Medical litigation: past, present and future

Before the 20th century legal actions against doctors were very unusual. Poor outcome of serious illness was commonplace and the general population understood little of disease processes. Moreover attitudes were very different.

In 1884, a child in London developed a severe upper respiratory infection with a blocked airway. Two doctors diagnosed croup. They performed a tracheotomy and told the father to suck on the tube to clear material from the trachea. The father did so and developed diphtheria. The child died but the father survived. He sued the doctors for failing to diagnose diphtheria and for failing to warn him of the dangers of infection.

The legal process was complex but the doctors won after incurring costs of more than £1000. The vicar of East Dulwich congratulated the doctors on a wrong redressed: 'The great sting of that wrong was that it was ungenerous and ungrateful; circumstances that ought to have elicited gratitude were turned into grounds for accusation and attack'. The president of the Royal College of Physicians made an appeal on behalf of the doctors and so much money poured in that the list was abruptly closed (Hawkins, 1985).

DEFENCE UNIONS

The following year the Medical Defence Union (MDU) was established to cover a broad range of interests of medical practitioners including advising and defending members in cases where proceedings involved questions of professional principle. The Medical Protection Society followed a few years later.

For many years there were so few cases of negligence that most doctors considered it not worthwhile joining a defence union. Indeed it was not until after the second world war that there was a perceptible change in public attitudes as reflected in an annual report of the MDU '...it is becoming easier for a claimant…to prove his case to the satisfaction of court…for whatever reason, it is inescapable that the courts have felt justified in accepting as proof of negligence evidence which would not have satisfied them, say, before the War'. (Medical Defence Union, 1947–8).

MEDICAL NEGLIGENCE CLAIMS

After 1960 the practice of hospital medicine became increasingly interventional. Adverse events in hospitals were common but accepted 'because to seek absolute safety would be to advocate therapeutic nihilism' (Schimmel, 1964). But with the 1980s came a marked increase in the incidence of claims of medical negligence. One can only speculate about the causes but a BBC documentary 'Minor Complications' in 1980 presumably played a significant part. It led to the formation of Action for Victims of Medical Accidents, a charity that has had a big impact on medical litigation and the response of government (Ransley, 2003).

Even so, the legal system was unfair. Only the wealthy and those entitled to publicly-funded means-tested legal aid could afford to sue. However, there was more than enough work for doctors acting as expert witnesses. By 1990 the costs of claims had risen so dramatically that NHS indemnity was introduced. Health authorities and their successors, NHS trusts, took over doctors' liability for claims involving NHS hospital care. However, the system was chaotic. Individual trusts used their own solicitors and few employed experienced claims managers.

To overcome these difficulties, in 1995, the NHS Litigation Authority (NHSLA) was established to set standards and to handle the larger claims (since 2002, all claims), and the Clinical Negligence Scheme for Trusts was introduced to pool the costs and to set insurance premiums for trusts.

CHANGES TO THE LEGAL PROCESS

Meanwhile, based on Lord Woolf's (1996) report into civil justice there were radical changes in the legal process. In April 1999 new civil procedure rules were established including providing a clear sequence of action for both parties (pre-action protocols with timescales); enabling claimants as well as defendants to make offers to settle (part 36 offers) and encouraging the use of single joint experts. These changes have led to speedier, more expert handling of claims and earlier settlement of cases. Alternative dispute resolution (principally by mediation) was encouraged but has been little used.

At the same time legal aid has became increasingly restricted. Less than 30% of the population are now eligible and their claims can be handled only by solicitors holding a clinical negligence franchise which is awarded, monitored and reviewed by the Legal Services Commission. In contrast, the use of conditional fee agreements is increasing. Lawyers enter into a contract with the claimant that provides for fees to be paid only if the case succeeds; the claimant buys insurance to cover the costs of losing; and the lawyers survive by having high 'success' fees. It is argued that this complex system is fairer than legal aid (Wickes, 2003).

IS THE NUMBER OF CLAIMS INCREASING?

There remains a widespread view that claims against NHS trusts are growing out of control, similar to medicolegal actions in the USA (Mello et al, 2003). This is not so. In 1996/7 around 4000 claims were reported to the NHSLA.

By 2000/1 the figure was 8000 but 2 years later it had fallen back to less than 7000. NHSLA expenditure has risen from £273 million in 1996/7 to £399 million in 1999/2000 and to £446 million in 2001/2 (at 2002 prices) (Donaldson, 2003).

Even so, the Chief Medical Officer (CMO) believes that there is case for further reform. He finds the present system complex, unfair, too slow and too costly in legal fees. It encourages secrecy and the practice of defensive medicine; and it may also be an obstacle to improved hospital care. Moreover the CMO believes that patients are dissatisfied with a perceived lack of explanation and apology, and the absence of reassurance that steps have been taken to prevent the repetition of accidents (Donaldson, 2003).

NHS REDRESS SCHEME

The CMO proposes the establishment of an NHS Redress Scheme with four main elements:

1. Investigation
2. Explanation and apology
3. The development and prompt delivery of an appropriate package of care
4. Payments for pain and suffering, for out-of-pocket expenses and for care that the NHS cannot provide (up to £30 000).

Families of neurologically-impaired babies would also be eligible if the birth was under NHS care and the impairment was birth-related (irrespective of causation). Again there would be a managed care package with considerable add-on payments. The scheme would be run by a national body building on the work of the NHSLA and would not take away the patient's right to sue through the courts. The proposals pose more questions than answers and so far the response has been muted. The defence societies have given a guarded welcome but the reaction of the British Medical Association remains uncertain (Dyer, 2003).

So the future of medical litigation is in the balance. The effects of Bristol are still with us. As the editor of the *BMJ* wrote 5 years ago 'the most profound effect (of Bristol) may be on the relationship between individual doctors and patients' (Smith, 1998). And the future of litigation may depend as much on how well we develop these relationships as on the general litigation-conscious culture. **HM**

KEY POINTS

- Over the past 7 years radical changes in the legal process (Lord Woolf's reforms) have led to speedier handling of medicolegal claims and earlier settlements.
- These changes have been associated with a modest increase in the number of claims. Currently these cost the NHS about £500 million a year.
- However, considerable dissatisfaction persists regarding the way in which complaints about medical care are handled.
- In June 2003 the Chief Medical Officer for England and Wales published a consultation paper, 'Making Amends', setting out proposals for reforming the approach to clinical negligence in the NHS.
- The Chief Medical Officer suggests establishing an NHS Redress Scheme (run by a national body) that would offer investigation, explanation and apology, appropriate packages of care and limited financial payments.
- If these proposals were to be implemented the need for legal input would be much reduced.

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