Compensation for adverse consequences of medical intervention

SUMMARY OF A REPORT OF THE ROYAL COLLEGE OF PHYSICIANS

Membership of the working party

Margaret E. H. Turner-Warwick, DBE DM FRCP (President)
Sir Raymond Hoffenberg, KBE MD FRCP (Chairman)
R. Dingwall, MA PhD (Honorary Secretary)
P. Fenn, BA BPhil (Honorary Secretary)
M. Ashley-Miller, FRCP FFCM
Mrs Diana Brehms, Barrister at Law
I. G. Chalmers, FRCP FFCM
The Reverend Professor G. R. Dunstan, CBE DD LLD HonFRCP
C. Ham, BA MPhil PhD
J. D. J. Havard, CBE MA MD LLM MRCP, Barrister at Law
D. Hull, FRCP
J. A. Johnson, MA
J. P. Miller, FRCP
G. M. Wood, MD MRCP(US)
D. A. Pyke, CBE MD FRCP (Registrar)
Sir Cecil Clothier, KCB QC (retired from working party, Jan 1990)
Observers
R. N. Palmer, MB LLB (Medical Protection Society)
Marguerite Smith, MRCP (Department of Health)
In attendance
Mrs Linda Connah, BA (Deputy Secretary)
Miss Elaine Stephenson, BA (Working Party Secretary)

Introduction

Towards the end of 1988, the Royal College of Physicians was becoming increasingly concerned about the problems raised for the practice of medicine as a result of the sharp growth in the frequency and severity of medical liability claims. The consequent increase in defence society subscriptions raised the spectre of problems with insurance availability, although it was recognised that the American experience of this was unlikely to be repeated in the UK, given the structural difference in health care systems between the two countries. The College also felt that the differences between medical and legal approaches to the analysis of adverse outcomes must lead to patients being investigated and treated in ways which were clinically inappropriate or undesirable, but undertaken by doctors rather with the intention of protecting themselves against possible legal action (that is, so-called 'defensive medicine'). The overriding principle of medical practice should be to meet the clinical needs of patients.

The College also recognised the growing public and professional concern about the inequities of the legal process of establishing negligence: like needs received unlike compensation, and sympathy for victims seemed to be leading to an excessive zeal in seeking minor faults in the practice of conscientious doctors in order to justify the award of damages by a finding of negligence. It was also felt that doctors should be informed about the current position in relation to their liability in tort, and the various proposals for alternative systems of no-fault compensation. In the light of these considerations, the College set up a Working Party to review the means of compensation for the adverse consequences of medical interventions.

Several commentators, including the British Medical Association, had argued that a 'no-fault' system of compensation for the adverse consequences of medical interventions would solve many of these problems. However, the Working Party recognised that the term 'no-fault' actually covered a number of schemes—many operating abroad—with rather different characteristics. In the British context, it was not clear that any of these represented an entirely satisfactory model. The Working Party therefore undertook a rather broader review of the problems in devising an equitable and efficient method of compensating patients who had been injured in the course of medical treatment. Rather than assuming priority from the start, 'no-fault' was evaluated among a set of policy options, and a somewhat more cumbersome title was introduced: Compensation for adverse consequences of medical intervention.

Terms of reference

The Working Party defined its terms of reference as follows:

a To consider the means of providing compensation and redress for people who have sustained some physical or psychological damage consequent upon an encounter with medical care;

b To investigate the efficiency and equity of the arrangements which currently exist in England and Wales, focusing particularly on the tort system;

c To evaluate the alternative compensation schemes which have been proposed or introduced in other countries, such as the no-fault systems in New Zealand, Sweden and Finland, with particular regard to their administrative costs and their implications for medical accountability and standards of care;
To make recommendations intended to improve the current position of injured patients.

**Compensation and redress**

Although it is important that people with genuine economic losses should see those made good, the report does not concentrate too narrowly on the issue of financial compensation. It is equally important to recognise that claims might arise out of a desire to seek an explanation or to hold the profession accountable for its failures. The term ‘redress’ was adopted to indicate that, even where there were no economic losses or where these did not fall within the terms of a compensation scheme, victims of medical interventions might be concerned to achieve a psychological closure on events. Patients and doctors might have a legitimate interest in being assured that a thorough process of enquiry had taken place and that appropriate remedial action had occurred.

The Working Party was aware that the current structure of the enquiry procedure is being discussed by all the medical organisations concerned, although the outcome of these discussions is not yet known. While the tort system was not designed to deal primarily with poor standards of medicine, it has nevertheless been argued that the threat of litigation is a significant influence on standards of medical practice, and to this extent it may be inadvisable to remove its influence without introducing some alternative sanction or incentive.

**Causation**

The inherent biological uncertainty and unpredictability of adverse outcomes following medical care render questions of causation particularly difficult. Nevertheless, it is necessary to find a way of establishing which cases should be entitled to some compensation from the health care system and which should look forward to some form of insurance, whether private or social.

Also, difficulties in establishing causation are compounded by difficulties in determining negligence. In establishing negligence the law requires that members of the medical profession give evidence in court to determine whether there was a body of reputable doctors who would approve the intervention in question. Again there are inherent uncertainties in relation to the rate at which new treatments are assimilated into current practice, which reinforce the impression that the adverse consequences of medical intervention involve issues which set this area of compensation apart from others.

**‘No-fault’ and ‘tort’ systems**

There has been much debate both within and outside the medical profession about the problems associated with the English law of tort, and the advantages or disadvantages of moving towards a ‘no-fault’ system of compensation, as has been introduced in some other countries. This debate has continued against a background of very little information about the respective alternatives. To help inform the debate, the report aims to set out clearly the various arguments surrounding the ‘tort’ and ‘no-fault’ systems.

**Compensation under tort—causation, fault and quantum**

To have a successful claim, three matters have to be established by the plaintiff:

i. **Causation**—was the damage caused by the medical intervention (or non-intervention) or partly or wholly by something else?

ii. **Negligence**—was there a failure of the doctors (or others) in their duty to the patient?

iii. **Amount of loss (quantum)**—this depends on the assessment of any future, present or past loss by the patient or other dependent on him.

**Causation**

A patient suing in negligence must prove a causal connection between his damage and the act or omission which is alleged to have caused the damage. This requires two stages of proof: he needs to show that the defendant’s conduct was one of the possible causes of the damage; and he needs to show that this conduct was the most likely of the possible causes on the ‘balance of probabilities’. It is often very difficult to distinguish whether any action or failure by doctors has caused damage or whether there is another cause wholly or partly responsible for the damage.

**Fault**

Negligence is defined in tort law as the breach of a duty to use reasonable care, as a result of which there is damage to another. While judges must rule on whether the standard of care is acceptable in any given situation, what is reasonable care in the context of medical negligence is in practice determined by the medical profession itself: it is that degree of care which a responsible group of fellow doctors in the appropriate specialty consider to be reasonable. In other words, the law requires that doctors apply an ordinary level of professional skill, not some absolute ideal. There is no negligence if damage results from normal risks associated with that particular branch of medical care provided the appropriate warnings have been given. Further, there is not negligence if the event leading to damage was unforeseeable, a factor which may be of particular relevance to medical intervention.

**Quantum**

If the hurdles of fault and negligence are overcome, the plaintiff will be entitled to a sum of damages (the
Disadvantages of tort

The Working Party concluded that the tort system is deficient as a means of providing compensation for the following reasons:

i Inequity to plaintiffs: similar patients are compensated differently depending firstly upon whether or not they can prove a causal connection between event and outcome, and secondly upon whether they can prove that damage was caused by a particular individual’s fault.

ii Delay: at the extreme, a case might not come forward until decades after the alleged damage occurred and then take another 4 or 5 years to reach a conclusion.

iii Cost: legal costs, particularly in smaller cases, regularly exceed damages in tort actions.

iv Quality of representation: plaintiffs may be represented by local solicitors with variable levels of skill and expertise in dealing with medical negligence cases.

v Inequity to defendants: there is an unfair burden of publicity placed on those doctors whose cases are heard in court rather than settled out of court.

vi Lump-sum awards: damages are predominantly paid on a lump-sum basis which means that the money may not be used for the purposes awarded.

vii Defensive practices: the threat of litigation may lead doctors to adopt practices which are designed primarily to avoid legal liability rather than to provide appropriate care for patients.

Alternatives to tort

The Working Party considered the following alternatives to the tort system:

i Patient insurance: The most successful working model of a no-fault system limited to the victims of medical interventions is the Patient Insurance Scheme which was set up in Sweden in 1975. The county councils, which provide health services in Sweden, pay an annual premium per inhabitant to a consortium of private insurers who then manage claims and payments. The scheme covers treatment injuries, diagnostic injuries, incorrect diagnoses, accidental injuries and iatrogenic infections or omission to treat, but there are some exclusions. There is a fairly high threshold to exclude minor injuries and psychological injuries are not eligible.

ii Accident compensation: A no-fault scheme for all accidents has existed in New Zealand since 1974, when the tort action was abolished for most personal injuries resulting from accidents, whether medical, road traffic, sports, industrial or whatever. The Accident Compensation Corporation is financed by special levies on employers and motorists and by general taxation. In the event of an accident, the victim can claim periodic payments of compensation for loss of earnings up to 80 per cent of previous income, lump-sum payments for permanent loss or impairment of a bodily function and for loss of enjoyment of life, pain and suffering; and reimbursement of medical costs.

iii General disability income: Under such a scheme, individuals would receive support on the basis of the fact and severity of their injury and its consequences, and would have to establish neither fault nor cause. Damage suffered following medical intervention would then be treated in exactly the same way as damage suffered in any other way, including chronic illness and congenital disability, as well as accidental injury.

RECOMMENDATIONS

The Working Party became aware during the course of considering the various options for reform that there remained inequities in any no-fault scheme limited to medical interventions, which arise out of the inherent difficulties in determining causation in this area. It was felt that the only permanent solution to these difficulties would be the implementation of a comprehensive disability income scheme for all illness- and injury-related disability irrespective of causation. However, it was recognised that, by its very nature, such a solution would require a trade-off to be made between the generosity of compensation and the breadth of coverage. The cost of such a scheme would therefore depend upon how this trade-off was resolved through the political process. In the absence of any impending resolution of this issue, the Working Party makes the following recommendations:

1. Introduction of a no-fault scheme

It is recommended that a no-fault scheme, limited to compensating the adverse consequences of medical inter-
vention, should be introduced with the following features:

i Economic damages recoverable under such a scheme should be capped, and prospective loss of earnings should be limited to average net earnings.

ii Non-economic damages (eg pain and suffering) should also be capped.

iii Those wishing to avoid any shortfall in their expectations under such a scheme should have recourse to the insurance market and consideration should be given to making the premiums tax-deductible.

iv Victims of medical mishaps should be disqualified from suing in negligence if they have already elected to claim under the no-fault compensation scheme on the same cause for action.

v The amounts payable under the no-fault compensation scheme in the form of a lump sum should be strictly limited. Wherever practicable, periodic payments should be made, subject to review at stated intervals.

2. Procedural rules for medical negligence actions

For those actions which continue to be brought in medical negligence, it is recommended that procedural rules should be reviewed in the light of the following principles:

i The court should be required to satisfy itself that evidence as to opinion (expert evidence) is admitted only from medical witnesses of appropriate expertise. The medical Royal Colleges and Faculties might give consideration to a way of ensuring that medical witnesses met this standard.

ii The Working Party supports the view of the Master of Rolls that there should be the fullest disclosure of all material facts, and relevant opinions including medical reports. The judgement in the Naylor case made it clear that there should be only the strongest possible reason for refusing or failing to disclose material facts (Naylor v Preston AHA [1987] 2 All ER 385).

iii The Working Party welcome the encouraging trend towards open and informal pre-trial meetings with a view to resolving matters in the interests of patients. It supports the statement in the Civil Justice Review that there should be a greater exchange of reports between sides, as the oral aspect of pre-trial procedures can give rise to considerable delay (Report of the Review Body on Civil Justice (1988) Cm. 394 para. 76). It also notes the recent amendment to Order 38 of the Rules of the Supreme Court which permits the Court to direct the exchange of experts' reports (Rules of the Supreme Court (Amendment No. 4) 1989 (S.I. 1989 No. 2427).

iv The Working Party believes that the Law Society's system of certification of solicitors should be encouraged as a means of developing legal expertise in medical negligence.

3. Medical accountability

The Working Party accepts that one of the major criticisms of no-fault schemes has been that they might remove a source of medical accountability. It is therefore recommended that the scheme proposed above should be accompanied by a separate mechanism for the scrutiny of each claim in which doctors were involved to ensure that appropriate care had not been transgressed. If transgression is demonstrated, questions of professional discipline should be pursued. Movement towards this end might be achieved in the interim by the strengthening of medical audit and peer review, increased emphasis on the monitoring of medical performance, and the further development of risk management schemes operated by hospitals and health authorities. The Royal College of Physicians itself has emphasised its commitment to this direction by making the implementation of audit procedures a condition of recognition of training posts. As a hospital without training approval would find it difficult to obtain any junior staff, this represents a powerful incentive to implement such audit procedures, although the quality of the latter would need to be carefully monitored in future.

4. National database

It is important that data on cases involving adverse consequences of medical intervention should be available for monitoring and scientific analysis. In the past the medical defence organisations have collected these data. The Working Party is concerned that health authorities should appreciate the importance of maintaining such a national database subsequent to the introduction of NHS Indemnity. It is therefore recommended that DHAs co-ordinate their approaches to this problem, either in conjunction with the defence organisations, or through the Department of Health. A comprehensive national database accessible to all would be an essential complement to the compensation reforms recommended above.

Summary

A limited no-fault scheme along the lines in the report would be a means by which reasonable levels of compensation could be provided promptly to the victims of medical intervention at relatively low administrative cost and with relative accessibility for those involved. However, the scheme would need to be carefully costed before implementation. This means that detailed consideration be given to the likely effects on the numbers of people claiming compensation, and the levels of compensation payable, as well as the administrative costs involved. The Working Party recognise that the relatively low costs associated with the Swedish Patient Insurance Scheme follow from the generosity of the Swedish social security provision for the dis-
Compensation for adverse consequences of medical intervention

enabled in relation to economic loss. However, the Working Party believe the restrictions suggested on the level of benefits under the scheme proposed in the report, are sufficient to imply an overall cost which is not excessive by comparison with the existing scheme, and that consideration should therefore be given to the appropriate means by which the scheme could be financed, and primary legislation drawn up. It is also emphasised that the improvements in the tort system, in accountability, and in data collection for risk management purposes are essential adjuncts to any such compensation scheme. Indeed, they would appear to be desirable independently of any future implementation of these no-fault proposals.

Copies of the full report are available from the College, price £8.00 (£9.00 overseas).