable In-Hospital Medical Injury Under the “No Fault” System in New Zealand*, 12 *QUALITY & SAFETY IN HEALTH CARE* 251, 256 (2003) [hereinafter Davis et al.: *Preventable In-Hospital Medical Injury*].

⁸⁵ See <http://www.hdc.org.nz/complaints/making-a-complaint>.

nationwide plan produces relatively few legitimate claims.⁸⁶

Second, while every plan focuses on managing costs and meeting budgets, it is not clear that the actual quality of medical care and patient safety really improves, either in theory or in practice. While the American systems successfully reduced the costs of insurance for OB-GYNs and vaccine suppliers, it is not obvious whether the quality of the respective services increased, or if the adverse events were used in a constructive, educational way to improve quality going forward. In New Zealand, claims data suggest the fraction of potentially compensable events (a rough measure of substandard care) nears the rate in the United States, which in turn implies that no-fault does not necessarily spur dramatic quality improvements.⁸⁷

III. SOLEIMANI'S SURVEYS OF DOCTOR REPORTING

Academic proposals for no-fault reforms have focused on system-level, administrative problems: costs, disability thresholds, payment caps, appeals, and defining compensable events. To date, no studies have looked systematically at doctors' attitudes about medical error and reporting. To better understand the role of individual physicians in medical reform, Farzad Soleimani asked the doctors themselves.

Soleimani conducted two surveys of doctors, one in the United States and one in New Zealand.⁸⁸ In both studies, he asked physicians of various specialties a series of similar questions to gauge their attitudes about reporting medical errors, both minor and serious.⁸⁹ These questionnaires provide direct, first-hand opinions about doctors' attitudes towards reporting under both the American tort and the New Zealand no-fault schemes.

⁸⁶ See generally Davis et al., *supra* note 7; see also Davis et al.: *Preventable In-Hospital Medical Injury*, *supra* note 84.

⁸⁷ Davis et al., *supra* note 7, at 852.

⁸⁸ Soleimani NZ, *supra* note 1; Soleimani US, *supra* note 1.

⁸⁹ *Id.*

A. Survey Parameters

Both surveys posed a hypothetical medical error, asking physicians whether they would report the error to the patient and/or the hospital depending on whether the iatrogenic harm was minor, serious, or fatal.⁹⁰ The questionnaires then asked whether doctors felt more comfortable reporting to their hospitals or the patients involved.⁹¹ If they were reluctant to report, doctors were asked to rank five possible reasons: fear of patient anxiety, fear of losing patient trust, the threat of malpractice litigation (United States) or public outcry (New Zealand), professional discipline, and embarrassment among peers.⁹² Finally, the surveys asked whether doctors believed reporting would increase or decrease the chance of litigation or complaints.⁹³

In addition to the replacement of “public outcry” with “malpractice litigation,” the U.S. study also asked American doctors whether they felt obligated to report to a third party, and if so, to name the most appropriate party.⁹⁴

B. Results

In the New Zealand survey, Soleimani invited 292 doctors to participate online. Of those, 128 (45%) responded over the course of four months.⁹⁵ As expected, the physicians felt increasingly obligated to report the hypothetical error, either to the patient or hospital, as the seriousness of the resulting harm increased.⁹⁶ The most important results, however, were the doctors’ reasons for reluctance in reporting, and their perceptions about the consequences of reporting. New Zealand doctors most feared public outcry and losing patient

⁹⁰ Soleimani NZ, *supra* note 1, at 4; Soleimani US, *supra* note 1, at 6.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ See Soleimani US, *supra* note 1.

⁹⁵ See Soleimani NZ, *supra* note 1.

⁹⁶ *Id.* at 5.

trust, which had statistically similar rankings.⁹⁷ The respondents also overwhelmingly believed that disclosing errors to patients would *decrease* the chance of patient complaints, with only 14% disagreeing.⁹⁸

The American study provided strikingly similar results. Soleimani's American study received 103 responses from 130 distributed surveys (79%).⁹⁹ Overall, the respondents felt an increasing responsibility to report increasingly serious patient injuries.¹⁰⁰ They attributed their reporting reluctance to fear of losing patient trust and the threat of litigation, which also carried statistically equivalent weight.¹⁰¹ American doctors also overwhelmingly believed that reporting would reduce the likelihood of litigation, with 94% of respondents feeling this way.¹⁰² Additionally, 49% of the survey participants would report iatrogenic injuries to a third party, although the doctors specified six different third parties with varying frequency.¹⁰³

C. Observations

Soleimani's results suggest at least three important comparative conclusions about reporting in tort and no-fault systems:

(1) Doctors' reasons for avoiding reporting errors are similar in both countries. Doctors in both surveys feared losing patient trust, while American doctors worried about litigation and their New Zealand counterparts feared public outcry.

One question the data raises is whether the threats of "litigation" and "public outcry" are comparable. The possibility of litigation does not exist in New Zealand's no-fault system¹⁰⁴, but litigation arguably

⁹⁷ *Id.* at 7.

⁹⁸ *Id.* at 8.

⁹⁹ Soleimani *US*, *supra* note 1, at 5.

¹⁰⁰ *Id.* at 10.

¹⁰¹ *Id.* at 13.

¹⁰² *Id.* at 11.

¹⁰³ *Id.* at 10.

¹⁰⁴ Soleimani *NZ*, *supra* note 1, at 1.

produces similar effects that public outcry would in New Zealand: it hurts doctors' reputations, exposes them to public media scrutiny, and deters future business. While the two factors do not equate precisely, they are probably similar enough to warrant comparison. At the very least, for American doctors, the results confirm that "[i]t is this fear [of litigation] that overrides well-documented studies that repeatedly state that authentic apology is what both patients and physicians want."¹⁰⁵

(2) Both American and New Zealand doctors feel that increased reporting actually *reduces* the chances of litigation or public outcry.¹⁰⁶ Common sense suggests that reporting mistakes is dangerous to doctors' careers, but the vast majority of surveyed physicians believed that better reporting should correlate with *fewer* complaints.¹⁰⁷

(3) Finally, and most importantly, the survey data suggests that the mere presence of a no-fault system alone does not make doctors more likely to report than their counterparts in a tort environment, nor does it necessarily increase the proportion of compensated medical injuries. Studies of medical injuries in New Zealand show that the ratio of successful claims to potentially compensable claims compares to the ratio in the United States.¹⁰⁸ Soleimani's survey results show that doctors in both nations have similar reasons for staying quiet. Doctors would also report at comparable frequencies overall; in fact, for the minor injury posed in the surveys, American doctors felt a much greater obligation to report the harm to the hospital (83% versus 45%).¹⁰⁹

Soleimani's data provides a narrow but useful set of information about doctors' actual attitudes and perceptions. Most studies of no-fault systems focus on *ex ante* determinations of economic feasibility and defining compensable events; most quality improvement studies

¹⁰⁵ Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 83 (2005).

¹⁰⁶ Soleimani NZ, *supra* note 1, at 6; Soleimani US, *supra* note 1, at 11.

¹⁰⁷ *Id.*

¹⁰⁸ Soleimani NZ, *supra* note 1, at 2.

¹⁰⁹ Compare Soleimani US at 10, with Soleimani NZ at 5.

focus on *ex ante* systemic reform, administration, and technology. By looking at the mindset of real doctors, these studies provide more concrete information about the psychological barriers that health reforms must overcome. More studies are needed.

IV. RECOMMENDATIONS FOR ERROR REPORTING AND NO-FAULT REFORM

Having examined Soleimani's survey data, the next question is how this direct information about doctors' attitudes should affect health care reform proposals. These proposals fall into two categories: medical error reporting (part of the broader patient safety movement) and no-fault advocacy.

A. Implications for Error Reporting

The Institute of Medicine (IOM) sparked the patient safety movement with its 2000 report on medical error and resulting injuries.¹¹⁰ After reporting that between 44,000 and 98,000 patient deaths result from healthcare errors annually, the IOM forcefully recommended a nationwide system for reporting errors.¹¹¹ In the wake of this work, public concern peaked, and several reporting plans circulated through Congress.¹¹²

If it catalyzed the patient safety movement, the IOM report also ignited controversy. Many experts disputed the IOM's death estimates, observing that the error range was so significant—around 50%—that the statistics could support a finding that iatrogenic deaths *decreased* during the study period.¹¹³ Moreover, defining critical terms such as “medical error” and “adverse event” poses major

¹¹⁰ COMM. ON QUALITY OF HEALTH CARE IN AM., INSTITUTE OF MEDICINE, *TO ERR IS HUMAN* (Linda Kohn et al. eds., 2000), available at <http://books.nap.edu/books/0309068371/html/index.html>.

¹¹¹ Maxine Harrington, *Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made a Measurable Difference?*, 15 HEALTH MATRIX 329, 329-30 (2005).

¹¹² *Id.*

¹¹³ *Id.* at 332.

methodological obstacles.¹¹⁴ Some observers claim that the IOM fell victim to “hindsight bias” by assuming that doctors can guess *ex ante* whether an error will result in serious or minor injury.¹¹⁵ Others have even questioned what “patient safety” means.¹¹⁶

These issues are essential, complex, and beyond the scope of this Paper. Soleimani’s results speak to doctors’ perceptions about the importance of reporting and any perceived barriers to open reporting, without defining or asking participants to define “error” or other fundamental concepts.

What implications do the Soleimani surveys have for medical error reporting reform? This Section first peruses some mainstream proposals and existing reporting systems and then briefly discusses how our new knowledge about doctors’ attitudes should affect these plans.

1. Existing Error Reporting Systems

The IOM proposed a new, federally administered Center for Patient Safety, which would cull results from nationwide reporting.¹¹⁷ Under the proposal, the IOM suggested two types of reporting: (1) mandatory, nationwide reporting for errors causing death or serious injury; and (2) voluntary, but confidential reporting for “near-misses.”¹¹⁸ The Center for Patient Safety would centralize the nationwide reports and maintain robust confidentiality guidelines to encourage voluntary reporting for near-miss incidents.¹¹⁹ Congress has considered several bills for this system since 2000, but as of 2005 none have passed.¹²⁰

In response, the medical profession expressed strong

¹¹⁴ *Id.* at 342-43.

¹¹⁵ *Id.* at 342.

¹¹⁶ See generally Palmer, *supra* note 25, at 1614 (advocating increased reporting as integral to increasing the role of empirical data in patient safety analysis).

¹¹⁷ Harrington, *supra* note 112, at 355.

¹¹⁸ *Id.* at 351.

¹¹⁹ *Id.* at 355-56.

¹²⁰ *Id.* at 355-57.

reservations about the feasibility of the voluntary reporting prong. As Harrington observed: “Concern over the legal protection of data, including the lack of confidentiality of the reports, is a substantial impediment. Professional associations criticized the IOM’s call for a mandatory reporting system because it was perceived as punitive and a continuation of the blaming of individuals for medical errors, and not the systems in which they worked.”¹²¹

Another prominent reporting proposal is the voluntary Sentinel Event Policy (SEP) run by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). JCAHO accredits thousands of hospitals throughout the United States.¹²² The SEP asks that participating hospitals volunteer any serious injuries or deaths in their facilities.¹²³ Experts widely acknowledge that the SEP suffers from underreporting due to confidentiality concerns.¹²⁴

Several other systems exist for specialized reporting purposes. The Food and Drug Administration (FDA) runs MedWatch, which collects serious adverse reactions to FDA-regulated substances.¹²⁵ The Centers for Disease Control administer VAERS, the Vaccine Adverse Event Report System, which monitors unexpected reactions to vaccines.¹²⁶ The Veterans Administration has its own Patient Safety Reporting System that encourages physicians to volunteer safety incidents.¹²⁷ Unlike the IOM plan and JCAHO’s SEP, these plans cull data about very limited subject matter (drugs, vaccines) or are voluntary systems. Taken as a whole, all reporting systems sit on a sliding scale that compromises confidentiality with availability of information to the public or regulators, and voluntary versus mandatory reporting.¹²⁸

¹²¹ *Id.* at 353 (footnotes omitted).

¹²² See The Joint Commission, available at <http://www.jointcommission.org/aboutus>.

¹²³ Harrington, *supra* note 112, at 359-60.

¹²⁴ *Id.* at 360.

¹²⁵ *Id.* at 357.

¹²⁶ *Id.* at 357-58.

¹²⁷ *Id.* at 359.

¹²⁸ Studdert & Brennan: *No Fault Compensation*, *supra* note 20, at 218.

2. *Applying Soleimani's Results*

Soleimani's survey results provide helpful insights about the importance of confidentiality to error reporting. For example, of the 103 participating doctors in the American study, only one named the JCAHO Sentinel Event Policy as the primary third-party organization that should receive an error report.¹²⁹ Confidentiality is still important; but "confidentiality" really applies most strongly to patient trust, threats of litigation in the United States, or public outcry in New Zealand. In the surveys, embarrassment in front of colleagues was not as statistically significant.¹³⁰ Most doctors (90% in New Zealand, 86% in the United States) thought that reporting *reduces* the risk of patient repercussions, in either the form of litigation or public recrimination.¹³¹ If the error reporting system empirically confirmed this belief, doctors would probably worry less about confidentiality. The Veterans Administration experience in Lexington, Kentucky—where a policy of informing patients of mistakes and apologizing for them reduced litigation and strengthened doctor-patient relations—already supports this belief.¹³² If a no-fault reporting system can reduce litigation and distrust, confidentiality might not be a worrisome barrier for physicians.

Therefore, an ideal reporting mechanism should offer more incentives—either carrots or sticks—for doctors to report. In the context of a no-fault system, reporting information must be open within the compensation system for injuries—otherwise doctors cannot learn from their mistakes or near-misses. Next, if patients truly sue or file against doctors less often in a reporting environment that openly acknowledges mistakes and cooperates in the patient compensation process, confidentiality would lose some significance.

¹²⁹ Soleimani *US* at 10. More respondents (two) failed to specify a third party than chose the SEP. *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² See Taft, *supra* note 105, at 83.

B. Implications for No-Fault Systems

Since the Harvard Medical Practice Study, many reformers have advocated a multitude of proposals for how to tweak the basic no-fault model to make it viable in the United States. At the broadest and highest level, Studdert and Brennan argue that an ideal no-fault system must satisfy five requirements: (1) encourage reporting; (2) encourage quality improvement; (3) find and remove negligent doctors; (4) reinforce honesty in the doctor-patient relationship; and (5) compensate efficiently.¹³³

Within this general, idealized model, others have offered many specific, more specialized ideas for how to implement new no-fault systems.

1. Proposed No-Fault Reforms

Enterprise liability: No-fault advocates repeatedly suggest that enterprise liability—making hospitals and healthcare institutions responsible for compensable adverse events—best encourages reform.¹³⁴ Some of these advocates recommend enterprise liability within the existing tort framework.¹³⁵ In theory, enterprise liability should provide better incentives to hospitals,¹³⁶ which are better positioned than individual physicians to implement systemic improvements.¹³⁷

Caps on noneconomic damages: Restricting noneconomic damages is primarily a cost-saving measure to make no-fault more palatable to state governments. Virginia's BIF does not award noneconomic damages, while the NVICP caps them at \$250,000.¹³⁸ In practice, though, administrators could always adjust both economic and

¹³³ Studdert & Brennan: *No Fault Compensation*, *supra* note 20, at 219.

¹³⁴ See, e.g., *id.*; Angus Corbett, *Regulating Compensation for Injuries Associated with Medical Error*, 28 SYDNEY L. REV. 259 (2006) (supporting enterprise liability instead of usual no-fault injury categories in Australia).

¹³⁵ Mello & Brennan, *supra* note 18, at 1625-26.

¹³⁶ Studdert & Brennan: *No Fault Compensation*, *supra* note 20, at 221.

¹³⁷ Mello & Brennan, *supra* note 18, at 1625.

¹³⁸ 42 U.S.C. § 300(aa)-15(a)(4) (2006).

noneconomic damages to limit the cost of compensating more injuries under no-fault.

Arbitration: As in other tort contexts, arbitration could reduce the costs of settling contentious disputes that do not fall neatly within designated compensable events. Studdert and Brennan emphasize that patient notice and consent would be important in arbitration clauses for medical care contracts. They point to the Kaiser Permanente model for guidance.¹³⁹

Trials for bad doctors: As Gellhorn notes, every healthcare system—tort or no-fault—must contain a robust mechanism for identifying and removing negligent physicians.¹⁴⁰ Disciplining substandard caregivers should increase overall quality.

Neo no-fault: With this scheme, if doctors voluntarily compensate victims for medical injuries, patients would give up their right to sue.¹⁴¹ Supporters argue that fast, guaranteed payment of economic damages is rare for injury victims, which should offset any fairness concerns.¹⁴² Furthermore, neo no-fault gives correct incentives to doctors and insurers because they must pay for their errors, even if they avoid the stigma and delay of malpractice suits.¹⁴³

Modifying DCEs: Redefining the designated compensable events is comparable to capping payments—they are ad hoc ways to reduce costs or expand the degree of compensation.

Elective no-fault: Paul Weiler and others recommend that states use a form of elective no-fault, which makes participation by healthcare institutions voluntary at first, to ease transition to a more permanent system.¹⁴⁴

¹³⁹ Studdert & Brennan: *Toward a Workable Model*, *supra* note 40, at 235-36.

¹⁴⁰ Gellhorn, *supra* note 22, at 207.

¹⁴¹ Hall et al., *supra* note 10, at 381-82; *see also* Jeffrey O'Connell, *Neo-No Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125, 129 (1986) (O'Connell supported this idea, which was introduced in Congress).

¹⁴² O'Connell, *supra* note 141, at 130.

¹⁴³ *See generally, id.*

¹⁴⁴ Weiler, *supra* note 8, at 944.

2. *Applying Soleimani's Results*

Most of the listed proposals focus on manipulating system-wide costs or spreading the risk of expensive iatrogenic injuries. Adding or deleting injuries from the DCE lists and capping pecuniary or nonpecuniary damages are reforms targeting high costs. Proposals like arbitration, neo no-fault, and elective no-fault are meant to win public acceptance of a no-fault system in a traditional tort society. Some mechanisms, like enterprise liability, could promote quality improvement if data from medical mistakes goes towards physician education and improvement, but tweaks to liability are mostly aimed at making no-fault more palatable to the medical profession.

In the mix of reform suggestions, medical error reporting seems to take a back seat. Studdert and Brennan list reporting as their first requirement for an ideal no-fault program, but they also (a) separate it from quality improvement, their second requirement, and (b) focus their efforts on making no-fault affordable in test states like Colorado and Utah.¹⁴⁵ Most no-fault proposals mention doctor reporting of medical mistakes as an important source of statistical information or as data for adjusting probabilities and overall program effectiveness.¹⁴⁶

However, Soleimani's surveys are evidence that error reporting should play a stronger role in no-fault reform. The survey results show that doctors in New Zealand still hesitate to report medical errors, while American doctors are not only reluctant to file errors, but lack a consensus about where error reports should go.¹⁴⁷ Creating incentives to report are essential not just for statistical data-gathering purposes, but for reducing costs. If the vast majority of physicians on the front lines of medical care, in both the United States and New Zealand, correctly believe that increased reporting

¹⁴⁵ See generally Studdert & Brennan: *No Fault Compensation*, *supra* note 20. Studdert and Brennan clearly value quality improvement, but their efforts to win widespread acceptance of no-fault seem to focus on cost and efficiency issues. See, e.g., Studdert, et al., *supra* note 27 (presenting results of a study estimating the costs of a no-fault system based on the Swedish model).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

decreases the probability of patient complaints, then comprehensive reporting serves an essential role in reducing claims volume, and therefore costs. Furthermore, only by increasing reporting can doctors learn from their mistakes—precisely the goal that the more recent patient safety movement has championed.¹⁴⁸ From a high-level perspective, the ideal no-fault system must not only manage costs through manipulation of compensable events and damage caps, but must make reporting central to the system.

V. RECOMMENDATIONS: INTEGRATING REPORTING AND NO-FAULT

There is no reason why health law reform cannot integrate lessons from patient safety to enhance the transparency of medical error.

A. Learning from Patient Safety: Make Reporting More Central to the No-Fault System

It is mildly surprising that error reporting is not a stronger component of no-fault reform proposals. However, given the temporal mismatch or disconnect between the no-fault movement and the patient safety movement, this omission makes historical sense.

The no-fault movement gained its greatest momentum from the Harvard Medical Practice Study, released in 1992.¹⁴⁹ In response to the malpractice insurance crises of the 1970s and 1980s,¹⁵⁰ the Harvard Study dissected thousands of patient records from New York State for medical errors, minor and serious, and concluded that the incidence of adverse medical events and negligence in hospitals was considerably higher than most people expected.¹⁵¹ The Study found that 3.7% of patients hospitalized in 1984 suffered adverse

¹⁴⁸ See generally Palmer, *supra* note 25.

¹⁴⁹ HMPS, *supra* note 4; see also Mello & Brennan, *supra* note 18, at 1600-01.

¹⁵⁰ Grad, *supra* note 17, at 1059.

¹⁵¹ HMPS, *supra* note 4, at 152.

events, while 1.0% of patients experienced adverse events due to medical negligence.¹⁵² According to Troyen Brennan, one of the Harvard Study investigators, and his colleagues, the Study's advocates undertook the research in support of no-fault compensation.¹⁵³ Indeed, advocates like Studdert, Brennan, and Lucian Leape used the Harvard Study as a springboard to more empirical analyses of medical error and advocacy for no-fault reform.¹⁵⁴ This movement peaked in the early 1990s.¹⁵⁵

Although seemingly complementary to the no-fault movement, the so-called patient safety movement gained ground almost a decade later. The IOM's 2000 report, which emphasized deaths from medical error instead of the frequency of adverse events, caused a public uproar about hospital conditions.¹⁵⁶ The patient safety movement championed systemic, organic reforms to hospital operations, such as using computers to check automatically for medication conflicts, drastically shortening patient waiting times for care, and eliminating illegible doctor handwriting on prescriptions.¹⁵⁷

As previously discussed, these two movements—no-fault and patient safety—emphasize different reforms. But if no-fault is to succeed, reformers should revitalize no-fault proposals based on lessons learned about reporting from the patient safety movement. It

¹⁵² Troyen Brennan et al., *Incidence Of Adverse Events And Negligence In Hospitalized Patients*, 324 NEW ENG. J. MED. 370, 371 (1991).

¹⁵³ Mello & Brennan, *supra* note 18, at 1600.

¹⁵⁴ Leape and Brennan followed the Harvard Study with papers explaining the results, Brennan et al., *supra* note 152; see generally Lucian Leape et al., *The Nature Of Adverse Events In Hospitalized Patients*, 324 NEW ENG. J. MED. 377 (1991). In the following years, they released more research that tended to support no-fault, such as Studdert and Brennan's study of whether the Swedish system could be cost-effective in the test states of Utah and Colorado. See Studdert, et al., *supra* note 27.

¹⁵⁵ Mello & Brennan, *supra* note 18, at 1600.

¹⁵⁶ Harrington, *supra* note 111, at 329-30.

¹⁵⁷ One such advocate is Don Berwick of the Institute for Healthcare Improvement (<http://www.ihl.org>). See Charles S. Lauer, *Focusing on the Important Part: Radicalizing Experience Sends Berwick on a Mission to Put the Patient First*, MODERN HEALTHCARE, Feb. 9, 2004, at 22; Mark Murray & Donald M. Berwick, *Advanced Access: Reducing Waiting and Delays in Primary Care*, 289 JAMA 1035, 1039 (2003). For a recent example of simple technological reforms, see Julie Jette, *Computers Stem Chaos; Smooth Operating at Quincy Medical*, PATRIOT LEDGER, March 29, 2005, at 19.

is worth repeating the most important implications from the Soleimani studies: even in a robust no-fault system like New Zealand, doctors still hesitate to report, even though the overwhelming majority of physicians both abroad and in the United States believe that reporting should *reduce* patient litigation and complaints.¹⁵⁸

President Barack Obama's health care proposals during the 2008 presidential campaign suggested political support for increased error reporting may be rising. The Obama-Biden health plan listed error reporting as a priority, and would "require providers to report preventable medical errors."¹⁵⁹ The proposal would also "require hospitals and providers to collect and publicly report measures of health care costs and quality, including data on preventable medical errors"¹⁶⁰

Instead of cost reduction, reporting should be the centerpiece of no-fault reform. Not only is reporting practically useful for obtaining statistical data, such as that used in the Harvard and IOM studies, it is also morally essential for reducing medical error, improving quality, and bolstering public trust in health care.

B. Tie Reporting to the Patient Compensation Process

It is simple to say that reporting should be an important, or even the single most important priority. But how should reporting be structured within an ideal no-fault proposal?

1. Attach a Presumption of Compensability to a Doctor's Report

No-fault administrators can provide stronger incentives for doctors to report by tying the reporting process to the patient compensation process. Doctor reports of medical errors should assist

¹⁵⁸ See Murray & Berwick, *supra* note 157.

¹⁵⁹ Obama-Biden Health Plan, *available at* <http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf> (last visited Dec. 7, 2008). However, given the current tumultuous climate surrounding President Obama's healthcare plan, it is unclear whether these increased reporting requirements will ultimately be implemented.

¹⁶⁰ *Id.*

the patient's compensation process. In Sweden, for example, physicians lack opposing financial or professional interests against compensating injury victims, so they usually cooperate with patients.¹⁶¹ One method could be to attach to a physician error report a presumption in favor of the patient that the injury should be compensated. After all, if the doctor's first-hand experience confirms an injury-causing error, compensation should be uncontested. The presence of a report need not create that presumption by itself, to the extent that it overrules the system's list of designated compensable events, but it should be strong evidence in favor of a patient's case for monetary awards. This should gradually reduce doctors' fears of losing patient trust, which the Soleimani studies identified as the factor most influential on doctors' attitudes towards reporting errors, as patients learn that doctors will assist them in the administrative process in case something goes wrong in the hospital.

What about confidentiality? If patients receive doctors' error reports, doctors' reputations might suffer. However, the confidentiality of the error reports could be preserved through contractual agreements with the patients. But within the no-fault compensation system, the information should be public. If reporting information is kept confidential, the information, at least, should still be used to train doctors and improve quality going forward.

2. Provide Feedback to Doctors When They Do Not Report Compensable Injuries

One way to train doctors to report compensable injuries is with a new rule: if a patient suffers a designated compensable event and receives compensation, and the patient's physician failed to report the injury and error, then the doctor should receive feedback.

This feedback can be positive, for example, if offered in the form of constructive criticism and training. With the proper training system and attitudes, unreported mistakes could be used alongside reported mistakes to educate doctors about what injuries are legally and practically preventable; the closer that doctors' reporting habits match the predefined compensable events, the faster quality will

¹⁶¹ Danzon, *supra* note 13, at 90.

improve. This type of positive feedback could provide excellent day-to-day training that shows doctors precisely how to recognize medical errors, and how to both minimize those errors, and report them to help their patients.

The feedback could also be negative, such as discipline or experience-rating for professional purposes. Missed injury reports could be used internally within hospitals to review physicians and adjust their compensation or status. This data could also be published so that patients could choose doctors who not only minimize errors, but also report their mistakes accurately. Moreover, this data could help with Studdert and Brennan's third requirement for no-fault identifying and removing bad doctors.¹⁶² Even doctors who make relatively few mistakes, but fail to report those few compensable events, could be disciplined.

Whether the feedback from this rule is positive, negative, or a mixture of both, the records should be entered into a national practitioners' database, confidential from the public but accessible to researchers and administrators. This proposed rule would provide a wealth of information about how the definitions of compensable events match doctors' reporting and practice habits. Again, an ideal no-fault system should focus on quality improvement; collecting and analyzing reporting data furthers this purpose. Simplifying the DCEs would also facilitate physician error feedback. In the ideal no-fault system, some type of incentive—even if partially negative—must be used to align doctors' practices with established standards for care.

C. Provide a Patient's Advocate to Assist Compensation

Existing studies suggest that an intermediary between doctors and patients could improve relationships between care providers and recipients. Studdert and Brennan list doctor-patient trust as their fourth feature for an ideal no-fault system.¹⁶³ Likewise, Soleimani's surveys suggest that doctors already believe that patients will trust doctors more if doctors report more errors.¹⁶⁴ But both doctors and

¹⁶² Studdert & Brennan: *No Fault Compensation*, *supra* note 20, at 219.

¹⁶³ *Id.*

¹⁶⁴ Soleimani *NZ*, *supra* note 1, at 8; Soleimani *US*, *supra* 1, at 11.

patients need more information about the reporting process.

Existing no-fault reform proposals seem to focus on limiting litigiousness or tweaking liability. Arbitration limits patients' options, while enterprise liability tries to tie hospitals to their doctors' mistakes. However, instead of trying to redefine liability and limit costs, an ideal system should provide more information. Sweden, for example, provides social workers who inform patients about their compensation options.¹⁶⁵

As the Swedish experience suggests, a patient's advocate could be a powerful ally for both patients and doctors.¹⁶⁶ An advocate is familiar with how the no-fault compensation system operates, and could relay this information to patients and physicians. Injured patients would benefit from more information about how to receive money for medical mistakes; doctors would benefit from informed patients, especially if they receive feedback on their reporting habits. Information is critical to a no-fault system, and neutral, well-informed patient advocates are ideal for conveying information.

D. Implement a Time Window for Reporting

Another small but important reform could be to implement a fixed time window for reporting. Like a statute of limitations, a limited time window would encourage timely reporting, limit physicians' fears of adverse claims many months after treatment, and preserve evidence of injury. As an example, a principal objective behind New Zealand's 2005 reforms was to encourage early patient claims in order to facilitate timely provision of assistance.¹⁶⁷

E. Cultivate a Culture of Reporting and Openness in Medical Training

Teaching physicians to communicate more closely with patients and report mistakes is nothing new—the patient safety movement has strongly and rightly advocated such reforms. But medical

¹⁶⁵ Studdert, et al., *supra* note 27, at 6.

¹⁶⁶ *Id.*

¹⁶⁷ See Bismark & Paterson, *supra* note 79, at 280.

education should go a step farther and characterize error reporting as a regular part of a working system, just like any other medical recordkeeping—not as a dismal event to avoid. Reporting adverse vaccine reactions through VAERS, for example, does not come across as anyone's "fault," but rather a routine data-gathering process. Implementing digital technology to facilitate reporting would also lower the activation barrier for doctors. Again, none of these culture-based suggestions are truly novel, but they stem from reprioritizing reporting.

Overall, greater transparency would also be a great boon to an error reporting system. While an ideal system would keep specific reports confidential, it should expose its inner workings to patients. If patients understand how the system works and the bureaucratic channels through which their paperwork travels, they are more likely to participate and report compensable events.

VI. CONCLUSION

An ideal no-fault health compensation system must contain costs to gain acceptance in the United States. But making cost the highest priority is a mistake. When we query doctors about their attitudes toward reporting medical mistakes, as Soleimani has, the doctors say they still hesitate to report because they fear litigation, public outcry, and loss of patient trust. They also strongly believe that increased reporting correlates with reduced patient claim frequency. These results suggest that reporting should be the core of an ideal no-fault system. Reporting provides statistical information, increases the range of compensation, and has the potential to increase patient-physician trust and improve care quality through constructive feedback. No-fault advocates should focus their efforts on designing a robust reporting system instead of worrying exclusively about administrability and expense.