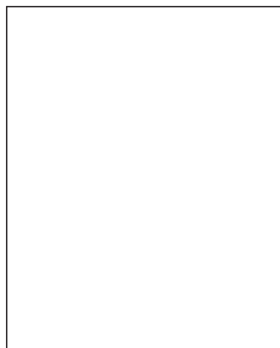
NFT 4/1997

Tort liability and patient insurance schemes – their influence on quality of care

by professor, dr.jur. **Bo von Eyben,** Faculty of Law, University of Copenhagen



Bo von Eyben

The key issue of this address is the actual and the potential contribution of the legal system of liability towards patients to create incentives for dentists – or other medical professions – to avoid injuries in connection with the treatment. The risk of causing injury to the patient is inherent in any kind of medical treatment. Some injuries are caused by lack of due care, others – and most – are not.

This paper was delivered at the 21st Annual Conference of the European Prosthodontec Association, Copenhagen the 27th August, 1997

A liability for faults

According to traditional rules of tort law a dentist is liable only for injuries caused by negligence, i.e. injuries resulting from examination or treatment (or lack of it) that do not meet the professional standard which could reasonably be required under the circumstances – in short: A liability for faults. The purposes of this liability are mainly compensation and deterrence, i.e.

- to provide compensation to the patient for any losses following from the injury
- to induce the dentist to perform according to the required standards of his profession.

Thus the system of tort liability is intended to be one contribution of the legal system to ensure a quality of care which meets the requirements of the professional standard. In this respect there is nothing special about liability for dentists – the same principles apply to liability for other groups of professionals, e.g. lawyers, accountants, engineers, etc. However, the difference between the medical and (most) other professions is precisely the risk of causing personal injury in the rendering of medical services. Bad advising from a lawyer or an accountant may cause economic disasters, but very rarely personal injuries. When personal injuries are involved, the compensation aspect of the liability system is likely to attract more attention, not only because the injured persons are denied compensation in the absence of faults, but also because the process of obtaining compensation is slow, cumbersome and costly. This is the reason why the tort liability system in a number of areas of personal injuries has been changed into so-called no-fault compensation schemes, in which the injured person's right to recover

damages does not depend on fault, but on some – more or less – objective criteria of what accidents are to be attributed to the activity in question. The patient insurance schemes that are operating in the Nordic countries are examples of such no-fault compensation schemes, designed to expand the right to damages beyond injuries caused by faults and to make the process of obtaining damages easier, quicker and less costly to the injured persons and to society.

The compensation system

The problem is, then, whether any deterrent function of the tort system has been sacrificed in our efforts to improve the compensating function of the system. If faults and no-faults are treated alike by the compensation system, it seems unable to serve the purpose of maintaining a standard of good care. If, furthermore, this means that dentists are less likely to observe the required standard of care than they were under the fault regime, the change to a no-fault scheme might even be said to be to the detriment of the patients. The medical notion that prevention is better than cure has a legal counterpart: Deterrence is better than compensation.

Two questions emerge from this proposition. The first is whether the traditional tort system, based on liability for negligence, actually has – or had – any deterrent *effect* (in an area like this one). The second is whether any such effect will be lost in a no-fault scheme, and whether a no-fault scheme may provide deterrence in other respects than the fault system.

Deterrent effect

As to the first question, it is important to note that we do not know whether the fault based liability system actually has the effect of promoting a level of care that fulfils the standard required by the law. One of the reasons for this is that other motivating factors may have the same effect. Some of them work outside the legal system (the dentist's professional ethics, his reputation among colleagues and among actual and potential patients), and some of them work within the legal system (disciplinary measures administered by The Complaints Board System and even punitive measures in cases of more gross violations of the dentist's duties towards the patient). Even if there is not complete identity between the principles of negligence in tort law and the basis for such other measures, all systems intend to discourage from substandard professional performance. Precisely because of the interaction of the various systems it is impossible to isolate the deterrent effect of the tort liability system – a well known problem in the social sciences. Therefore, the preventive value of the tort system remains a matter of speculation, equally impossible to prove as to disprove. One speculation – as good as any – could be that if all the other (legal and non-legal) incentives are insufficient to ensure conformity with a standard of good care, it seems unlikely that the prospects of tort liability can make any difference.

The economic aspects

This is due also to the fact that normally a dentist will not have to pay damages out of his own pocket because the liability is covered by a liability insurance – and if it is not, he may not have to pay out of his own pocket, either, because – depending on the level of damages in the particular country – the pocket may prove to be too small to pay the damages. In effect damages are not paid by the individual dentist who negligently caused the injury, but by all the dentists who have taken out that kind of liability insurance and paid the premiums accordingly, probably passing the costs to the patients or to the tax payers (depending

on the degree of socialization of dentistry in the country). From a pure economic point of view, there is no incentive to avoid liability – the damages have been prepaid in the form of insurance premiums. Of course the coverage may not necessarily absolve the dentists from all personal liability (e.g. there may be a certain self risk or limitation of the insurance sum), and if the insurance company finds it worthwhile it might use experience rating in the fixing of future premiums. But even so, the dentist will have to pay only a fraction of the costs of the injury he causes.

The non-economic aspects

However, more important is perhaps the non-economic aspects of being involved in a case of tort liability. It is simply an unpleasant experience to most people (including, I presume, dentists), apart from the stain on the dentist's professional pride the process may leave. Yet, the fact is that the risk of being involved in a case of tort liability is extremely small – much smaller than it should be according to the legal rules. The reason for this is simply that patients do not make claims for damages to the extent that they are entitled to. The reasons for this are many – a lack of knowledge of the fact that the injury may have been caused by a fault (the dentist will not be the first person to tell them), a lack of claims consciousness, reluctance to go to see a lawyer, etc. Even in America, a major study of the medical malpractice system showed that the ratio between the number of claims for damages that were actually made and the number of claims that probably could have been made was one to sixteen. Contrary to the widespread belief that the problem with the system in America is that any patient will claim and get enormous amounts of damages even if the claim is ill-founded from a medical point of view, this study (and others with it) showed convincingly that the real problem is that most well-founded claims are never made. Of course, this is one of the reasons for the search for an alternative compensation system, i.e. some no-fault scheme, that will make it easier for the patient to see whether he can make a claim – and easier to make it. The important inference in this context is however, that the malfunctioning of the tort liability system heavily compromises also whatever deterrent value the system might otherwise have.

The symbolic function of the notion of fault

What is left, then, is perhaps only a more symbolic function of the notion of fault. Despite the reservations, I have mentioned, it may still be argued that the negligence rule interplays with other – legal and non-legal – motivating factors in a mutually intensifying way, stressing the principle of exercising due care. On this level of abstraction, thoroughly moved from the unrealistic notion of an individual dentist contemplating the risk of being sued before engaging in a specific kind of treatment, it is, however, even more difficult to speculate on the possible effect of taking out one of the factors, the negligence rule. All we can say is that we cannot exclude the possibility that in the long run it might make a difference.

With this admittedly not very precise conclusion as to the deterrent value of tort liability, I now turn to the second question – the merits or the lack of merits of patient insurance schemes in this respect.

The merits or the lack of merits of patient insurance schemes

The patient insurance schemes in the Nordic countries do not impose an objective – or so-called strict – liability on doctors, dentists, etc. That would mean that the patients could claim damages for any injury in connection

with the treatment. Such a rule would not make sense, because – as mentioned – in many cases the treatment of the illness necessarily involves a certain risk of injury. Therefore, it is necessary to exclude from compensation risks that must be tolerated by the patients as the acceptable price for receiving curative treatment. For this reason the basic criterion in the Nordic schemes is an objective test of whether or not the injury could haven been avoided, which means that the patient has a right to damages not only if the injury *should* have been avoided (as the rule of negligence states), but also if the injury theoretically *could* have been avoided according to the "state of the art" of the profession in question, for instance by using another method of treatment which at hindsight would have been preferable (as opposed to the foresight valuation of the negligence rule). Besides, the schemes allow for compensation even in some cases of injury which are not avoidable in this sense, especially in cases of rare and unexpected complications that leave the patient in a state of health which is worse than it probably would have been if he had received no treatment at all.

The rule of negligence

The effect of these criteria has been a dramatic increase in the number of patients who receive compensation. Probably this is due not only to the expansion of the right to compensation, but also because negligently inflicted injuries which previously did not give occasion to claims are now entering the compensation system. The paradoxical experience seems to be that if we want to ensure that patients are compensated at least in cases of negligence, we have to do away with the rule of negligence. However, for the coverage of the patient insurance – and for the damages to the patient – the issue of negligence is irrelevant. Thus, even if a case clearly shows that the injury was in fact caused by negligence, the board which administers the patient insurance disregards this fact in its decision. The system is simply not designed to expose faults, but only to establish whether or not the patient has a right to compensation. One obvious argument against the patient insurance idea is therefore that when cases of negligence and non-negligence are treated alike this system can do nothing in respect of deterring from substandard treatment.

The degree of reproach

The answer to this objection is that the other legal measures against substandard performance still exist and that for many reasons these measures are more suitable to deal with faults that any compensation system can be. Disciplinary and punitive measures cannot be covered by liability insurance. Any sanction can and will be tailored to the degree of reproach, ranging from mild reprimands to imprisonment – as opposed to the all or nothing principle of tort law. Even the principle of negligence in tort law entails an impersonal and – in so far – objective standard which precludes an equation of negligence with moral blame. Besides, most faults fortunately do not result in injury, and without an injury no compensation system can be activated. Still, it was feared by some that once the patients were insured compensation on a no-fault basis, they would be less inclined to lodge complaints against doctors etc. with the health authorities, thus reducing the possibilities of the complaint system of establishing faults. There is, however, no indication that this has actually happened – the number of complaints keeps going up. In this context it is important to note that the patient still has an interest in the fault issue because that might release him from the duty to pay the dentist's fee – an issue of contract law that has nothing to do with the compensation system.

The financing of the tort liability system

To the extent that patient insurance is financed by premiums to an insurance company, there is no real difference from the financing of the tort liability system. Of course premiums will be higher in a no-fault scheme simply because more patients will be entitled to compensation. In principle, the inducement to avoid compensable injuries in order to keep down premiums is present also in the no-fault scheme – and even more so as the premium increase makes it more noticeable. Self-risk, experience rating and other insurance measures are possible also in a no-fault context – as you know from your car insurance. Besides, if one believes that at least serious faults should be marked by the compensation system also, nothing prevents the introduction of a certain right of recourse against the dentist in cases of e.g. gross negligence. Experience from other no-fault compensation schemes does not support the idea of recourse, but it is a way to reconcile the need for having an insurance which covers the patients completely with any wish one might have to make the dentist's freedom from personal liability less complete.

The calculation of insurance premiums

Economists try to convince us of the importance of risk differentiation in the calculation of insurance premiums. If activities are not charged according to the risk they represent, their accident costs will be externalized (as they put it) – which means that they are being subsidized by other, less risky activities, resulting in insufficient economic incentive for the risky activity to consider whether the risk can be reduced. In a medical context for instance, there is no doubt that surgical specialists represent a higher risk of injury than other specialists – and I suppose that it is true also of dental surgery. If all dentists pay the same insurance premium, the high-risk surgeon has – in so far – no incentive to consider whether risk reducing measures would be cheaper for him than to pay premiums to cover accidents that could be avoided by these measures.

Economic deterrence

This theory of so-called economic deterrence is, however, as speculative as any other theory of deterrence. One obvious objection against the theory is that individual decisions on safety measures are less important in the area of health services because they are subjected so extensively to public regulation and supervision. Besides, the costs of operating with highly differentiated insurance premiums are enormous, at least compared to the modest level of damages in the Nordic countries; in the United States, e.g., the situation is different. Finally – and most important – this problem is common to insurance systems based on fault and no-fault, except for the fact that in a fault based system the costs of almost all injuries caused by dentists are borne by the patients, which certainly involves total externalization of accident costs.

Thus, I do not believe that the compensation system, be it based on fault or no-fault, has any major *direct* influence on the quality of care. I suggested that the principle of negligence might have some indirect importance for supporting the concept of good care. The no-fault scheme cannot have this effect, and the question is therefore whether it might have other, indirect preventive effects.

The goal of prevention

In order to answer this question we will have to ask what injuries are covered by the goal of prevention. When this goal is considered part of the overall concept of quality of care, I

think that it becomes clear that there is no reason to restrict prevention to injuries caused by faults. It is of course important to do what we can to prevent faults, but it is far more important to prevent accidents. Any investigation of whether an injury was caused by a fault – in the tort liability system or any other legal context – tends to focus on the unusual aspects of the circumstances in a search for any deviation from normal procedures. What is easily overlooked in this search are the recurrent factors which may be involved in a large number of accidents, whether or not any deviation from normal procedures can be established, indicating e.g. that a certain method or technique of treatment involves risks of injury even if due care is exercised. If such recurrent factors are not taken into consideration, we will be inclined to think that injuries not caused by faults are unavoidable accidents. But in doing so we overlook the area between injuries that should have been avoided and injuries that could not have been avoided – in other words: Precisely the area of the main criterion for entitlement to compensation that is used by the patient insurance schemes.

Area of the main criterion for entitlement to compensation

Of course, utilizing the knowledge generated under the patient insurance of typical injuries in connection with various kinds of treatment presupposes that information of cases and decisions is made available not only to those directly involved in the case, but also to the dental profession in general, including especially dental science for research purposes. The fault system is unfit for producing a likewise applicable material, not only because the system focuses on individual wrongdoing, but also quite simply because the cases are few and information of them is scattered. In the patient insurance scheme, the authority to handle and decide all cases is vested in one board, providing the possibility of a comprehensive view of injuries. Such a knowledge is a necessary condition for any risk-reducing measures, but of course not a sufficient condition. The material only provides a basis for analysis and consideration, and specific instructions on safety measures cannot be expected to be directly deducible from it. What is important is that we try to learn not only from our faults, but also from other errors we commit, and still other misfortunes we cause. Even accidents which we consider truly accidental in the sense that they appear to be unavoidable by today's standards, may prove to be avoidable by tomorrow's standards, once we start to respond to the knowledge of what really produces the injuries, for instance by reducing the risk of human faults and errors. Even if a compensation system is a costly way to produce that knowledge, experience shows that it is not likely to be produced without a compensation scheme, and furthermore, a compensation scheme is better to tell us not only what causes injury, but also the costs of the injuries.

Conclusion

My conclusion is therefore that a no-fault patient insurance scheme is superior to the traditional fault-based tort liability system not only in regard to providing compensation, but also as a potential contribution to improved safety – and thus, improved quality of care. The fault system is quite simply inadequate in both respects. At worst, by abandoning this system we might give up a very modest contribution to legally based deterrence, but we are likely to gain a far more important basis for decisions on preventive measures.