



Pointmaker

THE MEDICO-LEGAL CRISIS

...AND HOW TO SOLVE IT

PAUL GOLDSMITH

SUMMARY

- The current system for assessing and paying medical claims for injury is expensive, unsustainable and can cause more harm than good.
- It is one of the government's greatest liabilities. The NHS currently estimates that liabilities for clinical negligence total £65 billion. The per capita cost of medical claims in the UK is over twice that of the US.
- The cost of claims is also increasing rapidly (by roughly 10% a year) and is set to increase even faster, not least because of the drop in the discount rate by which lump sum damages are assessed.
- GPs' indemnity payments have become so high that some are finding it has become too expensive to work, particularly for those working out of hours (where the risks of something going wrong are greatest).
- Patients themselves can suffer because sometimes they may not start to improve until the medico-legal process is completed (which typically takes many years). By that time, it can be much more difficult to rehabilitate from the original injury.
- The root cause of the problem is section 2 (4) of The Law Reform (Personal Injuries) Act 1948 which requires the body or individual paying compensation to disregard the availability of NHS care. This means the compensation payable is quantified on the basis the claimant will use the award only for private health care, even if they use the NHS. This should be repealed.
- NICE should define the appropriate, evidence based level of care required. This should apply to all citizens. Care and support would be activated as soon as it was identified that it was needed.
- In essence this would be No Fault compensation, but avoiding the problems of argument over entry criteria. Everybody would be treated equally.
- Much of the money freed up from reform of the medico-legal system should then be redirected into patient safety systems.



1. INTRODUCTION

The current medico-legal system is unsustainable, not fit for purpose and causes more harm than good. NHS clinical negligence claims are one of the biggest governmental liabilities, after pensions and nuclear decommissioning. And without significant reform, the problem is only going to get worse. As the National Audit Office recently pointed out:¹

“The cost of clinical negligence in trusts is significant and rising fast, placing increasing financial pressure on an already stretched health system. NHS Resolution and the Department are proposing incremental measures to reduce existing costs. But expected savings from these schemes are small compared with the predicted rise in the overall costs and liabilities of clinical negligence. The government needs to take a stronger and more integrated approach to fundamentally change the biggest drivers of increasing cost across the health and justice systems.”

This paper explores the size of the problem, the reasons behind it, and the consequences beyond the financial impact, before making recommendations to, in the words of the NAO, ‘fundamentally change the biggest drivers of costs’.

2. THE SIZE OF THE PROBLEM

Clinical negligence claims are a part of personal injury law. Personal injury law covers any situation in which an individual suffers either physical or psychological harm as a result of the actions or omissions of another individual or institution. Claimants who can prove the acts or omissions were negligent are awarded compensation with the intention of, as far as possible, returning them to the position they were in before the negligence happened. If a personal injury claim is made against a health care practitioner or institution such as the NHS, it is called clinical negligence.

Clinical negligence work arising from NHS care is paid from the NHS budget. The annual payout in the year ending March 2016 was £1.4bn. It is increasing at approximately 10% per annum. The NHS currently estimates that its total liabilities are £65bn – that is to pay for claims that are currently under investigation and for future claims arising from incidents that have happened, but no claim has been made yet.² In the March 2017 budget the Chancellor set aside a further £5.9bn for NHS claims, including GP claims, for the three years up to 2020.

The cost of claims is also likely to increase substantially following the drop in the discount rate from 2.5% to -0.75%, announced in February of this year, and effective from March 2017. The discount rate is the rate by which the value of damages are discounted to reflect the expected returns on the investment of the lump sum. Many in the insurance industry believe that

¹ National Audit Office, Managing the costs of clinical negligence in trusts, September 2017.

² NHS-Resolution-Annual-report-and-accounts-2016_17.pdf [Internet]. [cited 2017 Sep 5]. Available

from: http://resolution.nhs.uk/wp-content/uploads/2017/07/NHS-Resolution-Annual-report-and-accounts-2016_17.pdf



the reduction in the discount rate will result in over-compensation.

It is also striking that, while precise comparisons need to be made with care, head for head, the UK is paying out significantly more than the US in terms of medical negligence (although the US is considered to be an even more litigious nation than the UK). Diederich Healthcare estimates that over \$3.9 billion was spent in medical malpractice pay-outs in 2016,³ roughly \$US12 per citizen (£9). The equivalent figure for England for NHS Resolution is £24 per citizen (and note that this excludes payouts for private practice or for GP clinical negligence).

There is generally a long lag between the event and a claim being notified and concluded. Personal injury law allows a three-year time window from the date of the incident, or from knowledge of the incident, until when the claim must be initiated. Claims are on average initiated three to five years after the incident with a settlement date five to seven years after the incident. With minors, the three-year period

does not begin until one is 18 and when a patient lacks capacity, there is no time limit.

The standard of proof for personal injury claims is “on the balance of probabilities”, i.e. the judgement is that there was a 51% chance or greater of the injury having been caused by the action or omission. Contrast should be made with criminal proceedings where the legal test is “beyond all reasonable doubt”.

As explained later, the costs of the current system are not just an enormous financial burden, but also damage workforce retention, particularly in some sectors such as primary care (as GPs have to pay for their own indemnity for clinical negligence claims). In addition, and perhaps paradoxically, the system sometimes has a negative impact on the very people who have sustained an injury and which the system is intended to help.

³ <http://www.diederichhealthcare.com/the-standard/2016-medical-malpractice-payout-analysis/>

A case study on the futility of the 1948 Act

A 55 year old heavy smoker has evolving foot pain over five years and is seen on multiple occasions. He develops an ulcer which does not heal and eventually needs vascular surgery and an above knee amputation. For the sake of argument, let us say that good practice would have indicated surgery a couple of months earlier and this would have resulted in just a below knee amputation. The claim would be successful and the award would be all of the lifelong costs associated with an above-knee prosthesis minus the theoretical costs for the situation if there were only a below-knee prosthesis. However, it is of course impossible to buy that element of care privately. You can't just buy and rehabilitate half of a prosthesis. The whole prosthesis and associated care has to be provided on the NHS, or privately.



3. CAUSES OF THE PROBLEM

3.1 *The Law Reform (Personal Injuries) Act 1948*

The central problem is this piece of legislation, now dating back 70 years and completely inappropriate for the times we now live in. Specifically, the problem arises from section 2 (4) of the Act. This section requires the body or individual paying compensation to *disregard the availability of NHS care*.

This means the amount of compensation payable is quantified on the basis the claimant will use the award *only* for private health care, even though there is no obligation for that to happen once the compensation is paid. There was a logic to this back in 1948 as the NHS had only just been formed and more chronic disease management and rehabilitation was not well developed. The medical injury cases which are inevitably foremost in people's minds are the most severe ones and it was considered unsafe to rely on the newly formed NHS to provide an appropriately high level of care. Indeed, ironically, this element of the Act was introduced to overcome opposition from doctors to the 1946 National Health Service Act who had feared the loss of their private income.

Nowadays, we have a level of care which is unrecognisable from 1948. Furthermore, the Act did not foresee that some recipients of financial awards would continue to use state-funded care, or find that their disability improved after the conclusion of the case.

3.2 *Return to the same salaried position*

Personal injury law requires the financial award to reimburse future salaries. A person earning £150,000 a year beforehand would receive a pay-out that would include that equivalent of salary for the remainder of his or her working life. Therefore, two individuals treated on the NHS who have identical accidents can have dramatically different pay-outs. In terms of NHS liability funding, the low paid are subsidising the high paid. For example, £6.2m in damages, with £3m in legal costs, were awarded to a patient for facial nerve damage after plastic surgery, much of this figure reflecting loss of earnings.⁴ Perhaps they were a model or a musician.

1.5% of the population suffers a Bell's palsy (facial palsy) at some stage. Most recover, but 4% are left with a severe deficit. The NHS provides reanimation surgery through plastic surgery, but these people do not get multimillion pound cheques.

3.3 *No reappraisal*

The award is paid as a lump sum. If the patient gets better, the money apportioned for subsequent years cannot be reclaimed as the defendant has no further contact with the claimant. If future care is obtained through the NHS, the money stays with the claimant. If they take up a highly paid job, their award remains the same.

The most dramatic change in circumstance is death. If a £10 million pay-out is made for predicted care needs for the next 40 years and if the following day the patient dies, then the lump sum goes to their estate and not returned to the NHS.

⁴ The campaign – The MDU [Internet]. [cited 2017 Sep 5]. Available from:

<https://www.themdu.com/about-mdu/fair-compensation/the-campaign>



3.4 The problem of decompensation

The level of pay-out is based on the amount of care and treatment the claimant needs to continue to function as he or she would have done without the negligence. The medico-legal process takes a long time. Often many years. Recent reforms have aimed to streamline and expedite the process, but it is still measured in years rather than weeks or months. Some of this is the inevitable consequence of the need to wait until the full extent of the harm is apparent, as well as the need to ensure there are expert reviews. Disputes about causation – that is ascertaining if the injury was caused by the act or omission and to what extent – can also take considerable time.

The problem with the slow process for adults is that some disability can become a self-fulfilling prophecy. If one does not use a part of the body it starts to degenerate. This happens very quickly. For example, when immobilised, muscle mass is lost at the rate of 1% to 1.5% per day. Physiotherapists recognise this, hence the aphorism 'motion is lotion'. Acute low back pain responds better to normal activity than bed rest. Achilles tendon ruptures heal faster with early

mobilisation after surgery. As neuroscientist Daniel Wolpert put it, 'the origin and ultimate reason for the brain's existence is not to help us think or feel or create art, but to control the movement of the body'. The body is highly adaptive to circumstance. Use it or lose it. Disuse atrophy is a major problem. It is now widely recognised that a significant factor for limiting recovery from a variety of conditions is the presence of an ongoing medico-legal claim.⁵

Indeed, particularly in the personal injury sphere, patients may improve after the acute phase, as would be expected from the normal physiological time course, then deteriorate. Sometimes this can be because the search for evidence of 'damage' with sophisticated scans will pick up changes which have relatively little functional significance but cause considerable worry. This is rather like the previous practise of the radiology reporting of cervical spondylosis on plain neck X-rays leading some patients to conclude that every creak from a neck movement reflected impending spinal collapse, leading to less movement, worry and a downward spiral. Better practise would be to now communicate the scan as normal for age.

⁵ The academic literature on this subject is extensive. See, for example, Binder LM, Rohling ML. Money matters: a meta-analytic review of the effects of financial incentives on recovery after closed-head injury. *Am J Psychiatry*. 1996 Jan;153(1):7–10.; Rohling ML, Binder LM, Langhinrichsen-Rohling J. Money matters: A meta-analytic review of the association between financial compensation and the experience and treatment of chronic pain. *Health Psychol Off J Div Health Psychol Am Psychol Assoc*. 1995 Nov;14(6):537–47; Calder JDF, Whitehouse SL, Saxby TS. Results of isolated Lisfranc injuries and the effect of compensation claims. *J Bone Joint Surg Br*. 2004 May;86(4):527–30; Littleton SM, Cameron ID, Poustie SJ, Hughes DC, Robinson BJ, Neeman T, et al. The association of compensation on longer term health status for people with musculoskeletal injuries

following road traffic crashes: emergency department inception cohort study. *Injury*. 2011 Sep;42(9):927–33. Elbers NA, Hulst L, Cuijpers P, Akkermans AJ, Bruinvels DJ. Do compensation processes impair mental health? A meta-analysis. *Injury*. 2013 May;44(5):674–83.; Grant GM, O'Donnell ML, Spittal MJ, Creamer M, Studdert DM. Relationship between stressfulness of claiming for injury compensation and long-term recovery: a prospective cohort study. *JAMA Psychiatry*. 2014 Apr;71(4):446–53; Cassidy JD, Bendix T, Rasmussen C, Carroll L, Côté P. Re: Spearing and Connelly. Is compensation bad for your health? A systematic meta-review. *Injury* 2011;42:15-24. *Injury*. 2011 Apr;42(4):428-429-430; Anderson T, Heitger M, Macleod AD. Concussion and mild head injury. *Pract Neurol*. 2006 Dec 1;6(6):342–57.



4. WHAT IS THE MEDICO-LEGAL SYSTEM FOR?⁶

The following are *possible* reasons for the medico-legal system:

4.1 To rehabilitate

The principle behind the tort of negligence is to put the claimant back in the position he or she would have been had the negligence not occurred. In fact, *this is the only reason in law*. However, as argued above, the current system does not do this as it puts claimants who can prove negligence against the NHS in a different position because it provides those who were previously entirely reliant on NHS care with funds to pay for private care. Whether that is better for them medically is arguable, but it is certainly costly and expensive; and it diverts resource away from an individual with an identical injury but occurring for other reasons such as heredity, an accident, bad luck or where the legal test determined the balance of probabilities to be 49% rather than 51%.

4.2 To improve standards

There is no concept in law that personal injury litigation is intended to improve standards. Nevertheless, some see the medico-legal system as one of several components which

contribute to quality control and performance improvement. The question then is, how well does it achieve this and at what cost?

It has been claimed that were there to be an error-free system, then there would be no medico-legal claims or complaints. This is a naïve view point. A WHO review concluded the standard of healthcare provided by doctors working in the UK remains among the best in the world, whereas medico-legal claims have steadily risen.⁷

In fact, the rate of medical errors has trended downwards (although the data is patchy), despite the fact that more patients are being treated with more complex interdependencies and new treatments which raise greater hazards, such as more immunosuppression and multiple co-morbidities in the elderly.⁸

Three main systems which potentially contribute to patient safety and performance improvement in the NHS are incident reporting and associated system learning, the complaints system and the medico-legal system. Incident reporting and complaints are much more likely to be useful as they occur shortly after the incident, whereas claims are made several years later and settled another three or so years after this.

⁶ Technically, there is no medico-legal system, rather a tort of negligence based on case law. In the landmark 1932 case of *Donoghue v Stevenson*, Lord Atkins said: '... you must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour...'

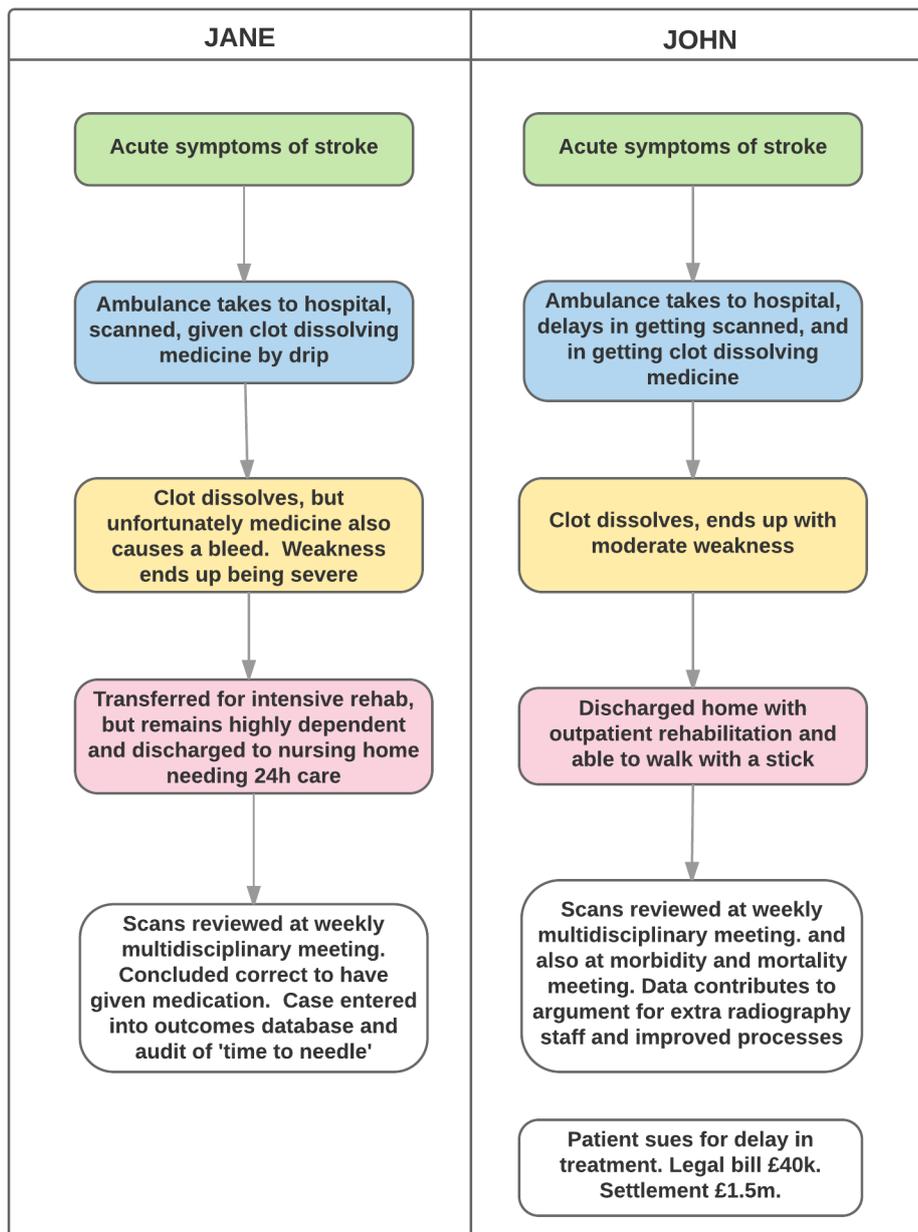
⁷ Davis K, Stremikis K, Squires D, Schoen C. *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally* [Internet]. 2014 [cited 2017 Jun 18]. Available from:

<http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>

⁸ See Illingworth J. *Is the NHS getting safer?* [Internet]. London: the Health Foundation; 2015 [cited 2017 Jun 18]. Available from: <http://www.thepatientvoice.org.uk/IsTheNHSGettingSafer.pdf> and NHS Safety Thermometer [Internet]. [cited 2017 Jun 18]. Available from: https://www.safetythermometer.nhs.uk/index.php?option=com_content&view=article&id=2&Itemid=106



TWO IDENTICAL PEOPLE, IDENTICAL STROKES, DIFFERENT OUTCOMES





In 2013/14, there were just over 1.5 million incidents reported in England, two-thirds of which resulted in no harm to the patient.⁹ Note that even when harm occurs, this does not necessarily mean there has been an error. For example, if someone had an epileptic fit and fractured a bone as they collapsed, this would be classified as 'severe harm', even though it was unavoidable. Or one might avoid the risk of a patient with severe Parkinson's falling by confining to a wheelchair, but be restricting freedom and quality of life. Detail and narrative are important when considering the headline figures.

In an analysis of a major NHS Trust with approximately 1.5 million discrete patient encounters per year, there were 13,266 patient related incidents reported in 2013/14.¹⁰ 96.5% of these incidents were classified as minor or insignificant. It is important to be reporting incidents. A low number is more worrying.

There were 702 formal written complaints. The average number of separate issues to be addressed per complaint was six. 29 progressed to the Ombudsman of which only three cases were partly or fully upheld. Only 5% of complaints related to a prior clinical incident.

There are two interpretations to this, neither mutually exclusive. One could be that complaints are picking up errors that are not being reported by staff. This is possible, particularly for the higher volume of more 'minor' complaints. For the more involved ones, the high volume of staff reporting and the low number of complaints

eventually upheld would suggest that this is at most only a part of the story and other factors should be considered. Communication issues are a common reported factor, although one needs to be careful to separate poor communication from patients simply disliking the message. The latter was identified as the reason behind 90% of cases in a separate study for the commonest 'difficult' complaints for neurologists – patients not happy with the diagnostic label rather than the diagnosis being wrong. There are sometimes financial or broader psychosocial drivers behind this. In reporting systems, this would be recorded as "poor communication". This may be an unusually high figure just relating to this speciality, but illustrates that one can draw wrong conclusions just looking at headline figures.

It is sometimes assumed that claims, errors and complaints all refer to the same cases. In the same analysis of a major NHS Trust, the Venn diagram of overlap between these groups was surprisingly small. It was also notable that the authors estimated there were ten FTEs employed just to deal with claims, eight for complaints and 1.5 for staff incident reporting, accepting that the latter is an underestimate as much will happen diffusely through all staff in their day-to-day work.

Indeed, great strides have been made over the last five to 10 years in NHS quality systems, led initially by the National Patient Safety Agency and now part of NHS Improvement. Examples of transformative practices include: the Surgical Safety Checklist; the Getting it Right First Time

⁹14. Organisation patient safety incident reports: 28 September 2016 | NHS Improvement [Internet]. [cited 2017 Jun 19]. Available from: <https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-28-september-2016/>

¹⁰ Goldsmith P, Moon J, Anderson P, Kirkup S, Williams S, Gray M. Do clinical incidents, complaints and medico-legal claims overlap? Int J Health Care Qual Assur. 2015;28(8):864–71.



initiative in orthopaedics, now being rolled out to more specialities; improved standards of training in obstetric intrapartum care.¹¹

Error reporting and data trends are monitored with increasing intensity by NHS England and NHS Improvement who have powers to take action if there are system failures.

It is now standard practice as part of a broader clinical governance for clinicians to meet and discuss learning opportunities arising from complaints and incidents, as well as learning points from any deaths which have occurred, building on the longer established morbidity and mortality meetings that were previously restricted to certain departments. As well as these formal meetings, informal corridor discussions are important. Working in a group rather than isolation is an important aid to quality and safety, and an argument for having hub and spoke arrangements with peripheral units linked to centres of excellence and avoiding isolated working. Similarly, the move to end single practise GPs is a good thing.

Despite these improvements, there is clearly much room for improvement. There is likely to be continuing underreporting, particularly in primary care. The majority (90%) of patient contacts occur in primary care, yet less than 1% of reported incidents were from primary care.¹²

4.3 To identify bad doctors

Many errors occur from systems failures rather than individual failures. When it is the latter, it is usually a one-off. However, there will be doctors and other practitioners who either need more training, restrictions put on their practise or should not be practising at all and should be struck off.

But this is not the role of the medico-legal system. There are a range of other investigations and sanctions from local disciplinary proceedings, GMC sanctions and criminal investigation. If there is any question about an individual's fitness to practise, then they will be referred to the General Medical Council, if a doctor, or equivalent body for other healthcare professionals. Indeed, for the same event a doctor can find himself the subject of, in series or in parallel, investigations ranging from the local complaints process, the Ombudsman, a coroner's inquiry, police investigation and possible trial, through to employer's disciplinary and/or GMC regulatory investigation, as well as a negligence claim, public and/or a Healthcare Safety Investigation Branch (HSIB) inquiry and trial by media. In part because of the very lengthy medico-legal process, there are cases of doctors having the sword of Damocles hanging over their head for decades before being cleared. Lack of proportionality and multiple jeopardy remain problems.

¹¹ See, for example, WHO surgical safety checklist and implementation manual [Internet]. WHO. [cited 2017 Jun 18]. Available from: http://www.who.int/patientsafety/safesurgery/ss_c hecklist/en/; Getting It Right First Time [Internet]. British Orthopaedic Association. 2014 [cited 2017 Jun 18]. Available from: <https://www.boa.ac.uk/pro- practice/getting-it-right-first-time/>; Draycott T,

Sagar R, Hogg S. The role of insurers in maternity safety. *Best Pract Res Clin Obstet Gynaecol*. 2015 Nov;29(8):1126–31. And Prompt Maternity Training [Internet]. [cited 2017 Jun 18]. Available from: <http://www.promptmaternity.org/training/>

¹² Illingworth, op.cit



4.4 To exact revenge

Although some will state that they are pursuing a claim to achieve system improvement, in fact the desire for punishment might be the underlying reason. Many studies based around the ultimatum game have shown that people do not always pursue rational self-interest. When deciding whether to accept a gift, people will reject situations they consider unfair, in effect punishing the other person for being insufficiently fair. It is not just a sense of justice that leads to people rejecting perceived unfair offers though, as in the ultimatum game they will still choose to enact punishment even if the opposite side will never know they have been punished, i.e. their rejection is not leading to any learning or social improvement. The lesson is, the reason people say they are initiating complaints or claims may not necessarily accurately reflect their unconscious drivers.

4.5 Financial gain

This ultimately is a main driver. There are large sums of money involved. Seeking a financial settlement is rational and understandable.

5. RESULTS OF THE PROBLEM

5.1 Diversion of finance

The biggest implication by far is that vast amounts of cash are being diverted from other uses. In the case of the NHS, this comes out of the NHS budget. To restate the level, the NHS has £65bn put aside. For personal, employers and public liability claims, this comes out of

higher car insurance, council tax bills and business insurance premiums. The Association of British Insurers believe the law currently costs motorists nearly £3m a day, with a 10% increase in premiums in 2015/16 due to medico-legal claims inflation.¹³ High business insurance premiums take money away that could be invested for productivity or job creation. Is this the most cost-effective way to make people's situations better in a fair and equitable way?

5.2 Urgent GP availability threatened

All doctors who do any work that is not indemnified by the NHS have to pay for medical indemnity for themselves. For hospital consultants working in the NHS, claims are made against their employer and paid on behalf of the NHS by NHS Resolution whereas for GPs, as they are effectively self-employed, they pay for the entire indemnity themselves. The average GP pays more than £8,000 per annum for indemnity. Rates are higher again for out-of-hours GPs, whose work is riskier because of its circumstances, for example they are often seeing patients they don't know and may not have access to the notes or only partial access to notes. GPs' indemnity payments have become so great that some are finding it has become too expensive to work out of hours. Last winter, and for two previous winters, NHS England reimbursed all indemnity costs for all GPs who agreed to undertake additional out of hours sessions during the winter period.

Separately, in recognition of the unsustainable rise in clinical negligence indemnity inflation and

¹³ ABI sets out what is needed to help reduce the rising cost of motor insurance. 2016 [cited 2017 Jun 18]. Available from: <https://www.abi.org.uk/news/news->

[articles/2016/10/abi-sets-out-what-is-needed-to-help-reduce-the-rising-cost-of-motor-insurance/](https://www.abi.org.uk/news/news-articles/2016/10/abi-sets-out-what-is-needed-to-help-reduce-the-rising-cost-of-motor-insurance/)



its effect on GP indemnity costs, NHS England undertook in July 2016 to reimburse all GPs for the inflationary element of their GP indemnity subscription for two years. The first payment was made to GP practices on 1 April 2017 and practices were expected to share it equally with all GPs who had taken out indemnity for the financial year up to 31 March 2017.

5.3 Fewer doctors

The financial cost and personal jeopardy is contributing to GPs deciding to retire early or reduce their workload. What is perhaps more surprising is it is also deterring young doctors from entering primary care. In a recent press release from the MDU, one trainee said 'Indemnity is sky-rocketing now. GP indemnity at present is at an unsustainable level. I am considering leaving the profession in my 30s'. Another GP trainee said: 'I am about to qualify and the indemnity costs are seriously making me consider leaving medicine. I have already started arranging interviews outside of medicine.'¹⁴

At a time of major shortages of doctors, this is highly undesirable. The jeopardy is greatest in those areas with the most difficult clinical situations and high recruitment issues – A&E and out-of-hours.

This has been made acutely worse with the drop in the discount rate announced in February of

this year. This rate influences the levels of payouts and leads to a near doubling of awards. A problem is current GPs are in effect paying for cases which relate to previous years, perhaps for colleagues who have now retired. If these costs are passed through to GPs, they may find them unaffordable and stop work.

The multiple and prolonged jeopardy of investigational processes also contributes to the high suicide rate amongst doctors, which is double that of the background population and more broadly high rates of poor mental health.¹⁵

5.4 Compensation encouraging decompensation.

As described above, patient themselves can suffer because they sometimes may not start to improve until the medico-legal process is completed, by which time it may be much more difficult to rehabilitate. This is particularly true for the large numbers of lower value claims. There is a heightened risk of ending up in a downward spiral. It may disincentivise work and the fulfilment which comes with that.

5.5 Withdrawal of service or defensive practise

There are reports of medical indemnity cover being withdrawn for areas such as spinal surgery in the UK, following the trend in the US

¹⁴ Newly qualified GPs may quit general practice over indemnity costs, MDU survey finds – The MDU [Internet]. [Cited 2017 Jun 18]. Available from: <https://www.themdu.com/press-centre/press-releases/newly-qualified-gps-may-quit-general-practice-over-indemnity-costs-mdu-survey-finds>

¹⁵ See Balch CM, Oreskovich MR, Dyrbye LN, Colaiano JM, Satele DV, Sloan JA, et al. Personal consequences of malpractice lawsuits on

American surgeons. J Am Coll Surg. 2011 Nov;213(5):657–67; 23; Charles SC, Frisch PR. Adverse Events, Stress, and Litigation: A Physician's Guide. First printing edition. Oxford ; New York, N.Y.: Oxford University Press; 2005; and BMJ Careers – Doctors and mental health [Internet]. [Cited 2017 Jun 18]. Available from: <http://careers.bmj.com/careers/advice/view-article.html?id=20002383>



of some obstetrics providers ceasing to provide care because of the extent of legal liabilities.¹⁶ As NHS care has to continue, perhaps this doesn't matter. There is a tension, however, between the ability to attract clinicians to 'exposed' units, preferring specialist centres, and local community and political demand to keep a local unit open. The narrative usually focuses around lack of money, when the clinical reality may be that doctors don't want to expose themselves and patients to excessive risk. This is against a backdrop of a national shortage of doctors and fixed national salaries.

What is more pervasive throughout all care may be the extent of unnecessary investigations and interventions, with risk of iatrogenic harm, as well as the financial cost.

5.6 Alternative systems piloted or suggested

There has been a recent DoH consultation on a new scheme for babies with neurological damage as a result of brain injury.¹⁷ One of the main changes would be to introduce a new test of 'avoidability'. This would result in many more payments as it would intentionally have a lower threshold than the 'reasonable body of practise'

Bolam test. The proposal is to pay out only 90% of what a court would award. The right to sue remains, so it would seem likely that many would use it as a test run for a full claim. Nevertheless, the idea of trying to provide support much more quickly and to a much broader group of patients is positive. Such schemes have been proposed before, for example by the then CMO, Liam Donaldson, in 2003 with Making Amends.¹⁸ The main likely reason this didn't progress was difficulty agreeing the definition of neurological damage that would have been the gateway to the scheme.

In the US, more than 30 states have some form of cap on clinical negligence costs. For example, California's landmark legislation, the Medical Injury Compensation Reform Act (MICRA) of 1975, was upheld again in November 2014, keeping a \$250,000 cap on non-economic damages in medical liability lawsuits.¹⁹

The no fault systems, such as those in Sweden and New Zealand are often regarded as desirable schemes. Making Amends and the more recent Birth Injury Rapid Resolution scheme fall short of these no-fault scheme and indeed what about the many babies with

^{16 25.} Xu X, Siefert KA, Jacobson PD, Lori JR, Ransom SB. The effects of medical liability on obstetric care supply in Michigan. *Am J Obstet Gynecol.* 2008 Feb;198(2):205.e1-9.

^{17 26.} A rapid resolution and redress scheme for severe avoidable birth injury: a consultation – RRR_consultation_A.pdf [Internet]. A rapid resolution and redress scheme for severe avoidable birth injury: a consultation – RRR_consultation_A.pdf. [cited 2017 Jun 18]. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/595811/RRR_consultation_A.pdf

¹⁸ Sir Liam Donaldson CMO. Making amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS [Internet]. 2003 [cited 2017 Jun 18]. Available from: http://webarchive.nationalarchives.gov.uk/content/+http://www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyandGuidance/DH_4010641

¹⁹ See <https://wire.ama-assn.org/ama-news/medical-liability-damages-cap-upheld>



unavoidable neurological damage through misfortune of genetics, accident or infection? Nor would they address the problems of inefficient use of public money and would retain the problems of argument over eligibility and blame.

Yet we are close to having the solution in the UK because we have the ultimate no fault scheme, the NHS. If you break your leg playing football the NHS will treat you, even though you voluntarily took the extra risk of playing football. Similarly, someone who doesn't keep fit or has an unhealthy life style still gets treated in exactly the same way.

6. NINE RECOMMENDATIONS

1. Section 2(4) of the 1948 Act should be repealed.
2. If one accepts treatment on the NHS, then one also accepts one will be treated by the NHS in the same way that one's neighbour with an identical injury sustained from sheer bad luck (e.g. heredity, a random illness) will be treated. The money saved from medico-legal reform should be used to fill any shortfall in the ability of the NHS and state more generally to put right both cases.
3. NICE should define the appropriate, evidence based level of care required and this would apply to all citizens.

This would mean care and support would be activated as soon as it was identified that care and support was required, with no delay for argument as to whether anyone was at fault, or whether there was 49% or 51% probability of fault. It would be delivered in an evidence based and cost effective

way, with everybody treated equally. A child with cerebral palsy would receive the same support as a child with an identical deficit from an obstetric accident.

In essence this is the ultimate form of No Fault compensation, but avoiding the problems of argument over entry criteria. Everybody gets treated equally. NICE determines the treatment package and the most efficient and evidence based delivery.

4. If an individual thought that NHS provision was insufficient, they have the right to take out insurance, for example, to cover loss of earnings. If they are a very high earner, then their premium would be correspondingly high. Similarly, if one wanted greater loss of earnings cover or private care as a result of a car accident, then one could select a high car insurance premium.
5. The financial award should be paid directly from the negligent party to the responsible body purchasing future care (e.g. NHS commissioner).
6. For all personal injury awards, loss of earnings should be fixed at the National Living Wage, or a multiple thereof, or a multiple of salary (e.g. Australia cap at 3x).
7. It should be easier for patients and families to both complain and make 'non-complaint' observations which might contribute a service improvement and without necessarily triggering a bureaucratic process.

Complaints where there is disagreement over diagnosis and management, with diagnosis and management concluded as



being correct, should be separately listed in reporting systems.

8. Greater resource should be put into patient safety systems, utilising money freed up from medico-legal reform. The focus currently is on 'never events', a misnomer as they do happen. There is the potential for learning from a greater range of patient safety incidents and possibly near misses. Incident investigations should be extended in scope. The learning element and sharing of learning should be improved. There should be audit of any changes that investigations demonstrate are needed. This will require additional money which should be released through medico-legal reform. Digital technologies and the data should be used to pick up 'risk signals'.
9. The situation for criminal clinical and personal injuries should remain the same with victim support, sanctions and compensation.



THE CENTRE FOR POLICY STUDIES

The Centre for Policy Studies is one of Britain's best-known and most respected think tanks. It is independent from all political parties and pressure groups, and relies on the support of all those who share its aims and ambitions.

Through our Associate Membership scheme, we welcome supporters who take an interest in our work. Associate Membership is available for £100 a year. Becoming an Associate will entitle you to all major CPS publications produced in a 12-month period; invitations to lectures and conferences; and advance notice by e-mail of our publications, briefing papers and invitations to special events.

Please contact Jenny Nicholson for more details at:

Centre for Policy Studies
57 Tufton Street
London SW1P 3QL
020 7222 4488
jenny@cps.org.uk

The aim of the Centre for Policy Studies is to develop and promote policies that provide freedom and encouragement for individuals to pursue the aspirations they have for themselves and their families, within the security and obligations of a stable and law-abiding nation. The views expressed in our publications are, however, the sole responsibility of the authors. Contributions are chosen for their value in informing public debate and should not be taken as representing a corporate view of the CPS or of its Directors. The CPS values its independence and does not carry on activities with the intention of affecting public support for any registered political party or for candidates at election, or to influence voters in a referendum.



THE AUTHOR

Dr Paul Goldsmith is a life sciences entrepreneur, policy strategist and a Consultant Neurologist. He graduated with a triple 1st from Cambridge and then a clinical scholarship from Oxford. Following general medical training, he completed a PhD in Cambridge using developmental biology systems to understand adult human disease. He has helped found and build both drug discovery and digital health companies.

He has extensive NHS operational and strategic experience, including in NHS England Strategic Clinical Networks, an Urgent and Emergency Care Vanguard and Clinical Senate. He is a Non-Executive Director of the Medical Defence Union which provides medico-legal cover for doctors.

Dr Paul Goldsmith writes in his personal capacity and this paper does not necessarily represent the views of any employer or organisation with which he is associated.

978-1-910627-52-5

© Centre for Policy Studies, October 2017