FOR THE RECORD

Scotland mulls no-fault compensation

No-fault compensation for clinical treatment injuries may finally be inching toward reality in Scotland as the government has launched public consultations on the financial and practical implications of introducing such a scheme to cover therapies provided by all public or private health care providers.

But while the Scottish government indicated in 2008 that no-fault compensation was its "favoured way forward," Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy Nicole Sturgeon cautioned in the government's new consultation document, *A Public Consultation on Recommendations for No-Fault Compensation in Scotland for Injuries Resulting from Clinical Treatment*, that it is not yet wedded to a no-fault approach. "No decision has been made in relation to whether a no-fault system should be introduced and I do not underestimate the complexity of introducing such a system. This consultation seeks wider views on the Review Group's recommendations in order to help in our understanding of what the practical implications are," Sturgeon states in the ministerial foreward to the consultation document (www.scotland.gov.uk/Resource/0039/00399081.pdf).

The government had appointed a review group in 2009 to recommend the essential criteria for a no-fault compensation plan. The expert panel, chaired by Sheila McLean, director of the Institute of Law and Ethics in Medicine at Glasgow University, urged the creation of a system that awarded compensation based on need and covered all medical treatment injuries in Scotland, i.e., all injuries that "can be caused, for example, by the treatment itself or by a failure to treat, as well as by faulty equipment, in which case there may be third party liability."

The Scottish consultation document notes that "the Review Group took a no-fault system to mean one in which there is no need to establish that any individual was negligent. However, they considered that the link between the (in)activity and the harm resulting from it (i.e. causation) would still need to be established." It added that research supports the proposition that "when an error has occurred, patients expect staff to make a meaningful apology, provide an explanation and take steps to prevent the error from recurring. The findings of their research would appear to support the contention that for many, if not most, patients this is the primary aim of taking a case forward, rather than a financial award."

Among the advantages of a no-fault compensation scheme identified in the consultation document are "a principled social/community response to personal injury which includes a recognition of community responsibility; comprehensive entitlement; full rehabilitation; fair and adequate compensation; and administrative efficiency." Among the disadvantages: "Potential lack of affordability, particularly in the context of large national populations; Financial compensation/entitlements in the existing schemes are set lower than would be the case in successful clinical negligence claims brought under delict/tort-based systems; [and] the removal of the threat of litigation which is sometimes said to provide an incentive for health practitioners and health institutions to avoid unsafe practices and promote institutional and professional accountability and learning in relation to (preventable/avoidable) medical injury."

The government also asks whether the no-fault scheme "should cover all clinical treatment injuries (e.g. private healthcare and independent contractors) and all registered healthcare professionals and not just those directly employed by NHS [National Health Service]Scotland? If not, why not? What, if any, difficulties do you foresee in including independent contractors (such as GPs, dentists etc) and private practice? What are your views on how a scheme could be designed to address these issues?"

The Scottish consultations are open through November (www.scotland.gov.uk/Publications/2012/08/4456/0).

In Canada, patients do not have access to no-fault compensation for injury suffered as a result of what are variously called adverse or avoidable events, misadventures, medical error or fault (www.cmaj.ca/lookup/doi/10.1503/cmaj.081020). Filing a complaint is often problematic and difficult (www.cmaj.ca/lookup/doi/10.1503/cmaj.071723). In the United States, the complaints system is slightly more user friendly, while malpractice awards, although infrequent, are typically enormous (www.cmaj.ca/lookup/doi/10.1503/cmaj.080209). European processes vary widely, with some jurisdictions coupling compensation schemes with the regulation of physicians and complaints (www.cmaj.ca/lookup/doi/10.1503/cmaj.080527). — Wayne Kondro, *CMAJ*

The Lone Star shuffle

Doctors in Texas who are sanctioned by hospitals and other health care organizations may lose their hospital privileges, but they often don't face additional disciplinary action from their state medical board, according to an analysis of the United States National Practitioner Data Bank.

The Texas Medical Board took no action against 459 of 793 (almost 58%) physicians that were disciplined by health care organizations in the state over the past 21 years, the Washington, D.C.–based nonprofit organization, Public Citizen, states in a report, *Public Citizen's Report On Dangerous Texas Medical Board Enforcement Deficiencies: Their Causes and Solutions* (www.citizen.org/documents/2063a.pdf).

"Many of the physicians were disciplined by hospitals and other health care

institutions because they were deemed an immediate threat to the health and safety of patients, [were] incompetent or negligent, they committed sexual misconduct or insurance fraud, they abused drugs or alcohol, or they provided substandard care to patients," the consumer advocacy organization states in a press release (www.citizen.org/pressroom/pressroomredirect.cfm?ID=3694).

The organization called on Texas Governor Rick Perry to take immediate action to improve the Texas Medical Board's performance and "thereby protect patients in Texas from physicians who should have been, but were not, disciplined."

Almost half the physicians — 47% — had one or more medical malpractice reports against them, says the report. One doctor paid out a total of US$2.4 million for malpractice claims between 1996 and 2008, for cases including removal of the wrong body part, a contraindicated procedure, the administration of the wrong dosage of medication and delays in treatment. In 2009, before the doctor retired, the physician was expelled from a professional medical society for unprofessional conduct. "Unfortunately, the Texas Medical Board allowed this physician to practice while committing 22 cases of medical malpractice," the report states.

Other doctors were disciplined by their health facilities but allowed to continue to practice, despite such serious offences as a conviction for four drive-by shootings of garages and automobiles belonging to a former business partner, the report adds. In another case, a doctor was arrested and pled guilty on charges of writing prescriptions in exchange for sexual favours.

The board's backlog of cases goes back in some cases seven years.

The report recommends using a great portion of licensing and renewal fees to hire more staff and follow up on disciplinary cases. Currently, the board brings in about US$60 million over a two-year period but keeps only US$20 million. The remainder goes into the state's general revenue fund.

"With this increased funding must come the responsibility to decrease the dangerous backlog of unresolved cases and to discipline a large proportion of the 459 Texas physicians found to have committed offenses serious enough to result in the severe credentialing actions against them by Texas hospitals and other health care entities," Dr. Sidney Wolfe, director of Public Citizen's health research group, states in the report's summary.

Wolfe adds in an interview that an independent monitor should be appointed to examine the board and recommend means of reducing delays in investigation and monitoring cases. "They should particularly focus on doctors who have one or more strikes against them. Since 2006 there has been a 57% increase in complaints to the board, but the budget and staff have gone up by only 12%–16% and in fact they are way behind in resolving cases."

Wolfe also believes all US state medical boards should follow the lead of the College of Physicians and Surgeons of Ontario and conduct unannounced audits of doctors' offices and records. "That's not being done anywhere in this country," he says. — Laura Eggertson, *CMAJ*

Court upholds funding of embryonic stem cell research

The United States National Institutes of Health (NIH) is entirely within its purview when it funds research based on human embryonic stem cells, a US appellate court has ruled.

Rejecting an appeal from adult stem-cell researchers James Sherley of the Boston Biomedical Research Institute in Watertown, Massachusetts, and Theresa Deisher, of AVM Biotechnology in Seattle, Washington, who sought to stop all federal funding of such research, the US Court of Appeals for the District of Columbia Circuit ruled that the Institutes of Health can fund research that uses stem cell lines that are derived from earlier destruction of an embryo, although they can't fund destructive cell-line derivation.

The ongoing controversy over federal funding of stem cell research stems from a 1996 law paced by the US Congress known as the Dickey–Wicker Amendment, which prohibits NIH from funding "the creation of a human embryo or embryos for research purposes; or research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero."

In 2001, former US president George Bush declared in an executive order that federal funds would be used for research on embryonic stem cells only if such cells were drawn from one of roughly 60 existing stem cell lines. But US President Barack Obama revoked that in 2009 by issuing a new executive order stating that the NIH "may support and conduct responsible, scientifically worthy human stem cell research, including human embryonic stem cell research, to the extent permitted by law."

NIH subsequently issued guidelines that stated a research project could be funded if the stem cell lines were "created by in vitro fertilization for reproductive purposes, no longer needed for that purpose, and voluntarily donated by the individuals who owned them."

Sherley and Deisher argued that an embryo had to have been destroyed in the creation of a stem cell line, and therefore the Dickey–Wicker Amendment had to have been violated. They also argued that any funding of human embryonic stem cell research increases demand for stem cell lines and therefore, creates an incentive to destroy more embryos to create more stem cells, thereby putting more embryos at risk.

But Chief Judge David Sentelle rejected the arguments.

"It is established that "research" as used in Dickey–Wicker is an ambiguous term, and that NIH's interpretation of the term "research" as a discrete project rather than an extended process is reasonable," Sentelle wrote in *Sherley v Sebelius* (www.cadc.uscourts.gov/internet/opinions.nsf/6C690438A9B43DD685257A64004EBF99/$file/11-5241-1391178.pdf). "Under that definition of 'research,' the destruction of embryos that occurs in the ESC [embryonic stem cell] derivation process is not a part of individual ESC research pro-

jects using already derived ESCs. Therefore, ESC research is no more 'research in which . . . embryos are . . . subjected to risk' than it was 'research in which . . . embryos are . . . destroyed.' Appellants' theory shifts focus from the embryo destroyed in the past to embryos for which an ESC research project 'incentivizes' future destruction. But none of those embryos are 'destroyed' or 'subjected to risk' in an ESC research project. The language of Dickey-Wicker does not ban funding for, e.g., research which provides an incentive to harm, destroy, or place at risk human embryos. As we have held before, the NIH interpretation of the statute's actual language is reasonable."

The ruling was "another step in the right direction," NIH Director Dr. Francis Collins stated in a press release. "NIH will continue to move forward, conducting and funding research in this very promising area of science. The ruling affirms our commitment to the patients afflicted by diseases that may one day be treatable using the results of this research" (www.nih.gov/about/director/08242012_stemcell_statement.htm). — Wayne Kondro, *CMAJ*

The Parti Québécois promises

The gap between election promises and what a government delivers is often vast, particularly for those of a minority variety. Quebec will be testing that truism after narrowly electing a minority Parti Québécois government led by Pauline Marois on Sept. 4.

During the campaign, Marois and her party promised substantial changes to the province's health care system, including revisions to the terms under which Ottawa transfers money to Quebec for health services. But while making those vows, Marois, a former provincial health minister, cautioned that many of those changes would require a full four-year term — and sovereignty. Her party's minority status will likely affect her ability to deliver on those promises. They included:

- A $59-million program to hire new health care professionals, including nurse practitioners, physiotherapists, nutritionists, psychologists and other specialists, adding them to the province's family medicine groups.
- A $36-million investment to hire 700–1000 physicians and to increase the number of family medicine groups to 300 from 243, so that within four years, every Quebecer will have access to a family doctor.
- New prescribing authorities for pharmacists to prescribe and renew medication for some infections and chronic illnesses, and access for pharmacists to laboratory test results.
- A $500-million homecare program for seniors, freeing up 1100 hospital beds.
- Preventive measures to fight junk food, sedentary lifestyles, smoking and sexually transmitted infections.
- Elevating the fight against cancer to a national (i.e. Quebec) priority and reorganizing the fight against cancer, in partnership with the community.
- Integrating new technologies in the health system, particularly those developed in Quebec.

Overall, the Parti Québécois election platform promised to restore "a real public health care system" that is universal, accessible, efficient and provides quality services.

During a debate with then-Premier Jean Charest, Marois also pledged to abolish the $200 flat health tax for individuals and $400 for families that the 2010 Liberal budget had announced. She also promised to revise the terms under which Ottawa distributes federal transfer payments for health care services, to ensure Quebec receives more of the funding than the current per capita formula would allow.

"Sovereignty would allow us to keep all the money we currently send to Ottawa. We would recover all the money. And we wouldn't be forced to participate in these vast national programs that we already have," she said during the election campaign.

On August 28, Parti Québécois candidate Daniel Breton said the party would also cancel a $58-million loan to renovate and re-open the Jeffrey Mine in Asbestos, Que., and would review the future of the asbestos industry in the province. — Laura Eggertson, *CMAJ*

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