No-Fault Compensation for injury resulting from medical treatment: Consultation Questions

1. The research team supporting the review reported (Farrell *et al*, 2010[19]) that previous research suggests that when an error has occurred, patients expect doctors to make a meaningful apology, provide an explanation and take steps to prevent the error from recurring. The findings of their research would appear to support the contention that for many, if not most, patients this is the primary aim, rather than a financial award.

2. The Scottish Public Services Ombudsman (SPSO) has published advice in relation to apology[20]. This advice was referenced in the guidance issued to NHSScotland in March 2012 on the handling and learning from feedback, comments, concerns and complaints.

Question 1: What, if any, steps do you feel are necessary or appropriate to ensure that when an error has occurred, patients receive a meaningful apology?

Whilst errors undoubtedly occur, the definition of an error is the key value-laden issue.

Example: A doctor prescribes a drug for a condition but the patient also has another condition for which the drug is contraindicated. The patient come to harm from the second condition. Is this an error? Many might say it is. However, the prescribing doctor thoughtfully balanced the risks and benefits before prescribing and whilst he accepts the patient was harmed he does not agree that this was an error. He does not wish his reputation as a thoughtful prescriber to be called into question so he will not agree that there was an error. He asks his own medical defence union to oppose any no-fault compensation by the NHS.

If you think this sounds fanciful, a patient with congestive heart failure and asthma will almost always be prescribed a beta blocker (indicated for heart failure but contraindicated in asthma). Some will be hospitalised with asthma.

NHS consultants take out professional indemnity insurance to protect their reputation and standing. Whereas the NHS might judge no-fault, this judgement is based on the admission of error and it is this error that is value laden.

The definition of error is the major problem we face. No one will wish to apologise for doing something that they do not consider an error on their part.

Example: a patient is hospitalised for left hypochondrial pain. They ask the doctor if this could be due to gallstones. The doctor says that gallstones cause right hypochondrial pain and tenderness and that the pain is unlikely to be due

[19] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report
[20] http://www.spso.org.uk/files/2011_March_SPSO%20Guidance%20on%20Apology.pdf

to gallstones. The patient is discharged. A few weeks later the patient is hospitalised with right hypochondrial pain and is diagnosed as having gallstones and gets pancreatitis from which the patient suffers harm. The patient thinks that the first doctor she saw made an error and could have prevented the pancreatitis if he had diagnosed gallstones and had them removed before progressing to pancreatitis. The doctor does not agree he made an error. The patient want an apology. The doctor does not agree. What does the NHS do?

Since the current system only pays up when negligence is proven, paying up without proving this rather implies that the doctor was negligent. Apologising for good practice is rather akin to admitting negligence. Who in their right mind would do this?

The problem faced by clinicians is that they have to take the best decision they can based upon the limited information they have at the time. In retrospect, when more information is available, they may wish they had taken a different decision. Was the first decision wrong? Or is that just the way things are?

Patient do not really understand the concept that there are benefits and risks of everything. Even if they read and signed a 20 page patient information sheet that clearly laid out these risks and benefits they will still want redress.

Blame is also part of the grieving process: "If only that doctor had done x my husband would be alive today" may well turn into a complaint, then a claim for compensation. Guilt is often part of this. "My mother (who I did not want to come and live with us) fell on the floor at home (and lay there for 20 hours) and then died because the NHS doctor did not treat her chest infection quickly enough". If the NHS apologises for this bad outcome but denies it is true then the lady pursues the NHS in the courts. If the NHS apologises and pays compensation (implying it is true) then the doctor rigorously defends this.

Having a committee sitting in judgement to decide (on the balance of probabilities) what defines an error will only escalate these issues as the doctor will get legal representation. So how can this circle be squared?

One option is for the NHS to apologise for all bad outcomes without admitting error. This will not appease the complainer and there is a logical inconsistency with apologising for no blame. In addition, eventually all patients have bad outcomes (they die) so the definition of a bad outcome is fraught with value judgements itself.

My solution to all of this is not legal. Instead it <u>requires</u> a meeting in private between the complainer and the doctor being complained about with the full medical records available to both sides. This usually sorts it all out. If this does not resolve the matter the next step is to require a meeting between the doctor (with supporting doctors) and the patient (with a doctor or lawyer supporting their case). Only then, if agreement cannot be reached should any legal case or no fault compensation be considered.

An anecdote might be useful here. A doctor is accused of an action by a patient. The doctor cannot remember the incident but agrees to meet with the patient with the case records. When the patient meets her first comment is "but you are not the doctor!". Further investigation reveals that the complainer was referring to a very junior doctor and the consultant being complained about was on annual leave at the time. The incident was closed when the junior doctor apologised.

3. The Review Group considered that the following were essential criteria for a compensation scheme for injuries resulting from medical treatment:

- The scheme provides an appropriate level of compensation to the patient, their family or carers
- The scheme is compatible with the European Convention on Human Rights
- The scheme is easy to access and use, without unnecessary barriers, for example created by cost or the difficulty of getting advice or support
- People are able to get the relevant specialist advice in using the scheme;
- Decisions about compensation are timely
- People who have used the scheme feel that they have been treated equitably
- The scheme is affordable
- The scheme makes proportionate use of time and resources
- The scheme has an appropriate balance between costs of administration (e.g. financial or time) and the level of compensation awarded
- Decisions about compensation are made through a robust and independent process
- The scheme has an independent appeal system
- The scheme treats staff and patients fairly/equitably
- A reasonable time limit is set for compensation claims.

Question 2. Do you agree that the principles and criteria set out above are essential in a compensation system?

Yes ☐ No √

I do not believe that the second last bullet point is viable given my answer to 1. The NHS will take a decision that minimises the cost. This is likely to be to pay compensation even when the doctor denies emphatically that he or she is at fault.

2.1 Are there any to which you would attach particular priority or importance? Are there any others you would add?

The second last bullet point is the one that will determine the success or failure of the scheme. The only way around this is to pay compensation when there is no error and no negligence. However, the scheme requires a causal link: catch-22. The problem is that no fault compensation does not really mean no-blame compensation. However you dress this up it is

a way of saving money by blaming doctors. Whereas this may not be an admissible admission of guilt, a jury (or a civil court) may not interpret this action as leniently. So a doctor may be accused of manslaughter once compensation is paid and the fact it was paid would support the case against him.

4. The Review Group identified a number of issues it believed were relevant to the likely success of any system and agreed that the following criteria were desirable, and considered and highlighted the importance of the wider issues detailed below:

Desirable

- The public in general trusts the scheme to deliver a fair outcome
- The scheme does not prevent patients from seeking other forms of non-financial redress, including through the NHS Complaints system
- The scheme encourages transparency in clinical decision-making
- The scheme contributes to rehabilitation and recovery.

Question 3: Do you agree that these criteria are desirable in a compensation system?

Yes ☐ No √

I cannot see the point of no fault compensation unless all further action stops.

3.1 Are there any others you think are desirable and should be included?

The doctor accused of the error or negligence must be able to appeal even after compensation is paid. We cannot have a one-sided appeal scheme.

Wider issues

- The scheme contributes to:
  - organisational, local and national learning
  - patient safety
  - quality improvement
- Lessons learned can be used to influence organisational risk management in the future
- The scheme encourages and supports safe disclosure of adverse events
- The scheme does not put barriers in place for referral to regulators of any cases which raise grounds for concern about professional misconduct or fitness to practise.

Question 4: Do you have views or ideas on how a compensation scheme could more effectively contribute to the wider issues identified above?

I suspect that such a scheme will force doctors to document and have witnesses to all decisions and actions. This will slow dramatically how they deal with patients. The concept of the doctor patient relationship

will change. The trust in doctors will be eroded. Doctors may distrust the NHS to act in their interest. Far from being an advance, such a scheme could be regressive.

I speak as someone who has not had a single complaint in at least the last 5 years. I know that colleagues in more difficult specialities where there are no easy answers get more complaints most of which are due to lack of comprehension. I think that what is needed is a comprehensive system of communication between complainer and clinical staff as a mandatory step before any scheme is implemented. The scheme must truly be no fault so it is no fault of the doctor that the patient was harmed. I cannot see how this can be achieved at present.

5. When considered the Review Group's suggested essential principles and criteria against other schemes and the Swedish model came out on top. Based on this the Review Group offered:

> **Recommendation 1 -** that consideration be given to the establishment of a no-fault scheme for medical injury, along the lines of the Swedish model, bearing in mind that no-fault schemes work best in tandem with adequate social welfare provision.

Question 5: Based on the background information on the system in operation in Sweden given in Annex A would you support the approach suggested in Recommendation 1?

Yes ☐ No √

If not, why not and what alternative system would you suggest?

The entire Swedish system starts when an error occurred. As described above this judgement is problematic. The Swedish system can then escalate action against the doctor. Given that 50% of doctors are by definition 'below average' and given the current test of competence is 'an ordinary doctor with ordinary skill' I think it will be very hard for a doctor to defend himself against spurious claims unless he spends his entire life documenting how he took difficult decisions.

Example: Patients with the worst heart function (left ventricular ejection fraction) benefit most from coronary revascularisation. However, these patients are at highest risk of dying during or due to surgery. Should a surgeon refuse to do these patients? If so, nobody gains anything. If he does operate and the patient dies is he at fault? Was this an error or was it the way things are?
If the wife brings an action saying the doctor should not have operated on her husband because there was a high chance of dying then given the evidence that this is true would not no-fault compensation be paid? So the surgeon is now guilty of an error and buoyed up by this the wife asks for criminal actions

for manslaughter to be instigated. Why would any surgeon ever operate again on patients who benefit most but die most?

Recommendation 2 - that eligibility for compensation should not be based on the 'avoidability' test as used in Sweden, but rather on a clear description of which injuries are **not** eligible for compensation under the no-fault scheme.

Question 6: Would you support the approach in Recommendation 2? This would mean for example that where treatment carries a known risk and the patient has given consent to that treatment it would not be eligible.

Yes √ **No** ☐

If not, why not?

We are straying into increasingly complex legal arguments here. Avoid ability is subjective. Causality is even more subjective (often it is the more likely than not test). Documented consent might be a defence but consent has to be shown to be informed.

Example: The new NICE hypertension guidelines suggest spironolactone as the fourth line agent of choice for hypertension. The guidelines also say that doctors should get informed consent to use spironolactone for hypertension because this is an unlicensed indication in the UK.

A doctor makes a note in the case records that reads "D/W patient" and prescribes this. Two weeks later the patient is hospitalised with renal failure and life threatening hyperkalaemia. The patient recovers but denies the doctor informed him of the risks. Did the doctor get informed consent? Would the patient be compensated?

I suspect that the patient would need to be given a patient information sheet for 24h then consent would have to be done with a witness and formally recorded. If this is the case, very few patients will end up getting spironolactone the best fourth line drug for hypertension!

If yes, what other injuries would you consider should not be eligible?

6. The Review Group was of the view that any recommended changes to a no-fault system should cover all healthcare professionals including those not directly employed by the National Health Service. The group believed that fairness dictated that all patients whether treated by the NHS or privately should have access to an improved system if possible. If this proved impossible, the group nonetheless believed that there were benefits that could be obtained by a move to no-fault for NHS patients. The group's preference was that **all** patients should be covered by the no-fault scheme and offered:

Recommendation 3 - that the no-fault scheme should cover all medical treatment injuries that occur in Scotland; (injuries can be caused, for example, by the treatment itself or by a failure to treat, as well as by faulty equipment, in which case there may be third party liability)

Recommendation 4 - that the scheme should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHSScotland.

(As explained in the Cabinet Secretary's foreword we acknowledge that further work is needed to help in our understanding of the volume, level and cost of compensation claims handled by the Medical Defence Unions and private healthcare providers. We will seek to explore this further with the relevant stakeholders during the consultation period.)

Question 7: Do you support the view that, if introduced, a no-fault scheme should cover all clinical treatment injuries (e.g. private healthcare and independent contractors) and all registered healthcare professionals and not just those directly employed by NHSScotland?

Yes √ **No** ☐

If not, why not?

However, I think it will be impossible to introduce for private work. Fortunately there is not much private work in Scotland.

7.1 What, if any, difficulties do you foresee in including independent contractors (such as GPs, dentist etc) and private practice?

These are not really the problem as they can be covered by contract. This will cost more because they will not give up indemnity insurance in the short term so the government will have to pay the costs of including them.

7.2 What are your views on how a scheme could be designed to address these issues?

A legal obligation to be part of a no-fault compensation scheme to practice in Scotland might be an avenue if it can be considered within the scope of the powers of a devolved government.

Question 8: The intention is that if introduced the no-fault system will not be retrospective. However, consideration will need to be given to when and how we could transfer to a new system and how outstanding claims could be handled if/when a no-fault system was introduced. What are your views on how outstanding claims might be handled?

I think there needs to be a transition date like everything else. If you claim before that date it is the old system, if on or after the new system.

7. The Review Group did not favour the use of a tariff system for compensation, as it felt that this would not address individual needs and it was unlikely that people would buy into a system where compensation was based on a tariff. The group therefore offered:

> **Recommendation 5 -** that any compensation awarded should be based on need rather than on a tariff based system;

Question 9: Do you support the approach in Recommendation 5?

Yes ☐ **No** √

If not, why not?

This introduces inequality. Need is a subjective assessment. Everyone will get different compensation for the same harm. This cannot be equitable.

9.1 What are your views on the assumption that the level of payments will be similar to those settled under the current system?

If this system is not cheaper then it should not be introduced. For most people, all they want is an apology and some almost token compensation. A few people will get permanent disability and this should be compensated at a level that is judged proportionate. I think that subjects should get offered the scheme OR go to court. Some may chose to go to court.

8. The Review Group was satisfied that a no-fault scheme established as they describe would be fully compatible with the requirements of the European Convention of Human Rights, based in particular on the need – as in Sweden and New Zealand – to build in appropriate appeals mechanisms, with an ultimate right to appeal to the courts on a point of fact or law. In addition, retention of the right to litigate will ensure that those for whom the no-fault system is felt to be inappropriate will still be able to raise claims using this route. The group recommended:

> **Recommendation 6 -** that claimants who fail under the no-fault scheme should retain the right to litigate, based on an improved litigation system

Recommendation 7 - that a claimant who fails in litigation should have a residual right to claim under the no-fault scheme

Recommendation 8 - that, should a claimant be successful under the no-fault scheme, any financial award made should be deducted from any award subsequently made as a result of litigation

Recommendation 9 - that appeal from the adjudication of the no-fault scheme should be available to a court of law on a point of law or fact.

Question 10: Do you support recommendations 6 – 9 as proposed by the Review Group?

Yes ☐ **No** √

If no, why not?

I think we should have a compensation scheme that is binding or they go to court. The choice should be made up-front. If we allow everything then everything will be done. So contract to the compensation scheme OR persuade a court. I bet 97% will chose the scheme.

10.1 Do you have any concerns that the Review Group's recommendations may not be fully compatible with the European Convention of Human Rights?

Yes ☐ **No** √

If yes, what are your concerns?

9. The Review Group offered suggestions for improvement to the existing system and these are reproduced in Annex B. The group recommended:

Recommendation 10 - that consideration should be given to our analysis of the problems in the current system, so that those who decide to litigate can benefit from them.

10. It is proposed that the suggested improvements will be taken forward as part of the forthcoming consultation on the Courts Reform Bill later this year by the Scottish

Government Justice Directorate. In particular the Scottish Civil Courts Review[21] recommended that pre-action protocols should be made compulsory and it is considered that this would assist in resolving many of the areas identified by the Review Group In addition, Sheriff Principle Taylor's Review of Expenses and Funding of Civil Litigation in Scotland[22], which is due to report at the end the year will consider a range of issues.

Question 11: Do you agree with the Review Group's suggestions for improvements to the existing system?

Yes √ **No** ☐

11.1 Do you have any comments on the proposed action in relation to these suggestions?

The pre-action protocol must include mandatory meetings of parties to try to resolve matters prior to action whether no fault or court.

11. The Review Group also considered whether or not the establishment of a scheme specific to neurologically impaired infants should be created (in the event that a general no-fault scheme is not introduced). Members considered that this group of patients arguably represents a special case and certainly accounts for the most significant sums awarded in compensation and legal costs. The Group were of the view that this was worthy of consideration.

Question 12: Would you support the establishment of a scheme specific to neurologically impaired infants if a general no-fault scheme is not introduced?

Yes √ **No** ☐

12.1 What are your views on the Review Group's suggestion that the future care component of any compensation in such cases could be provided in the form of a guarantee of delivery of services (both medical and social care) to meet the needs of the child, instead of by way of a monetary sum?

Agreed.

[21] http://www.scotcourts.gov.uk/civilcourtsreview/
[22] http://scotland.gov.uk/About/taylor-review

General Comments

We would welcome any further general comments you may wish to offer here.

I think there are lots of challenges to be addressed.

We are grateful for your response. Thank you.