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INTRODUCTION

Until recently, the application of general tort principles to medical malpractice cases was not an issue that attracted much attention in Denmark. However, due to the large number of medical injuries that were not compensated appropriately as a result of the shortcomings of the medical malpractice system, public consciousness of the need for tort reform increased. In addition, the experience of other Scandinavian countries, including Sweden, Norway, and Finland, which have had patient insurance schemes covering medical injuries for several years, contributed to Danish initiatives to reform medical malpractice. In 1992 Denmark introduced a no-fault system for compensating patients who suffer medical injury. This no-fault scheme was introduced through the enactment of the Patient Insurance Act (PIA), which compensates patients for personal injuries that result from medical care provided by hospitals owned and run by County administrations.[1]

This article begins by examining the political and historical background of the PIA, including Danish tort law, the medical malpractice system that the PIA replaced, and the tort principles that apply in medical malpractice cases. In section II, the article describes the injuries that are compensable under the Act and the way in which these injuries are indemnified. In sections III and IV, the article evaluates the legal and economic implications of Denmark's adoption of a no-fault system for compensating victims of medical injury. Finally, the paper evaluates the success of the PIA system based on data from 1992, the first year the PIA was in effect.

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1. Lov nr. 367 at 6. juni 1991 om patientforsikring [the Patient Insurance Act].

A. Tort Law and the Tort Liability Act

Danish tort law classifies cases involving physical harm to persons or property according to the degree of fault inherent in the tortious conduct. There are three degrees of tortious conduct under Danish law. The two highest degrees involve intentional negligent conduct. The third class, strict liability, is liability without fault. In Denmark, strict liability is imposed by statute for certain types of accidents ranging from injuries caused by dogs to nuclear accidents. If there is no statute imposing strict liability, negligence is the prevailing rule.

In medical malpractice cases, liability is traditionally imposed according to a fault principle. Thus, a patient-plaintiff who sustains a medical injury must seek recovery in court through a negligence action. The patient-plaintiff, who has the burden of proof, first must demonstrate that he or she has sustained a physical injury. Second, the plaintiff must prove that the attending physician was at fault. Third, the plaintiff must establish a connection between the injury sustained and the physician's negligent act or omission. In other words, the patient must prove cause in fact and proximate cause.

In cases where there is negligence per se or where the res ipsa loquitur doctrine applies, Danish courts shift the burden of proof from the patient-plaintiff to the defendant, who in most cases will be the hospital administrator or the hospital owner as the physician's employer. All employers are vicariously liable for faults committed by their employees. Employers generally do not have any right of subrogation against the employee-tortfeasor unless the tortfeasor acted intentionally or with gross negligence.

All health care professionals at public hospitals, including physicians, are full-time employees of the hospital and do not have their own private practices. Thus, the principle of vicarious liability in effect applies to all health care provided in public hospitals. Moreover, employees are not held liable for their actions if the employer has liability insurance that covers the acts of employees. Accordingly, in most Danish medical malpractice cases, the defendant is the clinic or hospital administrator rather than the attending physician.

A plaintiff who proves that he or she has sustained a compensable personal injury may recover for the adverse physical consequences of that injury. Damages for personal injury in Danish medical malpractice cases, as in all cases of personal injury, are

assessed according to the rules of the Tort Liability Act (TLA).[2] The purpose of the Act is to standardize damage awards for personal injury by establishing mandatory principles of assessment, or parameters. The TLA, which applies in all cases involving personal injury no matter what the theory of liability, provides detailed guidelines for determining both economic and noneconomic damages. Under the TLA, compensation awards are reduced by any amount that the patient receives from workers' compensation or social security benefits. Private insurance is considered a collateral source and does not adversely affect the amount of compensation allowed under the TLA. Finally, the TLA places caps on both noneconomic and economic damages.

The TLA entitles patients to economic damages, including lost wages and earnings, past and future pecuniary losses, and out-of-pocket expenses proximately caused by the injury.[3] Patients also receive compensation for the permanent loss of future earnings due to the injury.[4] Compensation for future loss of income is capitalized, based on the injured individual's past earnings. The TLA caps future economic losses at approximately $420,000. For individuals older than fifty-five years of age, however, these caps are lower.

The TLA also allows injured individuals to recover noneconomic damages, including damages for physical pain and permanent physical impairment. Under the TLA, compensation for pain and suffering is calculated per diem: individuals receive a predetermined amount for each day of physical pain. At present, the cap on compensation for pain and suffering is approximately $7,000.[5] Permanent physical impairment is capitalized, with the amount of damages based on a medically determined matrix of impairments.[6] Compensation for physical impairments is capped at $48,000. Additional caps apply if the injured person is older than sixty years of age.

By establishing parameters for the compensation of personal injury and imposing caps, the TLA makes it possible to predict the size of compensation awards. Given the present parameters

2. Lov om erstatningsansvar lbg. nr. 599 af 9/8 1986 med senere aendringer [the Tort Liability Act]. The TLA was enacted in 1984 and applies in all cases involving damages for personal injury no matter the theory of liability.
3. TLA paragraph 2.
4. TLA paragraph 5 section 1.
5. TLA paragraph 3.
6. TLA paragraph 4.

and caps, the maximum possible award is $500,000 plus expenses.

Compensation for personal injury in Denmark is highly regulated. The TLA establishes strict parameters, leaving little leeway for individual considerations when damages are awarded. The advantage of the TLA is that compensation awards for personal injury are uniform in size. Compensation is made more predictable; given the necessary information about the injury and its consequences, parties can predict the amount of compensation at stake. As a result, parties often agree about compensation even when liability is in dispute. By imposing caps and prohibiting punitive damages, the TLA helps curb the escalation of compensation awards for personal injury, and thus helps control overall health care costs.

The TLA's limits on economic damages may seem unfair to individuals with incomes that would result in compensations higher than the capped amounts. Individuals with high incomes are most likely to be affected by the cap on economic damages and to be undercompensated for their economic losses. Nevertheless, in light of the fact that Denmark provides for additional compensation in the form of free health care and social security benefits, the TLA's limits on economic and noneconomic damages seem reasonable.

B. The Patient Insurance Act

It has long been public policy in Denmark to compensate victims of accidents and misfortunes. Personal injury and injury to property are costly to Danish society, because the Danish social security system provides basic coverage for injuries suffered by any legal resident. In order to ensure that individuals are appropriately compensated, strict liability has been imposed by statute for injuries resulting from a number of everyday activities, ranging from injuries caused by dogs to injuries caused by nuclear accidents. As a component of strict liability, insurance is mandated in these areas. Other injuries for which strict liability is imposed are work-related injuries, which are compensated through workers' compensation, a mandatory insurance scheme. Liability insurance is also mandatory for car owners, who are strictly liable for any accidents involving their motor vehicles.

Medical injury and medical malpractice is another area where public policy considerations have prevailed. Increasingly, patients as well as physicians in Denmark have expressed dissatis-

faction with the negligence-based system of medical malpractice. Although medical injuries are not that different from other types of personal injury, the medical malpractice suit is the only type of personal injury suit that is regulated; all other tort actions involving personal injury are resolved through the traditional tort system. However, because Denmark provides medical care through a national health insurance scheme, medical malpractice, unlike other types of personal injury, has become a matter of public policy. In recent years public attention and critique have focused on a number of highly publicized medical malpractice cases involving public hospitals where the injured individuals were not compensated, despite public demand. Because public hospitals provide most institutional health care, compensation of medical injuries in these hospitals has become a matter of increasing public concern.[7] Moreover, the inherently unequal relationship between the injured patient and the state, which owns the hospital, is considered fundamentally unfair to the patient, who may recover only through litigation.

Empirical studies show that the traditional Danish tort system does not fairly compensate victims of medical injury. There are approximately 38,000 adverse events registered in Danish public hospitals each year. Approximately 22,000 of these adverse events are caused by errors in management, and approximately 9,000 are caused by negligence. However, the insurance com-

7. The National Health Insurance is provided largely by government funds, which come from general revenues. The Danish government provides health care in three settings. First, primary care is provided by general practitioners employed by the government. Their pay is based on the number of patients they have and the number of times they see each patient. Second, institutional care is provided through a system of hospitals and nursing homes organized and run by the county councils. Third, nonhospital community care is provided by district nurses and assistant nurses under the control of county and municipality authorities. These services are financed by local authority budgets supplemented by payments from the central government.

All Danish residents belong to one of two health insurance groups, and each resident enrolls with a general practitioner. Group one patients, the largest group, do not contribute anything to medical services. They are restricted in their choice of general practitioner in that they may choose a practitioner only in the area where they live. Group one patients also need a referral from their general practitioner in order to seek specialist treatment. Specialists are employed by the government and are paid on a case-by-case basis. Group two patients make copayments whenever they receive a medical service outside a hospital setting. Group two patients may choose any general practitioner who has an opening, and they may switch whenever they wish. Group two patients may also use specialists whenever they want to without a referral from their general practitioner. Lov nr. 490 af 21/7 1986 om offentlig sygesikring par. 2 [the National Health Insurance Act].

pany from which most Danish counties have purchased malpractice insurance for their hospitals receives, on average, only 225 medical malpractice claims per year.[8] Only 50 percent of these 225 claims are compensated. The wide gap between the number of medical negligence cases and the number of cases where patients receive compensation belies the assertion that medical malpractice suits compensate injured individuals, enhance the quality of care, and deter negligence.[9]

Due to increasing public consciousness of the need for malpractice reform, in 1986 a group working under the Department of the Interior produced a report on patient and pharmaceutical insurance schemes in other Scandinavian countries, especially Sweden, which provide comprehensive patient and pharmaceutical insurance.[10] The legislative procedure of the Patient Insurance Act began in 1987 and was finalized in 1991 with the passing of the Bill.

II. Description of the Patient Insurance Act

The PIA provides compensation for medical injuries in five distinct situations, ranging from injuries caused by substandard care to injuries that are considered unavoidable, such as infectious diseases. The patient injured by medical negligence must file his or her claim with the Patient Insurance Consortium (the Consortium), which reviews the claim and procures the information and evidence necessary to decide it. The Consortium is composed of insurance companies, which provide medical malpractice insurance for most counties, and self-insured counties. The Consortium has a number of claims reviewers and a panel of medical experts that review patient claims and determine, based on the TLA, the amount of compensation that the insurance companies must pay to the individual claimants. The claimant or the insurance company involved in paying the claim may appeal the Consortium's decisions to the Patient Injury Appeals Board (the Appeals Board).

This section describes the purpose of the PIA, the medical injuries that it covers, and its causation requirements. It then

8. Kommunernes Gensidige Forsikringsselskab.

9. Bo Von Eyben, Patientforsikring 17 (1993) [Patient Insurance 17 (1993)] [hereinafter Patient Insurance].

10. Patient- of laegemiddelforsikring, rapport fra den af Indenrigsministeriet nedsatte arbejdsgruppe vedroerende en dansk patient- og laegemiddelforsikringsordning (1986) [Report on Patient and Pharmaceutical Insurance in Denmark (1986)] [hereinafter the Report].

evaluates the expanded coverage of injuries under the Act. The claims resolution process and the organization of the Patient Insurance Consortium and the Patient Injury Appeals Board will be examined in a later section.

A. The Purpose of the Patient Insurance Act

According to the Explanatory Notes to the Patient Insurance Bill, the general purpose of the PIA is to ensure that more patients are compensated for injuries sustained from negligent or erroneous medical care. The Act provides compensation for medical injuries that are unexpected by the patient or unforeseeable by the physician. Compensation under the PIA is intended to be based on more objective grounds than it is under the tort system: under the PIA, the injury need not be described as negligent or wrongful.

The PIA is designed to supplant the medical malpractice suit, which is considered a cumbersome process for the injured person. Medical malpractice suits usually take a long time: some cases take more than five years from the time the patient first files a complaint with the hospital's insurance company until a final judicial decision is reached. Moreover, the rules of tort place a heavy burden on the patient, who must prove medical negligence and a causal link between the negligent act and the sustained injury. This burden of proof overwhelms many patients who might otherwise pursue their claims.[11] In addition, trials are expensive, time consuming, and the final outcome is often unpredictable.[12]

The PIA was passed in May 1991, and took effect on July 1, 1992.[13] Basically, the Act expands the doctrine of respondeat superior, or vicarious liability.[14] Under the Act, the owner and administrator of each hospital are vicariously liable for any adverse events caused by the physicians it employs.[15] The hospital-

11. Bemaerkninger til det af sundhedsministeren i folketingsaaret 1987-1988 1. samling fremsatte lovforslag nr. 151 spalte 3270 [the Explanatory notes to the Bill at 3270].

12. Carl Oldertz *et* Eva Tidefelt, *Compensation for Personal Injury in Sweden and Other Countries* at 54 (1988) Juristforlaget.

13. The Patient Insurance Act paragraph 21.

14. The Explanatory Notes to the Bill at 3233.

15. All physicians at hospitals are employed full time by the hospital. General practitioners usually cannot hold clinical privileges at a hospital. If inpatient treatment becomes necessary, the attending general practitioner will refer the patient to the nearest hospital or the hospital with the necessary expertise needed for the patient. The general practitioner will receive a copy of the patient's medical record, and

employer does not have any subrogation rights against the employee-tortfeasor unless the employee intentionally caused the patient's injury.[16] Thus, the PIA extends traditional vicarious liability to include intentional as well as negligent acts, although the hospital-employer has subrogation rights if the employee's act was intentional.

The PIA applies only to injures caused by medical care provided in hospitals owned and run by state or county councils.[17] The Act does not apply retroactively: it applies only to medical injuries caused after the date on which the Act took effect, July 1, 1992. The PIA does not cover injuries caused before the effective date of the Act, even if the physical damage resulting from the injury does not manifest itself until after the effective date of the Act. Patients with such injuries must proceed under the traditional tort system, which requires them to prove negligence and causation in order to recover damages. The PIA thus discriminates against a group of patients merely because they did not discover their injuries until after the PIA took effect. Arguably, the time of discovery would be a more fair determinant of whether or not an injury is covered by the PIA. The PIA is applied prospectively only, however, in order to make the number of compensable injuries more predictable, which makes it easier for insurance companies to set premiums. Thus, the injuries covered by the PIA have been limited for the convenience of insurance companies.

Although prospective application of the PIA limits the number of injuries covered under the Act, the lengthy statute of limitations for medical malpractice suits in Denmark allows for suits under the old system for at least several years to come. The statute of limitations for medical malpractice suits is five years from the date on which the patient discovers that he or she has been injured by medical negligence. However, the patient must file within twenty years of the negligent act or omission. Thus, if a patient discovers fifteen years after a medical inter-

subsequent to discharge from the hospital the patient will return to his or her general practitioner for follow-up care. Thus, a general practitioner only rarely is allowed to attend his patients at hospitals.

16. PIA paragraph 8.

17. Denmark is a unitary, divided into 275 municipalities for administrative purposes, with each of these having an elected district council. There are 14 larger units or counties, which also have elected councils. The majority of hospitals are public hospitals subsidized by the state and owned and run by the counties and municipalities. Public hospitals will hereinafter be referred to as hospitals owned by the state or the counties.

vention that he or she has been injured through medical negligence, the patient may still have a cause of action if suit is filed within the next five years.

B. Coverage

As mentioned above, the PIA covers only those injuries that occur as a result of medical or health care activities at hospitals owned and run by state or county councils. The PIA does not apply to the small number of private hospitals that provide health care services to persons who want to be treated on a fee-for-service basis outside the public health care system. However, some of these private hospitals have working agreements with the county councils to provide certain services for the public health system on a reimbursement basis.[18] The PIA applies to such private hospitals if fifty percent or more of the hospital's operating expenses arise from providing treatment for which the hospital is reimbursed by the state or the county.[19]

The scope of the PIA is relatively narrow when compared with the Danish legislature's original intentions. Injuries caused by general practitioners, physicians in private hospitals and clinics, and dentists are not compensable under the PIA. The exclusion of general practitioners was politically feasible because most medical malpractice takes place in hospitals, which provide more extensive and comprehensive medical care than do general practitioners.[20] Also, it is likely that the present patient insurance scheme will eventually be expanded to include general practitioners and private hospitals.[21]

The PIA covers only those injuries that occur in public hospitals as a result of medical examinations or tests, medical or sur-

18. Currently ten private hospitals have working agreements with the government: Kolonien Filadelfias Epilepsihospital, Sclerosehospitalet, Haslev, Sclerosehospitalet, Ry, Sct. Maria Hospital, Niels Steensen Hospital, Hvidoere Hospital, Dronning Alexandrines Gigtsanatorium, Gigthospitalet i Skaelskoer, Kong Christian den X's Gigthospital, Gigtsanatoriet Hans Jansens Hjem i Skaade.

19. Sundhedsministeriets bekendtgoerelse nr. 216 af 27. marts 1992 paragraf 3 stk. 1 1. pkt. jfr. paragraf 4 stk. 1 nr. 4 [The Government Notification no. 216, March 27. 1992 par. 3 section 1 cf. par. 4 section 1 subsection 4] [hereinafter Notification no. 216].

20. The number of inhabitants in Denmark is about 5,124,000. In 1993, 14,277 physicians were registered in Denmark of which 3,514 are general practitioners in private practices and 8,544 are full-time employed physicians at hospitals. In addition there are 840 specialists in private practices. In 1991, there were 28,072 available hospital beds and 1,087,126 discharges from public hospitals all over the country, accounting for approximately 8.5 million patient days.

21. Bo Von Eyben, Patient Insurance at 33.

gical treatment, or follow-up care.[22] It does not cover injuries sustained in a hospital bathroom or by falling from a hospital bed, nor does it cover injuries related to activities provided by the hospitals, such as a fitness-room work-out.

The PIA covers injuries resulting from health care services provided by any health care professional that the hospital employs, including physicians, nurses, and nurse's aides. In order for a patient alleging medical injury to receive compensation, the PIA requires that treatment take place on hospital premises on an inpatient basis. The PIA also covers patients discharged from the hospital who receive follow-up treatment on an outpatient basis as long as the hospital is in charge of the outpatient care.[23]

Because the PIA applies only to injuries resulting from health care services provided on hospital premises, in effect it applies only to the actions of medical professionals in their capacity as hospital employees. The PIA does not apply to injuries arising from emergency treatment provided by a physician outside the hospital setting when the physician is not on duty.[24] However, the PIA does cover treatment during transportation to the hospital or during transportation between hospitals if the transportation is provided by hospital ambulance services.[25]

Under the PIA, compensation for medical injury is available to any legal resident of Denmark who receives health care in a Danish public hospital. The PIA provides compensation if a fetus is injured as a result of treatment to the fetus or the mother if the fetus is born alive; otherwise only the mother's injuries are covered.[26] Thus, parents whose unborn child dies as a result of medical injury may recover only through a traditional medical malpractice suit, where they must prove negligence and causation.

The PIA provides compensation for injuries sustained by persons participating in medical research programs, as well as blood, tissue, and organ donors, even though such persons are not patients receiving health care. The political rationale for covering all such injuries is that persons who volunteer to participate in medical research and who donate blood, tissue, or

22. The PIA paragraph 1 section 1.
23. Notification no. 216 paragraph 5 section 3.
24. The Explanatory Notes to the Bill at 3282.
25. Notification no. 216 paragraph 5 section 3.
26. The Explanatory Notes to the Bill at 3282.

organs to help others should be compensated if they are injured.[27]

C. *The General Definition of Injury*

The PIA defines "injury" as physical injury, which includes any injury that results in physical damage, as well as psychological damage resulting from a physical injury. Thus, a patient who sustains physical injury and experiences neurosis as a result may recover all economic and noneconomic losses in connection with any extension of his or her illness caused by the neurosis. However, if the injury resulting from medical treatment is solely psychological, the PIA will not provide compensation, nor will it provide compensation for any physical damage resulting from the psychological harm.[28]

The PIA excludes psychological injuries because it is almost impossible to distinguish between mental conditions caused by an underlying illness and psychological injury caused by treatment.[29] However, the Act does not discriminate against mental health care patients if they sustain an injury of a physical nature. For example, patients who sustain dental injuries as a result of electroconvulsive therapy will be indemnified.[30] The PIA expands the general definition of injury for participants in medical research, who are entitled to compensation for all kinds of injury, including psychological injury.[31]

Under the PIA, injuries caused by drugs used in medical examinations or treatment are explicitly excluded from coverage.[32] The injuries not compensated are those caused by the drug itself. Drug side effects are not considered medical complications and are not compensated under the PIA.[33] However, if the patient's injury is caused by the way in which the physician administers the drug—for example, by prescribing too large a dose—the PIA might provide compensation.[34]

27. Notification no. 216 paragraph 1 section 2.
28. Bo Von Eyben, Patient Insurance at 183.
29. The Explanatory Notes at 3283.
30. The example is provided in Patient Insurance at 182.
31. The PIA paragraph 1 section 1 cf. paragraph 4 section 3.
32. The PIA paragraph 3 section 3 provides that injury caused by drugs used in examinations or treatment is not compensated.
33. Bo Von Eyben, Patient Insurance at 189.
34. In order to be compensable, the patient's injury would have to fall under one of the five categories described below.

The Danish legislatures originally intended the PIA to cover injuries sustained from pharmaceutical products. However, due to political disagreement and lobbying from the Danish pharmaceutical industry, the legislatures rejected an insurance scheme that would cover medical injuries caused by drugs. The final version of the PIA merely encourages pharmaceutical manufacturers to initiate a voluntary pharmaceutical insurance scheme that would complete the coverage of medical-related injuries in Danish public hospitals. Until a voluntary pharmaceutical insurance scheme is in place, patients injured by defective drugs must pursue their claims in court under a products liability theory or through a traditional medical malpractice action. Some commentators feel that the PIA's exclusion of injuries caused by pharmaceutical products seriously undermines the Act's goal of providing uniform coverage and compensation for medical injuries.[35] The fact that the establishment of a pharmaceutical insurance scheme is now left to the industry itself makes it highly unlikely that uniform coverage of medical injuries, which would include injuries caused by drugs, will ever be achieved.

The PIA provides only for injuries caused by medical examination or treatment; injuries caused by the underlying illness for which the patient is being treated and injuries caused by preexisting conditions are not compensable. Thus, the natural consequences of a patient's illness, such as death from an incurable disease, are not covered under the PIA. In addition, unexpected consequences of an illness or unexpected complications during the course of treatment are not covered if they are caused by the illness itself.

The Consortium, in cooperation with its panel of physicians, must make the almost impossible determination of whether an injury is caused by the illness for which the patient is being treated or whether the injury falls within one of the categories of injuries compensable under the PIA. With regard to infectious injuries, it is particular difficult to determine whether the infection is caused by the patient's own bacteria or bacterial disease or caused by bacteria to which the patient was exposed during the course of treatment. The legislatures have found that the Consortium is capable of distinguishing between physical injury caused by the underlying illness and injury caused by medical

35. Jens Thomsen, *"Jurist kritiserer ny patientforsikring,"* Berlingske Tidende den 14. juni 1992 [newspaper article printed in the Danish newspaper Berlingske Tidende June 14, 1992].

intervention. However, psychological injuries are excluded from coverage (except, as noted above, for participants in medical research) because it is impossible to distinguish between psychological injury caused by an underlying mental condition and psychological injury caused by treatment. The exclusion of psychological injuries thus appears to be based on considerations other than the practicality of distinction. The PIA will not be a pure, no-fault based compensation scheme unless it provides compensation for all injuries, regardless of whether they are caused by medical intervention or the patient's underlying illness, and regardless of whether they are physical or psychological. Such a compensation scheme would not be politically or economically feasible, however.

D. Description of the Five Categories of Compensable Injuries

This section examines each of the five categories of injuries that are compensable under the PIA. The first category applies to the situation where an experienced specialist would have performed the examination or treatment differently than the treating physician, thus avoiding the injury.[36] In the second category, the patient's injury is caused by defective medical equipment or instruments.[37] In the third category, a better or less risky treatment method was available and therefore should have been chosen.[38] The fourth category applies to the situation where injury in the form of infection or other complications is more extensive than reasonably expected for the particular illness.[39] The fifth category includes any injury caused to blood, tissue, or organ donors in the course of donation and any injury caused to persons, including patients, who participate in medical research programs.[40]

The injuries described in each of the five categories are classified according to the degree of avoidability. Categories one through three are classified as injuries that are avoidable. Categories four and five provide compensation for some unavoidable injuries, insofar as these injuries exceed what a reasonable patient should expect. In determining whether a patient's injury is

36. PIA paragraph 2 section 1 subsection 1.
37. PIA paragraph 2 section 1 subsection 2.
38. PIA paragraph 2 section 1 subsection 3.
39. PIA paragraph 2 section 2 subsection 4.
40. PIA paragraph 4 section 1.

one that could have been avoided, the Consortium does not judge or analyze the health care that was provided. Instead, the Consortium bases its determination solely on information about the patient, his or her illness, and the conditions under which the injury occurred. Thus the type of hospital, as well as the availability of specialists and sophisticated equipment, are factors that the Consortium may consider in determining avoidability. The standard is not a national standard of optimal care but the flexible standard employed in traditional malpractice cases, which is the standard of care in the community.[41]

Category One: The experienced specialist standard of care

The first category compensates patients for injuries caused by medical care that fails to meet the accepted standard of care for experienced specialists in the field.[42] This category includes claims of injury where the care provided falls below the standard of care applicable to an average reasonable physician in the community. These are the claims that, before the enactment of the PIA, would have been compensated through a traditional malpractice suit.

In addition to traditional negligence claims, the first category of injuries compensable under the PIA also includes claims relating to nonnegligent adverse events. These claims can be described as arising from physician errors in judgment; a specialist, because of his or her knowledge and experience, would in all probability have chosen a different treatment or performed the same treatment in a different manner, thus avoiding the injury. Thus, the Consortium applies a more stringent standard of care than the standard applicable in traditional malpractice suits.

The treatment giving rise to injury is judged according to the actual circumstances surrounding the patient at the time of treatment, and the availability of treatment methods and techniques at that time. Compensation is awarded regardless of whether the injury was caused by an incorrect diagnosis or because no diagnosis was made at all. The first category also includes injury caused by a medical intervention that is not medically justified or necessary, and injury caused by negligent

41. Sundhedsministeriets vejledning af 25. juni 1992 om erstatningskriterier i patientforsikringsloven p. 45 i Sundhedsministeriets lov om patientforsikring med dertil knyttede bekendtgoerelser og vejledninger September 1992 [Directions from the Department of Health on the Application of the Patient Insurance Act] [hereinafter Directions from the Department of Health].

42. The PIA paragraph 2 section 1 subsection 1.

performance of the intervention. However, the experienced specialist standard does not apply if the specialists disagree about the optimal course of treatment. Nevertheless, such claims might be compensable under "the alternative treatment standard" described in the third category.[43]

Even though the PIA is described as a no-fault compensation scheme, the first category of compensable injury clearly demonstrates that fault is still an issue. The category includes traditional negligence claims. Moreover, although tightening the standard of care will undoubtedly enhance the quality of care, general application of the standard of an experienced specialist indicates that the standard of care provided by a nonspecialist is not considered acceptable under the PIA.

The application of the "experienced specialist" standard to an injury that is covered by this first category is best demonstrated by the claim of a thirty-eight year-old woman who sustained an injury as a result of a sterilization operation. The woman was admitted to a public hospital to have an abortion and tubal ligation involving the procedure of electrodesiccation. Although the patient was discharged from the hospital the following day, she was readmitted later that same day complaining of stomach pains. The attending physician, who suspected the development of peritonitis, initiated surgery. Instead of revealing peritonitis, however, the surgery revealed a perforation of the patient's small intestine. The perforation was caused by the electrodesiccation procedure employed in connection with the sterilization.

The Patient Insurance Consortium determined that the patient's injury was compensable under the PIA as a category one injury.[44] The Consortium found that even though the perforation was not due to the negligence of the operating physician, the perforation could have been avoided if an experienced specialist had performed the surgery.[45] This case exemplifies the situation, typical under category one, in which the patient receives compensation even though the operating physician is not found to be at fault; all that is required is a finding that the injury could have been avoided if another, more expert, physician had performed the procedure. Although the treating physician is not personally liable for the medical injury, there is no doubt

43. The PIA paragraph 2 section 1 subsection 3.

44. The PIA paragraph 2 section 1 subsection 1.

45. The Annual Report of 1992 for the Patient Insurance Consortium at 22 [hereinafter the Annual Report].

that he or she could be stigmatized merely by being involved in an injury that could have been avoided. However, because the physician is not liable and therefore is not involved in the compensation phase, the physician is deprived of the right to justify his or her actions. In a traditional malpractice suit, the defendant physician is called as a witness, which provides an opportunity for the physician to justify his or her medical judgment or performance. Some physicians probably view the PIA system as a welcome means of reducing their involvement and responsibility in the compensation process, however, because testifying in court can be an unpleasant experience.

Data from 1992, the first year in which the PIA was in effect, suggests that most claims will fall within category one.[46] Fifty-four of the ninety-nine claims, or fifty-five percent, that the Consortium found to be compensable fell within this first category. The category includes injuries sustained either from negligence or errors of judgment. Because negligence claims existed before the enactment of the PIA (in the form of the traditional malpractice suit), claims of injury due to errors of judgment will account for the expected future increase in the number of compensable claims. The large number of claims in this category could also be explained by the fact that most medical injuries are caused by the intervention itself.

Category Two: Defective medical equipment and technical devices

The second category compensates patients for injury caused by medical equipment, instruments, and other technical devices employed in connection with medical examinations, diagnostic tests, or treatment.[47] Incorrect diagnoses as a result of defective technical devices employed in diagnostic tests are also included

46. Study on patient claims in the period July 1, 1992 to June 30, 1993 by the Patient Insurance Consortium. The Consortium received and examined 264 claims. 99 of these claims were compensated and another 165 of the claims were denied because the claims were not covered by the PIA. 81 of the 165 denied claims did not fall into any of the 5 categories covered by the PIA, and 29 of the denied claims were injuries caused before the PIA took effect. In 49 of the denied claims, compensations assessed according to the TLA would not meet the threshold of $3,000. Accordingly, these claims were not compensable under the PIA. An additional six claims were denied for other reasons. The 99 claims that the Consortium determined to be compensable were dispersed among the 5 categories as follows: the first category 54 claims, the second category 2 claims, the third category 3 claims, the fourth category 18 claims, and finally in the fifth category 22 claims.

47. The PIA paragraph 2 section 1 subsection 2.

in this category.[48] However, compensation for accidental injury caused by the use of the hospital facility itself, including the hospital building, elevators, doors, and beds, is excluded.[49]

Under the second category, hospitals are strictly liable for injuries caused by defective medical equipment or instruments or by the use of equipment. Under the PIA it is irrelevant whether the failure of medical equipment is caused by a defect in the equipment itself or by the health care professional's incorrect use of the equipment. Accordingly, the definition of "defect" in category two is fairly broad: it includes equipment malfunctions and defects, improper use of equipment, and improper maintenance. Furthermore, category two liability applies whether or not the health care professionals who use the equipment knew or should have known about the defect. The mere fact that an injury has occurred because of a defect in the equipment or the use of the equipment is sufficient to trigger indemnification under the PIA.

Injuries due to defective medical equipment may be compensable under the strict liability provisions of the Products Liability Act (PLA).[50] Because the PLA provides that consumers have a statutory right to pursue their claims, the PIA cannot preempt the PLA.[51] The PIA provides that an insurance company that indemnifies a claim of injury caused by defective equipment has a right of subrogation against the manufacturer or distributor under the PLA. Thus, liability under the PLA is enforced through subrogation rights. The injured claimant may choose to proceed under either the PLA or the PIA. However, since the claims process under the PIA is much less cumbersome than a product liability action, claimants are more likely to seek

48. The Explanatory Notes to the Bill at 3289.

49. The PIA paragraph 3 section 2 provides that hospitals are liable for accidental injuries sustained on the premises of the hospitals that are caused by negligence. Thus, the liability is based on general principles of tort law. Accordingly, accidental injury is compensated only if the hospital negligently has failed to keep the building in good repair or knew or should have known about a particular defect to the facility or building. The typical example of an accidental injury is the situation where a patient in a hospital falls out of bed or slips on the floor and is injured. According to the PIA paragraph 3 section 2 liability for accidents of this kind depends on whether the floor had been left wet at the time of the injury or the bed had a defect that the hospital knew or should have known about. In other words, liability depends on whether negligence has occurred. In the case where no negligence can be established, the injury is considered to be an accident for which liability cannot be imposed.

50. Lov nr. 371 af 7. juni 1989 om produktansvar [the Product Liability Act (PLA)].

51. The PIA paragraph 8a.

compensation under the PIA. Compensation under both the PIA and the PLA is awarded according to the principles of the Tort Liability Act.

The definition of a defective product under the PIA and the PLA is not always identical, however. The PLA defines a defective product as one that does not afford the necessary safety expected by the consumer;[52] the PIA does not qualify its definition of "defects" in any way. For example, the PIA does not require that a product be considered unsafe in order to be found defective. Thus, the PIA provides compensation for an injury caused by a needle that breaks off during surgery, regardless of whether the breaking of the needle would be found defective under the PLA. In addition, although the PLA provides for liability only if the product was defective at the time of distribution, the PIA does not distinguish between original defects and malfunction due to inappropriate use or the hospital's failure to maintain the equipment.[53] Furthermore, the PLA exempts manufacturers from liability if, at the time of manufacturing, the product conformed with state-of-the-art standards for that particular type of product.[54] Thus, claimants who cannot recover under the PLA for injuries caused by defective products that once were considered state-of-the-art still are entitled to compensation under the PIA. The PIA definition of "defect" clearly includes a much wider variety of defects than does the PLA definition. The only relationship between the two laws is the PIA provision allowing an insurance company that has indemnified an injury caused by defective medical equipment to initiate a PLA subrogation action against the manufacturer of the equipment.

During the first year in which the PIA was in effect, only two patient claims were compensated as category two injuries. The reason for the low number of claims in this group could be that even when equipment and instruments fail, the patient must demonstrate that the defective equipment resulted in an injury. The Consortium denied the claim of the estate of a fifty-year-old man who had a kidney transplant. According to the patient's medical records, the surgery went well without any complications. However, in the following weeks the transplanted kidney failed to function properly and the patient had x-rays taken. During the x-ray examination, part of the frame of the x-ray

52. The PLA paragraph 5.
53. Bo Von Eyben, Patient Insurance at 131.
54. PLA paragraph 7.

machine fell on the patient's stomach. The patient later died of peritonitis. The patient's estate filed a claim with the Consortium, but the Consortium denied compensation. It was found that the patient's death was the result of peritonitis, a complication that was caused by the kidney transplantation and not by the falling of the defective x-ray machine.[55] Causation is as essential to the success of a category two claim as it is to the success of claims in other categories.

By establishing a much broader definition of "defects" than the PLA, the PIA improves patient access to compensation for injury caused by defective products. However, the scope of the category is limited to defective products involved in medical procedures administered in public hospitals. If a patient is injured by hospital equipment that is not employed in medical procedures, the PIA's strict liability provisions do not apply, and the patient must prove that the hospital or its staff was negligent.

Category Three: Better or less risky alternative methods of treatment

The third category of injury compensates patients for injuries that could have been avoided if the treating physician had chosen a better or less risky method or course of treatment.[56] The Consortium determines what constitutes an appropriate "alternative treatment" by considering the events surrounding the patient's treatment retrospectively. Using information about the patient and the illness, including the circumstances of the treatment, any adverse events that occurred, and the severity of the injury sustained, the Consortium determines whether a better or less risky method or course of treatment was in fact available at the time. In order to qualify as a viable alternative, a method or course of treatment must be one that is generally accepted in the medical community. A treatment that is known to be less effective in treating a particular illness would not be considered a viable alternative even if, viewed retrospectively, that treatment would have been less risky or better for the patient. In other words, the availability of alternative treatments involves an objective determination based on the extent of general medical knowledge about the illness. An alternative treatment is one

55. The example is provided from the Annual Report at 24.
56. The PIA paragraph 2 section 1 subsection 3.

that is not only available but one that in all probability would have been less risky or more effective in avoiding the injury.

If the Consortium determines that acceptable alternative treatments were available, the patient is compensated for his or her injuries. However, a determination that a better or less risky method of treatment was available at the time does not necessarily mean that the alternative treatment was available at the treating hospital. A treatment that is provided at another hospital is considered to be an available alternative if time would have allowed the patient to be transferred to this other hospital. An alternative treatment is considered unavailable only if it was developed or accepted into use after the patient was treated.

The Consortium's determination regarding alternative methods or courses of treatment under category three is based on an objective standard of care. Unlike the experienced specialist standard in category two, it does not require the Consortium to determine whether an experienced specialist would have used an alternative method of treatment in a particular case. However, category three applies only to alternative methods or courses of treatment. The category does not include claims relating to diagnosis,[57] largely because a correct diagnosis often is not made until after a number of examinations and diagnostic tests have been performed. Retrospective examination of other available diagnoses, which if timely made could have prevented the patient's injury from occurring, could result in compensation awards in almost any case where a diagnosis is not made initially.[58]

Traditional medical malpractice law would not support many of the compensation awards available under category three. Under traditional malpractice law, the treating physician is expected to act on the information available to him at the time of the medical intervention. Accordingly, only those alternative treatments that were actually available at the time of treatment are considered in determining whether or not the physician was negligent. Under the PIA, however, compensation is based on a retrospective analysis of available alternative methods or courses of treatment. Only three claims have been indemnified

57. The PIA paragraph 3 section 1 provides that injury caused by an incorrect diagnosis is compensated only if the injury is covered under paragraph 2 section 1 subsections 1 and 2.

58. Directions from the Department of Health at 49.

under category three, which suggests that many patients are not aware of their ability to bring claims in this category. The retrospective nature of category three claims may make it difficult for both physicians and patients to recognize potential claims. As the PIA becomes more established, however, the number of claims in this category is likely to increase.

Category Four: Compensation for unavoidable injury

The fourth category provides compensation for unavoidable injuries sustained in connection with medical complications, including infections, insofar as the complication results in an injury that is more extensive than what the patient would reasonably expect.[59] Unlike categories one through three, which cover avoidable injuries, category four covers unavoidable injury. Not all complications are compensable, but the PIA does provide compensation for injuries caused by complications that are uncommon, unexpected, or disproportional to the underlying illness.

In assessing claims, the Consortium compares the severity of the complication with the severity of the illness. The Consortium must also determine whether the risk of complication was outweighed by the necessity of treatment and whether the injury caused by the complication was unexpected.[60] In order words, if the risk of a particular complication is known to accompany a particular type of treatment, injury sustained from that complication is not compensated. The underlying reason for the distinction could be that patients are informed about the benefits and risks of the examination or treatment and must give their consent. Hence, the PIA provides compensation for remote risks or extensive injuries from uncommon risks. However, as a matter of policy, compensation under category four does not depend on whether or not the physician in fact informed the patient about the known risks and complications of a particular treatment. A patient who was not properly informed does not automatically qualify for compensation.[61] The patient might, however, have a cause of action for lack of informed consent. In addition, under category four complications or infections must be caused by medical intervention and not by the underlying illness or disease. Thus, a patient who undergoes surgery for

59. The PIA paragraph 2 section 1 subsection 4.
60. Directions from the Department of Health at 50.
61. The Explanatory Notes to the Bill at 3293.

appendicitis will not be compensated for common infectious complications following the appendicitis. As a general rule, category four provides compensation only for those complications that go beyond what a patient must reasonably endure in the course of treatment for the underlying illness.

Category four is expected to apply to diagnostic medical procedures in particular. For example, a patient who is seriously injured from exposure to a contrast medium in connection with an x-ray examination will be compensated for his or her injury. Because category four does not provide many guidelines as to what kind of complications are severe, rare, or extensive enough to qualify for compensation, the Consortium will have to develop some guidelines of its own to assist patients and physicians in determining whether or not to file a claim. This determination will be based primarily on medical knowledge and expertise. During the first year in which the PIA was in effect, eighteen of ninety-nine claims were indemnified under category four, suggesting that the Consortium will give the category a fairly wide application.

Category Five: Indemnification for participation in medical research and organ donation

The fifth and final category of injury compensable under the PIA includes injuries caused by participation in medical research programs or participation in organ, blood, or tissue donation procedures at public hospitals.[62] Category five applies to healthy persons—volunteers as well as paid participants—and patients who participate in medical research programs at a hospital covered by the PIA. This category covers injuries of any kind caused by the participation in a research or organ donation program. In no circumstance will a participant have to endure injury without receiving compensation.

Category five is broader in scope than the other four categories—particularly category four, which covers only rare and severe complications or complications that are more extensive that a reasonable patient would expect. Unlike the other four categories, category five also covers psychological injuries caused by participation in medical research.[63] The rationale behind this broad coverage is that it is only fair to compensate

62. The PIA paragraph 4 section 1.

63. The PIA paragraph 4 section 3 provides that psychological injury to healthy persons participating in medical research is compensated.

otherwise healthy persons who are injured through participation in experimental treatment.[64] The type of injury compensable under category five does not include injury caused by drugs, however. Under the PIA, injury caused by drugs is not compensable under any category, including category five.[65]

The requirements for proving causation under category five are also less strict than in the other categories. Under category five, an injury is compensable as long as the injury *may* have been caused by participation in a research or donation program. If there is any doubt as to the cause of the injury, causation will be resolved in favor of the patient and compensation.

The Patient Insurance Consortium indemnified twenty-two claims in category five in 1992, which makes it the category with the second-largest number of indemnified claims. The large number of claims compensated under category five can be attributed to its broad definition of compensable injury and its less stringent burden of proof.

E. Causation

Under the PIA, the patient has the burden of proving injury and causation. First, the patient must prove that he or she has sustained an injury. Moreover, the injury must have been caused in one of the ways described in categories one through five. The patient has the burden of proving by a fair preponderance of the evidence that his or her injury falls into one of the five categories.[66] A preponderance of the evidence standard means that the patient must show that it is more likely than not (a likelihood of fifty-one percent) that the injury was caused in one of the ways described in the PIA.[67]

The preponderance standard is identical to the standard of proof applicable in traditional medical malpractice cases. However, even though the standard and burden of proof under the PIA are similar to those in traditional malpractice cases, the PIA makes it much easier for patients to obtain compensation. The patient-plaintiff's burden of proof in traditional medical malpractice cases is considerably more difficult because the patient-plaintiff has neither the same access to medical informa-

64. The Explanatory Notes at 3295.
65. The PIA paragraph 3 section 3.
66. The PIA paragraph 2 section 1 subsections 1 through 4 and paragraph 4 section 1.
67. The Explanatory Notes to the Bill at 3286.

tion nor the same expertise as the physician-defendant. The plaintiff's burden is increased by the fact that Danish civil procedure does not allow the parties to present the testimony of medical experts as evidence. Instead, both parties submit written questions to a neutral, ad hoc panel of medical experts appointed by the court. If the defendant is the owner of the hospital, the defendant has an automatic advantage over the patient-plaintiff, who must hire medical experts to help in posing relevant questions to the panel of medical experts. The physician-defendant also has an advantage: he or she can testify as to the treatment of the patient, whereas the patient-plaintiff typically will have little or no recollection or knowledge of the medical or surgical treatment rendered.

Under the PIA, the Consortium procures the information and evidence necessary to decide the patient's claim objectively.[68] The Consortium, rather than the patient, goes through the cumbersome process of obtaining the relevant information from medical records, nurses' records, and other hospital records. Once the patient files a claim, the entire process of examining the claim and procuring information is left to the Consortium. Even though the ultimate burden of proof remains with the patient-plaintiff, the PIA's requirement that the Consortium procure the information necessary to decide the patient's claim in effect relaxes the plaintiff's standard and burden of proof.

When the Patient Insurance Consortium determines the issue of causation it must examine three levels of causality. The first question is whether the injury was caused by medical or surgical treatment that the patient received in a public hospital. If so, the next question is whether the injury was caused in one of the five ways described in the PIA.[69] If the injury falls within one of these five categories, a final determination is made as to the extent to which the particular medical intervention contributed to the injury. If the patient's claim fails any of these three tests of causation, the injury is not compensated.

68. The PIA paragraph 13 section 1 provides that the Patient Insurance Consortium is assigned to receive claims from patients and to procure information regarding the cases in order to decide whether the claims are compensable.

69. The PIA paragraph 2 section 1 subsections 1 through 4 or paragraph 4 section 1.

F. Examination of the No-fault Nature of the PIA

The PIA is called a no-fault compensation scheme. In general, no-fault systems are designed to make the issues of breach of duty and negligence irrelevant for purposes of determining compensation. Injured patients need only show causation and injury. However, although the PIA removes the issue of compensation from the issue of negligence, the injured patient still needs to prove that his or her injury falls within one of the five categories of injury compensable under the PIA. The injured patient must also establish a causal link between the injury and a health care service that he or she received in a public hospital, as well as demonstrate the extent to which the health care service contributed to the injury.

The PIA requirements relating to injury and causation do not seem to have greatly simplified the review process. In addition, because the definition of compensable injuries under three of the five categories is based on a criterion of avoidability, the PIA cannot be considered a pure no-fault system. Categories one through three provide compensation for injuries that could have been avoided if the physician had been more experienced, more skilled, or more careful. So, although the purpose of the PIA is to abandon fault as a criterion for compensation, a finding that the patient's injury was avoidable does to some extent imply that the physician's behavior was faulty. The PIA merely broadens the concept of negligence or fault to include acts or omissions that could have been avoided; thus, it is not a pure no-fault system. Only category four, which provides compensation for unavoidable injuries, and category five, which provides compensation for injuries sustained by participants in medical research and organ donation programs, can be described as providing pure no-fault compensation.

Despite the fact that the PIA is not a pure no-fault system, there is no doubt that a much larger number and variety of medical injuries will be compensated under the PIA than under negligence-based medical malpractice law. First, the number and variety of claims will expand because, in some categories, the PIA tightens the standard of care to that of an experienced specialist. Second, the PIA's retrospective analysis of available alternative treatments will also contribute to an increased number of compensable claims. Finally, the PIA will further contribute to an increase in the number of compensated claims by relaxing the patient's standard and burden of proof. Thus, although the

PIA does not qualify as a pure no-fault compensation scheme, it does meet the political objective of easing access to compensation for individuals injured by a medical intervention.

III. Indemnification of the Injured Patient

A. *Application of TLA Principles to the PIA*

Once the Patient Insurance Consortium determines that an injury is compensable under the PIA, it determines how much compensation the injured person is entitled to receive. Except for a few modifications, the PIA provides that compensable injuries are to be indemnified according to the principles of the Tort Liability Act. Both economic and noneconomic damages, such as medical expenses, lost wages, loss of future earnings, pain and suffering, permanent physical impairment, and loss of support, are compensated according to the principles of the TLA. As mentioned in section I, the TLA establishes parameters for compensation that are binding on the parties.

Before employing the assessment methods of the TLA, however, the Consortium must determine whether the claimant's injury is ready for assessment. Because the medical condition must be final in order to be assessable, only injuries that are unlikely to improve or develop further can be the basis for the assessment of economic and noneconomic damages.

B. *The PIA Exceptions to the TLA*

The Patient Insurance Consortium awards compensation only if the damages under the TLA amount to more than $3,000.[70] If damages are less than $3,000, the patient receives compensation; if compensation is more than $3,000, the patient is compensated for the full amount. The purpose of this rule is to preclude patients from recovering for minor and trivial injuries under the PIA. Patients claiming less than $3,000 in damages must pursue their claims through traditional medical malpractice suits. However, many patients decide not to pursue their small claims in court, because in many instances the costs of litigating the suit exceed the expected compensation. The purpose of establishing a $3,000 threshold is to assure that the more serious injuries that profoundly affect the lives of the injured persons are compensated. The need for compensation is most pronounced in cases of prolonged illness, where the economic consequences are most

70. The PIA paragraph 5 section 2 subsection 1.

severe.[71] Presumably, refusing minor and trivial claims will ensure that administrative and economic resources are available to review claims based on more serious injuries. Therefore, the determination of whether or not a claim is compensable under the PIA is based on an assessment of whether or not the injury would result in compensation of more than $3,000. However, it is not always possible for the Consortium to predict whether a claim will meet the damages threshold without thoroughly reviewing the claim. The Consortium has therefore decided as a matter of policy to consider and determine the merit of all claims, including those that appear to be minor and trivial, and then deny indemnification to claims that result in compensations of less than the required $3,000 minimum threshold.[72] The Consortium does not exclude minor and trivial injuries from meritorious review though it does exclude them from the category of compensable injuries.

During the first year in which the PIA was in effect, the Consortium denied forty-nine claims because of the minimum threshold. The Consortium denied thirty-six of these claims without reviewing the merits; the remaining thirteen required further review. Although all of the thirteen claims were found to be compensable, they were ultimately denied because they did not go over the minimum threshold.[73]

The $3,000 minimum threshold has some serious flaws. First, the rule may discourage some injured persons from filing claims with the Consortium because they mistakenly believe that their injures are minor and trivial under the PIA. Second, the rule contradicts the PIA's underlying purpose, which is to provide compensation for avoidable injuries. Although a number of these claims are in fact compensable, the Consortium denies compensation—not because of the nature of the injury, but because the injury does not result in damages of more than $3,000. Describing injuries that result in damages of less than $3,000 as minor and trivial is considered inappropriate by people to whom $3,000 is a considerable amount of money.[74] Third, the rule is fundamentally unfair because in fact it does not distinguish between minor and serious injuries. Instead, the rule discriminates against persons with low incomes. The TLA establishes param-

71. Bo Von Eyben, Patient Insurance at 240.
72. The Annual Report at 27.
73. Interview with Ole Graugaard from the Patient Insurance Consortium (August 6, 1993) [hereinafter the Interview with the Consortium].
74. The Interview with the Consortium.

eters for compensating economic losses. According to the principles of the TLA, persons with high incomes are more likely to be compensated for minor injuries, because their economic losses will accumulate at a faster rate than will the economic losses of persons with low incomes. Individuals with low incomes might have to sustain more serious injuries than persons with high incomes in order to accumulate lost wages of more than $3,000.[75] Finally, the $3,000 rule makes it more difficult for low-income persons to obtain compensation than it was under the old malpractice system. Now claimants must file with the PIC and await the outcome of the claims resolution process before they can initiate a medical malpractice suit.

The $3,000 rule is an unfortunate way of establishing an economic threshold. An alternative method, which would establish an economic threshold without eliminating the right to compensation, is to enforce a qualifying period for economic losses. Several commentators have suggested that a qualifying period would be more straightforward and fair because time, rather than income level, would be the determining factor.[76]

Under the PIA the Secretary of the Department for Health has the authority to limit the standardized TLA compensation for lost wages and pain and suffering[77] by imposing a qualifying period, so that only injuries that cause the patient to lose wages for more than three months are compensated. The Secretary is not likely to exercise this authority, however, because the $3,000 rule already restricts the scope of compensation.[78]

Another deviation from the TLA is found in paragraph 8 of the PIA, which provides that claims of subrogation are not covered under the PIA except for liability according to the PLA.[79] Thus, an employer who continues to pay an employee who is injured or ill does not have a right of subrogation under the PIA because the Act only applies to patient claims for compensation. By the same token, if an injured or ill individual continues to receive wages from the employer, that individual will not receive compensation for lost wages under the PIA.[80] Private in-

75. Hans Davidsen og Arne Notkin *" Oh ve - oh klage"*, Weekendavisen den 14. august 1992 [newspaper article printed in the Danish newspaper Weekendavisen August 14, 1992].
76. The Interview with the Consortium.
77. The PIA paragraph 5 section 2 subsection 2.
78. Bo Von Eyben, Patient Insurance at 244.
79. The PIA paragraph 8a.
80. Bo Von Eyben, Patient Insurance at 244.

surance sources released in connection with a sustained injury are considered to be collateral sources of compensation. Private insurance companies therefore do not have a right of subrogation under the PIA. The PIA is a system composed to truly compensate the individuals who suffer injury in connection with health care activities in hospitals.

Under the TLA, compensation for personal injury is reduced or eliminated if the negligence of the injured person contributed to the injury in any way. The PIA modifies this rule by providing that compensation will be reduced only if the injured person has contributed to the injury intentionally or through gross negligence.[81] This modification of the rule regarding contributory negligence is part of the PIA's no-fault approach to patient compensation. Under the PIA, patients receive compensation without an administrative or judicial finding that the physician is at fault. It would be inconsistent if compensation could be reduced or eliminated because the injured person contributed to the injury. However, under the PIA, a patient still has a duty to follow reasonable directions from his or her physician in order to avoid adverse consequences. A patient's failure to comply with medical directions after medical intervention will adversely affect the assessment of damages.[82]

Finally, the PIA's statute of limitations differs from the statute of limitations under the TLA. The PIA's statute of limitations involves a two-pronged test.[83] First, claims must be filed within five years of the date on which the injured person discovered or should have discovered the injury. Second, claims must be filed within ten years of the date on which the patient was actually injured. The first prong of the test is similar to the statute of limitations enforced under the TLA, which requires injured persons to file their claims within five years of the date on which they discovered their injury. However, the second prong of the PIA test is an absolute limitation: the knowledge of the injured person is irrelevant to the question of whether the ten-year deadline has been met. Accordingly, if a person discovers an injury eight years after the medical intervention that allegedly caused the injury, the claim must be filed within the remaining two years of the PIA's ten-year absolute time period. The statute of limitations is met by filing a claim with the Consortium;

81. The PIA paragraph 6.
82. Bo Von Eyben, Patient Insurance at 246.
83. The PIA paragraph 19.

the injured person does not need to offer information about why he or she believes the claim is compensable.

C. The Claims Resolution Process

1. The organization of the Patient Insurance Consortium

The self-insured county councils, the self-insured hospitals owned by the state, and the insurance companies that insure hospital owners automatically become members of the Patient Insurance Consortium. The Consortium reviews patient claims and determines whether the insurance companies and the self-insured hospital owners must indemnify the claims. Both claimants and the insurance companies may appeal the Consortium's decisions to the Patient Injury Appeals Board. The fact that the members of the Consortium are the insurance companies and self-insured counties that indemnify claims creates a potential conflict of interest: the fewer claims the Consortium decides to be compensable, the fewer compensation awards Consortium members must pay. The Appeals Board, which acts independently under the authority of the Secretary of Health, is the only governmental body that supervises the Consortium. Thus, under the PIA, patient claims are resolved through an administrative process that arguably does not ensure the same impartial resolution that a traditional malpractice suit provides.

The Consortium consists of an executive committee and a Secretariat. The executive committee, which consists of seven members, is selected by the members of the Consortium. The committee is the governing authority of the Consortium; its role is to make administrative decisions concerning Consortium policy. The Secretariat establishes procedures for the reviewing process and reviews claims from patients around the country.[84]

The Consortium is also planning to establish a medical review panel consisting of medical specialists who will assist in the claims review process. In order for a physician to qualify for this panel, he or she must be the chief of a consulting medical staff within his or her specialty at a major hospital. At present, the panel consists of four physicians. Each claim is reviewed by the two physicians on the panel who are experts in the particular medical field that the claim involves. The physicians are paid for their medical reviews on an hourly basis. The Consortium is planning to increase the number of specialists on the panel so

84. The Annual Report at 10.

that it can review claims involving medical specialties.[85] Because the determination of whether or not a claim falls within one of the PIA's five categories of compensable injuries is based largely on medical expertise, the panel of physicians affiliated with the Consortium will have a decisive influence on the review process.

2. The resolution of claims

The injured patient initiates the review process by filing a claim with the Consortium, using a claim form that is available at all public hospitals. The patient should be able to initiate the administrative process without enlisting the services of an attorney. In fact, the Consortium discourages the use of attorneys by covering all costs involved in the review process except for attorneys' fees.[86] None of the 264 patients who filed claims during the first year in which the PIA was in effect was assisted by an attorney.[87]

Because only a small number of Danish attorneys specialize in medical malpractice law and because the number of medical malpractice suits over the years has been fairly small, the legal profession in Denmark does not view the PIA's elimination of attorneys' services as a major setback. In addition, because attorneys in Denmark are generally not paid on a contingency fee basis, medical malpractice law is not as economically attractive as it is in the United States. Nevertheless, the PIA's *de facto* elimination of the attorney's role in the recovery process does leave claimants without any professional to assist them in the presentation of their case. Enlisting the services of an attorney seems even more appropriate when one considers that insurance companies administer the Consortium's claims resolution process. Although the PIA seems to have made patient access to compensation less difficult and less expensive, the elimination of the attorney's role in the recovery process leaves the claimant alone with the Consortium and the insurance companies.

The Consortium does, however, resolve patient claims through an adjudicatory-like administrative process. Because it administers procedures that are adjudicatory in nature, the Consortium is bound by Denmark's Administrative Procedures Act

85. The Annual Report at 12 and the Interview with the Consortium.
86. The Interview with the Consortium.
87. The Interview with the Consortium.

(APA) even though it is not an administrative agency.[88] The APA rules relating to the competence of evidence, freedom of information, and hearing procedures are particularly relevant in the claims resolution process. The APA also provides that all administrative remedies, including appeal to the Patient Injury Appeals Board, must be exhausted before the parties can seek judicial review.

The PIA requires that the Consortium procure the information necessary to review the claim.[89] Once the necessary information is obtained, the Consortium's claims reviewer initiates an investigation, which includes a review of the medical records and a consultation with the physician panel. The physicians review the claim and present their medical conclusions to the claims reviewer, who determines whether the claim falls within one of the five categories of injury compensable under the PIA. The Consortium has the authority to acquire depositions or written affidavits from witnesses as part of its investigation.[90] Depositions and affidavits are necessary in only a small number of cases, in which the aid of attorneys might be required.

If the claims reviewer determines that the patient's injury is compensable under the PIA, he or she must then assess the extent of the patient's injury in order to determine the size of the compensation award appropriate under the TLA. This determination is again based on the medical opinion of the Consortium's advising physicians. Once the claims reviewer has determined the appropriate amount of compensation, both the claimant and the insurance company responsible for indemnifying the patient's claim are notified of the Consortium's decision. If a claim is denied, according to the APA the claims reviewer must notify the claimant of the reasons for the denial and inform the claimant of his or her right to appeal the decision to the Patient Appeals Board.

The PIA's review process seems elaborate and time consuming, but in fact it resolves claims more quickly than the traditional malpractice system. During the first year in which the PIA was in effect, the average time lapse between the filing of a claim and the final decision was three months, compared with an

88. Lovbekendtgoerelse nr. 652 af 23. juli 1992 of forvaltningslovens anvendelse paa Patientforsikringsforeningens virksomhed, paragraf 1 [the Government Notification no. 652 July 23. 1992 paragraph 1] [hereinafter Notification no 652]. The Notification provides that the Administrative Procedures Act applies to the PIA.

89. The PIA paragraph 13 section 1.

90. The PIA paragraph 13 section 2.

average of eighteen to twenty-four months before the PIA was in effect. Although the number of claims for 1993 and the years following is expected to increase, the time required for claims resolution is expected to increase by only fifteen days, for a total of three and one-half months.[91] Because the Consortium expects an average of two thousand claims per year when the PIA's review system is fully established,[92] it is unrealistic to expect that the period will remain three and one half months unless the Secretariat is expanded dramatically. Moreover, claims reviewers are not always able to determine the size of compensation awards with the same speed with which they make the initial determination regarding whether the claim falls within one of the five categories of injury compensable under the PIA. It is sometimes impossible to determine whether or not a compensable injury will cause permanent physical impairment within a period of time as short as three and one-half months. A claim involving an injury that requires prolonged recovery or multiple surgeries may not be resolved until a year after the claim is filed.

At present, however, the PIA does seem to compensate patients more quickly than the traditional malpractice system. Patients whose PIA claims are successful receive the same amount of money as they would under the traditional malpractice system because both PIA indemnification awards and damage awards in a medical malpractice suit are determined according to the principles of the TLA.[93]

Patients and insurance companies may appeal Consortium decisions by filing an appeal with the Patient Injury Appeals Board[94] within three months of receiving notification of the decision.[95] The Patient Injury Appeals Board has nine members. The Department of Health appoints five of the board members; of these five, one must be a judge, and two must be medical experts. The Association of County Councils appoints two members of the Board, and the Danish Association for the Disabled appoints the remaining two. All board members are ap-

91. The Interview with the Consortium.

92. The Interview with the Consortium.

93. However, as discussed above in section III(B), the TLA does not apply if the patient's PIA claim results in damages of less than $3,000, in which case the patient receives no compensation at all.

94. The PIA paragraph 15 section 1 provides that decisions made by the Consortium are reviewable by the Patient Injury Appeals Board.

95. The PIA paragraph 15 section 2.

pointed for a period of four years and receive compensation for participating in the review of individual claims.[96]

The Board reviews the merits of each claim it receives on appeal. As part of the appellate review process, the Consortium must provide comments on its decisions. Apart from the Consortium's comments, the Appeals Board receives no information. The Board relies solely on information already obtained by the Consortium from medical and nursing records and from the Consortium's physician review panel. The scope of the Board's review is limited by its sources of information; the Board does not have the economic resources to initiate a new investigation or to conduct an independent medical review of the claim. The Board must rely on the medical conclusions of the physicians affiliated with the Consortium. Filing an appeal with the Appeals Board is the final step in the PIA's administrative review process. However, because the Appeals Board makes its decision without questioning the basis of information, the chances of having an unfavorable decision by the Consortium revoked seem fairly small. All decisions of the Appeals Board are binding on the parties unless the parties seek judicial review within six months of receiving the Board's decision.[97] The scope of judicial review is unlimited: courts can try questions of both fact and law.

Any one with a legal interest has standing to appeal the Consortium's decision to the Appeals Board, including the injured patient and the insurance company that insured the hospital involved.[98] However, the physician whose diagnosis, choice of treatment, or performance of treatment are questioned and judged by the Consortium and its panel of medical experts is not included in the group of individuals considered to have a legal interest in the Consortium's decision. Although physicians are not directly involved—that is, the physician is not named as a party to the claim, is not economically liable, and has no standing to appeal the Consortium's decision—the physician's medical judgment and skills are at issue when the Consortium resolves claims. The Consortium's decision to award compensation to an individual patient may affect the reputation of the physician involved. It seems contradictory that a no-fault com-

96. The PIA paragraph 14 section 3.

97. The PIA paragraph 16 section 1 and section 2 provides that the Appeals Board's decisions are reviewable by the courts. Suit must be filed within six months of notification of the Board's decision.

98. The Explanatory Notes to paragraph 15 in the Bill at 3309.

pensation scheme can still stigmatize physicians, but most of the injuries that are compensable under PIA categories one through three are characterized as injuries that could have been avoided if the physician had more expertise and experience. On the other hand, in a traditional medical malpractice case the physician also has very little influence in deciding whether to pursue or settle a case; such decisions are made by the hospital as the physician's employer and its insurance company.

Because the drafters of the PIA did not expect many claimants to appeal the Consortium's decisions, few economic or administrative resources were invested in the Appeals Board. During the first year in which the PIA was in effect, nineteen claimants filed appeals with the Appeals Board. During the same period, the Consortium denied coverage and indemnification for 165 of 264 claims. Thus, 11 percent of the claimants who received unfavorable reviews by the Consortium proceeded with their claims to the Appeals Board.[99] Information on the number of the Consortium's decisions affirmed or revoked is not available at the present time.

The fairly high percentage of appeals demands that the Appeals Board be given the resources necessary to provide thorough and effective review of claims, including the resources necessary to procure independent medical review of each claim. Without these resources, the Appeals Board will become just an administrative obstacle that claimants must overcome before they can obtain judicial review of Consortium decisions.

IV. The Success of the PIA

A. The Economic Consequences of the PIA

In 1985, before the enactment of the PIA, insurance companies in Denmark received 225 claims of medical injury. Two hundred of these claims were received by Kommunernes Gensidige Forsikringsselskab (KgF), an insurance company that is owned by the counties and insures public hospitals. Of the 200, half were found to have been caused by negligence and the claimants were compensated. The insurance companies paid a total of $1.4 million in compensation to individuals who suffered negligent medical injury—an average of $14,000 per compen-

99. The statistical information is provided from the Interview with the Consortium.

sated claim.[100] Most medical malpractice suits, however, typically concern claims of less than $14,000.

During the first year in which the PIA was in effect, the Consortium compensated 99 of the 264 claims that it received. Although not all claimants have yet received their compensation, the compensation payments are expected to amount to approximately $3 million, an average of $32,000 per compensated claim. Based on the experience of other Scandinavian countries that have no-fault systems for compensating medical injury, the number of compensable claims in Denmark will eventually increase to about 2,000 per year, or approximately $14 million in compensation payments.[101]

The average amount of compensation per claim appears to have increased from $14,000 to $32,000. However, the TLA guidelines for determining the size of compensation awards have remained unchanged under the PIA. Although the increase in the size of the average compensation award under the PIA could be attributed to an increase in the number of severe injuries, which entitle the injured individuals to more compensation, it is more likely that the increase is due to the fact that the PIA eases access to compensation and provides more extensive coverage, including coverage for serious injuries that used to be considered adverse events. Not surprisingly, the no-fault system established under the PIA will be far more expensive for hospital owners and their insurance companies than the traditional medical malpractice system.

B. Evaluation of the PIA

The goal of most medical malpractice systems is to compensate injured patients and to deter and punish negligent physicians. The main goal of Denmark's PIA, however, is to compensate patients who have been injured by health care activities. The PIA's no-fault system does nothing to further the goals of deterring and punishing the physicians involved in medical injuries. The system's failure to deter or punish could encourage hospitals and physicians to relax the standard or quality of care. This section will examine the PIA's approach to fulfilling the goal of the traditional malpractice system.

100. The Explanatory Notes to the Bill at 3273.

101. For example, Sweden and Norway have had no-fault compensation systems for several years. The Interview with the Consortium.

1. The goal of compensation

The system established under the PIA seems to compensate a much larger group of injured individuals than the traditional medical malpractice system. The PIA's definition of compensable injuries encompasses a number of nonnegligent acts and omissions that would not be compensated under the traditional system. 264 claims were filed with the Consortium during 1992, the first year in which the PIA was in effect, compared with 225 claims filed under the traditional system. Estimates suggest that the number of claims filed with the Consortium will gradually increase to more than 2,000 claims per year. The greater number of claims that are filed now and will be filed in the years to come indicates that the PIA covers a wider range of negligent acts, omissions, and types of medical injuries. Access to compensation has improved: the PIA's administrative procedure works faster than the judicial system. At present, only three and one-half months elapse from the time a claim is filed until the claimant receives notification of the Consortium's decision. This is considerably less than the time required for a decision by the judicial system, where a medical malpractice suit can go on for years. Moreover, because the Consortium has the burden of procuring the information necessary to determine claims, the process of obtaining compensation is that much less cumbersome and expensive for claimants. The PIA's administrative process, which is more manageable than the judicial system, also keeps down the costs. However, the fact that the PIA has eliminated attorney services is unfortunate for patients, who are left to rely on the Consortium to make reasonable decisions during the review process.[102]

Because the principles of the TLA apply to the system established under the PIA in the same way that they apply in a traditional medical malpractice case, compensation awards are very uniform. Thus, the issue of undercompensation generally does not arise. The only exception to the TLA principles is the rule that injuries resulting in damages of less than $3,000 are not compensable. This rule denies compensation to a large number of patients with otherwise compensable injuries. In 1992, 13 of 112 claims were denied solely because of the $3,000 rule;[103] for claimants who fail to meet the $3,000 threshold, the PIA does

102. The Explanatory Notes to the Bill at 3273 and the Interview with the Consortium.

103. The Interview with the Consortium.

not offer just compensation. The PIA establishes a $3,000 threshold in order to limit the cost of minor and trivial claims, but the same effect could be achieved by imposing a qualifying period for lost wages so that lost wages for the first 60 days of a person's illness are not recoverable. Although patients who are denied compensation under the PIA can proceed with their claim in court, many will find the court process too costly and cumbersome.

2. The goals of deterrence and punishment

A system in which claims are brought against a hospital and are indemnified through the hospital's insurance does not create any economic deterrent for physicians, because their malpractice or poor performance is not sanctioned by any economic penalties. However, the PIA is a no-fault system: deterring and punishing negligent physicians is not its goal. The PIA was enacted to compensate patients for medical injuries that could have been avoided. The fact that an injury was avoidable does not necessarily mean that negligence was involved.

The lack of deterrence argument has not had much support as an argument against the PIA. The practice of medicine in Denmark is highly regulated. The regulations and sanctions that are imposed on negligent physicians create a deterrent factor, but it is questionable how much the threat of a medical malpractice suit contributes to deterrence. Apparently the threat of a lawsuit does not deter physicians from performing negligently, because a large number of negligent injuries occur each year.[104] Furthermore, because medical malpractice suits are filed only in a small number of negligence cases, the threat of a malpractice suit probably does not affect most physicians. In addition, most medical malpractice suits are filed only against the hospital and not against the treating physicians. According to the TLA, employers are vicariously liable for the negligence of their employees. If an employer has liability insurance that covers the actions of its employees, the employees cannot be held liable for their own negligent actions. Thus, employees are liable and subject to lawsuits only if they act intentionally or with gross negligence.[105] Malpractice suits deter negligence only indirectly in that the negligent physician is responsible for the employer's involvement in a malpractice suit.

104. Bo Von Eyben, Patient Insurance at 17.
105. The TLA paragraph 19 section 3.

Physicians do not have absolute immunity from poor performance or negligent behavior, however. In 1987 a Patient Complaints Board was established to review the practices of medical professionals, including physicians, nurses, and nurse's aides.[106] Complaints may be brought by patients, the relatives of patients, and the Health Care Department, which supervises the quality and delivery of care in all Danish hospitals. The Department of Health appoints all sixteen members of the Patient Complaints Board. In reviewing complaints, the Board must notify the health care professional whose conduct or performance is at issue and give the individual time to comment on the complaint. The Health Care Department is also asked to comment on the case. After receiving information and comments from the parties involved, the Board determines whether the complaint has merit and may initiate disciplinary action or recommend to the Attorney General that criminal charges be brought under the Medical Practice Act. Thus, even though deterrence is not an explicit component of the PIA, the Patient Complaints Board should have the effect of deterring medical negligence.

Before the PIA took effect, the Patient Complaints Board functioned in tandem with the medical malpractice system. In fact, Board decisions were often used as evidence in medical malpractice suits to support the party whom the Board's decision favored. The Patient Complaints Board continues to play an important disciplinary role even after the implementation of the PIA, because physicians do not want to be stigmatized by disciplinary or criminal sanctions for malpractice. In addition, the Consortium may rely on Board decisions in its claims review process. However, the Board may in turn rely on a Consortium decision when reviewing a physician's professional conduct and performance. This is unfortunate, because under the PIA's no-fault system the physician has no opportunity to defend himself against the patient's allegations of negligence.

The PIA is based on cooperation between the physicians and the Consortium. The no-fault nature of the PIA's insurance

106. Lov nr. 397 af 10. juni 1987 om sundhedsvaesnets centralstyrelse mv. paragraph 12 stk. 1 [the Patient Complaints Board par. 12 section 1]. The Patient Complaints Board (Patientklagenaevnet) deals with the professional conduct and performance of health care professionals and complaints concerning medical care and treatment, inpatient as well as outpatient treatment. All medical staffs are placed under the authority of the Board. The Board has the authority to take disciplinary actions as well as recommend criminal prosecution.

scheme and the fact that physicians are not personally involved in the claims resolution process makes physicians less reluctant to admit that an adverse event has occurred; therefore, physicians are more likely to inform their patients about the possibility of obtaining compensation through the PIA.[107] The Consortium registers and analyzes the types of claims received in order to evaluate the types of injury that are most common or most costly to indemnify. Health care providers are given access to the Consortium's information and statistics so that they may correct or change those medical procedures that most frequently give rise to injuries.[108] The information in the Consortium's database relates only to medical injuries and not to the physicians involved. Thus, a hospital that is deciding whether or not to employ a particular physician does not have access to information about the physician's past performance.

CONCLUSION

Denmark's Patient Insurance Act establishes a system for compensating patients injured by medical negligence, but it is not a pure no-fault system. As demonstrated in section II of this article, three of the five categories of injuries compensable under the Act involve a degree of fault on the part of the health care worker. The system established under the PIA is not perfect: patients with less than $3,000 in damages receive no compensation for their injuries unless they go outside the PIA system, to court; patients are not represented by attorneys during the claims resolution process and must rely on the Consortium to act in good faith; and physicians, though not personally liable for the economic consequences of their negligence, are deprived of an opportunity to defend their reputations during the claims review process.

However, based on data from 1992, the first year in which the PIA was in effect, the PIA appears to be a good but expensive alternative to the traditional medical malpractice system. During 1992 the PIA compensated a large number of patients who would otherwise have to carry the burden of medical injury themselves. Once the system is fully established, the PIA will indemnify about 2,000 claims each year, which is a tremendous improvement over the average of 225 claims that were compensated each year under the traditional malpractice system.

107. The Interview with the Consortium.
108. The Annual Report 1992 at 17.