Is It Time to Adopt a No-Fault Scheme to Compensate Injured Patients?

Elaine Gibson

THE TORT SYSTEM IS roundly indicted for its inadequacies in providing compensation in response to injury. More egregious is its response to injuries incurred due to negligence in the provision of healthcare services specifically. Despite numerous calls for reform, tort-based compensation has persisted as the norm to date. However, recent developments regarding physician malpractice lead to consideration of the possibility of a move to "no-fault" compensation for healthcare-related injuries. In this paper, I explore these developments, examine programs in various foreign jurisdictions which have adopted no-fault compensation for medical injury, and discuss the wisdom and feasibility of adopting an administratively-based compensation system for healthcare-related injury in Canada.

A number of jurisdictions around the world have created administrative bodies whose role is to assess and allocate appropriate compensation in response to healthcare-related injuries. The primary motivation has been either to accomplish greater justice or to deal with burgeoning costs of the medical malpractice system (often accompanied by threatened collapse of the major insurer). The administrative scheme adopted may replace tort completely vis-a-vis claims within its purview, or it may permit the claimant to select either to pursue the administrative route or to launch a civil lawsuit. The scheme may be comprehensive, i.e., attempting to cover all healthcare-related injury,

LE SYSTÈME DE RESPONSABILITÉ civile délictuelle est généralement blâmé pour ses faiblesses à d'indemniser en cas de lésions. La plus remarquable est sa réponse aux lésions découlant de la négligence dans la prestation de services de santé en particulier. Malgré de nombreuses demandes de réforme, l'indemnisation fondée sur la responsabilité civile délictuelle a continué d'être la norme à ce jour. Cependant, de récents développements concernant les fautes professionnelles des médecins ont mené à étudier la possibilité de passer à une indemnisation sans égard à la faute pour les lésions liées aux soins de santé. Dans notre article, nous explorons ces développements, nous examinons les programmes de diverses compétences étrangères qui ont adopté une approche d'indemnisation sans égard à la faute pour les lésions liées aux soins médicaux, et nous discutons du bien-fondé et de la faisabilité d'adopter un régime d'indemnisation administratif sans égard à la faute pour les lésions liées aux soins médicaux au Canada.

Un certain nombre de ressorts ont, de par le monde, mis sur pied des organismes administratifs dont le rôde est d'évaluer et de déterminer l'indemnisation appropriée en cas de lésions attribuables aux soins médicaux. La motivation première pour la création de tels organismes était soit d'obtenir une plus grande justice, soit de juguler les coûts croissants du système d'indemnisation des fautes professionnelles médicales qui, souvent, menaçaient de faillite les principaux assureurs. Le modèle administratif

or may be limited to a particular type or extent of injury. For example, three jurisdictions have adopted programs exclusively focused on serious neurological injury surrounding birth trauma.

Under these administrative schemes, an injured claimant must establish that the claimant fits within the program criteria, and therefore is entitled to compensation. The claimant is aided in the process by program administrative staff, and often by the complainant's health care provider. Thus, the adversarial relationship between plaintiff and defendant is replaced by a system wherein the care provider may provide assistance to the injured person in seeking compensation.

Numerous prominent individuals have argued in favour of reform of the Canadian tort-based medical malpractice, but governments have not been highly motivated to take action. However, the Canadian Medical Protective Association has recently sharply hiked the premiums paid for the defence of physicians and residents, in some cases an increase of close to 100 percent from 2014–15 to 2015–16. The lion's share of these premiums is funded by provincial governments, whose budgets are straining as a result. The question to be addressed in this paper is: Are events now such that governments will indeed be motivated to take on reform, perhaps radical reform? These recent price increases, combined with an enhanced focus on patient safety, may provide the stimulus for revision of our system's response to healthcare-related injury.

adopté pourrait remplacer complètement la responsabilité civile délictuelle pour les cas relevant de sa compétence, ou il pourrait permettre au demandeur de choisir la voie administrative ou d'intenter une poursuite au civil. Le modèle pourrait être exhaustif, c.-à-d. tenter de couvrir tous les cas de lésions découlant de soins médicaux, ou se limiter à un type particulier ou à une étendue de lésions. Par exemple, trois ressorts ont adapté des programmes portant exclusivement sur les lésions neurologiques graves découlant de traumatismes de naissance.

Selon ces modèles, la partie demanderesse lésée doit établir qu'elle répond aux critères du programme et a donc droit à une indemnisation. Le personnel administratif du programme vient en aide au demandeur/demanderesse dans le cadre du processus et, fréquemment, le dispensateur de soins de santé en fait autant. Ainsi, les rapports fondés sur la contradiction entre le plaignant et le défendeur sont remplacés par un système dans lequel le dispensateur de soins peut aider la personne lésée à obtenir une indemnisation.

De nombreuses personnalités ont plaidé en faveur d'une réforme du système canadien d'indemnisation des fautes professionnelles médicales fondé sur la responsabilité délictuelle, mais les gouvernements n'ont jusqu'à maintenant pas été très motivés à agir. Cependant, l'Association canadienne de protection médicale a récemment augmenté de façon considérable les primes à payer pour défendre les médecins et les résidents; dans certains cas, l'augmentation atteint presque 100 p. 100 entre 2014–2015 et 2015–2016. La part du lion de ces primes est financée par les gouvernements provinciaux dont les budgets écopent de façon conséquente. La question à débattre dans cette présentation est la

suivante : Les choses en sont-elles rendues à un point où les gouvernements seront motivés à entreprendre une réforme, peut-être même une réforme radicale ? Ces récentes augmentations de coûts venant s'ajouter à l'importance accrue accordée à la sécurité des patients pourraient bien être l'incitation voulue pour une révision de notre système de réponse aux lésions découlant de fautes médicales professionnelles.

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I. INTRODUCTION

The Canadian fault-based system of redress in law for injury due to medical malpractice functions poorly. An exceedingly small percentage of aggrieved patients ever commence legal action, and far fewer receive compensation as a result. A number of jurisdictions outside Canada have rejected a fault-based response to medical malpractice and instead have adopted a "no-fault" scheme to respond to medical mishaps. In this paper I explore some of the reasons for the low-functioning Canadian system, and examine whether or not a no-fault scheme of compensation for medical injury might perform in superior fashion.

A legal action commenced due to injury incurred while in receipt of healthcare services or treatment is commonly referred to as a medical malpractice lawsuit. This suit in civil negligence is brought by the plaintiff, who must establish that he or she was injured due to an action or failure to act on the part of the healthcare provider. The core of this action is proof on a balance of probabilities that the healthcare provider failed to meet the standard of care required in the circumstances, and that this failure caused injury to the plaintiff. Thus, we speak of the system being "fault-based" in that the plaintiff must establish that the injury resulted from the healthcare provider being "at fault," that is, having been negligent in falling below the requisite standard of care.

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This paper commences with a discussion of the legal response to medical malpractice in Canada. I explore the low rates of compensation and reasons therefor. The prominent role of the Canadian Medical Protective Association (CMPA) is highlighted, and calls for reform are discussed. The need for reform is often said to be rooted in our fault-based system, and therefore some have argued that a no-fault system may be preferable.

I then turn to an examination of the no-fault compensation schemes that have been adopted in ten jurisdictions around the world (Denmark, Finland, Iceland, Norway, Sweden, New Zealand, Virginia, Florida, Japan, and France). These schemes can be comprehensive—i.e., intended to replace the fault-based system entirely—or restricted to a particular type or severity of injury—e.g., solely covering obstetrically-induced brain injury. In particular, I examine their administrative structure, the threshold criteria to qualify for compensation, whether or not there remains an option to bring a lawsuit for negligence, what damages are available under the administrative scheme, and how the various schemes are subsidized.

Next, I undertake a comparison between Canada's fault-based response to medical malpractice and no-fault jurisdictions, examining the performance of these two major types of systems on the criteria of compensation, deterrence, corrective justice, and distributive justice. Primary aims of our fault-based tort system include compensation and deterrence. Aristotle first discussed the normative goals of corrective and distributive justice. A range of aims—retribution by the aggrieved party against the tortfeasor, appeasement, and atonement—may be grouped under the Aristotelian concept of corrective justice. And the concept of distributive justice, I propose, is at the heart of any broadly-based administrative scheme such as no-fault.

No-fault and fault-based systems of response to medical malpractice each have strengths and weaknesses on the basis of these criteria. The application of a distributive justice lens casts a fresh light on no-fault. Ultimately, I conclude that three factors—the recent acute increase in CMPA fees, the fact that provincial governments (and therefore taxpayers) heavily subsidize these fees, and the focus of the patient safety movement on enhancing openness in revealing error—combine to make this an appropriate time to consider adopting a no-fault medical malpractice system in Canada.

II. LEGAL RESPONSE TO MEDICAL MALPRACTICE IN CANADA

The major Canadian system of response in law to medical malpractice is a civil negligence action.[1] Key elements that must be established are that a duty of care was owed on the part of the health care provider, that there was a failure in meeting the requisite standard of care which caused injury to the patient, and that the injury was not too remote from the negligent action. In this section I calculate the rates of receipt of compensation for medical mishaps in Canada based on the available evidence, and determine that the rates are low. Next, I examine potential reasons for the low rates. The role of the CMPA is discussed, followed by numerous calls for reform of the Canadian system of response to medical malpractice.

A. Compensation Rates

The rate of medical malpractice compensation in response to medically induced injury is exceedingly low. Civil justice statistics are not routinely available in Canada, but various estimates have been made. In 1990, Robert Prichard indicated that less than ten percent of viable negligence claims resulted in compensation.[2] Gerald Robertson has speculated that perhaps only two percent of injured patients are compensated.[3] An examination of the statistics available in the areas of medically induced injury and medical malpractice claim rates may prove beneficial.

The Canadian Adverse Events Study was the first and only major study of iatrogenic injury in Canada.[4] Its authors reported that Canadian acute care hospitals in the year 2000 had an incidence rate of 7.5 adverse events per 100 admissions. They estimated that 70,000 adverse events, defined as "unintended injuries or complications resulting in death, disability or prolonged hospital stay that arise from health care management,"[5] were "pot-

1 Note that the patient can also launch a disciplinary complaint with the provincial college of the health care provider.

2 J Robert S Prichard, *Liability and Compensation in Health Care: A Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care* (Toronto: University of Toronto Press, 1990) at 5.

3 Gerald B Robertson, "A View of the Future: Emerging Developments in Health Care Liability" (2008) Visions Special Ed Health LJ 1 at 9.

4 G Ross Baker et al, "The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada" (2004) 170:11 CMAJ 1678. An iatrogenic injury is one "induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures": see *Merriam Webster*, *sub verbo* "iatrogenic", online: <www.merriam-webster.com>.

5 *Ibid*.

entially preventable,"[6] and that 36.9 percent of those—i.e., 25,830—were rated as "highly preventable."[7]

Next, consider the statistics as to legal actions. The CMPA, which represents the lion's share of physicians in Canada against lawsuits, publishes an annual report. In 2014, 866 legal actions were commenced against physicians.[8] 1,092 legal actions were resolved in 2014; of these, 394 resulted in a settlement, 587 were dismissed, discontinued, or abandoned, and a meagre 111 were heard. Of the hearings in 2014,[9] the plaintiff was successful in 26 cases and the defendant physician in 85 (yielding a success rate of 30 percent).

Thus, very few legal actions are commenced, and a majority of plaintiffs who do commence claims are unsuccessful at receiving any compensation (whether through settlement or judgment). And the rate of claims commenced is in decline. The 2014 rate was the second-lowest in a number of years, and far below the peak in 1995 of 1,415 legal actions.[10]

It is interesting to compare these statistics to the 2004 Canadian Adverse Events Study, outlined above. Not all preventable adverse events would result in a successful negligence claim, so I utilize the conservative calculation base of solely 'highly preventable' adverse events. Linking the 25,830 highly preventable adverse events with the 866 legal actions commenced yields a rate of 3.35 percent. In other words, only approximately 3.35 percent of highly preventable adverse events appear to result in the

6 The potentially preventable adverse events are a sub-set of adverse events; for example, an unanticipatable allergic reaction to a medication constitutes an adverse event, but is not potentially preventable.

7 The Canadian Institute for Health Information estimated in 2004 that preventable adverse events are one of the leading causes of death in Canada (resulting in more deaths than from breast cancer, motor vehicle injuries, and HIV combined). Canadian Institute for Health Information, "Health Care in Canada" (2004) at 42–43, online: <https://secure.cihi.ca/free_products/hcic2004_e.pdf>.

8 Canadian Medical Protective Association, "2014 Annual Report" (2014) at 8, online: <https://www.cmpa-acpm.ca/documents/10179/301941554/15_AR_full_edition-e.pdf> [CMPA, "2014 Annual Report"].

9 Presumably these figures include both trial and appellate court cases.

10 The rate of cases commenced per thousand physicians in 2000 was 22.2; in 2014 it was 9.5, a drop of approximately 60 percent. In 2000, the CMPA had 60,099 members. That year, there were 1337 cases commenced against CMPA members, which amounts to approximately 22.2 commenced cases per 1000 members. (1337/60099) × 1000 = 22.247. In 2014, the CMPA had 91,569 members and there were 866 cases commenced against CMPA members. That amounts to approximately 9.5 commenced cases per 1000 CMPA members. (866/91569) × 1000 = 9.457. See Canadian Medical Protective Association, "2000 Annual Report" (2000) at 8 [on file with author] and CMPA, "2014 Annual Report", *supra* note 8 at 30.

commencement of a legal action. Further, as outlined above, most of the small number of actions actually commenced are unsuccessful.[11]

The contrast between the incidence of highly preventable adverse events and successful legal claims is startling and indeed problematic. Why are the numbers so low?

Briefly, there are a number of salient reasons.[12] First, physicians are held to a less rigorous standard of care in negligence law than perhaps any other person: if they can establish that they conformed to standard medical practice, unless the area is fraught with obvious risk, it is not possible to find that their practice was negligent.[13] Second, causation in medical malpractice is extremely difficult to establish due to the complexities of the human body, the uncertainty inherent in medical practice, and the co-morbidities that are frequently present when one is receiving medical treatment or service. This means it is essential that the plaintiff engage medical expertise to bring evidence of causation—the expenses involved are considerable. Claims on the smaller side are not worth pursuing. Third, major resources are exhausted in sorting out potential liability as between the physician and health care facility, as the facility is not responsible for liability on the part of physicians with visiting privileges.[14] Fourth, an unsuccessful plaintiff may be ordered to pay up to two-thirds of the defendant's costs. Flood and Thomas point out that this makes it risky to go head-to-head with a well-financed opponent.[15] The fifth reason is the unique role and function of the CMPA.

11 It is important to realize that the Canadian Adverse Events Study was limited to hospital-based injuries, whereas the CMPA statistics include legal actions for incidents that occurred outside hospitals; the percentage of claims brought would be substantially lower if non-hospital-based injuries were included as well. Note also that these calculations assume that the 2004 statistics are representative of the contemporary incidence of adverse events; more recent statistics are not available.

12 Note that this list is not intended to be exhaustive. For example, the incidence of mortality is high for patients undergoing medical procedures, and a wrongful death claim is often not worth pursuing due to the lower damages that result.

13 *Ter Neuzen v Korn*, [1995] 3 SCR 674 at para 51, 127 DLR (4th) 577.

14 *Yepremian v Scarborough General Hospital* (1980), 28 OR (2d) 494, 110 DLR (3d) 513.

15 Colleen M Flood & Bryan Thomas, "Canadian Medical Malpractice Law in 2011: Missing the Mark on Patient Safety" (2011) 86:3 Chicago-Kent L Rev 1053 at 1068.

B. Role of the Canadian Medical Protective Association

Approximately 95 percent of Canadian physicians purchase protection against medical malpractice lawsuits through the CMPA.[16] From its inception in 1901, the CMPA has aimed to provide vigorous defence with the aim of preserving the reputations of its physician members.[17] In 1911, the CMPA's founder Dr. R.H.W. Powell stated: "We have struck terror into the evil minded who have sought to besmirch and even blackmail members of our noble profession."[18]

In its 1919 Annual Report, Dr. Powell expounded on the notion of the need for aggressive defence of the good reputations of physicians utilizing warfare tactics:

> Our organization does not consist in the fights we have put up or in the open success we have had but rather in the silent influence we have swayed against litigants who for a money gain have sought to blast the reputation of conscientious, painstaking and reputable practitioners knowing or suspecting that they have an easy mark and that to avoid publicity a medical man will often submit to what amounts to blackmail. . . . These litigants have found out that our Counsel stands ready to accept service of the writ and *your Executive stands ready with a bank account to furnish the sinews of war*. . . . Dozens and dozens of cases have thus been strangled at their inception and have disappeared like dew off the grass.[19]

The stated mission of the CMPA is "to protect the professional integrity of physicians and to contribute to a high quality health care system by promoting safer medical care in Canada."[20] It describes itself as a "valued world-class provider of medical liability protection, a champion of medico-legal risk reduction and recognized as an important contributor to the Canadian health care system."[21] A report published by the Secretary-Gen-

16 Tracey Peever, "Defend the Doctor, Protect the Patient", *Advantage Magazine* (15 December 2015), online: <advantagemagazine.ca>.

17 The CMPA was incorporated by Act of the Federal Parliament in 1913. Interview of Dr. John Gray, Executive Director/CEO of the CMPA by McGill Journal of Law and Health (22 October 2011), online: <mjlh.mcgill.ca>.

18 WDS Thomas, *A Physician's Foresight, A Profession's Pride: A History of the Canadian Medical Protective Association 1901–2001* (Ottawa: CMPA, 2001) at 8.

19 *Ibid* [emphasis added].

20 Canadian Medical Protective Association, *CMPA Strategic Plan 2011–2015* (Canada: 2011) at 3, online: <https://www.cmpa-acpm.ca/documents/10179/24871/com_strategic_plan_2011-e.pdf>.

21 *Ibid*.

eral of the Organization for Economic Co-operation and Development (OECD) in 2006 praised the CMPA model for its sound financial and actuarial risk management and described it as "quasi-unique" in its successful operation over decades.[22]

Just what the CMPA actually succeeds at doing must be carefully considered. The CMPA explicitly functions not as an insurance company, but as a "mutual defence organization."[23] This skews the likelihood of settlement and the legal concept that plaintiffs and defendants are 'equal' in the eyes of the law. Plaintiffs are disadvantaged by what has been described by Justice Moore as the "scorched earth policy" of legal counsel in defending a medical malpractice action in Ontario.[24]

An Ontario judge recently admonished the physician defendant for apparent delay tactics in the case of an infant plaintiff whose thumb was operated on instead of her baby finger:

> In a case where the contemporaneous surgical note candidly and succinctly recognizes that the intended surgery was not performed, to deny liability for four years and then force the plaintiff to incur the costs of preparing for and conducting aborted discoveries and then to incur the costs of this motion would suggest an intentional strategy of delay. Plaintiffs don't have the war chest and endurance of professional defendants.[25]

The ability of physician defendants to hire top medical experts has been criticized by plaintiff medical malpractice lawyer John McKiggan as skewing the balance as between plaintiff and defendant:

> In 2009, the CMPA spent $12 million dollars to hire medical experts to defend doctors in malpractice claims. This is one area where the CMPA has a tremendous advantage. They have a "stable" of experienced medical experts they can call upon to defend doctors accused of malpractice. Most

22 Organization for Economic Co-Operation and Development, *Medical Malpractice: Prevention Insurance and Coverage Options*, Policy Issues in Insurance, No. 11 (OECD Publishing, 2006) at 40–41.

23 Interview of Dr. John Gray, *supra* note 17.

24 *Frazer v Haukioja*, 62 CCLT (3d) 280 at para 2, [2008] OJ No 5306 (QL) (Ont Sup Ct). Presumably Justice Moore was echoing Paul Harte's reference to scorched earth tactics on the part of the CMPA, as quoted in Michael Ganley, "Hard-Nosed Medical Protective Association Has a Winning Record", *The Lawyers Weekly* (13 June 2003), online: <medlit.info>.

25 *Ornstein (Litigation Guardian of) v Starr*, 2011 ONSC 4220 at para 76, 108 OR (3d) 380.

> patients cannot afford to have several experts look at their cases in order to find the one that will give them the "best" answer.[26]

Finally, the CMPA covers all awards and settlements in negligence, no matter how high the amount. This results in physicians not paying out-of-pocket when there is a finding of negligence or settlement in favour of the plaintiff. This in turn reduces the incentive on the part of the physician to settle the case.

C. Calls for Reform

There have been calls for reform of the legal response to medical malpractice in Canada from a range of sources over the years. In 1980, Justice Linden presided over a case in which the plaintiff had been profoundly injured due to an adverse reaction to a drug. However, as the treating physicians had not been at fault, no compensation could be ordered. Justice Linden wrote:

> The law, as it now stands, can furnish no compensation to the plaintiff in these circumstances and on this evidence. Perhaps, when it learns about the result of this litigation, the legislature will see fit to consider looking into this question of compensation for people who suffer rare allergic reactions to *drugs through the fault of nobody*. If this litigation stimulates such a governmental study, then it will not have been in vain for the plaintiff and for others like him who may suffer similar reactions to this and other drugs in the years ahead.[27]

Robert Prichard prepared a ground-breaking report with recommendations for the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care in 1990. He reflected on rapid increases in CMPA costs, and estimated that over $200 million was being spent annually on liability insurance for physicians and health care institutions.[28] He also found that over 50 percent of the dollars spent on medical malpractice went toward funding the litigation and not to the injured patients,[29] and that plaintiffs receive com-

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26 Susan McIver & Robin Wyndham, *After the Error: Speaking Out About Patient Safety to Save Lives* (Toronto: ECW Press, 2013) at 236.

27 *Davidson v Connaught Laboratories* (1980), [1981] 14 CCLT 251 at 281, [1980] OJ No 153 (QL) (Ont Sup Ct) [emphasis added].

28 Prichard, *supra* note 2 at 3.

29 *Ibid* at 4.

pensation in less than 10 percent of potentially viable claims.[30] Ultimately he concluded that the tort system should be retained in order to promote deterrence, but that a no-fault scheme should be created to compensate those who suffer serious avoidable injuries (i.e., permanent partial disability or loss of capacity for eight weeks or more); plaintiffs would have the option of claiming in tort or under the administrative scheme.[31]

The CMPA did not concur in Robert Prichard's suggestion to create a broad no-fault system. Following an examination of alternative approaches to medical injury in 2005, it concluded that the Canadian liability model is "fundamentally sound and is very likely the best possible model for our circumstances."[32] It did, however, endorse further research into the possible creation of a no-fault system for patients suffering birth-related neurological injury.[33] It also recommended that the reporting of adverse events be mandated and analyzed in the interest of patient safety, but that there be a firewall between this information and the tort system.[34]

In 1996, Ontario Health Minister Jim Wilson threatened to refuse to contribute toward physicians' CMPA fees.[35] In response, the CMPA commissioned a review of its operations to be conducted by Justice Dubin.[36] He suggested in his report that there be further study of "the incremental introduction of an administrative medical injury compensation scheme"[37] and referred specifically to the Virginia neurological birth injury scheme, but did not endorse the concept of no-fault generally.

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30 *Ibid* at 5.

31 *Ibid* at 6–7. In a talk given eight years later on why there had not been significant adoption of his recommendations, Prichard reflected: "It was too ambitious to think we could change the whole system in a federal country in one step. It is a province-by-province challenge and I think the recommendations did not take into account the political anatomy of the era. I think what we need to do is develop experiments." G Ross Baker & Peter Norton, *Patient Safety and Healthcare Error in the Canadian Healthcare System: A Systematic Review and Analysis of Leading Practices in Canada with Reference to Key Initiatives Elsewhere* (Canada: 2006) at 135, online: Health Canada <www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-patient-securit-rev-exam/2001-patient-securit-rev-exam-eng.pdf>.

32 Canadian Medical Protective Association, *Medical Liability Practices in Canada: Towards the Right Balance: A Report* (Canada: 2005) at 22, online: <books.scholarsportal.info>.

33 *Ibid* at 20.

34 *Ibid* at 19.

35 Sarah Beer, "But Will it Benefit Patients? Malpractice Insurance and the Dubin Report" (1997) 43 Can Family Physician at 577.

36 Charles L Dubin, *An Independent Review of the Canadian Medical Protective Association* (Ottawa: Canadian Medical Protective Association, 1996).

37 *Ibid* at 146.

The CMPA has accumulated substantial reserves: in 1997 reserves totalled $1.1 billion[38] and as of 2014 they constituted $3.2 billion.[39] The $1.1 billion, adjusted for inflation, would amount to just over $1.5 billion in 2014 dollars. This means that, in 2014 dollars, the reserves have more than doubled in 17 years. Interestingly, governments across Canada have been heavily subsidizing physician CMPA fees, such that many provinces cover 90 percent of physicians' defence insurance fees, and Saskatchewan covers 100 percent. This approach developed as a result of fee negotiations, and reflects the fact that physicians are prevented from direct-billing patients if their insurance rates increase.[40] All provinces outside of Ontario and Quebec have seen a dramatic increase of approximately 95 percent year-over-year from 2014–15 to 2015–16.[41] In Nova Scotia, for instance, up to 2014–15, the government was providing reimbursement to physicians totalling 90 percent of CMPA premium fees in excess of $1,500 and 100 percent of resident physician premium fees. CMPA fees for Nova Scotia physicians totalled $7,610,100 in 2014–15, and jumped to $15,076,300 in 2015–16, constituting a dramatic 98.1 percent increase from the previous year.[42]

Justice Krever conducted a Royal Commission of Inquiry on the Blood System in Canada. In his 1997 Report, he recommended a no-fault administrative scheme "for compensating persons who suffer serious, adverse consequences as a result of the administration of blood components or blood products."[43] Subsequently, he has argued that Canada needs a comprehensive no-fault system responding to medical injuries.[44] The Health Council of Canada has called for an examination of no-fault compensation

38 *Ibid* at 118.

39 CMPA, "2014 Annual Report", *supra* note 8 at 17.

40 *Canada Health Act*, RSC 1985, c C-6, s 18.

41 Ontario is incurring an 18% increase over the same period, and Quebec's rates are not changing. See CMAJ, "Legal Fees Nearly Double for Many MDs" (2014) 186:14 CMAJ 1051 at 1051, online: <www.ncbi.nlm.nih.gov/pmc/articles/PMC4188644/pdf/1861051.pdf>.

42 Information on file with author. Note that the CMPA recently announced an adjustment in fee structures commencing in 2016, with British Columbia and Alberta in a newly-created separate region from Saskatchewan, Manitoba, the Atlantic region, and the territories. See CMAJ, "CMPA Fees Will Go Up—and Down" (2015) 187:14 CMAJ 1039 at 1039, online: <www.cmaj.ca/content/early/2015/09/08/cmaj.109-5149.full.pdf>.

43 Canada, Library of Parliament, *Canada's Blood Supply Ten Years After the Krever Commission*, by Sonya Norris (Ottawa: Library of Parliament, 10 July 2008) at 7, online: <www.lop.parl.gc.ca/content/lop/researchpublications/prb0814-e.pdf>.

44 Owen Dyer, "Canada's Legal System Cheats Patients and Doctors Alike" (2005) 2:19 National Rev Medicine <www.nationalreviewofmedicine.com>.

for medical injuries,[45] as has the Canadian Patient Safety Institute.[46] In 2015, the Center for Patient Protection called for the elimination of taxpayer subsidization of CMPA liability defence fees.[47]

Canada is not unique in experiencing concerns with the medical malpractice system. There has been an increasing tendency to treat medical malpractice as a unique aspect of tort law by introducing reforms specifically aimed at addressing problems in this area.[48] In a 1996 review of the overall civil justice system in the U.K., Lord Woolf indicated he was singling out medical malpractice for the most intense scrutiny, because during the course of his examination "it became increasingly obvious that it was in the area of medical negligence that the civil justice system was failing most conspicuously to meet the needs of litigants."[49] Some of the reforms internationally have been tort-based, such as placing caps on non-economic loss. In addition, a number of jurisdictions have adopted no-fault medical injury administrative schemes. In the next section I explore these schemes, first discussing the comprehensive and then the non-comprehensive no-fault models.

III. NO-FAULT COMPENSATION SCHEMES

Ten jurisdictions around the world have adopted a no-fault compensation scheme, sometimes referred to as a "health court,"[50] for patient injury.[51] This includes all the Nordic countries (Denmark, Finland, Iceland,

45 Health Council of Canada, Press Release, "Canadians Need Quality—Not Just Quicker—Health Care, Health Council of Canada Says in Second Annual Report" (7 February 2006), online: Health Council of Canada <www.healthcouncilcanada.ca>.

46 Joan M Gilmour, "Patient Safety, Medical Error and Tort Law: An International Comparison", *Commissioned Reports and Studies* (Toronto: Health Canada, 2006) Paper 42 at 36, online: <digitalcommons.osgoode.yorku.ca>.

47 "Eliminate Taxpayer Subsidy of Doctor's Insurance", *The Center for Patient Protection*, online: <www.patientprotection.healthcare>.

48 CP McGrath, "Medical Malpractice and Compensation in Global Perspective: Vienna 3–4 December 2010" (2011) 27:1 Professional Negligence 4 at 12.

49 Lord Woolf, *Access to Justice: Final Report: Final Report to the Lord Chancellor on the Civil Justice System in England and Wales* (UK: Ministry of Justice, 1996) at ch 15, online: <webarchive.nationalarchives.gov.uk>.

50 Michelle M Mello, Allen Kachalia & David M Studdert, "Administrative Compensation for Medical Injuries: Lessons From Three Foreign Systems", online: (2011) Pub 1517 Vol 14 The Commonwealth Fund at page 2 <www.commonwealthfund.org/~/media/files/publications/issue-brief/2011/jul/1517_mello_admin_compensation_med_injuries.pdf>.

51 The German Democratic Republic also had a no-fault medical injury compensation scheme, but the reunification of Germany resulted in its demise. See Mark S Stauch, "Medical Mal-

Norway, and Sweden), New Zealand, Virginia, Florida, Japan, and France. These jurisdictions have done so based on one of two primary motivations: either to enhance patient experience and outcomes following iatrogenic injury, or to deal with burgeoning insurance costs.

In either case, at its core, an administrative scheme is established that is intended to replace or supplement a tort-based system of compensation for injury incurred as a result of a medical mishap. The key ingredients in the schemes to be discussed are twofold: first, the absence of need to establish the negligence of a defendant in causing the injury in order to qualify for compensation; and second, the creation of an administrative body designed to handle claims.[52] The scheme may be comprehensive in nature or may be restricted to a certain type or extent of injury. The threshold to qualify for compensation is invariably more inclusive than the tort-based approach.

In this section I discuss the structures established in the various jurisdictions to administer the no-fault programs, followed by an exploration of the threshold criteria a patient must meet in order to qualify for compensation. Whether or not one has the option to bring a negligence action and what damages one may receive if successful are discussed. Finally, I briefly outline how the no-fault programs are funded.

A. Administrative Structure

A claim is commenced when the injured patient submits an application to an administrative body, which may be a Crown corporation[53] or, in the case of Virginia, the Workers' Compensation Commission.[54] In Sweden,

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practice and Compensation in Germany" (2012) 86:3 Chicago-Kent L Rev 1139 at 1166. In 2015, the South African Medical Association called on its government to bring in a no-fault compensation scheme for victims of medical mistake who do not meet the tort standard for compensation. See Government Employees Medical Scheme, News Release, "No Fault Insurance Proposed in the Face of Rising Claims" (20 March 2015), online: GEMS News <www.gems.gov.za>.

52 Wales, for instance, has established a scheme for recovery for injuries of up to 25,000 pounds and created an administrative body to review claims. However, the requirement of a finding of negligence on the part of the health care provider places it outside the scope of this no-fault classification. See Lyons Davidson Solicitors, News Release, "NHS Redress Scheme for Welsh Clinical Negligence Claims: One Year On" (30 March 2012), online: Lyons Davidson News and Insight <www.lyonsdavidson.co.uk>.

53 Stephen Todd, "Treatment Injury in New Zealand" (2011) 86:3 Chicago-Kent L Rev 1169 at 1173, 1179, 1183.

54 Clarke T Edwards, "The Impact of a No-Fault Tort Reform on Physician Decision-Making: A Look at Virginia's Birth Injury Program" (2011) 80:1 Revista Jurídica UPR 285 at 295.

approximately 60 to 80 percent of claims are facilitated through a health care provider and in Denmark, the physician files approximately 15 percent of all claims or, in most cases, assists the patient.[55] There is an obligation on the part of health care professionals to advise an injured patient of the possibility of compensation, and each hospital has one or more patient counsellors to advise patients of their rights and to assist with the process. By contrast, in France the patient completes the application, and there is no obligation on the part of the physician to assist.[56]

Legal services are commonly used in Virginia,[57] but are generally considered unnecessary in the Nordic countries. For instance, in Denmark, lawyers participate in filing about 10 percent of the claims.[58] The initial claims assessment is conducted by one or more assessors following review by one to three independent medical experts.[59] Florida is unique in having an administrative law judge assess the claim at first instance.[60] Each program has an internal appeal process and, if unsuccessful, recourse to the judicial system on further appeal.[61]

B. Threshold Criteria to Qualify for Compensation

Denmark's threshold criteria are typical of the Nordic-based model, which replaces the negligence standard with a series of broader tests. The first basis on which a claimant qualifies for compensation under the Danish no-fault regime is the avoidability rule. If the injury could have been avoided under optimal circumstances, the patient qualifies for compensation. There are two ways one can qualify. First, the patient qualifies if he or she

55 Mello, Kachalia & Studdert, *supra* note 50 at 5.

56 Janine Barbot, Isabelle Parizot & Myriam Winance, "'No-Fault' Compensation for Victims of Medical Injuries. Ten Years of Implementing the French Model" (2014) 114:2 Health Policy 236 at 242.

57 UK, The No-Fault Compensation Review Group, *No-Fault Compensation Schemes for Medical Injury: A Review* (Interim Report) by Anne-Maree Farrell, Sarah Devaney & Amber Dar (Scotland: Scottish Government Social Research, 2010) at 55, online: <http://www.gov.scot/Resource/0039/00394407.pdf>.

58 Mello, Kachalia & Studdert, *supra* note 50 at 5.

59 Allen B Kachalia et al, "Beyond Negligence: Availability and Medical Injury Compensation" (2008) 66:2 Social Science & Medicine 387 at 389–90; Randall R Bovbjerg, Frank A Sloan & Peter J Rankin, "Administrative Performance of 'No-Fault' Compensation for Medical Injury" (1997) 60:2 Law & Contemp Probs 71 at 82–83.

60 The Florida Birth-Related Neurological Injury Compensation Association, "Eligibility & Benefits", online: <www.nica.com> [Neurological Injury Compensation Association].

61 Mello, Kachalia & Studdert, *supra* note 50 at 6; Bovbjerg, Sloan & Rankin, *supra* note 59 at 83–84.

can establish that the injury could have been avoided if the health care provider had used another treatment method that would have been equally effective. The other treatment method must have been available at the time of treatment, but the treatment need not have been known as equally effective—in other words, information that becomes available after the time of treatment may be used in determining its relative effectiveness.[62]

Second, and in the alternative, the patient receives compensation if he or she can establish that the best health care provider in the particular field would have acted differently; the assumption is that the injury would thereby have been avoided.[63] This is the standard of the "experienced specialist," which may be contrasted to that of the "reasonable physician" under Canadian law.[64] Recovery is possible due to an injury caused by an incorrect or delayed diagnosis if the experienced specialist would on a balance of probabilities have acted differently. If resources or facilities are not available, there is no recovery unless the experienced specialist would have referred the patient elsewhere, and that referral would on a balance of probabilities have prevented the injury.[65]

A third basis for recovery arises in a circumstance in which the treatment injury was unavoidable, but the extent of injury incurred exceeds that which the reasonable patient should endure. Both the relative seriousness of the injury and its likelihood of occurrence (i.e., it occurs in less than two percent of cases) are relevant to the assessment of endurability.[66]

The patient also receives damages for injury caused by the malfunction of equipment used for examination or treatment; the reason for the malfunction is not of relevance.[67] Thus, the standard is that of strict liability.

Threshold criteria are similar throughout the Nordic countries, with the following exceptions. In Sweden, the endurability rule (i.e., the criterion that applies where the extent of injury incurred exceeds that which the reasonable patient should endure) applies only to infections, instead of to injury broadly as in Denmark.[68] The Swedish legislation explicitly states that, for injuries sustained through accident, recovery is not lim-

62 Vibe Ulfbeck, Mette Hartlev & Mårten Schultz, "Malpractice in Scandinavia" (2012) 87:1 Chicago-Kent L Rev 111 at 119–20.

63 Jocelyn Downie et al, *Patient Safety Law: From Silos to Systems* (Canada: Health Canada, 2006) at Appendix 2: Country Reports, Denmark at 15.

64 Ulfbeck, Hartlev & Schultz, *supra* note 62 at 117, n 24; Flood & Thomas, *supra* note 15 at 1071.

65 Ulfbeck, Hartlev & Schultz, *supra* note 62 at 117–18.

66 M Erichsen, "The Danish Patient Insurance System" (2001) 20 Med & L 355 at 364–65.

67 Ulfbeck, Hartlev & Schultz, *supra* note 62 at 118–19.

68 *Ibid* at 120.

ited to those who would be compensated under tort rules.[69] Norway does not have the experienced specialist standard; rather, there is strict liability for treatment injuries.[70] The Norwegian legislation also states that if the cause of injury is unknown, but was likely an external influence during treatment, it is to be presumed that a failure in supply of the health care service was the cause.[71]

New Zealand adopted a comprehensive no-fault accidental injury compensation scheme in 1974. Its scope is unique internationally in that it covers not only medical injury but accidental injury, however incurred, including workplace and automobile accident injuries. Applicability of the program to medical malpractice has varied over the years. Initially, the program covered "personal injury by accident," which de facto included medical malpractice.[72] By 1992, economic concerns led to a change such that to be compensable, the injury had to constitute either "medical error"—defined as failure to observe a reasonable standard of care and skill—or "medical mishap"—defined as an adverse consequence of treatment that is rare (occurs in less than one percent of cases) and severe (disability or prolonged hospitalization).[73] The scheme became primarily fault-based in its requirement of a breach in the standard of care and causation of injury.[74]

The revised scheme resulted in a substantial increase in utilization of legal services by physicians, a greater use of the common law by plaintiffs, and systemic delays in the functioning of the administrative scheme.[75] The introduction of a fault-based aspect pitted the interests of health care providers against injured patients in adversarial fashion. A review of the medical malpractice aspect of the scheme led to further reform and expansion in 2005. The 1992 categories were removed and replaced by the singular requirement of a personal injury that resulted from a "treatment injury."[76] Excluded are injuries that are an ordinary consequence of treatment, solely

69 *Ibid* at 121; Finland has an equivalent rule.

70 *Ibid* at 117, n 24.

71 *Ibid* at 126.

72 Todd, *supra* note 52 at 1179.

73 *Ibid* at 1187.

74 *Ibid* at 1199.

75 Joanna Manning, "New Zealand's Remedial Response to Adverse Events in Healthcare" (2008) 16:2 Torts LJ 120 at 142 [Manning, "Remedial Response"].

76 Todd, *supra* note 52 at 1179. Joanna Manning is concerned that aspects of negligence law are creeping in to judicial review of the New Zealand treatment injury criterion: Joanna M Manning, "Plus ça change, plus c'est la même chose: Negligence and Treatment Injury in New Zealand's Accident Compensation Scheme" (2014) 14:1–2 Medical Law Intl 22.

attributable to resource allocation, or caused by a person delaying consent to treatment.

All remaining no-fault programs other than the Nordic and New Zealand programs are non-comprehensive in scope, being limited to a particular type or severity of injury. Those based on type of injury focus on obstetrical injury. France's program focuses on severe injury.

Three jurisdictions—Virginia, Florida, and most recently Japan—have adopted no-fault programs in response to birth-related injury. Obstetrical injuries are arguably the most expensive medical liability injury type due to their potential severity, combined with the likelihood that the injury will likely endure for the life of the child. To qualify in Virginia, the infant must have incurred an injury to the brain or spinal cord during live birth due to mechanical injury or oxygen deprivation which causes cognitive disability requiring permanent assistance.[77] This narrow category has ensured the number of claims are kept low (i.e., an average of ten per year).[78] Florida's plan is similar. The birth must have occurred in a hospital. Injury sustained during resuscitation immediately following delivery is included.[79] To qualify for the Japanese scheme, an infant must usually be born after 33 weeks of pregnancy, weigh more than 2,000 grams at birth, be diagnosed with cerebral palsy (impaired muscle coordination and/or other disability typically caused by brain damage before or at birth) of high severity, and must not die within the first six months.[80]

France's program is aimed at compensation for severe injury. The first category of patients eligible for the program consists of patients who experience a "medical hazard"[81] directly attributable to prevention, diagnosis, or treatment.[82] This has also been described as a serious and unpredictable injury "without relation to their previous state of health

77 Edwards, *supra* note 54 at 294.

78 *Ibid* at 295.

79 Neurological Injury Compensation Association, *supra* note 60.

80 Robert B Leflar, "The Law of Medical Misadventure in Japan" (2012) 87:1 Chicago-Kent L Rev 79 at 107, n 135 [Leflar, "Medical Misadventure"].

81 Also translated to 'medical accident'. See Dominique Thouvenin, "French Medical Malpractice Compensation Since the Act of March 4, 2002: Liability Rules Combined with Indemnification Rules and Correlated with Several Kinds of Proceedings" (2011) 4:1 Drexel L Rev 165 at 184.

82 Geneviève Helleringer, "Medical Malpractice and Compensation in France, Part II: Compensation Based on National Solidarity" (2011) 86:3 Chicago-Kent L Rev 1125 at 1126. Note that in 2010 Belgium enacted legislation providing no-fault coverage for persons within this first category, also covering victims in situations in which liability insurance coverage is non-existent or inadequate: Nicole Atwill, "Belgium: New Law on Compensation of Vic-

and its foreseeable evolution."[83] Next, the injury must be abnormal in relation to the patient's health status. The hazard must have caused a serious harm, measured in terms of magnitude of loss of capacity. The disability rate must exceed 25 percent for a minimum of six months over a 12-month period.[84] One also qualifies if rendered permanently unable to perform one's previous occupation. The second category consists of those who experience a hospital-acquired infection that results in disability greater than 25 percent. Third, is compensation for those who acquire HIV or Hepatitis C infection through blood transfusion. A rebuttable presumption of causality exists between the transfusion or injection and the infection.[85] These categories have been expanded in recent years to include care provided by professionals outside their area of specialization, harms from growth hormone, and victims of nuclear testing.[86]

As has been demonstrated, the criteria for qualification differ from one no-fault regime to another. However, in each case, provided that the injury is of the right type and/or magnitude to fit within the program, the circumstance for receipt of compensation is more broad than in a fault-based medical malpractice legal system.

C. Option to Sue in Negligence

A significant difference between programs is whether or not recovery in negligence is still available. Sweden leaves open the option for a patient to sue for medical malpractice, whereas in Denmark such a lawsuit is not permitted except in case of product liability.[87] In Sweden the tort system is seldom used for medical malpractice, being relied on primarily for injuries not covered by the no-fault scheme;[88] 99.9 percent of claims are resolved without recourse to court despite injured patients having the option to sue in tort.[89] The New Zealand scheme is exclusive in that one

tims of No-Fault Medical Accidents" *The Library of Congress* (4 May 2010), online: <www.loc.gov>.

83 Barbot, Parizot & Winance, *supra* note 56 at 238.

84 Helleringer, *supra* note 82 at 1127.

85 *Ibid* at 1129–30.

86 *Ibid* at 1130–31.

87 Ulfbeck, Hartlev & Schultz, *supra* note 62 at 116–17.

88 *Ibid* at 116.

89 Kaj Essinger, "The Swedish Medical Injury Insurance" *LÖF* (20 February 2009) at 5, online: <www.vm.gov.lv/images/userfiles/phoebe/ministrija_sabiedribas_lidzdaliba_ab75e1a6c38b637dc22573d800293aaa/zviedrijas_traumu_apdrosin.pdf>.

is not entitled to sue in tort for any injuries covered by the scheme—lawsuits are permitted primarily in cases of mental harm unaccompanied by physical injury or if one is claiming for exemplary damages.[90] In Japan, negligence lawsuits are permitted.[91] Florida's program is optional, but a tort lawsuit is prohibited once a child is accepted into the plan.[92]

The French program is unique in that it retains tort liability as the primary source of compensation, and indeed a patient who fits within the category of having experienced a medical hazard is only eligible if negligence cannot be established.[93] This leads to the arguably perverse need for a fault-based analysis as a prerequisite to qualifying for the no-fault program.

D. Damages

The Nordic systems assess damages in accordance with general tort principles, except that punitive damages are not available, and awards for non-economic loss are capped. There is an ultimate compensation limit of US$1.2 million in Sweden[94] and US$1.7 million in Denmark.[95] New Zealand assesses damages based on statutory criteria, with a focus on rehabilitation; weekly compensation payments are available in cases of ongoing incapacity to work 30 hours per week.[96] Non-economic loss compensation is capped at US$85,000.[97] Japan has a maximum payment per child of US$375,000,[98] whereas in France the no-fault scheme has no cap on indemnification.[99]

90 Gilmour, *supra* note 46 at 188.

91 Naoko Akimoto, "Towards a No-Fault Compensation System for Medical Accidents in Japan" in McDonnell Academy Scholars, *Global Leadership Visions* (St. Louis: Washington University in St. Louis, 2013), online: <mcdonnell-pubs.wustl.edu/Oped2011-13/2F497C74A42AB95A6ECACC9FE7231DCD/GLV%20cropped%202011-2013.pdf>.

92 Neurological Injury Compensation Association, *supra* note 60.

93 Thouvenin, *supra* note 81 at 174–75.

94 Mello, Kachalia & Studdert, *supra* note 50 at 12.

95 *Ibid* at 7.

96 Farrell, Devaney & Dar, *supra* note 57 at 26.

97 Mello, Kachalia & Studdert, *supra* note 50 at 12.

98 Akimoto, *supra* note 91 at 21.

99 Simon Taylor, *Medical Accident Liability and Redress in English and French Law* (Cambridge: Cambridge University Press, 2015) at 53–54.

E. Program Funding

Funding for the no-fault programs comes from a range of sources. The French program is state-operated and is funded through a combination of social security contributions from employers and employees, general income-based contributions, and state-imposed taxes.[100] In New Zealand, funding for the accident compensation scheme includes levies on employers, the self-employed, and government. Levies were originally calculated on a pay-as-you-go basis, but the program is moving toward a fully-funded accounting system, including future costs of the claim.[101] The government is empowered by statute to impose levies on registered health professionals and organizations that provide medical treatment; however, this power has not been utilized.[102] Patient liability insurance is mandatory in Sweden,[103] and is maintained by county council districts in both Sweden[104] and Denmark.[105] Private insurance companies cover doctors without a contract with the district, a range of other healthcare practitioners, and nursing homes.[106]

In Virginia, participating physicians and hospitals pay a set premium and are eligible for lower insurance premiums for medical malpractice. Non-participating physicians must also contribute toward the program, which is required to operate on an actuarially-sound basis.[107] The Florida program is funded similarly to Virginia's, except that the state of Florida also granted $40 million at the commencement of the program.[108] Japan's program is financed by a levy on each pregnant woman at participating facilities, and the money is then passed on to private insurance companies. The levy is returned to the pregnant woman through her government-sponsored health insurance plan.[109] Ultimately, then, the program is funded through the social insurance system, with private insurance companies covering the liability and standing to incur profit or loss from its operation.

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100 Barbot, Parizot & Winance, *supra* note 56 at 241.
101 Todd, *supra* note 52 at 1184.
102 *Ibid* at 1185.
103 Essinger, *supra* note 90 at 1.
104 Ulfbeck, Hartlev & Schultz, *supra* note 63 at 114–15.
105 Downie et al, *supra* note 64 at Appendix 2: Country Reports, Denmark at 15.
106 Essinger, *supra* note 89 at 2.
107 Farrell, Devaney & Dar, *supra* note 57 at 54.
108 *Ibid* at 58.
109 Leflar, "Medical Misadventure", *supra* note 80 at 107, n 137.

IV. COMPARISON BETWEEN CANADA'S FAULT-BASED APPROACH AND NO-FAULT[110]

In the last section I outlined details of the various no-fault schemes. This section examines their performance as compared to Canada's fault-based approach to compensation for medical malpractice. The criteria to be applied are the extent to which the contrasting approaches may be seen to meet the goals of compensation, deterrence, corrective justice, and distributive justice.

A. Compensation

It is widely recognized that no-fault schemes are superior at providing compensation as compared to fault-based approaches. There are two main reasons for this: the broader range of persons who receive compensation, and the significantly lower costs of administration.

The number of claims is significantly higher in each of the jurisdictions with a comprehensive no-fault scheme as compared to prior to the scheme's introduction. As well, most of the Nordic countries have seen increases year-over-year in the number of claims and the amount of compensation awarded.[111] Mello, Kachalia, and Studdert examined the Swedish and Danish systems and found that about ten percent of injured patients enter a claim as compared to two to three percent in the U.S.[112] The number of people receiving compensation is also significantly higher. The success rate of applicants receiving compensation varies depending on the country, from approximately 30 percent in Finland, 32 percent in Norway, and 35 percent in Denmark, to 44 percent in Sweden.[113] In New Zealand,

110 Note that extrapolation from jurisdictions outside Canada should be done with caution, as the performance of their systems is in part dependent on government-funded health care and social services networks in place. For example, Sweden's social welfare system covers 80 percent of the first year of lost wages following injury, as well as significant services for a disabled infant, so it is not necessary that the no-fault scheme incur these expenses: Essinger, *supra* note 89 at 4. The operation of a jurisdiction's legal system may also be of relevance. As one example, "until 2013 the UK provided legal aid for qualifying applicants to bring a medical malpractice claim, significantly driving up the number of tort-based claims": Barcan+Kirby, "The impact of legal aid changes on victims of medical negligence" (6 February 2013), *Barcan+Kirby* (blog), online : <barcankirby.co.uk>. Also, differing standards for fault-based liability between different jurisdictions influence outcomes.

111 Ulfbeck, Hartley & Schultz, *supra* note 62 at 128. For recent Finnish figures see Finnish Patient Insurance Centre, "Statistics of Patient Injuries" (2014), online: <www.pvk.fi>.

112 Mello, Kachalia & Studdert, *supra* note 50 at 5.

113 Ulfbeck, Hartlev & Schultz, *supra* note 62 at 127–28.

following the 2005 reforms, the number of claims increased in each year up to 2009–10, at which time there was a slight drop.[114] The overall acceptance rate increased from 40 to 66 percent. From the inception of the French system in 2002 to 2009, the number of claims gradually increased year-to-year.[115] 34 percent of claims were successful.[116]

By comparison, in Canada, approximately 41.5 percent of CMPA expenditures in 2014 were allocated to legal and expert costs and administration.[117] In the U.S., approximately 55 to 60 percent of total system costs are attributable to overhead.[118] Thus, in tort-based jurisdictions, aggrieved patients are deprived of a very high portion of the total expenditures.

The size of awards tends to be suppressed in no-fault jurisdictions. In 2009, the average compensation award in Sweden was approximately US$20,000, in Denmark was US$40,000, and in New Zealand was a very low US$4,450.[119] A successful claim in Japan on behalf of a severely injured child results in a lump sum payment of US$75,000 plus US$300,000 paid over a 20-year period.[120] These rates compare to median damages of $215,700 in Canada in 2014,[121] and approximately US$324,000 per award in the U.S.[122]

There are significant administrative cost savings in jurisdictions with no-fault schemes as compared to fault-based jurisdictions. Overhead costs in Denmark and Sweden constitute approximately 17 percent of total system costs.[123] In New Zealand, administrative costs are remarkably low: for 2013–14 the claims handling costs amounted to 12.7 percent of total claims paid.[124] Administrative costs associated with medical malpractice have de-

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114 Todd, *supra* note 52 at 1200–01.

115 Barbot, Parizot & Winance, *supra* note 56 at 241.

116 *Ibid* at 242.

117 CMPA, "2014 Annual Report", *supra* note 8 at 21–22 (note that this figure does not include judicial system costs). For 2014, the CMPA's stated expenses for "Awards, settlements, legal, and experts" totalled $405 million. Of that $405 million, payments to patients through awards and settlements accounted for $237 million. That leaves $168 million for "legal and experts," which amounts to approximately 41.5% of the $405 million total expenditures.

118 Mello, Kachalia & Studdert, *supra* note 50 at 7.

119 *Ibid*.

120 Robert B Leflar, "Public and Private Justice: Redressing Health Care Harm in Japan" (2011) 4 Drexel L Rev 243 at 262 [Leflar, "Public and Private Justice"].

121 CMPA, "2014 Annual Report", *supra* note 8 at 30.

122 Mello, Kachalia & Studdert, *supra* note 50 at 7.

123 *Ibid*.

124 Accident Compensation Corporation, *Annual Report 2014* (New Zealand: 2014) at 44, online: <www.acc.co.nz/PRD_EXT_CSMP/groups/external_communications/documents/reports_results/annual_report_2014.pdf>.

clined in Virginia, and the administrative costs for the birth-related injury program are very low relative to the compensation awarded.[125]

Ulfbeck, Hartley, and Schultz conclude that the Nordic systems are working well, and contrast this to what they describe as "the perceived absurdities in other jurisdictions," referring in particular to the American medical malpractice tort system.[126] They confirm that the aim of providing patients with easier access to compensation has definitely been accomplished.[127] There is general consensus that the New Zealand scheme performs well at providing compensation; while awards are not as high as some would wish, the fact that so many more people receive compensation as compared to in a tort-based system is considered to more than make up for the relatively low size of awards.[128]

Kirsten Armstrong and Daniel Tess of PricewaterhouseCoopers prepared a report for a 2008 conference of the Institute of Actuaries of Australia.[129] They compared a range of jurisdictions internationally as to whether compensation for injury was based on tort liability, no-fault, or a composite of the two. Note that while medical injury was one component, the study was more broadly based in that it also included workplace injury and automobile accidents. They identified the superior performance of no-fault systems in terms of compensation, in that a significantly higher proportion of claimants are covered and administrative costs are significantly lower. As to total expenditures in fault-based versus no-fault jurisdictions, they found as follows:

> There is no clear evidence that fault, no fault or blended schemes are, overall, more expensive than the other scheme types in aggregate, but we note that more people are compensated under no fault schemes, hence the per claimant cost is overall cheaper under no fault schemes.[130]

125 Edwards, *supra* note 54 at 295.

126 Ulfbeck, Hartley & Schultz, *supra* note 62 at 115, 129.

127 *Ibid* at 129.

128 Kirsten Armstrong, Daniel Tess & PricewaterhouseCoopers, *Fault Versus No Fault—Reviewing the International Evidence* (Australia: Institute of Actuaries of Australia, 2008) at 34, online: <actuaries.asn.au/Library/Events/GIS/2008/GIS08_3d_Paper_Tess,Armstrong_Fault%20versus%20No%20Fault%20-%20reviewing%20the%20international%20evidence.pdf>, Mello, Kachalia & Studdert, *supra* note 50 at 8, Todd, *supra* note 52 at 1210–11.

129 Armstrong, Tess & PricewaterhouseCoopers, *supra* note 128.

130 *Ibid* at 34.

B. Deterrence

A major stated aim of tort law is the deterrence of negligent activity. The idea is that both the defendant and others will avoid repeating their negligent behaviour in the future if a legal action is concluded in favour of the plaintiff. There is concern that, in a jurisdiction in which there is no need to attribute fault to the healthcare provider, the deterrent effect of an adverse judgment will be lost. This in turn is believed by some to cause an increase in the incidence of iatrogenic injury.[131]

The evidence as to the operative effect of deterrence in medical malpractice liability is weak. A Canadian study by Dewees and Trebilcock found that physicians tend to change their practice methods in terms of ordering diagnostic tests and enhancing communications and record-keeping due to threat of medical malpractice liability.[132] However, it is not clear that these measures actually result in better care or reduce injury rates. They concluded that "[t]he evidence concerning the impact of practice changes on the ultimate medical injury rate is quite fragmentary and inconclusive."[133]

Similarly, Mello and Brennan undertook a review of existing studies on deterrence in medical malpractice liability in the American context, and concluded that the evidence of its effect is weak.[134] They attribute this to a range of factors, including the presence of insurance, the premiums of which are not experience-rated;[135] a poor fit between those inclined to commence lawsuits and those who have actually been injured due to medical malpractice;[136] and externalization of the costs of medical malpractice.[137]

Anne-Maree Farrell cites data from 2001 indicating that the rate of preventable adverse events is similar as between New Zealand and the tort-based liability systems in Australia and the U.S.[138] This suggests that

131 See generally Manning, "Remedial Response", *supra* note 75.

132 Don Dewees & Michael J Trebilcock, "The Efficacy of the Tort System and Its Alternatives: A Review of Empirical Evidence" (1992) 30:1 Osgoode Hall LJ 57 at 80.

133 *Ibid* at 82.

134 Michelle M Mello & Troyen A Brennan, "Deterrence of Medical Errors: Theory and Evidence of Malpractice Reform" (2002) 80:7 Texas L Rev 1595 at 1615.

135 *Ibid* at 1616.

136 *Ibid* at 1618.

137 *Ibid* at 1620.

138 Anne-Maree Farrell, "No-Fault Compensation for Medical Injury: Principles, Practice and Prospects for Reform" in Pamela R Ferguson & Graeme T Laurie, eds, *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean* (Farnham, UK: Ashgate Publishing, 2015) 155 at 169.

deterrence may not be reduced in a no-fault system. After a review of information from a range of countries, Stephen Todd concludes that the evidence about loss of a deterrent factor in no-fault is equivocal at best, and that this is not sufficient ground for not having a no-fault system given its other positive characteristics.[139]

In the Canadian context, the CMPA covers all awards and settlements in negligence, no matter how high the amount. This results in physicians not being out-of-pocket when there is a finding of negligence or settlement in favour of the plaintiff, which diminishes any potential deterrent effect. Further, premiums are not experience-rated, so the potential for individual deterrence due to financial disincentives is greatly reduced.

Joanna Manning discusses the position of the patient safety movement, which is that fault-based medical malpractice liability is actually counterproductive to deterrence. It suppresses the open acknowledgement of error. From a systems perspective, "[a] just culture encouraging open disclosure of error and learning from mistakes by health professionals, rather than one of blame and secrecy, is necessary to do this. . . . Some highly influential voices consider that the deadlock can only be broken by complete abolition of tort and replacement with some kind of no-fault model."[140]

C. Corrective Justice

Aristotle postulated that an unjust gain for the defendant should be rectified by compensating for the loss of the plaintiff. Thus, in corrective justice terms, the relationship between the parties is the source of the need for recompense of one to the other—referred to by Ernest Weinrib as the correlativity as between the "doer and sufferer of the same injustice."[141]

There are a range of aims of tort law sometimes categorized as falling under the heading of corrective justice: retribution, atonement, and appeasement. Compensation focuses on the plaintiff and deterrence on the tortfeasor and others similarly situated, whereas matters such as atonement concern both parties to the tortious interaction—the act of wrongdoing by one party creates the need for atonement by the other, and atonement should only be granted in law if there has indeed been wrongdoing in the transaction as between the parties.

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139 Todd, *supra* note 52 at 1214.

140 Manning, "Remedial Response", *supra* note 75 at 136–37.

141 Ernest J Weinrib, "Civil Recourse and Corrective Justice" (2011) 39:1 Fla St UL Rev 273 at 273 [Weinrib, "Civil Recourse"].

Does a fault-based system perform better at meeting the demands of corrective justice than a no-fault system for addressing medical malpractice? Plaintiffs don't get to appear before a judge under most no-fault schemes, and are therefore deprived of the ability for a "reckoning" by the defendant. However, the statistics previously outlined reveal that only a tiny portion of those injured due to medical error ever get to enter a claim in Canada, let alone a court hearing, so the aims of corrective justice in this regard are seldom met. But to the extent that plaintiffs are deprived at least in theory, it is necessary that alternative systems be developed in conjunction with the creation of a no-fault system.

A no-fault scheme must be accompanied by robust patient-complaint and error-reporting systems. The Nordic countries have extensive error-reporting systems; the information therein is shielded from use in the discipline system.[142] The systems are used to identify common errors, which ideally leads to system improvements and enhanced patient safety. New Zealand has in place a national medication error-reporting system.[143] It also created, in 1996, the position of national Health and Disability Commissioner, who is to investigate complaints of adverse events in public hospitals.[144]

Mello, Kachalia, and Studdert examined the Swedish and Danish systems and concluded that while there has been controversy over the appropriate standard for compensation, and questions about the adequacy of awards, "there has been no discussion of returning to a fault-based system of tort liability for medical injuries."[145] They indicate that there is not adequate evidence as to whether patient safety is enhanced, but that the strong independent systems of complaints investigation and discipline have enhanced transparency and safety improvement, and allayed concerns about lack of deterrence in a no-fault system.

D. Distributive Justice

Distributive justice concerns the equitable allocation of goods and resources among members of society. There is disagreement as to whether distributive

142 Farrell, Devaney & Dar, *supra* note 57 at 38.

143 Health Quality & Safety Commission New Zealand, *Our Programmes*, online: <www.hqsc.govt.nz>.

144 Marie M Bismark et al, "Claiming Behaviour in a No-Fault System of Medical Injury: A Descriptive Analysis of Claimants and Non-Claimants" (2006) 185:4 Medical J Austl 203.

145 Mello, Kachalia & Studdert, *supra* note 50 at 8.

justice is an appropriate aim of tort law, with arguments on both sides.[146] Corrective justice enthusiast Ernest Weinrib views it as inappropriate to apply a distributive justice lens to tort law because it is categorically different from corrective justice, which is singly focussed on the interaction between two individuals. And he sees the relationship as core to the finding of liability.[147] However, Peter Cane has responded that tort law combines corrective and distributive justice elements.[148] The judicial system shapes the rules that determine the distribution of the burdens and benefits of liability among a society's members, which is a decidedly distributive justice function. Dewees and Trebilcock took this concept further by applying the normative goal of distributive justice, along with deterrence and corrective justice, to their examination of the tort system and compensatory alternatives to tort. They included as one of their areas of focus the possible range of responses to medical malpractice.[149]

Distributive justice is particularly salient when comparing fault and no-fault compensation for medical injury. It demands that we step back from the immediate transaction between health care provider and patient to focus on how society is optimally served. Thus, the weighing of health outcomes, views of participants, health expenditures overall, and system efficiencies rise to the fore in examining the performance of fault-based and no-fault programs.

1. Health Outcomes

In Canada, the median time from commencement of a medical malpractice action to resolution was 38 months in 2013.[150] Similarly, in the U.S., the time frame for a malpractice claim is three years.[151] By comparison, the average time from filing a claim to initial decision is seven months in Denmark and eight months in Sweden.[152] In New Zealand, the median time for assessment is a mere 37 days.[153] French claims take on average 7.5 months between sub-

146 Weinrib, "Civil Recourse", *supra* note 142; Peter Cane, "Distributive Justice and Tort Law" (2001) 1:4 NZLR 401.

147 Ernest J Weinrib, "Corrective Justice in a Nutshell" (2002) 52:4 UTLJ 349.

148 Cane, *supra* note 146.

149 Dewees & Trebilcock, *supra* note 132 at 59–61, 79.

150 Canadian Medical Protective Association, "2013 Annual Report" (2013) at 6 [publication on file with author].

151 Mello, Kachalia & Studdert, *supra* note 50 at 6.

152 *Ibid*.

153 Todd, *supra* note 52 at 1201.

mission of the claim and decision.[154] The difference in time frames makes a difference in terms of health and recovery. The Australian actuaries' study comparing fault to no-fault regimes around the world found that claimants have better health outcomes in no-fault systems.[155] There are a number of reasons given: receipt of compensation is dramatically more rapid, resulting in faster access to treatment; periodic benefits are superior to lump-sum payments; and administrative schemes can focus on rehabilitation and returning the injured person to work.[156] In addition, there are disincentives to recovery in a tort system, in that damages are assessed as of the date of trial, which can be many years after injury was incurred.

2. Views of Participants

The views of various constituents of society are significant in examining distributive justice goals. It has been demonstrated that there is a high degree of dissatisfaction with Canada's fault-based medical malpractice system. The level of satisfaction with no-fault programs can be assessed from a range of perspectives. Physicians are uniformly positive in the no-fault jurisdictions for which evidence is available. In a survey conducted in New Zealand, 88.5 percent of physician respondents disagreed with the statement "medical complaints should be resolved in a court of law."[157] In Denmark, the national physician governing body championed the move to no-fault. They were motivated primarily to improve the legal recourse available to patients injured through the receipt of health care services. They found it unreasonable that they were in a perceived conflict of interest in terms of their ability to help injured patients, and sought to be able to assist them in establishing their claims. They also disliked the expenditure of time and energy to sort through liability as between a physician and health facility.[158]

All birth-related neurological injury schemes are voluntary for physicians. It is significant to note that over 90 percent of eligible physicians have opted in to the Virginia and Florida programs.[159] In Japan, almost all

154 Barbot, Parizot & Winance, *supra* note 56 at 242–43.

155 Armstrong, Tess & PricewaterhouseCoopers, *supra* note 128 at 34.

156 *Ibid*.

157 Wayne Cunningham, "New Zealand Doctors' Attitudes Towards the Complaints and Disciplinary Process" (2004) 117:1198 NZ Medical J 1 at 5.

158 Downie et al, *supra* note 63 at Appendix 2: Country Reports, Denmark at 13.

159 James M Jeffords, "No-Fault Compensation for Medical Malpractice", *The University of Vermont* (9 March 2010) at 4, online: <http://www.uvm.edu/~vlrs/Health/No%20Fault%20Medical.pdf>.-

childbirth facilities have opted in to the no-fault program (99.7 percent).[160] The Japan Medical Association is supportive of extending the obstetrical injury no-fault program to medical malpractice more broadly,[161] and a commission has been appointed to consider the appropriateness of such a development.[162]

It is perhaps not surprising that physicians are supportive of no-fault, especially in the jurisdictions in which a tort action is no longer permitted. Physicians experience anxiety, guilt, and shame when sued,[163] so relief from having to anticipate a lawsuit is a significant bonus. Further, with the fear of liability removed, physicians are keen to support patients in their attempts to obtain compensation for injury.

The legal community tends not to be supportive of no-fault, due to its diminished role. Scotland has been considering whether to adopt a no-fault scheme. When polled, the Forum of Insurance Lawyers responded in opposition,[164] and the Scottish Association of Personal Injury Lawyers expressed a range of concerns.[165]

However, some lawyers are supportive of no-fault. The Japan Federation of Bar Associations is supportive of a move to broader no-fault beyond the present birth-related neurological injury scheme.[166] And, writing from a Scandinavian perspective, academics Ulfbeck, Hartley, and Schultz wryly comment:

> Scandinavian lawyers will generally talk about malpractice law in the U.S., or rather the stories about malpractice law in the U.S., with a tone of horror in their voices. One of the most common arguments in favour of the Nordic model in this area is that it successfully avoids the (supposedly) perverse effects of malpractice law in the U.S.[167]

Views of the public and of patients under no-fault schemes provide valuable insight. In New Zealand, a poll taken in 2013–14 found that public

160 Leflar, "Medical Misadventure", *supra* note 80 at 108.

161 *Ibid* at 110.

162 Leflar, "Public and Private Justice", *supra* note 120 at 263.

163 The American College of Obstetricians and Gynecologists, "Committee Opinion Number 551: Coping With the Stress of Medical Professional Liability Litigation" (2013), online: <www.acog.org>.

164 UK, The Scottish Government, *Consultation on Recommendations for No-Fault Compensation in Scotland for Injuries Resulting From Clinical Treatment* (Consultation Report) (Edinburgh: The Scottish Government, 2014) at 19, online: <www.gov.scot >.

165 *Ibid* at 13, 18, 20.

166 Leflar, "Medical Misadventure", *supra* note 80 at 109.

167 Ulfbeck, Hartlev & Schultz, *supra* note 62 at 115, 129.

trust and confidence in the system stood at 54 percent. Turning specifically to those who had utilized the services of the system, 75 percent of clients surveyed indicated they were satisfied with the service they had received.[168]

3. Health Expenditures

It is important to examine overall costs to society in the context of distributive justice. In 2014 Tom Vandersteegen et al. undertook an examination of medical malpractice systems as determinants of health spending in OECD countries.[169] Their overall conclusion was that no-fault schemes for medical injuries resulted in significantly decreased health expenditures per capita, provided that there was an uncoupling of deterrence and compensation—i.e., the New Zealand and Nordic schemes remove the requirement that a patient establish fault on the part of the physician. On the other hand, the French scheme has a moderately higher level of health care spending. This may be attributable to the fact that, in France, the patient must establish the absence of a claim in negligence in order to be eligible for the no-fault scheme. Thus, the attempted attribution of fault is a preliminary requirement in France. The authors propose that this may result from the practice of defensive medicine on the part of French physicians because of the increase in potential liability.[170]

4. System Efficiencies

The fault-based medical malpractice system performs particularly poorly on the criterion of efficiency. As has been demonstrated previously, a very high portion of costs of the system are expended on legal fees, the retention of expert witnesses by each of the parties to the dispute, and costs of access to the judicial system, including accompanying lengthy delays. These delays in turn exacerbate problems with rehabilitation. No-fault serves to reduce these inefficiencies and place a greater portion of expenditures in the hands of injured patients.

Distributive justice aspects are problematic in our fault-based system for a number of reasons. Governments across Canada are covering by far

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168 Accident Compensation Corporation, *supra* note 124 at 10.

169 Tom Vandersteegen et al, "The Impact of No-Fault Compensation on Health Care Expenditures: An Empirical Study of OECD Countries" (2014) 119 Health Policy 367 at 371, online: <www.elsevier.com>.

170 *Ibid*. The authors caution that one exercise caution in interpreting these findings due to the recent introduction of the French no-fault regime.

the greatest share of CMPA defence fees, meaning that substantial fiscal resources of government are ultimately utilized in defence of physicians against claims of patients injured due to medical error. Further, the high cost of bringing a lawsuit for medical malpractice, with the accompanying need for lawyers and expert witnesses, makes doing so prohibitive for most injured patients, especially those of lower socioeconomic status. A no-fault system is inherently an acknowledgement of collective responsibility by the state to provide care for those injured due to medical mishap.[171] Thus, no-fault is clearly superior in serving distributive justice goals.

V. CONCLUSION

It has been demonstrated that no-fault compensation schemes have advantages on a number of fronts: a serious reduction in administrative costs, including cost savings to the judicial system; a reduction in the need for legal services; a major increase in the number of injured patients receiving compensation; a reduction in the time from launching a claim to receipt of an award; the physician can become an ally to the patient in seeking compensation; and amounts of awards can be controlled through regulated caps and charts. There is also scope for significant rehabilitation components, as incorporated into the New Zealand scheme.[172] Patient health outcomes are enhanced as a result of a rehabilitation focus combined with expeditious handling of claims, and the need to prolong injury in order to enhance the size of the damages award is reduced or removed. The neutrality of having independent experts in no-fault has considerable advantages over the tort-based approach, including cost, regional disparities in terms of access to experts to testify, and the non-impartiality of expert witnesses in medical malpractice.

There are disadvantages as well. Depending on the scheme, and its vulnerability to cost-cutting due to downturns in the economy, award levels may be seriously depressed. Start-up costs can be substantial, especially with an anticipated major increase in the number of claims. The removal of the need to establish fault reduces deterrent effects on behaviour. There are concerns that victims of medical injury are treated more favourably than persons with other illnesses or disabilities.

171 Farrell, *supra* note 138.

172 Farrell, Devaney & Dar, *supra* note 57 at 23.

How does no-fault compare to a fault-based system according to the normative goals of compensation, deterrence, corrective justice, and distributive justice? First, no-fault schemes are superior at providing compensation. As estimated previously, perhaps 3.35 percent of injured patients with viable claims in Canada commence legal action, and less than half of those receive any form of compensation in our tort-based system. The vigorous defence policies of the CMPA result in a system wherein injured parties are less likely to receive compensation than they would in a non-medical malpractice tort-based lawsuit. While the average award may be lower under no-fault, the fact that many more persons are able to receive compensation (due to the broader scope for recovery combined with lower costs of administration) more than makes up for the reduction in size of award.

Second, when it comes to deterrence, the evidence that deterrence is operative in a fault-based medical malpractice jurisdiction is weak at best, and is countered by comparative evidence from New Zealand that the incidence of preventable adverse events is similar to that of Australia and the U.S., both of which are fault-based. The Canadian system, in which physicians' defence is fully covered by the CMPA and premiums are not experience-based, is particularly weak on deterrence. And it is argued by the patient safety movement that deterrence is reduced in a fault-based system due to the accompanying suppression of error acknowledgement as compared to a system in which error may be openly acknowledged without the accompanying fear of litigation.

Next, it has been demonstrated that corrective justice may be reduced under no-fault schemes. It is essential that any no-fault program be accompanied by robust error-reporting systems and patient complaint mechanisms.

Finally, no-fault programs shine when distributive justice goals are examined. Health outcomes are enhanced due to the substantially shorter time frames between injury and receipt of compensation. Treatment availability, rehabilitation, and return to work are all enhanced. Participants in no-fault jurisdictions, including physicians, members of the public, and injured patients, are all supportive of the system. Total health expenditures are reduced provided there is an uncoupling of deterrence and compensation, and system efficiencies are uniformly more positive under no-fault schemes. The substantial provincial government contributions toward CMPA premiums mean that, strangely, physicians are being subsidized by taxpayers to defend themselves against the claims of injured patients. From a distributive justice perspective, this seems perverse.

Thus, on balance, no-fault medical malpractice compensation schemes are superior on a range of criteria. They appear to fall short only when it comes to corrective justice aims, a failing which may be alleviated with enhanced patient complaint and error reporting systems.

Robert Prichard recommended in 1990 that an optional no-fault administrative compensation scheme for serious medical injuries should be created for Canadians.[173] This recommendation was never adopted, due in part to inertia and relative satisfaction with the status quo at the time.[174] The recent sharp increase in CMPA fees, the government's role in subsidizing these fees at the expense of taxpayers, and a greatly enhanced patient safety agenda may serve as joint catalysts to re-open the discussion. Recent evidence as to the solid performance record of no-fault programs around the world on a range of criteria presents fresh opportunity for Canadians to consider adopting a no-fault model of compensation for medical injury.

173 Prichard, *supra* note 2 at 7.

174 Baker & Norton, *supra* note 31 at 134.