

Commentary: Some Questions about No-Fault Reform of the Medical Liability System

Commentaire : quelques questions sur la réforme sans égard à la responsabilité dans le régime de responsabilité médicale

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Abstract

No-fault reform has been highlighted as a solution to a pressing problem in the context of Canadian medical malpractice claims: less than 1% of those harmed in the course of medical care receive any compensation for their injuries. Lee et al. (2021) suggest that a shift to a no-fault system is the answer for Canada's malpractice system. No-fault reform would certainly improve access to compensation but compensation is not the only reason to pursue a malpractice claim. Accountability and safety are important considerations that are not addressed by a move to a no-fault system.

Résumé

La réforme sans égard à la responsabilité a été présentée comme solution à un problème urgent dans le contexte des réclamations pour faute professionnelle médicale au Canada : moins de 1 % des personnes qui ont subi un préjudice dans le cadre de soins médicaux reçoivent une indemnisation. Lee et al. (2021) suggèrent que le passage à un système sans faute est la solution pour le système canadien concernant les fautes professionnelles. Une réforme sans égard à la responsabilité améliorerait certainement l'accès à l'indemnisation. Mais l'indemnisation n'est pas la seule raison d'intenter une action en justice pour faute professionnelle. La responsabilité et la sécurité sont des points importants qui ne sont pas abordés dans le passage à un système sans faute.

Introduction

The central question raised by Lee et al. (2021) is whether it is time to reform medical malpractice insurance in Canada. The authors make the case for reform of the malpractice system via the adoption of a “no-fault” compensation scheme. Their argument is based on several facts: (1) the Canadian Medical Protective Association (CMPA) is not an insurer, but a defence fund (*Shannon v. Canadian Medical Protective Association* 2016); (2) almost all (95%) Canadian physicians are members of the CMPA (Flood and Thomas 2011); (3) only a small fraction of those injured in the course of receiving medical care are compensated for their injuries; and (4) Canadian taxpayers subsidize physicians’ CMPA fees. These facts are not in dispute, although it is not clear whether or how all of the facts connect with one another. More precisely, it is not clear whether the structure of the CMPA as a mutual defence organization is connected to the challenge in obtaining compensation by those injured as a result of medical malpractice. Leaving that question to another day, I will focus on some fundamental questions that must be addressed if we are to contemplate implementing a no-fault medical malpractice compensation scheme.

Discussion

I agree with Lee et al. (2021) that the medical malpractice system is overdue for reform (Prichard 1990). The current system requires the injured party to initiate a tort claim in order to be compensated for their injuries. It is an expensive and slow process (Gilmour 2006; Prichard 1990). It is also inefficient (Mello et al. 2011) and ineffective, at least, insofar as we measure efficacy as being related to the proportion of claimants who receive any compensation for their injuries (Gibson 2016). The estimate provided by Lee et al. (2021) indicates that less than 1% of injured patients receive compensation in our current system. Several factors tilt the balance in favour of malpractice defendants. Many injured patients lack the financial means to initiate a tort claim. Those who are able to initiate a claim will face considerable expense in proving it or wind up paying a significant proportion of their damages award in legal fees and related expenses. In addition, claimants face a formidable and well-resourced opponent in the CMPA (Nosheen and Culbert 2019). To add insult to injury, physicians’ CMPA membership fees are subsidized by provincial governments, meaning that taxpayers pay for a considerable portion of these fees (Flood and Thomas 2011).

The solution proposed by Lee et al. (2021) is a no-fault compensation scheme for medical malpractice claims. They suggest that adopting a no-fault system will allow for a much higher proportion of injured patients to receive compensation at a cost to Canadian governments that may not be much higher than the amounts currently being paid to subsidize CMPA dues. I think it is important to acknowledge that while the Canadian public might be more receptive to a shift to a no-fault system in a context where they are paying a sizable proportion of CMPA fees, there is no guarantee that governments will be prepared to commit stable, ongoing funding for such a system. The provinces could, in theory, cease or reduce payments for CMPA dues at any point as Alberta has threatened to do (Schuster et al. 2020).

A no-fault system is feasible only with a commitment to ongoing funding, which, in all likelihood, will need to be increased over time. This funding question is a question that goes to the design of the healthcare system, rather than to the reform of the malpractice system.

It is clear from other jurisdictions where no-fault systems have been implemented that such a system would create significant administrative cost savings and improve the likelihood that those injured by medical error will receive some compensation for their injuries (Mello et al. 2011). These are both goals worth pursuing. But compensation is not the only reason why a person might wish to pursue a malpractice claim. In some cases, the motivation for pursuing a claim has more to do with the desire to see providers held accountable, and to prevent similar conduct and outcomes in the future (Vincent et al. 1994). Any approach we take to dealing with medical malpractice should not only provide compensation for injured patients but also incentivize safe and appropriate care, and ensure that there is some mechanism for accountability. A no-fault system cannot address these concerns.

Given that compensation is not the only rationale for a malpractice system, it is essential to consider how physician negligence will be addressed in a no-fault context. As Lee et al. (2021) note, some jurisdictions that have adopted no-fault compensation models leave the issue of physician negligence to regulators as part of the professional discipline role (Lee et al. 2021). Though not a focus of their argument, the authors seem to view this as a plausible method to deal with provider negligence.

In Canada, the medical profession is self-regulating (Epps 2011). It is well known that professional self-regulation involves an inherent conflict of interest arising out of the dual mandate to promote the public interest and, at the same time, safeguard the interests of the profession (Collier 2012; Zarzeczny 2017). The system of professional self-regulation is increasingly being questioned, with critics arguing that regulatory bodies are biased in favour of the professions they govern (Dhillon and Burns-Pieper 2018; Epps 2011). Indeed, governments in several jurisdictions have contemplated (or acted on) moving away from self-regulation owing to the perceived inability of regulatory bodies to respond effectively to professional misconduct. In the UK, the medical profession no longer has the privilege of self-regulation (Dixon-Woods et al. 2011). The Alberta government recently passed legislation specifying penalties for sexual abuse or misconduct by healthcare providers in the wake of news about a physician having his medical licence reinstated after being convicted for sexually assaulting a patient and a nurse (Gerein 2018; *Health Professions Act* 2000). Is professional self-regulation the right place to situate responsibility for professional negligence?

Even if we can overcome conflict of interest–related concerns, I am not sure that it is wise to leave the profession to define for itself what kind of conduct constitutes negligence or malpractice. The current tort-based malpractice system requires the court to assess the standard of care that providers must meet in assessing, treating and counselling patients (Nelson and Ogbogu 2018; Robertson and Picard 2017). Within the judicial approach, there is considerable deference to medical expertise when adjudicating negligence claims (Foster 2018). There is a risk that this concern will be intensified if we grant complete control over

what constitutes appropriate patient care to the providers of that care. Discipline for provider misconduct might make sense as the responsibility of the regulator but that does not necessarily mean that the regulator is best placed to deal with negligence. To elaborate, most providers can likely imagine themselves making a careless error in the provision of medical treatment, and that might lead to considerable reluctance to conclude that a colleague has acted negligently.

Conclusion

In view of these considerations, how should we handle medical malpractice claims? This is a complex topic and one that cannot be fully addressed in a short commentary. That said, it is essential to highlight the need to consider malpractice reform beyond the compensation-related benefits of a no-fault system. One option is to adopt a blended tort/no-fault system. In a pure no-fault system, the claimants' right to pursue a tort claim is extinguished, as is the case with Canadian workers' compensation schemes. But there are variations on the no-fault theme that could be explored, including leaving open the option to sue for malpractice in at least some cases. For example, Ontario's motor vehicle accident compensation system combines tort and no-fault, whereby a party that is injured in a motor vehicle accident, for which he or she is not at fault, may pursue a tort claim against the at-fault driver if the injuries cause "permanent serious disfigurement or permanent serious impairment of an important physical, mental or psychological function" (Marshall 2017: 15). A blended tort/no-fault approach does not address the concern raised by Lee et al. (2021) about taxpayer-borne costs of CMPA membership dues in that the costs might actually increase due to such a system rather than decrease. Another approach might be to hand over professional negligence claims to physician regulators but with meaningful oversight from outside the profession to ensure some degree of accountability (Cayton 2018).

To be sure, these concerns about how to ensure accountability in circumstances in which physicians are at fault may not be compelling when weighed against a system that will see far more claimants compensated at a far lower cost. This is particularly true if, as Lee et al. (2021) suggest, additional benefits also flow from the adoption of a no-fault system. But it is also important to note that injured patients will have to be prepared to accept that along with a much higher likelihood of receiving some compensation for their injuries, the amount they would receive would be far less in a no-fault system than if they were to succeed in a tort claim (Mello et al. 2011).

Lee et al. (2021) may be correct – it may be the case that the time has come that Canadian providers, patients and governments are ready to shift to no-fault malpractice compensation schemes. But there remain some key questions to consider before we take this leap.

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