Education and debate

The future of clinical negligence litigation?

Brian Capstick

The UK's proposed reforms of claims for clinical injury risk fuelling a compensation culture

About 7500 clinical negligence claims are brought each year in England.¹ The current system has been criticised by some as complex, inequitable, and expensive in terms of time and legal fee. However, the cost of negligence claims in 2001-2 was £446m,² less than 1% of the budget for the NHS. Last year, the chief medical officer published a consultation document, *Making Amends*, which set out proposals for a NHS redress scheme that would provide adjudication for certain clinical negligence claims without the need for legal proceedings.² It draws on experience in the United States, New Zealand, France, and Scandinavia, which have similar problems. So how will the proposals work, and what will they mean for the NHS?

What is the redress scheme?

The proposed NHS redress scheme will provide an administrative rather than a judicial route for claims up to £30 000 (€43 640, \$54 420) and claims arising from severe neurological impairment related to birth (box). Initially, these schemes would apply only to the hospital sector but would eventually be extended to primary care.

The redress scheme proposes that hospitals investigate all adverse events, not only in response to a

Proposals for NHS redress scheme²

- To provide investigations and remedial treatment when clinical injury arises during hospital care plus financial compensation in some cases
- Patients with claims under £30 000 would be eligible if their injury had been caused by serious shortcomings in NHS care
- People with severe, birth related, neurological impairment (including cerebral palsy) that was evident within eight years of birth would be eligible for compensation without proving fault

complaint or claim by the patient. *Making Amends* predicts about 850 000 adverse events a year, many more than the 33 000 complaints concerning hospital care or the 6797 new clinical claims reported to the NHS Litigation Authority in 2002-3. Although prompt investigation of adverse events that lead to serious injury is a sound risk management measure,³ investigating the larger number of adverse events that cause only minor harm will greatly increase the workload.

When an investigation shows that something has gone wrong, clinicians will have to disclose this to the

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Reforms could result in more cases of medical negligence coming to court

patient or family. This will be part of a new statutory duty of candour (to support the General Medical Council's code of practice). Although candour may disarm some potential claimants, others may construe the admission as an invitation to pursue a claim.

The next step for people who decide to pursue a smaller claim would be for the hospital to develop and deliver a package of remedial care. However, since care is in theory already provided to people who need it, it is not clear what this provision would add unless it permits queue jumping or treatment that would not normally be available under the NHS.

Compensation for smaller claims

An expert panel will determine eligibility for compensation under the final component of the redress package for smaller claims. This is not a "no fault" scheme, and compensation will depend on some determination of fault. Patients will be eligible for payment for "serious shortcomings" in NHS care if the harm could have been avoided and if the adverse outcome was not the result of the natural progression of the illness. It is not clear whether "serious shortcomings in NHS care" will be a softer test than the existing test of negligence but, if it is softer, the success rate for claimants could rise.

The compensation element of the proposed scheme for smaller claims is modelled on the "Resolve" scheme, which was piloted by the NHS Litigation Authority for six months beginning in January 2002. Claims valued at less than £15 000 were referred to the authority for determination of liability by a single expert. There were no defence legal costs, and claimants' lawyers' fees were capped at £1500. Additional fees were paid to the clinical expert and the scheme managers. More than 200 cases were enrolled. Involvement of clinicians implicated in the event was limited to the statement they normally make to their hospital when a claim arises.

Although such a scheme undoubtedly reduces the defence costs incurred in processing compensation payments, almost all of the claims made under the pilot would not have been made under the conventional legal system.⁴ By removing the risk that the loser may ultimately have to pay the winner's legal costs, the proposed scheme removes any deterrent to borderline or frivolous claims. Coupled with the duty of candour and the publicity that would no doubt attend a national scheme, this could boost the compensation culture that, up to now, it has been public policy to prevent.

On the other hand, *Making Amends* will do little to tackle the problem of claims that are settled for relatively small amounts after years of accruing disproportionately large legal bills.⁵ The delay is sometimes because claims are initially inflated by claimants or their lawyers and take time to be brought down to earth by the defence. One solution might be to cap claimants' costs at, say, 10% of the compensation recovered unless a good reason was shown for a higher amount.

What sort of claims will be covered?

The table shows some of the types of case that would be eligible for compensation under the scheme. The sample is drawn from a cohort of 222 clinical negligence claims arising from hospital care that were closed between 1 January and 30 June 2003 by my firm, which

Injuries that might qualify for payment under the NHS redress scheme for smaller claims

Type of claim	No of cases
Unintended damage during surgery	35
Procedure not properly carried out	19
Unnecessary operation	10
Infection	12
Drug error	9
Retained objects	6
Anaesthetic	7
Inadequate consent	2
Equipment failure	1
Failure to monitor	1
Total	102

defends clinical negligence claims arising from several NHS hospitals in London and the south east England. In the year to 30 November 2003, the firm took on the defence of 347 clinical negligence cases.

The remaining 122 cases in our sample comprised 38 obstetric claims (of which 29 concerned severe birth related neurological impairment), seven others, and 77 claims based on delays in diagnosis that would be excluded from the redress scheme because the injuries resulted from the natural progression of the illness. *Making Amends* does not include harm resulting from delayed diagnosis in its definition of events eligible for compensation, and the omission of such injuries from the scheme seems unfair, especially if it is to be extended to primary care, where 57% of all claims concern delays in diagnosis.²

Claims for severe, birth related, neurological impairment

In addition to the scheme for smaller claims, *Making Amends* proposes the introduction of a separate scheme for compensating those who suffer severe, birth related, neurological impairment, including cerebral palsy. Claimants would not have to prove negligence or any other degree of fault to qualify for payment, but the requirement to prove that the injury was birth related could mean that many of the arguments about causation that currently occur in obstetric litigation would continue. Successful claimants could expect to receive up to £50 000 as an initial lump sum for pain and suffering, up to £50 000 as a lump sum for home adaptations, and up to £100 000 a year for additional care that the NHS may not be able to provide.

Obstetric litigation accounts for about 50% by value of all clinical negligence cases reported to the clinical negligence scheme for trusts,⁶ and these claims have been the cause of growing disquiet for many years.⁷ The incidence of cerebral palsy, the most common type of birth related neurological impairment to figure in the litigation, has remained fairly constant at 2-3/1000 births, despite improving standards of perinatal care. Estimates of the proportion of cerebral palsy in term babies that is birth related vary from 36% to 10%.⁸⁻⁹ The proportion of term births in which birth asphyxia causes cerebral palsy is 1 in about 3600 (although the Swedish study would put the figure nearer to 1 in 1200).^{8-10 11} The proportion that could have been prevented by non-negligent care will be smaller still.

The rarity of birth related cerebral palsy makes many cases difficult to prevent by any reasonably sustainable level of vigilance during maternity care. There may be a case, therefore, for a statutory reform of the law of negligence to give clinicians who attend women in childbirth the same protection from litigation as rescuers in the fire or police service.¹² This would free clinicians from legal liability for failing to prevent neurological impairment caused by a disease process and limit their liability in negligence to any new dangers that they introduce. It seems appropriate to review the position alongside the proposals for a no fault scheme.

Increased fairness?

Currently, judicial decisions have inflated awards to the point where amounts over £3 million are not uncommon for the minority of people with cerebral palsy who can prove fault. Such awards seem excessive both by absolute standards and by comparison with losers in the litigation lottery, who get nothing. It would be fairer if the huge sums involved were distributed more evenly, but will the proposals in *Making Amends* achieve this?

Unfortunately, it seems unlikely. As with the scheme for claims under £30 000, the scheme's promise of possible compensation for no outlay by the claimant and at no risk is likely to encourage more claimants rather than reduce them. People who discover that they have a good claim in negligence when they apply to the scheme are likely to switch to a negligence based claim to get the higher levels of compensation available from the courts. The result may be that the number of claims may rise and the scheme will only add a new class of beneficiary. The size of the new class would depend partly on the extent to which low birthweight babies are included and the rigour with which the requirement for the injury to be birth related is applied. Merely moving the boundary between winners and losers would not achieve greater fairness when other equally deserving groups, such as people with Down's syndrome or non-birth related cerebral palsy, are excluded.

What next?

In conclusion, further proposals are required to limit the cost of processing inflated claims and to consider whether clinicians should be given some protection from litigation alleging a failure to prevent birth related impairment. As it stands, *Making Amends* proposes to make it easier to pursue small claims and birth related claims, without necessarily reducing the number of claims processed through the conventional legal system and perhaps encouraging even more of them. The task of dealing with the greater number of inquiries into their practice would inevitably create an added burden for clinicians and hospital managers.

Of course, there is no reason why society should not deploy more of the resources available for health care to compensate people with small claims or birth related neurological impairment. It remains to be seen, however, whether the chief medical officer's thoughtful and comprehensive assessment of clinical negligence litigation will persuade Treasury mandarins to meet the cost of the proposed redress scheme.

Summary points

The government is proposing to reform procedures for compensating for clinical injury

The reforms will greatly increase the number of inquiries into clinical practice

The number of litigation claims would also be likely to increase

The scheme excludes injuries due to delay in diagnosis

It will not reduce the excessive legal costs of processing inflated claims that are eventually settled for small amounts

Competing interests: BC is the senior partner of a solicitors' firm that defends clinical negligence litigation and managing director of Datix, a company that develops clinical risk management software.

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- 2 Department of Health. *Making Amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS*. London: DoH, 2003. www.doh.gov.uk/makingamends/pdf/cmomakingamends.pdf (accessed 27 Jan 2003).
- 3 Capstick B. *Quality counts—your 12 point plan to cut the cost of claims*. London: Capsticks Solicitors, 1991.
- 4 NHS Litigation Authority. *Report and accounts 2003*. London: NHSLA, 2003:4.
- 5 National Audit Office. *Handling clinical negligence claims in England*. London: Stationery Office, 2001. (HC 403 2000-2001).
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- 12 Capital and Counties plc v Hampshire CC and others [1997] QB 1004. (Accepted 8 January 2004)

Too late for Christmas: quiz answers

No one got any of the answers to our Christmas quiz¹ right—so there is no winner—but here at last are the answers.

In figure 1, the magnetic resonance image was of a mince pie—you might be looking for the traditional sixpence, but this is dangerous because combining metals and superconducting magnets can lead to dangerous flying objects.

Figure 2 showed a mechanical laxative. Patented during the 1930s, the Kolon Motor would have been mounted on the bathroom wall with the base vertical. With your abdomen against the plate, you would turn the side levers and massage with the colon-shaped contours of the plate would initiate relief from constipation—externally.

Figure 3 obviously showed the interior of some sort of box—it was actually a box used to store that essential accessory, a ladies' fan. An endoscope would be useful for reading the newspaper stories, and dating the box and fan—these were from 1806.

Thanks to Benjamin J Holloway and Richard Wellings, radiology department, Walsgrave Hospital, Coventry for the mince pies; Jennifer Cox and Cassandra Crosby, Yarmouth Country Museum, Nova Scotia, Canada for the Kolon Motor, and Rory McGouran, Queen Elizabeth Hospital, King's Lynn, for dating the fan box.

- 1 Christmas quiz. *BMJ* 2003;327:1448.

Commentary: what's the problem?

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Brian Capstick's views will come as a surprise to people who suppose that negligence litigation is out of control or a large burden to the NHS. As he shows, it costs well under 1% of turnover, and most of that is the cost of caring for birth injured children, a bill that ought to be met under any system. Given that there are 850 000 adverse events causing harm, 6000 claims seems modest.

The volume of claims is also falling. *Making Amends* noted that it had fallen in two successive years from a peak of 8000. The Legal Services Commission's new evidence to the chief medical officer's inquiry is that last year they issued only 6000 new certificates and closed 8000 files. This compares with 18 000 new certificates at the peak in 1991. Since 55% of certificates do not result in writs being issued, it is likely that only 2700 new writs will be issued next year.

Time and costs

Capstick refers to the problem of cases that take over five years to resolve as highlighted in the 2001 National Audit Office report.¹ The chairman of the Public Accounts Committee in parliament described this as an almost systematic lack of compassion. However, the report looked only at an atypical group of cases: those concerning events before 1995 and closed in 2000. It ignored the cases closed before 2000 and the fact that the legal system changed in 1998. In November 2003, the Litigation Authority announced that the resolution time for cases under £30 000 had fallen to eight

months. This means the average case is now settled under English tort law faster than it is settled under the New Zealand no fault scheme.

Nor is it true that that much money could be saved by mediation. About 98% of claims are settled without going to trial, virtually all of them by simple negotiation or a payment into court, both of which are much quicker and cheaper than mediation.

Today the English system provides a swift and reasonably robust means of disposing of a modest volume of claims. Any alternative is likely to expand the number of cases. Capstick is surely right when he says that publicising a system in which there is no penalty for a spurious claim would attract a much larger proportion of the 850 000 who are harmed. There are good arguments for expanding the compensation culture, but those against seem more popular.

When liability is conceded in the redress scheme, lawyers will be engaged by many claimants anxious to maximise the value of the concession made. Obviously, legal fees for disputing liability can be avoided if liability is conceded at the start, but far more arguments about the amount of compensation will exhaust any savings.

Competing interests: BL is senior partner at a firm of solicitors that specialises in advising the healthcare professions and the NHS.

1 National Audit Office. *Handling clinical negligence claims in England*. London: Stationery Office, 2001. (HC 403 2000-2001).

Pride comes ...

To supplement both my income and my experience, I, like many junior hospital doctors in London in the late 1960s, did odd surgeries for general practitioners at weekends and some emergency home visits then and at night. The latter were telephoned through to my home in Dulwich. Single visits were poor value, as you got considerably less than the general practitioner was reimbursed, but you might get a run of visits, telephoning in after each one. They meant driving all over south London, from the inner slums and housing estates to the leafy suburbs and beyond, to Kent. Travelling under the aegis of a doctor's medical bag was then relatively safe, although it provoked attempted theft later. I felt really threatened only once, when approached aggressively by two policemen in a patrol car when I had stopped in a deserted shopping street at 3 am to use a public telephone. Thinking they were definitely on to a criminal, they were reluctant to change their minds.

This particular summons was to a young man with a stiff neck, seen inconclusively both by an emergency doctor and in an accident and emergency department. He was allegedly deteriorating. The caller was querying meningitis. I set out to Docklands. The address was in a largely deserted and boarded up, soon to be demolished, row of ancient tenement buildings, erected in the previous century by a charitable trust. They were dank, dark, and silent except for the drip and trickle of overflow pipes leaking from a great height. With some difficulty I located the right building, entered, mounted a decrepit stone staircase in

appalling light, and found the flat I needed. I was greeted effusively and with great deference by an Asian immigrant concerned about his son.

The young man was lying in the shadow of a single low-powered bulb, in a bed with no sheets. He did indeed have a stiff neck. Rhythmically it went into involuntary spasm, pulling his head backwards on to his pillow—spasmodic retrocollis, an extrapyramidal syndrome. He had chronic schizophrenia and was receiving depot injections at a clinic to control it. I explained to the father that, although distressing, the spasms were not a serious threat to his son and that they were caused by his medication. This would need adjusting by those managing it, whom he should contact for advice when he could.

I left the tenement flat a transiently heroic figure—one up on two other doctors in my diagnosis, explanation, and management, and with the flowery and elaborate compliments and thanks of the father ringing in my ears. Missing the top step off the darkened passage, I skidded and crashed all the way down the first flight of stairs, my precious status symbol, the medical bag, thumping and bumping alongside to join me in a heap at the bottom. Shaken, and suitably chastened, I picked myself up and made a bruised withdrawal towards the dimly visible exit—enriched by a few shillings and by an unforgettable experience.

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