Could no-fault compensation for medical errors improve care and reduce costs?

ABSTRACT

The costs of litigation are large and increasing, to a level that places a drain on precious health-care resources and affects the way medicine is practised. This article examines whether a change to a no-fault legal system would lead to reduced costs and improved patient care.

Internationally the costs of litigation are large and increasing, to a level that places a drain on precious health-care resources and affects the way medicine is practised. The costs of litigation are huge – NHS Resolution (formerly the NHS Litigation Authority) in England estimates that for the whole of the NHS in England in 2016–17 the costs were £1.7 billion (Brady, 2018) and they are increasing. The costs in the United States of America are estimated at 1.66% of gross domestic product, which is 2.6 times higher than the percentage of gross domestic product in Europe. The liability costs in European countries such as Germany and Denmark have been calculated as increasing by 13% and 25% per year since 2008 (Hinton and McKnight, 2013).

Further, the nature of the claims is changing, with the number of claims for clinical negligence below £3000 having increased by 26% over the last 10 years (Foges, 2018). The increase in the volume of smaller claims leads to a disproportionate increase in legal costs, as certain legal costs are unrelated to the size of the claim. Surgery is one of the principal areas attracting an increase in both claims volume and damage costs within the NHS (Oh et al, 2018).

This article examines the costs associated with litigation within the NHS, using trauma and orthopaedics as a case example, and considers whether a change to a no-fault legal system would lead to reduced costs and improved patient care.

The existing system in the UK

Currently, for a patient to succeed in his/her claim, the patient has to establish that the action or inaction taken by the clinician was negligent. In England and most other jurisdictions, in order to succeed in a claim for clinical negligence, the patient has to establish three factors:

1. The doctor owed the patient a duty of care
2. The doctor's actions were negligent
3. The injury suffered by the patient was caused by the doctor's negligence.

The first of the factors is often automatic, as the doctor is employed to treat the patient, and courts have been slow to apply a relationship when the doctor is out socially and gets involved in helping someone who acutely becomes unwell – a good Samaritan act (Brown, 2010).

The critical question is what constitutes negligence, the second factor, and thus has the doctor breached the duty of care he/she owed to the patient? This is breached when the treatment falls below the standard expected of the doctor, being judged at the level of ordinary skill rather expecting them to be miracle workers or possessing the highest expert skill [Bolan v Friern Hospital Management Committee 1957]. A court, in deciding whether there has been a breach, assesses independent medical evidence on the doctor's actions and whether a responsible body of medical opinion supports these actions at the time when the incident occurred [Bolitho v City and Hackney Health Authority 1997].

The third test is whether the established negligence lead directly to the harm suffered by the patient, with the harm being actual harm rather than potential harm that occurred coincidently at the time of the established negligent actions by the doctor.

These three factors need to be established by the patient on the balance of probabilities, namely more probable than not (51%). Then a court assesses the harm and consequential loss, and makes an appropriate award.

The winning party will have their costs paid by the other side; at the conclusion of the trial the court usually assesses these to make sure that the claimed costs are reasonable. There has been extensive legal reform in personal injury including clinical negligence within the English jurisdiction, with one of the principal aims being to reduce costs (Hyde, 2018).

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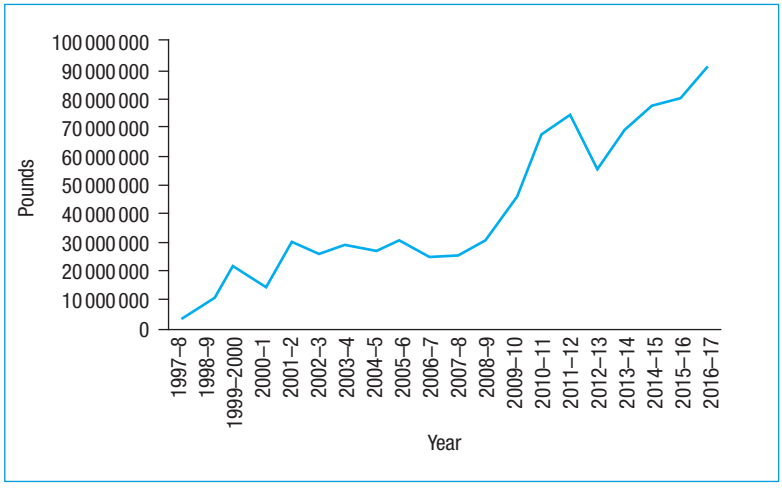

Figure 1. Total sum of damages paid.

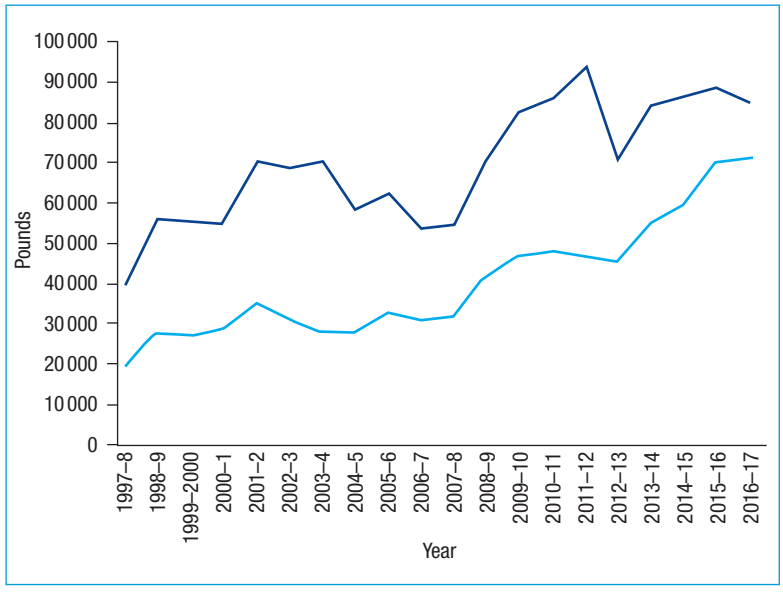

Figure 2. Average cost (£) and damages awarded between 1997 and 2017.

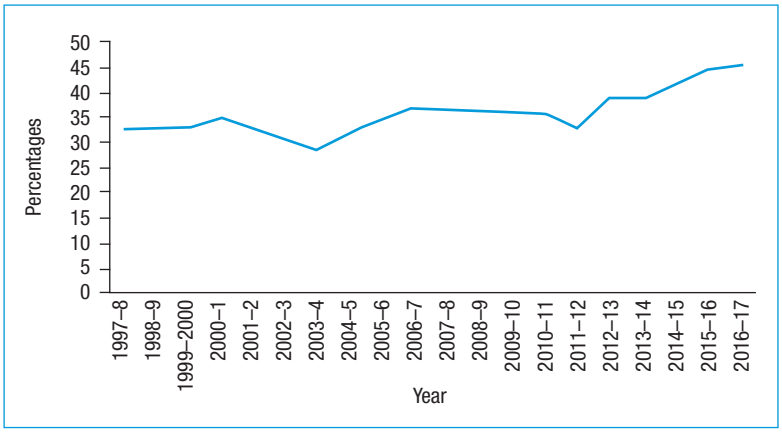

Figure 3. Legal costs as a proportion of the damages (%).

A case study: orthopaedic and trauma surgery within the NHS

Trauma and orthopaedics surgery accounts for 48% of legal claims against the surgical arm of the NHS – the largest proportion of claims of all surgical specialities within the NHS (Dyer, 2013; Mead, 2014). A freedom of information request was made to NHS Resolution, seeking details of claims within trauma and orthopaedics over the last 20 years. These data were distilled into the number of successful claims (settled before or after a civil trial), the amount of damages, and the amount of both defence and claimant costs (*Figures 1–3*). NHS Resolution is a not-for-profit arm of the NHS that is responsible for the indemnity scheme operated on behalf of the Secretary of State for Health and covers clinical negligence claims against the NHS.

The number of legal cases involving trauma and orthopaedics has increased dramatically over the last 20 years, with a 1283% increase in the number of claims. The cost of the damages awarded or paid by NHS Resolution in the last financial year was in the region of £90.5 million, which represents a 2956% increase over the 20-year timeframe (*Figure 1*). These amounts (*Figure 2*) demonstrate an upward progression of both the average damages secured and the average overall costs of the actions. Even more troubling is the increase in the proportion of the damages which is received by the lawyers on either side (*Figure 3*). In 1997–8, the cost of litigation accounted for 33% of the damages, whereas in 2016–17 this had risen to 46%. The cost of the overall litigation in 2016–17 amounted to approximately £76 million *vs* damages awarded to patients of £90.5 million.

What is no-fault litigation?

Currently in order for a patient's claim to be successful, it has to be established that the action or inaction taken by the clinician was negligent. In a no-fault system the focus shifts to the link between the action and/or inaction by the clinician and the harm resulting from it. The primary objective is rehabilitation rather than financial compensation, although money remains an important feature. The British Medical Association (2016) supported the idea of a no-fault system in the past, when the idea was being canvassed by the Scottish Government. No-fault schemes already operate in England on a very narrow basis, for example the Criminal Injuries Compensation Scheme, which compensates those injured as a result of criminal actions. This scheme has a minimum threshold of £1000 damages and thus small injuries are excluded (Ministry of Justice, 2012).

The advantages of the no-fault system are:

- Patients would obtain compensation quicker as there would not be the need to establish fault
- The award would be made by administrative means or via tribunal rather than by an adversarial process which would mean payment would be quicker
- If implemented well there would be cost saving in reduced legal fee payouts.

In this environment, there could be a complete paradigm shift, as it would encourage transparency between clinicians

and patients. The desire to work in medicine comes from a calling to help people, thus without a constant fear of 'being sued', there will be a chance to learn more deeply from adverse events and hopefully this would also lead more readily to their disclosure.

International examples

Currently, there are two national schemes that operate in New Zealand and Sweden, with small local schemes operating for birth-related neurological injuries in Virginia and Florida in the United States of America. The scheme in New Zealand applies to all types of personal injury, including medical negligence, whereas the Swedish scheme applies to medical injury only.

New Zealand

The system in New Zealand, when it was applied to medical treatment, was aimed at promoting a focus on learning from medical error and developing a system of reporting that was underpinned by concern over patient safety rather than attributing blame to individual clinicians (McLay et al, 2004; Oliphant, 2007). Fundamentally, in order to fall within the scheme the Injury Prevention, Rehabilitation and Compensation Act 2001 states that the patient has to establish that the injury 'is caused by treatment; and is not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including the person's underlying health condition at the time of the treatment; and the clinical knowledge at the time of the treatment'.

Unless the claim is high cost or borderline, the claim is investigated by the Accident Compensation Corporation (the body responsible for administering the scheme) and a decision made within 2 months. For claims of higher value or which are borderline there are strict time limits in which decisions have to be made (in the region of 9 months). These are small timeframes compared to the average time a case takes to be litigated in the UK. The funding of the New Zealand scheme, which is met by the state, cost in the region of £8 3984 400 in 2010 (Farrell et al, 2010). If the patient is unhappy about the decision, then there is an independent review body to whom an appeal can be made.

Sweden

In 1975 Sweden made the move to a no-fault scheme in medical negligence, which was then followed by Finland, Denmark and Norway. The motivation for the change in the system was along similar social and legal lines to New Zealand. The eligibility criteria under the Swedish scheme are centred on the concept of 'avoidability', namely, a patient receiving compensation if he/she has suffered injury that could have been avoided. The right to take the matter to civil court still exists in Sweden, although this is only exercised in 15% of cases (Hellbacher et al, 2007; Kachalia et al, 2007). The scheme is funded by a combination of regional income tax and private medical practitioners, and operates like a quasi-medical injury insurance company.

Possible impact in England

In 2003, it was estimated that the introduction of the no-fault scheme in England would cost in the region of £973.5 million for clinical negligence and £1.25 billion across the whole civil system (Farrell et al, 2010). In the medium term this would be offset against the inevitable reduction of the payment of legal costs, when the legal costs associated with one surgical speciality of orthopaedics amount to £76 million.

Discussion

The increase in costs for damages and the associated costs of lawyers has dramatically increased in trauma and orthopaedics alone in 2017, damages cost the NHS £90 million, in addition to £76 million in costs. However, it has been established that, rather than financial compensation, in response to a medical error, the primary aim of the injured patient is a desire for the doctor to make a meaningful apology, provide an explanation and put in place measures to stop it reoccurring (Farrell et al, 2010; Sammer et al, 2010). In an adversarial system where the patient has to establish liability there is a tension between fulfilling this need and the health-care provider admitting liability.

Many medical regulatory bodies throughout the world encourage a spirit of openness and transparency. In England, there is a duty of candour on doctors, nurses and midwives to speak to a patient in a timely manner if something has gone wrong, apologise and report the error (General Medical Council, 2013). This is modelled on the approach to error in the aviation industry (Syed, 2015). In practice, the spirit of candour fails to translate into a genuine apology. In the authors' experience, if an apology is forthcoming, it fails to be meaningful with phrases like 'I am sorry you feel your treatment was inadequate' being used, and is often supervised by hospital lawyers for fear of clinicians increasing the legal exposure. Stifled by this tension, the explanation neither satisfies the patient's desire for a genuine apology or the regulatory requirement of candour.

The introduction of a no-fault system into England would bring a level of transparency and openness that cannot exist in the current landscape. The cost of introduction into cases of medical error alone would reduce the estimated costs considerably. Further, although more individuals would fall within the system, this could be offset with a minimum tariff, i.e. £3000. If a patient's damages amounted to less than £3000, then the individual would not be entitled to any compensation. It would reduce the number of claims and involve an individual patient acceptance that when using a free, state-provided health system that damages will not be paid unless the harm was substantial. The calling to practice medicine and supervising medical bodies' regulation leads to good patient care, rather than the threat of being sued. The fact that it may be difficult to initially develop a system that includes private medicine and other independent contracts does not mean that a system cannot be developed.

KEY POINTS

- The introduction of a no-fault system into England would introduce a level of transparency and openness that cannot exist in the current landscape.
- Even against a background of a duty of candour, there remains a tension in an adversarial legal system, which focuses on fault.
- The focus on fault needs to be removed for there to be genuine apologies and investigation of medical error, which could be achieved by the introduction of a no-fault scheme in medicine.

Conclusions

Although governing bodies such as the General Medical Council encourage candour, there remains the tension of an adversarial system which focuses on fault. For there to be genuine apologies and investigation of medical error, the focus on fault needs to be removed, which could be achieved by the introduction of a no-fault scheme in medicine. **BJHM**

Conflict of interest: none.

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