Debate & Analysis

No-fault, no difference:

no-fault compensation for medical injury and healthcare ethics and practice

Overuse of medicines and medical interventions, patient safety, and rising costs are among the greatest challenges facing modern health care. Because medical malpractice systems are thought to be a driving factor, it is logical to consider alternative medical regulatory structures.[1] New Zealand's experience with no-fault compensation for medical injury and separate medical professional accountability processes may provide insights. Now that the no-fault system has been fully in place for a decade, it is timely to reflect critically on potential lessons for health systems around the world.

NEW ZEALAND'S NO-FAULT ALTERNATIVE

The three main functions of a medical regulatory system are to provide compensation for injury, accountability, and deterrence, and mechanisms that enable learning. In 1974 New Zealand introduced a publicly-funded accident compensation scheme with the goals of minimising the incidence and impact of injury. The scheme provides assistance with the cost of treatment and rehabilitation for all personal injuries, regardless of fault, and in exchange bans suing for compensatory damages. Medical injury has always been covered under the scheme. Consequently, in New Zealand there is no culture of suing doctors for damages and doctors pay comparatively low medical indemnity fees of around £790 per annum. Doctors are held to account under separate processes including the Medical Council of New Zealand's competence and fitness to practise processes, an independent patient complaints system, and a separate disciplinary process. The patient complaints system was introduced in 1994 on recommendation of a 1988 government report that found wanting the prior accountability processes in an environment where patients were unable to sue.[2] In New Zealand, patient complaints are not a demand for financial recompense but a demand that an individual be held to account for perceived wrongdoing. A patient may lodge both a claim for treatment injury compensation and, regardless of injury, a complaint against a practitioner.

Although medical injury has always been covered under the scheme, the compensation of medical injury has not always been without fault for doctors. Prior to 2005, patients could obtain compensation by proving medical error. Because all findings of error were reported to the Medical Council, compensation could bring disciplinary repercussions for doctors. Fear of punishment and/or reputational damage discouraged some doctors (and some patients) from participating in the compensation claims process, unfairly restricting access to compensation for injured patients. This situation was rectified in 2005 under the 'no-fault' legislative reforms. The reforms extended eligibility to all injuries caused by treatment and replaced the prior reporting duties with a new duty to report *'risk of harm to the public'* to the *'authorities responsible for patient safety'*. These changes freed doctors to participate in the compensation claims process with little fear, and improved information flows within the system.

> *"Separating accountability from compensation doesn't make all that much difference to doctors."*

HEALTHCARE ETHICS AND PRACTICE UNDER NO-FAULT

It is not known what influence, if any, the no-fault system has on healthcare ethics and practice. It is not easy to change attitudes and behaviour, but given the power of legislation it is not unreasonable to expect that the no-fault reforms would induce change.[3] However, assessing a unitary influence on practice is always going to be challenging given the myriad of factors at play. There is little evidence anywhere showing the influence of regulation on professional behaviour and practice.[4]

Under New Zealand's no-fault reforms, accountability was separated from compensation: claims acceptance no longer implies wrongdoing and seldom results in punishment.[5] Doctors have responded to the changes by assisting more patients to lodge claims for compensation, improving access to compensation for injured patients and generating more patient safety data for learning. There is no legal requirement to learn from these data, and no funding followed the legislative change, but initial analyses indicate that for most injuries there is no hint of error.[6] This suggests that to improve patient safety, in addition to minimising error, we need to minimise patient exposure to treatment risk, where appropriate.

It is yet to be seen whether New Zealand's regulatory system has struck the right balance in the trade-off between accountability and learning.[7] Few poorly performing doctors are identified and reported via compensation. However, patient safety is not likely to be greatly threatened by this because the greatest threat to patient safety comes not from the few poorly performing doctors but rather from all doctors, the majority of whom are competent and well-intentioned.[8] The compensation scheme has always paid doctors to treat the injuries they cause, providing a perverse incentive to injure, but there is no evidence to suggest patients in New Zealand are any less safe than those in other jurisdictions.

Arguably the medical regulatory environment under New Zealand's no-fault system is less punitive than that created under a malpractice system. New Zealand's patient complaints process was not designed to punish but to *'promote and protect the rights'* of patients. Nevertheless, it is generally accepted that most practitioners do find the process punishing. Complaints hurt (or punish) regardless of outcome.[9] For the regulated, punishment

> *"When things turn out badly, moral blame and shame are unavoidable."*

"The medical professional regulatory system should be designed to nurture rather than stifle professionalism."

lies not only in the penalty but also in the process.[10] It may be possible to insure against the cost of malpractice litigation and disciplinary findings, but it is not possible to insure against the personal cost of stress, time, and reputational damage engendered by complaints. Doctors are highly motivated to avoid complaints. But to avoid complaints, because complaints concern not only poor performance, doctors are generally better seeking to increase patient satisfaction than performance. And higher patient satisfaction is associated with higher healthcare utilisation and costs.[11] Counterintuitively, New Zealand's no-fault system may drive over-utilisation as much, or as little, as any malpractice system.

The appropriate use of resources may not thrive in a punitive regulatory environment, but a less punitive environment, in itself, may not induce change. Reducing the risk of punishment might enable the rational use of resources, but it does not enforce it. Countries with very different liability systems have experienced similar growth in healthcare spending.[12] It may be that *perceived* rather than actual risk of punishment drives behaviour.[13] In any case, it is not just punishment that can arouse fear and influence behaviour. Doctors have been motivated (or fearful) long before the threat of punishment arose. Medicine is a practice in uncertainty. Uncertainty can instil fear. In a practice in uncertainty error is inevitable, and when things turn out badly moral blame and shame are unavoidable. The desire to reduce uncertainty and the deterrent effect of a personal sense of shame motivate doctors regardless of the regulatory structure. This is probably just as well because patient safety often still relies on doctors practising according to their professional values. Professional values tend to be consistent across countries, but behaviour can vary depending on external factors.[14] External factors (including the medical professional regulatory system) should be designed to nurture rather than stifle professionalism.

CONCLUSION: NO-FAULT, NO DIFFERENCE

New Zealand's system of no-fault compensation for treatment injury provides more equitable access to compensation more efficiently than a malpractice system. It also generates novel patient safety data for learning, although these have yet to translate into improvement in patient safety. Despite widespread interest in malpractice reform as a means of slowing the rate of growth of healthcare costs, this analysis suggests such reform is likely to be unrewarding. Separating accountability from compensation does not make all that much difference to doctors. Processes to hold doctors to account are important in any medical regulatory structure, but they can instil fear and drive behaviour regardless of the system of compensation. Nonetheless, the absence of a culture of suing in New Zealand does support the development of an atmosphere more conducive to thriving professional values and norms, although policies that foster professionalism remain elusive.

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