I'll Tell You What Happened if You Promise Not to Sue Me—Will No-Fault Liability Improve Patient Safety through Increased Reporting of Medical Errors?

K. James Sangston

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I'LL TELL YOU WHAT HAPPENED IF YOU PROMISE NOT TO SUE ME—WILL NO-FAULT LIABILITY IMPROVE PATIENT SAFETY THROUGH INCREASED REPORTING OF MEDICAL ERRORS?

INTRODUCTION

Seeking medical care in the United States can be dangerous to your health.\(^1\) A recent Institute of Medicine report has focused the public’s attention on the alarming rate of occurrence of medical errors in this country.\(^2\) The data in the report suggest that between 44,000 and 98,000 deaths occur each year in the United States from preventable medical errors.\(^3\) These errors include administering wrong medicine to a patient or administering the correct medicine but in the wrong dosage.\(^4\)

Even prior to the alarm raised by this report, reformers were advocating a “systems” approach to error prevention and correction similar to the approach taken in the aviation industry to improve patient safety by eliminating preventable errors.\(^5\) The goal of the

\(^1\) See generally To Err is Human: Building a Safer Health System (Linda T. Kohn et al. eds., Washington, D.C. Institute of Medicine 2000), available at http://www.nap.edu/openbook/0309068371/html/html [hereinafter To Err is Human] (providing a general discussion of the problem of medical error, its prevalence in the United States, its relationship to patient injury, and the general silence that heretofore has surrounded the issue and recommending possible strategies for dealing with the problem).

\(^2\) See id.

\(^3\) See id. But see Rodney A. Hayward & Timothy P. Hofer, Estimating Hospital Deaths Due to Medical Errors: Preventability is in the Eye of the Reviewer, 286 JAMA 415, 416 (2001) (suggesting that these estimates of the number of deaths caused by preventable medical errors are overestimates); Medical Errors: One-Fourth of Medical Errors Preventable, But Deaths Due to Errors Low, JAMA REPORTS 9 HEALTH CARE POL. 1202 (BNA) (July 30, 2001), available at http://pubs.bna.com/ip/BNA/hcp.nsf/idl (suggesting that a more accurate assessment of the data shows that deaths due to preventable medical errors are between 5,000 and 15,000 annually).


\(^5\) See id. (observing that the complex medical environment in which hard-to-detect errors occur frequently is similar to other environments where accidents, such as the Three Mile Island and Challenger accidents, arose due to faulty system design). See also Lucian L. Leape, Foreword: Preventing Medical Accidents: Is “Systems Analysis” the Answer?, 27 AM. J. L. & MED. 145, 147
systems approach to error prevention is to identify and modify or eliminate the conditions that facilitate error occurrence.\(^6\) For example, post-accident analysis of a Canadian plane crash in which the plane took off with ice on its wings revealed several conditions, such as aircraft design, poor government oversight, management’s disregard of the need for de-icing, and insufficient maintenance and training procedures, that combined to facilitate the final error of consequence—the plane taking off with ice on its wings and subsequently crashing.\(^7\)

A systems approach relies heavily on the notion that practitioners must first identify errors before they can study, understand, and eventually correct or prevent them.\(^8\) In the aviation industry, agency-implemented mechanisms to facilitate error reporting have been quite successful in reducing the occurrence of errors.\(^9\)

However, this country’s legal system poses impediments to error reporting in the healthcare industry (and thus the subsequent increase in patient safety through error reduction).\(^10\) Doctors are reportedly reluctant to disclose errors to patients because of fears that the patient will seek a malpractice judgment against them.\(^11\) Further, doctors are reluctant to report errors to administrative bodies out of fear that the report will be discoverable in civil litigation.\(^12\) Unfortunately, safety

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(2001) [hereinafter Leape, Foreword] (arguing that a systems approach to error prevention will create an environment in which practitioners will be free to provide quality healthcare consistent with their training).


7. See Helmreich, supra note 6, at 783.


9. See infra notes 32-34 and accompanying text.


efforts cannot eliminate unreported errors. Thus, fears engendered by the current tort liability system may undermine any attempt to facilitate error reporting in the healthcare industry.

In addition to discouraging reporting, the current legal system impedes the actual practice of medicine in this country. In particular, doctors allegedly engage in defensive medicine, refuse to take high-risk cases, and avoid certain high-risk practice areas in order to reduce the likelihood of a malpractice claim. Critics argue that the current legal system leads to higher costs, decreased quality of care, and lower access to the healthcare system. Although changing the legal system to give no-fault immunity to medical practitioners arguably may be a sensible mechanism for improving healthcare delivery, this Note focuses only on the question of whether a no-fault system that relieves practitioners of tort liability for medical errors will lead to improved patient safety through increased error reporting.

Although the “malpractice crisis” of the 1980s has passed, reformers are once again calling for a no-fault compensation system in response to the perceived crisis of under-reporting of medical errors and the consequent danger to patients. This Note presents a critical assessment of a no-fault system’s validity as a mechanism to increase patient safety.

Part I discusses the general concept of error. Part II discusses how the legal and medical communities perceive the role and impact

13. See Liang, supra note 10, at 29 (stating that successful error reporting is the basis for safety increases in the aviation industry).
14. Studdert & Brennan, supra note 8, at 218. (discussing the “tension between error reporting and the [medical] malpractice system”).
15. See generally Liang, Patient Injury, supra note 10.
16. See id.
17. See id.
18. See infra Parts II–V.
20. See infra Parts II–IV.
21. See infra Part I.
of the current tort system in promoting patient safety. Part III presents a no-fault compensation proposal offered to promote patient safety through improved error-reporting, and Part IV critiques this proposal in light of the various perspectives discussed in Parts I and II. This Note concludes that a system of no-fault liability coupled with experience rating, as used in the workers’ compensation system, will effectively promote patient safety through improved reporting of implementation errors (as opposed to judgment errors) identified as preventable through a systems approach.

I. SYSTEMS THINKING AND MEDICAL ERROR

A. Error in General

An error occurs when one fails to undertake or complete an intended action or when one conceives an action incapable of or ill-suited to achieving the intended aim. Errors fall naturally into one of the following two categories: (1) implementation errors, which are unintended failures to complete an often routine task, and (2) judgment errors, which are failures to conceive a proper plan to achieve the intended goal. Researchers generally view errors as having one of two distinct causes—human fallibility or inadequate defenses to overcome error-inducing conditions inherent in the system under operation. Systems errors are those errors caused or facilitated by the conditions in which the human operator works. Researchers further classify systems errors as follows: (1) latent errors, which encompass defects in the system through which a person is working, and (2) active errors, which encompass the

22. See infra Part II.
23. See infra Part III.
24. See infra Part IV.
25. See infra Part I for a discussion of implementation and judgment errors.
26. See infra Conclusion.
28. See Liang, supra note 10, at 28.
29. See Reason, supra note 6, at 768.
30. See id.
failures and rules violations of the system operators. These two error classifications are not mutually exclusive.

The systems approach to errors focuses on defenses and barriers to error and how these defenses or barriers interact—or fail to interact—to prevent the occurrence of errors, which systems analysts see as inevitable. One researcher has described the occurrence of systems errors with the aid of a “Swiss cheese” model: a complex system comprised of multiple “slices” that contain “holes” through which errors occur. As long as the “holes” don’t line up, the system traps the error before it causes an undesired outcome. However, when the “holes” do line up, an error can propagate throughout the system and lead to a final bad outcome. Both latent conditions in the system and active errors by participants create the “holes,” which continually appear and disappear during the dynamic operation of a complex system.

B. Systems Analysis in Error Elimination

A system for error study purposes typically involves the following common characteristics: (1) the system is complex, (2) the system imposes high-level technical requirements on the operator, (3) system operation requires quick reaction times, (4) the system operates non-stop (twenty-four hours a day), and (5) only a small percentage of errors actually lead to adverse events. For systems errors, attempts to locate the cause of the error typically focus more attention on the latent aspect of the error than the active aspect. To achieve the

31. See id. at 769. Latham, supra note 27, at 165; Liang, supra note 10, at 27.
32. See Latham, supra note 27, at 165, for a discussion of the latent/active classification in the context of a systems implementation error.
33. See Reason, supra note 6, at 768 (distinguishing the “person approach,” which focuses on assigning individual blame for errors and corrects those errors by improving the person’s proficiency, from the “system approach,” which recognizes human fallibility, focuses on identifying systemic factors that encourage or facilitate error occurrence, and corrects those errors by building defense mechanisms into the system to catch the inevitable error when it occurs).
34. See id.
35. See id.
36. See id.
37. See id.
38. See Liang, supra note 10, at 28-29.
39. See Studdert & Brennan, supra note 8, at 218.
primary goal of error prevention, researchers have developed a systems safeguard methodology that detects latent errors as the system is operating, changes the system process, and assesses the impact of the change on the error occurrence.\textsuperscript{40} This error-correction process depends critically on error detection to initiate the feedback process that ultimately corrects the error.\textsuperscript{41}

A systems approach to error prevention recognizes that analysts cannot change aspects of human cognitive features that lead to error occurrence, but analysts may design systems to reveal the occurrence of errors and to initiate procedures to mitigate or prevent the errors thus revealed.\textsuperscript{42} Factors that underlie systemic approaches to error prevention include cultural attitudes within the particular profession or organization, management and other interpersonal aspects of the systems operation, and stress of the work environment.\textsuperscript{43} In high risk, high pressure industries such as aviation and healthcare, failure to recognize diminished capability due to stress and the resultant reduction in teamwork and communication may contribute significantly to the occurrence of errors.\textsuperscript{44} Systemic approaches to identifying, understanding, and eliminating these error-inducing factors include surveys to collect data on workers’ attitudes, identification of error-reducing behaviors, intervention training to change attitudes and associated behaviors, simulations to study effects of stress on teamwork, and ultimately changes to mitigate or eliminate the error-producing conditions.\textsuperscript{45}

In the aviation industry, which involves a complex system imposing stringent technical demands on pilots who must frequently react in very short time frames, systems analysis has dramatically

\textsuperscript{40} See Liang, supra note 10, at 29-30.

\textsuperscript{41} See id. at 29, 46.

\textsuperscript{42} See Thomas W. Nolan, Systems Changes to Improve Patient Safety, 320 Brit. Med. J. 771, 771 (2000). A bank teller machine that returns the user’s bank card before dispensing the money typifies a systems approach to preventing the error of forgotten cards: a user is more likely to forget his card than to forget his money. Id.


\textsuperscript{44} See Sexton et al., supra note 48, at 745. See also Helmreich, supra note 6, at 783-84 (stating that factors such as fatigue, overwork, fear, mental overload, communications breakdowns, and poor decision making contribute to the occurrence of errors).

\textsuperscript{45} See Sexton et al., supra note 43, at 745; see also Helmreich, supra note 6, at 783.
improved safety. Human factors researchers have developed both survey questionnaires and simulators to reveal cockpit and flight management attitudes and practices that lead to errors. For example, a recent survey revealed that only twenty-six percent of pilots surveyed felt they performed effectively in critical situations despite being fatigued. This attitude contrasts sharply with the attitude of consultant surgeons, seventy percent of whom felt they continued to be effective despite fatigue. Human factors researchers attribute this difference to the aviation industry’s emphasis on education and training in order to facilitate industry acceptance of human limitations and fallibility when under stress. Consistent with the attitude that errors are inevitable, the aviation industry implements various safeguards, including: (1) multiple instruments and redundancies to catch and absorb errors before they manifest adverse outcomes, (2) standardized procedures in the form of protocols and checklists, and (3) regular, specifically detailed systems maintenance.

The Air Safety Reporting System (ASRS), a confidential, non-punitive error and near-miss reporting system that yields data on and insights about errors and the conditions that lead to the errors, provides another essential mechanism enabling passenger safety

46. See Lucian L. Leape, Error in Medicine, 272 JAMA 1851 (1994).
47. See Sexton et al., supra note 43, at 745-45. For example, analysts posed questions designed to elicit the perceptions of both pilots and junior team members with respect to performance capabilities when under stress, ability to ignore personal problems at work, and the proper authority relationship between senior and junior team members. Id. at 746.
48. See id.
49. See id.
50. See id. at 748. After the emergence of jet technology in the 1950s eliminated many of the mechanical errors that to that time had led to airplane accidents, the aviation industry began to note that errors occurred from communication and other teamwork failures. Id. Collection of data both before and after training programs demonstrated improvements to safety from attitudinal changes in the cockpit and led to selection of pilots who possessed both technical proficiency and organization and teamwork-oriented attitudes consistent with error reduction and prevention. Id. Moreover, aviation industry training shifted from a focus on training individuals to training entire crews, a shift that led to further attitudinal changes on the part of captains, who came to rely on crew members as resources to help identify and, if possible, trap errors before they could lead to accidents. Id. at 748-49. Further countermeasures to aviation errors include briefings, cross-checking, and plan review or modification. See Helmreich, supra note 6, at 783.
51. See Leape, supra note 46.
improvement in the airline industry. This system, established in 1975 by the Federal Aviation Administration (FAA) and administered by the National Aeronautics and Space Administration (NASA), collects reports from pilots, air traffic controllers, flight attendants, ground crew, and other aviation industry personnel to identify incidents or situations that the reporter believes compromised aviation safety. To encourage reporting, the confidential system provides limited immunity: the FAA does not use ASRS-collected information against the reporter in any enforcement action and waives fines and penalties for an unintentional violation of Federal Aviation Regulations if the violation is reported within ten days of its occurrence. In maintaining this system, NASA supports human factors research to identify ways to reduce errors and improve aviation safety.

C. The Nature of Medical Errors

Medical errors arise as both implementation errors and judgment errors. A common error in a hospital setting is the medication error, which can manifest both as an implementation error and a judgment error; fortunately, it does not always result in patient injury. Other errors include improper diagnoses, late treatment, and failure to provide aftercare to the patient.

As an illustration of how a series of errors, in the absence of mechanisms to trap or absorb them, can lead to a medically adverse outcome, consider the following example. A Spanish-speaking woman with a history of syphilis gave birth to a healthy male child.

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52. See Helmreich, supra note 6, at 782; Leape, supra note 46; Liang, supra note 10, at 29-30.
54. See id. This limited immunity does not apply to reports of accidents or to reports of criminal activity. Id.
55. See id.
56. See To Err is Human, supra note 1, at 4.
57. See Leape, supra note 46.
58. See id.
60. See id.
Because the medical staff was unable to ascertain if the woman had successfully sought treatment for the syphilis, and the neonatologist was concerned that the language barrier hampered his attempts to communicate effectively the need for follow-up treatment for the baby boy, the doctor decided to diagnose and treat the child for congenital syphilis before discharge. A local infectious disease specialist advised the doctor to perform a diagnostic lumbar puncture and to administer a single dose of penicillin G Benzathine, IM, at a dosage of 50,000 units/kg.

The next day, a different doctor performed the diagnostic lumbar puncture and wrote an order for one dose of the recommended medicine, which he specified as "Benzathine Pen G, 150,000 U IM." When the pharmacist, who was unfamiliar with this drug, filled the order, she read the "U" as a "0" and provided 1,500,000 units instead of the requested 150,000 units. Unfortunately, the pharmacy computer system did not generate any warning that such a dose represented an overdose for a newborn child. The pharmacist prepared syringes containing 2.5 milliliters (ml) (equal to 1,500,000 units) of the medicine and sent them to the nursing staff. Because the maximum volume of medicine that could be administered to a newborn via intramuscular injection was 0.5 ml, the head nurse was concerned about giving the baby five injections in order to administer the entire dose. This concern led her to research the possibility of giving the dosage to the child intravenously instead. The reference she consulted indicated that penicillin G (not penicillin G Benzathine) could be safely administered intravenously. She mistakenly interpreted "Benzathine" as a brand name and concluded

61. See id.
62. See id.
63. See id. The notation "IM" indicates that the drug is to be administered via intramuscular injection as opposed to intravenously, which would be indicated by a notation "IV." Id.
64. See Mederrors.com, supra note 59.
65. See id.
66. See id.
67. See id.
68. See id.
69. See id.
that she could safely administer the drug intravenously.\textsuperscript{70} The
unusual way in which the requesting doctor had written “Benzathine
Pen G” instead of “penicillin G Benzathine” reinforced her mistake
that “Benzathine” indicated a brand name.\textsuperscript{71} Although the syringes
were labeled “IM only,” neither of the two nurses who administered
the drug noticed the warning, which was partially concealed by the
syringe plunger and thus appeared as “I only,” a warning that is
consistent with intravenous administration.\textsuperscript{72} In their concern that the
baby be spared the unnecessary pain of multiple intramuscular
injections, the nurses administered the ten-fold overdose of the drug
intravenously and thereby caused the baby’s death.\textsuperscript{73} This series of
errors leading to the child’s death illustrates how the “holes” in the
“Swiss cheese” model of systems errors can line up to lead to
disastrous consequences.\textsuperscript{74}

Although medical errors may manifest as both implementation
errors and as judgment errors,\textsuperscript{75} advocates of systems analysis focus
on implementation errors.\textsuperscript{76} Thus, a busy nurse responsible for
multiple patients may make a medication error by forgetting to
administer the proper dose at the proper time.\textsuperscript{77} Systems analysts
correct this type of error (at least in part) by implementing unit-
dosing to eliminate dose measuring by an overworked nurse.\textsuperscript{78} In
anesthesia practice, providers have identified causes of errors,
implemented fail-safe approaches, and emphasized training to reduce
error rates from 1 in 10,000 to 20,000 to 1 in 200,000 in little over a
ten-year period.\textsuperscript{79}

\textsuperscript{70} See Mederrors.com, supra note 59.
\textsuperscript{71} See id.
\textsuperscript{72} See id.
\textsuperscript{73} See id.
\textsuperscript{74} See supra notes 34-37 and accompanying text.
\textsuperscript{75} See Latham, supra note 7, for a discussion of the difficulty in classifying medical errors
according to the implementation/judgment dichotomy.
\textsuperscript{76} See Latham, supra note 27, at 164.
\textsuperscript{77} See Leape, supra note 46.
\textsuperscript{78} See id.
\textsuperscript{79} See id.
II. Compatibility of Current Tort System with Systems Approach to Eliminating Medical Error

A. Goals and Policies of the Current Tort System in Addressing Medical Errors

The United States’ tort system deals with medical error primarily through the cause of action for negligence. In this context, the law imposes a duty on a physician or other healthcare provider to exercise sound medical judgment and to use reasonably available equipment and facilities in delivering medical care to the patient. The general goals of the tort system are compensation to the injured patient, deterrence of the provider’s harmful behavior, and fairness to both parties. Because compensating individuals for all adverse events would be prohibitively expensive to society, the tort system compensates only the subset of these adverse events caused by negligence. Thus, the tort system seeks to deter behavior that falls below the standard of care established by the medical community itself. It deters this behavior by shifting the cost of the negligent act from the innocent victim patient to the negligent tortfeasor provider. This cost shifting purportedly imposes an incentive on the provider to practice non-negligent medicine.

B. Patient Aspirations and Motivations

A fundamental aspect of the medical malpractice tort system is that the injured patient plaintiff must initiate suit to recover compensation and give practitioners the deterrence incentive. While patients may file a tort suit to seek compensation, evidence also suggests that

81. See, e.g., Hall v. Hilbun, 466 So.2d 856, 872-73 (Miss. 1985).
83. See Studdert & Brennan, Toward a Workable Model, supra note 19, at 231.
84. See Barry R. Furrow et al., Health Law § 4-35 (2d ed. 2000).
86. See Liang, supra note 11, at 91-92.
87. See, e.g., Fed. R. Civ. P. 3 (stating that a civil action commences when the plaintiff files a complaint).
patients sue, at least in part, to seek information or to punish the doctor's failure to disclose the mistake.\textsuperscript{88}

\textit{C. Physician Fears and Reactions}

Proper operation of tort law in achieving its deterrence goals presumes that doctors recognize and appreciate tort law incentives and agree with the legal understanding of negligence.\textsuperscript{89} The notion that doctors understand negligence in the legal sense and properly react to its incentives, however, is in doubt.\textsuperscript{90} First, many doctors equate an adverse outcome with negligence.\textsuperscript{91} In part, a medical culture that emphasizes perfection causes this misunderstanding.\textsuperscript{92} In part, doctors genuinely misunderstand the tort law doctrine of negligence.\textsuperscript{93} Second, doctors, when asked to apply a legal standard to a given set of facts, often reach significantly different conclusions from both juries and other doctors.\textsuperscript{94} Doctors do not always agree as to what constitutes the standard of care,\textsuperscript{95} and juries may reach conclusions about negligence for reasons other than whether the doctor provided proper care.\textsuperscript{96} Empirical evidence suggests that favorable plaintiffs' verdicts correlate with the severity of the injury: the more severe the injury, the more likely the jury will favor the plaintiff.\textsuperscript{97} Doctors conclude that they are susceptible to liability even when they exercise the required standard of care.\textsuperscript{98} Consequently, doctors fear that the tort system does not abide by its own rules in deciding medical malpractice cases.\textsuperscript{99} Furthermore,

\begin{itemize}
  \item \textsuperscript{88} See Kathleen Ruroede, \textit{Attitudes of Risk Management Professionals Toward Disclosure of Medical Mistakes}, 12 \textit{RISK: HEALTH, SAFETY & ENV'T} 67, 70 (2001).
  \item \textsuperscript{89} See Liang, supra note 11, at 61.
  \item \textsuperscript{90} See id. at 67.
  \item \textsuperscript{91} See id. at 65.
  \item \textsuperscript{92} See Leape, supra note 46 ("How can there be an error without negligence?").
  \item \textsuperscript{93} See Liang, supra note 11, at 64-65 (reporting that of twenty radiologists surveyed, none was able to identify all four elements of the negligence cause of action, and that most doctors' knowledge of the legal doctrine is from the press).
  \item \textsuperscript{94} See id. at 73.
  \item \textsuperscript{95} See id. at 66.
  \item \textsuperscript{96} See id. at 75-76.
  \item \textsuperscript{97} See Liang, supra note 10, at 35-36.
  \item \textsuperscript{98} Cf. Liang, supra note 11, at 67.
  \item \textsuperscript{99} See Liang, supra note 10, at 36.
\end{itemize}
evidence suggests that patients often sue doctors for non-negligent care.\textsuperscript{100} Finally, doctors fear that juries have a hindsight bias in assessing malpractice claims.\textsuperscript{101}

This tort law misunderstanding coupled with a medical culture that demands perfection gives physicians great incentive to conceal errors.\textsuperscript{102} Physicians see the legal system as their opponent\textsuperscript{103} and, therefore, prefer not to disclose errors.\textsuperscript{104} In particular, although the medical industry uses risk management and quality assurance to control error,\textsuperscript{105} doctors remain reluctant to disclose errors for fear that such disclosures will be discoverable in civil litigation.\textsuperscript{106}

Although educating physicians to correct their misunderstanding of negligence is one possible approach, evidence suggests that risk management seminars are ineffective and may even lead to an increase in patient injury.\textsuperscript{107} Moreover, increased efforts at risk management and quality assurance are arguably not likely to reduce systemic errors because such practices focus on incidents and individual behavior and often ignore near-misses.\textsuperscript{108}

In recognition of the complex nature of medical errors, medical and legal researchers are calling for application of systems analysis to address the problems of medical error.\textsuperscript{109} Advocates of this approach, however, fear that practitioners will not report errors for the reasons outlined earlier in this Note.\textsuperscript{110} Unfortunately, the systems approach to error correction will fail in the absence of error

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\textsuperscript{100} See Bryan A. Liang, \textit{Access to Health Care in the United States}, 22 J. LEGAL MED. 211, 223 n.31 (2001).

\textsuperscript{101} See Liang, supra note 10, at 37.

\textsuperscript{102} See Leape, supra note 46; Liang, supra note 10, at 28.

\textsuperscript{103} See Michael A. Greenberg, \textit{The Consequences of Truth Telling}, 266 JAMA 66 (1991) (Letter to the Editor) (stating “[a] small number of lawyers, driven by greed, find every opportunity to become wealthy on our human errors”); Liang, supra note 10, at 28, 32.

\textsuperscript{104} See Ruroede, supra note 88, at 70.

\textsuperscript{105} See Leape, supra note 46.

\textsuperscript{106} See Liang, supra note 10, at 39; see also State ex rel. Dixon v. Darnold, 939 S.W.2d 66, 70-71 (Mo. Ct. Appl 1997).

\textsuperscript{107} See Liang, supra note 10, at 37-38 (observing that doctors who participate in risk management seminars have a greater chance of being sued than doctors who don’t participate).

\textsuperscript{108} See Leape, supra note 46.


\textsuperscript{110} See supra notes 52-73 and accompanying text.
reporting. Possible steps to encourage reporting include conditioning accreditation on satisfaction of reporting requirements and granting broader discovery. More expansive versions of these ideas include imposing vicarious liability on hospitals and managed care organizations (MCOs) and providing no-fault compensation for victims of medical error.

III. STUDDERT AND BRENNAN’S PROPOSAL FOR A NO-FAULT COMPENSATION SYSTEM TO PROMOTE PATIENT SAFETY

In general, an injury resolution system is no-fault if it replaces the fault-liability inquiry of the tort system with a no-fault identification of compensable injuries. With respect to the tort goals of compensation and deterrence, a no-fault system compensates a broader range of injuries by making claims easier to assert and administer; it also deters the injury-producing practices by identifying negative practices through expert resolution of claims and economic incentives that reduce the unwanted behavior. In addition, replacing predictive, lump-sum payments with periodic payments for incurred losses is an essential feature of a no-fault system. A broad array of options is available for defining the system. Administration may be public or private; procedures may be formal or informal; coverage may be mandatory or voluntary; benefits may be comprehensive or basic; premium-setting may use community or experience rating; solvency may be publicly or privately guaranteed; and loss-prevention mechanisms may be

111. See Liang, supra note 10, at 46.
112. See id.
114. See Bovbjerg & Sloan, supra note 19, at 55; Studdert & Brennan, Toward a Workable Model, supra note 19; David M. Studdert & Troyen A. Brennan, supra note 8, at 221; Paul C. Weiler, The Case for No-Fault Medical Liability, 52 Md. L. REV. 908 (1993).
115. See Bovbjerg & Sloan, supra note 19, at 64.
116. See id. at 65.
117. See id. at 71.
118. See id. at 68-69.
systemic or discretionary.\textsuperscript{119} For the targeted purpose of error prevention, the system must further compel or at least facilitate error reporting and must include a mechanism for identifying and eliminating willfully malevolent providers.\textsuperscript{120}

Studdert and Brennan have proposed a no-fault compensation plan to increase patient safety through improved error reporting and subsequent systems analysis to eliminate latent implementation errors.\textsuperscript{121} The plan, modeled after a Swedish no-fault plan,\textsuperscript{122} identifies and compensates injuries caused by treatment not medically justified or treatment for which the outcome was “avoidable.”\textsuperscript{123} To eliminate minor but administratively expensive claims, the plan denies compensation to any patient who hasn’t suffered a minimum number of poor health days as measured by either a length of hospital stay or a number of sick days.\textsuperscript{124} The plan makes scheduled payments for both pecuniary and pain-and-suffering losses.\textsuperscript{125} To answer concerns that a no-fault system reduces the physician’s motivation to be careful, the system proponents identify experience rating as utilized in the workers’ compensation system as the mechanism for premium-setting.\textsuperscript{126} Experience rating imposes economic pressures on the hospital or MCO to implement patient safety initiatives.\textsuperscript{127} Thus, the proposal effectively imposes liability on the hospital or MCO for the occurrence of a compensable injury.\textsuperscript{128}

A no-fault compensation system allegedly enables providers to report errors and thereby improve patient safety.\textsuperscript{129} An indispensable

\textsuperscript{119} See id.
\textsuperscript{120} See Studdert & Brennan, Toward a Workable Model, supra note 83, at 228.
\textsuperscript{121} See id. at 231; Studdert & Brennan, supra note 8, at 217; David M. Studdert et al., Can the United States Afford a “No-Fault” System of Compensation for Medical Injury?, 60 LAW & CONTEMP. PROBS. 1, 3 (1997).
\textsuperscript{123} Studdert et al., supra note 121, at 7.
\textsuperscript{124} Studdert & Brennan, supra note 8, at 220.
\textsuperscript{125} See id.
\textsuperscript{126} See id. at 221.
\textsuperscript{127} See id.
\textsuperscript{128} See id.
\textsuperscript{129} See id. at 219.
feature of the system is therefore the transmission of error reports to a
central repository—possibly state-based central agency—for root
cause analysis and subsequent dissemination of the analysis
results.\footnote{See Studdert & Brennan, supra note 8, at 220.} Strictly confidential reporting would mirror the successful
ASRS aviation reporting system, and the central agency would share
reports with both local institutions initiating safety efforts and state-
run agencies undertaking broader safety initiatives.\footnote{See id. at 219.}

Studdert and Brennan define the optimal system, whether fault-
based or not, for increasing patient safety through prevention of
medical errors as comprising five essential attributes.\footnote{See id. at 219.} First, the
system must lead to error reporting by practitioners.\footnote{See id.}
Second, along with error reporting, the system should encourage improved quality
of care, particularly through economic incentives.\footnote{See id.}
Third, the system must identify and eliminate grossly negligent or intentionally
malevolent practitioners.\footnote{See id.}
Fourth, the optimal system should facilitate an open and honest patient-doctor relationship in which the
doctor informs the patient when a preventable error has occurred.\footnote{See id. at 219.} Finally, the optimal system will render due compensation quickly,
fairly, affordably, and reliably.\footnote{See id. at 219.} Proponents argue that a no-fault
compensation system will achieve these five goals better than the
current tort system.\footnote{See David M. Studdert & Troyen A. Brennan, No-Fault Compensation for Medical Injuries: The
Prospect for Error Prevention, 286 J. AM. MED. ASSOC. 217, 220 (2001).}
In particular, a no-fault system will allegedly encourage error reporting by removing the threat of litigation that
currently raises a barrier to error reporting.\footnote{See id. at 219.}
V. Compatibility of No-Fault Proposal with Patient Safety Goal

Ultimately a no-fault system replaces the injuries compensable under the current tort system—negligent injuries—with another set of compensable injuries—preventable adverse-event injuries in the case of the Studdert and Brennan proposal. Policy arguments that such a replacement will lead to improved patient safety motivate the call for this replacement. This Part investigates whether these policy arguments justify the change.

The primary argument in support of a no-fault system is that it, unlike the current tort system, will encourage practitioners to report errors and thereby satisfy the first optimal factor of Studdert and Brennan. Medical practitioners commit their lives to improving their patients’ health and thus have a strong interest in error prevention but will not endanger their careers and livelihoods to report errors in the face of possible litigation. Error reporting under limited immunity in other industries, particularly the aviation industry, has led to dramatic increases in safety and will potentially lead to similar increases in patient safety in the healthcare industry. Moreover, the reporting experience of the Veterans Administration (VA) Hospital, where federal law immunizes the medical staff from tort liability, demonstrates that no-fault protection for medical practitioners will in fact lead to improved error reporting.

Even in the absence of a legal duty, doctors have an ethical duty to disclose a significant error to the patient. The VA hospital system represents one success story in this regard. The risk manager of a VA hospital routinely reveals significant errors to patients despite the

140. See Studdert & Brennan, Toward a Workable Model, supra note 83, at 231-32.
141. See id. at 231.
142. See supra notes 121-141 and accompanying text.
144. See supra Part II.C.
145. See supra Part I.B.
146. See infra notes 148-152 and accompanying text.
147. See Ruroede, supra note 88, at 72.
148. See Steve S. Kraman & Ginny Hamm, Risk Management: Extreme Honesty May be the Best Policy, 131 ANNALS INTERNAL MED. 963, 963 (1999); Ruroede, supra note 88, at 73.
tort liability risk to the hospital; the mean settlement payment to patients is $720,000. See Kraman & Hamm, supra note 148, at 966. Ruroede, supra note 88, at 73. This amount is approximately half of the mean judgment awarded in the tort system for medical malpractice cases. See Ruroede, supra note 88, at 73. Often the providers themselves, who are immune to tort liability, bring the error to the attention of the risk manager. See Stephen S. Kraman & Ginny Hamm, Trust-Based Patient Safety Program, U.S. MEDICINE: THE VOICE OF FEDERAL MEDICINE, March 27, 2001 (relating that providers have a “very high” rate of self-reporting of errors). Disclosure of mistakes arguably helps both the patient and the doctor to recover from the impact of the error. See Ruroede, supra note 88, at 72; see also Kraman & Hamm, supra note 150 (stating that providers who have made an error need support and generally are in favor of disclosure once they understand that disclosure improves healthcare delivery without labeling them as “bad”). Moreover, evidence suggests that disclosure reduces the incidence of malpractice suits by as much as fifty percent. Fear of civil litigation does not prevent error reporting in the aviation industry. See Kraman & Hamm, supra note 148, at 966. Ruroede, supra note 88, at 73. See Leape, Foreword, supra note 109, at 147. See William M. Sage, Principles, Pragmatism, and Medical Injury, 286 JAMA 226, 227 (2001) (reporting that the NPDB is “all but ignored”); see also Leape, supra note 46 (reporting that independent of litigation concerns, doctors fail to report errors also for fear of censure or worse from colleagues). However, chronic underreporting to the National Practitioner Data Bank (NPDB), which provides limited immunity in the form of amnesty for reporters, demonstrates that limited immunity does not suffice for the healthcare industry. One explanation for the underreporting is that report amnesty extends only to reporters, not to the potentially liable wrongdoers, so organizations remain reluctant to report errors because of the medical culture’s attitude toward mistakes. However, the same concern in the aviation industry has not inhibited reporting, even though any information reported to the ASRS is discoverable in litigation and potentially inculpatory for the implicated airline personnel. Fear of civil litigation does not prevent error reporting in the aviation industry. The observation that doctors, unlike airline personnel, are potential “deep pockets” in

149. See Kraman & Hamm, supra note 148, at 966. Ruroede, supra note 88, at 73. This amount is approximately half of the mean judgment awarded in the tort system for medical malpractice cases. See Ruroede, supra note 88, at 73.
150. See Stephen S. Kraman & Ginny Hamm, Trust-Based Patient Safety Program, U.S. MEDICINE: THE VOICE OF FEDERAL MEDICINE, March 27, 2001 (relating that providers have a “very high” rate of self-reporting of errors).
151. See Ruroede, supra note 88, at 72; see also Kraman & Hamm, supra note 150 (stating that providers who have made an error need support and generally are in favor of disclosure once they understand that disclosure improves healthcare delivery without labeling them as “bad”).
152. See Ruroede, supra note 88, at 71.
153. See Leape, Foreword, supra note 109, at 147.
154. See William M. Sage, Principles, Pragmatism, and Medical Injury, 286 JAMA 226, 227 (2001) (reporting that the NPDB is “all but ignored”); see also Leape, supra note 46 (reporting that independent of litigation concerns, doctors fail to report errors also for fear of censure or worse from colleagues).
156. See Liang, supra note 10, at 29.
157. See id. at 42.
tort litigation offers a possible explanation for the different responses in these two industries.\textsuperscript{158} However, this argument equally justifies imposition of vicarious liability on the organization within the present tort system, rather than replacement of the current system with no-fault.\textsuperscript{159}

The medical culture itself, independent of liability fears, discourages error reporting by treating mistakes as failures for which the wrongdoer becomes a scapegoat.\textsuperscript{160} Further, shifting liability from the provider to the organization simply shifts the source of the physician’s fear to the organization, which may potentially be liable under corporate negligence principles for utilizing doctors who make mistakes.\textsuperscript{161} Even if immune from tort liability, practitioners would still risk both the possible loss of privileges due to an error and the prospect of a negative report to the NPDB.\textsuperscript{162} Thus, if the medical culture’s bias against disclosure is a more powerful impediment than fear of liability, removing the fear of liability through no-fault will fail as a mechanism to encourage error reporting.\textsuperscript{163}

The second optimal factor identified by Studdert and Brennan encourages quality of care improvements through economic incentives.\textsuperscript{164} The implication for their no-fault proposal is that experience rating as used in the workers’ compensation system will give the organization the necessary incentive to improve quality by reducing patient injuries.\textsuperscript{165} However, the patient compensation problem fundamentally differs from the workers’ compensation problem because victims of industrial accidents, unlike victims of medical accidents, generally know when an accident has occurred.\textsuperscript{166}

\begin{itemize}
\item \textsuperscript{158} See id.
\item \textsuperscript{159} See, e.g., supra note 113.
\item \textsuperscript{160} See Leape, supra note 46; Ruroede, supra note 88, at 71.
\item \textsuperscript{161} See Furrow et al., supra note 80.
\item \textsuperscript{162} Even in the VA hospital system where practitioners already have immunity from tort liability, they still face these same risks. Kraman & Hamm, supra note 148, at 966. See also Kraman & Hamm, supra note 150 (reporting that some practitioners were still reluctant to disclose errors despite immunity from personal liability).
\item \textsuperscript{163} See Latham, supra note 27, for an argument that more liability, not less, is needed to compel error reporting.
\item \textsuperscript{164} See supra note 102 and accompanying text.
\item \textsuperscript{165} See supra notes 94, 126 and accompanying text.
\item \textsuperscript{166} See generally Peter M. Lencsis, Workers Compensation: A Reference and Guide (1998).
\end{itemize}
Unlike the current impetus for no-fault compensation to reduce medical errors, the impetus for the workers compensations’ system was a need to address a high number of tort claims in hazardous industries, not a need to induce error reporting. Furthermore, even though experience rating in the workers’ compensation system has arguably increased worker safety, the status of doctors as independent contractors rather than as employees of hospitals and MCOs makes its application more difficult in the healthcare industry. For example, in today’s managed care setting, healthcare workers still face the prospect of organizational discipline, which may continue to discourage error reporting, even if the law would impose no liability on the individual provider. In addition, application of experience rating to the solo or small practitioner is particularly difficult.

The third optimal factor eliminates grossly negligent or willfully malevolent doctors. Because identification of such actors is essentially a fault-based inquiry, even a no-fault system will necessarily have some fault-determination aspect, perhaps even utilizing the current tort system itself.

The fourth optimal factor facilitates an open and honest relationship between doctor and patient. Although no-fault will arguably accomplish this goal, the traditional tort system can also accomplish this goal, as evidenced by the disclosure experience of the VA hospital system, even with the threat of liability. Furthermore, the tort system also recognizes a cause of action for negligent failure to provide informed consent. In this way, the tort

169. See Sage, supra note 154, at 227.
170. See id. at 227.
171. See Studdert & Brennan, supra note 8, at 221.
172. See supra note 135 and accompanying text.
173. See Studdert & Brennan, Toward a Workable Model, supra note 83, at 228.
174. See supra note 136 and accompanying text.
175. See id.
176. See supra note 148 and accompanying text.
177. See Furrow et al., supra note 80.
system has sought to change the traditional doctor-patient relationship from one in which the doctor’s primary goal was to obtain the patient’s agreement with the doctor’s recommendations, to one in which the doctor’s goal is to sufficiently inform the patient to enable the patient to determine the best course of action. Ultimately, the doctor-patient relationship reflects society’s view of medical ethics; tort law frequently seeks to buttress or guide the medical community’s ethical considerations and thus arguably seeks to foster an open and honest relationship between doctor and patient.

The fifth and final optimal factor encourages fast, reliable, fair, and administratively easy payment of patient compensation. Proponents argue that no-fault accomplishes this goal. However, the experience of the VA hospital system demonstrates that the tort system also accomplishes this goal, at least where the healthcare community embraces its ethical duty to disclose errors and does not succumb to fear of tort liability.

The policy arguments for replacing the traditional tort system with a no-fault compensation system do not clearly favor one system over the other, but modifying the Studdert and Brennan proposal to restrict compensation to a class of errors clearly amenable to identification and correction through systems analysis may shift the balance in favor of no-fault. Doctors working together with risk managers and systems analysts would develop the list of compensable events. Because doctors would be contributing to the

178. See id.
180. See supra note 137 and accompanying text.
181. See Studdert & Brennan, Toward a Workable Model, supra note 88, at 73.
182. See Ruroede, supra note 88, at 73.
183. See, e.g., Laurence R. Tancredi, Designated Compensable Events: A No-Fault Approach to Medical Malpractice, 10 LAW, MED. & HEALTH CARE 200, 201 (1982) (suggesting an approach to patient compensation based on no-fault insurance against injuries due to adverse medical events designated as avoidable); The National Quality Forum, available at http://www.qualityforum.org (suggesting a list of twenty-seven “never events” that should form the nucleus of a list of events to be reported in any national reporting system designed to improve patient safety).
184. See Tancredi, supra note 183, at 201.
identification of errors caused by systems (not individuals), the anti-disclosure medical bias based on fear of community censure loses much of its justification.185

An underlying premise of current thinking about medical errors is that the system, not the healthcare provider, is the real source of the problem.186 However, not all observers agree that systems instead of healthcare workers are the source of the problem; these critics argue that systems are the setting, not the source, of the problem.187 If, however, the medical, legal, and scientific communities were to agree that systems do in fact cause certain specified errors, then no-fault compensation for injuries arising from these errors would be appropriate and should facilitate both reporting and correction of these errors.188

Finally, the healthcare delivery process differs from other service settings in which one party has a duty of care to another because “the harm and suffering [is] caused by the actions of individuals whose sole purpose is to relieve suffering and in whom the victim places a profound and personal trust—doctors and nurses.”189 Although this unique situation may justify granting healthcare providers no-fault protection, the victim’s “profound and personal” trust in the healthcare provider may also arguably justify imposing more liability.190

CONCLUSION

A no-fault compensation system as proposed by Studdert and Brennan, but restricted to an enumerated list of errors correctable through systems analysis, will effectively increase patient safety.191 However, traditional tort liability will necessarily continue to play a

185. See id.; see also Leape et al., supra note 4.
186. See Latham, supra note 27, at 165; see also Leape, Foreword, supra note 109, at 148.
187. See Latham, supra note 27, at 165.
188. See generally Leape, Foreword, supra note 109.
189. Leape, Foreword, supra note 109, at 145.
190. Compare Leape, Foreword, supra note 109 (arguing error-correction efforts that emphasize blame are misguided), with Latham, supra note 27 (arguing that error-correction efforts that de-emphasize blame are misguided).
191. See supra Parts II–IV.
role in ensuring patient safety through deterrence of injury-causing practices not identifiable and correctable by systems analysis, namely malevolent practices\textsuperscript{192} and practices due to judgment errors.\textsuperscript{193} Because hospitals and the MCOs implementing the system can effectively correct systems errors, experience rating will give them the necessary and appropriate incentive to do so, thereby increasing patient safety.\textsuperscript{194} Thus, a form of no-fault compensation coupled with experience rating for a limited class of errors, identified as correctable by systems analysis, will promote error reporting and increase patient safety.\textsuperscript{195} In addition, the law should prohibit the hospital or MCO from disciplining the healthcare provider for reporting an error in the designated class.\textsuperscript{196} The policy underlying this suggestion is that the identified class of errors comprises those errors that are the fault of the "system," not the individuals implementing the system.\textsuperscript{197} Thus, the practitioner who reports the error actually helps both the patient and the organization by making the system safer, and the organization should not punish her.\textsuperscript{198} This safeguard, however, will not prevent the organization from disciplining careless, incompetent, or genuinely malevolent practitioners.\textsuperscript{199} Indeed the law imposes a duty on the organization to do so or else face liability in tort for corporate negligence.\textsuperscript{200} Identification of a compensable class of errors will allow the organization to discipline these persons and simultaneously will facilitate non-punitive reporting of errors in order to promote patient safety.\textsuperscript{201}

\textit{K. James Sangston}

\textsuperscript{192} See supra notes 135-136 and accompanying text.
\textsuperscript{193} See To Err is Human, supra note 1, which defers consideration of judgment errors to a later report.
\textsuperscript{194} See Studdert & Brennan, Toward a Workable Model, supra note 83, at 231.
\textsuperscript{195} See id.
\textsuperscript{196} See Tancredi, supra note 183, at 201.
\textsuperscript{197} See Leape et al., supra note 4.
\textsuperscript{198} See supra notes 121-123 and accompanying text.
\textsuperscript{199} See supra notes 135-136 and accompanying text.
\textsuperscript{200} See BARRY R. FURROW ET AL., HEALTH LAW § 7-4 (2d ed. 2000).
\textsuperscript{201} See supra note 185 for suggested approaches to defining this class.