What Happened to No-Fault? The Role of Error Reporting in Healthcare Reform

Henry Y Huang
Farzad Soleimani
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 and looks to the patient safety movement and its focus on medical error reporting to suggest improvements to no-fault proposals. The Article looks specifically to surveys of doctors’ attitudes towards reporting in both the United States and New Zealand—providing a contrast between tort and no-fault approaches—conducted by Farzad Soleimani. 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. Soleimani’s data suggests that, more than costs or efficiency, error reporting should be the centerpiece of a no-fault system.

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. The push for quality reforms and error reporting, however, surfaced near the turn of the millennium. 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. And it 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 necessary) introduction to no-fault and current reform proposals in Parts 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, follow.

I. No-fault systems and medical error reporting: why a divergence?

Modern health care 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 some countries like New Zealand, where a no-fault system (NFS) compensates the injured without assigning legal blame to doctors.¹

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 DCEs²), along with a fixed schedule of damages, both economic and noneconomic. An administrative system then handles patient claims and resolves factual disputes, without officially penalizing physicians.³ In theory, no-fault systems should promote error reporting because they remove the negative consequences of litigation. The American Workers’ Compensation and automobile insurance systems are examples of no-fault compensation programs,⁴ though defining accidents and errors in those systems is probably less complicated than in medicine.

However, experts cannot be sure that no-fault alone really encourages more reporting or compensates more victims than tort-based systems. This issue is critical because many reform efforts, such as the World Health Organization’s “World Alliance on Patient Safety.” stress no-fault and the generalized importance of “reporting and learning” without connecting the two.⁵ 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.

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1 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 does.
3 See Mark A. Hall, Mary Anne Bobinski & David Orentlicher, Health Care Law and Ethics 357 (6th ed. 2003).
A. Criticisms of existing compensation systems

The central questions are why reporting and compensation are too infrequent, and 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 the critiques of each.

1. Tort

Criticism of the negligence-based tort system abounds. Observers claim that tort is inefficient: only 40% of medical malpractice insurance dollars go to the victims, while 90% of first-party health insurance dollars reach the insured.\(^6\) Not only does litigation undercompensate victims as a class, lawsuits consume time and delay awards to legitimate claimants. For injured patients, the litigation expense also deters small but legitimate claims, although some see this as a benefit.\(^7\) For physicians, litigation expenses lead to extremely high malpractice liability insurance premiums for certain specialties, such as obstetrics and gynecology, which sparked insurance “crises” in the mid-1970s and 1980s and, in some states, in the 2000s.\(^8\) Moreover, doctors have argued that steep litigation costs cause doctors to practice defensive medicine—unnecessary or harmful treatments used to avoid litigation. While health policy analysts dispute the true cost of defensive medicine (a questionable 2003 American Medical Association study


\(^7\) Id. at 86.

estimated that 30% of doctors pass on complex cases\(^9\), it remains a strong argument against the medical tort system. Other research has shown that malpractice litigation only minimally deters negligent or substandard care.\(^{10}\)

David Studdert and Troyen Brennan cite a less tangible harm from litigation: loss of trust in the doctor-patient relationship. Because it is so adversarial, “[m]alpractice litigation induces silence and bitterness.”\(^{11}\) This loss of trust is especially troublesome because most Americans may be willing to forgo blame for their medical injuries if they can get fair compensation.\(^{12}\) Malpractice suits also divert doctors’ professional attention from the hospital to the courtroom.\(^{13}\)

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.\(^{14}\) However, critics say that tort reforms are only stopgap tweaks to the system that do not address the underlying goal of improving patient safety.\(^{15}\)

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

\(^{9}\) Jordyn McAfee, Medical Malpractice Crisis Fractional or Fictional?, 9 Mich. St. J. Med. & Law 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.”).

\(^{10}\) Id.


\(^{13}\) Grad, supra note 8, at 1066.

\(^{14}\) Id. at 1076-85; Bovbjerg & Sloan, supra note 4, at 62.

injuries will be much more expensive in total than the present system because so many injuries
now are entirely uncompensated."\textsuperscript{16} 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.\textsuperscript{17} For example, New Zealand
redefined its list of compensable events, previously known as “medical misadventures,” in 1992
to reduce compensation costs.\textsuperscript{18} For these reasons, most no-fault advocates target the cost
problem in their research.

Critics also argue that no-fault produces the wrong incentives for doctors and victims.
Simply put, without fault in the compensation process, there is no (or at least less) stigma
associated with fault, and therefore less incentive to prevent mistakes.\textsuperscript{19} 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 appeal procedure.\textsuperscript{20} On the surface, Sweden’s system has
low overhead costs, but only because it “forgo[es] all links between compensation and injury
prevention.”\textsuperscript{21} Danzon also criticizes the New Zealand system because it eliminates “all links

\textsuperscript{16} HALL, supra note 3, at 358.
\textsuperscript{17} David Studdert, et al., Can the United States Afford a “No-Fault” System for Compensation of
Medical Injury?, 60 LAW & CONTEMP. PROBS. 1 (1997).
\textsuperscript{18} Davis, supra note 1, at 835-36.
\textsuperscript{19} Bovbjerg & Sloan, supra note 4, at 73. But it is not clear that no-fault eliminates all stigma
attached to medical mistakes. Farzad Soleimani, Learning from Mistakes in New Zealand
Hospitals: What Else Do We Need Besides “No-Fault”? 10 (forthcoming), suggests that doctors
in New Zealand still avoid reporting errors because of media reprisals, despite immunity from
legal blame.
\textsuperscript{20} Danzon, supra note 6, at 90.
\textsuperscript{21} Id. at 90.
between compensation and deterrence” of injuries, resulting in many unnecessary injuries and inappropriately compensated claims.  

So for 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.  

Furthermore, no-fault countries might not rigorously pursue negligent or incompetent doctors. For all these reasons, some countries like Canada have not rigorously pursued a change to no-fault.

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. The Section briefly discusses these programs and respective critiques. The following table summarizes these plans’ key features:

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22 Id. at 91. But injured New Zealand patients may still file complaints, which might provide some deterrent effect. See infra note 63.

23 Davis, supra note 1, 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, infra note 60, at 2.

24 Gellhorn, supra note 12, at 207.

<table>
<thead>
<tr>
<th>Compensable events</th>
<th>VA/FL NICA&lt;sup&gt;26&lt;/sup&gt;</th>
<th>NVICP&lt;sup&gt;27&lt;/sup&gt;</th>
<th>NZ</th>
<th>Sweden&lt;sup&gt;28&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined by BIF/NICA statutes</td>
<td>Vaccine Injury Table</td>
<td>“Treatment injuries”</td>
<td>SCE – uniform set of criteria based on “avoidability”</td>
<td></td>
</tr>
<tr>
<td>Disability threshold?</td>
<td>Yes: babies must have grievous birth-related neurological injuries; weight requirement (FL)</td>
<td>Yes: defined by Vaccine Injury Table</td>
<td>Yes: 10% injury and 13-week threshold 14 hospital days or 28 disability days</td>
<td>Yes: 10 hospital days or 30 sick days; deductible for injuries at 1/20th of a “base sum”&lt;sup&gt;29&lt;/sup&gt;</td>
</tr>
<tr>
<td>End of payments?</td>
<td>No: ongoing for child’s lifetime, with flexibility for changing expenses</td>
<td>No?</td>
<td>Yes: at 85% recovery</td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting – voluntary or involuntary?</td>
<td>Workers’ Comp. Commissions receive claims</td>
<td>Voluntary: through VAERS</td>
<td>Voluntary?</td>
<td>Involuntary: physician must file report if patient alleges injury.&lt;sup&gt;30&lt;/sup&gt;</td>
</tr>
<tr>
<td>Payment caps?</td>
<td>Yes: economics only (VA); $100k for noneconomics (FL)</td>
<td>Yes: $250k economics $30k cap for noneconomics</td>
<td>Yes: schedule</td>
<td>Yes: capped at 200 times a “base sum”</td>
</tr>
<tr>
<td>Discipline for bad doctors</td>
<td>?</td>
<td>NA</td>
<td>Handled by Accident Compensation Corporation&lt;sup&gt;31&lt;/sup&gt;</td>
<td>Patients can always file malpractice suits</td>
</tr>
<tr>
<td>Appeals possible?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</table>

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.\textsuperscript{32} 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.\textsuperscript{33} Both systems provide damages to the families of children suffering severe brain injuries from birth, with 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, and excludes genetic conditions.\textsuperscript{34}

While NICA may be “the most significant experiment with compensation for medical injury yet undertaken in the United States,”\textsuperscript{35} the results of these compensation experiments are mixed. In these two states, no-fault programs have reduced malpractice insurance premiums for obstetrics and gynecology specialists, with over 90\% of them choosing to participate in the program, and participation by Medicaid physicians increasing.\textsuperscript{36} However, detractors point out that the program is very narrow and provides little actual compensation. From 1989 through 1997, only 86 of 225 filing families received payments.\textsuperscript{37} If the no-fault review process denies them money, they can file malpractice claims as an additional remedy,\textsuperscript{38} and many qualifying


\textsuperscript{33} Bovbjerg & Sloan, \textit{supra} note 4, at 82 n.122, 84. Peter Davis notes that the New Zealand no-fault system originated with reforms to workers’ compensation as well.

\textsuperscript{34} \textit{Id.} at 90.


\textsuperscript{36} Bovbjerg & Sloan, \textit{supra} note 4, at 99-100.

\textsuperscript{37} Fritz & Brennan, \textit{supra} note 35, at 501.

\textsuperscript{38} Bovbjerg & Sloan, \textit{supra} note 4, at 89.
parents file both tort and no-fault claims. 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. 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.” Finally, most parents lack knowledge of how BIF and NICA operate, and must hire attorneys, 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 products liability litigation. These fears threatened the entire vaccination program because, with millions of distributed vaccines, the chances of some prohibitively expensive (and legitimate) lawsuits was quite high. 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. The law reflected a public consensus that neither the children nor the drug companies should pay for the costs of adverse reactions to vaccines.

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 presumptively compensable. If the injury falls outside the Table, the claimant must

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39 Fritz, supra note 35, at 499.
40 Bovbjerg & Sloan, supra note 4, at 84.
41 Id. at 88.
42 Steel, supra note 27, at 146.
44 Steel, supra note 27, at 146.
45 Id.
produce scientific evidence to a court-appointed special master to prove causation.\textsuperscript{46} Losing claimants can appeal to the Court of Federal Claims, or to the Federal Circuit.\textsuperscript{47}

On 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.\textsuperscript{48} 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.\textsuperscript{49} 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.\textsuperscript{50} Following a survey of 786 NVICP cases, Derry Ridgway concluded that the program suffers from problems common to all no-faults: the need for expensive counsel and experts, costly causation disputes, and resistance from the plaintiffs’ bar.\textsuperscript{51}

\textbf{3. The “European” no-fault plans}

In contrast to the piecemeal American approach towards no-fault, some European governments have adopted nationwide fault-free approaches to rectifying all medical injuries. These countries include Sweden, Finland, Denmark, and (not really European) New Zealand.

\textsuperscript{46} Id. at 154-59.\\
\textsuperscript{47} Id. at 158.\\
\textsuperscript{49} Steel, \textit{supra} note 27, at 170-71.\\
\textsuperscript{50} Id. at 165-66.\\
\textsuperscript{51} Derry, \textit{supra} note 48, at 85.
The most scholarship is available about the Swedish and New Zealand models, summarized in the table above. Sweden started its system in the 1970s in collaboration with insurance companies. A central administrative body, the FCC, decides all claims, usually within six months. Hospitals distribute information packets, while social workers explain how to file. Claimants denied compensation can appeal to a special panel, and then through arbitration. The system does not permit malpractice lawsuits. Furthermore, Sweden applies a minimum injury threshold for compensation: the victim must suffer ten days in a hospital or thirty sick days from work. Sweden controls costs by adjusting the predefined compensable injuries—Swedish Compensation Events (SCEs)—payments, and allowable claims.

New Zealand initiated its system in 1972 with the Accident Compensation Act, abolishing tort liability for medical mishap. The Accident Compensation Corporation handles all claims based on designated compensable events (DCEs), revised periodically, most recently in 1992. In 2005, New Zealand introduced the new term “treatment injury” to include all injuries suffered during treatment from health professionals. New Zealand also uses a disability

52 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 17, at 3. The most comparisons of American tort and foreign no-fault seem to center around New Zealand. See, e.g., Gellhorn supra note 12; Davis, supra note 1.
53 Studdert, et al., supra note 17, at 5-6.
54 Id. at 6.
55 Id. at 6.
56 Davis, supra note 1, at 835-36.
57 Weiler, supra note 2, at 933.
58 Davis, supra note 1, at 836.
threshold—fifteen hospital days or twenty-eight disability days out of work\textsuperscript{60}—and ends payments to patients once they reach 85\% recovery.\textsuperscript{61}

Critiques of these systems come from all quarters. Some focus on unmanageable system costs and underdeterrence of substandard service, as Section I(A)(2) discussed. Other scholars claim that no-fault simply fails to compensate more people than a traditional tort approach. Based on empirical studies of New Zealand no-fault medical claims, Peter Davis concludes that New Zealanders bring no 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.”\textsuperscript{62} Additionally, the New Zealand system still permits patient complaints with the Health and Disability Commissioner that are independent of any claims for compensation.\textsuperscript{63}

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

\textsuperscript{60} Studdert & Brennan, \textit{ supra} note 28, at 232.
\textsuperscript{61} Studdert et al., \textit{ supra} note 17, at 15.
\textsuperscript{62} Davis, \textit{ supra} note 1, at 851-52; Peter Davis et al., \textit{Preventable In-Hospital Medical Injury Under the “No Fault” System in New Zealand}, 12 \textit{QUALITY & SAFETY IN HEALTH CARE} 251, 256 (2003).
\textsuperscript{63} \textit{See} http://www.hdc.org.nz/complaints/making-a-complaint.
barriers to potential claimants because of attorney and expert fee caps. And as Davis’s work tends to show, even New Zealand’s nationwide plan produces relatively few legitimate claims.

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 that the quality of the respective services has increased, or that adverse events are used in a constructive, educational way to improve quality going forward. In New Zealand at least, claims data suggests that 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.

II. 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.64 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. These

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64 Farzad Soleimani, Physicians’ Attitudes Towards Reporting Different Types of Medical Errors and Their Perceived Possibility of Lawsuits if They Report [hereinafter Soleimani US] (forthcoming); Farzad Soleimani, Learning from Mistakes in New Zealand Hospitals: What Else Do We Need Besides “No-Fault”? [hereinafter Soleimani NZ] (forthcoming).
questionnaires provide direct, first-hand opinions about doctors’ attitudes towards reporting under both the American tort and the New Zealand no-fault schemes.

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. The questionnaires then asked whether doctors felt more comfortable reporting to their hospitals or the patients involved. 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. Finally, the surveys asked whether doctors believed reporting would increase or decrease the chance of litigation or complaints.65

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.66

B. Results

In the New Zealand survey, Soleimani invited 292 doctors to participate online. Of those, 128 (44%) responded over the course of four months.67 As expected, the physicians felt increasingly obligated to report the hypothetical error, either to the patient or hospital, as the

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65 Soleimani US at 6, Soleimani NZ at 4.
67 Soleimani NZ at 1.
seriousness of the resulting harm increased. 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 trust, which had statistically equal rankings. The respondents also overwhelmingly believed that disclosing errors to patients would decrease the chance of patient complaints, with only 14% disagreeing.

The American study provided strikingly similar results. Soleimani’s American study received 103 responses from 130 distributed surveys (79%). Overall, the respondents felt an increasing responsibility to report increasingly serious patient injuries. They attributed their reporting reluctance to fear of losing patient trust and the threat of litigation, which also carried statistically equivalent weight. And American doctors also overwhelmingly believed that reporting would reduce the likelihood of litigation, with 94% of respondents feeling this way. 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.

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

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68 Id. at 5.  
69 Id. at 6.  
70 Soleimani US at 5.  
71 Id. at 10.  
72 Id. at 13.  
73 Id. at 11.  
74 Id. at 10.
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 system, but litigation arguably produces similar effects that public outcry would in the United States: 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.”

(2). Both American and New Zealand doctors feel that increased reporting actually reduces the chances of litigation or public outcry. 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.

(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. 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%).

76 Soleimani NZ at 2.
77 Compare Soleimani US at 10, with Soleimani NZ at 5.
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 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.

III. 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. 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. In the wake of this work, public concern peaked, and several reporting plans circulated through Congress.

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

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significant—around 50%—that the statistics could support a finding that iatrogenic deaths decreased during the study period.\textsuperscript{80} Moreover, defining critical terms such as “medical error” and “adverse event” poses major methodological obstacles. 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.\textsuperscript{81} Others have even questioned what “patient safety” means.\textsuperscript{82}

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. 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.”\textsuperscript{83} The Center for Patient Safety would centralize the nationwide reports and maintain robust confidentiality guidelines to encourage

\textsuperscript{80} Id. at 331.
\textsuperscript{81} Id. at 343.
\textsuperscript{82} See generally Palmer, supra note 15.
\textsuperscript{83} Harrington, supra note 79, at 351.
voluntary reporting for near-miss incidents. Congress has considered several bills for this system since 2000, but none have passed as of 2005.\footnote{Id. at 355-57.}

In response, the medical profession expressed strong 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.”\footnote{Id. at 353 (footnotes omitted).}

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.\footnote{See The Joint Commission, http://www.jointcommission.org/AccreditationPrograms.} The SEP asks that participating hospitals volunteer any serious injuries or deaths in their facilities.\footnote{Harrington, supra note 79, at 359-60.} Experts widely acknowledge that the SEP suffers from underreporting due to confidentiality concerns.\footnote{Id. at 360.}

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.\footnote{Id. at 358.} The Centers for Disease Control administers VAERS, the Vaccine Adverse Event Report System, which monitors unexpected reactions to vaccines.\footnote{Id. at 358-59.} The Veterans Administration has its own Patient Safety Reporting System that encourages physicians to
volunteer safety incidents. 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.

2. Applying Soleimani’s results

Soleimani’s survey results provide helpful insights about the importance of confidentiality to error reporting. As an 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. Confidentiality is still important; but “confidentiality” really applies most strongly to patient trust, and to the 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. 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. 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 support this belief. If a no-fault reporting system can reduce litigation and distrust, confidentiality might not be a worrisome barrier for physicians.

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91 Id. at 359.
92 Studdert & Brennan, supra note 11, at 218.
93 Soleimani US at 10. More respondents (two) failed to specify a third party than chose the SEP.
94 See Taft, supra note 75, at 83.
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.

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.95

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

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95 Studdert & Brennan, supra note 11, at 221.
encourages reform. Some of these advocates recommend enterprise liability within the existing tort framework. In theory, enterprise liability should provide better incentives to hospitals, which are better positioned than individual physicians to implement systemic improvements.

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. In practice, though, administrators could always adjust both economic and 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, and point to the Kaiser Permanente model for guidance.

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. 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. Supporters argue that fast and guaranteed

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97 Mello, supra note 9, at 1624.
98 Studdert & Brennan, supra note 11, at 221.
99 Mello, supra note 9, at 1625.
100 42 U.S.C. § 300(aa)-10.
101 Studdert & Brennan, supra note 28, at 235.
102 Gellhorn supra note 24.
payment of economic damages is rare for injury victims, which should offset any fairness concerns.\textsuperscript{104} 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.

\textit{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.

\textit{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.\textsuperscript{105}

\section*{2. Applying Soleimani’s results}

Most of the listed proposals focus on manipulating systemwide 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 no-fault 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

\begin{flushright}
\textsuperscript{103} HALL, supra note 3, at 359. Jeffrey O’Connell, \textit{Neo-No Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives}, 49 LAW & CONTEMP. PROBS. 125, 129 (1986), supported this idea, which was introduced in Congress.
\textsuperscript{104} O’Connell, \textit{supra} note 103, at 130.
\textsuperscript{105} Weiler, \textit{supra} note 2, at 936.
\end{flushright}
efforts on making no-fault affordable in test states like Colorado and Utah. 106 Most no-fault proposals mention doctor reporting of medical mistakes as an important source of statistical information, or data for adjusting probabilities and overall program effectiveness.

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. 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 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. 107 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.

IV. 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

106 See generally Studdert & Brennan, supra note 11. 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 17.

107 See generally Palmer, supra note 15.
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. In response to the malpractice insurance crises of the 1970s and 1980s, 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. The Study found that 3.7% of patients hospitalized in 1984 suffered adverse events, while 1.0% of patients experienced adverse events due to medical negligence. 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. 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. This movement peaked in the early 1990s.

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

109 Grad, supra note 8, at 1059.
110 HMPS.
112 Mello, supra note 9, at 1600.
113 Leape and Brennan followed the Harvard Study with papers explaining the results, Brennan et al, supra note 111; 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. Studdert, et al., supra note 17.
114 Mello, supra note 9, at 1600.
emphasized deaths from medical error instead of the frequency of adverse events, caused a public uproar about hospital conditions. But 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.

We have already seen in the previous Section that these two movements—no-fault and patient safety—emphasize different reforms. But if no-fault is to succeed, reformers should revitalize no-fault proposals with lessons about reporting from the patient safety movement. It 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.

Barack Obama’s health care proposals suggest that political support for increased error reporting may be rising. The Obama-Biden health plan lists error reporting as a priority, and would “require providers to report preventable medical errors.” The President-elect also promises to “require hospitals and providers to collect and publicly report measures of health care costs and quality, including data on preventable medical errors . . .”

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115 Harrington, supra note 79, at 329-30.
118 Id.
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 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 important, or even the single most important
priority—many healthcare reform advocates would agree. 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 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.\textsuperscript{119} One method would 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—

\textsuperscript{119} Danzon, \textit{supra} note 6, at 90.
tied for the most influential factor in the Soleimani studies—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 must be open. If reporting information is kept confidential from the public, the information 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, the doctor should receive feedback.

This feedback can be positive, 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 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, in the form of discipline or experience-rating for professional purposes. Missed injury reports could be used within hospitals internally, 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 report their mistakes accurately.
Moreover, this data could help with Studdert and Brennan’s third requirement for no-fault—identifying and removing bad doctors. 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 mix of both, the records should enter a national practitioners’ database, confidential from the public but accessible to researchers and administrators. This proposed rule should 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, and collecting and using data about reporting furthers this purpose. Simplying the DCEs would also facilitate physician feedback on errors. But 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. Likewise, Soleimani’s surveys suggest that doctors already believe that patients will trust doctors more if doctors report more errors. But both doctors and 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.\textsuperscript{120}

As the Swedish experience suggests, a patient’s advocate could be a powerful ally for both patients and doctors. Such an advocate could be familiar with how the no-fault compensation system operates, and 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, as discussed above. Information will be critical to a no-fault system, and neutral, well-informed patient advocates would be an ideal way to convey information.

\textbf{D. Implement a time window for reporting}

Another small but important reform would 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 to facilitate timely provision of assistance.\textsuperscript{121}

\textbf{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 education should go a step farther and characterize error reporting as a regular part of a working system, just like any other medical recordkeeping, and not a dismal event to avoid.

\textsuperscript{120} Studdert, \textit{supra} note 17, at 6.
\textsuperscript{121} See Bismark & Paterson, \textit{supra} note 59.
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 where their paperwork travels, they are more likely to participate and report compensable events.

**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 towards 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.