

**FRENCH MEDICAL MALPRACTICE COMPENSATION
SINCE THE ACT OF MARCH 4, 2002: LIABILITY RULES
COMBINED WITH INDEMNIFICATION RULES AND
CORRELATED WITH SEVERAL KINDS OF
PROCEEDINGS**

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INTRODUCTION

The Act of March 4, 2002 (Kouchner Act),¹ aimed to improve the conditions for compensation of medical accidents, taking into account both the interests of patients and the concerns of doctors. The reforms were made possible by advancing the idea that “the existing system was satisfactory neither for the victims, nor for health professionals.”² Patients wanted to receive better compensation, equal treatment, and more rapid recovery.³ Health professionals felt that the courts interpreted rules in ways that expanded their liability. They expressed “growing concern” at this development, fearing a *dérive à l'américaine* (“a drift to the United States”) and the development of “defensive” medicine, a shift perceived as deleterious to patients’ interests.⁴

We must not forget that the rules of civil liability determine who will compensate the injured and, consequently, assume the cost ultimately paid by insurers. In the early 1990s, insurers and health professionals concluded that medical liability rules were administered in a manner too favorable toward injured patients, leading insurers to pay more and more compensation. In the Declaration of October 14, 1992,⁵ medical insurers, in conjunction with physician unions and the Presidents of the College of Physicians, observed that, while medicine had become more effective over the last twenty-five years, medical risk had increased significantly in proportion to its effectiveness.

This finding led to a proposal for the distribution of the financial burden of medical accidents according to their relation to medical fault or risk: doctors would be responsible for the mistakes they make, but only in cases of fault. The risk of medical care (whether

1. Loi 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé [Law 2002-303 of March 4, 2002 on Patients’ Rights and Quality of the Health System], JOURNAL OFFICIEL DE LA REPUBLIQUE FRANÇAISE [J.O.] [OFFICIAL GAZETTE OF FRANCE], Mar. 4, 2002, p. 4118.

2. ASSEMBLÉE NATIONALE REP. NO. 3688, at 27 (2002), available at <http://www.assemblee-nationale.fr/11/pdf/rap-info/i3688.pdf>.

3. The French system of medical liability has been criticized for its excessive complexity. See *infra* pp. 169-73.

4. ASSEMBLÉE NATIONALE REP. NO. 3263, at 7 (2001), available at <http://www.assemblee-nationale.fr/11/pdf/rapports/r3263-3.pdf>.

5. DIDIER TABUTEAU, *Déclaration du 14 octobre 1992 des médecins libéraux sur le risque médical* [Declaration of October 14, 1992 Private Practitioners on Medical Risk], in RISQUE THERAPEUTIQUE ET RESPONSABILITE HOSPITALIERE [HOSPITAL THERAPEUTIC RISK AND RESPONSIBILITY] 132-134 (1995).

preventive, diagnostic, or therapeutic) that is not linked to a fault when medical intervention has produced abnormal consequences, is an inherent therapeutic risk and must be compensated by public funds in the name of national solidarity.⁶ This demand was expressed in a context in which victims sought compensation for severe damage and consequences in two high-profile areas: (1) the disability of a child born with serious congenital defects not detected by prenatal diagnostic testing,⁷ and (2) nosocomial infections (i.e., infections contracted in a medical facility). Because of these claims—brought by both the injured patients and the treating doctors through their insurers—the legislature considered it necessary to introduce new rules.

Noting that the issues raised by medical malpractice and medical accidents had long been “the subject of numerous reports and proposals”⁸ that had failed to produce an adequate solution,⁹ the government of Lionel Jospin, who served as Prime Minister from 1997 to 2002, established a new system to better compensate medical accidents. The Kouchner Act¹⁰ intended to “clarify the rules governing medical liability: liability for negligence, the national solidarity¹¹ for inherent therapeutic risks,”¹² and “to allow victims’ assistance and

6. See *infra* Sidebar 1.

7. See Brigitte Feuillet, *The Perruche Case and French Medical Liability*, 4 DREXEL L. REV. 139 (2011).

8. Five reports and twenty law propositions preceded the Act of March 4, 2002. See GENEVIEVE VINEY, *L’INDEMNISATION DES ACCIDENTS MEDICAUX* [MEDICAL ACCIDENT COMPENSATION] 1, 103–16 (1997).

9. *Projet de loi relatif aux droits des malades et à la qualité du système de santé* [Bill on Patient Rights and Quality of the Health System], Assemblée Nationale, 11^{ème} législature, no. 3258, at 10 (2001), available at <http://www.assemblee-nationale.fr/11/pdf/projets/pl3258.pdf>.

10. S. Daël, *Philosophie générale de la réforme de la responsabilité médicale* [General Philosophy of the Reform of Medical Liability], in GEORGES FAURE, *LA LOI DU 4 MARS 2002: CONTINUITÉ OU NOUVEAUTE EN DROIT MÉDICAL?* [THE LAW OF MARCH 4, 2002: CONTINUITY OR INNOVATION IN MEDICAL LAW?] 9–18 (2003); PATRICE JOURDAIN ET AL., *LE NOUVEAU DROIT DES MALADES* [THE NEW RIGHTS OF PATIENTS] 83–95 (2002); J. Penneau, *Présentation générale critique des dispositions relatives à la réparation des conséquences des risques sanitaires* [Overview of Critical Provisions Relating to Compensation of the Consequences of Health Risks], in FAURE, *supra*, at 19–35; C. Radé, *La réforme de la responsabilité médicale après la loi du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé* [The Reform of Medical Liability Under the Law of March 4, 2002 on Patients’ Rights and Quality of the Health System], 5 *RESPONSABILITE CIVILE ET ASSURANCE* 4–12 (2002).

11. See *infra* Sidebar 1. Specifically, accidents due to therapeutic risks are compensated by the National Office for Compensation for Medical Accidents (ONIAM), a public body financed by public funds. See generally *INDEMNISATION DU RISQUE MÉDICAL PAR LA SOLIDARITÉ NATIONALE*, <http://www.oniam.fr> (last visited Dec. 8, 2011) (providing general information about the ONIAM).

12. ASSEMBLÉE NATIONALE REP. NO. 3263, at 14–15.

compensation."¹³ In short, the Kouchner Act produced three major innovations. First, it did not change the liability rules for medical accidents, but it did consolidate them.¹⁴ Second, it created a new right to compensation by the National Office for Compensation for Medical Accidents¹⁵ for certain inherent therapeutic risks. And third, it created a new procedure for settlement via three newly established bodies.

The first of these bodies is the Regional Commissions for Conciliation and Compensation of Medical Accidents, Iatrogenic Diseases, and Nosocomial Infections (CRCI or Conciliation Commissions), which facilitates the speedy resolution of serious accidents using Alternative Dispute Resolution (ADR). The second is the National Office for Compensation for Medical Accidents (ONIAM or Public Guarantee Fund), which funds (1) the operations of the Conciliation Commissions and (2) victim compensation in the name of national solidarity when no fault-based liability exists. The third body is the National Commission on Medical Damages (CNAMed or Medical Damages Commission), which establishes a list of experts to evaluate medical injuries and harmonizes the practices of the Conciliation Commissions in order to avoid disparities in the treatment of claims.

These new rules, however, have not made a clean sweep of the previous medical liability rules. Therefore, to understand the current French system of compensation for medical accidents, it is necessary to combine the new rules for compensation of accidents with previous liability rules, both of which are applied by courts and the Conciliation Commissions. In Part I of this Article, I discuss legal liability rules that continue to apply. In Part II, I explain how the Kouchner Act consolidated liability rules applicable to medical accidents and created a new right to compensation for certain therapeutic hazards. Finally, in Part III, I describe the new procedure for settlement through the Conciliation Commissions.

13. ASSEMBLÉE NATIONALE REP. NO. 3263, at 14–15.

14. Note that the Kouchner Act is concerned only with compensation and not criminal liability.

15. The French term is *Office National d'Indemnisation des Accidents Médicaux*. See *supra* note 11.

I. UNTIL THE ACT OF MARCH 4, 2002, COMPENSATION FOR
MEDICAL ACCIDENTS CAME ABOUT BY INVOKING THE USUAL
RULES OF LIABILITY

Liability rules were born with the new society created by the French Revolution of 1789. Two categories exist: rules of indemnity liability¹⁶ and rules of criminal liability.¹⁷ Whether liability is civil or criminal, the goal is the same—namely, to redress a harm through either a penalty or monetary damages. The general liability rules under French law still apply to medical accidents. These regulations include the rules of liability for damages (from the Civil Code of 1804 and the principles of administrative liability enacted by the Council of State in the mid-nineteenth century) and the rules of criminal liability (based on the Penal Code of 1810 and the Penal Code of 1992).

Two categories of rules for compensatory liability exist because each applies to different kinds of relationships—one for users of medical services in the private sector and one for users of public services. French law distinguishes between the following two broad categories of social relations: those governed by private law and those governed by public law. The first governs the relationship between individuals, whether natural or legal persons; the latter organizes the relationship between two public entities and the relationship between a public entity and a private party.

For this reason, in the second half of the nineteenth century, the Council of State decided that the Civil Code's liability rules could not be applied to determine the liability of public servants working in the public sector.¹⁸ This decision, supported by a long line of cases, is justified by the idea of a separation between the State and the society and therefore the public and private spheres. State action, based on serving the public interest and public functions, is regard-

16. The rules of indemnity liability were created by the Civil Code of 1804; the principle of liability is expressed in Article 1382: "Any act whatever of man, which causes damage to another, obliges the one by whose fault it occurred, to compensate it." CODE CIVIL [C. CIV.] [CIVIL CODE] art. 1382.

17. Criminal liability is guided by the principle of "legality of crimes and punishments" expressed in Article 7 of the Declaration of the Rights of Man and of the Citizen of 1789: "No man can be accused, arrested, or detained except in the cases determined by law, and in the manner prescribed by it." Déclaration des droits de l'Homme et du Citoyen [Declaration of the Rights of Man and of the Citizen] art. 7 (1789). This means that the state can not prosecute a citizen unless his behavior is an offense under the Penal Code.

18. TC, Dec. 6, 1855, Rec. Lebon 705 (discussing the liability of the postal service for erroneously delivering a letter containing diamonds to a namesake other than addressee).

ed differently than actions taken by private individuals, and thus should not be governed by the same rules. That is, the relationship between an individual person and the State is seen as fundamentally different than the relationship between two private individuals.

It was concluded that the public sphere could not be regulated by the Civil Code, which governs relations among private actors. So, it was necessary to create another system of rules, based on public administrative law. This is a distinct system with its own logic and solutions to problems. These separate rules are justified by the needs of government services.

It is worth noting that individual liability can occur when conduct stems from a private professional or medical facility. Administrative liability, in contrast, applies only to a governmental entity for failures of the public service. In the latter case, medical care errors are not considered to be attributable to an individual health professional, but to the public hospital service itself.¹⁹

The French health system has two distinct sectors: a private sector with private practitioners and hospitals, and a public sector operated through public hospitals with publicly employed physicians. In the private sector, the patient contracts with private providers, private hospitals, and other facilities. In the public sector, the patient is a user of public services and public facilities. The major difference between civil and public administrative liability rules is the following: for acts by a doctor, midwife, or nurse employed by a public hospital, only the liability of the public hospital service can be invoked for the failure of a public service and not for the actions of an individual doctor, midwife, or nurse cannot be sustained.

There are also two distinct court systems in France. Judicial courts hear trials based on civil liability rules that govern private practice, while administrative courts hear trials based on administrative liability rules that govern the public medical sector.²⁰ Because directly suing a public administration is forbidden, patients seeking restitution from a public hospital must first request compensation directly from the hospital.

The rules of criminal liability permit sanctions against a person whose reckless behavior caused harm to an individual's bodily integrity. Any accident involving a violation of an individual's physical integrity may give rise to criminal liability for harm to the integ-

19. See DOMINIQUE THOUVENIN, *LA RESPONSABILITE MEDICALE* [MEDICAL LIABILITY] (1995).

20. A victim may also file a claim with an insurer's business or health facility requesting compensation.

rity of the person,²¹ or for the person's loss of life.²² Examples include offenses such as involuntary assault and battery or, in cases of a medical accident, manslaughter. The doctor, health professional, or director of a private or public hospital can be sued for, and possibly convicted of, such offenses.²³ However, a criminal trial is not a private dispute conducted for the benefit of the victim; rather, the community is seen as the beneficiary of any sentence meted out. This notion is evidenced by the fact that even if a harmed patient initiates the criminal process, the prosecution is directed by a public prosecutor.

The victim can also seek compensation in criminal court for damages to property and physical injury resulting from an offense. In such a case, the court applies the rules of liability for civil compensation. But this course of action is not available to redress acts of professionals employed in public hospitals because criminal courts do not have the authority to determine compensation for public hospital liability²⁴ due to an old rule of French law that prohibits judicial

21. CODE PENAL [C. PEN.] [PENAL CODE] art. 222-19.

Causing a total incapacity to work in excess of three months to another person by clumsiness, rashness, inattention, negligence or breach of an obligation of safety or prudence imposed by statute or regulations, in the circumstances and according to the distinctions laid down by article 121-3, is punished by two years' imprisonment and a fine of €30,000. In the event of a deliberate violation of an obligation of safety or prudence imposed by statute or regulation, the penalty incurred is increased to three years' imprisonment and to a fine of €45,000.

Id.

22. *Id.* art. 221-6.

Causing the death of another person by clumsiness, rashness, inattention, negligence or breach of an obligation of safety or prudence imposed by statute or regulations, in the circumstances and according to the distinctions laid down by article 121-3, constitutes manslaughter punished by three years' imprisonment and a fine of €45,000. In the event of a deliberate violation of an obligation of safety or prudence imposed by statute or regulations, the penalty is increased to five years' imprisonment and to a fine of €75,000.

Id.

23. *Id.* art. 121-2.

Legal persons, with the exception of the State, are criminally liable for the offences committed on their account by their organs or representatives, according to the distinctions set out in articles 121-4 and 121-7. . . . However, local public authorities and their associations incur criminal liability only for offenses committed in the course of their activities which may be exercised through public service delegation conventions. The criminal liability of legal persons does not exclude that of any natural persons who are perpetrators or accomplices to the same act, subject to the provisions of the fourth paragraph of article 121-3.

Id. (emphasis added).

24. Prior to March 5, 2007, when Law No. 2007-291 was enacted, a victim could bring a civil action directly before an investigating judge. Loi 2007-291 du 5 mars 2007 tendant à ren-

courts from adjudicating disputes that involve issues of public administration.²⁵

Finally, we should note that there is no hierarchy among the rules of liability for damages and criminal liability rules. Victims can choose to bring suits through either the civil or criminal process.

French medical liability has been criticized for its excessive complexity due to these two systems of liability rules and courts. It has been argued that the system results in disparate and unequal treatment, depending on whether an accident occurs in the private or public medical sector.

II. THE CONSOLIDATION OF LIABILITY RULES FOR COMPENSATION OF MEDICAL ACCIDENTS AND A NEW RIGHT OF REDRESS FOR BAD OUTCOMES DUE TO INHERENT THERAPEUTIC RISK

The Kouchner Act reaffirmed the existing system of liability²⁶ based on fault of health professionals and institutions: “[H]ealth professionals, as well as any institution, service or organization in

forcer l'équilibre de la procédure pénale [Law 2007-291 of March 5, 2007 to Strengthen the Balance of Criminal Procedure], J.O., Mar. 6, 2007, p. 4206. Under the new law, victims must first file a complaint with the police court or public prosecutor. CODE DE PROCEDURE PENALE [C. PR. PEN.] [CODE OF CRIMINAL PROCEDURE] art. 85.

Any person claiming to have suffered harm from a felony or misdemeanor may petition to become a civil party by filing a complaint with the competent investigating judge in accordance with the provisions of articles 52, 52-1 and 706-42. However, the complaint with a civil party is admissible only on the condition the person justifies what the prosecutor has made known, following a complaint filed before him or a service from the judicial police, that they would not prosecute, or that a period of three months has passed since he filed a complaint before the magistrate.

Id.

25. “[J]udges cannot, on penalty of forfeiture, disturb in any manner whatsoever, the operations of administrative bodies, or cite before them the reasoning of their functions.” Loi des 16-24 août 1790 sur l’organisation judiciaire [Law of August 16-24, 1790 on the Judiciary], COLLECTION COMPLETE, DECRETS, ORDONNANCES, REGLEMENTS ET AVIS DU CONSEIL D’ÉTAT (DUVERGIER & BOCQUET) [DUV. & BOC.] [COMPLETE COLLECTION OF THE DECREES, ORDERS, REGULATIONS AND OPINIONS OF THE COUNCIL OF STATE], 1834, pp. 310-13.

26. This law also mandated “insurance professionals and health institutions in private practice, health facilities, health services and organizations . . . engaged in prevention, diagnosis or care as well as producers, operators and suppliers of health . . . used in connection with these activities . . . to purchase insurance to protect them for their civil or administrative liability which may be incurred as a result of injury to third parties resulting from attacks on the person, occurring in the context of all of this activity.” CODE DE LA SANTE PUBLIQUE [C. SANTE PUB.] [CODE OF PUBLIC HEALTH] art. L. 1142-2. The law adds that “insurance contracts written under the first paragraph may provide for benefit limits” and that “[i]nsurance for health professionals, institutions, departments and agencies mentioned in the first subparagraph shall cover their employees acting within the scope of the mission assigned to them, even if they have an independent exercise of the medical profession.” *Id.*

which are made individual acts of prevention, diagnosis, or care are only responsible for the harmful consequences of acts of prevention, diagnosis, or treatment in cases of misconduct.”²⁷ The existing rules continue to apply; civil liability to private medicine, and administrative liability to public medicine.

In addition, the Kouchner Act stated that “the institutions, services, and organizations mentioned above are liable for damages resulting from nosocomial infections, unless they produce evidence of a foreign cause.”²⁸ This created a legal presumption. After the law’s enactment, private insurers²⁹ argued that they could not bear the increased financial risk for nosocomial infections and lobbied for changes. In response, Parliament passed the Act of December 30, 2002 (Revised Kouchner Act). It provided support through the Public Guarantee Fund for the most serious injuries due to nosocomial infections – those that disable an individual’s capacity by more than 25% or cause death. Although the Public Guarantee Fund compensates these injuries,³⁰ it has a right of subrogation against medical facilities responsible.

At this stage of the analysis, an explanation is needed. Since the beginning of this Article, we have used the expression “medical malpractice.” It is necessary to specify exactly what that term includes. Medical liability concerns not only the activity of doctors but also the activity of other health professionals (midwives, nurses, dentists, physiotherapists, etc.). “The evaluation of the act of care is at the heart of medical liability.”³¹ However, medical liability does not apply to injuries caused by defective products, whether drugs or biological products of human origin, as these concern consumer

27. *Id.* art. L. 1142-1 I al. 1.

28. *Id.* art. L. 1142-1 I al. 2.

29. Philippe Pierre, *Assurance, responsabilité et santé: réflexions sur une trilogie en devenir* [*Insurance, Liability, and Health: Reflections on a Trilogy in the Making*], *REVUE DE DROIT SANITAIRE ET SOCIAL* [LAW REVIEW OF HEALTH AND SOCIAL CARE] 6 (2010).

30. In its latest progress report, the Public Guarantee Fund says the number of nosocomial infections supported by national solidarity is seventy-four for 2010, a 6% increase compared to nosocomial infections recognized as compensable by the Conciliation Commissions during that year. OFFICE NATIONAL D’INDEMNISATION DES ACCIDENTS MÉDICAUX [NATIONAL OFFICE FOR COMPENSATION FOR MEDICAL ACCIDENTS] [ONIAM], *RAPPORT D’ACTIVITÉ 2010* [2010 ACTIVITY REPORT] 14 (2011) [hereinafter 2010 REPORT], available at <http://www.oniam.fr/IMG/rapportsoniam/rapport2010.pdf>.

31. Evelyne Serverin, *Une approche socio-juridique d’une question de santé publique : la contamination sanguine par le virus de l’hépatite C* [*Socio-Legal Approach to a Public Health Issue : Blood Contamination by Hepatitis C*], in *LES MONDES DU DROIT DE LA RESPONSABILITÉ : REGARDS SUR LE DROIT EN ACTION* [WORLDS OF TORT LAW: A LOOK AT THE LAW IN ACTION], Paris, LGDJ, coll. *Droit et société*, 2003, pp. 121–154.

law.³² In these cases, product liability is at issue, not the conduct of the prescriber.³³ Unless the patient complains about an error in prescription—for example, the use of the wrong blood grouping or an unnecessary or inappropriate prescription—product liability attaches.

The Kouchner Act created a new right to redress for bad outcomes due to inherent therapeutic risk. The Report of the General Inspector of Social Affairs and the General Inspector of Judicial Services on Liability and Compensation for Inherent Therapeutic Risks proposed this new right to redress.³⁴ The report clearly defined “inherent therapeutic risk” as “an injury stemming from acts of medical diagnosis or treatment which exceed those of failure or the therapy, and whose consequences are distinct from the patient’s condition and its expected development.”³⁵ The Kouchner Act therefore states that, “when the liability of a professional, institution, department[,] agency . . . or producer of products is not involved, a medical accident, an iatrogenic disease, or a nosocomial infection qualifies for compensation for damages to the patient, and in case of death, compensation to beneficiaries in the name of national solidarity.”³⁶

Because the redressment of bad outcomes due to inherent therapeutic risk is a subsidiary claim, it has implications on how to characterize the injury: it must be analyzed in two stages. First, one examines whether a provider or medical facility committed a fault that caused the accident, giving rise to liability. If it turns out that there is no party legally responsible, then one can determine whether

32. Dominique Thouvenin, *Responsabilité médicale: de quoi s'agit-il exactement?* [Medical Liability: What is It Exactly?], Vol. 24, 2 SCIENCES SOCIALES ET SANTÉ [SOCIAL SCIENCE AND HEALTH] 35, 35-42 (2006).

33. “A producer is liable for damages caused by a defect in his product, whether he was bound by a contract with the injured person or not.” C. CIV. art. 1386-2. “The provisions of this Title shall apply to compensation for damage caused by personal injury. They shall apply also to compensation for damage above an amount fixed by décret to an item of property other than the defective product itself.” *Id.*

34. INSPECTION GENERALE DES AFFAIRES SOCIALES ET INSPECTION GENERALE DES SERVICES JUDICIAIRES [INSPECTOR GENERAL OF SOCIAL AFFAIRS AND INSPECTOR GENERAL OF JUDICIAL SERVICES], RAPPORT SUR LA RESPONSABILITE MEDICALE ET L'INDEMNISATION DE L'ALEA THERAPEUTIQUE [REPORT ON MEDICAL LIABILITY AND COMPENSATION FOR THERAPEUTIC HAZARDS] 68 (1999). That report also recommended the creation of a fund, the ONIAM, the National Commission of Medical Accidents, and the Regional Commissions for Compensation.

35. *Id.*

36. “The act also provides that [w]hen they are directly attributable to acts of prevention, diagnostic or treatment acts and have had consequences for the patient with regard to its abnormal state of health as the foreseeable development of it and have a serious nature . . . measured against the loss of functional ability and consequences on the life and work. . . .” C. SANTE PUB. art. L. 1142-1.

there are grounds for compensation by the Public Guarantee Fund. The absence of fault does not *ipso facto* entitle the injured patient to public compensation. The lack of legal liability is necessary but not sufficient. Second, one examines if the conditions for compensation by the compensation fund are met. The Public Guarantee Fund only compensates injuries directly linked to acts of prevention, diagnosis, or treatment that cause abnormal consequences for the patient's health and its likely evolution. Furthermore, the fund only provides compensation for very serious injuries.

A 1993 case provides an example of finding a bad outcome due to inherent therapeutic risk. In the case, a person with neurological disorders underwent a spinal arteriography in order to diagnose the origin of the disorders,³⁷ but the procedure rendered the patient a paraplegic for life.³⁸ The court held that the injury was unrelated to the patient's initial condition and was not a natural evolution of the expected path of the affection.³⁹

Another case provides an example of finding no injury due to inherent therapeutic risk. In this case, a man with a brain tumor underwent surgery that normally entails a risk of hemiplegia. As a result of the surgery, the man became a hemiplegic.⁴⁰ The court held that there was no fault in the performance of the surgery; the injury was a foreseeable risk related to the patient's initial medical condition, and consequently, the injury was not due to inherent therapeutic risk.⁴¹

This is not a regime of provider liability without fault. The Public Guarantee Fund is not a provider of medical care and, therefore, is not liable for damages; it simply compensates certain bad outcomes to promote social solidarity.

37. CE, Apr. 9, 1993, *Bianchi*, REVUE FRANÇAISE DE DROIT ADMINISTRATIF [REV. FR. DR. ADM.] 573, concl. J. Daël. This case was decided before the Kouchner Act, but it involved the first application of the legal concept of inherent therapeutic risk. Therefore, this example is always cited in French legal literature.

38. *Id.*

39. *Id.*

40. TA Versailles, July 28, 2005, D. 2005, 2364-68, obs. D. Thouvenin (discussing the scope of a CRCI's opinion).

41. *Id.*

III. THE CREATION OF A NEW ALTERNATIVE DISPUTE RESOLUTION PROCESS

A regional conciliation commission oversees the ADR process. There are twenty-five commissions grouped into six regional hubs.⁴² Each commission is composed of representatives from patient associations, providers, medical facilities, payers (both private insurers and the Public Guarantee Fund), medical experts in the evaluation of bodily impairment, and a magistrate from either a judicial or administrative law court who chairs the commission.⁴³

The Regional Commissions for Conciliation and Compensation for Medical Accidents, Iatrogenic Diseases, and Nosocomial Infections were created to promote three goals: (1) prompt compensation for certain medical injuries based on improved expertise;⁴⁴ (2) organization of a single compensation system that avoids the drawbacks of the dual systems of civil and administrative liability rules and judicial and administrative law courts, respectively; and (3) single agency determination of whether an accident should be compensated according to liability rules or by the Public Guarantee Fund, or a combination of both.

The Regional Conciliation Commissions are a form of ADR that both European⁴⁵ and French law⁴⁶ have favored over the past twenty

42. C. SANTÉ PUB. art. L. 1142-5.

43. *Id.* art. L. 1142-6 al.1.

44. Parliament wanted to create a corps of quality experts to improve the quality of medical expertise and to address the criticisms expressed in the General Inspector of Social Affairs and the General Inspector of Judicial Services Report on Medical Liability and Compensation for Therapeutic Hazards. See Inspection Générale des Affaires Sociales et Inspection Générale des Services Judiciaires, *supra* note 33, at 72 (noting that "the independence or the technical competences of the experts was not always guaranteed").

45. This concept has been promoted under the aegis of the Council of Europe. See, e.g., Evelyne Serverin, *Quels lieux pour la médiation civile, rapport pour le groupe de travail du Comité d'experts sur l'efficacité de la justice (CEPEJ) de novembre 2000* [What Place for Civil Mediation: Report to the Working Group Committee of Experts on the Efficiency of Justice from November 2000], REVUE NATIONALE DES BARREAUX, Jan.-June 2002, at 9-49. This report was available online, but after two years, it was removed from the site. Because it was very interesting, the National French Bar decided to publish it. The CEPEJ worked to enable a better implementation of the Recommendations of the Committee of Ministers concerning mediation. In order to fulfil its tasks, the CEPEJ has in particular assessed the impact in the states of the existing Recommendations of the Committee of Ministers concerning mediation. See Eur. Comm'n for the Efficiency of Justice, *Better Implementation of Mediation in the Member States of the Council of Europe - Concrete Rules and Provisions* (CEPEJ Study No. 5), available at http://www.coe.int/t/dghl/cooperation/cepej/series/Etudes5Ameliorer_en.pdf (providing recommendations adopted by the Committee of Ministers and guidelines drafted by CEPEJ) [hereinafter CEPEJ, *Implementation*]; Comm. of Ministers of the Council of Eur., Recommendation No. R(98)1 on Family Mediation, adopted on Jan. 21, 1998 at the 616th Meeting of the Minister's Deputies, *reprinted*

years to address diverse disputes in all areas of social life. They are not intended to discourage access to courts by citizens, but as a complementary means to resolve disputes.⁴⁷ They respect and follow key legal principles, notably “the impartiality of the body, the efficiency of the procedure and the publicising and transparency of proceedings.”⁴⁸

According to the Act, the ADR process is guided by three principles: it’s “free,” it’s “easy,” and it’s “quick.” First, claimants pay no fees, and the Public Guarantee Fund pays for the expert assessment. Second, claimants start the process by filing a simple form, and the Conciliation Commission investigates the case. Claimants can proceed without a lawyer, but a lawyer can represent them if they wish. Third, the Conciliation Commission has six months to decide each case.⁴⁹

in CEPEJ, Implementation, supra, at 6; Comm. of Ministers of the Council of Eur., Recommendation No. Rec(99)19 Concerning Mediation in Penal Matters, adopted on Sept. 15, 1999 at the 679th Meeting of the Ministers’ Deputies, *reprinted in CEPEJ, Implementation, supra*, at 24; Comm. of Ministers of the Council of Eur., Recommendation Rec(2001)9 on Alternatives to Litigation Between Administrative Authorities and Private Parties, adopted Sept. 5, 2001 at the 762d Meeting of the Minister’s Deputies, *reprinted in CEPEJ, Implementation, supra*, at 38; Comm. of Ministers of the Council of Eur., Recommendation Rec(2002)10 on Mediation in Civil Matters, adopted Sept. 18, 2002 at the 808th Meeting of the Minister’s Deputies, *reprinted in CEPEJ, Implementation, supra*, at 10. Also, from the European Commission, see Commission Recommendation 98/257, 1998 O.J. (L 115) 31 (EC) (discussing the principles applicable to the bodies responsible for out-of-court settlement of consumer disputes); 2001 O.J. (L 109) 56 (discussing the principles for out-of-court bodies involved in the consensual resolution of consumer disputes), *available at* <http://eur-lex.europa.eu>.

46. Such is the case, for example, of justice conciliators created by the Act of February 8, 1995 and the Decree of July 22, 1996. Décret 96-652 du 22 juillet 1996 relatif à la conciliation et à la médiation judiciaires [Decree 96-652 of July 22, 1996 on Conciliation and Mediation Courts], J.O., July 23, 1996, p. 11125; Loi 95-125 du 8 février 1995 relative à l’organisation des juridictions et à la procédure civile, pénale et administrative [Law 95-125 of February 8, 1995 on the Organization of Jurisdictions and Civil, Criminal, and Administrative Procedure], J.O., Feb. 9, 1995, p. 2175.

47. Victims are “not obligated to enter into a conciliation procedure.” Florence G’sell-Macrez, *Symposium on Medical Malpractice and Compensation in Global Perspective: Part I: Medical Malpractice and Compensation in France, Part I: The French Rules of Medical Liability Since the Patients’ Rights Law of March 4, 2002*, 83 CHI.-KENT L. REV. 1093, 1121 (2011).

48. Second considering of 1998 O.J. (L 115) 31 (EC) (involving the principles applicable to the bodies responsible for out-of-court settlement of consumer disputes). Commission Recommendation, *supra* note 44.

49. These delays are, in fact, longer, often between nine and eleven months. *Procédures Devant les CRCI [Procedures Before the CRCI]*, COMMISSIONS REGIONALES DE CONCILIATION ET D’INDEMNISATION DES ACCIDENTS MEDICAUX, DES AFFECTIONS IATROGENES ET DES INFECTIONS NOSOCOMIALES [REGIONAL COMMISSIONS OF CONCILIATION AND MEDICAL ACCIDENT COMPENSATION FOR IATROGENIC DISEASES AND NOSOCOMIAL INFECTIONS], <http://www.commissions-crci.fr/procdures.php> (last visited Dec. 9, 2011).

In addition, the ADR process does not preclude suing for damages in court.⁵⁰ The injured patient can forego the ADR process, sue in court at the same time,⁵¹ or bring suit after completion of the ADR process.

A major benefit of using Conciliation Commissions is that they can review cases that result in bad outcomes in both the private and public sectors. This is particularly helpful when the patient was treated in both; for example, a patient may be treated first in a private facility and later in a public hospital. If a patient has been cared for by many providers over a long time period, the Commission evaluates the entire course of medical treatment.⁵² It determines whether the bad outcome gives rise, in part, to liability due to fault and, in part, to a right to compensation through the Public Guarantee Fund, which covers inherent therapeutic risks. In contrast, when an injured patient wishes to litigate, they must proceed in separate judicial and administrative courts, and each court may only consider the medical treatment under its jurisdiction, rather than the whole medical treatment.

However, the ADR process is only available when a claimant seeks compensation for the most serious injuries. Indeed, the legislature decided that access to Conciliation Commissions would be available only to "solve the problem of serious accidents. . . . The social efficiency of the process would be compromised if these commissions [were clogged] by a mass of records of minor accidents"⁵³

I will review three main points that characterize Conciliation Commissions: (1) the scope of their jurisdiction; (2) the role of the expert evaluation in their proceedings; and (3) their powers related to compensation.

50. In accordance with Article 6 of the European Human Rights Convention, access to the courts is a fundamental right with no exceptions. Commission Recommendation 98/257, *supra* note 44 ("Out-of-court procedures cannot be designed to replace court procedures; therefore, use of the out-of-court alternative may not deprive consumer of their right to bring the matter before the courts unless they expressly agree to do so, in full awareness of the facts and only after the dispute has materialised.").

51. In this case, each of the injured patients must be informed that a parallel process is being conducted.

52. The Commission is unique, and, for this reason, has the authority to examine both private and public medical accidents.

53. *Projet de loi relatif aux droits des malades et à la qualité du système de santé* [Bill on Patient Rights and the Quality of the Health System], Ass. Nat. 3258, 11th PARL. (2001).

A. The Jurisdiction of Conciliation Commissions

Parliament intended to limit the Conciliation Commissions' jurisdiction to patients who suffer from personal injuries that exceed a high threshold. These injuries include death, a permanent impairment affecting more than 25% of bodily capacity, or loss of employment for over six months.⁵⁴ For example, injuries causing paraplegia fit into this category, but injuries causing loss of vision in one eye do not. For injured patients, the difficulty is that their claims for compensation are only justiciable if their injuries are above the statutory threshold.

A Conciliation Commission must first conduct a preliminary investigation. While the Commission requires certain information to assess a claim, most claims for compensation are incomplete, often lacking vital documents, such as the medical record or the medical certificate certifying the injury.⁵⁵ Unfortunately, the Commission will close a case if the file remains incomplete despite several requests for patients to provide missing documents.⁵⁶ The second step is examining whether the request is justiciable. The Conciliation Commission must determine if the case meets the injury threshold granting it jurisdiction.⁵⁷ Cases that do not meet this threshold are dismissed.⁵⁸ For such cases, the Commission selects experts to evaluate the medical issues.⁵⁹

54. C. SANTE PUB. art. L. 1142-1 I.

55. See, e.g., COMMISSION NATIONALE DES ACCIDENTS MEDICAUX, RAPPORT ANNUEL AU PARLEMENT ET AU GOUVERNEMENT [NATIONAL COMMISSION ON MEDICAL ACCIDENTS, ANNUAL REPORT TO PARLIAMENT AND GOVERNMENT] 35 (2009-2010), available at http://www.cnamed.sante.gouv.fr/IMG/pdf/CNAMed_09-10.pdf.

56. The average time between the date of the request and the completion of the file is five weeks. *Id.* at 17.

57. For example, of the 4271 claims filed in 2009, 23% (984 cases) were dismissed for lack of jurisdiction, and experts were appointed in 77% of cases (3287 cases). *Id.* at 17.

58. This is referred to as a "negative outcome." This expression has been used by the National Commission on Medical Damages since the second report. COMMISSION NATIONALE DES ACCIDENTS MEDICAUX, RAPPORT ANNUEL AU PARLEMENT ET AU GOUVERNEMENT [NATIONAL COMMISSION ON MEDICAL ACCIDENTS, ANNUAL REPORT TO PARLIAMENT AND GOVERNMENT] 19 (2004-2005), available at http://www.cnamed.sante.gouv.fr/IMG/pdf/CNAMed_04-05.pdf.

59. Experts are required for the Commission to render an opinion. C. SANTE PUB. art. L. 1142-9.

B. *The Key Role of Experts in Conciliation Commissions*

In response to a governmental report⁶⁰ criticizing the lack of technical competence and the impartiality of experts⁶¹ used in medical lawsuits, Parliament sought to improve the assessment of medical treatment and patient injuries by creating an official body of experts.⁶² The Kouchner Act addresses three issues: (1) the designation of experts in medical injury or accident claims; (2) their choice by Conciliation Commissions; and (3) the role of the expertise.⁶³

1. *The designation of "experts in medical accidents" for medical injuries*

The Kouchner Act appointed the Medical Damages Commission as the authority to designate experts in medical injuries and accidents.⁶⁴ The Act established two main principles.⁶⁵ First, the analysis of facts must be performed by a practitioner in the relevant medical specialty.⁶⁶ For example, if the medical injury involves anesthesia, an anesthesiologist must evaluate the case. Second, the analysis of the harm caused by the injury should be subject to a careful evaluation because a medical specialist does not always have training in the evaluation of bodily impairment and disabilities.

Therefore, the Medical Damages Commission assesses every candidate who seeks registration as an "expert in medical accidents" to

60. INSPECTION GÉNÉRALE DES AFFAIRES SOCIALES ET INSPECTION GÉNÉRALE DES SERVICES JUDICIAIRES, RAPPORT SUR LA RESPONSABILITÉ MÉDICALE ET L'INDEMNISATION DE L'ALEA THERAPEUTIQUE [INSPECTOR GENERAL OF SOCIAL AFFAIRS AND INSPECTOR GENERAL OF JUDICIAL SERVICES, REPORT ON MEDICAL LIABILITY AND COMPENSATION FOR THERAPEUTIC HAZARDS] 43 (1999) ("[I]ndependence and technical competence are not always guaranteed by the current patterns of selection or controlled with sufficient vigilance.").

61. This report considered it necessary to guarantee the quality of expertise because, "in the absence of such expertise, thorough, independent and contradictory, in a word beyond reproach, doubt or suspicion would always remain in the mind of the victim as to the responsibility of the practitioner or health establishment." *Id.* at 72.

62. *Id.* at 74-75.

63. Loi 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé [Law 2002-303 of March 4, 2002 on Patients' Rights and Quality of the Health System], J.O., Mar. 4, 2002, p. 4118.

64. The Act uses the expression "experts in medical accidents," rather than "physician experts in medical accidents." C. SANTÉ PUB. art. L. 1142-10. A midwife, nurse, or physiotherapist can therefore apply for designation as an expert; but, in fact, the overwhelming majority of professionals applying for designation as experts are physicians.

65. See Dominique Thouvenin, *Commission nationale des accidents médicaux: Rôle et missions* [National Commission on Medical Accidents: Role and Mission], 520 REVUE HOSPITALIERE DE FRANCE [HOSPITAL REVIEW OF FRANCE] 60-63 (2008).

66. *Id.* at 61.

determine whether they have (1) technical competence in the medical specialty and (2) experience in evaluating physical impairment and disability.⁶⁷ If the physician is registered, the Medical Damages Commission specifies whether the physician is an expert regarding (1) the practice of a particular medical specialty, (2) the assessment of bodily impairment and loss of function, or (3) both of these matters.⁶⁸

2. *The choice of experts by the Conciliation Commissions*

The list of registered physicians drawn up by the Medical Damages Commission is passed on to the Conciliation Commissions, allowing them to choose the experts. The Act established the principle of collective expertise.⁶⁹ The Commission uses “a panel of experts chosen from the national list of experts in medical accidents,” but the Act recognizes that the Commission “may, however, when it considers appropriate, designate one expert selected on the same list.”⁷⁰

Two items are of interest. First, the Medical Damages Commission was created one year⁷¹ after the Conciliation Commission, and it took another year before a decree set conditions for appointment as an expert in medical claims.⁷² For this reason, initially, commissions were authorized to appoint individuals to evaluate cases from a separate list of court-appointed experts.⁷³ Therefore, between 2003 and 2008, Conciliation Commissions designated experts who were

67. Article L. 1142-11 of the Public Health Code prescribes that the Commission must conduct “an assessment of knowledge and professional practices.” Two members of this Commission review each application, including (1) information that the candidate supplies (his or her diploma, medical license, area of practice, development of medical skills, and publications) and (2) examples of the candidate’s previous expert reports. C. SANTÉ PUB. art. L. 1142-11.

68. See Thouvenin, *supra* note 64, at 61.

69. C. SANTÉ PUB. art. L. 1142-12.

70. *Id.*

71. Arrêté du 3 juin 2003 portant nomination à la Commission nationale des accidents médicaux instituée par l’article L. 1142-10 du code de la santé publique [Order of June 3, 2003 on Appointment to the Medical Damages Commission Provided for by Article L. 1142-10 of the Public Health Code], J.O., June 22, 2003, p. 10537.

72. Décret No. 2004-1405 du 23 décembre 2004 relatif à l’inscription sur la liste des experts en accidents médicaux prévue par l’article L.1142-10 du code de la santé publique [Decree No. 2004-1405 of December 23, 2004 on the Entry on the List of Medical Experts in Accidents Under Article L. 1142-10 of the Code of Public Health], J.O., Dec. 28, 2004, p. 22094.

73. The rules for nomination of court-appointed experts are fixed by the decree of December 31, 1974, J.O., Jan. 5, 1975, p. 264.

not on the selected experts list.⁷⁴ Second, adoption of the important practice of using a collective expert panel for evaluations rather than a single expert has increased over time.⁷⁵ However, it is still the practice in less than half of cases so far.⁷⁶ The reason expert panels have not been used more frequently is to reduce delays. The deadline for filing expert reports is three months for a single expert and four months for a panel of experts. In practice, however, it takes on average about five months to obtain the expert report.⁷⁷

Overall, the percentage of experts consulted has been relatively stable over time. About 60% of the experts consulted come from within surgical disciplines as well as gynecology-obstetrics and anesthesia-intensive care.⁷⁸ This provides an idea of practice specialties in which bad outcomes occur.

In France, under all legal codes (civil procedure, criminal procedure, and administrative procedure), court-appointed experts are neither witnesses nor decision-makers. The expert is a technician consulted to conduct examinations or assess facts.⁷⁹ The expert offers an opinion on a technical matter. The legal authority that chooses the expert can accept or reject the expert opinion. However, over the last twenty years, the role of experts has changed. Today, expert opinions do more than merely clarify issues—they are also key to determining the outcome of cases. In practice, experts are engaged in the decision-making process.⁸⁰

As a result, in reviewing one French medical malpractice case, the European Court of Human Rights considered that “*the question the expert was instructed to answer was identical with the one that the Court*

74. Their percentage has gradually decreased. The National Commission of Medical Damages stated, in its most recent report of 2009-2010, that only 8% of the designated experts were not on its selected experts list (while in the report of 2005-2006, there was still 16%). COMMISSION NATIONALE DES ACCIDENTS MÉDICAUX, *supra* note 54, at 21.

75. *Id.* at 20.

76. It was 45% in 2009-2010. This percentage is steadily increasing—41% last year, and 43%, 39%, and 27% in previous years. *Id.*

77. *Id.* at 22.

78. *Id.*

79. “The judge may commission any person of his choice to set him straight in the form of findings, consultation or an expertise on a question of fact that requires the insight of a *technician*.” NOUVEAU CODE DE PROCÉDURE CIVILE [N.C.P.C.] [NEW CODE OF CIVIL PROCEDURE] art. 232 (emphasis added). “The experts’ task is precisely set out in the decision ordering the expert opinion and may *only address the examination of technical questions*.” C. PR. PÉN art. 158 (emphasis added).

80. Robert Castel, *Savoirs d’expertise et production de normes* [Expert Knowledge and the Production of Norms], in FRANÇOIS CHAZEL ET JACQUES COMMAILLE, *NORMES JURIDIQUES ET RÉGULATION SOCIALE* [LEGAL RULES AND SOCIAL REGULATION] 177-188 (LGDJ, 1991).

had determined, namely whether the circumstances in which halothane had been administered to the applicants' daughter disclosed negligence on the part of the hospital" and that "thus, although the administrative court was not in law bound by the expert's findings, his report was likely to have a *preponderant influence on the assessment of the facts* by that court."⁸¹ Accordingly, the court decided "that compliance with the principle of adversarial procedure meant that where a court ordered the production of an expert report, *the parties should be able to challenge before the expert the evidence he had taken into account in carrying out his instructions.*"⁸²

The Conciliation Commissions are not courts, but the rules governing their use of experts are similar to those of courts. The Kouchner Act states that "the expert panel or the expert *ensures* the adversarial nature of expertise, which takes place in the presence of the parties These can be assisted by a person or persons of their choice. The team of experts or expert takes into consideration the observations of the parties and shall, upon request, report all relevant documents. One can take the initiative to seek the opinion of another professional."⁸³ If the Commission is unsatisfied with the expert report, it can appoint a new expert.

C. The Conciliation Commissions' Powers Regarding Compensation

After receiving the expert's report, the Conciliation Commission meets to review the case. It is not required to hear the claimant or other concerned parties, including medical providers, medical facilities, or their insurers.

The Conciliation Commission has two options. First, it may decide not to render an opinion when it holds there are no grounds for compensation, a situation which occurs in 54% of cases. These cases are rejected for the following reasons: (1) the damages fall below the minimum threshold (33%), (2) there was no causal relationship between the treatment and the disability (46%), and (3) there was no fault or inherent therapeutic risk covered by the law (17%). Second, the Commission may render an opinion indicating the damages sustained, whether a provider or medical facility is liable, and whether the injury is compensable by the Public Guarantee Fund. Its opinion

81. *Montovanelli v. France*, No. 8/1996/627/810, ¶ 36 (1997), <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=695900&portal=hbkm&source=externalbydocnumber> (last visited Dec. 8, 2011) (emphasis added).

82. *Id.* ¶ 31.

83. C. SANTÉ PUB. art. L. 1142-12 al. 7.

shall specify “the circumstances, causes, nature, and extent of the damage, as well as the compensation plan applied,”⁸⁴ but it lacks authority to recommend a level of settlement payment.

Overall, Commissions have found liability in half of cases and a right to Public Guarantee Fund compensation in the other half of cases.

1. *Are Conciliation Commission opinions binding?*

The law specifies that the Conciliation Commissions “*facilitate* the settlement of disputes relating to medical accidents,”⁸⁵ whether based on a fault or on an inherent therapeutic risk. The Commission lacks authority to impose a settlement on the claimant. It does not resolve the dispute, but it helps the person who considers himself the victim of a medical accident find a solution by examining the claim and, if the legal conditions are met, by the opinion it issues.

The opinion of the Commission is transmitted to all relevant parties: the claimant, medical professionals, medical facilities, private insurers, and the Public Guarantee Fund. In addition, the expert evaluation is attached to the opinion with all the documents submitted by the applicant.

A key question is whether private insurers and the Public Guarantee Fund are obligated to follow the opinion of a Conciliation Commission when it recommends they make payment. The two highest courts (the Council of State⁸⁶ and the Court of Cassation⁸⁷) decided that the Conciliation Commissions “are administrative commissions whose mission is to facilitate, by preparatory measures, a possible amicable settlement of disputes related to medical accidents.”⁸⁸ Because a Commission pronounces an opinion, both courts agree that the opinion issued by a Commission does not bind the insurer.

The dispute is not resolved by a settlement proposal because it is only on the basis of the opinion rendered that a victim will enter into negotiations. But as it is a question of opinion, the decision may not be followed by both the insurer and the Public Guarantee Fund. Also, it is possible that the victim does not agree with the opinion.

84. *Id.* art. L. 1142-8 al. 1.

85. *Id.* art. L. 1142-5 al. 1 (emphasis added).

86. CE, Oct. 10, 2007, Rec. Lebon 206590.

87. Cour de cassation [Cass.] [supreme court for judicial matters] 1e civ., May 6, 2010, Bull. civ. I, No. 09-66947.

88. *Id.*; CE, Oct. 10, 2007, Rec. Lebon 306590.

Several situations are possible. First, the victim may reject the opinion, believing that the assessment of the extent of his or her injury is insufficient. The Commission does not set any monetary value for a disability. It only appraises the extent of damages; for example, declaring that the patient sustained impairments of 30% of bodily capacity, or that the patient will need assistance for daily living activities for a certain number of hours each day. The patient cannot contest the Commission's finding regarding his or her level of disability. Therefore, if the victim does not agree with the opinion, the only option is to bring an action for damages in the court of competent jurisdiction.⁸⁹ But, if the action for damages is unsuccessful in court (because the court decides that the legal conditions for compensation are not met), the patient cannot later choose to accept any settlement offer previously made by the insurer or the Public Guarantee Fund.⁹⁰

Second, it must be determined whether a fault or an inherent therapeutic risk existed. In the first case (fault), within four months of receiving the Conciliation Commission, the firm that insures the responsible civil or administrative party has the option of making an offer of compensation as full settlement.⁹¹ But if the victim does not meet his or her legal burden, and his or her claim fails, the patient waives the right to later accept settlement offers previously made by the insurer or the Public Guarantee Fund. But an insurer only offers compensation if the victim agrees to be legally bound to the terms of the settlement. If the insurer makes an offer, acceptance of that transaction by the victim merits a transaction within the meaning of the Civil Code.⁹² Therefore, it ends any subsequent litigation—civil or administrative—based on the same claims. The victim may, however, present a new claim before the Conciliation Commission if the victim's health worsens.

89. C. SANTÉ PUB. art. L. 1142-8 al. 3.

90. "He cannot effectively rely on elements of the mutual agreement that he deliberately chose to leave." Tribunal de grande instance [TGI] [ordinary court of original jurisdiction] Rodez, May, 19, 2005, unpublished.

91. C. SANTÉ PUB. art. L. 1142-14 al. 1 ("[T]he insurer which guarantees the civil or administrative liability of the person held responsible by the board to redress the dependants of the victim, within four months of receiving notice, [may make] an offer of full compensation for harm suffered.").

92. C. CIV. art. 2044 ("A compromise is a contract by which the parties settle an arisen controversy, or prevent a controversy from arising. A compromise has the same effect as a judgment."); see also C. CIV. art. 2052 ("Compromises have, between the parties, the authority of *res judicata* of a final judgment.").

If the insurer does not make a settlement offer or refuses to pay the compensation,⁹³ the claimant has the right to seek compensation from the Public Guarantee Fund, which can then stand in the place of the insurer and offer the patient compensation.⁹⁴ If the patient accepts, then the Public Guarantee Fund may seek reimbursement from the private insurer by right of subrogation. If the insurer refuses to pay, the Public Guarantee Fund can seek to collect payment from the insurer in court. In several cases, private insurers that refused to make payment have won in court. This occurred when courts found an absence of necessary conditions to entitle the claimant to payment by the insurers. In these situation, the claimant does not lose the benefit, but the Public Guarantee Fund bears the cost.⁹⁵

In the second case (inherent therapeutic risk), "when the Conciliation Commission considers that the injury can be compensated by the Public Guarantee Fund," it "addresses to the victim, within four months after receiving the opinion, an offer of compensation for the full harm suffered."⁹⁶ Furthermore, since private insurers can refuse to pay compensation, the Public Guarantee Fund may also adopt this position if it finds that the victim's injury was not caused by inherent therapeutic risks.⁹⁷

IV. CONCLUSION

The necessary information is now available to assess the benefits and limitations of the new system. The use of the ADR process is optional because it is an alternative to courts. As a result, injured patients can seek compensation through the Conciliation Commissions⁹⁸ and subsequently seek remedies through courts, or they can

93. C. SANTÉ PUB. art. L. 1142-15 al. 1 ("In case of silence or explicit rejection of the insurer to make an offer" the Public Guarantee Fund "is substituted for the insurer.") (emphasis added).

94. *Id.* art. L. 1142-15 al. 2 ("In this case, the provisions of Article L. 1142-14, particularly relating to the offer of compensation and payment of allowances, apply to the office. . . .") (emphasis added). These are the conditions of the offer to the medical liability insurer.

95. In its latest progress report, the Public Guarantee Fund indicates that from 2007 to 2010, 880 cases resulted in substitution. Of the €1,671,359 at stake in the litigation, for which a lasting solution was found in 2010, €193,167, or 71%, was recovered, either in litigation or in the framework of a mutual agreement with the insurance company. 2010 REPORT, *supra* note 29.

96. C. SANTÉ PUB. art. L. 1142-17.

97. The refusal rate is low, however, only comprising 6% of all opinions issued in 2010. See 2010 REPORT, *supra* note 29, at 13.

98. The Council of State decided that "the use of this procedure by the victim is not exclusive to the referred competent court of an action for damages, which may intervene by the ini-

proceed to courts directly. It is clear that the Conciliation Commissions enable people who have never had access to justice to obtain redress. This point is made by Dominique Martin,⁹⁹ Director of the Public Guarantee Fund since its inception.¹⁰⁰

Overall, patients' associations are satisfied with the new Conciliation Commissions because they are free,¹⁰¹ they require no recourse to a lawyer, and they appear to have shorter processing times than litigation. The patients' associations note, however, an imbalance detrimental to victims when the Conciliation Commissions hold their meetings; professionals and health establishments are systematically surrounded by boards, while the victim is often alone and distressed by the questions asked.¹⁰²

But the virtues of the Conciliation Commissions are tempered by two main limitations: their restriction to serious accidents and their lack of authority to settle disputes. First, as the lawyers specializing in these issues and the patients' associations immediately noted, restricting the jurisdiction of Conciliation Commissions to serious accidents reduces their benefit.¹⁰³ The legislature set a high injury threshold because it feared an influx of requests¹⁰⁴ and wanted to avoid encumbering Conciliation Commissions with a mass of minor

tative of the victim prior to the initiation, or during it, after the failure of the attempted settlement." CE, Oct. 10, 2007, Rec. Lebon 306590.

99. Dominique Martin is now the Director of Risk Management of the National Health Insurance (since October 3, 2011).

100. Dominique Martin, *Indemnisation: La voie du règlement amiable* [Compensation: The Way of Friendly Settlement] 520 REVUE HOSPITALIERE DE FRANCE [HOSPITAL REVIEW OF FRANCE] 50, 74-75 (2008).

101. The cost of expertise is supported by the Public Guarantee Fund. According to its latest annual report, "[T]he expert's fees remained stable (€2.96 million in 2009 and €3.07 million in 2010) despite the increase in the number of expedited expertise (expertise in 2009 was 3243 compared to 3992 in 2010, an increase of 23%)." 2010 REPORT, *supra* note 29.

102. For example, the Association for Assistance to Victims of Personal Injury notes that "[t]he victim is alone with the opposing party and the various medical experts and lawyers appointed by the various insurance practitioners or institutions in question." *Les Limites de la Loi Kouchner* [The Limits of the Kouchner Act], ASSOCIATION D'AIDE AUX VICTIMES D'ACCIDENTS CORPORELS [ASSOCIATION FOR ASSISTANCE TO VICTIMS OF PERSONAL INJURY], http://www.aavac.asso.fr/loi_kouchner/loi_4_mars_2002_limites_loi_kouchner.php (last visited Dec. 9, 2011).

103. For example, the Association for Assistance to Victims of Personal Injury notes that "access to compensation boards is determined by the severity of consequences" and believes "it is, without doubt, one of the worst provisions of the law." *Id.*

104. There were an estimated 10,000 requests during the first year of operation of the Conciliation Commissions. An impact study was requested by the Government prior to the adoption of the bill, but is no longer on the official website of the National Assembly (eleventh Legislature 1997-2002). These statements are based on the author's memory of this study provided by Claude Evin.

accidents. But the access to the Conciliation Commissions is very broad¹⁰⁵ because it is not possible to know immediately the severity of an injury, except in cases of death. So Conciliation Commissions initially consider a very large number of claims¹⁰⁶ to avoid depriving victims of the benefit of expertise. This choice implies that Conciliation Commissions will reject many claims after they receive expert evaluation and determine that the claimant's injury falls below the threshold, a disappointing occurrence for victims who then have their cases closed without an opinion. Twenty-five percent of initial requests are rejected for failing to meet the requisite threshold, but about 30% of files that remain after evaluation by experts are later rejected.¹⁰⁷ Therefore, the Interassociation Health Collective¹⁰⁸ advocates lowering the threshold from 25% to 15%.¹⁰⁹

Second, the Kouchner Act does not give Conciliation Commissions the power to make binding decisions or to recommend the level of compensation. Commissions do not resolve disputes; they assist by providing expert evaluation and an opinion,¹¹⁰ which the victim and insurer can use as the basis for discussion if they wish to reach a settlement outside of court. But insurers and the Public Guarantee Fund may choose not to offer compensation since they are not required to follow Conciliation Commission opinions.¹¹¹

When the insurer refuses to offer compensation, the victim may seek payment from the Public Guarantee Fund, which can act as a financial guarantor. This seems to be the Achilles' heel of the sys-

105. It can be utilized by "any person who is believed to be a victim of damages attributable to" a medical accident. C. SANTÉ PUB. art. L. 1142-7.

106. COMMISSION NATIONALE DES ACCIDENTS MÉDICAUX, RAPPORT ANNUEL AU PARLEMENT ET AU GOUVERNEMENT [NATIONAL COMMISSION ON MEDICAL ACCIDENTS, ANNUAL REPORT TO PARLIAMENT AND GOVERNMENT] 42 (2006-2007), available at http://www.cnamed.sante.gouv.fr/IMG/pdf/Rapport_CNAMED_06-07.pdf.

107. Figures obtained by analyzing the CNAMed reports made since 2004. See *id.*; *Les rapports de la CNAMed au Parlement et au Gouvernement* [CNAMed Reports to Parliament and Government], COMMISSION NATIONALE DES ACCIDENTS MÉDICAUX, <http://www.cnamed.sante.gouv.fr/Les-rapports-de-la-CNAMED-au.html>.

108. It brings together thirty-two associations involved in the health field. See COLLECTIF INTERASSOCIATIF SUR LA SANTE [INTERASSOCIATIVE GROUP ON HEALTH], <http://www.leciss.org> (last visited Dec. 9, 2011).

109. COLLECTIF INTERASSOCIATIF SUR LA SANTÉ, SANTÉ: CHANGER DE LOGICIEL! [INTERASSOCIATIVE GROUP ON HEALTH: CHANGE SOFTWARE!], 5, 70, available at http://www.leciss.org/sites/default/files/Livre-blanc-CISS_Sante-Changer-de-Logiciel_BasseDef.pdf.

110. When conditions are right to render it, it must be sent with the expert report to the insurer and to the Public Guarantee Fund to determine whether compensation for the damages should be accepted. C. SANTÉ PUB. art. L. 1142-9.

111. *Id.* art. L. 1142-15.

tem. When the insurer refuses to offer compensation, it is usually because it believes that it is not legally liable, contrary to the opinion of the Conciliation Commission. The result is secondary litigation¹¹² initiated by the Public Guarantee Fund, which aims to raise recovery from the current rate of 71% to 100% and to have courts establish what constitutes inherent therapeutic hazards that are the responsibility of the Public Guarantee Fund.¹¹³

However, when the refusal emanates from the insurer to terminate the procedure, and because the opinion does not become mandatory, the victim may file with the Public Guarantee Fund, which replaces the insurer in order to make an offer.¹¹⁴ In a way, it acts as a financial guarantor so that the victim is compensated. This solution seems to be the Achilles' heel of the system established by the 2002 Act for the following reasons: when the insurer refuses to make an offer, it is usually because it believes that the conditions of liability are not met, or that the accident should be compensated by the Public Guarantee Fund. Of course, it then turns against the insurer to recover the amount of compensation paid to the victim. But because it refused to compensate the accident, one can argue that the insurer can no longer accept reimbursement in the amount that is claimed from the Public Guarantee Fund. This refusal is explained not by any ill will, but because the insurer genuinely believes, at the time the claim was initially filed, that the victim was not entitled to compensation.

In closing, more analysis of medical accidents, which constitute a major social issue, is needed. They are a problem for injured patients as well as for professionals and health institutions required to bear the cost of insurance for such accidents, and for the Public Guarantee Fund, which compensates inherent therapeutic hazards. We now have a complex system for allocating costs of accidents¹¹⁵ borne by

112. According to the Activity Report of the Fund, "[L]itigation occupies an increasing share in the activity of the institution under medical accidents: the active file is over 1500 files." 2010 REPORT, *supra* note 29, at 24.

113. This choice is a "direct application of public policy conducted by the institution." It seeks, under the supervision of the judge, to bring out clear criteria for identifying medical malpractice, as opposed to therapeutic hazard, because "the fair definition of the border between intervention of national solidarity and compensation from the traditional tort liability regime, particularly the separation of misconduct from therapeutic hazard, is a major issue for the sustainability of the system." *Id.* at 25.

114. C. SANTÉ PUB. art. L. 1142-15.

115. See THIERRY KIRAT, *ÉCONOMIE DU DROIT* [ECONOMICS OF LAW] 91 (1999).

the victim, the wrongdoer, and the general public.¹¹⁶ But many questions remain. To better understand the cost of claims and to identify the most avoidable accidents, the Observatory of Medical Risks was created in 2005.¹¹⁷ Founded initially with the aim of improving information on medical liability insurance, as well as to ensure that professionals paid adequate premiums, its mission is now the analysis of all “data relating to medical accidents, iatrogenic and nosocomial infections, and their compensation and all financial or other consequences that flow from them.”¹¹⁸ The 2010 ONIAM report provides interesting information on methods of settlement, the investigations, the circumstances surrounding accidents, their nature, and the relevant specialties in which accidents frequently occur.¹¹⁹

Current data is valuable, but we still lack clear data on the distribution of claims among different kinds of medical interventions. We also lack information about how Conciliation Commissions and courts assess accountability for inherent therapeutic risks and the extent to which there are differences in compensation between those victims who proceed to bring their claims in court and those who reach a settlement with the insurer or the ONIAM through the ADR process.

The Kouchner Act should be commended for bringing undeniable improvements. Yet, the fact remains that with the creation of a new right to compensation and the availability of new means to settle disputes, there are new potential sources of disparities between fault and no-fault compensation, as well as differences between compensation based on settlement outside of courts and settlement through litigation. Such differences create new inequities among victims of medical accidents.

We do not know, however, whether these disparities are present, and if so, whether differences in compensation are large or frequent. Reliable data detailing strategies used by victims of medical accidents and whether they seek compensation mainly through Concili-

116. This includes social security, which supports health care costs generated by medical accident. See G'ssell-Macrez, *supra* note 46, at 1093. The expression “social security” in France refers to the public social insurance system, which mostly covers health care like Medicare or Medicaid in the United States, or publicly funded retirement pensions. *Id.* at 1093 n.4.

117. The “observatoire des risques médicaux” is attached to ONIAM. *Id.* at 1122; see also *Observatoire de risques médicaux (ORM)* [Observatory of Medical Risk], OFFICE NATIONAL D'INDEMNISATION DES ACCIDENTS MÉDICAUX [NATIONAL OFFICE OF MEDICAL ACCIDENT COMPENSATION], <http://www.oniam.fr/bases-de-donnees/observatoire-des-risques-medicaux-orm> (last visited Dec. 9, 2011).

118. C. SANTÉ PUB. art. L. 1142-29.

119. See 2010 REPORT, *supra* note 29.

ation Commissions or litigation is also unavailable. It is equally important to know what criteria insurers and courts use to determine compensation in order to verify whether there is unequal treatment for identical accidents.¹²⁰

120. It is frequently asserted that the ADR process yields less generous compensation than legal action. But to check the accuracy of this assertion, it is necessary to conduct a comparative study. For a discussion of the methods that could be used to compare the two systems, see EVELYNE SERVERIN, *L'ACCIDENT CORPOREL DE LA CIRCULATION, ENTRE TRANSACTIONNEL ET JURIDICTIONNEL* [TRAFFIC ACCIDENT PERSONAL INJURIES: BETWEEN SETTLEMENTS AND LAWSUITS] (1997); Evelyne Serverin, *Negotiation of Disputed Rights or How the Law Comes to Economics*, in *LAW AND ECONOMICS IN CIVIL LAW COUNTRIES* 43-60 (Bruno Deffains & Thierry Kirat eds., 2001).

SIDEBAR 1: THE CONCEPT OF SOLIDARITY

Solidarity is a fundamental French political idea that became prominent in the nineteenth century. Its roots lie in the ideal of “Fraternity,” articulated in the French Revolution motto: “Liberty, Equality, and Fraternity.” As Professor Gérard Soulier explains, “Solidarity or fraternity: the idea is the same on the political level; it comes to substitute the charity or benevolence which are the marks of the unequal society of the ‘Old Régime’ by mutual support and mutual aid that seem natural in a society of equal citizens.”¹²¹

Since the late nineteenth century, solidarity served as a foundation¹²² for the French State model, which is based on the idea that “every citizen contributes to social development and in return, society undertakes to correct injustice, and establish or reestablish equality.”¹²³ This doctrine has prompted the development of the welfare state and social legislation, and the theoretical and practical expansion of public service. Solidarity has been linked to the consolidation of the Republic in France. It is part of French republican ethics.

In the aftermath of World War II, the Preamble to the Constitution of October 27, 1946,¹²⁴ proclaimed that the nation “guarantees to all, particularly children, mothers and elderly workers, protection of health, material security, rest and recreation” via “solidarity and equality of all French burdens resulting from national calamities.” Examples of such state relief include the 1946 budget’s inclusion of a special tariff, the solidarity tax, and thirty years later, following a severe drought, Parliament’s enactment of a drought tax to relieve financially distressed farmers.

121. G. S., *Verbo Solidarité [Solidarity]*, in *LE DICTIONNAIRE CULTUREL EN LANGUE FRANÇAISE* 864, 864 (Alain Rey ed., 2005).

122. The policy of solidarity was theorized by Léon Bourgeois, who was the *président du Conseil*. His texts on the topic include LEON BOURGEOIS, *SOLIDARITE* (Nabu Press 2010) (1896) and LEON BOURGEOIS, *ESSAI D’UNE PHILOSOPHIE DE LA SOLIDARITE* (Nabu Press 2011) (1902).

123. G. S., *supra* note 120, at 865.

124. This preamble remains in force in the current Constitution, the Constitution of October 4, 1958, which explicitly states, “The French people solemnly proclaim their attachment to the Rights of Man and the principles of national sovereignty as defined by the Declaration of 1789, confirmed and complemented by the Preamble to the Constitution of 1946.” 1958 CONST. pmbl., para. 1 (emphasis added), available at http://www.conseil-constitutionnel.fr/conseil-constitutionnel/root/bank_mm/anglais/constiution_anglais_oct2009.pdf.

The French social security system was created after the Second World War¹²⁵ pursuant to the same principles.¹²⁶ The current French Social Security Code states that “the organization of social security is founded on the principle of national solidarity.”¹²⁷ All individuals are obligated to contribute financially to the social security system, which provides for social benefits including health care, via payroll charges¹²⁸ based on earned income. The social security system entitles each sick person to reimbursement for care under conditions that are the same for all.

Social security in France is therefore a unified system because collective financing enables the management of social support. Benefits are disconnected from the amounts paid by each socially insured person, allowing redistribution among all those socially insured. That is, all those who contribute and do not need assistance make it possible to cover the care for those who are sick. This system is the antithesis of private insurance. Individuals who are socially insured are not subject to premiums based on individual risk factors such as age, sex, or medical history; the system avoids these discriminations.

125. Ordonnance 45-2250 du 4 octobre 1945 portant organisation de la Sécurité Sociale [Ordonnance 45-2250 of October 4, 1945 on the Organization of Social Security], J.O., Oct. 6, 1945, p. 6280 (“[T]here shall be established an organization of social security.”).

126. There existed a tendency during the war to place social security among the priority concerns of states. A report by Lord William Beveridge played a particularly prominent role in the discussions surrounding the potential adoption of a social security system. SIR WILLIAM BEVERIDGE, *SOCIAL INSURANCE AND ALLIED SERVICES* (1942).

127. CODE DE LA SÉCURITÉ SOCIALE [C. SEC. SOC.] [SOCIAL SECURITY CODE] art. L. 111-1.

[Social security] guarantees workers and their families against the risks of any kind which can reduce or eliminate their earning capacity. It also covers the costs of maternity and family responsibilities. It provides for all others person and for family members residing on French territory, covering the expenses of sickness and maternity.

Id.

128. Assorted taxes used to finance social security have been created, including the general social contribution (CSG), which was introduced on December 29, 1990, Loi de finances pour 1991, 90-1168 du 29 décembre 1990 [Law 90-1168 of December 29, 1991 on Finances for 1991], J.O., Dec. 30, 1990, p. 16367. It is defined in C. SEC. SOC. art. L136-1.

SIDEBAR 2: DATA FROM THE 2010 REPORT OF THE MEDICAL ACCIDENTS OBSERVATORY¹²⁹*Mission of the Medical Accidents Observatory*

The Medical Accidents Observatory analyzes data on medical accidents, iatrogenic and nosocomial infections, their compensation, and the financial and other consequences that flow from them. The data is reported by professionals, health organizations, insurers,¹³⁰ Conciliation Commissions, the Public Guarantee Fund, and the Insurance Firms and Mutuals Regulator.¹³¹ The database used for the 2010 report included more than 4000 cases of medical accidents that settled for €15,000 or more and that occurred between 2006 and 2009. The total payment amount for this time period was €470,790,080.

Payments

Settlement amount calculations reflected compensation paid to victims and those having the right to claims of social organizations.¹³² The average payment amount was €115,333.

Payments charged to the Public Guarantee Fund only occurred in 38.6% of cases, yet accounted for 53% of total payments. The aver-

129. This sidebar summarizes data reported in an overview of the 2010 report of the Medical Accidents Observatory. OBSERVATOIRE DE RISQUES MÉDICAUX, RAPPORT 2010 DE L'OBSERVATOIRE DES RISQUES MÉDICAUX [2010 REPORT OF THE MEDICAL ACCIDENTS OBSERVATORY] 5-7 (2010).

130. Insurers include institutions responsible for their own insurance. Public assistance hospitals in Paris are one such example.

131. The Ordinance of January 21, 2010, integrated the Insurance Firms and Mutuals Regulator (*Autorité de Contrôle des assurances et des mutuelles*) into the French Prudential Authority (*Autorité de Contrôle Prudentiel*), an independent entity operating under the auspices of the French Central Bank, and tasked with ensuring the stability of the financial system and protecting banking and insurance customers. Ordonnance 2010-76 du 21 janvier 2010 portant fusion des autorités d'agrément et de contrôle de la banque et de l'assurance [Ordinance 2010-76 of January 21, 2010 on the Merger with the Authorities for Approval and Control of the Bank and Insurance], J.O., Jan. 22, 2010, p. 1392 (ratified as Loi 2010-1249 art. 12.1 du 22 octobre 2010 de régulation bancaire et financière [Law 2010-12499 art. 12.1 of October 22, 2010 on the Regulation of Banking and Finance], J.O. Oct. 23, 2010, p. 18984).

132. Compensation includes social security and mutuals. Social security comprises mandatory public insurance to cover major social risks, including medical expenses, maternity care, lost income due to industrial accidents and occupational diseases, disability, death, pensions and retirement benefits, and supplemental income for families. Mutual societies sell optional complementary health insurance that covers medical expenses not covered by social security.

age Public Guarantee Fund payment was about 1.8 times higher than insurer payments. This is attributable to the fact that the Public Guarantee Fund only provides compensation for serious injuries.

Interestingly, about 50% of cases accounted for just over 10% of the total amounts paid, while 1% of cases accounted for nearly 20%. The specifics were as follows:

- Approximately 50% of cases consisted of payments between €15,000 and €50,000; these cases accounted for only 12% of the global payment amount.
- Roughly 38% of cases involved payments between €50,000 and €200,000; these cases accounted for 30% of the total payments amount.
- Less than 12% of cases consisted of payments between €200,000 and €1 million; these cases accounted for 39% of the global settlement payouts.
- Approximately 1% of cases involved payments in excess of €1 million; these cases accounted for 19% of the total settlement payments.
- Thirteen cases had settlements of more than €2 million; these cases accounted for more than 10% of the total payments amount.

Forty percent of claims were filed in the same year as the injury occurred; 80% were filed within two years. Five percent of cases involved claims made five or more years after the injury occurred.

One-third of the cases were settled in less than two years. Twenty percent of cases took approximately five years to settle, and 10% took more than ten.

Seventy percent of cases settled without litigation. Eighty percent of these nonlitigious cases had been reviewed by a Conciliation Commission. Ninety-eight percent of cases handled by the Public Guarantee Fund were settled without litigation. Fifty-two percent of insurer-handled cases were settled amicably.

Cases settled without litigation accounted for 78% of the total payments amount. The average payment for cases settled without litigation was 50% greater than the average payment in litigated cases.

Accidents

Medical care was the primary cause of accidents, responsible for 85% of cases. Inherent therapeutic risks were the most frequent

cause of injuries (34% of cases), followed by negligence (27% of cases). Eighteen percent of cases involved nosocomial infections. Organizational misconduct occurred in 4% of cases, and 3% of cases involved accidents due to prescription or product dispensing issues. The nature of the accident was unknown in 1% of cases; the remaining 14% of cases involved other or unknown causes.

Specialties

The average payment amount was just over €115,000. Payment amounts varied per physician specialty. Surgical disciplines, excluding obstetrics and cosmetic surgery, were the main source of cases (accounting for nearly 60%). These cases, in turn, accounted for €280 million worth of payments, and thus accounted for the largest proportion of the total payments amount.

The disciplines of anesthesia, resuscitation, and emergency medicine accounted for more than 260 cases and €41 million in payments (an average of nearly €160,000 per case). Other disciplines, besides laboratory testing and pathology, accounted for 502 cases and €71 million in payments, resulting in a payment average of just over €140,000. Obstetricians accounted for 172 cases and €17 million in compensation, with an average payment amount of €97,000. Midwives accounted for seven cases and €1.7 million in settlement payments.

Trends

The number of compensated cases generally increased over the four-year time period, but the growth trajectory varied depending on whether compensation stemmed from the Public Guarantee Fund or from an insurer. Cases compensated by the Public Guarantee Fund grew steadily from 2006 to 2009. However, cases compensated by insurers displayed an irregular growth pattern: there was an overall increase in cases between 2006 and 2009 but an unexplained decrease in 2008.

The proportion of cases compensated for acts of care, by far the leading cause of accidents, had increased over the four-year period (from 80% of cases in 2006 to 89% in 2009). The proportion of cases compensated for medical misdiagnosis, however, declined (from 11% of cases in 2006 to approximately 6% in 2009).

The number of cases compensated for injuries stemming from inherent therapeutic risks increased significantly and steadily between

2006 and 2009 (to 1.5 times the number of cases compensated for acts of negligence). The proportion of cases involving nosocomial infections remained stable over the four-year period (occurring in 17% to 18% of cases).

In 2006, surgical specialties other than obstetrics and aesthetics accounted for more than 50% of compensated cases; this proportion increased to more than 60% in 2008 and 2009.