

## FOREWORD: THE VALUE OF COMPARATIVE PERSPECTIVES

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The reform of medical malpractice litigation has been a constant refrain in legislative and academic circles for forty-five years, starting with the 1970 “crisis” in medical liability insurance. In fact, as Rob Field has noted, calls for reform go back to the 1800s. Once lawyers began to sue on behalf of injured patients, doctors began to complain. Why? Because suits (1) target high status professionals and their own deeply felt needs to be perfect; (2) inflict pain on them not only by imposed damage costs, but also by the mere fact of naming them as defendants; and (3) present a dramatic story of injury and draw attention to bad medicine, reminding everyone how dangerous medicine can be. Nothing has changed, except that medicine is far more dangerous today in the frequency of harms caused—the consequence of modern medicine’s power to treat far more health care problems with powerful and invasive tools.

In this volume of the *Drexel Law Review*, we are proud to present a rich selection of comparative perspectives on the operation of malpractice litigation and regulation in countries not often examined in the health policy literature—Australia, India, Japan, and Mexico. In spite of our common beliefs in American exceptionalism, it turns out there is much to learn from the struggles of other countries with medical errors and patient injury. We have assembled a first-class group of experts to consider the lessons of comparative approaches, and the authors, and the very capable law review staff, have worked hard to produce this lengthy volume. It makes a substantial and original contribution to the literature of comparative civil liability.

### PATIENT SAFETY AND MEDICAL LIABILITY: ARE WE AT A FORK IN THE ROAD?

We begin with Rob Field’s fascinating article on the history of litigation in the U.S. and the surprisingly familiar complaints by physicians. He looks at changes in medicine and society over 175

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years, finding significant areas of change in medicine that fuel malpractice litigation. These factors include advancing technology, standardization and oversight of practice, and the expansion of physician autonomy. Of these three, Field finds that physician autonomy may be a central factor fueling litigation. He writes: "Not only could this aspect of modern practice be altered without jeopardizing the quality of clinical care, it may represent the most important of the three in promoting litigation. By functioning in a commercial marketplace, medicine subjects itself to the strictures and public attitudes that apply to other businesses." The tension between a professional relationship built on trust, and market-driven medicine, is one that haunts us today.

My Article looks broadly at the arguments made by reformers in recent times as they try to sort out the pros and cons of the claims for reform. I position patient safety as the central goal of meaningful medical malpractice reform in the twenty-first century. The tort and insurance systems have been tinkered with enough, progressively limiting patient access to compensation. It is time to consider a range of reforms that promote the rapid exposure of adverse events that harm patients in hospitals and penalize those who conceal or remain oblivious to such events. Tort reform to date has been largely one-sided, pushed by insurers and physicians, and it has turned out to be largely ineffective. I argue that it is time to force adverse event disclosure in the spirit of modern patient safety trends toward full information and consumer choice.

#### COMPARATIVE PERSPECTIVES I: FRENCH REFORMS OF LIABILITY AND COMPENSATION

The French system is the first case study in legislation reform of malpractice cases. In four articles that provide a wide-ranging look at various aspects of malpractice reform in France, experts on the French malpractice system weigh in. Marc Rodwin opens the discussion with a look at the 2002 reforms – the Kouchner bills. He examines the structural problems with litigation in France, from the lack of contingency fees to the problem of serious harms when fault cannot be proved. He then discusses the two stages of the French reforms. Reforms created a public fund designed to compensate patients experiencing bad outcomes in the absence of fault, assuming financial responsibility for medical negligence. The second reforms created an option allowing patients to seek compensation for certain serious bad outcomes under a State-

supervised, non-adversarial process. Rodwin gives us a good explanation of the French system and its differences from the U.S. as prelude to the next three articles by French scholars examining the various reforms. And he makes a final comparative point: American politics in the area of tort reform has lost its classic pragmatism, instead running aground on the shoals of intense ideological and special interest differences: “In contrast, within a decade of when medical malpractice became a hot policy issue, France implemented reforms that increased the number of injured patients compensated—including many with grave injuries not caused by negligence—through an alternative to the traditional judicial process.” The French example provides us with a useful case study of reforms that can improve the patient-claiming process and expand the rights of severely injured patients.

The next three articles present a meticulous examination of specific French reforms. Brigitte Feuillet tackles the *Perruche* case, which involved what we call a wrongful life claim. The doctor treating Ms. Perruche had failed to detect the fetus’s rubella, caused by the mother’s contraction of the disease during her pregnancy. Her child was born with severe disabilities as a result, and the mother would have aborted had she known of her son’s condition. The French Supreme Court awarded damages not only to the mother but also to the child for his disability. Feuillet argues that this holding violates French civil liability principles, failing to require proof of a causal link between a physician’s negligence and damages suffered. She examines the legal and ethical repercussions of this decision for French law and the high costs it threatened to impose on insurers and providers in such obstetric disaster cases.

Philippe Pierre next examines what has happened to French compensation since the Kouchner Act and its revisions. He examines the reforms nine years later, concluding that the Acts increased access to both insurance and compensation. In a careful treatment of the Acts’ effects on case resolution and private insurance, he finds that administrative complexity was increased in the effort to reconcile private and public insurance. The main objectives of the Kouchner Act were to provide compensation for injured patients—even in the absence of negligence—and to reallocate the related financial burden. Pierre argues that the Kouchner Act represents only an evolution in France of more public guarantees and less litigation. He observes how it modified the role of private insurance as part of creating a new Public Guarantee Fund in the name of national solidarity. It also relieved insurers

from responsibility for *Perruche*-type obstetric injuries. The revised Act has now added hospital-borne infections to the Public Guarantee Fund coverage. He notes that “[t]he idea motivating this change was that these claims should be a national responsibility reflecting social solidarity.”

The last of the French scholars, Dominique Thouvenin, discusses the detailed legal parameters of the complex Kouchner Act reforms, noting that they combined indemnification rules with liability and offered a new version of ADR. The Act revised the usual French liability rules for medical accident compensation. It consolidated the old approach with a new right of compensation for bad outcomes due to “inherent therapeutic risk.” At the same time, it created a new alternative dispute resolution process through the creation of Conciliation Commissions, with a new role for experts in medical accidents to assess patient injury. Thouvenin describes this new entity in detail and discusses its strengths and weaknesses. She also provides an interesting sidebar on the French notion of “solidarity,” a concept that we Americans contest over in our constant struggles over our competing ideologies of individual versus community responsibility for harms.

#### COMPARATIVE PERSPECTIVES II: AUSTRALIA, INDIA, MEXICO, AND JAPAN

Angus Corbett introduces us to the Australia liability crisis of 2002 and reformers’ responses to the perception that plaintiffs were bringing too many claims and that the system was getting too expensive. The tort reform response applied to all tort claims, not just medical malpractice, is familiar to Americans in its general features: excluding liability for harm by altering the standard of care, reducing plaintiff damages by modifying contributory negligence, and modifying damage rules and the payment of costs by the parties. The second major component of reform was specific to medical malpractice, altering medical indemnity insurance. Corbett discusses the range of reforms implemented by the Australian government, from premium subsidies to changes in the types of policies sold. He reports that reform was successful in its narrow goals of lowering premium costs. Corbett notes, however, the negative consequences of these reforms: less compensation for injured parties, and a failure to articulate a connection between reform and the goals of increasing patient safety and lowering the incidence of medical adverse events over time.

Nathan Cortez then turns our focus to two developing countries, India and Mexico, for some interesting reforms that allowed for improvements in medical injury compensation. He notes that our usual provincialism about developing countries is not justified; medical liability law is worth studying in these countries because they struggle with the same problems we have: how to maintain a fair system for handling complaints while holding physicians accountable and deterring further medical errors where physicians often have a protected status and great judicial deference. Cortez first explores India, a common law jurisdiction, and then Mexico, a civil code country. He describes how each country has reformed its legal system in large part by bypassing problematic civil courts, either through consumer forums or an arbitration system. He notes the virtues of the Mexican reforms, in particular, as offering us a valuable idea for consideration.

Rob Leflar next continues his fascinating research on reforms in Japan in his thoughtful article. Japan relies on private law adjudication, and Leflar discusses four features of Japanese law that distinguish Japan from the U.S. He observes, first, that the criminal law in Japan is an integral part of regulating medical quality. Second, a new project is underway to provide an impartial investigation of hospital death cases, which will, it is hoped, better promote safety changes and rapid claims resolution. Third, the government has created new health care divisions of urban trial courts. Finally, he notes a new obstetrical injury no-fault compensation system. Leflar tells a compelling story of the history of errors that led to these reforms, and he suggests that claims are indeed being processed more rapidly and that no-fault liability is proving to be workable and may gain traction in Japan in other areas of medical liability.

U.S. PERSPECTIVES ON REFORM:  
ONE EXAMPLE OF BARRIERS TO EFFECTIVE REFORM

The last presenter in our Symposium, Haavi Morreim, returns us to the U.S. and one of our earlier attempts to reform medical quality. She looks at the Health Care Quality Improvement Act (HCQIA), and one of its central components, the National Practitioner Data Bank (NPDB). The Data Bank was intended to gather information on providers so that hospitals making credentialing decisions could have full information about applying physicians. Morreim explores the unintended consequences of the HCQIA, as physicians sought

strategies to avoid having to record claims in the database created by the Act. She argues that reports on medical malpractice payments “can significantly interfere with recent improvements in the management of medical error and quality improvement.” Physicians want to avoid a black mark in the Data Bank and have developed work-arounds that thwart the purposes of the HCQIA.

This volume of the *Drexel Law Review* offers truly unique perspectives on our chronic medical liability reform dilemma. We see other countries struggling with most of the same issues and working toward insurance reform, alternative State-funded systems, and judicial reforms to improve the litigation process. There are indeed lessons to learn from other countries, and we are grateful for the detailed and thoughtful work done by these authors in giving us windows into reform alternatives that we might evaluate for our own improvement.