Medicolegal

Litigation for medical accidents

CLARE DYER

Some English regional health authorities are beginning to experience rates of medical litigation approaching those in the United States. The rate of claims nation wide is eight times higher now than it was 10 years ago, and the rate of increase is rising. Rates for hospital claims doubled from the mid-1970s to the early 1980s, doubled again by 1985, and doubled again over the past two to three years.

This disturbing picture of the English medical litigation scene emerged at a joint conference on medical accident litigation that was held on 24 March by the Faculty of Law at Southampton University and *The Health Service Journal*. The figures, extracted by Mr Paul Fenn of Wolfson College, Oxford, from a briefing paper on compensation for medical accidents that he and two coresearchers are preparing for publication this summer, show that, at least in numbers of claims if not in size, fears of British litigation rates reaching American heights are looking less and less far fetched.

Rising numbers of claims

The figures for growth in numbers of claims come from data on past claims against two sample regional health authorities. The researchers emphasise that they are based on only a limited sample of hospital claims, but both regions show a similar picture. Other figures, for recent claims from seven regions, show that a typical region is experiencing rates of claims of between six and 10 per 100 000 population. But in two adjacent authorities—Mersey and North Western—claims are running twice as high, nearing American rates.

Sizes of settlements are, however, still well below American values, and Mr Fenn argued that differences in the provision for health care and legal services in the two countries suggest that the gap will remain. Settlements in the United Kingdom have averaged between £10 000 and £20 000 in recent years, compared with an average of £53 000 in the United States in 1984. Less than half of the total cost of operating the medical malpractice system in the United States (around \$3.3 billion), found its way to the injured patients; the rest went in costs of investigation and legal fees. Mr Fenn said that in England and Wales in 1988 health authorities would spend an estimated £10m on payments to patients, together with £3m on legal costs. Adding in the projected defence society totals of £32.2m gives an overall figure of around £45m.

The rise in rates of claims has, however, been accompanied by an increase in the proportion of claims withdrawn or abandoned, from around 60% (in line with the American rate) to over 70%. Why have patients become keener to sue? Mr Fenn came up with no explanation for the extra litigiousness of patients in the north west, but he suggested that the combined effects of publicity, referral

networks, and the legal profession's own increasing tendency to specialise and compete for business were likely causes for the general trend.

How to reduce claims

Dr John Wall, deputy secretary of the Medical Defence Union, broadly agreed with Mr Fenn's assessment of the factors behind the increase in claims. He said that the rates of rise in figures from the health service were matched by the union's experience throughout the United Kingdom. What brakes could be applied? Good experts were one answer, he said, and the Medical Defence Union urged doctors to act as experts for plaintiffs' lawyers if they could possibly take on the work. No fault compensation was another: members' subscriptions in New Zealand were currently only £100. Arbitration of claims was being looked at by working parties, though it had drawbacks and could cost as much in legal fees. Structured settlements, which would allow patients as much as they needed each year for their lifetime, would get round the difficulty of having to guess in advance how long patients would live. Lump sum settlements were the equivalent of pools wins for some but not enough for others.

Mr Arnold Simanowitz, director of Action for the Victims of Medical Accidents, said that the medical profession had a fundamental role in denying justice to victims of medical accidents. The first problem was for a patient to know that an accident had taken place. Another hurdle was getting a medical opinion, without which no claim could succeed. Most doctors would not give opinions because they just did not want to. Others gave opinions but always gave the benefit of doubt to the doctor, often without being aware of what they were doing. Time and again, he said, Action for the Victims of Medical Accidents saw experts' opinions that suggested no negligence when a second opinion not only disagreed but made it quite clear that the first opinion was unsustainable. This was later confirmed when the claim was settled. Often solicitors would rely on an unreliable opinion and the case would be dropped.

Doctors' duty to patients

Mr Simanowitz's plea for more openness on the part of doctors echoed opening remarks by Lord Donaldson, Master of the Rolls, who argued that doctors owed patients a duty to explain what had happened when treatment went wrong. This did not require any change in the law, he submitted, but merely a wider recognition of what the law might already be.

The duty to give patients full information stretched beyond informing them in advance of the risks of a proposed treatment. "Having placed his life in their hands, a patient is surely entitled to say that the duty of care extends to requiring the carers to tell him what in fact they did with his life at a time when he may have been anaesthetised, or at least was in no position to assess the position for

himself. Doctors need not say "I have been negligent." But if things have gone wrong, I have no doubt that the patient is entitled to the fullest disclosure of what was done, what was not done and what happened."

Lord Donaldson said that making disagreeable choices about the allocation of resources was part of health authorities' responsibilities and, within wide limits, the courts would not interfere. But allocating adequate resources to a limited number of patients was one thing. Allocating inadequate resources to a larger number might be quite another and could expose the NHS to liability. The duty of care owed to patients arose only when they were accepted as patients, but once accepted patients were entitled to expect that they would be looked after properly. There must be a question whether

junior doctors working long hours could retain their professional skills towards the end of their duty. If because of fatigue induced by the system a patient were harmed the authority might well be liable in damages.

No fault compensation was superficially attractive, Lord Donaldson concluded, but open to several objections. Deciding what accidents should qualify for compensation would be difficult. If the category were broad the cost would be enormous and the compensation payable would necessarily have to be restricted. This would be unfair to those who had suffered the most. If the category were narrow it would not be just to deny those falling outside it the right to sue for negligence if they could prove it, and this would nullify one of the main advantages of such a scheme.

Medicine and the Media

IS OUR HEALTH affected by the electromagnetic field associated with power supply lines and household electrical appliances? This question was asked in *Panorama* last month (BBC1, 22 March), and the most interesting aspect of the programme was not what was said, or how it was said, but the reactions of people to it. The following day *Open Air* (BBC1) invited questions and comments by phone for reporter Tom Mangold and Dr Michel Coleman of the International Agency for Research on Cancer. They must have been disappointed by the reactions.

The programme was well balanced. Conflicting opinions were given by various scientists who have studied the effects of electromagnetic fields, but no one was dogmatic. All those interviewed were circumspect about drawing the conclusion that the fields—as has been suggested—could be a factor in childhood cancers. It was emphasised throughout the programme that the connection was unproved. A Swedish worker stated explicitly that it was not something that a person should worry about; smoking, alcohol, and motor cars damaged far more people. Certainly, he said, it was something society should investigate, but no hard conclusions could yet be drawn.

The human angle intruded twice into the programme, and I think detracted from the overall message. We heard from the mother of a child with leukaemia and from an American man with a brain tumour. He had lived under power lines all his life, and there were dramatic shots of the basketball net fixed to the bottom of the pylon in his back yard. He was anxious that this should be a lesson for others in the future; his sister was less altruistic and was in the process of suing the power company. The programme suggested strongly that her brother's tumour grew as rapidly as it did because of the influence of the power lines. This should not, however, have distorted the conclusions of anyone who watched the whole programme.

These were some of the questions and comments from callers to *Open Air*:

"The BBC should be ashamed of themselves for scaremongering, without having any real evidence to back up their statements."

"Is it safe to use my electric blanket?"

"The BBC shouldn't broadcast such alarmist programmes without better evidence."

"I'm very concerned about my 14 month old daughter."

"My house is under a power line, how am I going to sell it now?"

"How near to a power line is it safe to be?"

"Is there a magnetic field from the substation at the bottom of the garden?"

"My son has leukaemia and we live near a power line."

The BBC has been accused of presenting unbalanced programmes, but this programme was not unbalanced in either direction. Ignoring the two short sections already alluded to, it is difficult to see how Tom Mangold could have made it more clear that the programme was to inform not alarm. Nonetheless, there was panic in the phone calls, although this does not tell us what proportion of watchers were worried.

What are the media to do? People seem almost to will themselves to misinterpret and misunderstand. Not surprisingly, you will remember the frightening aspects if your child's health is apparently at risk. There is also the, generally healthy, feeling that unpleasant facts are kept secret, and the recently disclosed truth about the accident at Windscale in the '50s has not helped. On the other hand, the general public has no concept of probability. People are prepared to take enormous self imposed risks, but see the smallest externally imposed risk as unacceptable. In a television interview some years ago a group of housewives who lived near a large motorway interchange were worrying about the effects on their children of lead in exhaust fumes. Half the housewives were smoking cigarettes.

Horizon, on BBC2 an hour and a half before *Panorama* the same evening, repeated the programme about Richard Feynman, the physicist and Nobel laureate who died earlier this year. In a wonderfully engaging interview, this brilliant man spoke of his simple philosophy of wanting to know things—of really *knowing*. As he said, when he reads that someone has claimed, for instance, that natural foods are better for you, he knows how difficult it is to collect data, how difficult it is to account for unsuspected variability. He knows "what it is to know something." We can no longer ask Richard Feynman whether electromagnetic fields may cause cancer, although his answer would have been worth knowing. None of the scientists on *Panorama* claimed to know the answer either, but it didn't stop many people deciding that they should start worrying. It is a good illustration of the enormous gulf between those who know and understand and those who don't and worry.—NEVILLE GOODMAN, senior lecturer in anaesthesia, Bristol.