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The unbearable lightness of culpability: the compensation for damages in the practice of medicine[1]

A insustentável leveza da culpa: a compensação de danos no exercício da medicina

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Abstract

In face of the growing difficulties presented by tort liability in dealing with medical malpractice and patient's compensation, many advocate the implementation of a no-fault system, i.e., a mechanism in which the patient is compensated through an economic fund of risk socialization, in disregard of the demonstration of the physician's negligence. In this study, we compared the main notes of the no-fault model with the classical model grounded in culpability, to determine which one is the most suitable in terms of justice, improvement of health care delivery and patient's safety.

We concluded that, despite the fact that the no-fault model carries many advantages, it also involves several difficulties, risks and fragilities. In particular, it is doubtful that it promotes diligence in health delivery, since usually the health care professional does not suffer any sanction. Furthermore, it can only operate successfully in light of very particular conditions, not found in the majority of legal orders. Therefore, we do not consider it the most adequate solution, at least when implemented as a general mechanism to deal with injuries caused by medical treatments.

Keywords: Medical Malpractice; Negligence; No-fault; Compensation; Accountability.

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Resumo

Diante das crescentes dificuldades apresentadas pela responsabilidade civil para lidar com a má-prática médica e com a compensação aos pacientes, muitos advogam a implementação do sistema *no-fault*, isto é, um mecanismo no qual o paciente é compensado por via de um fundo económico de socialização do risco, independentemente da demonstração de negligência por parte do médico. Neste estudo comparámos as principais notas do modelo *no-fault* com o clássico modelo fundado na culpa, com vista a determinar qual o mais adequado em termos de justiça, melhoria dos cuidados de saúde e segurança do paciente.

Concluímos que, apesar de o modelo *no-fault* trazer muitas vantagens, também envolve sérias dificuldades, riscos e fragilidades. Nomeadamente, é duvidoso que promova a diligência na prestação de cuidados médicos, dado que em regra não se verifica qualquer sanção para o profissional de saúde. Além disso, só pode operar com sucesso em condições muito concretas, que não se encontram na maior parte das ordens jurídicas. Por conseguinte, não cremos que seja a solução mais adequada, pelo menos quando implementada como um mecanismo geral para lidar com danos causados por tratamentos médicos.

Palavras-chave: Má-prática Médica; Negligência; *No-fault*; Compensação; Responsabilização.

Framing the issue: what are we talking about?

When the patient suffers an injury in the context of a medical act, the victim and family express a number of concerns, in relation to which the law is responsible, directly or indirectly, for providing a response: (a) obtaining compensation to cover patrimonial and non-patrimonial damages; (b) sanctioning the author, eventually preventing him from continuing to practice medicine; (c) obtaining an explanation concerning the event; (d) receiving an apology or, at least, a gesture of empathy; (e) ensuring awareness of the behavior, so the author of the damage can correct it and avoid its repetition in the future.

However, the current legal model of dealing with medical malpractice – whether culpable or not, i.e., representing a genuine medical malpractice or just an honest mistake (Raposo, 2013, p. 13-16) – seems able to fulfill only those first two aspirations and only imperfectly, leaving patients, health professionals, health institutions and the community in general frustrated with the results offered by the legal world.

Due to the many limitations presented by the model founded on negligence of the agent, the transition to a model that disregards the health professional's fault has been suggested – the so-called no-fault model – already adopted in some areas, such as New Zealand and the Nordic countries, and also in other legal systems in a more limited manner, such as in some states of the USA, in France and in Belgium.

This suggestion is founded on the recognition of the failure of the traditional model, based on the classic canons of tort liability assessed in court by judges who are lay in medical issues, seeking to find fault (liability in health care delivery will be objective only in few cases, as happens regarding clinical trials in various legal systems) and a culprit to whom all injuries will be attributed. Instead, the intention is to introduce another model, more concerned with compensating the injured patient than finger-pointing and identifying faults (although, as we shall see, fault never truly disappears). It is

understood that the source of most injuries is in the system – in the service, in the hospital or even in the general health system – and not in the individual. Therefore, the patient will be compensated regardless of whether or not there is any fault (i.e., medical malpractice), whose existence is not even determined.

However, and as we will demonstrate in this study, the proposal to generalize the no-fault model fails due to two major obstacles: first, this model is not necessarily best suited in terms of security and patient compensation, the main objectives that any system which is implemented should aspire. Second, even if this is in fact the best model, it is certain that its implementation requires contextual requirements (not only legal, but sociological and economic) that may exist only in very specific geographies (The Canadian Medical Protection Association, 2006).

Brief characterization of the no-fault model

Apart from some generic notes, it is not easy to point identifying traits of this model because, in reality, the system in New Zealand is quite different from the Nordic one, and they are also distinguished from the others. For example, the Nordic mechanism is covered by money raised through insurance paid by health providers, while the New Zealand model is funded by taxpayers; on the other hand, while in the Nordic case the concept of "avoidability" delineates the range of insured injuries, making it one of the basic elements of all the compensatory structure, the New Zealand solution disregards the preventable nature of injury; on the other hand, still, among the Nordic countries (except for Denmark), the injured person keeps as a rule the option to counter act legally, while in New Zealand this possibility is excluded regarding the injury covered by the no-fault fund.

Bearing in mind the differences, we will then describe in broad strokes the main achievements of this system, which still serves as case study for the others.

The Scandinavian model

The Scandinavian model refers to the Nordic countries, although its paradigmatic version is the Swedish version, the others being inspired by it; thus, we will use mainly Sweden as an example in this brief explanation.

The Swedish patient compensation program, the Landstingens Ömsesidiga Försäkringsbolag (LÖF), began in the mid-1970s, with the creation of a global social security scheme, intended to cover the negative results arising from medical treatment.

In this model (Johansson, 2010; Kachalia et al., 2008; Ulfbeck; Hartlev; Schultz, 2013; World Bank, 2004), the cost of compensation is covered by an insurance paid by the health professionals themselves. Initially, participation was voluntary; however, it became mandatory due to the Patientskadelagen, a decree in 1996. Currently, it covers acts committed by physicians working in public hospitals, but also acts of those who, while working in private practice, have an agreement with the State.

This fund covers injuries resulting from treatment and diagnosis, as long as they were preventable. It also covers lesions caused by medical equipment or prosthesis, either by improper use or product defect, although in this second case a special regime of objective liability is provided. Injuries not related to medical care delivery (falls, fires) are also compensated if arising from particular risks to which the patient is exposed during medical care. In the case of injuries related to infections, these are compensated in terms of no-fault, if the infectious agent has been transmitted from an external source and its effects exceed those of the patient's underlying disease. It is observed that not all injuries are covered. Even in the case of injuries which fall within its scope of application, it works as a subsidiary mechanism of the national security system, which, in fact, pays for most of the compensations.

Concerning the procedure, let us also observe the Swedish case: patients' complaints are processed by the Personskadereglering AB (PSR), composed by specialists with medical or legal training,

who have powers to investigate a complaint (for example, interviewing the patient or requiring medical records). Those who are not satisfied with the compensation may request a review of the decision to a panel, choose arbitration or resort to a judicial court. The patient may go directly to the court; however, generally, judicial process is only chosen when the injury is not covered by the compensation fund, which is a faster and simpler way, given that the patient is not required to provide the required evidence of tort liability (except for causalities, whose demonstration by the patient remains necessary (Ulfbeck, Hartlev, Schultz, 2013). Regarding this point, Denmark presents a particularity, because the patient there cannot resort to judicial process when the injury in question is covered by the no-fault scheme (Ulfbeck, Hartlev, Schultz, 2013). So, in this case, the choice for the mechanism of action is not the result of a voluntary decision of the patient, which raises some constitutional issues of right of access to courts.

A characteristic which is common to the Nordic models is that the bodies that examine applications for compensation of patients do not deal with disciplinary issues, and information gathered by them is not even communicated to the disciplinary bodies. That is, there is an absolute firewall between the compensation process and the sanctions process (Mello et al., 2006), which also raises some issues of accountability of the health care provider.

The New Zealand model

The model in force in New Zealand currently (Bismark et al., 2006; Bismark; Paterson, 2006; Malcolm; Barnett, 2007) had its origin in a legal change occurred in 1974, when a fault-independent compensation system was implemented, the Accident Compensation Corporation (ACC). As in the Nordic case, this format is also founded on a monetary fund of risk socialization, funded by taxpayers.

It is observed that not all injuries suffered by patients are compensated in the context of this model, but only those that can be characterized as a treatment injury. This concept is defined in a broad sense, to include injuries resulting from diagnosis, from the treatment *proprio sensu*, from the absence of treatment, from failure of an instrument or machine, from omission of informed consent and from infections (Farrell, Devaney, Dar, 2010; Kachalia et al., 2008; Quick, 2012). Thus, for purposes of compensation, the indemnifiable injury will be that suffered by a person who receives health treatment from a properly licensed health professional, provided that it was caused by treatment (legal causation); but not being a necessary consequence of the said treatment (therefore, it does not include hair loss during chemotherapy, for example). All patients who suffer an injury of this type are eligible for compensation (Kachalia et al., 2008).

This concept of "injury resulting from treatment" was not originally part of the compensation model, only having appeared in 2005, when the established system was the target of a relevant legal amendment, by which the concepts of medical error (medical malpractice) and of medical mishap (medical accident) were removed from the evaluation of injury. In fact, until 2005, the system worked based on these concepts: the medical error intended to translate the breach of the duty of care that should be required from a physician (coinciding, basically, with the typical negligence of tort liability); while the medical accident dealt with rare events (whose percentage of occurrence were lower than 1%) and severe (which caused disability or prolonged hospital stay) resulting from the treatment, therefore, including non-negligent injuries (Davis et al., 2002). Since this classification was subject of multiple criticisms, both concepts were replaced by a single one, the *treatment injury* – that is, *injury resulting from treatment* - closer to the core idea of the no-fault model.

Another important amendment to this mechanism lies in the separation between compensatory and sanctioning procedures. Initially, there was no separation between the granting of indemnization and disciplinary procedures, but after 2005 the ACC is only bound to report to the Board of Medicine the risks of injury to the public (Kachalia

et al., 2008). However, disciplinary measures are rare and only applied to physicians convicted in civil and criminal cases, because normally only the physician's performance review procedure is carried out. The ACC has not any sanctioning role, since it is a body heavily oriented toward patient safety (Bismark; Paterson, 2006). In fact, the entire system is more oriented towards promoting the quality of medical care than penalizing health providers. The dimension that is most linked to the idea of accountability reports to the Disability Commission, to the Medical Council and to the Health Practitioner Disciplinary Tribunal, but even there without the sanctioning orientation, typical of guilt-oriented models.

Following the typical reasoning of the other no-fault models, the physician's negligence is not required and, now diverging from other models of the same nature, not even the avoidability of injury is demanded. But this does not mean that all injuries here are included, as it does not include injuries fully or partially caused by the underlying condition of the person, injuries solely attributable to resource allocation decisions, injuries resulting from undue delay of consent for medical treatment, and injuries that are a necessary part or a normal consequence of treatment.

The process of obtaining compensation begins with the submission of an application to the ACC, usually prepared only with the help of a health care professional, since legal support is not necessary (Kachalia et al., 2008). The whole process develops fairly quickly, because usually the decision is obtained in two or three weeks, and the deadline for the decision is nine months.

Whenever the damage suffered by the patient is covered by the no-fault scheme, resorting to judicial process is not allowed, even if the patient chooses to abstain from submitting an application to the ACC. Despite a potential violation of the right of access to court, it is understood that it is a sort of social contract, even having the consent of the courts. The only option available to the patient to use legal channels is the claim of damages in the event of particularly serious conducts, for which the mere equity compensation is not sufficient; or when the patient wishes to claim punitive damages (Farrell; Devaney; Dar, 2010; OECD, 2006). However, in fact, patients rarely have an interest in accessing the judicial process, given its cost and slowness. On the other hand, the processes decided in the ACC are substantially less expensive and quite fast.

The American model

The USA States maintain the classic system based on fault for most medical acts; however, we can find solutions of no-fault for specific situations (Coppolo, 2003).

Thus, in the states of Virginia and Florida no-fault solutions exist, even if only established for neurological injuries related to childbirth, and only provided that the birth occurred in a hospital that is part of this program, with a physician who is also part of the program. These scenarios were elected to be dealt with according to the no-fault model because for them the rate of success of a claim for damages in court is very high and the compensation may also be very high. Also regarding injuries resulting from vaccine – albeit not all, since the definition of indemnifiable injury is quite restricted – a no-fault scheme was implemented at the national level, the National Vaccine Injury Compensation Program.

Characterization of injuries to be compensated

Requirements demanded for compensation

Although the requirements vary from one legal system to another, it is possible to point out some common traits, which we will describe.

Contrary to what one might think, not all injuries can be compensated under the no-fault rules, because eligibility requirements must be taken into consideration (Von Eyben, 2001; Farrell; Devaney; Dar, 2010; World Bank, 2004).

Usually, it is required that the application reaches a certain level of severity. For example,

in Sweden it is necessary that the patient's condition has lasted a minimum of 30 days, or to be hospitalized for at least 10 days, suffer permanent disability or pass away. Thus, the amount to be compensated depends more on the eligibility of the patient (which, in turn, depends on the severity of the injury) than on the culpability of the physician.

In addition, the injury must have occurred during medical treatment and because of it, which ultimately brings us to the requirement of causation, here understood in terms similar to those governing legal responsibility.

This treatment has to be provided by a licensed physician or under his/her responsibility, because the community only accepts the communitarization of risk as for medical acts with public recognition in terms of professional competence.

The Nordic also require an additional assumption: the medical act in question must also be considered not medically justified. This means that the injury in question could have been avoided (avoidability) if the patient had been submitted to the appropriate treatment.

Despite these limitations and exclusions, still the gamut of indemnifiable injuries remains broader than when compared with the model founded on negligence. However, the no-fault fund will not cover all injuries, since, actually, a substantial part of the financial cost is covered by the national system of social security. But, *et pour cause*, the no-fault model assumes, as a requirement of its functioning, a strong system of social security (Bismark; Paterson, 2006).

Avoidability of injury

The designation of the no-fault model is misleading, bringing the idea that this model abstracts completely from culpability. Actually, that is not the case. First, because it does not annihilate the criminal liability, which undoubtedly stands for conducts deemed criminal. Then, because there are still medical acts subject to the rules of tort liability, which is generally subjective. Finally, because even when supposedly entering the strict no-fault sphere, culpability still persists in some forms of implementation of this model, but now under the cover of avoidability.

It is a concept that the Nordic coined especially for this model and that is intended to express the idea that only avoidable injuries will be compensated, which contradicts the traditional belief that this system compensates all injuries. In fact, in the Nordic model, to obtain compensation on the part of the patient depends on prior assessment of the injury avoidability (Kachalia et al., 2008), that is, to assess whether the injury would have happened if another medical assistance (it remains to be known whether any other or the best possible assistance, as we shall analyze in the following point) had been provided to the patient.

However, we must point out that the patient must always demonstrate the causal relation between the conduct of the physician and the suffered (avoidable) injury. This is probably the main reason why it can be difficult to compensate under the criterion of avoidability, as according to some studies only 40% of the claims are successful (Bogdan, 2011).

Avoidability and negligence

Some authors argue that, in fact, avoidability is not that different from negligence, because, if the injury could have been avoided, it means that the health professional did not provide proper medical care to the patient; in short, he was negligent (Maccourt; Bernstein, 2009; Mehlman; Nance, 2007). As Mehlman and Nance (2007) ask, "what physician would not experience shame upon being accused of an avoidable error?" (p. 66).

However, the point is knowing what is meant by "adequate medical care" for this effect: whether any care that avoids the damaging result (and, in this case, in fact, both concepts end up translating the same level of requirement) or rather the best possible care (and, if so, the unavoidability exceeds the standard of conduct of the common physician and, therefore, it will be possible to compensate a wider gamut of injuries than observed for negligence). In other words, the avoidable injury (OECD, 2006) will

be the one that would not have occurred if the physician had provided other medical care to the patient or, in another option, that which would result in the best medical care possible?

The formula of avoidable injury that seems more correct to us is that which requires from the physician the best medical care that exists, according to the best practices established. Not because it seems to us that this should be the standard conduct to assess the behavior of physicians, but because this is the only way to distinguish unavoidability, while new and autonomous criterion, from negligence, as is reflected in the Civil and Criminal Codes (Mehlman; Nance, 2007). In fact, negligence assesses the physician's conduct according to the criterion of *bonus pater familias*, i.e., the good father of a family used to measure the culpability of the agent under legal responsibility, which translates in the conduct model of the common man, transmuted here into the common physician (Raposo, 2013). Thus, it would easily me mistaken for avoidability if it could be translated into mere provision of other alternative medical care that in the concrete case presented as more effective, although not necessarily the best. The only way to distinguish both concepts is to understand that the evaluation standard used by avoidability goes far beyond the standard of care established by the common physician standard.

Parallel to this is the question of whether a physician should be required to have a conduct that equals the common physician or the super physician. It seems to us that, in a model that imputes responsibility for compensation to the physician, the only acceptable standard of conduct will be of the common physician, given that the law cannot require them to be perfect, martyrs or heroes. Imposing a penalty on the agent for not respecting a behavior that goes beyond the scope of understanding or performance of the normal person is not the purpose of tort liability. Instead, the purpose is to seek a model founded on socialization of risk, in which the main objective is to compensate the harmed, but without compensation being paid by the agent, it allows for a different response. In this second hypothesis, the most demanding criterion is not only acceptable but recommendable, given that the objective is not to outline a standard of conduct that is demandable from the agent under penalty of punishment, but rather to identify the damage to compensate. Thus, using the standard of conduct of the best physician, the avoidability establishes for health professionals a more demanding standard of conduct, without sanction, however, when their conduct is below this standard; at the same time that it turns out to be more generous to the patient, increasing the likelihood of receiving compensation.

The doctrine has emphasized that the patient has not the right to receive the best possible treatment as a result of this, because everything will depend on the resources available in the particular circumstances. That is, the lack of human or technical resources operates as a cause of exclusion from compensation. But if the so-called "best doctor" had sent the patient to a better equipped hospital, instead of providing a treatment founded on scarce resources, the patient will be entitled to receive compensation (Ulfbeck; Hartlev; Schultz, 2013).

Still, some events considered avoidable could not be prevented with adequate health care, not even with the best possible assistance on the part of the physician, since they would occur anyway. They could only be avoided through some other mechanism, such as the use of more sophisticated instruments, not available in that hospital; or if the chain of communication in the institution had functioned more effectively, providing relevant information about the patient to all members of the medical staff; or if the tasks within the team had been more appropriately distributed. In all these hypotheses, we refer to damage that would have been avoided only by the institution. But not always they will characterize a negligent behavior on the part of the institution (as a legal entity that is equally subject to be accountable), but, in fact, flaws in the system itself (IOM, 1999). Also these latter scenarios are subject to compensation in a model founded on negligence; however, in good accuracy, they represent a *sui generis* form of culpability, which

in the European continental law are analyzed in the light of the institutes of *faute de service*, when the failure is due to a single person, even if not identifiable, and *faute du service*, when the failure is due to the service itself (Raposo, 2013). If in the first case it is still possible to uncover a fault, although anonymous, in the second it seems difficult, given that many times failures are present only in the functioning of an institution, but whose culpability cannot be imputed, not even to the collective person itself.

Avoidability and objective liability

So far we can conclude that avoidability constitutes a more stringent criterion than negligence – despite some definitions of avoidability considering it almost the same as negligence (Udell; Kendall, 2005) - by which under this standard negligent behavior will be indemnifiable, but also those others that could have been avoided, but that are not negligent.

Still, this criterion is not as stringent as to match the objective liability, which in turn corresponds to health care provided in perfect conditions. Actually, it is in a midpoint between the duty of care imposed by negligence and the objective liability (Kachalia et al., 2008). In fact, although substantially expanding the roster of patients eligible for compensation, the number of compensated people will not be as extensive as it would be in the context of an objective liability, since the latter would give compensation to damage arising from unavoidable complications, not even with the best medical care possible, and that, therefore, will not be compensated under the criterion of avoidability.

Criteria to assess the avoidability of damage

As already mentioned, the first difficulty in identifying the potentially indemnifiable damages is to know the standard of medical conduct to be adopted for the purposes of assessing the avoidability of damage. If, as we have advocated, the criterion of "best medical care possible" is adopted, we will be moving away from the standard of conduct of the "common physician', replacing it by that of the "experienced specialist" (Kachalia et al., 2008). According to the latter, compensation is granted when it is possible to assume that an experienced specialist in the field in question would have acted differently in the circumstances of the case and would have, thus, avoided the injury.

On the other hand, if it is understood that those injuries that would have been prevented by another physician - not necessarily the best one - will be avoidable, the standard used to assess the compensation will be another one: the criterion of "alternative treatment". According to this, compensation shall be granted if, based on a further assessment, it is possible to conclude that the injury could have been avoided if another treatment had been used.

Any of these two criteria can operate with a criterion of reasonableness, that recommends the compensation of those damages that are more severe than would be expected from the patient's pathology and from the treatment provided. The idea that justifies this criterion is that, although some injuries are expected, others are disproportionate when considering the disease and its normal consequences (Ulfbeck; Hartlev; Schultz, 2013).

Whatever the standard of conduct used – the best standard of care or simply a better standard of care – this assessment usually takes into consideration not only the information available at the time of treatment, but also information available only later. However, the alternative treatment in itself will have to be accessible at the time of intervention (and not only at the time of evaluation), i.e., it is required that this could have been an actual choice for the physician (Ulfbeck; Hartlev; Schultz, 2013).

In short, injury avoidability should be assessed considering other possible alternatives for treatment that were actually available at the time the medical act was practiced, that were equally safe and efficient and that could have avoided the injury, with additional requirement of medical evidence demonstrating the superiority of the treatment. When all these requirements are verified, the claim of the victim will be successful. However, this as-

sessment is not permissible for the compensation for injuries resulting from omitted or delayed diagnoses, otherwise the compensation for these damages would be automatic in practical terms.

From the exposition presented above it is already possible to understand that one of the pressing difficulties of this model is to know which events are avoidable. To facilitate the evaluation process, some authors have proposed a list of eligible events, presumed avoidable, although in the particular situation the health professional can demonstrate otherwise and rebut the presumption. For these events, the accelerated-compensation events designation has been suggested (Mello et al., 2006). One of the advantages of such a list would be to promote deterrence, since professionals would know that if their conduct causes some of the injuries in the list, the patient would be entitled to compensation, without the need for subsequent evaluation. However, we do not see to what extent this solution promotes deterrence, given that the occurrence of one of these events does not determine any liability for the physician. Also, the patient's compensation - only effect resulting from this - cannot be considered as a hypothetical deterrent threat in relation to behaviors that are not very diligent. On the other hand, the rigidity of such a list also lends itself to criticism, because abstract formulations of compensatory events abstract from the particularities of the concrete situation, which, in fact, can dictate an opposite solution for the case. That is, medicine hardly lends itself to this kind of standardization, so the potential benefits would be only speed and reduction of costs in evaluating the case, resulting precisely from the referred standardization.

Evaluation of two models: fault vs no-fault

To elect which of these two models – the fault model or the no-fault model - is the best is no easy task, since both have benefits and weaknesses. However, in recent times, what stand out are the criticisms of the model based on fault (Kachalia et al., 2008; OECD, 2006).

Let us start with the related antagonism and the consequent excessive consumption of time and money (of the injured persons and of the State), precisely because of the manner (also contentious) that the dispute is resolved. The resulting conflict can worsen the health of the patient, a problem particularly acute in the case of patients who still need medical attention, often due to the injured suffered itself, and that lack financial resources to cover the expenses.

These are added with the negative effects that a litigation process has on health professionals, their careers and also personal lives (Ong; Kachalia, 2013). The demoralization, social disregard and shame before their peers surely do not improve medical care delivery.

Another of its weaknesses is related to the harmful effects of excessive negative prevention (overdeterrence). On the one hand, the fear of being sued and of a possible conviction, a fear that is pushing doctors to defensive medicine and to leave some medical specialties deserted, such as Obstetrics, Gynecology, and Surgery (OECD, 2006). On the other hand, the atmosphere of fear and secrecy leads health workers to hide information from patients and even from colleagues, when nowadays it is scientifically accepted that many of the mistakes committed could be studied and prevented in the future. The apologies to the victims are also made impossible by the climate of silence, even though they could be powerful balms for the conflict.

The current image of the judicial process as a kind of Russian Roulette has also been highly criticized, since excessive compensations are paid to people that may not deserve them (both because there was no injury or because this injury cannot be guiltily attributed to anyone) and, on the other hand, those who were truly victims of negligence are left with nothing. Disparity of assessments and uncertainty concerning the outcome prove equally damaging to health professionals, who do not know what the law expects from them, taking into account the discrepancies - and even antinomies - between judicial decisions.

Despite criticism of the model based on fault, let us not ignore its possibilities (OECD, 2006). For

example, the greater flexibility in the allocation of compensation, taking into account the specific particularities of each case, which hardly occurs in the no-fault model, whose compensations are more standardized; the fact of covering different types of damages, including non-patrimonial damages, frequently neglected by the no-fault system; and the effect of preventing future harmful conducts, absent in the no-fault system due to its lack of accountability, perhaps the greatest weakness of this model and that even today has not been properly addressed.

We recognize that in a changing world (whether in Law or Medicine) the benefits of the no-fault system seem more seductive (Farrell et al., 2010; OECD, 2006), because they intend to respond to many of the critics made to the negligence model. It is a faster, less costly (Bismark; Paterson, 2006) and less contentious way of resolving the litigation, allowing the injured party to have access to medical care more quickly and covering a greater number of victims. On the other hand, the fact that health professionals are not so concerned about the possibility of being sued facilitates transparency and notification of errors and adverse events; hence, it seems to increase the possibility of learning from mistakes and, at the same time, substantially improves relations between patients and health professionals. The fact that the pressure on doctors diminishes – there is no imposition in terms of finding a culprit (Mello et al., 2006), paying very expensive insurance premiums, going to court or appearing on the cover of newspapers – also avoids the danger of defensive medicine.

However, let us not get carried away by impulses arising from enthusiasm, because the no-fault model also has its weaknesses (Farrell et al., 2010; Maccourt; Barnett, 2009; OECD, 2006). For example, the value of compensations may be higher than what would be needed to cover the damages, especially those that are not of patrimonial nature, which oftentimes are simply excluded. Even regarding patrimonial damages, the amount awarded may not correspond to the amount necessary to compensate the damage, since as a rule there are fixed limits to the amounts to be allocated. And not all damages are compensated, because usually the damage to be compensated is always limited (for example, let us remember the concept of *treatment injury*, in force in the New Zealand model, and of *avoidable event*, the latter so expensive to the Nordic). Another obstacle to compensation is the fact that the injured person has to continue to prove the causal link (Bush; Chen; Bush, 1975), which turns out to be as difficult as in the model of negligence, which may lead some requests to fail.

It has also been argued that in terms of patient safety the advantages from the no-fault model are not as expressive as its advocates want to make us think, since errors can eventually be more reported, but are not necessarily more studied. Even the very conclusion that the percentage of notified adverse events is higher in the no-fault system lacks sufficient grounds, given that several studies show that there is no substantial difference in this respect compared to the model founded on negligence (Schwartz, 2013).

In addition, the disappearance of the threat of litigation may annihilate the encouragement to safer practices, since, in good accuracy, the health professional is never penalized. It is true that in some communities the agent does not need the threat of sanction to raise the standard of conduct, as it seems to occur in the Nordic countries and in New Zealand. However, these are very particular contexts (and even there the effectiveness of the no-fault model has been challenged in relation to incentives to security). On the other hand, in most social contexts it is feared that the disappearance of one of the threats of sanction (of course, the criminal accountability would always persist) may lead the agents to adopt a more lax behavior.

On the other hand, there is a serious risk of a raise in the rate of ungrounded claims, stimulated by the apparent ease of the procedure, a risk so much more serious in particularly litigating societies.

In addition, improvement in relations between health professionals and patients should not be taken for granted, since the existence of apologies or explanations is not necessarily an imperative of the no-fault system.

The decrease of costs can also be more apparent than real. First, because in some communities all the injured persons would resort to the risk socialization fund, which would raise the amount of the sums paid. Then, because, actually, two devices for reaction must be kept – the courts (which is still necessary for damages excluded from the no-fault model, for appeals, as an alternative means of reaction and for the criminal proceedings) and the administrative bodies – in operation, each with their own costs.

In terms of the fundamental right of access to courts, problems have also arisen, because some systems require the incident to necessarily be resolved by administrative means, without allowing those that were harmed the use of litigation courses.

Some final remarks

Despite the seductive nature of the no-fault system – the absence of the spectrum of guilt and accusation, the decrease of confrontation, the possibility to compensate more patients – it must be acknowledged that it also presents serious flaws, including the almost complete absence of accountability, the refusal of compensation in relation to various damages and the potential degradation of the standard of conduct of health professionals.

However, even if the no-fault model is in fact considered superior to the fault-based model - which, as we exposed in the chapter above, we do not have as evident - it is certain that it will not be able to operate in any and all legal systems, as it lacks some specific assumptions of functioning. In fact, its practical applicability is limited to very specific contexts, that hardly exist in most countries: on the one hand, a robust social security system, since the patient compensation model has necessarily a subsidiary role in relation to that system, which turns out to cover most of the expenses; on the other hand, a community that is not very litigating, because if all potentially eligible patients submit claims the system will fall; on the other hand still, a community of health care providers that is able to maintain a standard of conduct consistent with good medical practices regardless of the threat of civil penalty. When this specific context does not occur, as generally it does not, this model cannot flourish.

Therefore, the no-fault model cannot be transposed to the majority of legal systems, except for very particular injuries, as happens in the USA states of Virginia and Florida regarding the neurological injuries in newborns and in the French law concerning injuries resulting from nosocomial infections. When implemented only for a restricted gamut of injuries, it already seems to us that it may be a solution to consider. The most suitable injuries for this will be those whose obtention of compensation in court is particularly difficult, in particular because proving the requirements of the health care professional's responsibility is complex and, often, almost impossible; or because the injuries may be more severe than the reprehensibility of the conduct of the agent.

As we believe, the fault-based model must remain as the basic mechanism to deal with medical liability, albeit subject to a set of reforms aimed at improving its performance in relation to the basic objectives intended by the medical tort liability: increasing patient safety, compensating victims for injuries and preventing future practice of the same mistake. While recognizing that currently the fault-based medical tort liability proves unable to achieve these objectives successfully, we believe that its improvement should be the aim, instead of its replacement.

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