MEDICINE, LAW & SOCIETY
Vol. 9, No. 2, pp. 73 - 84, October 2016

No Fault Compensation for Medical Injuries

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Abstract For decades in both Europe and the United states , the issue of compensation for victims of medical injuries has led to lively debates. Many scholars have analyzed the adverse effects of the „tort system" (based on negligence standards and court proceedings) on the increasing costs of insurance premiums, on the patient-doctor relationship and the quality of care. These debates have led to changes in compensation in some countries. Compensation would be based not on negligence, but rather on a broader avoidable medical injury standard. Some nations have long operated administrative schemes based on no fault principle. No fault compensaton model for victims of medical injuries might be characterized by the choices it makes regarding some key issues: (a) the definiton of compensation criteria in particular the status given to fault; (b) the organization of the decision-making process. What type of body adjudicates medical claims? (c) Who finances the mechanism. What injuries are likely to be compensated for, to what extent and by whom? This article reviews the origins and operations of the no fault systems, the evolution of their compensation criteria, and how these criteria are actually applied.

KEYWORDS: injury • compensation • liability • medical • errors • negligence

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DOI 10.18690/24637955.9.2.73-84(2016)
ISSN 2463-7955 Print
Available online at http://journals.um.si.

1 Introduction

In classic civil law, patients, doctors and medical institutions that treat the patient are in a legal relationship. This generally applies to both the so-called Anglo-Saxon as well as continental legal systems, even though theoretical differences in terms of the exact nature of this relationship can be found in both groups (Merry & McCall, 2008; Heberer, 2013). However, in both systems the assessment of compensation for any damage caused by a medical treatment relies on finding the provider at fault. If there is no fault, there is also no liability for damages in this legal relationship (Heberer, 2013; Studdert & Brennan, 2001; Farrell, Devaney & Dar, 2010). Legal situation in Slovenia is similar. In Slovenia, the liability of doctors for damages is not regulated by a special act, and general provisions on liability under the Code of Obligations (OZ) apply in this respect instead. In Slovenian legal system, the liability for medical errors is possible on both contractual and tort basis, although always in accordance with the principle of guilt (Samec Berghaus & Pristovšek, 2016). The liability of doctors and medical institutions is thus based solely on negligence and on each of its degrees. In case of the civil liability of a doctor, unlike in criminal liability, slight negligence, which is assessed as an objective category, with objective criteria for negligence, is sufficient. In order to determine negligence, courts in civil litigation examine whether a doctor performed medical activity in accordance with standards of professional diligence, or standards of professional expertise, acquired by a similar doctor in the same line of work and under similar circumstances. For the establishment and assessment of liability for damages or damage (pecuniary and non-pecuniary) in civil litigation, it is necessary to define and clarify individual presumptions that must be simultaneously fulfilled - wrongful, harmful conduct or unlawfulness, causal link, damage and liability. A fair pecuniary compensation brings a certain sense of satisfaction to the injured party, which should alleviate his or her problems. The purpose of the compensation for non-pecuniary damage is neither the repayment of damage nor the punishment of the person who caused the damage (injuring party). The established Slovenian case law also emphasises the function of compensation or reparation in case of the pecuniary damage and satisfaction in case of the non-pecuniary damage.[1]

The assessment of appropriate compensation for any damage suffered during or after medical treatment in civil litigation, and therefore in accordance with the principles of classical civil law, was frequently a target of serious legal, medical and public criticism (Merry & McCall, 2008; Farrell, Devaney & Dar, 2010; Ferguson & Laurie, 2016; Oliphant & Wright, 2013; Durant, 2008; Kachalia et al. 2008). Patients are complaining that medical procedures are long and result in high costs that not everyone can afford (Studdert & Brennan, 2001). In countries with Anglo-Saxon legal system, professional insurance premiums are so high that they affect the medical profession. All presumptions that must be determined and clarified in the assessment of compensation for any damages suffered during a medical treatment were heavily criticised. In medical procedures, it is often very

difficult to distinguish between a complication and medical error (Flis, 1994). Proving wrongful harmful conduct can be challenging and time-consuming, while the so-called objective criteria for negligence can be very vague[2].The so-called standard of assessment of a doctor in the same line of work under similar circumstances could be controversial (Moffet & Moore, 2011). An example in the Anglo-Saxon law is the Bolam test, according to which a doctor is not held liable if he or she practices his or her profession in the same way as most other doctors, even though better medical procedures might exist or other specialists in a specific field of medicine might differ in their opinion[3]. Even the understanding or interpretation of the standard of professional diligence and duty (Moffet & Moore, 2011), as well as the causal link and the understanding of the purpose of possible compensation and its amount[4] may be disputed (Merry & McCall, 2008). Critics of the "classical" fault-based system further argue that it forces doctors to practice the so-called defensive medicine, which may be harmful to patients. It increases tensions between the doctor and the patient and undermines the partnership model of their relationship. Fault-finding frequently hinders broader analysis of systemic errors in healthcare, since the employees resists such actions, and, according to critics, leads to the concealment of medical errors and hinders the process of the prevention of medical errors and further research of medical models that could lead to the improved safety of patients (Merry & McCall, 2008). A detailed analysis of some major disasters (the Chernobyl disaster, the Space Shuttle Challenger disaster, etc.) has shown that accidents or severe mistakes are usually a consequence of a sequence and a long series of "latent" errors in complex systems, while the mismanagement by individuals arises as a "necessary consequence" of an inadequately organised system (Reason, 1990). The aforementioned and numerous other critics of "classical" civil legal system of fault-finding in case of medical injuries have led to a further research of new models in the pursuit of suitable compensation in such cases (Farrell, Devaney & Dar, 2010; Danzon, 1994; Barbot, Parizot & Winance, 2014; Serwach, 2015). In Anglo-Saxon legal system, the altered model is called "no-fault compensation", in French "*indemnisation sans faute*", in German "*verschuldensunabhaengige Patientenentshaedigung*", while Sweden was the first country to implement it in practice (Danzon, 1994). Later on, the fundamentals of the Swedish model were adopted by Norway, Denmark, Finland and Iceland, even though the so-called Nordic model differs in the respective countries (Kachalia et al., 2008). A similar but less comprehensive regulation of no fault compensation for medical injuries applies in France, Belgium, Poland, partly in Austria, and in the Anglo-Saxon legal system in New Zealand and to a limited extent in some U.S. states (Florida, Virginia for nervous defects that occurred in the course of childbirth) (Farrell, Devaney & Dar, 2010; Kachalia et al., 2008; Barbot, Parizot & Winance, 2014).

The advantages of the no fault compensation for medical injuries are mainly based on the fact that they are dependent only on the event (deterioration of health as a consequence of a medical treatment) and that administrative procedure for compensation is supposed to be easier, faster, cheaper and less complicated for the

patients (Barbot, Parizot & Winance, 2014). A more detailed analysis of individual systems, however, demonstrates that complications already arise over the basic definition of the concept - what is a medical injury? The term "medical error" is deliberately not applied, since such designation already points to the person at fault. The term "medical injury" should cover any physical impairment or deterioration of health that occur during medical treatment and are not a result of the natural course of disease. This terminology is important because it influences a decision-making process, although it is substantively and conceptually different in individual "no fault" systems. Any such designation exposes the issue of causation, which has to be proven even in the so-called "no fault" systems - there is a causal link between the process of medical treatment or the patient's stay in a healthcare facility and the occurrence of medical injury which is not related to the natural course of disease (Hoffman, 2009). If there is no causal link, there is no compensation in "no fault" systems either. If it is necessary to prove causation, additional questions naturally arise. What and which exactly are the criteria for compensation? Which body decides whether and when someone is entitled to compensation without fault-finding? How to guarantee the neutrality of such body? What impact do the decisions of such body have on "classical" civil litigation? Who provides the funds for compensation? The purpose of this article is to analyse some of these issues raised in various "no fault" systems.

2 Sweden and the Nordic scheme

Sweden has already implemented special insurance for patients in 1975. It was voluntary. In 1997, it was replaced by a new act, which introduced compulsory insurance - Patient Insurance Act (Johansson, 2010). The act established a public institute (Swedish Patient Insurance Association), which processes all patients' claims related to the issue of compensation. The institute is financed primarily by insurance premiums that have to be paid by healthcare providers. The institute has its own insurance company. The Swedish scheme classifies claims for compensation for medical injuries into five categories: a) treatment injury; b) diagnostic injury; c) material-related injury; d) infection injury; and e) accident-related injury. In the appeal procedure, it is necessary to prove causation (injury or damage to health is associated with medical treatment and is not a result of the natural course of the disease). Any injuries or damage to health that are caused by incorrect medication are covered under a separate scheme. The criterion for compensation is not the proof of fault but the question whether the injury or damage to health could have been avoided. The avoidability rule has thus replaced the concept of negligence. A similar schemes operate in Norway, Finland and Iceland. These countries amended their own legislation in this field in 2006. The common name for no-fault compensation for medical injuries in these countries is Nordic scheme. There are some minor differences between the countries, but not to the extent that would make it impossible to talk about a common scheme (Farrell, Devaney & Dar, 2010; Kachalia et al., 2008).

The focus does not lie in whether medical treatment was performed in accordance with appropriate professional standards or whether other average doctors would have acted in a similar way under similar circumstances. Rather, the question arises whether an experienced specialist in the same field would have taken the same approach under optimal circumstances. We are therefore talking about a much higher standard than is ordinarily used by courts in civil litigation (these are no longer standards of expertise of a similar doctor in the same line of work under similar circumstances but the expertise of *the best specialist under optimal circumstances*). In certain cases, the evaluation of events might even deviate from the principle of "ex ante" - a retrospective assessment is therefore exceptionally permitted. The application of the criterion of alternative procedures is allowed as well: if there is a medical procedure in use that is equivalent and equally safe, and it would be possible to avoid physical impairment (deterioration of health) in case of its implementation, then the patient is entitled to compensation (Kachalia et al., 2008). This principle has its limits. It is not applicable when two completely equivalent methods exist (Kachalia et al., 2008).

A statute of limitation on the patient's claim expires three years from the moment that the patient became aware of the injury or ten years from the time the injury occurred. The patient submits a claim with the institute (Swedish Patient Insurance Association) by him- or herself, or it may be submitted by his or her relatives after his or her death. The appeal procedure is conducted without charge. The claim is considered by a special employee of the institute ("handler" - Swedish Patient Insurance Association), who has clinical or legal background, or both. His role partly corresponds to that of the Patient Ombudsman in Slovenia and partly to that of the insurance liquidator in insurance companies. This person has the right to access all medical records. In disputed cases, he or she can consult experienced specialists in different fields of medicine. If a decision is reached that the claim for compensation is justified, compensation is paid for pecuniary and non-pecuniary damage, or it can also be paid with a lump sum that covers both. Regulated are both the minimum and maximum amounts of compensation. On average, the payment amounts to about 22,000 US dollars (Kachalia et al., 2008). Compensation is granted in approximately 45 % of submitted claims, the rest are rejected. This means that every second claim is rejected. If a patient does not agree with the decision, he or she may appeal to the next instance. The Patient Claims Panel is a part of the institute (Swedish Patient Insurance Association) and usually consists of seven members. If a patient is not satisfied with the decision of the Panel either, he or she may appeal to the court in the "classical procedure" of civil litigation. If his or her appeal to the court is successful, the amount of payment is the same as if the compensation had been awarded by the institute (Kachalia et al., 2008). Approximately eighty percent of all claims are decided within the first eight months (Kachalia et al., 2008).

In the process of examination of the loss event, the questions of possible legal or disciplinary accountability of a healthcare institute or individual healthcare

employee involved in the event are not addressed by the institute (Swedish Patient Insurance Association). For this reason, the Nordic scheme was described as a scheme that has erected a "Chinese wall" between compensation and possible disciplinary and other consequences for healthcare facility or medical personnel (Kachalia et al., 2008).

3 Denmark

Denmark has adopted a similar scheme as Sweden with some significantly different details. Their model was introduced in 1992 and has since been amended several times (Erichsen 2001). Legal grounds are provided by Danish Patient Insurance Act. Patients' claims are processed by Danish Patient Insurance Association. It is a public institute, funded by the state.

The Danish scheme classifies claims of patients for compensation for medical injuries into four categories: a) treatment injury; b) diagnostic injury; c) equipment-related injury and d) accident related injury. In the appeal procedure, it is necessary to prove causation (injury or damage to health is associated with medical treatment and not a result of the natural course of the disease). Any injuries or damage to health that are caused by incorrect medication are covered under a separate scheme. In Denmark, the criterion for compensation is not the proof of fault either, but the question whether the injury or damage to health could have been avoided. The avoidability rule has thus also replaced the concept of negligence in Denmark. When determining the substantive merits of the appeal (assessment of causation) *the criterion of the treatment of the best specialist under optimal circumstances is followed as well, while the principle of retroactive assessment is not permitted.* Events are assessed according to the "ex ante" principle. A somewhat unusual endurability rule was also enacted. A patient is entitled to compensation for any medical error (naturally, without fault-finding), even in the case of rare and unusual complications, but the injury must result in a level of disability that exceeds what the patient should reasonably have been expected to endure. In the assessment of the latter, it is necessary to consider the development of the underlying disease, the likelihood of the injury sustained and the question of the urgency of treatment. A typical example of the endurability rule would be the emergence of catastrophic consequences following a precise and *lege artis* spinal surgery. As a complication of discectomy, epidural abscess occurs, resulting in paraplegia. While no one is at fault (*lege artis* procedure), the nature of the consequences is such that it exceeds what the patient should reasonably have been expected to endure (Farrell, Devaney & Dar, 2010; Kachalia et al., 2008).

A statute of limitation on the patient's claim expires three years from the moment that the patient became aware of the injury or ten years from the time the injury occurred. The patient submits a claim with the institute (Danish Patient Insurance Association) by him- or herself, or it may be submitted by his or her relatives after

his or her death. The appeal procedure is conducted without charge. The claim is considered by a special employee of the institute. Eighty percent of all claims are decided within the first seven months. The maximum amount of (pecuniary and non-pecuniary) compensation is limited. In Denmark, the average amount of awarded compensations is 30,000 US dollars. On average, compensation is awarded in 43 % of cases. The appeal procedure is similar to the one in Sweden.

The Nordic no-fault compensation scheme does not include the claims resulting from the violation of patient rights (violation of privacy, patient not receiving the information related to his or her health status, lack of patient's consent, etc.). Furthermore, it does not include the mental health cases. (Serwach, 2015).

4 France

France has a complex healthcare system and an equally complex system of appeals. A doctor in France is in principle a public employee, appeals are adjudicated under the principles of public law, and administrative courts have the jurisdiction to issue decisions. France has a dual system (fault and no-fault liability) in the assessment of possible compensations for medical injuries. In some cases, the assessment follows the "no-fault" principle, while all other legal options also remain available to the patients. In 2002, France adopted a special act which in certain cases allows an out-of-court settlement under the "no fault" principle (Barbot, Parizot & Winance, 2014). The act of 2002 established 25 regional commissions (CRCI-*Commissions regionales de conciliation et d'indemnisation*). The commissions are supposed to be independent and consist of about twenty members, representatives of healthcare institutions, insurance companies and patients. The regional commission will award compensation to each patient who suffered a severe and unexpected treatment-related injury in out-of-court proceedings. However, the injury (or a nosocomial infection) must result in at least 25% disability and may not be the result of a faulty conduct (medical injury as a consequence of an accident, an unusual complication or circumstances, etc.)! No limits are determined to the amount of compensation (pecuniary and non-pecuniary damage). In such cases, ONIAM (*Office national d'indemnisation des Accidents Medicaux*) is in charge of compensation. It is financed by social contributions (French system of solidarity - *la solidarité nationale).* If the disability is lower than 25% or is a consequence of a faulty conduct, the patient must employ regular legal options. The average compensation granted in France in out-of-court proceedings is 102,000 US dollars (Barbot, Parizot & Winance, 2014).

5 Poland

In 2012, Poland adopted a new Patient Rights Act that provides an out-of-court settlement for cases of medical injury, suffered during a medical treatment, which are not a consequence of the natural course of a disease. Polish act also uses

different terminology than other regulations. It does not refer to a medical injury but to a medical event. The estimated maximum amount of compensation is 24,000 EUR in case of physical impairment or deterioration of health, and 71,500 EUR in case of death. The relative statute of limitation is one year, while the absolute is three years. The applications are accepted by special commissions, established in voivodships. There are sixteen commissions consisting of doctors and lawyers. The commission's decision is legally binding for insurance companies. A patient who is not satisfied with the decision can take other legal actions. If, however, he or she accepts compensation, he or she is no longer entitled to take part in "classical" civil litigation (Serwach, 2015). A disadvantage of the Polish system, which is supposed to have imitated the Nordic scheme, is its voluntary character. Polish medical institutions are required to take insurance against possible compensations, intended for out-of-court settlements. However, this insurance is voluntary. Hospitals that fail to take it are excluded from the system.

6 Austria

Austrian system, like French, has a dual nature - fault and no-fault. In 2001, Austria adopted the principle of no fault compensation (*verschuldensunabhaengige Patientenentshaedigung*). The principle was included in the Federal Hospitals Act (*Bundesgesetz über Krankenanstalten und Kuranstalten*-KAKuG). The principle of no fault compensation applies only in cases where liability for damages cannot be determined or liability in the legal sense simply does not exist, and a rare complication with severe consequences occurred during treatment[5]. A maximum amount of compensation is provided, though it varies among different Austrian states (22,000 EUR in Lower Austria and Styria and 70,000 EUR in Vienna). The statute of limitation is three years. If the injured party filed a civil action or started a procedure for an out-of-court settlement with Medical Chamber, they are no longer entitled to compensation under this procedure.

Special funds are administering compensations. Financial sustainability of these funds is ensured by the payers of healthcare services, who are required to contribute a certain amount to the fund (the amount per day and per patient is about 0.7 EUR). Compensation is determined by a special commission, which consists of a representative of patients, a representative of the state and a representative of the medical chamber.

7 New Zealand

No fault compensation scheme in New Zealand has evolved through injury insurance, intended for all residents who lost their jobs as a result of a work accident (Miller 1989). In 1974, New Zealand adopted a system under which compensation was guaranteed for any type of injury. A newly established fund

Accident Compensation Corporation (ACC) was responsible for administering compensations. ACC is financed by taxation and contributions. The fund did not explicitly address medical injuries, but they did grant compensation for medical misadventure (Corkill 2002). The concept of medical misadventure was open to various interpretations. That is why two concepts were introduced in 1992, "medical error" and "medical mishap". Medical error was defined as an error resulting from the failure to uphold professional standards of care or medical treatment, and mishap was defined as a rare event that occurs despite the appropriate treatment in less than one percent of cases and results in severe consequences for the patient's health or requires a long-term hospitalisation (Bismark & Pateson, 2006). In practice, especially in cases of medical errors, it was necessary to find the person at fault when determining compensation (but not for other accidents). In 2005, the new legislation merged both concepts (error and mishap) and introduced the concept of "treatment injury", while the fault-finding in medical cases was abandoned, and with it also the duality within the system. The change in the terminology allowed for consideration of all cases of health deterioration during the treatment process. Explicitly excluded are the cases where medical injury is a necessary part of the treatment (e.g. scarring after a surgery), a normal consequence of the treatment (e.g. hair loss due to tumour treatments) or a consequence of the natural course of the disease. The cases of mental illnesses are also excluded, except where there is a direct causal link between the physical impairment and deterioration of mental health (Farrell, Devaney & Dar, 2010). The cases of failed sterilisation or prevention of pregnancy are excluded as well. Pregnancy by itself is not a medical injury.

A patient files a claim for compensation with the assistance of his or her personal doctor with the ACC unit. The patient must partly cover the costs of the application, but may request to be reimbursed for such costs if the appeal is granted. The relative statute of limitation is twelve months. The application is reviewed by a special adviser, while the complex applications are considered by special commission. (Farrell, Devaney & Dar, 2010). Citizens of New Zealand may also claim compensation for injuries that have occurred as a result of accidents outside the country. A claimant may request reimbursement of various expenses, e.g. costs of treatment or compensation for pecuniary and non-pecuniary damages. If the claimant disagrees with the ACC's decision, he or she can appeal to the higher instance and even requests an independent opinion, which is paid by the ACC. If the claimant is still dissatisfied, he or she can appeal to the court.

Prior to the adoption of the act of 2005, the ACC was required to report the alleged errors to various disciplinary authorities. After 2005, the ACC is required to report to the responsible authorities only those cases that are likely to represent a risk for the broader public.

8 USA

In the United States of America (USA), high costs of judicial proceedings and professional insurances are typically encountered in cases of medical injuries (Studdert & Brennan, 2001). In some U.S. states, the costs of private insurance began to grow so rapidly that certain occupational groups in the field of medicine from the medical field were left out. In the state of Virginia, more and more obstetricians were excluded from the insurance system, because insurance companies were not willing to insure their professional liability (Farrell, Devaney & Dar, 2010; Patel, 1995). In 1987, an act was thus adopted which implemented a no-fault compensation scheme for the cases of neurological injuries suffered in the course of childbirth. The programme is financed with contributions paid by the participating obstetricians and hospitals for obstetrics, which are diverted to a special fund. Participation in the programme is voluntary. A new-born is eligible for compensation if he or she suffered a neurological injury caused by deprivation of oxygen or mechanical injury that occurred during childbirth. The injury may also occur after childbirth as a consequence of resuscitation. The injury must be permanent and of such nature that the injured person requires a life-long care and assistance by other persons. If the parents choose to file a claim and request compensation in the scope of the programme, they can expect a life-long monetary support for their child in case of a favourable decision. The fund reimburses all costs of medical treatment and care, and when a child reaches 18 years of age, the family can request compensation for pecuniary damage for the child as well. A similar programme exists in Florida.

The analysis of both programmes indicates that a rate of parents who decide for compensation under these programmes is much lower from what could be expected (Farrell, Devaney & Dar, 2010). Reasons for that are many, but among the most frequently listed are a very narrow definition of neurological injury and an inadequate legal assistance. In civil litigation before courts, payments for lawyers are much higher, but so are compensations.

9 Conclusion

The systems of no fault compensation for medical injuries were implemented only in certain countries (Farrell, Devaney & Dar, 2010). The analysis of these systems indicates that their advantage lies in a somewhat faster decision-making process and perhaps, only in principle, in a higher level of neutrality of the authority that determines criteria for compensation (Farrell, Devaney & Dar, 2010; Kachalia et al. 2008; Barbot, Parizot & Winance, 2014). The accessibility should also increase, while administrative costs should be significantly lower than the ones in classical civil litigation (Farrell, Devaney & Dar, 2010; Barbot, Parizot & Winance, 2014). A wider implementation of the described systems is probably hindered by some of their characteristics. These include limitation of the amount of compensation and, in some systems, their duality, which is reflected in different

amounts of compensation granted for comparable physical impairments (physical impairment caused by a car accident results in higher compensation compared to physical impairment caused by a medical injury), a narrow definition of the inclusion criteria, and especially the demonstration of causal connection between medical procedures and medical injury, which substantively resembles the process of fault-finding and is in this crucial point not particularly different from a similar process in the "classical" civil litigation. The systems described above are also not the systems that could be characterised as the no-fault systems without any reservations. The analyses also demonstrate that these systems in many cases restrict the access to civil courts and as a consequence potentially violate fundamental human rights (Farrell, Devaney & Dar, 2010). They generally also do not allow the affected patients to receive an apology for medical injury or to find the person responsible for the injury. However, the opposite is also true: healthcare employees are not able to prove that in case of the medical event, for which they might have been falsely accused, their conduct was entirely *lege artis*.

The assumption that compensation systems will increase the safety of patients and reduce the number of medical errors has as yet not been confirmed by any research (Farrell, Devaney & Dar, 2010; Barbot, Parizot & Winance, 2014). However, they did bring satisfaction to those patients who were treated entirely *lege artis*, but have nevertheless suffered severe physical impairments due to rare and severe complications. Such patients would not have been granted any compensation in civil litigation (entirely *lege artis* treatment), but special funds allow them to receive compensation for pecuniary damage or even lifetime annuity (e. g. Austria).

Notes

[1] Case VS0015689, Judgement II Ips 130/2012, VSM I Cp 1032/2011.
[2] Case of Kress v. France. European court of human rights. App. no. 39594/8.
[3] Bolitho v City and Hackney Health Authority [1997] 4 All ER 771-United Kingdom law.
[4] Case VS0015689, Judgement II Ips 130/2012, VSM I Cp 1032/2011
[5] Landesrecht Salzburg. Gesamte Rechtsvorschrift fuer Patientenentschaedigungsgesetz, Fassung 16.9.16. Paragraph 3.

References

Barbot, J., Parizot, I. & Winance, M. (2014) „No-fault“ compensation for victims of medical injuries. Ten years of implementing the French model, *Health Policy*, 114(2/3), pp. 236-245, doi: 10.1016/j.healthpol.2013.09.004.

Bismark, M. & Pateson R. (2006) No-Fault Compensation In New Zealand: Harmonizing Injury Compensation, Provider Accountability, And Patient Safety, *Health Affairs*, 25(1), pp. 278–283, doi: 10.1377/hlthaff.25.1.278.

Corkill, B. (2002) *Medical Misadventure - Development of the Statutory Concept and its Place in the Current Medico-Legal Environment.* Independent Comissioned report for the Accident Compensation Corporation.

Danzon, P. M. (1994) The Swedish patient compensation system: myths and realities, *International review of law and economics*, 14(4), pp. 453-466, doi: 10.1016/0144-8188(94)90026-4.

Durant, C. I. (2008) Evolution des droits du patient. Indemnisation sans faute des dammages lies aux soins de sante: le droit medical en movement, In: Koziol, H. & Steininger, B. C. (eds.) *European tort law. Tort and insurance law. Yearbook* (Wien, New York: Springer Verlag) .

Erichsen, M. (2001) The danish patient insurance scheme, *Medicine and Law*, 20(3), pp. 355-369.

Farrell, A. M., Devaney, S. & Dar, A. (2010) *No-fault compensation schemes for medical injury: a review. Interim report* (Scotish government social research), available at www.gov.scot/Resource/0039/00394407.pdf (September 19, 2016).

Ferguson, P. R. & Laurie, G. T. (eds.) (2016) *Inspiring a medico-legal revolution*: *Essays in Honour of Sheila McLean* (New York: Routledge).

Flis, V. (1994) Medicinska napaka, In: *Medicina in pravo II* (Maribor: Slovensko zdravniško društvo v Mariboru in Pravniško društvo v Mariboru).

Heberer, J. (2013) *Arzt und Recht* (Berlin: MWV Medizinisch Wissenschaftliche Verlagsgesellschaft) .

Hoffman, S. Z. (2009) No fault solutions to the problem of medical injuries: a focus on Sweden as a model, *Annals of Health Law and Advance Directive*, 18, pp. 73-93.

Johansson, H. (2010) The Swedish siystem for compensation of patient injuries. *Upsala Journal of Medical Sciences*; 115(2), pp. 88-90, doi: 10.3109/03009730903350749.

Kachalia, A. B., Mello, M. M., Brennan, T. A & Studdert, D. M. (2008) Beyond negligence: avoidalbility and medical injury compensation, *Social science and medicine,* 66(2), pp. 387-402, doi: 10.1016/j.socscimed.2007.08.020.

Merry, A. & McCall Smith (eds). (2008) *Errors, Medicine and the Law* (Cambridge: Cambridge University Press).

Miller, R. S. (1989) The future of New Zealand,s accident sompensdation sheme, *University of Hawai Law Review*, 11(1), pp. 3-80.

Moffet, P. & Moore, G. (2011) The standard of care: legal definitons: the bad and good news, *Western Journal of Emergency Medicine*, 12(1), pp. 109-112.

Oliphant, K. & Wright, W. R. (eds.) (2013) *Medical malpractice and compensation in global perspective* (Berlin: DeGruyter Verlag).

Patel, K. (1995) No-fault medical liability in Virginia and Florida: a preliminary evaluation, *Evaluation and Health professions*, 18(2), pp. 137-151.

Reason J. (1990) *Human Error* (New York: Cambridge university press).

Samec Berghaus, N. & Pristovšek, R. F. (2016) Nova dognanja o odškodninski odgovornosti zdravnikov, In: Kraljić, S., Reberšek Gorišek, J. & Rijavec, V. (eds.) *Medicina in pravo. Razmerje med pacientom in zdravnikom*. (Maribor: LeXonomica.Press), available at http://conferences.lexonomica.press/index.php/MLS/ml2016/paper/viewFile/11/12 (September 18, 2016), doi: 10.18690/9789616399760.2016.

Serwach, M. (2015) No fault insurance systems in polish law and other european legal systems, *Prawo asekuracyjne*, 82(1), pp. 33-45.

Studdert, D. M & Brennan, T. A. (2001) No-fault compensation for medical injuries. The prospect for error prevention, *JAMA*, 286, pp. 217-223.