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No-Fault Solutions to the Problem of Medical Injuries: A Focus on Sweden as a Model*

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The medical malpractice tort system in the United States is based on three main goals: deterrence of unsafe practices, compensation for injured persons, and corrective justice.¹ The tort system is not accomplishing these goals. Recurring medical injuries, uneven payment of damages, and a lack of clearly defined success and fairness in the justice system render the current medical malpractice system largely ineffective.

In 2000, the Institute of Medicine reported that medical errors in hospitals cause as many as 98,000 deaths per year. This report and others² call attention to the question of whether or not the tort system properly deters medical error.³ The

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¹ Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 57 (1998); see also David M. Studdert, Michelle M. Mello, & Troyen A. Brennan, *Health Policy Report: Medical Malpractice*, 350 NEW ENG. J. MED. 283, 283 (2004).

² See Jeremy Coylewright, *No Fault, No Worries...Combining a No-Fault Medical Malpractice Act a the National Single-Payer Health Insurance Plan*, 4 IND. HEALTH LAW REVIEW 31, 37 (2007) (citing a Harvard study showing that only 12.5% of injured patients actually filed suit against their providers, and only a fraction of those claimants "actually recover any form of economic compensation..."); see also Studdert, Mello, & Brennan, *supra* note 1, at 285 (stating that a Harvard Study found "alarming estimates of the burden of medical injury...").

³ See Studdert, Mello, & Brennan, *supra* note 1, at 285 ("[E]vidence that the system deters medical negligence can be characterized as limited at best.").

litigation process is often lengthy and expensive.⁴ The injured are not always fairly compensated; awards frequently vary for similar injuries.⁵ Often doctors' malpractice insurance is so high they are forced to leave the practice of medicine, or alternatively practice in a different state with lower premiums.⁶ The adversarial nature of litigation pits patient against provider, which weakens the doctor-patient relationship. Injured persons may not receive justice and fairness because they may not be compensated equitably and within a reasonable amount of time after being injured.

An optimal medical liability system improves patient care and safety, works to prevent medical errors, and compensates injuries.⁷ Myriad solutions have been proposed as alternatives to the existing tort system.⁸ A no-fault solution to the problem of medical injuries would radically change the current mindset regarding medical injury in the United States. No-fault poses an interesting, and perhaps viable, alternative to the current tort system.

Section I of this article discusses the concepts of a no-fault system for medical injuries, including legislative reform, contract reform, and the pros and cons to such a system. Section II focuses on Sweden's no-fault model of compensation for medical injury. Finally, Section III analyzes how this system would work in the United States and the prospects of no-fault solutions for the problem of medical injuries in the United States.

⁴ See RANDALL R. BOVBJERG & BRIAN RAYMOND, KAISER PERMANENTE INST. FOR HEALTH POLICY, PATIENT SAFETY, JUST COMPENSATION AND MEDICAL LIABILITY REFORM 8 (2003), available at http://www.kpihp.org/publications/docs/patient_safety.pdf (stating that the average litigation time period for medical malpractice cases was 45 months); see also Jeffrey O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125, 125 (1986) [hereinafter *Neo-No-Fault Remedies*].

⁵ BOVBJERG & RAYMOND, *supra* note 4, at 9 ("[R]elatively minor injuries tend to be overcompensated relative to economic loss and more serious injuries under-compensated."); see also Jeffrey O'Connell, *A "Neo No-Fault" Contract in Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers*, 73 CAL. L. REV. 898, 899 (1985) [hereinafter *Neo No-Fault Contract*] (characterizing the tort system as a "lottery").

⁶ BOVBJERG & RAYMOND, *supra* note 4, at 4.

⁷ David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 219 (2001) [hereinafter *Error Prevention*].

⁸ Studdert, Mello, & Brennan, *supra* note 1, at 288-89 (citing different reforms or overhauls of the tort system that have been implemented or considered, including mediation, medical courts, arbitration, damages caps, attorney fee limits, and enterprise liability).

I. CONCEPTS OF A NO-FAULT SYSTEM FOR MEDICAL INJURIES

A no-fault compensation system (NFCS) for medical injuries would completely overhaul the current tort liability system. The claimant must prove four elements in the tort-based model for medical injury: duty, injury, causation, and negligence.⁹ The Restatement (Third) of Torts, in speaking to the negligence doctrine, states that "[a]n actor ordinarily has a duty to exercise reasonable care when the actor's conduct creates a risk of physical harm."¹⁰ Thus, doctors have a duty to exercise reasonable care to avoid causing physical harm to their patients. Patients bring injury claims based on this negligence doctrine when they believe a doctor has violated the duty owed to the plaintiff patient through this negligence standard of conduct which, for a physician, is the requirement to exercise the "knowledge, skill and care ordinarily possessed and employed by members of the profession..."¹¹ Many of these injury claims either "never reach the courts or, if litigated successfully, result in recovery which is not rationally related to the nature and scope of the wrong."¹² In addition, the negligence-based malpractice system results in prohibitive costs for provider malpractice insurance, which increases the costs of medical care.¹³

The goal of no-fault is to "improve upon the injury resolution of tort liability by replacing the existing fault remedy and liability insurance with a new no-fault alternative..."¹⁴ NFCSSs "eliminate the requirement of proving negligence."¹⁵ Further seeking to improve upon compensation and justice for those injured, no-fault's broadened eligibility scheme covers more individuals and eases access by "lowering the difficulties for asserting a claim."¹⁶ No-fault may

⁹ *Error Prevention*, *supra* note 7, at 219.

¹⁰ RESTATEMENT (THIRD) OF TORTS: LIAB. PHYSICAL HARM § 7 (2005).

¹¹ W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 187 (5th ed. 1984).

¹² Josephine Y. King, *No Fault Compensation for Medical Injuries*, 8 J. CONTEMP. HEALTH L. & POL'Y 227, 228 (1992).

¹³ Studdert, Mello, & Brennan, *supra* note 1 at 286 (discussing that tort law increases costs and encourages defensive medicine, including ordering of tests and procedures that are of marginal or no medical benefit).

¹⁴ Bovbjerg & Sloan, *supra* note 1, at 64.

¹⁵ *Error Prevention*, *supra* note 7, at 219.

¹⁶ Bovbjerg & Sloan, *supra* note 1, at 65,

also improve deterrence of injuries, as better monitoring of injuries, “expert resolution of claims,” and “systematic case finding,” including improved incentives for doctors and hospitals, may prevent injuries.¹⁷ A NFCS offers an appealing alternative to the current system by better achieving the goals of compensation, deterrence, and justice. A NFCS could be implemented through legislative channels, private contract, or a comprehensive no-fault system. Sweden’s comprehensive no-fault payment system for medical injuries is a useful model to examine. While opponents of no-fault cite excessive cost, causation issues, and lack of deterrence for arguments against such a system, policymakers in the United States can draw on Sweden’s experience to reform our current tort system.

A. *Legislative Reform*

No-fault legislative reform could take a number of approaches, from covering only certain types of injuries to a comprehensive medical liability scheme. Congress has proposed statutory no-fault compensation plans in the past.¹⁸ For example, a healthcare provider facing a potential tort claim would have the option to foreclose any claim for personal injury against him or her by offering, within a brief fixed time, periodic payments toward the claimant’s net economic loss.¹⁹ By statute, this tendered offer would foreclose any personal injury claim.²⁰ Such a statute either could be implemented on a state-by-state or national level. The statute could be designed to give a potential plaintiff the option to choose between a definite recovery of net economic loss or pursue a claim in tort.²¹ Alternatively, the statute could give the potential claimant no

¹⁷ *Id.*

¹⁸ *Neo-No-Fault Remedies*, *supra* note 4, at 129.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

option to refuse the tendered offer.²² The logistics would depend on the legislature and the proposal.²³

B. Private Contract

A no-fault system would be a controversial change from the current tort system. Because legislatures, both state and national, are reluctant to pass contentious statutes, private contract reform may offer a less divisive and challenging mechanism for implementing a no-fault system. Jeffrey O'Connell is the primary proponent of what he calls a "neo no-fault contract," agreed upon before a medical intervention, which would guarantee a post-medical intervention settlement offer.²⁴ At the time a patient meets with a doctor, the provider would "bind itself to offer no-fault benefits for economic . . . loss in the event of a resulting personal injury."²⁵ Prior to treatment, the patient would sign a contract with the doctor or organization accepting the no-fault benefits in lieu of a tort claim if he or she subsequently was injured.²⁶ The patient would be fully informed of his or her waiver of the right to sue in tort. The contract could be structured to exclude smaller cases; for example, "the contract could include a deductible of \$10,000 of actual medical expense or wage loss below which the tender need not be made."²⁷

This scheme would not place blame on the provider or serve as an admission of fault because the patient and doctor agreed beforehand to tender the offer in case of an adverse outcome.²⁸ Insurance companies might embrace this scheme because they would not be at risk of paying large, outlying awards won in litigation for pain and suffering. They also would improve their ability to predict

²² *Id.*

²³ See *Neo-No-Fault Remedies*, *supra* note 4, at 134-35 (discussing several parts to such plans, including exclusion of smaller claims before a provider makes a tender offer and including reasonable attorneys' fees in connection with the payment).

²⁴ *Neo No-Fault Contract*, *supra* note 5, at 906-07.

²⁵ *Id.* at 906.

²⁶ *Id.*

²⁷ *Id.* at 909.

²⁸ See *id.* at 910.

payments. Patients would bargain for the opportunity to receive faster payment for their injuries without the uncertainty of litigation. Doctors may appreciate the ease of payment and lack of blame for their actions. As the settlement offer is no longer discretionary, a “defendant [doctor] or an insurer need not fear that the offer to cover net economic loss will be perceived simply as an opening bid or as a signal of weakness,” which in the current system can encourage plaintiffs and attorneys to delay proceedings to obtain a larger settlement.²⁹

In contrast to a binding contract, an injured party could be given the option to accept the tendered offer for net economic loss within a certain time period or file a tort claim.³⁰ It is unclear if this method would result in adverse selection, with those parties with greater injuries and stronger claims pursuing the claim in tort, thus negating the positive effects the private contract method would have on the existing malpractice tort system and insurance.³¹ However, parties who have suffered injuries may be averse to risk and therefore choose to accept certain, prompt payment over uncertain, delayed awards.³²

With either statutory or contractual no-fault, the system could be designed to impose the duty to tender an offer upon the injuring party or allow the injuring party the opportunity to choose to tender or risk a tort suit.³³ Similarly, either system could compel the injured party to accept the tendered offer by pre-determined agreement or allow the party to accept or reject the offer for net economic loss and pursue in tort.³⁴ The designer of the individual proposal would determine which options to apply.

²⁹ *Neo-No-Fault Remedies*, *supra* note 4, at 132.

³⁰ *Id.*

³¹ *Neo No-Fault Contract*, *supra* note 5, at 911.

³² *Id.*

³³ *Neo-No-Fault Remedies*, *supra* note 4, at 135-36.

³⁴ *Id.* at 136.

C. Comprehensive No-Fault Compensation

In a comprehensive no-fault compensation system, “the injurer must tender, and the injured party must accept.”³⁵ This scheme makes medical providers strictly liable “for reimbursing losses due to preventable injury, completely eliminating the requirement for any injured patient to prove provider negligence in court.”³⁶ Patients would be entitled to compensation when they suffer a disability caused by medical treatment “irrespective of whether the treatment was negligent.”³⁷ The compensable event is based on preventability instead of negligence.³⁸ However, questions such as “just what constitute[s] an injury, how noneconomic loss such as pain and suffering [will] be determined and quantified, and how . . . [damages will] be apportioned among multiple participants in the course of treatment” remain.³⁹ The NFCS could use a medical panel to determine what constitutes an injury and if the injury was preventable, or the system could rely on a pre-determined list of avoidable class of events to make such a decision.⁴⁰

An enterprise liability system would help solve the problem of damage apportionment and also would improve patient safety. It has been documented that the “aberrant behavior of individual providers is a relatively infrequent explanation for harm,” and instead the “greatest potential for patient safety advances” lie in “institutional... accountability.”⁴¹ Many comprehensive no-fault schemes suggest an enterprise liability system “whereby the hospital [or healthcare provider] is responsible for the no-fault premiums.”⁴² In such a system, doctors affiliate with a hospital or other healthcare organization, and this

³⁵ *Id.*

³⁶ BOVBJERG & RAYMOND, *supra* note 4, at 20.

³⁷ Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 920 (1993).

³⁸ BOVBJERG & RAYMOND, *supra* note 4, at 20.

³⁹ COMMITTEE TO STUDY ALTERNATIVES TO THE PRESENT SYSTEM, PHYSICIAN INSURERS ASSOCIATION OF AMERICA, A COMPREHENSIVE REVIEW OF ALTERNATIVES TO THE PRESENT SYSTEM OF RESOLVING MEDICAL LIABILITY CLAIMS 52 (1989).

⁴⁰ BOVBJERG & RAYMOND, *supra* note 4, at 20.

⁴¹ *Error Prevention*, *supra* note 7, at 221.

⁴² Chandler Gregg, Comment, *The Medical Malpractice Crisis: A Problem with No Answer?*, 70 MO. L. REV. 307, 332 (2005).

entity becomes the principal target of liability.⁴³ Individual doctors would no longer “bear the costs associated with an injury.”⁴⁴ The enterprise—in this case the hospital, health plan, or other physician-employing organization—“would be ‘strictly liable’ in both a legal and economic sense by meeting the costs of liability premiums for all affiliated staff.”⁴⁵ The hospital takes out insurance and becomes exclusively liable for injuries that occur within the hospital. The hospital or organization then implements safety measures based on the doctors’ individual reporting of events and can take a proactive approach internally to evaluate their doctors without passing the “fault” of the injurious event onto the doctors themselves.⁴⁶ The hospital or provider organization will assume the fault for the medical error, rather than the physician. Doctors should have greater incentive to report events because they will not face the negative image of a malpractice lawsuit.

Enterprise liability has the potential to greatly improve patient safety as well. Errors are best addressed not with each individual physician, but with a holistic approach, focusing on the entire system in which health care delivery takes place. The “benefits of knowledge about preventable events outweigh the costs associated with short-term premium increases” because the hospital can design system improvements to reduce error, which will “lead to lower premiums in the long run.”⁴⁷ Systematic error reduction will be realized by addressing the “environment in which individuals doctors and nurses work.”⁴⁸ Hospitals and large “health care organizations are in a far better position than individuals providers to see opportunities to improve patient safety and to act on those insights.”⁴⁹ Enterprise liability thus theoretically incentivizes doctors to report

⁴³ Weiler, *supra* note 37, at 920.

⁴⁴ *Error Prevention*, *supra* note 7, at 221.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ Philip G. Peters, Jr., *Resuscitating Hospital Enterprise Liability*, 73 Mo. L. REV. 369, 379 (2008).

⁴⁹ *Id.* at 378.

errors and improves patient safety, paving the way for a comprehensive no-fault compensation system.

The process for a NFCS would be relatively straightforward. After a patient is injured as a result of medical treatment, he or she would submit a claim through an administrative process, perhaps to a medical screening panel, to determine whether the treatment caused the injury.⁵⁰ Administration of this scheme “would reside in a specialized and accessible tribunal that would utilize explicit criteria and schedules to decide what events are compensable and what payments are appropriate.”⁵¹

Designated compensable events (DCEs) have been proposed as a way to determine which medical procedures and injuries are compensable.⁵² DCEs are “formulas that spell out that if a patient undergoes a certain medical procedure . . . and later displays a particular outcome . . . , the latter injury would automatically be compensable to the extent it produces the kinds of disabling loss that are covered by the plan’s benefit schedule.”⁵³ Administrators can use DCEs to save time by applying the formulas to stated claims, “saving them from having to conduct a full-scale inquiry about medical causation in each individual case.”⁵⁴ DCEs lower costs by reducing time spent on determining compensable injuries and damages.

D. Pros and Cons to No-Fault

There are strong arguments for and against a NFCS for medical injuries. Proponents of the system cite the fair, more efficient compensation. No-fault allows more claimants to receive damages for their injuries because it removes the barrier of requiring a finding of negligence before compensating for an injury.⁵⁵

⁵⁰ See Weiler, *supra* note 37, at 928-29.

⁵¹ *Id.* at 920.

⁵² *Id.* at 933.

⁵³ *Id.* at 932.

⁵⁴ *Id.*

⁵⁵ PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 147 (1993) (“[C]urrently only a tiny fraction of

A claimant is compensated for an injury regardless of negligence, thus enveloping many more injured parties into the scheme.⁵⁶ Injured parties receive the compensation more quickly and efficiently through a streamlined administrative body, rather than through the slow and costly tort system.⁵⁷ Proponents also point to benefits for physicians, such as lower malpractice premiums and a less adversarial arrangement between patient and provider.⁵⁸ Physicians and injured parties are spared the uncertainty and indignity of a trial. Physicians can focus on practicing medicine, instead of worrying about whether their insurance premiums will become prohibitive to their practice.

Opponents of the no-fault scheme often cite excessive cost as a negative factor. While the system may not save a great amount, as it compensates more total claimants, no-fault payments could be capped at a pre-determined dollar amount, or could “concentrate liability dollars on victims of longer-term injuries...”⁵⁹ It is also important to note that “the size of any one damage award would typically be more modest than the magnitude of damages paid under the current open-ended regime of tort damages for both financial losses and pain and suffering,” revealing further potential for cost savings.⁶⁰ Total costs depend on the individual system design. However, administrative and legal expenses are greatly reduced in a no-fault system, offsetting other cost increases brought about by increased claimants or severely injured claimants.⁶¹

In addition, some compensation plans target funds to the most significantly disabled victims to save costs, with a deductible based either on duration of disability or dollar amount of loss.⁶² Excluding “more numerous short-lived disabilities” and focusing on the “longer-lasting disability[ies] that

negligently injured patients . . . ever realize on their tort right to compensation for . . . injuries.”) [hereinafter MEASURE OF MALPRACTICE].

⁵⁶ See *Error Prevention*, *supra* note 7, at 220.

⁵⁷ See *supra* note 4 and text accompanying notes 54-56.

⁵⁸ See *supra* notes 50-51 and accompanying text.

⁵⁹ MEASURE OF MALPRACTICE, *supra* note 55, at 145.

⁶⁰ *Id.* At 147.

⁶¹ Weiler, *supra* note 37, at 926.

⁶² See *id.* at 923.

affect far fewer patients” would lower costs by decreasing administrative burdens and would allow other private sources, such as insurance or employers granting sick leave, to pay the bill.⁶³ There are other ways to reduce costs of the program through specific award provisions.⁶⁴ It is unclear whether a no-fault medical liability model in the United States would be less affordable than the current tort model, but some research and experience indicates that no-fault would be affordable.⁶⁵ In any case, using disability and loss thresholds could be a structural safeguard against prohibitive costs.

Opponents to a NFCS also reference the problem of causation. Critics argue that “finding the true cause of a patient’s disability would typically be as difficult as determining the doctor’s fault under the current malpractice system.”⁶⁶ It can be difficult to prove that medical treatment caused a patient’s injury because a “patient who enters a hospital may already be suffering from an underlying illness which itself may be the cause of the eventual disability.”⁶⁷ When assessing liability, the disability after medical treatment must “fall outside the range of intended or expected consequences of the treatment.”⁶⁸ However, tort law requires a finding that “a doctor was at fault in the standard of care provided” and “must then make a second determination of whether the medical negligence was actually the cause of harm to the patient.”⁶⁹ A NFCS would reduce these steps to the determination of whether the injury was an unexpected result. DCEs could additionally help determine “problems of medical injury

⁶³ MEASURE OF MALPRACTICE, *supra* note 55, at 80.

⁶⁴ Weiler, *supra* note 37, at 924 (stating that “only a designated proportion of net lost wages should be replaced” and “mandatory patient compensation should reimburse only those losses not covered by other sources of public and private loss insurance”).

⁶⁵ *Id.* at 925 (noting the “Harvard Study” found that no-fault would be affordable compared to the present costs of malpractice insurance and states could purchase this comprehensive plan for “roughly the same amount of money they are now spending on the existing malpractice insurance system”).

⁶⁶ *Id.* at 927-28.

⁶⁷ *Id.* at 928.

⁶⁸ *Id.* at 928-29.

⁶⁹ *Id.* at 932.

causation by identifying those treatment-outcome relationships” that meet the compensable injury requirement for unexpected or avoidable adverse events.⁷⁰

One of the most cited criticisms of a no-fault plan is that its “superiority as a sensible mechanism for compensating . . . patient injuries is outweighed by its deficiency as an instrument for preventing future patient injuries.”⁷¹ Essentially, these critics argue that current tort law serves a deterrent function by inducing doctors to treat patients more carefully, and doctors will no longer have a “legal motivation to avoid substandard patient care.”⁷² These critics believe no-fault may result in a decreased incentive for high quality care and an increase in medical injuries.

On the contrary, a NFCS may actually result in greater deterrence of injuries than the existing tort system. Combined with enterprise liability, medical no-fault “retains legal incentives for injury prevention because it imposes liability for compensating claimants upon the institutional providers responsible for patient care.”⁷³ While no-fault “sacrifices the injury-prevention potential of litigation focusing on individual blame,” the system creates financial incentives for institutions to “control careless behavior of individual providers” and to innovate “advanced and safer medical techniques for avoiding currently ‘unavoidable’ adverse outcomes.”⁷⁴ Organizations would employ either self-insurance or outside insurance, and “any institution in which more injuries occurred would bear a correspondingly higher financial burden.”⁷⁵ Hospitals and other provider organizations thus have incentives to “look for patterns of injury causation” to ultimately decrease accidents and increase patient safety.⁷⁶

In addition, a no-fault program could improve patient safety. If doctors are no longer personally liable for a medical injury, they may have an incentive to

⁷⁰ *Id.* at 933.

⁷¹ Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 434 (1994).

⁷² Weiler, *supra* note 37, at 940.

⁷³ Abraham & Weiler, *supra* note 71, at 434.

⁷⁴ *Id.* at 434-35.

⁷⁵ MEASURE OF MALPRACTICE, *supra* note 55, at 148.

⁷⁶ *Id.*

report injuries more readily, thus promoting an open forum for evaluating safety within an institution.⁷⁷ This openness and accountability will ideally trigger investment in “research and innovation in safer medical techniques.”⁷⁸

II. SWEDEN’S NO-FAULT MODEL OF COMPENSATION AND ITS APPLICABILITY TO THE UNITED STATES

New Zealand and four Scandinavian countries (Sweden, Finland, Denmark, and Norway) have implemented some form of a comprehensive no-fault payment system for medical injuries.⁷⁹ Sweden’s no-fault approach may be the most attractive among the international models due to the abundance of research on this country’s system and the degree of physician involvement in the claims process.⁸⁰ Sweden has a system of national health insurance financed by tax revenues, where most private healthcare providers are included in the national system.⁸¹ Tort law is seldom used in connection with medical services; instead, Sweden has created a universal no-fault compensation system.⁸² In 1997, Sweden implemented the Patient Damages Act, a compulsory insurance scheme for every caregiver.⁸³ The providers’ differing insurance companies form a Patient Insurance Alliance, which delegates the investigation and adjustment of patients’ claims to the company called Patients Damages Adjustment, translated as “PSR.”⁸⁴

⁷⁷ This has been the case in Sweden. See Weiler, *supra* note 37, at 927 (stating that “if the experience in Sweden is any indication, some doctors will often help their patients secure disability benefits for treatment-related injuries, rather than fight tooth-and-nail against such an outcome”).

⁷⁸ MEASURE OF MALPRACTICE, *supra* note 55, at 148-49.

⁷⁹ Error Prevention, *supra* note 7, at 219.

⁸⁰ *Id.*; see also M. Studdert et al., *Can the United States Afford a “No-Fault” System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1 (1997) [hereinafter *Can the United States Afford?*]

⁸¹ Lotta Wendel, *Compensation in the Swedish Health Care Sector*, in 8 TORT AND INSURANCE LAW: NO FAULT COMPENSATION IN THE HEALTH CARE SECTOR 367, 367 (Jos Dute, Michael G. Faure & Helmut Koziol eds., 2004).

⁸² *Id.*

⁸³ *Id.* at 368 (noting that beginning in 1975 Sweden had a voluntary system of no-fault compensation but changed to a compulsory system because of a significant rise in the number of private care providers who did not join the system).

⁸⁴ *Id.* at 370.

The Patient Damages Act covers harm that is caused “in connection with medical care or treatment performed in Sweden.”⁸⁵ The caregiver, a government entity or a private provider, is responsible for obtaining insurance,⁸⁶ and employing doctors. In the United States, the caregiver would be comparable to a hospital or other provider organization.⁸⁷ Pamphlets describing the Swedish compensation fund are available to all patients treated in Swedish hospitals.⁸⁸ The application for benefits is available in clinics and hospitals.⁸⁹ After the patient files the claim, the treating physician completes a report on the alleged injury.⁹⁰ Physicians actively participate in approximately sixty percent to eighty percent of claims by notifying patients of possible medical injuries, referring patients to social workers for assistance, and “even helping patients [file] claims.”⁹¹ A national central claims office then decides “whether the injury was caused by the treatment and whether the injur[y] could have been avoided.”⁹²

The Swedish patient does not have to prove negligence but must “prove a causal connection—a considerable likelihood—that the damage was caused by the health care.”⁹³ The patient bears the burden of proof that the damage is due to medical examination, care, or treatment.⁹⁴ This burden of proof encompasses four steps: (1) whether there is a causal connection between the medical treatment and the injury; (2) whether the treatment was medically motivated; (3) whether the chosen method was made in accordance with scientific knowledge and professional experience; and (4) whether it would have been possible to avoid the injury if another method or treatment had been used.⁹⁵ The assessment of whether

⁸⁵ *Id.*

⁸⁶ *Id.* at 371.

⁸⁷ Wendel, *supra* note 81, at 372.

⁸⁸ *Can the United States Afford?*, *supra* note 80, at 6.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Error Prevention*, *supra* note 7, at 219.

⁹² Kristie Tappan, *Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform?*, 46 B.C. L. REV. 1095, 1109 (2005).

⁹³ Wendel, *supra* note 81, at 372.

⁹⁴ *Id.*

⁹⁵ If the patient first proves there is a connection between the medical treatment and the injury, the system proceeds to the second step. The patient is compensated if the treatment was not medically

the injury could have been avoided is reviewed against the standard of an experienced specialist provider under similar circumstances, which in practice very much appears to evaluate “whether the care provider has made a mistake, although less emphasis is placed on the issue of individual blame.”⁹⁶ This standard does not differ markedly from the assessment criteria used in a tort liability system, but it is less individualized and has less stringent requirements on proving the causal link.⁹⁷

Physical as well as psychological damages are compensated.⁹⁸ “The patient is entitled to economic compensation for loss of income . . . and compensation for non-pecuniary loss,” such as physical suffering.⁹⁹ In 1998, the PSR received 8552 claims, forty-five percent of which resulted in compensation.¹⁰⁰ Awarded amounts ranged from \$120 to \$883,000; the average compensation was approximately \$9900.¹⁰¹ The total cost for the insurance in 1998 was approximately \$31.4 million.¹⁰² Decisions made by the PSR can first be appealed to the Board on Patients Damages and then either to an arbitration board or to a court, but, according to the PSR, less than ten cases are brought in

motivated. If the treatment was medically motivated, the PSR considers whether the chosen method was medically correct. The patient is compensated if the method was not in accordance with scientific knowledge and professional experience. Finally, if the treatment was in accordance with the standard knowledge and experience, the company considers whether an injury could have been avoided with another method. “[T]here is seldom a different method which would have been possible to use without any risk,” and if there was not, the patient does not receive compensation. *Id.* at 372-73.

This method appears complicated, but essentially the patient is compensated if the injury resulted from medical treatment, the treatment was medically justified, and the outcome was avoidable. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1627 (2002).

⁹⁶ Jos Dute, *A Comparison of No-Fault Compensation Schemes*, in 8 TORT AND INSURANCE LAW: NO FAULT COMPENSATION IN THE HEALTH CARE SECTOR 444, 479 (Jos Dute, Michael G. Faure & Helmut Koziol eds., 2004).

⁹⁷ *Id.*

⁹⁸ Wendel, *supra* note 81, at 374.

⁹⁹ *Id.* at 383.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* Converted amounts to U.S. dollars based on an exchange rate of one U.S. dollar to 8.06 Swedish kronor. XE, <http://www.xe.com> (last visited April 16, 2009) [hereinafter Converted to U.S. dollars].

¹⁰² Wendel, *supra* note 81, at 383; Converted to U.S. dollars, *supra* note 101.

court each year.¹⁰³ An injured party is not precluded from recovering in tort against the provider after recovering pursuant to the Patient Damages Act.¹⁰⁴ The Swedish government considered barring injured persons from pursuing a claim in court, but assumed it would be “natural for a claimant to use the faster and cheaper path towards compensation first, before considering court.”¹⁰⁵

The Swedish fund imposes an injury threshold.¹⁰⁶ A patient must have spent at least ten days in the hospital or accumulated at least thirty sick days before being eligible for compensation.¹⁰⁷ This demarcation demonstrates that the Swedish system intends to compensate only the most seriously injured patients.

Criticism of the Swedish system includes its lack of publicity, which prevents many patients from receiving the compensation to which they are entitled and has led to calls for a more open and transparent system.¹⁰⁸ Generally, the Swedish population seems to agree that “compensation for medical malpractice should be based on a no-fault principle.”¹⁰⁹

III. PROSPECTS FOR NO-FAULT SOLUTIONS IN THE UNITED STATES

The Swedish NFCS approach is an attractive alternative to the current tort system in the United States. An optimal medical compensation scheme will retain the goals of the tort system: compensation, deterrence, and justice. A well-designed system also will reduce medical errors and effectively compensate resulting injuries.¹¹⁰ The Swedish system better fulfills these goals than the current tort system in the United States. Sweden’s model of no-fault, premised on the criteria of avoidability and implemented through an enterprise liability structure, reduces error and compensates injured parties effectively.

¹⁰³ Wendel, *supra* note 81, at 370, 383.

¹⁰⁴ *Id.* at 384.

¹⁰⁵ *Id.*

¹⁰⁶ *Can the United States Afford?*, *supra* note 80, at 8.

¹⁰⁷ *Id.*

¹⁰⁸ Dute, *supra* note 96, at 474.

¹⁰⁹ Wendel, *supra* note 81, at 386.

¹¹⁰ C Vincent, Editorial, *Compensation as a Duty of Care: The Case for “No Fault,”* QUALITY & SAFETY HEALTH CARE, Aug. 2003, at 240, 240.

Essentially, the Swedish approach compensates adverse events that are avoidable.¹¹¹ As stated earlier, an injury is compensable under the Swedish approach if the injury resulted from the medical treatment, the treatment was medically justified, and the outcome was avoidable.¹¹² The concept of avoidable errors “invokes the idea of error reduction through changes in *systems* of care, whereas the concept of negligence suggests that errors can be reduced” by individual action.¹¹³ The current tort system, based on negligence, encourages providers to hide errors, while the concept of avoidable adverse events “overcomes the problem of moral condemnation and encourages” a system-wide approach to error prevention and patient safety.¹¹⁴

A NFCS in the United States could adopt Sweden’s caregiver-insurance-purchasing model, which is similar to the enterprise liability model. Under this model, hospitals, rather than the treating physicians, would pay for medical errors.¹¹⁵ Compensation would require a finding that the injury was avoidable, rather than a finding of negligence.¹¹⁶ An administrative body would process claims and make compensation decisions rather than a court of law.¹¹⁷ “Patients [w]ould be permitted to opt into a no-fault model at the point of receiving care by choosing a participating physician or hospital.”¹¹⁸ If a patient was injured during the course of treatment, he or she would fill out a compensation request at the hospital, similar to the Swedish system.¹¹⁹ The patient’s request would be submitted to a board or administrative body to determine if the injury was avoidable, and the provider organization would be liable for any avoidable adverse outcome.¹²⁰

¹¹¹ Mello & Brennan, *supra* note 95, at 1627.

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.* at 1628.

¹¹⁵ See Kristie Tappan, *Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform?*, 46 B.C. L. REV. 1095, 1110 (2005).

¹¹⁶ *Id.* at 1110-11.

¹¹⁷ *Id.* at 1111.

¹¹⁸ *Error Prevention*, *supra* note 7, at 222.

¹¹⁹ *Id.* at 219.

¹²⁰ *Id.* at 219-20.

In designing a no-fault scheme for the United States, the cost of the system will depend on the number of claims awarded, the average amount paid, and the administrative expenses.¹²¹ Designers can structure the system as they choose with regard to full compensation for losses, pecuniary versus non-pecuniary costs, deductibles on damages, or thresholds for injury or losses.¹²² A disability threshold, as utilized in Sweden, would make costs more predictable and equitable, as compared to the current tort system, where damage awards are often unpredictable and unfair.¹²³ Use of deductibles and injury thresholds would help reduce costs and fund the most seriously injured parties.¹²⁴ In addition, DCEs would help lower administrative costs and increase efficiency by providing a pre-determined list to help an administrative body decide when and how much compensation is appropriate.¹²⁵ Cost estimates vary, but one study estimated the national costs of compensating avoidable medical injuries in the range of \$37.6 billion to \$50 billion—thereby not increasing the total cost of the liability system “relative to the status quo.”¹²⁶

Embracing a “Swedish-style approach could lead to a system that is both affordable and positioned to compensate a considerably larger proportion of medically injured patients than the current malpractice system manages or even allows.”¹²⁷ It appears that patients have easier access to no-fault compensation systems than to the courts, and care providers will be “more likely to inform patients of the possibility of submitting injury claims under a no-fault system.”¹²⁸ Therefore, using an avoidability standard similar to Sweden’s and an administrative claims processing mechanism will compensate more injuries than under the present system.¹²⁹

¹²¹ Dute, *supra* note 96, at 468.

¹²² *Id.* at 469; *see also supra* notes 62-63 and accompanying text.

¹²³ *See* Tappan, *supra* note 115, at 1121-22.

¹²⁴ *See supra* notes 62-63 and accompanying text.

¹²⁵ *See supra* text accompanying notes 52-54.

¹²⁶ Mello & Brennan, *supra* note 95, at 1632.

¹²⁷ *Can the United States Afford?*, *supra* note 80, at 33.

¹²⁸ Dute, *supra* note 96, at 467.

¹²⁹ Mello & Brennan, *supra* note 95, at 1634.

Additionally, the Swedish no-fault system would deter future errors in the United States by encouraging doctors to report errors. Doctors would more readily report injuries because they would no longer be directly liable for medical errors and would not face exorbitant malpractice premium increases every time an adverse event occurred.¹³⁰ In an enterprise liability system, hospitals or other provider organizations would be responsible for payment if medical errors occur.¹³¹ Hospitals and health care organizations are in the best position to initiate system-wide improvements in health care delivery; therefore, if they are strictly liable for medical errors, they will have an incentive to improve safety and reduce errors and injuries.¹³² By reporting injuries more effectively, the no-fault system also encourages hospitals to educate their providers on patient safety and other problems that arise in patient care.¹³³

The no-fault compensation scheme promotes justice as well. Injured parties should be compensated more quickly and fairly under a NFCS, especially if the system utilizes DCEs or a similar process to streamline the claims process. The administrative system ensures a more even and consistent spread of damages among the injured, rather than depending on the uncertainty of a trial to determine what an injured party will receive.¹³⁴ As already stated, the NFCS also would compensate a greater number of injured parties than the current tort system, and it could focus on the more seriously injured through threshold disability levels, thus promoting justice for the most deserving parties.

Both physicians and patients probably would benefit from a NFCS similar to Sweden's system. Physicians resent the current malpractice litigation system, and they likely would prefer the "rational and honest approach" used in identifying avoidable adverse events.¹³⁵ This approach would appeal to

¹³⁰ See Tappan, *supra* note 115, at 1116-17.

¹³¹ See *id.* at 1117.

¹³² *Id.* at 1116.

¹³³ Tappan, *supra* note 115, at 1117.

¹³⁴ See MEASURE OF MALPRACTICE, *supra* note 55, at 4-5 (describing the "unpredictability" of medical malpractice awards); see also BOVBJERG & RAYMOND, *supra* note 4.

¹³⁵ Mello & Brennan, *supra* note 95, at 1629.

physicians “who are bound by ethical precepts to disclose errors . . . but face a conflict of interest under the current negligence-based system in doing so.”¹³⁶ Also, patients would appreciate the rapid compensation and transparency in reporting errors in addition to the increased trust between provider and patient.¹³⁷ The NFCS allows the care provider to remain the patient’s ally instead of becoming an adversary when injuries occur during treatment.¹³⁸ However, the provider will have to change his or her outlook on reporting errors; he or she must express a greater willingness to report errors and consent to “greater transparency in the institutional processes that analyze medical errors.”¹³⁹ Patients also must relinquish their “shot at the ticket in the litigation lottery” and be more willing to accept a no-fault form of payment, even if it is less than they *might* have received under the current tort system.¹⁴⁰

One main barrier to implementing a NFCS in the United States is the lack of a highly developed social security system that compensates injured patients, whereas this type of system exists in New Zealand and the aforementioned Scandinavian countries.¹⁴¹ The Swedish system relies on its social security to compensate parties in addition to the Patient Damages Act.¹⁴² Thus, a NFCS should be combined with an extensive social security structure for maximum economic and care benefits.¹⁴³

Another barrier to implementing a Swedish-like NFCS is the availability of tort remedies. If patients are allowed to recover under both systems of liability, there is almost no doubt that they will take advantage of this aspect and recover under both no-fault and tort remedies. The no-fault system should retain the option to sue under tort law, as the Swedish system does, because this is a stalwart of the United States’ compensation system and would be difficult to eliminate

¹³⁶ *Id.*

¹³⁷ *See id.*

¹³⁸ Dute, *supra* note 96, at 473.

¹³⁹ Coylewright, *supra* note 2, at 56.

¹⁴⁰ *Id.* at 55.

¹⁴¹ Dute, *supra* note 96, at 448.

¹⁴² *Id.*

¹⁴³ Wendel, *supra* note 81, at 385.

altogether for political reasons. The Association of Trial Lawyers of America is not likely to support a no-fault compensation scheme, as members benefit from protracted legal battles and large tort settlements. This group can be expected to lobby extensively against any no-fault plan.¹⁴⁴ Attorneys who bring medical malpractice claims “probably stand to lose the most if a no-fault system were implemented,” as they would no longer be needed for patients to receive compensation for medical errors.¹⁴⁵ Thus, these attorneys will be a powerful opposition force to NFCS for medical injuries.

However, the no-fault compensation must be attractive enough to lure injured parties away from pursuing claims in tort and entice them to accept the risk-free and fair no-fault compensation, foreclosing future tort claims.¹⁴⁶ Access to the traditional tort system should remain available for “suits alleging willful and wanton behavior on behalf of medical providers.”¹⁴⁷

The Swedish no-fault scheme provides a helpful model for creating a comprehensive no-fault solution for the problem of medical injuries in the United States. Many features of a NFCS make it an attractive alternative to the tort liability system. Overall, the current system could benefit from no-fault’s improvement on compensation, deterrence, and justice for medical injuries.

¹⁴⁴ Mello & Brennan, *supra* note 37, at 1628-29.

¹⁴⁵ Tappan, *supra* note 115, at 1126-27.

¹⁴⁶ See *supra* notes 104-105 and accompanying text.

¹⁴⁷ Coylewright, *supra* note 2, at 46.