W.H. van Boom, A. Pinna, Shifts from Liability to Solidarity: The Example of Compensation of Birth Defects, in: W.H. van Boom, M.G. Faure (eds.), Shifts in Compensation between Private and Public Systems, Vienna: Springer 2007, p. 143-180

Shifts from Liability to Solidarity: The Example of Compensation of Birth Defects

Willem H. van Boom and Andrea Pinna[*]

I. Introduction and Research Question

Being born is not without its dangers. Compared to the risks of medical treatment in general, the risk of a pregnant woman and her unborn child sustaining some kind of peri-natal injury is quite considerable.[1] Sometimes the physician or the hospital involved can be held accountable for the injuries that result. Roughly speaking three sets of cases typically arise. First, complications can arise in the delicate delivery process in which the physician does not act or react with the required competence (e.g., the obstetrician may fail to respond adequately to sudden asphyxia during labour, causing cerebral palsy). Second, during pregnancy the physician can err in diagnosing correctly and thus fail to read the early signs of complications or even fail to detect severe genetic defects. In the latter case, the parents may want to argue that they would have terminated pregnancy if they had known of the defects. Third, after correct diagnosis of a defect, the physician fails to properly terminate the pregnancy as requested by the parents and, therefore, leads to the birth of an unwanted handicapped child. 1

In most western legal systems these three sets of cases have been tried in civil liability procedures, either on the basis of breach of contractual duty of care or on the basis of tortious liability for negligent act or omission by a physician or hospital.[2] The loopholes and drawbacks of such civil procedures are well 2

[*] Professor of Private Law and Assistant Professor respectively at the Rotterdam Institute of Private Law, Erasmus University Rotterdam. Melissa Moncada Castillo gave indispensable research assistance. This paper was concluded in Spring 2006; subsequent developments were not included.

[1] *Margaret Brazier*, The Case for a No-Fault Compensation Scheme for Medical Accidents, in: Sheila A.M. McLean (ed.), Compensation for Damage – An International Perspective (1993) 54; *Willem H. van Boom*, Compensatie voor geboorteschade – van aansprakelijkheid naar 'no-fault'? AV&S 2006, 8.

[2] For an overview of these cases, see, e.g., *Dan B. Dobbs*, Torts and Compensation (1993) 448 ff.; *Dan B. Dobbs*, The Law of Torts (2000) 781 ff.; *Jonathan Montgomery*, Health Care Law (2003) 418 f.; *Jay M. Zitter*, Liability of Hospital, Physician, or other Medical Personnel for

known: procedures are time-consuming, in most jurisdictions quite expensive (and sometimes even prohibitively expensive), they are burdensome for claimants and defendants alike, the outcome depends on the hard to obtain evidence of what went wrong, on whether the physician or hospital acted negligently, and whether this negligence caused the damage.[3] Moreover, some courts and legislatures have excluded some or all claims for birth defects, arguing that the gift of life in itself – however miserable – cannot be considered an adverse event.[4]

3 In some jurisdictions obstetrics and gynaecology rank high or even the highest – usually together with emergency care, anaesthetics and (cosmetic) surgery – as far as the numbers of malpractice claims is concerned.[5] Unsurprisingly, it is believed that the sharp increase of insurance premiums for obstetrics and gynaecology in a number of countries is caused, in part at least, by a growing number of successful malpractice claims.

Death or Injury to Mother or Child Caused by Improper Diagnosis and Treatment of Mother Relating to and During Pregnancy, 7 A.L.R. 5th 1; *Jay M. Zitter*, Liability of Hospital, Physician, or other Medical Personnel for Death or Injury to Mother or Child Caused by Improper Treatment during Labor, 6 A.L.R. 5th 490; *Gregory G. Sarno*, Tort Liability for Wrongfully Causing One to be Born, 83 A.L.R. 3d 15.

[3] See generally *Linda Mulcahy*, Threatening Behaviour? The challenge posed by medical negligence claims, in: Michael Freeman and Andrew Lewis (ed.), Law and Medicine (2000) 102 f.; *Randall R. Bovbjerg et al.*, Administrative Performance of "No-Fault" Compensation for Medical Injury, 71 Law and Contemporary Problems 1997, 71 f.; *Sheila A.M. McLean*, Can No-Fault Analysis Ease the Problems of Medical Injury Litigation? in: Sheila A.M. McLean (ed.), Compensation for Damage – An International Perspective (1993) 77; *Department of Health*, Making Amends – A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS (2003; hereafter: *Making Amends*) 51 ff; *Hans J. Radau*, Ersetzung der Arzthaftung durch Versicherungsschutz – Eine Untersuchung am Beispiel der Patientenunfallversicherung in Schweden (1993) 73 ff. On the (relatively low) success rate of medical malpractice claims in England, see *Michael A. Jones*, Compensation in the English Health Care Sector, in: Jos Dute et al. (ed.), No-Fault Compensation in the Health Care Sector (2004) 161 ff.

[4] See, e.g., the state of Utah, which has straightforwardly banned some claims for birth defects. Code Ann. Utah § 78-11-24 ("Act or omission preventing abortion not actionable") reads: "A cause of action shall not arise, and damages shall not be awarded, on behalf of any person, based on the claim that but for the act or omission of another, a person would not have been permitted to have been born alive but would have been aborted." There is also a strand in case law barring claims for maintenance of healthy children (failed sterilization cases etcetera) and/or merely allowing claims for excess cost of unhealthy children. See, e.g., in England, *McFarlane v Tayside Health Board* [2000] 2 AC 59; in France, Civ. I, 25 June 1991 Dalloz 1991, J., p. 566, with annotation Ph. Le Tourneau; JCP 1992.II.21784, with annotation J.-F. Barbiéri. The reasoning behind these cases seems to have a similar background: one cannot claim for the cost of the upbringing of a perfectly healthy child, however unwanted the pregnancy was.

[5] *Yvonne Lambert-Faivre*, Droit du dommage corporel – Systèmes d'indemnisation (2004) 840; compare also the list given by *Proposition de loi organisant l'indemnisation des accidents médicaux sans faute médicale* (Statutory Draft) Sénat de Belgique 2003 (proposal sumbitted by M. A. Destexhe) 4. See also *Mulcahy* (fn. 3) 92 ff.; *Peter Davis et al.*, Compensation for Medical Injury in New Zealand: Does 'No-Fault' Increase the Level of Claims Making and Reduce Social and Clinical Selectivity? 27 J. of Health Politics, Policy and Law 2002, 851.

We know that the claim frequency is high and on the rise in some countries.[6] But the stakes are extremely high as well: brain injury of a newborn for instance ranks very high among the costliest of categories of medical malpractice.[7] This is hardly surprising. Imagine a newborn with a severe mental disability; it will need special health care for years to come, it will require special housing and nursing, it will forfeit any chance of financially maintaining itself between the age of 18 and 65, and the parents will typically substitute family income with care-giving hours. 4

All these circumstances account for the extensive financial loss experienced by the families involved. It also accounts for the dramatic emotions that both families and doctors will experience surrounding a liability claim.[8] In liability claims, only the emotions of the disabled child and its family are converted into monetary values: claims for pain, suffering, loss of amenities, etc. The amount of these claims varies considerably from legal system to legal system: moderate in some, excessive and thus leading to more concern in others.[9] 5

In some countries the advancing liability system has caused increasing alarm to obstetricians and gynaecologists.[10] A dramatic rise in liability insurance premiums and the withdrawal of liability insurers have been said to cause defensive medicine and a shortage of specialist health care professionals. The problems surrounding compensation for birth defects caused by medical negligence have prompted some legislatures to ask themselves the question whether the liability system is appropriate to cater to the needs of caring, nursing, and teaching of a severely handicapped child and alleviating the burden on their families. Some legislators have responded to the use of the private law compensation system with statutory exclusions of liability or shifts towards alternative compensation schemes. As Davis c.s. note: "regulatory systems that rely on administrative mechanisms for patient compensation without the legal requirement to prove fault (…) have a considerable fascination for policy makers and professional leaders".[11] 6

[6] See on medical malpractice in general, e.g., *Montgomery* (fn. 2) 203 ff.; *Mulcahy* (fn. 3) 83; *Comptroller and Auditor General House of Commons*, Handling clinical negligence claims in England (2001) 14 f.

[7] *Paul Fenn et al.*, The Economics of Clinical Negligence Reform in England, 114 The Economic Journal 2004, F279 f. Data collected by the NHS Litigation Authority suggest that brain-damaged babies account for 5 per cent of the malpractice cases but 60 to 80 per cent of the total cost. See *Making Amends* (fn. 3) 47 and *Margaret Brazier*, Medicine, Patients And The Law (2003) 244. Cf. *Jones* (fn. 3) 163; *HOPE*, Insurance and malpractice (2004) 6. See also *ACC*, A comprehensive study of the cost of accepted medical misadventure claims (2003) 11 ff, ranking obstetrics as the clinical group with the highest amounts in compensation payouts under the New-Zealand no-fault compensation scheme.

[8] On pain and suffering of the family involved, see the figures presented by *Kathryn Whetten-Goldstein et al.*, Compensation for Birth-Related Injury, 153 Arch. Pediatr. Adolesc. Med. 1999, 44. See also *Making Amends* (fn. 3) 46.

[9] For the U.S., see *Gregory G. Sarno*, Recoverability of Compensatory Damages for mental anguish or Emotional Distress for tortiously causing another's birth, 74 A.L.R. 4th 798.

[10] For a brief introduction, see *Joseph E. Stiglitz*, Economics of the Public Sector (2000) 312 f.

[11] *Davis et al.*, 27 J. of Health Politics, Policy and Law 2002, 834.

7 The main political motives for these shifts, however, differ. Sometimes, political pressure from the medical profession seems to have been the prime motivator for merely excluding liability, whereas in other jurisdictions a genuine alternative compensation scheme for the liability system has been put in place. In other jurisdictions the political pressure originated from insurance companies threatening to step out (of some sectors) of the medical professional insurance if certain measures were not duly taken.[12]

8 This raises the question of whether and to what extent policymakers act rationally when fully shifting from liability to an alternative scheme. Are these shifts based on a thorough analysis of the problems experienced by the children, their families, the physicians and hospitals involved? What do the underlying causes of these problems tell us about the policy choices made?

9 Against this background, this paper sets out to give an overview of these responses, to evaluate the alternatives for liability law that have been adopted in some jurisdictions, and to analyse the policy implications of the paths chosen.

II. An Overview of Shifts From Liability Towards Alternative Arrangements

1. Preliminary Remarks

10 What does a shift from liability law imply? We think there is a gliding scale between shifts from fault-based to strict liability, to vicarious liability of hospitals, compulsory liability insurance, and even replacing liability law altogether with some sort of no-fault compensation scheme. However, there are two considerations in this respect. First, there is no such thing as "the" no-fault alternative to liability law. The variations are numerous. The alternative arrangements do, however, show some common features.

11 Second, alternative arrangements usually depart from the axiom of *full compensation* for pecuniary *and* non-pecuniary loss. The claimant is usually forced to make sacrifices in this respect in return for benefits concerning the speed of procedure, legal aid, and requirements for admittance to the scheme.

12 An alternative scheme does not always imply a substantial shift from liability law. It is noteworthy that in New Zealand, until recently iatrogenic injury was compensated only in case of negligence of the physician or in the event of a "medical mishap" – which boils down to the materialisation of a rare risk inherent to the treatment with severe adverse consequences.[13] If we take away this category of "mishaps", what is left is a fault-based liability system. The difference to a "genuine" liability system, however, is substantial. The adjudi-

[12] Such has been the case in France; see *Andrea Pinna*, La responsabilité médicale en France après la Loi du 4 mars 2002, in: G. de Oliveira (ed.), Temas de direito da medicina (2005) 95 ff.

[13] On the New Zealand regime with regard to medical injury, see, e.g., *Davis et al.*, 27 J. of Health Politics, Policy and Law 2002, 835 ff.

cation process differs, the amounts of damages differ, and the funding and administration of the system differs.

Recently, the New Zealand no-fault compensation scheme was amended by the *New Zealand Injury Prevention, Rehabilitation, and Compensation Amendment Act (No. 2) 2005*. With this rather radical amendment, the New Zealand compensation scheme has shifted away from attribution of medical injury towards a compensation mechanism that seems to filter out questions of fault and substandard care.[14] In the new scheme, injury is compensated if caused by treatment (including diagnosis, consent issues, equipment used, etc.) and is "not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment", including the patients' underlying condition, and clinical knowledge at the time of treatment. Treatment injury does not include injury solely caused by resource allocation decisions.[15] 13

Shifts without changing liability law may, however, also be fairly adequate. First, the introduction of compulsory liability insurance may repress some of the ailments of the liability system. It may serve as a means to prevent insolvency (as it has, e.g., in automobile insurance) and it can also serve as a means to ensure insurability of specific medical professionals (compulsory solidarity).[16] Second, a major catastrophe may provoke political powers to compensate with taxpayers' money. In Germany, the injuries caused by the drug Kontergan (also known under the name of Softenon, Diëthylstilbestrol) prompted the legislature to establish a specific trust fund. This trust provides periodic and fixed compensation, reflecting the percentage of disability. The payments are free from income tax and are not reduced by other social security arrangements.[17] By providing this *ad hoc* compensation for an urgent and immediate societal problem, governments can sometimes meet the most pressing needs of important pressure groups. 14

In the following, we will focus on some of the most prominent alternative arrangements for liability law concerning the compensation of birth defects. It is in Virginia and Florida that the earliest shifts from liability towards solidarity have been enacted. France has recently followed this trend. In other jurisdictions like the United Kingdom and Belgium proposals of statutes and official reports seem to point in the same direction. 15

[14] Critical of the (then) proposed changes in the scheme, *Ken Oliphant*, Beyond Woodhouse: Devising New Principles for Determining ACC Boundary Issues, Vict. U. Wellington L. Rev. 2004, 927 f.

[15] S. 32 Injury Prevention, Rehabilitation, and Compensation Act. Note that s. 32 (3) states: 'The fact that the treatment did not achieve a desired result does not, of itself, constitute treatment injury'.

[16] On the functions of compulsory liability insurance in general, see, e.g., Pflichtversicherung – Segnung oder Sündenfall (Dokumentation über ein Symposium am 28.–30. Oktober 2004 im Schloss Marbach, Öhningen) (2005); *Gerhard Wagner*, Comparative report and final conclusions, in: Gerhard Wagner (ed.), Tort and Insurance Law (2005) 311 ff.; *Michael Faure and T. Hartlief*, Verplichte verzekering, in: N. Tiggele-Van der Velde et al. (ed.), De Wansink Bundel – Van draden en daden (2006) 223 ff.

[17] Gesetz uber die Errichtung einer Stiftung 'Hilfswerk fur behinderte Kinder' (StHG) 1971.

2. Specific Shifts in the USA: Virginia and Florida

a) Virginia (USA)

16 In the 1980s the medical profession in Virginia faced increasing liability insurance premiums, refusal of the three insurance companies operating the market for obstetrics and gynaecology liability insurance to underwrite new policies, and subsequently the withdrawal of one of the insurers. At the time, the rural areas of the state were experiencing a sharp decrease in the availability of obstetric care.[18] It was believed that these alarming developments were caused by the high claim rate against obstetricians and gynaecologists for negligently executing their professional duties (2–3 times the average rate of all other physicians), combined with the fact that the amount in damages per case was considerably above the average of claims against other medical professions.

17 As a result, the Medical Society of Virginia proposed a shift from negligence to a no-fault compensation scheme.[19] This resulted in the 1987 Virginia Birth-Related Neurological Injury Compensation Program. Note that the Virginia Program – as well as the Florida NICA scheme which we will discuss infra no. 24) – was lobbied for by physicians who were under attack from a deep insurance crisis, and not by families in distress.[20]

18 The Virginia Program basically works as follows. By delivering a baby in a hospital that participates in the Program, the expecting parents automatically waive the right to file claims in a civil court for injuries sustained during delivery.[21] If the child suffers neurological injury during birth (e.g., brain damage by asphyxia), then the Program applies. Compensation for the negligent misdiagnosis of genetic defects is outside the Program. There is, however, the complication of assessing the causal relationship between birth complications and the neurological injury. In some cases the Program has to work with presumed rather than proved causation, leaving it vulnerable to "leakage" into the Program.[22]

19 The Program offers reimbursement of all medical expenses, care and nursing of the handicapped child, special accommodation if necessary, as well as periodical compensation of loss of earnings from the age of 18 to 65. Instead of compensating by means of a lump sum, the agency responsible for executing the Program compensates on a periodical basis. Reasonable legal costs are

[18] *Joint Legislative Audit and Review Commission of the Virginia General Assembly (hereafter: JLARC)*, Review of the Virginia Birth-Related Neurological Injury Compensation Program (2003) 1–3.

[19] *JLARC* (fn. 18) 1; *Frank A. Sloan et al.*, The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ, 60 Law and Contemporary Problems 1997, 38 f.

[20] *Frank A. Sloan*, Public Medical Malpractice Insurance (2004) 68; *David M. Studdert et al.*, The Jury Is Still In: Florida's Birth-Related Neurological Injury Compensation Plan after a Decade, 25 J. of Health Politics, Policy and Law 2000, 502; *Bovbjerg et al.,* 71 Law and Contemporary Problems 1997, 74. Cf. *Oliphant*, Vict. U. Wellington L. Rev. 2004, 934.

[21] *JLARC* (fn. 18) ii.

[22] Cf.*McKelway*, Richmond Times Dispatch Jan. 31 2003, B-1.

compensated on an hourly-basis. The Program bars claims for non-pecuniary loss, punitive damage or pecuniary losses suffered by the parents.[23]

The Program is funded by annual assessments paid by physicians and hospitals. The assessments are not experience rated, i.e., the rates paid by physicians and hospitals is not connected to the number of adverse events in which a specific hospital or physician was involved.[24] Liability insurance companies may be assessed as well, according to a percentage of their overall turnover. General taxes are not a source of funding.[25] 20

Proof of negligence on the part of the physician is not required. Therefore, it seems plausible that more cases get compensated than under the negligence system. Moreover, although the category of genetic defects is outside the Program, it is nevertheless believed that the total amount that is contributed by physicians and hospitals to the Program annually[26] in fact exceeds the total cost of the medical negligence system. This is remarkable given the fact that the latter system was capped anyway.[27] This may lead us to conclude that in practice the Program is reaching out to more families and with more resources than the negligence system did.[28] It could be argued that in the long run this may lead obstetricians and gynaecologists to preferring the liability system with financial caps over the more generous Program,[29] thus forcing the legislature to consider making the Program compulsory.[30] 21

After the enactment of the Program, the insurability of liability risks improved considerably.[31] However, a recent evaluation of the Program has shown that the availability of obstetric care in rural areas has not increased. Moreover, ac- 22

[23] *JLARC* (fn. 18) 25.

[24] *Randall R. Bovbjerg and Frank A. Sloan*, No-Fault for Medical Injury: Theory and Evidence, 67 U. Cin. L. Rev. 1998, 102 f.

[25] *Sloan* (fn. 20) 5 f. Cf. *Bovbjerg/Sloan*, 67 U. Cin. L. Rev. 1998, 93 f.

[26] Note that 80–90% of the expenses of the Program actually reaches the families and that merely some 10–20% is needed for administrative, financial and legal expenses to administrate the Program (*JLARC* (fn. 18) 9). It is commonly assumed that tort systems are more expensive to run. For an admirable effort to synthesize some of the available data, see *R.M.P.P. Casçao*, Prevention and Compensation of Treatment Injury: A Roadmap for Reform (2005) 100 ff.

[27] *JLARC* (fn. 18) iv.

[28] *JLARC* (fn. 18) 25–26. Note that this is in part explained by the fact that under the law of Virginia, medical malpractice claims are capped at $ 1.6 million. See *JLARC* (fn. 18) 29–40. In turn this would explain the fact that most participating families state that they are happier with the Program than they would have been with a claim in tort (*JLARC* (fn. 18) 28). On the effect of caps on the awards for infants, see also *Nicholas M. Pace et al.*, Capping Non-Economic Awards in Medical Malpractice Trials (RAND report) (2004), xxiii.

[29] Note that the Program is voluntary; a considerable number of physicians have not opted for the Program. See *Bill McKelway*, Program At A Crossroads; No-Fault Proposals Focus On Care, Richmond Times Dispatch Aug. 13 2002, A-1.

[30] Cf. *Michael I. Krauss*, Which Tort Reform Options? Legal Times March 28 2005, 27.

[31] In Virginia, there has been a decrease in malpractice premiums from $ 36,000 in 1989 to $ 25,000 in 1992. The annual assessment for physicians to the Program was $ 5,000. Obstetricians still find the amounts they have to pay too high. See *Frank A. Sloan et al.*, The influence of obstetric no-fault compensation on obstetricians' practice patterns, 179 Am J Obstet Gynecol 1998, 675.

tuarial calculations show that the Program is most likely to develop deficits in the future given the fact that allowing a child into the Program is a "life-time commitment" for the executing agency rather than the one-off discharge of a lump sum.[32] Additionally, the admittance to the Program depends on the causal connection between the birth and the neurological injury, which is increasingly considered to be an impracticable test.

23 As a result, the Virginia legislature will somehow be forced in the near future to either choose to increase the physicians' financial contribution to the Program, or to make physician participation mandatory, to reduce the amounts distributed to the children and their families, or even to stop the Program completely.[33]

b) Florida (USA)

24 In 1988, the state of Florida enacted the Birth-Related Neurological Injury Compensation Act (NICA).[34] The NICA is comparable to the Virginia Program and so were the insurance problems that prompted physicians to press the legislature into enacting the NICA.[35] The NICA covers birth-related neurological injury, i.e., injury to the brain or spinal cord of a live infant weighing at least 2,500 grams at birth. The injury must be caused by oxygen deprivation or by mechanical cause, in the course of labor, delivery or immediately after delivery. The infant must be permanently and substantially mentally *and* physically impaired.

25 Health care providers are free to opt for the NICA, and the majority of obstetricians have in fact opted in.[36] Expecting parents who receive prenatal treatment should be notified of the applicability of NICA.

26 The NICA has been criticised for its modest scope.[37] Indeed, the NICA is more restrictive than the Virginia Program. The latter could cover stillbirth and premature deliveries while the former excludes these cases.[38] The limited scope of both schemes is in part intentional: by implementing these statutes, both legislatures created very limited "carve outs" from the liability systems in order to tackle a small portion of very serious injury cases.[39]

27 These cumulative conditions have led to the rejection of a considerable number of NICA applications. Remarkably, the number of liability claims has not dropped and in fact the NICA seems to fulfil a filter function: claims denied

[32] *JLARC* (fn. 18) 6, 43–45. See also *Sloan* (fn. 20) 59; and the critical remarks on the public accountability of these institutions at p. 70 ff. Cf. *Bovbjerg/Sloan*, 67 U. Cin. L. Rev. 1998, 110 f.
[33] On these choices, see, e.g., *Krauss*, Legal Times March 28 2005, 37.
[34] A brief description of NICA can be found in *Sloan et al.*, 60 Law and Contemporary Problems 1997, 37 f.
[35] *Bovbjerg et al.,* 71 Law and Contemporary Problems 1997, 75 f.
[36] *Studdert et al.*, 25 J. of Health Politics, Policy and Law 2000, 502.
[37] See *Frank A. Sloan et al.*, No-Fault System of Compensation for Obstetric Injury: Winners and Losers, 91 Obstetrics & Gynecology 1998, 437 ff., who report that out of an estimated 479 children with birth-related injuries (between 1989 and 1991), only 13 were compensated under NICA.
[38] *Bovbjerg et al.,* 71 Law and Contemporary Problems 1997, 80.
[39] *Bovbjerg et al.,* 71 Law and Contemporary Problems 1997, 98.

under NICA, and subsequently filed in a civil court – for example because the injuries were of a congenital nature and therefore rejected under NICA – had an increased success rate.[40] Indeed, NICA has not stopped liability insurance premiums for obstetricians and gynaecologists from soaring.[41]

3. Shifts in France

Traditionally, French liability law is very lenient towards victims and quite tough on wrongdoers.[42] To a certain degree this has also been the case with liability for diagnostic errors and peri-natal negligence. In 1996, the Cour de Cassation allowed claims of maintenance of a disabled child for the fact of having been born with disabilities that were not diagnosed by the physician during the pregnancy.[43] This solution has been confirmed in the 2000 *Perruche* case where the Cour de Cassation allowed a claim by a severely handicapped child who had been misdiagnosed before birth as not having been affected by the rubella contracted by the mother.[44] The mother would have had the pregnancy terminated if the test had been performed according to standard. The negligence of the health care provider had deprived her of her free choice in this respect, and therefore the child's claim for material and non-pecuniary damages was allowed by the Cour de Cassation.

28

[40] See *Studdert et al.*, 25 J. of Health Politics, Policy and Law 2000, 515.

[41] *John C. Hitt*, Governor's Select Task Force on Healthcare Professional Liability Insurance (2003) 306.

[42] For an overview and criticism of the French liability culture, see, e.g., *Ph. Rémy*, Critique du système français de responsabilité civile, Droit et cultures 1996, 31 ff.

[43] Cass. Civ. I, 26 March 1996, Bull. civ. I, no. 155, and Cass. Civ. I, 26 March 1996, Bull. civ. I, no. 156, Dalloz 1997, J., p. 35 with annotation J. Roche-Dahan, RTD Civ. 1996, p. 623 with annotation P. Jourdain. These cases concern the maintenance cost of the child ('les conséquences dommageables définitives des troubles de l'enfant') and the health care cost. See *Anne Morris/Severine Saintier*, To Be Or Not To Be: Is That The Question? Wrongful Life And Misconceptions, 11 Medical Law Review 2003, 176.

[44] Cass. A.P. 17 November 2000, Bull. A.P. no. 9. Among the huge number of doctrinal works and commentaries of this case, see *F. Terré*, Le prix de la vie, J.C.P. 2000, 2267; *C. Labrousse-Riou and B. Mathieu*, La vie humaine peut-elle être un préjudice? Dalloz 2000, no. 44.; *G. Mémeteau*, L'action de vie dommageable, J.C.P. 2000, I.279; J.C.P. 2000.II.10438, report P. Sargos, concl. J. Sainte-Rose, note F. Chabas; *M. Gobert*, La Cour de cassation méritait-elle le pilori? Petites Affiches 8 décembre 2000, 4; *G. Viney*, Brèves remarques à propos d'un arrêt qui affecte l'image de la justice dans l'opinion, J.C.P. 2001, I.286; *C. Radé*, Être ou ne pas être? Telle n'est pas la question! Resp.civ.assur. 2001, 4; *P. Murat*, L'affaire Perruche: où l'humanisme cède à l'utilitarisme, Droit de la famille 2001, comm. 11; *J.L. Aubert*, Indemnisation d'une existence handicapée qui, selon le choix de la mère, n'aurait pas dû être, D. Chr. 2001, 489; *L. Aynès*, Préjudice de l'enfant handicapé: la plainte de JOB devant la Cour de cassation, D. Chr. 2001, 492; *F. Dreifuss-Netter*, Observations hétérodoxes sur la question du préjudice de l'enfant victime d'un handicap congénital non décelé pendant la grossesse, Médecine et Droit 2001, no. 46 p. 2 ff; *Yvonne Lambert-Faivre*, La réparation de l'accident médical: obligation de sécurité, oui, aléa thérapeutique, non, Dalloz 2001, 570; *B. Markesinis*, Réflexion d'un comparatiste anglais sur et à partir de l'arrêt Perruche, RTD civ. 2001, 77. Cf. *Lambert-Faivre* (fn. 5) 736 ff., *Véronique Rachet-Darfeuille*, Compensation in the French Health Care Sector, in: Jos Dute et al. (ed.), No-Fault Compensation in the Health Care Sector (2004) 233 ff, and *Philippe Brun*, France, in: Helmut Koziol and Barbara C. Steininger (ed.), European Tort Law 2002 (2003) 183.

29 The *Perruche* case turned out to be a "bridge too far" for French society: the Cour de Cassation decision led to an outbreak of public indignation voiced by doctors, the clergy, pro-life activists, and politicians.[45] One of the criticisms was that it was not the health care professional that had caused the disability but a natural cause. So, the argument went, liability should have been rejected for lack of direct causation of the disability.[46] As a result of this societal upheaval, the Act of 4 March 2002 was enacted, excluding liability for medical malpractice such as that in the *Perruche* case.[47] This important reform of French health law, declaring in its first Article:

- That no person can be said to suffer damage from the mere fact of having been born (art. 1-I first sentence).[48]
- That the person born with a handicap as a result of a medical error can claim damages in full insofar as the error directly caused the handicap, worsened it, or actively obstructed its mitigation (art. 1-I second sentence).
- That in case of liability arising from a *faute caractérisée*[49] committed by the medical professional or the institution – i.e., the negligent omission that rendered discovery of the handicap impossible – the parents can claim compensation for the loss they themselves suffer. This loss may include immaterial loss (for the fact that the parents' autonomy and their right to choose abortion has been violated). The specific expenses of maintaining a disabled child cannot be claimed from the liable party. Instead, these are said to be covered by *la solidarité nationale*.[50] We will return shortly to what this concept actually entails in practice.

30 In effect, children suffering from disability brought about by natural causes (such as was the case in the *Perruche* case) and undetected by negligent health care professionals can no longer claim non-pecuniary loss for the fact of living a disabled life.[51] In such a case the parents are merely allowed to claim non-

[45] *Lambert-Faivre* (fn. 5) 737; JurisClasseur Resp. Civ. & Ass. Fasc. 440-20, no. 80.

[46] Arguing this, *D. Mazeaud*, Naissance, handicap et lien de causalité, Dalloz 2000, no. 44; *D. Mazeaud*, Réflexions sur un malentendu, D. Chr. 2001, 352. *Contra*, *P.-Y. Gautier*, "Les distances du juge" à propos d'un débat éthique sur la responsabilité civile, J.C.P. 2001, I.287. See also the references at *Lambert-Faivre* (fn. 5) 739; *Kathrin Arnold*, 'Kind als Schaden' in Frankreich – Unter besonderer Berücksichtigung des 'Anti-Perruche-Gesetzes', VersR 2004, 311.

[47] *Loi no. 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé*, J. Off. 5 march 2002, 4118 ff. For a commentary, see, e.g., *P. Jourdain*, Loi anti-Perruche: une loi démagogique, D. Chr. 2002, 891.

[48] This was not contested in case law with regard to healthy children; both civil and administrative courts rejected such claims; see Cass. Civ. I, 25 June 1991, quote above, note no. =; Conseil d'Etat, 2 July 1982, Dalloz 1984, J. p 425, with annotation D'Onorio; AJDA 1983, p 206, with annotation Chapuisat. Cf. *Lambert-Faivre* (fn. 5) 736; *Arnold*, VersR 2004, 310.

[49] On that requirement, see *Lambert-Faivre* (fn. 5) 740; *Arnold*, VersR 2004, 312.

[50] *Arnold*, VersR 2004, 312.

[51] This is at least the idea behind the principle 'Nul ne peut se prévaloir d'un préjudice du seul fait de sa naissance', although the words 'du seul fait' might suggest that such a claim might well be feasible if additional facts (such as pain and suffering) were put forward. See *Brun* (fn. 44) 183. However, the legislature intended to strike out all claims for non-pecuniary loss by the disabled child itself. See *Arnold*, VersR 2004, 311; *Morris/Saintier*, 11 Medical Law Review 2003, 189.

pecuniary loss.[52] In practice, however, the cost of claiming may well outweigh the potential financial benefits of an award for non-pecuniary loss. The parents cannot claim the cost of maintenance from the liable health care provider. Instead, these should be requested from *solidarité nationale*.[53] Some authors remark that the financial position of parents of a disabled child has deteriorated as a result. The parents are supposed to address the state for the cost of maintaining the disabled child. Social security, however, cannot guarantee full compensation as liability law can, leaving the parents to bear the legal and actual burden of maintaining their child without full compensation.[54] In fact, until recently social security had not been able to guarantee *any* compensation. Although the French legislature was quick in shifting from liability law to *solidarité nationale* (i.e., tax-funded state compensation), it was slow in fully implementing this shift.[55] Only recently has it promulgated the Act on the equal rights and opportunities of disabled persons, which provides for a comprehensive social security net for disabled persons from the cradle to the grave,[56] whatever the origin of the disability is.[57] Although this tax-funded social security scheme may have drawbacks, a major advantage seems to be the central idea that an "elaborate plan" is drafted that is focussed on assessing the needs, the possibilities of self-development and the future possibilities of the handicapped child. Taking this as a starting point, a future-oriented compensation plan is drafted and executed.[58] Such an approach may well address the needs of the injured child and his family more effectively than a civil court lump-sum award would.[59]

In order to sketch the full picture, it should be noted that the Act of 4 March 2002 did not have as a sole purpose the withholding of civil liability compensation from disabled children like *Nicolas Perruche* and their families. The Act has also potentially ameliorated the position of some other victims, notably those of hospital acquired infections (nosocomial infections) and of *l'aléa thérapeutique*, the inherent risks of treatment.[60] The position of the former cat- 31

[52] *Brun* (fn. 44) 184.

[53] *Morris/Saintier*, 11 Medical Law Review 2003, 190; JurisClasseur Resp. Civ. & Ass. Fasc. 440-20, no. 81.

[54] *Lambert-Faivre* (fn. 5) 740; *Rachet-Darfeuille* (fn. 44) 238.

[55] Cf. *Morris/Saintier*, 11 Medical Law Review 2003, 188 f.

[56] Loi no. 2005-102 du 11 février 2005 pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées, J.Off. 12 February 2005, 2353 ff.

[57] The principle now laid down in art. L. 114-1-1 Code de l'Action Sociale et des Familles reads: "La personne handicapée a droit à la compensation des conséquences de son handicap quels que soient l'origine et la nature de sa déficience, son âge ou son mode de vie." ("The disabled person has a right to be compensated for the consequences of his disability, whatever the origin or character of his insufficiency, his age or way of life").

[58] See art. 11 Loi no. 2005-102 du 11 février 2005 pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées.

[59] Note, however, that the French law of damages allows the court to award damages to the injured party not only in the form of a lump sum, but by way of annuities (*rente*). See, Rép. Civ. Dalloz, V° Dommages et intérêts, by Ch. Lapoyade Deschamps, 1997, nos. 62 ff.

[60] Note that French law is vague on what constitutes *l'alea thérapeutique*. In art. L. 1142-1-1 (inserted by the *Loi n° 2002-1577 du 30 décembre 2002 relative à la responsabilité civile*

egory of victims was altogether not bad prior to the Act, because the liability of hospital and clinics for nosocomial infection was strict and the victim could receive compensation without proving negligence of the health care professional.[61] The victim still had to prove the existence of a causal link, i.e. the nosocomial feature of the infection, which was in practice burdensome.[62] Concerning the latter category, victims of the "medical mishaps" did not receive any compensation from the negligence system, because it was impossible to establish a fault on the side of the physician.[63] Only administrative courts that have jurisdiction for medical liability cases arising from treatments in public hospitals had accepted the compensation of the damage to a patient arising out of a foreseeable risk whose materialisation leads to consequences that have no relation to the previous situation of the patient.[64] The Act of 4 March 2002 and the subsequent Act of 30 December 2002[65] have changed all this. Compensation for these adverse events should be obtained from *solidarité nationale* if the event directly resulted in a permanent disability in excess of percentage to be fixed by decree, but not higher than 25%.[66] For injury below that threshold, the patient can only hold the professional liable in case of negligence.[67] This threshold is generally considered to be very high and to limit the compensation of the *aléa thérapeutique* to a very small part of the overall number of medical accidents.[68] Authors justify this choice by the fact that at the time of

médicale) it is referred to as 'dommages résultant de l'intervention, en cas de circonstances exceptionnelles' (injury resulting from the treatment, in case of exceptional circumstances). The concept seems to refer to foreseeable inherent risks (possible side effects) of the treatment, which cannot be avoided. See, e.g., *Pinna* (fn. 12) nr. 7; *Rachet-Darfeuille* (fn. 44) 226; *Suzanne Galand-Carval*, France, in: Michael Faure and Helmut Koziol (ed.), Cases on Medical Malpractice in a Comparative Perspective (2001) 108 f. Note that the concept bears resemblance to the term 'medical mishap' formerly used in the New Zealand no-fault compensation scheme (until the introduction of the 2005 Injury Prevention, Rehabilitation, and Compensation Amendment Act). Also note that the New Zealand concept of 'medical mishap' has been abandoned because it was thought to be confusing and arbitrary.

[61] Cass. Civ. I, 29 June 1999, Dalloz 1999, J. 559 with annotation D. Thouvenin; Conseil d'Etat, 9 December 1988, *Cohen*, Dalloz 1990, J. 487, with annotation Thouronde and Touchard. Cf. *Lambert-Faivre* (fn. 5) 782.

[62] See, e.g., Cass. Civ. I, 27 March 2001, Bull. civ. I, no. 87.

[63] *Lambert-Faivre* (fn. 5) 777 f.

[64] Conseil d'Etat, 9 April 1993, J.C.P. 1993.II.22061, with annotation J. Moreau. Holding the exact opposite, Cass. Civ. I, 8 November 2000, Bull. civ. I, no. 287; J.C.P. 2001.II.10493, with annotations Sargos and Chabas.

[65] Loi no. 2002-1577 du 30 décembre 2002. This Act was propelled by an acute liability insurance crisis in France following the Act of 4 March 2002, although there is no proof of a direct causal link between the Act of 4 March and the subsequent crisis. The Act of 30 December 2002 has partially shifted the burden of losses caused by hospital acquired infections and the 'alea thérapeutique' from liability insurance policies to 'solidarité nationale', and has opened the possibility of a system of claims made-coverage. See, e.g., *Sophie Hocquet-Berg*, Résponsabilité médicale sans faute (Fasc. 440-60), in: (ed.), JurisClasseur Responsabilité et Assurances (2004), no. 102.

[66] Article D. 1142-1 of the Code de la santé publique has decided for 24%.

[67] With regard to hospital acquired infections, art. L. 1142-1 Code de la Santé Publique stipulates that the burden of proof with regard to negligence is reversed. See *Lambert-Faivre* (fn. 5) 785.

[68] *Yvonne Lambert-Faivre*, De la gravité à géométrie variable d'un dommage corporel, 811 ff. Dalloz 2004, 811.

the shift from liability to solidarity it was very difficult to anticipate the amount of accidents covered by this compensation scheme because of the absence of statistical data and, therefore, the impossibility of evaluating the cost of compensation of the *aléa thérapeutique*.[69] After collection of ex post data it will be possible to adjust this threshold.

The system of compensation funded by *solidarité nationale* is in part administered by the regional commissions for mediation and compensation CRCI (*Commission régionale de conciliation et d'indemnisation*) and the national office ONIAM (*Office National d'Indemnisation des accidents médicaux*).[70] ONIAM operates as a distribution channel for the compensation of hospital acquired infections and *l'aléa thérapeutique*, as well as a recourse agency for awards funded through private liability insurance.[71] Since ONIAM has only operated from 2002, no definitive conclusions on the costs and benefits of this institution can be drawn. It is clear however, that in 2004 a total of 133 compensation awards cost the taxpayer a total of € 3.8 million (on average € 28,750 per case).[72] With regard to hospital infections, the data show that elderly people and newborns are more prone than others to fall prey to infections.[73] 32

To conclude, analysing the various shifts in compensation that the recent French legislation has caused, we find that physicians, hospitals, and their liability insurers are immune to liability claims for birth defects. Children with birth defects and their families can only claim compensation from the State on the basis of specific social security arrangements. Contrastingly, victims of hospital acquired infections and of *l'aléa thérapeutique* can either claim full compensation from the ONIAM or the physician, hospital and their liability insurer, depending on the extent of the percentage of disability (i.e., under or over 24%). So, in effect, the cause and moment of injury can be decisive: a child who is born with a genetic defect as a result of negligent misdiagnosis may be treated differently than a healthy newborn who is seriously disabled after birth by a hospital acquired infection. 33

4. Developments in the United Kingdom

The 1961 withdrawal of Thalidomide from the British market gave cause for rethinking the compensation system for birth defects. The manufacturers contested causation, and it was only with great difficulty and after many years that settlements were reached. As a result of the discussion that followed from the 34

[69] *P. Sargos*, Le nouveau régime juridique des infections nosocomiales, J.C.P. 25 June 2002, aperçu rapide, 276.

[70] See *Lambert-Faivre* (fn. 5) 707 ff.; *Brun* (fn. 44) 186 ff; *Duncan Fairgrieve*, State Liability in Tort (2003) 255 ff.

[71] ONIAM, after having compensated the victim, has the right to pursue a recourse claim against negligent health care providers (art. L. 1142-17 Code de la Santé Publique).

[72] *ONIAM*, Office National d'Indemnisation des Accidents Médicaux – Rapport d'Activité Second Semestre 2004 (2004), p. 7. Note that in this period the expert expenses amounted to € 881.900, which seems to be a high amount in relation to the awards.

[73] Cf. *ONIAM* (fn. 72) 12.

Thalidomide affair, the Law Commission was requested to advise on the legal aspects of the injuries of unborn children. The 1974 Report was implemented in the 1976 Congenital Disabilities (Civil Liability) Act.[74]

35 The Law Commission did not propose to completely abolish claims for perinatal injury. Instead, it advised that in principle liability vis-à-vis the child should be allowed in cases of "pre-conception negligence" (e.g., negligent treatment of the mother before conception that causes injury to the child afterwards).[75] With regard to claims by the child based on the mere assertion that it should not have been born and that it actually had been born due to the physician's negligence, the Law Commission took a pragmatic approach: "Law is an artefact and, if social justice requires that there should be a remedy given a wrong, then logic should not stand in the way."[76] The Commission ultimately concluded, however, that negligent medical advice should not be allowed to result in liability vis-à-vis the child because it would "place an almost intolerable burden on medical advisers in their socially and morally exacting role." The Commission feared subconscious pressure to advise abortions.[77] It did, however, not advise the exclusion of the parents' claim.

36 Subsequently, in 1991 it was decided *Rance v. Mid-Downs HA* that the parents of a genetically disabled child can claim compensation from the health care provider for negligent misdiagnosis, provided that they can show that they would have terminated the pregnancy if the diagnosis has been correct.[78] In the 1982 *McKay v Essex Health Authority* case,[79] it had already been decided that the child itself cannot claim compensation for wrongful existence. The child had suffered from the mother's rubella and it would have been aborted if the mother's suspicion of having contracted rubella had been confirmed by the blood tests she had asked for. However, as a result of the negligent mislaying of the blood samples she was diagnosed as not suffering from rubella. Nevertheless, the Court of Appeal did not allow the child's claim on the grounds that it would constitute a violation of the sanctity of human life and that the court

[74] *G. Dworkin*, Pearson: Implications for Severely-Handicapped Children and Products Liability, in: David K. Allen et al. (ed.), Accident Compensation After Pearson (1979) 162 f. The Act has been supplemented with specific rules on liability to the child for injuries caused in the course of infertility treatments. See S. 1A 1976 Congenital Disabilities (Civil Liability), inserted by the Human Fertilisation and Embryology Act 1990 Ch. 37 s. 44.

[75] The commission did allow for the exception where parents knowingly accepted the risk of disability of the foetus. See *Law Commission*, Report on Injuries to Unborn Children (report No. 60) (1974) 31, and s. 1 (4) of the 1976 Congenital Disabilities (Civil Liability) Act: "In the case of an occurrence preceding the time of conception, the defendant is not answerable to the child if at that time either or both of the parents knew the risk of their child being born disabled (that is to say, the particular risk created by the occurrence); but should it be the child's father who is the defendant, this subsection does not apply if he knew of the risk and the mother did not." Cf. *Adrian Whitfield*, Actions Arising from Birth, in: Andrew Grubb (ed.), Principles of Medical Law (2004) 806 ff.

[76] *Law Commission* (fn. 75) 34.

[77] *Law Commission* (fn. 75) 32 ff.

[78] *Rance v. Mid-Downs HA* [1991] 1 All ER 801.

[79] *McKay v Essex Health Authority* [1982] QB 1166. See *Whitfield* (fn. 75) 814 ff.

could not be expected to evaluate non-existence for the purpose of awarding damages for denying the child the right of non-existence.[80]

37 In the more recent report, *DoH*, Making Amends – A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS (2003), the Chief Medical Officer recommends that a specific redress scheme for newborns with neurological birth defects be put in place. The suggested scheme would apply to severe neurological injury related to or resulting from birth; the care package and compensation would be based on a "severity index". Genetic or congenital defects would be excluded from the scheme. The proposed scheme would comprise a managed care package, reimbursement of excess cost, adaptations, and a lump sum payment for non-pecuniary loss of £ 50,000 (€ 72,000). The report suggested that a permanent national body administer the scheme.[81]

38 The *Making Amends* report also suggests that government should provide accessible high quality care to severely neurologically impaired and physically disabled children, regardless of cause.[82] This would imply more infants receiving specific care. Implementing these proposals would basically lead to a reshaping of the NHS in order to facilitate this spectrum of health care as well. Indeed, it seems that currently steps in this direction are being taken.[83]

39 It should be noted that in some countries, the managed care package for brain-injured infants as suggested by *Making Amends*, is standard health care practice for all disabled newborns – whatever the cause. These packages are usually funded through general taxation. The introduction in 2004 of the *National Service Framework for children, young people and maternity services* ("the Children's NSF") seems to be a step into this direction.

III. What Encourages the Shifts?

1. Introduction

40 Reasons for implementing a shift from liability to some form of alternative compensation scheme are manifold. In France, restraining the judiciary's activism seems to have been the overriding reason for shifting from liability to solidarity.[84] The activism was felt to be contrary to public morals and societal values. Contrastingly, in Virginia and Florida the reform was lobbied for by physicians during severe malpractice insurance crises.[85] The UK reforms seem

[80] Briefly on this case, see *Montgomery* (fn. 2) 419.
[81] *Making Amends* (fn. 3) 120 ff. Cf. *Jones* (fn. 3) 174 f.
[82] *Making Amends* (fn. 3)125.
[83] See *Department of Health*, Statement of intent – Improving Health Services for disabled children and young people and those with complex health needs (2005).
[84] Cf. *J.C.J. Dute et al.*, Onderzoek No-fault compensatiesysteem (2002) 174. Note, however, that there is also the element of pressure on French physicians by increasing insurance premium rates that prompted the shift from liability to solidarity with regard to hospital acquired infections and the 'aléa'; see footnote 65.
[85] See fn. 20.

to have been propelled by both financial considerations concerning the National Health Service[86] and the concern for effectively addressing the needs of disabled children.

2. The Role of Insurance

41 Physicians' fear of being held liable seems to increase with every increase of their insurance premiums. But are the increases and general insurability scarcity really linked to the liability system itself?[87] It seems plausible that liability practice is in part responsible for the increase of malpractice insurance premiums. Obviously, there is evidence of the rise in the cost of medical care, private care and nursing,[88] and in some jurisdictions the increased amounts for non-pecuniary loss awarded to severely disabled children may have increased as well. These nominal increases, however, do not fully account for potentially soaring malpractice insurance premiums. We feel that the causes must, in part at least, be sought elsewhere.

42 Liability insurance in general and malpractice insurance in particular are among the most difficult businesses in the insurance industry. For one, a fully reliable method for calculating premiums, and for deciding the extent and demarcation of risk pools seems unavailable.[89] This "insurer ambiguity" may lead to the calculation of premiums on the basis of historical losses, which may not always reflect actual risk exposure and which may need serious adjustment after a catastrophic year.[90] Insurance companies have been experiencing reduced investment income and a backlash from the September 11, 2001 terrorist attacks.[91] Furthermore, specific characteristics of the insurance business practice add to the risk of market instability. First, liability insurers obtain a substantial part of their profit margin on turnover on *investment return*. If stock markets suddenly plunge, so do the returns of insurance companies.[92]

[86] Financial considerations are in part also the basis for innovations in the claim settlement process in general, as instigated by the NHS Redress Bill 2005.

[87] For an overview of the opponents and proponents of this view, see *Neil Vidmar et al.*, Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida, 54 DePaul L. Rev. 2005, 315–318.

[88] *Mark C. Rahdert*, Covering Accident Costs (1995) 121.

[89] *Paul C. Weiler et al.*, A Measure of Malpractice – Medical Injury, Malpractice Litigation, and Patient Compensation (1993) 18; *Rahdert* (fn. 88) 109 ff. See also *Paul Fenn et al.*, Current cost of medical negligence in NHS hospitals: analysis of claims database, 320 BMJ 2000, 1570, who report on a related topic (the difficulty of calculating the value of outstanding negligence claims against the NHS).

[90] Cf. *Michael G. Faure*, Economic observations concerning optimal prevention and compensation of damage caused by medical malpractice, in: Jos Dute et al. (ed.), No-Fault Compensation in the Health Care Sector (2004) 47 f.

[91] See, e.g., *CBO*, Limiting Tort Liability for Medical Malpractice (2004) 4; *Robert Lowes*, Malpractice: Do other countries hold the key? Medical Economics July 25, 2003, 58.

[92] *Sloan* (fn. 20) 19 f.

Second, in some European countries the number of medical liability insurers has dropped, resulting in virtual monopolies. Some hospitals have chosen to self-insure or to form voluntary risk sharing arrangements with other hospitals.[93] In this situation monopolistic pricing practices may lead to market failures and finally to a business cycle with artificially low premiums alternated by sharp premium rises.[94] 43

As regards the European situation, our impression is that the root cause for shifts and proposed shifts from liability to some alternative compensation scheme may well lie in the intrinsic characteristics of liability insurance markets. Invariably, the medical profession calls for liability reform and indeed the regulatory response is all too often (1) changing liability law, (2) introducing compulsory liability insurance, and (3) providing a state-funded reinsurance facility without considering further legislative details.[95] An in-depth analysis of the insurance market characteristics seems to be missing and regulatory innovation with regard to insurance business practice hardly ever seems to be applied. 44

Which of these intrinsic characteristics deserve further analysis? If we take a closer look at the theoretical features of malpractice insurance of obstetricians and gynaecologists, we can observe the following. Given that both the chances of treatment related injury and the damage are disproportionately high compared to other physicians, we can safely assume that the risk pool of obstetricians and gynaecologists is more expensive for insurers to underwrite than the average medical risk pool. This may have caused insurance companies to isolate obstetrics and gynaecology from the other medical risk pools thus obliging them to pay a higher premium reflecting the risk posed by their speciality. In competitive liability insurance markets this instrument of risk differentiation will be used to fight adverse selection.[96] 45

So if it is true that obstetricians and gynaecologists are selected by insurers as to construct a separate pool of risks, isolated from other physicians, then this may have been an antidote against a cycle of adverse selection. If left untreat- 46

[93] See *Michael Faure*, Comparative Analysis, in: Michael Faure and Helmut Koziol (ed.), Cases on Medical Malpractice in a Comparative Perspective (2001) 300 f.

[94] *Rahdert* (fn. 88) 113 f.

[95] It is striking that the anti-Perruche developments in France have also led to the introduction of compulsory liability insurance for health professionals. Art. L 1142-2 Code de la Santé Publique imposes the obligation to obtain liability insurance, with a € 45,000 (sic!) penalty for breach and the prohibition to exercise the medical profession (art. L. 1142-25 Code de la Santé Publique).

[96] Seminal *George L. Priest*, The Current Insurance Crisis and Modern Tort Law, Yale L.J. 1987, 521 ff. On the theory of risk differentiation and the balance between solidarity amongst broad risk pools and narrowing down the pool in order to prevent adverse selection, see, e.g., *J.-Matthias Graf von der Schulenburg*, Versicherungsökonomik (2005) 315, *Dieter Farny*, Versicherungsbetriebslehre (2000) 45 ff., 413 f. See also *Michael Faure and T. Hartlief*, Remedies for Expanding Liability, 18 Oxford J. Legal Stud. 1998, 681 ff.; *M.G. Faure*, Risk differentiation endangered by recent policy trends? (2005); *Wouter P.J. Wils*, Insurance Risk Classifications in the EC: Regulatory Outlook, 14 Oxford J. Legal Stud. 1994, 449 ff.; *Faure* (fn. 90) 51.

ed, adverse selection is a major predictor for skyrocketing premiums, insurer withdrawal, and finally uninsurability.[97] So what may have happened is that premium differentiation has been introduced or enhanced. Thus, physicians in general may no longer be co-funding the specific liability risks of obstetricians and gynaecologists. This in itself may have been a shift "from solidarity to isolation" which has left the basis for spreading the total loss of negligently caused birth defects quite small. In fact, this basis may turn out to be too small for obstetricians and gynaecologists to demand any kind of insurance. Instead, they may choose to demand legislative intervention in liability law.

47 However, a situation of isolation may also originate in the structure of the national health care system itself. If this system is built on individual specialists independently contracting with hospitals without being employed, then the liability insurance market may also be built around these independent individuals instead of around the aggregated risk pool of the entire hospital.[98] In effect, the health care system and the employment relations between hospitals and specialists may in part be one of the causes for the insurance problems of obstetricians and gynaecologists. Note that this may be an important institutional difference of health care organisation between the U.S.A. and most European countries.

48 Until now, we worked from the presumption that liability insurers have stepped up their risk differentiation policy. In practice, however, the opposite has proved to be true as well.[99] As noted, in health case systems that leave malpractice insurance to individual physicians it is virtually impossible to make experience rating feasible.[100] But even in countries where the hospitals are the insurance carrier for the benefit of all staff and independent specialists, hospital insurance premiums are sometimes still being roughly calculated on the basis of the number of available hospital beds.[101] The premiums may also be based on broad aggregates reflecting specialty and location of practice, but may fail to take into account other relevant parameters required for an appropriate risk assessment.[102] In insurance markets that tend towards oligopolistic

[97] Cf. *Rahdert* (fn. 88) 46 ff., 146. Note that fighting adverse selection may well lead to complete uninsurability of 'bad risks': demand for an unaffordable expensive policy may break down. This is what may have happened to the former NHS medical defence organisations system. See *Jones* (fn. 3) 183.

[98] *David M. Studdert and Troyen A. Brennan*, No-Fault Compensation for Medical Injuries – The Prospect for Error Prevention, 286 JAMA 2001, 221 point to individualized commercial malpractice policies standing in the way of efficient experience rating. Cf. *Don Dewees et al.*, Exploring the Domain of Accident Law – Taking the facts seriously (1996) 101. See also *David M. Studdert and Troyen A. Brennan*, Toward a Workable Model of "No-Fault" Compensation for Medical Injury, 27 Am J. L. & Med. 2001, 231, and *Frank A. Sloan*, Experience Rating: Does It Make Sense for Medical Malpractice Insurance? 80 The American Economic Review 1990, 132.

[99] *Frank A. Sloan*, Experience Rating: Does It Make Sense for Medical Malpractice Insurance? 80 The American Economic Review 1990, 128 ff.

[100] Cf. *Weiler et al.* (fn. 89) 115.

[101] *Faure* (fn. 90) 53. Cf. *Dewees et al.* (fn. 98) 101; *Sloan* (fn. 20) 18 f.

[102] Cf. *CBO* (fn. 91) 3.

pricing, there seems to be little incentive for insurance companies to refine the basis of their premium calculation, although there is some statistical evidence – in the United States at least – that past liability performance of hospitals is an indicator for future loss and that experience rating reduces claim frequency and injury rates.[103]

49 Building on the aforementioned, we can conclude that in an ideal market without failures, the liability risks of obstetrics and gynaecology would be differentiated according to both the risk pool theory and the experience rating standards. In an ideal market the price level of the obstetric and gynaecological services would reflect this different risk level and "bad doctors" would thus be forced out of business.[104] From a law and economics point of view, charging gynaecologists the right price is the natural thing to do. In practice, however, obstetrics and gynaecology could get entangled in the insurers' web: intensified risk differentiation amongst the various medical professions would lead to soaring premiums for obstetricians and gynaecologists, while in practice the public regulation of the health care cost will usually restrain them from increasing treatment fees.[105]

50 Health care is widely acknowledged to be far removed from the ideal of a perfect market, so we cannot expect the liability insurance to be perfect either. Ultimately, the question is whether society is willing to adjust health care budgets for obstetrics and gynaecology to reflect the true cost of the liability system or to accept – in extreme situations – a reduced availability of obstetric and gynaecological health care. A third alternative would be to accept a cap in the extent of the damage to be compensated.

51 We should not expect serious beneficial effects on affordability when shifting from liability to an alternative compensation scheme. The problems experienced in liability insurance practice do not automatically disappear with the introduction of a no-fault compensation scheme. For instance, if the insurability problem in the liability insurance market is caused by insufficient risk differentiation, then a no-fault system will experience similar problems if it does not introduce some sort of differentiated premium structure.[106] As a result, legislators may find themselves between the Devil and the deep blue sea: if the no-fault system is constructed as a national solidarity system, then the insurability problem is traded in a tax pressure problem, and if it is funded by means of the central distribution of health care resources, similar problems

[103] *Sloan*, 80 The American Economic Review 1990, 129.
[104] *Dewees et al.* (fn. 98) 101.
[105] *Faure* (fn. 90) 52; *Faure* (fn. 93) 300.
[106] The New Zealand scheme shows that the compensation for medical injuries is funded in a similar fashion as liability systems are funded with liability insurance. The system allows for premium differentiation between the various specialists, experience rating and claim thresholds and ceilings (deductibles, stop-loss, etc.). These are instruments common to liability insurance practice, and they are used in this no-fault scheme as well. Cf. *Colleen M. Flood*, New Zealand's No-Fault Accident Compensation Scheme: Paradise or Panacea? 8 Health Law Review 1999, 7.

will arise ultimately. Furthermore, a no-fault compensation scheme as such will not address the issue of inherent market failure in health care. Applying the perfect market model of malpractice insurance in theory might lead to unaffordable obstetric care, which is obviously unacceptable from a societal point of view.[107]

52 Therefore, an alternative compensation system that does not have a broader financial basis than the one used by liability systems – i.e., insurance contributions from physicians and hospitals – will experience similar limited funding problems as liability systems have.[108] The only solution then is to involve general taxation through the national health care budget in the funding. Preferably, this additional funding should be carefully distributed and should not end up to an excessive extent in the pockets of private insurance companies. Surely this is a formidable legislative challenge, but we feel that in the case of obstetrics and gynaecology few alternatives are left when uninsurability has taken its toll.

3. Physicians' Adverse Experiences with Liability Systems

53 Opponents of the increasing liability pressure on the medical profession in general, and obstetrics and gynaecology in particular, invariably state that defensive medicine is currently practiced *as a result* of this pressure.[109] Although these voices should be taken very seriously, there does seem to be ground for scepticism.[110] There is no empirical research that substantiates the existence of defensive medicine in European jurisdictions;[111] the available sources refer-

[107] *William M. Sage*, The Forgotten Third: Liability Insurance And The Medical Malpractice Crisis, 23 Health Affairs 2004, 16.

[108] *Sloan* (fn. 20) 6; 58; 69.

[109] See, e.g., *American College of Physicians*, Beyond MICRA – New Ideas for Liability Reform, 122 Annals of Internal Medicine 1995, 466 ff. Cf. *Making Amends* (fn. 3) 110. See also *Faure* (fn. 90) 40; *Nicholas Summerton*, Positive and negative factors in defensive medicine: a questionnaire study of general practitioners, 310 BMJ 1995, 27 ff. See also the official comment of the Belgian *Ordre des médecins* to Article 2 (reversal of the burden of proof on the provider of the service) of the EC draft directive on the liability of the suppliers of services: "Ce serait très rapidement une responsabilité sans faute, un dédommagement systématique couvert par les assurances dont le montant des primes s'élèverait de façon considérable; ces primes se répercuteraient sur le prix des soins, ce qui n'est pas possible dans le cadre des conventions de sécurité sociale. Cela conduirait, avec certitude, au fait que des médecins refuseraient de soigner, hors urgences, tout patient ou toute maladie tant soit peu sévère et cela altérerait profondément le domaine de la santé", in Bulletin du Conseil national, no. 52, p. 24.

[110] *Montgomery* (fn. 2) 202 ff., 209 ff.; *Mulcahy* (fn. 3) 81 ff.

[111] *Montgomery* (fn. 2) 209 ff. On the (lack of strong) empirical evidence for defensive medicine in the U.S.A., see *Frank A. Sloan et al.*, Tort Liability and Obstetricians' Care Levels, 17 Int. Rev. of Law & Ecs. 1997, 245 ff.; *Laura-Mae Baldwin et al.*, Defensive Medicine and Obstetrics, 274 JAMA 1995, 1606 ff.; *CBO* (fn. 91) 6. See also *Lisa Dubay et al.*, The impact of malpractice fears on caesarean section rates, 18 J. of Health Economics 1999, 491 ff. (arguing that the impact of the increase on total costs is small). Generally critical on the empirical underpinning of defensive medicine: *David A. Hyman and Charles Silver*, The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution? 90 Cornell L.Rev. 2005, 937 ff.; cf. *Randall R. Bovbjerg et al.*, Defensive Medicine and Tort Reform: New Evidence in an Old Bottle, 21 Journal of Health Politics, Policy and Law 1996,

ring to these practices are anecdotal at best. And evidence of a *necessary* causal nexus between these alleged practices and liability regimes is absent as well.[112] In other words: physicians might be overreacting.

First, in most European legal systems it is not the lawyers but – in principle[113] – the medical professional standard itself that decides whether and under what circumstances a physician is in fact negligent.[114] Thus, the standard usually applied is the one set by peers and accepted in the physician's practice community; the law can merely be said to translate the findings of peers into liability.[115] So, in this respect it seems that there is no rational reason for excessive defensive medicine. But perhaps physicians have a distorted perception of the magnitude of the threat of liability and the position of courts in the process,[116] possibly nourished by the steep annual increase of liability insurance premiums.[117] Distorted perception is indeed commonplace when it comes to the "compensation culture".[118] 54

267 ff. For possible evidence on defensive medicine with regard to treatment of cardiac illness in elderly people, see *Daniel P. Kessler and Mark B. McClellan*, Do Doctors Practice Defensive Medicine? 111 Quarterly J. of Ecs. 1996, 353 ff. Sometimes, the evidence presented relates to what physicians *say* about the relationship between the threat of liability and their behaviour (see, e.g., *David Klingman et al.*, Measuring Defensive Medicine Using Clinical Scenario Surveys, 21 Journal of Health Politics, Policy and Law 1996, 185 ff. Cf. *J. Dijkman*, Overconsumptie door claimcultuur? in: Raad voor de Volksgezondheid (ed.), Met het oog op gepaste zorg (2004) 175). In American research, there is evidence of a correlation of the number of practising physicians (cf. with references *L.T. Visscher*, Een rechtseconomische analyse van het Nederlandse onrechtmatigedaadsrecht (2005) 292) in a specific state and the legal restraints (caps on non-pecuniary loss and punitive damages) on liability law. This may indeed be strong evidence of interstate migration of physicians choosing the lowest insurance premiums and a preference for high income, but does it prove that physicians practice defensive medicine (i.e., unnecessary and inefficient care)? Moreover, the results will be difficult to duplicate in a European context. The fact of the matter is that proving a correlation (let alone causation) between physician behaviour and liability law is extremely difficult.

[112] See, e.g., *Daniel P. Kessler and Mark B. McClellan*, Malpractice law and health care reform: optimal liability policy in an area of managed care, 84 Journal of Public Economics 2002, reporting on alternatives for tort reform that may pose a counterweight to defensive practices.

[113] On the friction between endogenous standards and external, court-made standards in medical malpractice, see, e.g., *Christopher Newdick*, Who should we treat? – Rights, Rationing, and Resources in the NHS (2005) 135 ff. Cf. *Virginia A. Sharpe/Alan I. Faden*, Medical Harm – Historical, Conceptual, and Ethical Dimensions of Iatrogenic Illness (1998) 100 ff.

[114] See, e.g., *Montgomery* (fn. 2) 169 ff. See also *Elizabeth Wicks et al.*, Late Termination of Pregnancy for Fetal Abnormality: Medical and Legal Perspectives, Med. L. Rev. 2004, 289 f.

[115] *Montgomery* (fn. 2) 189.

[116] *Weiler et al.* (fn. 89) 124 ff. Cf. *Dijkman* (fn. 111) 163 ff.

[117] There is some evidence suggesting a correlation between defensive medicine and the perceived burden of insurance premiums. See *David M. Studdert et al.*, Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, 293 JAMA 2005, 2609 ff.

[118] See, e.g., *Better Regulation Task Force*, Better Routes to Redress (2004); *Michael Faure/Ton Hartlief*, Het kabinet en de claimcultuur. Over de (onbezonnen) Hollandse vrees voor Amerikaanse toestanden of het Hollands medicijn voor Amerikaanse ziektes, Nederlands Juristenblad 1999, 2007 ff.

55 On the other hand, in some jurisdictions there have indeed been clear-cut landslide cases that have strongly improved the legal position of patients. It seems plausible that such developments could cause the number of claims to soar, thus amplifying physicians' perceptions of an ever proliferating claim culture. In France, for instance, the former absence of a compensation scheme for medical accidents had as a consequence that courts developed a policy of alleviating the requirement of a fault of the physician as a condition for medical liability. Before the Act of 4 March 2002 a clear trend in the case law showed that the liability of physicians was easily admitted because there were no alternatives for compensation of "medical mishaps".[119] The case law after the entry into force of the 2002 Act and after the creation of a scheme for compensation of the *aléa thérapeutique* has adopted a more restrictive conception of the fault of the physician.[120]

56 All this is a genuine cause for serious concern. Even if there is no indisputable evidence of an overgrowth of claim culture in the European health care, there seems to be enough evidence in the minds of some physicians and their professional associations. It is safe to conclude that a considerable number of physicians, politicians and lobbyists are firmly *convinced* that the liability system is a nuisance, distracting them from their tasks and that it is impeding good clinical practice by over-deterrence.[121] Sometimes, it seems that commentators opposing claims for birth defects tend to forget that the issue is not really about valuing life and birth. Central to the issue is the fact that a health care provider was negligent in performing his obligations.[122] In our view, the law's primary task is to prevent such negligence from happening. Merely taking away the element of liability will neither help to prevent injury, nor will it enhance and enforce health care standards. Admittedly, there is something to be said for the opposite argument as well: leaving the liability system as it is may be equally unhelpful in enhancing and enforcing health care standards.[123] But do we have evidence underpinning either of these two arguments?

57 The truth is that we have no firm empirical evidence that liability for medical malpractice provides (additional and/or efficient) incentives for injury prevention. Physician interest groups are eager to stress that professional standards, disciplinary law and criminal law, and even the Hippocratic oath, provide more than enough incentive for careful doctoring.[124] Although plausible, there

[119] *Pinna* (fn. 12) nos. 12 ff and the analysis of case law therein.
[120] *Pinna* (fn. 12) nos. 16 ff.
[121] See, e.g., *Alec Samuels*, The English Tort System for Medical Mishaps, 72 Medico-Legal Journal 2004, 147, arguing that 'Doctors exercise defensive medicine, cover up their mistakes, and feel aggrieved at being pilloried for their mistakes, or alleged mistakes, when they have been doing their best in stressful circumstances'.
[122] A point stressed by *Morris/Saintier*, 11 Medical Law Review 2003, 170.
[123] *Making Amends* (fn. 3) 110. Moreover, there is something to be said for the argument put forward by the British Medical Association (Press statement July 2003) that the greater the degree of incompetence or physician's recklessness, the more certain it is that the case will be settled out of court. Indeed, such silent settlements in themselves do not add to prevention or public accountability.
[124] Cf. *Weiler et al.* (fn. 89) 113.

is no firm evidence for this position either. We simply don't know. There is, however, some evidence that the number of patients claiming under the liability system is extremely low in comparison to the population of patients being injured by medical negligence.[125] The evidence relates, however, to the United States of America. Whether it is relevant for Europe remains to be seen.[126] If indeed the same is true for Europe, it may lead policymakers to conclude that the pressure from the liability system is evidently not strong enough to provoke intense risk management, and instead more patients should be encouraged to bring their claim forward. If this argument is valid, then abolition of liability law would not be the right next step. A more appropriate step would be to, on the one hand, facilitate patients to bring claims forward, or in any case have their claims settled without deferment, and on the other to safeguard a real feedback-loop from the claims procedure to some sort of health care quality improvement instrument.

58 The argument has been put forward by several authors that the liability system cannot provide optimal *ex ante* incentives to the competent doctor who occasionally falters, but will merely harass and demotivate him after the event.[127] If it is true that physicians feel they are individually being held accountable for the occurrence of events they cannot individually avoid, then the question should be addressed whether the duties that liability law imposes on individual physicians might better be rephrased into corporate duties.[128] This change of perspective might shift the focal point from individual agency towards a system of *enterprise liability* of hospitals and health care centres.[129] On the other hand, it is at least equally important that individual doctors are concerned by the fact that they did not properly treat their patient, as by the fact of having to compensate after being held liable. Therefore, genuine interplay between the compensation scheme – be it a tort system or a no-fault system –, the professional disciplinary boards and the available health care quality improvement instruments (i.e., standards boards, et cetera) seems indispensable.

59 Shifting the focus from individual physicians' responsibility to the working environment would force the law no longer to isolate negligent acts of individual physicians – irrespective of whether they work as employees or as independent contractors within the hospital walls – but to focus instead on the *organisational failures* that did not prevent human error.[130] Evidence indeed shows that organisations are more apt than individuals at inducing improve-

[125] See, with further references, 62 f.; *Dewees et al.* (fn. 98) 95 ff. (evidence for U.S.A.).

[126] *Casçao* (fn. 26) 96 ff. does present some figures but the sources quoted do not fully underpin the suggested similarity between the U.S.A. and Europe. The available data do not enable us to make stronger statements than that not all persons wronged by medical negligence pursue their claim.

[127] *Brazier*, (fn. 7) 244 f. Cf. *Montgomery* (fn. 2) 189.

[128] Cf. *Dewees et al.* (fn. 98) 97 f.

[129] *Sharpe/Faden*, (fn. 113) 137 ff.; *American College of Physicians*, 122 Annals of Internal Medicine 1995, 466 ff.

[130] Cf. *Jones* (fn. 3) 180; *American College of Physicians*, 122 Annals of Internal Medicine 1995, 466 ff.

ments in quality care, risk management, and injury avoidance.[131] Thus, to a certain extent liability law – or whatever system providing incentives for accident avoidance – should be focussed more on what organisations can do to prevent injury and to learn from adverse events.

60 If, however, the physicians' dismay stems from the perception that in the liability process, competent and dedicated physicians are wrongly being held judged and blamed for what supposedly went wrong, then we should focus on how to inform and educate physicians of the idea behind accountability, quality care, and risk management in general, and disciplinary action and civil suits specifically.[132] Disgust amongst physicians often seems to find its root cause in unawareness and lack of information concerning other dimensions on health care than their own medical professional dimension. Additionally, it seems plausible that the medical culture of physician infallibility and extreme feelings of failure in the face of adverse events, strongly contribute to this typical reaction.[133] Therefore, the medical profession may want to consider offering compulsory courses on managing legal risks in medical education that could help prevent unpleasant surprises in a physician's later career.[134] The same has been proposed as palliative of the poor inclination of doctors to fulfil their informational duties.[135] Furthermore, research has shown that poor communication and physicians' insensitivity – or rather, the patient's perception of poor communication and insensitivity[136] – can increase the chances of being held liable for adverse events.[137] There-

[131] See the various contributions by, e.g., Leape, Vincent and Reason, and Rosenthal, in: *Marilynn M. Rosenthal et al.* (eds.), Medical Mishaps – Pieces of the Puzzle (1999).

[132] Cf. *Lord Woolf*, Access to Justice – Final Report to the Lord Chancellor on the civil justice system in England and Wales (1996) Chapter IV-15, recommendation 1. Empirical research has shown that physicians have insufficient knowledge of liability law. See, with further references, *Montgomery* (fn. 2) 210 f. Note that distorted risk perception and the effect on organisational behaviour is a much broader theme that raises serious policy questions. See, e.g., *B.S. Markesinis et al.*, Tortious Liability of Statutory Bodies (1999) 79 ff., and the speech delivered by the English Prime Minister Tony Blair on 26 May 2005 at the Institute of Public Policy Research (www.number10.gov.uk). Cf. *Better Regulation Task Force*, Better Routes to Redress (2004).

[133] On that psychological background, see *Sharpe/Faden*, (fn. 113) 137 ff.

[134] Likewise, informing and education lawyers and judges on the physician's frame of reference should be on the agenda as well. See, e.g., *Making Amends* (fn. 3) 128.

[135] *J.-F. Burgelin*, L'obligation d'informer le patient, expliquée aux médecins, in Rapport annuel de la Cour de cassation 1999, La Documentation Française, 2000, p. 71, stating that: "peut-être y a-t-il un examen de conscience à faire chez certains médecins qui avaient, qui ont encore parfois, tendance à sous-estimer les capacités d'écoute et de compréhension de leur interlocuteur. Je pense qu'il y a là un thème de réflexions pour les instances compétentes en matière de formation des praticiens. À défaut de faire renaître un humanisme qui faisait autrefois partie de la nature même du médecin et qui le guidait utilement dans sa relation avec le malade, il pourrait être enseigné aux jeunes futurs médecins comment mener un entretien d'information avec un patient: il y a des méthodes, des recettes, des savoir-faire pour cela. Pourquoi ne pas les leur enseigner?"

[136] Cf. *Sharpe/Faden*, (fn. 113) 121 ff.; *Natalie G. Correia*, Adverse events: Reducing the risk of litigation, 69 Cleveland Clinic Journal of Medicine 2002, 15 ff.

[137] Seminal *C. Vincent et al.*, Why do people sue doctors? A study of patients and relatives taking legal action, 343 Lancet 1994, 1609 ff; cf. *Mulcahy* (fn. 3) 98 f.;

fore, physicians' communicative skills under distressing circumstances should be under scrutiny as well.[138]

4. Families' Needs

It is striking that the needs of disabled children and their families have hardly been given a strong voice in the political debate concerning alternatives to liability. Physicians, politicians, and the insurance industry have dominated the debate. However, there are indications that the affected children and their families have needs that are not fully addressed by the liability system. 61

Evidence from socio-legal studies into the legal handling of injury seems to suggest that families of the disabled child want fair and open communication with the physician and staff involved.[139] Sympathy from the physician is the least they expect. Families will typically experience the need for an impartial investigation of the incident that provides them with explanations of what went wrong and why it went wrong. If the injury was avoidable, they will seek reassurance about the action taken to prevent repetition.[140] This strongly relates to the need for *attribution*. Bereaved parents of a deceased child or grieving parents of a permanently disabled child desire fact-finding and attribution of the cause.[141] This may conflict with a culture of denial or with (perceived) contractual obligations with liability insurers to deny any responsibility.[142] 62

Furthermore, the child and the family would like their immediate financial needs to be addressed. Parents will typically need continuous care for the disabled child, the extent of which depends on an assessment of the needs and development prospects, and which can be adjusted to changes. A health care system that does not readily provide this will lure parents into the liability maze. 63

Speed and predictability seem essential as well. If negligence is found, then liability law prides itself on compensating these pecuniary needs in full. In practice, however, compensation is obtained only after a number of years of litigation or settlement negotiations. Furthermore, a number of liability systems seem to focus on compensating future needs by means of a lump sum, 64

[138] Cf. *B.A.J.M.de Mol*, Was mijn dokter goed genoeg? in: Peter Lens/Philip Kahn (ed.), Over de schreef – over functioneren en disfunctioneren van artsen (2001) 177 ff.; H.B.M. van de Wiel and J. Wouda, Wat nou, over de schreef?, in: Lens/Kahn, o.c. 195 ff.

[139] Cf. *Sloan et al.*, 60 Law and Contemporary Problems 1997, 35 ff.

[140] *Making Amends* (fn. 3) 115; *Mulcahy* (fn. 3) 98.

[141] *Sloan et al.*, 60 Law and Contemporary Problems 1997, 50 ff. Cf. *Making Amends* (fn. 3) 110: "(…) even patients who receive compensation often remain dissatisfied if they do not also receive the explanations or apologies they seek or reassurance about the action taken to prevent repetition." Cf. *Mulcahy* (fn. 3) 98; *Alan Merry/Alexander McCall Smith*, Errors, Medicine and the Law (2001) 220 f.

[142] In the Netherlands, for instance, uninformed doctors have been found to believe that they are not allowed to admit responsibility on penalty of losing all coverage under their liability insurance (which is, however, not in accordance with insurance law).

calculated on the expected future needs.[143] Rather than a lump sum that evaporates prematurely, children and their families need periodical reimbursement of expenses incurred.[144]

65 However, disposing of a lump sum payment without thoroughly assessing the need for periodical compensation and reimbursement does not seem to be the appropriate approach either.[145] Therefore, a shift from a system of lump sums for future expenses and losses towards a system of periodical reimbursement would lead to a certain amount in administrative cost – the cost of reassessment of the needs of the child and the family, a procedure for review and appeal, etc.[146] It would also necessitate a different approach to calculating outstanding liabilities,[147] because funding these costs "as you go" involves intergenerational transfers, could lead to economic inefficiency and could thus cause insurability problems.[148]

66 Do disabled children and families also need pecuniary amends for pain and suffering? Awarding the child with compensation of non-pecuniary loss for having been born with birth defects provokes the most indignation and repulsion. Some argue that the law, by allowing claims for non-pecuniary loss, signals that the child has a right not to be born.[149] Quite disturbing in this respect is the association sometimes implied between liability law and eugenetics.[150] We doubt that civil courts by allowing claims for non-pecuniary loss intend to negate that a disabled life is worth living. We suspect the courts rather try to signal that money can make a disabled life more bearable. If this is true, then we should focus on whether the law should continue to file these claims under the heading of non-pecuniary loss. Perhaps a more acceptable alternative

[143] Note that with regard to the cost of maintaining the child, some liability systems distinguish between liability for misdiagnosing congenital defects and negligence causing an 'exogenous' disability. In the former case, sometimes full compensation for maintenance cost is awarded (including the cost after reaching the age of 18 years; see, e.g., the Dutch Supreme Court ruling (Hoge Raad 18 March 2005)). In the latter case, in some jurisdictions compensation will only cover the *extra* cost of the disability compared to the cost of the child in the original healthy state (see, e.g., *Parkinson v St. James and Seacroft University Hospital NHS Trust* [2002] QB 266).

[144] *Making Amends* (fn. 3) 115; *Jones* (fn. 3) 182 f. Cf. *Dute et al.* (fn. 84) 190. Stepping away from lump sum payments has also been part of reform in some instances in the U.S.A.; see *Weiler et al.* (fn. 89) 9. Note, however, *Oliphant*, Vict. U. Wellington L. Rev. 2004, 935, arguing the possibility of a lump sum as a measure of a solace under no-fault compensation.

[145] Cf. *Flood*, 8 Health Law Review 1999, 5.

[146] Such a system of periodical payments may also cater to the need of victims to retain control over their finances (on the empirical underpinning of that need, see, e.g., *The Law Commission*, Personal Injury Compensation: How Much is Enough? (Law Com. no. 225) (1994) 259.

[147] As the Virginia Program has shown, it can be quite difficult to assess these future costs.

[148] Cf. *Sloan* (fn. 20) 4 f.; 39 ff.

[149] See, e.g., *C.Labrousse-Riou/B.Mathieu*, Dalloz 2000, no. 44; *C. Radé*, Être ou ne pas être? Telle n'est pas la question!, Resp.civ.assur. 2001, 4; *Aynès*, D. Chr. 2001, 492.

[150] E.g., *Comité Consultatif National d'Ethique pour les sciences de la vie et de la santé*, Handicaps Congénitaux et Préjudice (2001). For a compelling overview of arguments concerning parental responsibilities in this respect, see *Eric Rakowski*, Who Should Pay for Bad Genes? 90 California L. Rev. 2002, 1345 ff.

heading is feasible. Perhaps renaming the head of damage can prove helpful, for example, by excluding claims for non-pecuniary loss of the disabled child and substituting them with a fixed amount in their personal "disability trust fund" – intended to cover general future pecuniary expenses (next to the award for specific pecuniary loss, cost of care and nursing, etc.).

All in all, we think that practically speaking children and their families can do without compensation for their misery, provided that the calculation of pecuniary loss is fair and leads to truly full and speedy compensation. The case for abandoning compensation for non-pecuniary loss then becomes even stronger if the awards are extremely high: in that case prioritising health care resources for purposes other than compensation for non-pecuniary loss seems the sensible thing to do.[151] From a dogmatic point of view, however, we would advise to proceed with caution. Excluding an important head of damage would change the private law system and should only be considered if the advantages of doing so have been firmly warranted. This remains to be seen. 67

IV. Concerns That Any Alternative Arrangement Should Address

1. Introduction

In the United States, some states have considered or are currently considering implementing schemes comparable to the Florida and Virginia initiatives.[152] However, in practice there is considerable reluctance to follow the example set by Florida and Virginia. The Maryland legislature has rejected the adoption of a no-fault compensation scheme similar to the Virginia Program, out of fear of uncontrollable financial obligations. A legislative initiative in the state of Washington to introduce a Program comparable to the Virginia Program has not yet been accepted either.[153] Among the reasons for choosing not to shift from liability to an alternative scheme three stand out: interest group counterweight pressure (e.g., personal injury lawyers advocating the adversarial system), fear of lack of control for effective cost containment and fear of leakage into the scheme of non-avoidable harm. 68

Of course a great deal of ethical, religious and semi-legal objections have been raised against compensating birth defects within the boundaries of liability law. It has been argued that compensating birth defects through liability law would obstruct the acceptance of physical and mental disabilities in society, and would weaken family relationships and community bonds.[154] The counterargument, however, would be that liability law potentially and theoretically has that effect in all personal injury cases. In effect, the logical and sickening consequence of the argument would be that disabled persons should not re- 69

[151] Cf. *P.S. Atiyah*, The Damages Lottery (1997) 81.
[152] Cf. *Bovbjerg et al.,* 71 Law and Contemporary Problems 1997, 76 note 26.
[153] HB 1859 Washington State House of Representatives Bill.
[154] *Wendy F. Hensel*, The Disabling Impact Of Wrongful Birth And Wrongful Life Actions, 40 Harvard Civil Rights-Civil Liberties Law Review 2005, 141 ff.

ceive any specific attention from society and politics at all in order to stimulate their acceptance. Naturally, that is taking the argument too far, but it does show that the reasoning against compensation is sometimes seriously flawed (not to mention without empirical underpinning).[155]

70 What the opposition against compensation also tends to show is that the negative attitude is mainly directed against compensation for *non-pecuniary losses*. Clearly, there is an emotional and ethical dimension to this discussion that absorbs the attention from where it is most needed: the financial needs of disabled children and their families. If an alternative scheme could redress this objection, then an important hurdle would be overcome. A scheme that would ensure truly full and lasting compensation within a relatively short period without the energy-consuming adversarial legal procedure could perhaps do without compensation for non-pecuniary loss.

71 Having said this, we should not expect miracles from alternative systems. No-fault compensation alternatives are not the cure for all deficiencies of liability systems.[156] There are two obvious issues that need to be dealt with: causation and funding.

2. Causation and Avoidability

72 With regard to causation, we have to keep in mind that medical injury is difficult to prove and firm evidence of a causal connection between injury and negligence can be hard to obtain. This is in practice the most complex issue in medical malpractice cases, where experts are very often appointed to ascertain the existence of the causal link. The nature of this evidentiary problem would not change if legislation were to shift from liability to no-fault compensation.[157] At the most, the procedural conditions and evidentiary procedure could be moderated to streamline and accelerate the process.[158]

73 Any scheme that will compensate on the basis of a *causal* connection between the medical treatment of mother and child on the one hand and the injury on the other will have to delimit and define the adverse event.[159] It would also have to monitor the application of these definitions in practice, because a lenient stance of the body resolving the submitted claims (the court, committee

[155] Other examples of flawed reasoning concerning claims for birth defects are: 'if liability for birth defects is accepted, then physicians would be forced to abort defective foetuses'; 'if physicians can be held liable for misdiagnosis, then parents could be held liable by their child if they decide not to terminate pregnancy in case they have been informed'.

[156] *Faure* (fn. 90) 62. Cf. *H. Koziol*, Verschuldensunabhängige Ersatzansprüche bei Behandlungsfehlern? Recht der Medizin 1994, 5 f.

[157] *Bernhard A. Koch/Helmut Koziol*, Compensation in the Austrian Health Care Sector, in: Jos Dute et al. (ed.), No-Fault Compensation in the Health Care Sector (2004) 116 ff.

[158] Note that this could be achieved in a moderated liability system as well.

[159] On the problems of causation with no-fault compensation, see *Making Amends* (fn. 3) 104 f. See also *Helmut Koziol*, Deficiency of Regulation and Approach to Solutions: Conclusions from the Comparative Research, in: Michael Faure and Helmut Koziol (ed.), Cases on Medical Malpractice in a Comparative Perspective (2001) 317 f.

etc.) will immediately affect the extent and affordability of the scheme. Monitoring activity will necessarily mean cost in terms of time, procedure, expert opinion and legal fees. The nature of these costs is the same as in a liability system, although the amounts may be fixed at a different level.

74 This is not a theoretical problem; leniency with regard to proof of causation is a widespread and accepted phenomenon in liability systems and it is known to arise in no-fault schemes as well. In the Florida NICA Program for instance, proof of birth-related neurological injury is required. However, a rebuttable presumption is used in case of brain injury or spinal cord injury caused by oxygen deprivation.[160] This may lead to "leakage" into the Program of brain injury with natural causes, because it is particularly difficult to ascertain a concrete causative relationship between brain injury and asphyxia.[161]

75 A no-fault scheme for birth defects that would not require proof of causation or some proof of avoidability of the injury will depart strongly from the classical liability system and even from the "classical" no-fault idea of avoidability.[162] Instead, it will incline towards a pure social security program for disabled children. Indeed, the nature of the typical damage may provide justification for such a policy shift. Imagine for instance that cerebral palsy is the most common birth defect associated with negligence – which it is – and that it is extremely difficult in individual cases to tell whether the defect has a natural cause or could have been avoided by correct medical treatment – which it is –, then the idea of pulling birth defect cases out of the liability system and shifting towards an alternative compensation scheme that does not rely on proof of the cause of the birth defect sounds appealing.[163] It might well be a more efficient method of compensating. It may also have redistributional effects, as statistics show that a great number of families of disabled children have low family incomes.[164]

76 The obvious drawback of such a targeted approach of compensation issues is that, by solving one of the most pressing problem, the problems with the remaining categories of liability will automatically grow more important. Once we have resolved the plight of the neonatals, others will demand equal treatment, leaving policymakers with the difficult question of which cases are equally deserving.[165] But then again, that is the ordinary cycle of policymaking: solve one problem, face the next.

[160] § 766.309 (1) (a) Florida Statutes.

[161] *Making Amends* (fn. 3) 47.

[162] On these phenomena, e.g., *Faure* (fn. 90) 66 ff. See also, from a more general starting point on causal responsibility and social solidarity, *Oliphant*, Vict. U. Wellington L. Rev. 2004, 916 f.

[163] For general considerations concerning the validity of shifting from liability to no-fault compensation for specific victims and leaving others within the liability system, see *Dute et al.* (fn. 84) 202 ff.

[164] See *Department of Health/Department for Education and Skills*, Disabled Children and Young People and those with Complex Health Needs 9.

[165] Cf. *Rahdert* (fn. 89) 29, stating that "priority in any insurance program should always be given to the longer-lasting disabilities that affect far fewer patients but inflict severe or even catastrophic losses on the individual and family concerned."

3. Who Will Pay the Price?

77 This brings us to the second issue that a no-fault scheme would have to deal with: funding. The obvious effect of increasing the number of potential claimants by introducing a no-fault compensation scheme for birth-related injury would be that the number of awards would increase as well. This is an often raised objection against no-fault compensation in general.[166] We feel it should not be seen as an objection, but rather as a choice: is society ready "to accept lower individual payments as the corollary of greater access to compensation"?[167] At the end of the day, it is a policy choice to weigh the cost and benefit and choose the right balance.

78 Some legal systems indeed seem to have chosen to wipe out the differences in legal outcome – at least in some respects – between disability in children caused by nature and disability caused by man. The cost of these programs are bound to be higher than systems that start from the concept of avoidability of the injury, because the number of cases involved are bound to be higher as well.[168] In some countries the political and cultural background will be more in favour of such solidarity than in others.[169]

79 Furthermore, choosing an alternative arrangement over liability law may have some other effects with regard to funding. In a number of legal systems, liability law is used as an instrument for recourse on tortfeasors and their third-party insurers. Thus, recourse for public spending in the area of disability benefits, etc. is based on some form of derivative recourse action of the state or its auxiliaries. A shift away from liability towards a no-fault system then raises the question what to do with the derivative recourse action: if it cannot be based on liability for medical negligence, what should it be based on?

4. The Need for Direction in Risk Management

80 Furthermore, it has often been said that instead of compensating after the event, a truly effective system would focus on affecting changes in the organisational structure of hospitals and other health organisations ("systems approach") rather than just ascribing individual blame and compensating.[170]

[166] See, e.g., the calculations by *Fenn et al.*, 114 The Economic Journal 2004, F288 ff. Cf. *Making Amends* (fn. 3) 106 f.

[167] Association of British Insurers, response 30 October 2001 to Department of Health 'Clinical Negligence – what are the issues and options for reform?'.

[168] Note that the additional expenses of such a no-fault systems in jurisdictions that currently have liability systems with uncapped punitive or exemplary damages and excessive awards for non-pecuniary loss will be far less higher than in jurisdictions that do not have these features.

[169] On what we would call the 'cultural gap' between liability systems and solidarity systems (or more in general, 'loss distribution without liability'), see the memorable *Albert A. Ehrenzweig*, Psychoanalytical Jurisprudence (1971) 242 ff.

[170] *Studdert and Brennan*, 286 JAMA 2001, 217 ff.; *Dewees et al.* (fn. 98) 97 f. See also the research into effectiveness of risk management programs, reported by *Laura L. Morlock/Faye E. Malitz*, Do Hospital Risk Management Programs Make a Difference? 54 Law and Contemporary Problems 1991, 1 ff. See also *Raad voor Gezondheidsonderzoek*, Advies Onderzoek

A further point that should not be taken lightly is *the need for attribution*. As stated above, bereaved parents of a deceased child or grieving parents of a permanently disabled child desire fact-finding and attribution of the cause.[171] Any alternative compensation scheme that does not address these needs will probably face an increase in criminal or disciplinary charges against obstetricians and gynaecologists.[172] Therefore, fact-finding, attribution and future prevention should be part of any system.[173] It is safe to say that such a procedure will help in improving the quality of the organisation and lead to the provision of better medical services. 81

Against this background one would expect that alternative systems for compensating birth defects that exclude liability of health care providers are combined with specific regulatory instruments to monitor and enforce health care quality, to implement organisational changes after some adverse event, and to ensure an open and cooperative communication of physicians. However, neither the Florida NICA nor the Virginia Program were designed to incorporate specific incentives for precaution.[174] 82

Indeed, in France there is the *Observatoire des risques médicaux* (a branch of ONIAM).[175] This "observatory for medical risks" purports to collect data on the incidence of medical adverse events. This may help to get a clearer picture of what goes wrong where and why. It may even provide an incentive to health care providers to enhance their care in order to avoid damage to their reputation as a result of the publication of the data.[176] However, the main function of the observatory is to gain a better understanding of the statistics of medical accidents in order to verify the adequacy of the cost of insurance premiums paid by health care professionals with the real risks of professional liability. The reason of this research has to be found in the very limited number of insurance providers on the French market after the recent retreat of American insurance companies from the market and in the increase of insurance premiums despite the creation of a solidarity system.[177] 83

The Florida Patient's Compensation Fund has the power, in theory at least, to establish a risk management system focussing on:[178] 84

- Investigating and analyzing of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

Patientveiligheid (2005); *Stephen C. Schoenbaum/Randall R. Bovbjerg*, Malpractice Reform Must Include Steps To Prevent Medical Injury, 140 Annals of Internal Medicine 2004, 51 ff.

171 See supra fn. 141.

172 In a similar vein *Brazier*(fn. 7) 255 f.

173 *Bovbjerg/Sloan*, 67 U. Cin. L. Rev. 1998, 110. Cf. *Making Amends* (fn. 3) 107 f.

174 *Bovbjerg/Sloan*, 67 U. Cin. L. Rev. 1998, 103.

175 Art. L. 1142-29 CSP (as inserted by Loi no. 2004-810 of 13 August 2004 on health insurance).

176 *Lambert-Faivre* (fn. 5) 825.

177 Statement by *Xavier Bertrand*, Secretary of State in charge of the medical insurance, Le Quotidien du Médecin, 14 April 2005.

178 § 766.105 Florida Statutes.

- Developing appropriate measures to minimize the risk of injuries and adverse incidents to patients;
- Analyzing patient grievances which relate to patient care and medical services quality.

85 At the same time, however, research has shown that the no-fault scheme in Florida has led to a firm decrease in physicians' involvement in the compensation process. More than half the obstetricians whose patient had filed a no-fault claim were unaware of the fact that a claim had been filed.[179] This seems to point towards contradictory policies: on the one hand, handling claims without involving physicians or hospitals limits the chances of improving health care quality by feeding information from the claims process back into the organisation.[180]

5. Tackling Defensive Medicine

86 If liability systems yield inefficient health care – by spending more resources than is cost-efficient – then the law has failed at striking the right balance. Under any system this should be a concern. The mere fact, however, that physicians *change* their behaviour under influence of liability rules does in itself not imply waste. This is only the case whenever the societal benefits of the precaution do not outweigh the cost. Although measuring this cost and benefit trade off is quite difficult, we are inclined to believe that the existing expertise in health economics can take this calculation quite far.

87 We also believe that inefficient defensive medicine is more likely to arise in health care systems in which individual physicians have room to adjust their working method to their individual risk perception.[181] In those health care systems it seems essential to make physicians aware of their limited appraisal of the liability system, to give unbiased information to the medical profession about the causes of soaring insurance premiums, and to ensure that the profession as a whole can be held accountable for changes in health care strategy by individual physicians.

6. A Duty of Candour

88 Furthermore, it is said that the way in which the liability system holds honourable physicians accountable for honest mistakes induces them to withhold information and to cover up their mistakes.[182] Contrastingly, doctors operating

[179] *Sloan et al.*, 179 Am J Obstet Gynecol 1998, 675.

[180] See also *Bovbjerg/Sloan*, 67 U. Cin. L. Rev. 1998, 111, stressing that it is unfortunate that systematic efforts at quality improvement are not undertaken under no-fault regimes.

[181] Some jurisdictions have chosen to confront physicians that perform defensive medicine by giving unnecessary treatment with disciplinary sanctions. See, e.g., § 766.111 Florida Statutes.

[182] *Making Amends* (fn. 3) 116 ff; *Studdert/Brennan*, 286 JAMA 2001, 218; *Studdert/Brennan*, 27 Am J. L. & Med. 2001, 228.

under no-fault regimes are said to gladly admit something had gone wrong and help to fill out the forms applications for no-fault compensation.[183]

89 It does indeed seem true that individual physicians are sickened by the prospect of being held liable (or even accountable), especially when they genuinely feel that they did their best in the circumstances. This may well provoke physicians to be obstructive when liability steps into the surgery. But is it really true that a no-fault system can stimulate candour whereas liability discourages it?[184] If true, surely this difference must be caused by a difference in financial responsibilities. The most plausible explanation is that doctors under a no-fault scheme are not personally burdened with the financial consequences of avoidable injuries. This means that either the amounts awarded are low or the losses are somehow effectively (and solidarily) spread over society as a whole.

90 It has been suggested that physicians should be under a duty to disclose information, as part of a "leniency program" in disciplinary action. By being candid the physician would have to be exempt from disciplinary action.[185] Others emphasize the need for non-report penalties.[186] We feel that issues of compensation and prevention should not be mixed lightly with incentives to induce candour. Most jurisdictions – irrespective of whether they have a tort liability system or a no-fault system – will adhere to the fundamental idea that doctors should be honest and disclose when treatment has gone wrong.

91 We would like to have a better indication of the extent of the problem before suggesting radical measures. How often do physicians cover up their mistakes, how often are they caught, and how effective are the criminal and disciplinary sanctions? Do doctors really display this cover-up behaviour? And if so, is this a result of the prospect of being held liable?[187] Furthermore, we suggest further research into insurance policy solutions for this problem: it seems that using serious annual deductibles may provide an incentive to hospitals for reporting *all* adverse events even if no direct damage has yet emerged from the event.[188]

[183] On the allegedly helpful role of physicians in a no-fault system, see, e.g., the contribution to this volume by Cascao/Hendrickx; *Casçao* (fn. 26) 119; *Rahdert* (fn. 89) 145; *M. Mikkonen*, Compensation in the Finnish Health Care Sector, in: Jos Dute et al. (ed.), No-Fault Compensation in the Health Care Sector (2004) 199. Indeed, *Sloan et al.*, 179 Am J Obstet Gynecol 1998, 671 ff. find empirical evidence of physicians' satisfaction with no-fault compensation. Contrastingly, however, it is argued that under the New Zealand compensation scheme physicians remain reluctant to cooperate in case of medical error. See *Davis et al.*, 27 J. of Health Politics, Policy and Law 2002, 850. Similar reluctance was found in research under the Virginia Program; see *Sloan* (fn. 20) 59 f.

[184] Sceptical of the 'miracle' of alternative compensation in this respect, *Koch/Koziol* (fn. 157) 118; *Koziol* (fn. 159) 319.

[185] *Making Amends* (fn. 3) 125. On the duty to explain, see also *Montgomery* (fn. 2) 191 f.

[186] *Sverre Grepperud*, Medical Errors: Mandatory Reporting, Voluntary Reporting, or Both? 20 European Journal of Law and Economics 2005, 99.

[187] See the critical observations of *Hyman and Silver*, 90 Cornell L.Rev. 2005, 909 ff.

[188] *Sloan*, 80 The American Economic Review 1990, 130.

92 Furthermore, we would like to suggest that research into the factual foundations of physicians' risk perception is essential: if we undertook empirical research into defensive medicine, it might well show that physicians overestimate the chance of being found liable.[189] This risk perception may perhaps be distorted; it nevertheless is a factor to be taken into account.

93 Research may also show that this overestimation is fed by the fact that in the last decade or so liability insurers have raised premiums dramatically and in many countries an unsound market situation of oligopoly and insurer withdrawal has occurred. This points us to the serious situation in the European medical liability and insurance practice, with which we dealt supra no. 41 ff.

V. Advocating a Shift or Improving Liability Law?

94 Liability law, although a system in place for centuries and firmly embedded in western society,[190] is not sacred. If reform is necessary, we should engage in it immediately. But rather than leaping, we should first look.[191] Do we have quantifiable evidence of the malfunctioning; do we have strong evidence of the causes thereof? Or should we believe the all too often undocumented sweeping assertions of interest groups?[192] Empirical research for Europe is the least that should be undertaken, and we can think of a number of questions that need answering:[193]

- How often are physicians in general sued for damages, compared to the number of treatments? What is the success rate? What seem to be predictors for the filing of a claim and its success?
- How does the liability system fit in the social security system? Is the latter a comprehensive system that takes care of most out-of-pocket expenses, thus leaving little incentive for filing a liability claim?
- How lenient is the liability system with regard to claims for peri-natal damage? Does it work with reversal of burden of proof, and if so, can we statistically deduce the number of claims that are settled or sustained in court without there truly being negligence or causation?
- How is the insurance market for obstetrics and gynaecology malpractice coverage built up? How are premiums calculated, and is the method used reliable? Is the coverage compulsory, the premium fixed, the risk pool of obstetricians and gynaecologists isolated or aggregated with other physicians? Do individual physicians pay the premiums individually, or do hos-

[189] There is some empirical evidence for this argument in U.S.A. jurisdictions; see *Bovbjerg/Sloan*, 67 U. Cin. L. Rev. 1998, 105, quoting research that found that physicians quitting obstetrics because of the threat of liability claims do so under liability systems to the same extent as under no-fault systems (sic!).

[190] *Terence G. Ison*, The Forensic Lottery (1967) 107 mockingly notes that the long association of the liability system with established institutions makes it 'a more glamorous system than social insurance'.

[191] In a similar vein, *Koziol* (fn. 159) 315 f.

[192] Cf. *Rahdert* (fn. 88) 2 f.

[193] On the need for collection of data, see also *Adrian Towse/Patricia Danzon*, Medical Negligence and the NHS: an economic analysis, 8 Health Economics 1999, 93 ff.

pitals take out a cover for the entire hospital enterprise? What causative relationship, if any, exists between changes in liability law or practice and the rise of premiums?
- What incentives do lawyers have in filing claims?[194] Do they receive remuneration on an hourly-basis or do they work on a contingency fee-basis?[195]
- In most European countries there is no system of comprehensive data collection. Is there any statutory obligation of medical liability insurers to submit detailed reports of all closed claims to a government agency? In Florida for instance there is, and it allows for longitudinal study of how the liability system evolves.[196]

Apart from financial motives for holding physicians responsible for birth defects, there are some socio-economic considerations that should be taken into account as well. It may perhaps seem crude to mention, but we must accept that in fact the costs of raising and maintaining children with birth defects are part of the price society has to pay for medical and scientific *progress*. We can safely assume that some hundred years ago most of the disabled newborns – and their mothers no doubt – would have died (which a lot of neonatals did anyway). The continuing advancement of health care has made peri-natal death and disease less and less common. It seems to be an "evolutionary rule" in liability law that the more exceptional some type of damage becomes, the more it will be litigated. We think that claims for birth defects are also subject to this evolutionary run. 95

That point of view, however, cannot conceal that the liability system is adversarial by procedure and capricious by nature. What then should a possible shift towards some alternative arrangement be aiming at? Do all disabled children and their families deserve special attention, or should we leave the liability system as it is? Would a special treatment of these victims amount to favouritism to the detriment of others who deserve comparable compassion?[197] The answer to these questions would strongly depend on the status quo in any given country with regard to the social security benefits that disabled children and their families receive in case there is no one to hold liable for the adversity. In Western Europe, some of the direct and most pressing needs of children and their families are met through social security,[198] although the exact extent of this safety net strongly varies from country to country. However, the overall 96

[194] *Bovbjerg et al.,* 71 Law and Contemporary Problems 1997, 102, speculate that the cause of few eligible cases reaching NICA may well be found in the fact that lawyers have an economic incentive to choose tort.

[195] This should be researched in combination with the amounts for non-pecuniary loss; if jurisdictions award huge amounts for non-pecuniary loss *and* allow contingency fees, then the incentives for active pursuit of promising claims by lawyers are irresistible.

[196] *Vidmar et al.*, 54 DePaul L. Rev. 2005, 318.

[197] Similar questions are put forward persuasively by *Koziol* (fn. 159) 315 ff.

[198] We would not go as far as *Faure* (fn. 90) 57 f., stating that *most* of the medical expenses and the income loss are covered (see also *Koch/Koziol* (fn. 157) 119). Our impression is that – especially with regard to birth defects – social security merely covers a basic part of both heads of damage.

picture seems to be that the help offered by public health care and social care institutions may well be above the level of care provided in the United States. If so, this may in part explain some of the differences between the United States of America and Europe in the level of litigation pressure on gynaecologists and obstetricians.[199]

97 This leads us to argue that the wider the financial gap between those having and those not having recourse to liability law, the stronger the political case for a comprehensive no-fault compensation scheme (or rather: a comprehensive health care program) that encompasses all peri-natal and congenital disabilities of whatever cause and that abolishes liability law for this category of personal injury.

98 Furthermore, there is the matter of interface in any given legal system between the compensation system for birth disabilities and the way health care is financed. It seems that in a number of European health care systems the principle of solidarity has not only brought about fixed pricing mechanisms, but has also put liability law and liability insurance in a difficult environment to survive.

99 As already mentioned supra no. 41 ff. there is little opportunity for hospitals and physicians to charge clients with fees that reflect the liability risk inherent to the service. Recall that in a perfect market the cost of negligence would be internalised and then spread amongst consumers through the price of the product. The market without failures (e.g., with complete information symmetry) would then lead to consumers choosing the best service at the lowest price, which in turn would provide health care providers with an incentive to reduce the number of injuries. At the same time, if health care was a perfect market situation, consumers would have to pay the doctors' fees that reflected their health situation and the cost of the treatment. Then, the price of obstetric and gynaecological care could go beyond the budget of the poor. This would lead to an unequal distribution of health in favour of the rich, which in Europe at least is considered to be unacceptable social injustice. Therefore, in most European countries solidarity dictates that some sort of compulsory health insurance scheme cross-subsidizes good and bad risks and redistributes wealth.

100 So, while theory has it that a pathologist should charge a relatively lower fee than a gynaecologist because he is far less likely to be held liable than a gynaecologist, in practice health care systems regulate fees. At the same time the malpractice insurance industry is usually left unregulated, which puts the physician (or hospital, depending on who pays for the insurance) in a position unable to transfer this increasing insurance premium onto the health care consumer.[200]

[199] Naturally, other major differences are the amounts awarded for non-pecuniary loss and punitive damages and the remuneration of claimants' lawyers.

[200] Cf. *J.C.J. Dute et al.*, Evaluatie Tijdelijk besluit verplichte verzekering bij medisch-wetenschappelijk onderzoek met mensen (2002) 173.

There is something to be said for linking liability with the way health care is financed. If health care is all about redistributing wealth, should this axioma not also be reflected in the malpractice liability and insurance system? For instance, if health care costs are spread through taxation, should the externalities of health care not also be distributed by taxation? Indeed, expecting the government to step in and regulate and redistribute the cost of the health care industry but not expecting government to step in and extend the regulatory operation to the compensation schemes seems somewhat illogical. If the government decides on the distribution of health, should it not also decide on the redistribution of obstetric and gynaecological adverse events? And if so, what kind of premium mechanism for liability insurance would this entail? Would pathologists have to take out compulsory liability insurance in order to keep gynaecology affordable? Admittedly, these are questions that cannot be addressed at an abstract level. They do need addressing, however, but on a national level and the answers will very much depend on the way health care is financed in a given jurisdiction. 101

VI. Conclusions

Liability systems have sometimes been called "luxury systems" for the "unhappy few".[201] In fact, the unhappy few claiming from this system are of statistical insignificance by any measure.[202] Children and their families successfully claiming from their physician are outnumbered by far by those with genetic defects, lasting disabilities by prenatal disease or postnatal injury for which no one can be held liable. 102

In our opinion, what sets the statistical insignificant apart from the masses is the avoidability of the injuries sustained. Therefore, liability systems can only be justified by the ulterior aim of reducing the number of accidents and injuries. If the liability system does a poor job on error reduction, we should work at improving the system. If we ultimately are convinced that other mechanisms (health care inspectorates, criminal law or disciplinary rules) provide superior incentives for prevention, then society might consider abandoning a liability system in favour of a system that is merely aiming for compensation. 103

With regard to compensation as a function of liability systems, the quest for alternative compensation systems in the area of iatrogenic injury also raises the key question whether we want to redistribute the proceeds of the current system over other – and presumably: more – beneficiaries.[203] Choosing a system that compensates all children with birth defects (and their families), irrespective of whether caused by nature of by man, may sound appealing if we have notions like distributive justice, social solidarity and equal opportunities 104

[201] E.g., *Ton Hartlief*, Ieder draagt zijn eigen schade – Enige opmerkingen over de fundamenten van en ontwikkelingen in het aansprakelijkheidsrecht (1997).

[202] Cf. *Dworkin*, (fn. 74) 166.

[203] Cf. Christiane Wendehorst, Compensation in the German Health Care Sector, in: *Jos Dute et al.*, No-Fault Compensation in the Health Care Sector (2004) 295 f.;

in mind.[204] Such a broad scheme would come a long way in alleviating the burden of the stricken families and providing coverage for an adversity they could not insure against before the event.[205]

105 In some countries these notions are more popular than in others, but in any event a no-fault compensation scheme in itself does not help to prevent and reduce the incidence of such iatrogenic birth defects. Therefore, corporate accountability, evaluation of what went wrong, and the compulsion to *learn* from mistakes, are pivotal to any system.[206] If the liability system does not efficiently provide those features, but merely allows lawyers to *earn* from mistakes, then we should start out with amending the liability system as it stands. In short: considering alternatives for liability should also be the moment to raise the question whether enough is being done to prevent the injury from happening and, if not, what else can be done to avoid injury? Compensating injury that could be avoided at lower cost for society is always a second-best solution. Against this background we should like to warn against hare-brained reform. American reform efforts have shown that times of crisis are not the best moment to consider alternatives to the liability system. As Sloan rightly observes: "Crisis may be a precondition for change, but programs enacted during crises respond primarily to stakeholder lobbying and may not make sound policy".[207]

[204] A full shift from cause-based compensation schemes to social security for illness and accidents has of course been proposed on numerous occasions in the various European countries. See, e.g., *Donald Harris et al.*, Compensation and Support for Illness and Injury (1984) 317 ff.; *Atiyah* (fn. 151).

[205] On these arguments in favour of no-fault compensation concerning disabled neonatals, see *Oliphant*, Vict. U. Wellington L. Rev. 2004, 935.

[206] Cf. the various contributions to *Linda T. Kohn et al.* (eds.), To Err is Human – Building A Safer Health System (2000).

[207] *Sloan* (fn. 20) 67.