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?

I have been a qualified doctor for five years and an anaesthetic specialist trainee for two. It is my experience that the vast majority of doctors wish to apologise when an error has occurred. For juniors in particular, the biggest obstacle was often a fear that apologising would imply that they were somehow legally 'at fault' and would lead to them or their consultant being sued. A no-fault compensation scheme would likely increase the number of meaningful apologies by allaying this fear. It would also make the atmosphere between family and doctors less polarised.

That said, there will be instances where the personalities of the doctor or family involved will mean that an apology considered 'meaningful' may not be given or received. In those circumstances, a system similar to New Zealand where an arbitrating body can bring non-financial sanctions against the doctor would be appropriate.

[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

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** ☐

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

The timeliness of the scheme in particular, and also some means for patients who 'fall through the cracks' by being in a unusual situation that is not scheduled under the scheme to get their case heard

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 ☐

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

I would underline the importance of patients being able to seek non-financial redress.

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?

Yes – the scheme would help shift societies perception that 'a good doctor never makes mistakes' to 'a good doctor will always make mistakes but learns from them', and enable systems to be put in place to reduce the likelihood of error. For a more in-depth discussion of this, please see the work of Martin Bromiley, an airline pilot who lost his wife during a 'routine' operation and helped introduce human factors training to medicine.

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?

> **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**

While by and large I agree with this, care must be taken that it does not lead to pressure to inform patients of every conceivable risk of every procedure. While that may be appropriate for some patients, for others, in particular some elderly patients, it can be confusing and frightening.

For example, for a simple day case anaesthetic, there are risks of: haematoma and infection from IV cannulae, reactions to drugs including malignant hyperthermia and anaphylaxis, aspiration, laryngospasm, damage to teeth, the buccal cavity and the pharynx, unexpected difficult intubation with the chance of laryngeal injury, emergency cricothyroidotomy and hypoxic brain injury – and all those before the surgery has even started.

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?

There are arguments on both sides for this. For: it would simplify arrangements in both the public and private sector and reduce the burden on the courts, as well as promoting the 'no-fault' medical culture for all areas of healthcare.

Against: at present, it is very much the choice of both the patient and the doctor to engage in treatment privately. I do not see why state protections should be granted to doctors and patients who chose to go 'behind the NHS' back'. However, if seeking some treatment options privately becomes unavoidable in the future, for example non-funded cancer treatments, then this argument is no longer valid.

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

An interesting question is that of 'alternative medicine' practitioners, such as chiropractors and osteopaths. Perhaps they could be included if they agreed to professional registration, collecting morbidity data etc? This might be a useful route towards applying regulation to a sometimes well-intentioned and competent but also a sometimes dangerous and exploitative sector of healthcare.

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

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 this is more a legal than clinical question, so I am not best placed to answer.

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?

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

I think if truly based on need, then the payments may vary quite widely from the current system. The only downside of no tariff is that it then shifts the burden onto the patient to prove the extent of their needs. This may disadvantage the inarticulate or those of limited means.

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?

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?

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

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

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** ☐

Absolutely. I think that this is one of the most important areas where we could ease the burden on the parents of severely disabled infants, and also avoid driving a wedge between them and their doctors.

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?

The one advantage of giving parents a monetary sum is that it directly empowers them to choose the care that they feel is best for their child. Offering services alone might impair this very personal choice. If concern was of the money being diverted away from the child, then perhaps some could be held in trust, and released only to appropriate bodies? This would add significantly to the burden of administration however.

General Comments

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

I feel very strongly that a scheme of this nature should be introduced to Scotland. I have recently finished a year working in New Zealand and seen first-hand the benefits that it can offer.

While in New Zealand, I was involved in a horrific case relating to the spontaneous death of a 37 week-old fetus. While it was accepted that no one was directly at fault, the lack of the threat of litigation meant that all the staff involved were able to work wholeheartedly with the family to help them overcome their terrible loss. I feel that had the incident taken place in Scotland, while everyone would have had the same intentions, they may have felt a little inhibited by the very human urge to 'cover their backs'.

I have also spent time working in a poor community in America and seen the opposite system, where overburdened parents have had to struggle through the courts to secure a financial settlement for their neurologically-damaged children. This was often at a huge personal cost, in terms of time and money that would have been better spent caring for their children. It was particularly difficult for those of a lower educational level or limited means.

Finally, I would refer once again to the work of Martin Bromiley and others into the human factors surrounding medical error. We must move to a culture that says 'all good doctors will make mistakes' and also one that recognises that it is usually a succession of small errors that leads to a bad outcome, rather than one person who is 'at fault'. We need to honestly and fearlessly examine mistakes when they occur and to build in systems to prevent them occurring again. I sincerely believe that introducing a 'no fault' system would help with that cultural shift.

I am a conscientious, hardworking middle-grade doctor. As such, I know that I have and will make mistakes. I do not and cannot know everything, or make the right judgement call every time. The only consolation is that I might learn from them.

We are grateful for your response. Thank you.