No-Fault Compensation for injury resulting from medical treatment
BMA Scotland response

Background

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 150,000 representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 members. BMA Scotland welcomes the opportunity to comment on the Scottish Government's consultation on the introduction of No-Fault compensation for injury resulting from medical treatment in Scotland. Attached below is our response to this consultation and we look forward to continuing to contribute to this process.

The BMA supports in principle No Fault Compensation, and would support the introduction of a scheme that improves on the current system to the benefit of all parties involved provided that it does not increase costs to the NHS and divert money away from patient care. If the Scottish Government decides to go ahead and introduce a No Fault Compensation scheme, it must be structured in such a way that it will help patients avoid the costs, stress and delays of going through the legal system, and remove the threat of litigation which can adversely affect patient/doctor relationships. A no fault compensation scheme has the potential to offer significant advantages to patients and doctors in terms of reducing delays and stress through going an extended legal system.

The proposed scheme is based on detailed comparatively narrow research commissioned by the Scottish Government based on closed cases in secondary care over the last ten years. This research has made a number of assumptions, for instance on the volume of claims under a new system remaining at the same level. There is historically an issue of underclaiming in Scotland for medical negligence, and removing the barriers to seek compensation may see a significant rise in claims.

The Review Group has recommended that claimants will retain the right to litigate. While the Scottish Government research concluded that most cases would at least start in a no fault compensation scheme and the volume of cases going to litigation would be reduced significantly, we nonetheless have concerns that retaining the two systems and the right to litigate would mean there would still be a potential threat to the doctor / patient relationship.

Attached below is our response to this consultation and we look forward to continuing to contribute to this process.

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?

Medical negligence claims are prompted by perceived medical negligence but also a breakdown in relations between patient and the medical provider[1]. The research commissioned by the Scottish Government[2] notes that pursuers' key stated motivation is the desire for validation of their explanation of what went wrong. Dissatisfaction which results in suing a medical professional is often tied to problems of communication, staff attitude, poor general care and issues around resourcing, and enhancing the complaints procedure may address some of these sources of grievance. A no-fault scheme will not necessarily address these non-clinical aspects of care, and may result in some patients continuing to feel unhappy about the care that they have received. A meaningful apology is vital to addressing this, and can help repair a damaged relationship and restore dignity and trust, which is fundamental to the relationship between doctor and patient.[3]

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[1] J Cohen, "Toward Candor after Medical Error: The First Apology Law", Harvard Health Policy Review, Vol 5, No 1, Spring 2004, 21.

[2] *A study of medical negligence claiming in Scotland,* F Stephen, A Melville, T Krause, University of Manchester, Scottish Government Social Research, 2012.

[3] Scottish Public Services Ombudsman, *Our guidance on apology,*
http://www.spso.org.uk/files/2011_March_SPSO%20Guidance%20on%20Apology.pdf

The NHS complaints process has been improved for patients (and relatives) to try to ensure that the NHS can learn from mistakes and that organisations within the NHS operate in a more transparent manner. The complaints process was reviewed and updated in 2005 and more recently, the Patient Rights Act 2011 has further modernised the complaints process and provides independent support for patients wishing to take a complaint forward and ensure that organisations learn from mistakes. Patients can give feedback, make comments or raise concern about the healthcare received, and to make a complaint using the NHS complaints procedure[4]. The Patient Rights Act requires NHS boards to monitor feedback and complaints received[5].

Within the medical profession, doctors are expected to be open and honest with patients when things go wrong. The General Medical Council's Good Medical Practice Guidance[6] states:

> *"30. If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.*
>
> *"31. Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange."*

Good Medical Practice clearly sets out the principles and values on which good practice is founded and these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it is also intended to let the public know what they can expect from doctors. If doctors do not adhere to the principles outlined in Good Medical Practice, their registration can be called into question.

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

We agree the principles and criteria agreed by the Review Group are comprehensive and essential if the Scottish Government decides to go ahead and introduce a no fault compensation system. A no fault compensation scheme has the potential to offer significant advantages to patients and doctors in terms of reducing delays and stress through going an extended legal process. The Woolfe reforms in England and Wales mean that claims are now settled within a shorter timescale, especially in lower value cases, whereas this is not the case in Scotland. Delays in dealing with negligence claims can be distressing for patients and at present they can only receive compensation if the injury can be attributed to the negligence on the part of those caring for them, and even then, only after prolonged legal processes often involving action in the courts. It is important that a no fault compensation scheme adheres to appropriate timescales.

It is vital that if the scheme is introduced it is both affordable and sustainable over the long-term. In the current financial climate, the Scottish Government faces some very difficult public spending decisions. The repeated rounds of efficiency targets that the NHS has already faced in recent years mean that areas where further savings can be made without impacting directly on patient services have become ever more limited. The core functions of the NHS must be prioritised to maintain quality of care and patient safety, with an emphasis on services that are evidence-based and provide value for money while maintaining clinical standards. We do not support policy initiatives which take money away from clinical services, and close scrutiny must be paid to the costs associated with the implementation of any new initiatives in terms of opportunity cost and overall value for money.

The analysis of data on closed cases provided by the Central Legal Office since 2004 gives some idea of the potential expenditure implications of a no-fault scheme within secondary care. However, as the study

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[4] http://www.hris.org.uk/index.aspx?o=1025

[5] *Guidance on Handling and Learning from Feedback, Comments, Concerns and Complaints about NHS Health Care Services*, (CEL 8, 2012), Scottish Government http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf

[6] Good Medical Practice, GMC www.gmc-uk.org/guidance/good_medical_practice.asp

points out, this is not a prediction of what a no-fault scheme would cost in the future but are cost estimates of what public expenditure would have been in an average year in the recent past for cases handled by the CLO had the proposed no-fault scheme been in existence. This data does not include the fact that under the current system the majority of successful claims are settled by NHS boards out of court. No figures have been given for this and no allowances have been calculated into the estimated figures to reflect this, yet it has been assumed that payments under a no-fault scheme would be of the same magnitude as successful claims under the current litigation system.

The same research commissioned by the Scottish Government also indicates that there is currently an issue of underclaiming in Scotland, where people with a potential medical negligence claim do not pursue their legal entitlements, and the need to prove negligence has been a significant barrier to obtaining compensation. It would therefore seem likely that if the system made it easier for patients and existing barriers were removed, then the number of claims may be considerably higher under a no-fault compensation scheme. There may therefore potentially be a significant underestimate of costs as the extent of underclaiming is unquantifiable. If a No Fault compensation scheme is introduced in Scotland resources must not be diverted from front-end services to cover a potential rise in claims. We agree that further work is needed to help understand the volume and level of compensation claims, and would welcome the opportunity to comment on more detailed figures, although recognise the difficulty in identifying hypothetical costs. There also needs to be work done on how arrangements would work in cross-border situations.

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

No fault schemes have been criticised for failing to provide the explanations and apologies which claimants seek. Scotland, unlike England and Wales, continues to operate a system where complaints and legal claims cannot run concurrently. If a complainant indicates in writing an intention to instigate legal proceedings (or has already done so), the NHS complaints procedure must be immediately suspended, and the complainant advised that the complaints procedure will not go ahead[7]. It therefore seems sensible that the scheme should not prevent patients from seeking other forms of non-financial redress, including through the NHS complaints system. Research indicates that pursuers identify themselves as seeking validation for their experience rather than financial compensation, although inevitably interpreting motivation is subjective and there are significantly different perspectives.[8]

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

The currently fault-based system operated by NHSScotland for medical injury claims means that compensation is based on showing negligence, which can create tensions and mistrust between patient and practitioner. As noted above, a no-fault compensation scheme in itself may not address non-clinical aspects of care, and this may lead to some patients continuing to feel unhappy with the overall treatment that they have received. It is important that careful consideration is given as to how such a scheme would interact with the complaints process and how patients may seek to address disputes. Pursuants assert that they are motivated by concern to prevent others from experiencing the same poor treatment, and a compensation scheme should be able to support that there will be improvements and lessons learned, and encourage and support safe disclosure of adverse events.

The scheme should not put barriers in place for referral to regulators which raise grounds for concern about professional misconduct or fitness to practise, nor should they lead to inappropriate increases in referrals in order to attach blame for medical incidents which are recognised under a no fault scheme. Doctors are strictly regulated under the Medical Act 1983 by the General Medical Council which is an

[7] Paragraphs 473-474, http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf

[8] Research Findings No 113/2012, *A Study of Medical Negligence Claiming in Scotland,* Social Research, Health and Community Care.

independent, accountable regulator and has a duty to ensure proper standards in the practice of medicine[9]. The introduction of a no fault compensation scheme must not impact on existing regulation.

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?

The recommendation from the Review Group is clear that no-fault schemes work best in tandem with adequate social welfare provision. If a no fault scheme is introduced in Scotland it must be affordable and as recommendation 1 notes, it must be considered within the context of the social welfare provision available. Sweden is one of the most highly developed welfare states in the world, with the second highest public social spending as a percentage of its GDP, and third highest total (public and private) social spending at 30.2% of its GDP. It would be helpful to know what is deemed to be adequate levels of social welfare provision when considering introducing a no fault compensation scheme in Scotland based on the existing Swedish model. In the context of ongoing public sector restraint and increasing welfare cuts being implemented across the UK, consideration must be given to whether it is realistic to anticipate improved levels of social welfare provision to match the Swedish model, which has a comprehensive social welfare system in place provided through local taxation.

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

It is important to have clear descriptions in place regarding what would be covered in a no fault scheme. Some issues may be more appropriately addressed through a complaints system, and there should not be an automatic assumption that the no fault compensation scheme is suitable for every circumstance. There also needs to be very careful consideration around what would not be eligible for compensation under a no-fault scheme, and under what circumstances, for example if consent was given to a high risk procedure would this then be eligible under this scheme? As the Review Group noted, the lack of a need to establish fault will make the scheme more open to claimants, however these criteria need to be very clearly agreed and described, if that includes consent to risks of treatment. It is likely that if the scheme is introduced there would be a number of challenges around where the line is drawn in determining which injuries are and are not eligible for compensation. We consider that there needs to be a clear definition whether the scheme is defined in terms of providing compensation to all those damaged in medical incidents or only those where there has been some degree of error, whether avoidable or not. The definition and principles of causation must be clearly defined.

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?

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

The current system covers medical negligence claims made directly against employed NHS board staff, and covers all aspects of hospital care. We recognise the logic in recommending that any move to a no-fault system should cover all healthcare professionals in the NHS in a single scheme to ensure one system

[9] Guidance to the GMC's Fitness to Practice Rules, 2004, http://www.gmcuk.org/Guidance_to_the_FtP_Rules__2_.pdf_35398575.pdf

from the patient's perspective. However, the detailed work which was commissioned to look into the potential cost of such a scheme refers only to health care professionals employed by NHS Scotland, allowing only a direct comparison of expenditure with that of the current system. This gives an outline of what public expenditure would have been in a typical year over the recent past for cases handle by the Central Legal Office had the proposed no-fault scheme been in existence. The estimates given do not include the costs should the proposed scheme be extended to include independent primary care providers who are currently represented by defence organisations, or private practice. Without a similar detailed breakdown of current costs and estimates across all the proposed groups, we are therefore unable to provide comment on the proposal that a no-fault scheme should be extended beyond those directly employed by NHSScotland.

The report refers briefly to difficulties in including independent contractors who provide services under the NHS and private practice in any no-fault scheme for a number of reasons, which include their existing indemnity arrangements and the need to take into consideration any historical liabilities. However the Review Group did not consider this further and again it is difficult to comment in detail. There could be considerable variability across Scotland and we would suggest a more detailed review of existing arrangements and proposals around how further groups would be included so we could provide more comment.

There may be considerable difficulties in extending the scope of the scheme beyond the NHS to include private practice, both in practice and in how it is perceived by the public. Again further information of the scale and scope of such a proposal is needed in order to be able to provide detailed comment. It is clear that if a no-fault compensation scheme is introduced in Scotland it will be a complex process and there must be clarity about what is and what is not covered by such a scheme, and there must be very clear evidence that extending the scheme could be appropriately financed on a long-term basis.

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?

The historic nature of potential claims must be given full and detailed consideration and clear guidance given to who will be covered under a no fault compensation scheme. If it is broadened to include all healthcare professionals not currently covered under CNORIS this would require careful analysis of existing claims and how retrospective claims would be handled. Given that there are a number of providers for indemnity in Scotland outwith the CNORIS scheme there is a considerable amount of data to analyse and assess in terms of potential liabilities.

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?

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

Arguments against no fault schemes often centre on the assumption that all harm of whatever severity would automatically be compensated. Given the estimated level of adverse events within the healthcare system and the number of complaints relating to clinical treatment, a comprehensive no-fault scheme, where payment was automatically available for injury resulting from treatment or missed diagnosis, would open up the potential for tens of thousands of claims per year. Identifying compensation on individual need rather than a tariff based system would address this to some extent.

There would need to be clear information about what the average level of award would be in a no fault compensation system. The assumption that the levels of claims would be similar to those settled under the existing negligence arrangements is unproven. Definition of 'need' where there is fault but no negligence does not currently exist within the Scottish legal system. Patients suffering unforeseen injury arising from medical investigation or treatment can, at present, only receive compensation if the injury

can be attributed to the negligence on the part of those caring for them. The Scottish Government commissioned research reports that an adjudicator would have to make an award and the claimant would then decide whether to take it further and sue for negligence.

We are therefore unable to comment on the assumption that the level of payments will be similar to those settled under the current system other than to note that there seem to be a significant amount of factors which may impact on the level of payments, including the scale and scope of such a scheme and the potential for significantly increased claims. The Scottish Government commissioned research makes assumptions in its financial modelling, and it would have been helpful had the impact of different assumptions been tested.

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

The consultation proposes that claimants who fail under the no-fault scheme should retain the right to litigate and that claimants who fail in litigation should have a residual right to claim under the no-fault scheme. It seems appropriate that a claimant who is successful under the no-fault scheme would have that amount deducted from any subsequent award made as a result of litigation. The choice of whether to seek compensation under the no fault compensation scheme or under the existing clinical negligence system would therefore be a personal decision made by the claimant. The research makes the assumption that all claims will begin in no fault compensation where the burden of proof is significantly lower. Should someone fail under no fault compensation, it is considered unlikely that they will then go on to claim for negligence as the burden of proof, costs and risks are significantly higher. However, this may not be the case, and there may be increased legal costs arising from claims which are successful under no fault compensation and which are then pursued through litigation. While the Review Group concluded that fewer people would resort to litigation than at present, nonetheless that group still potentially exists with all the associated legal costs. The dual system may be perceived as 'two bites at the cherry' for a single claim, with negligence claimants pursuing the more 'profitable' negligence claim, but we recognise that it may not be possible to remove the right to litigate within the existing legal system in Scotland. Unfortunately retaining the two processes means that the threat of litigation would remain and potentially damage patient doctor relationships in the future, undermining one of the significant benefits of a no fault compensation scheme.

The difficulties in the current litigation system are being looked at by the Taylor Review of Expenses and Funding of Civil Litigation in Scotland. However the consultation for the Taylor Review has acknowledged that while the Review Group proposed that the no fault scheme should cover all medical treatment injuries that occur in Scotland, it also recommended that claimants who fail to be compensated under the no fault scheme should retain the right to litigate, "based on an improved litigation system."

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

The difficulties in the current litigation system are being looked at by the Taylor Review of Expenses and Funding of Civil Litigation in Scotland. We understand that a final report will be issued in the summer of 2013 for Scottish Ministers to consider, and we look forward to the recommendations in that report and how it would impact on medical negligence litigation. This may address some of the concerns of the review group, including the availability of clinical negligence specialists and also the disproportionality of legal expenses to claim value.

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?

We understand that the amount paid out by NHS boards has risen considerably recently although the number of claims has remained comparatively stable. A major contributor to the damages paid out is the

small number of claims that involve catastrophic injury, and a significant proportion of such claims are likely to be in relation to babies born with severe neurological impairment. Should a general no-fault scheme not be introduced in Scotland we agree that further consideration should be given to whether it is feasible to introduce a scheme specific to neurologically impaired infants. Careful consideration would need to be given whether they retained a residual right to litigate, and again introduction of such a scheme would depend on the level of social welfare support and hospital care available.

General Comments

If the Scottish Government decides to introduce a No Fault Compensation scheme it must be structured in such a way that it will help patients avoid the costs, stress and delays of going through the legal system. The scheme should enable claims to be settled more quickly and fairly, and to the satisfaction of patients, clinicians and the NHS. There must be clear and careful consideration given to the extent of the scheme with more detailed information about potential costs if the scheme is extended rather than relying on comparatively narrow historic data.

Removing the threat of litigation may encourage better communication between doctor and patient in explaining the nature and cause of any mishap to the patient concerned, encouraging accountability by the doctor to his/her patient in accordance with Good Medical Practice guidelines. Unfortunately while the model proposed by the Scottish Government would take many claimants out of the current system of litigation there would still be some that would seek redress through this mechanism. We support the principle of No Fault Compensation, and would support the introduction of a no fault compensation scheme that improves on the current system to the benefit of all parties involved. At a time when major savings are being demanded of the NHS, it is important that any new scheme does not increase costs to the NHS and divert money away from patient care.