

Health and Community Care

A Study of Medical Negligence Claiming in Scotland

Frank Stephen, Angela Melville and Tammy Krause¹
School of Law, University of Manchester

This report summarises the findings of a study of medical negligence claiming in Scotland. The study was commissioned to inform the work of the No-fault Compensation Review Group which was established in 2009 to consider the potential benefits to patients of the introduction of a no-fault compensation scheme for medical negligence claims in Scotland. The study involved interviews with pursuers and other stakeholders as well as analysis of data on closed medical negligence claims under the present system.

Main Findings

- Patient grievances appear to involve an often complex and overlapping mix of concerns about communication breakdown, poor staff attitudes, inadequate general care and generally feeling disempowered. However it was felt that the complaints system is not geared towards addressing these issues.
- Pursuers interviewed had invariably attempted to have their concerns listened to via complaints procedures. The process of filing a complaint was in the main perceived to be accessible by pursuers interviewed. NHS staff suggested that the vast majority of complaints are resolved at local level.
- The main source of dissatisfaction around the complaints process was insufficient explanations, which pursuers suggested was the primary motivation for pursuing a claim. Another motivation was to protect other patients from similar experiences.
- Analysis of the claims data shows that the settlement of a claim is influenced by a range of factors. These include the level of experience of the pursuer's solicitor in medical negligence claiming and the financial value of the claim. Relatively small value claims appear less likely to result in settlement. In those which do settle, the cost of dealing with the claim often exceeds the award.
- The study explored the potential expenditure implications of a no-fault scheme based on the analysis of CLO data on closed cases. Estimates were calculated based on a range of assumptions about how a no-fault system might operate as well as costs of the current system in recent years.
- Both lower and upper estimates are provided. At the lower end the costs of a no-fault scheme would be similar to the existing scheme, while at the upper end costs in a typical year could increase by one half.
- A no-fault scheme will not necessarily address non-clinical aspects of care, and this may leave some patients continuing to feel disgruntled. It is important therefore that any new scheme is tied into the entire process including the complaints process by which patients attempt to resolve disputes.

¹ The researchers also acknowledge the research assistance from Jamie Irving

Background

NHSScotland currently operates a fault-based compensation scheme for medical injury claims, meaning that compensation is predicated on showing that the health provider was negligent. The No-fault Compensation Review Group was established in 2009 to consider the potential benefits to patients of the introduction of a no-fault compensation scheme for medical negligence claims.

The need to consider the potential benefits of a no-fault scheme arises from concerns with the current system of resolving medical claims in the UK. These include issues with claimants not pursuing a complaint or a claim, claims being delayed, claimants experiencing difficulties in funding claims, and expense of experts (National Audit Office 2001, Symon 2000 Fenn et al 2000). Fault-based schemes focus mainly on the need to prove negligence, and it has been argued that this focus does little to improve the quality of care, produces defensive medical practices, discourages error reporting and institutional learning, and blocks transparency (Studdert and Brennan 2001).

This study was commissioned to provide information on the current medical negligence claiming system in Scotland. It informed the work of the Review Group whose report was published in February 2011 and is available at <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport>. The report includes a recommendation that consideration is given to establishing a no-fault system in Scotland for all medical injuries along the lines of the system in operation in Sweden.

The Study

The study was conducted in four parts:

- Part 1: a literature review of existing no-fault schemes in other countries
- Part 2: interviews with 30 pursuers and interviews and focus groups involving 42 key stakeholders (including pursuer solicitors, representatives from defender groups, patient support and advice groups; and medical practitioners from a range of services).
- Part 3: analysis of data provided by the Central Legal Office (CLO) concerning claims closed since 1989.
- Part 4: estimation of the potential operating costs of the proposed no-fault system using CLO data.

This report summarises the findings from stages two, three and four. The literature review is reported elsewhere: www.scotland.gov.uk/Resource/Doc/924/0099427.pdf

Key findings

A medical negligence claim is typically an end point in a process. The starting point consists of an adverse event taking place or a patient perceiving that an adverse event has taken place. Most pursuers interviewed had attempted to make a complaint prior to seeking legal advice and many provided feedback on their experiences of doing so. As a result many of the findings from this study relate to events leading up to the claims process. A medical negligence scheme must therefore be understood in terms of the process which a dissatisfied patient moves up through from adverse event to making a claim. It is possible that changes to any of the earlier stages of this process may change eventual claiming behaviour.

Adverse events

Institutional learning and tracking of errors are important features of health systems. NHS staff mostly appeared satisfied that a system of reporting was in place which ensured lessons were being learned. However, staff identified a number of problems that persist and barriers to reporting of errors, including being worried about the threat of litigation, feeling a sense of professional shame or embarrassment and being fearful that an error may harm professional reputation.

There was little support from NHS stakeholders interviewed for the implementation of compulsory reporting in Scotland. They felt that continuing cultural change would alleviate problems rather than stricter regulation.

Whilst there appeared to be mechanisms for institutional learning from errors within individual clinical teams, it was felt that there was less opportunity for institutional learning across Health Boards for example where there are patterns of errors.

Patient grievances

The findings suggest that patient dissatisfaction is an outcome of multiple factors. Pursuers felt that the combination of poor communication, staff attitude to listening to patients, lack of availability of consultants, as well as failure to diagnose, resulted in a medical injury. An accumulation of problems led to a sense of disempowerment. This finding correlates with previous research which suggests patients do not sue simply because they have been injured. Complaints frequently focus on communication, attitudes, general problems and waiting times, not on issues of treatment, tests, diagnosis and surgery.

These findings point towards ways to potentially decrease patient dissatisfaction, which are not necessarily tied to the implementation of a new scheme. A new compensation scheme would not address these problems; these would need to be tackled institutionally and before the patient makes a complaint.

Complaints

Pursuers interviewed had invariably attempted to have their concerns listened to via the complaints process. When this failed they sought legal redress.

Our research suggests that for the most part the process of filing a complaint was perceived to be accessible by pursuers interviewed. NHS staff suggested that the vast majority of complaints are resolved at local level. The main source of dissatisfaction around the complaints process was insufficient explanations. Many complaints concerned communication problems, however it was felt that the complaints systems is not geared towards addressing these issues.

Many patients and families need support to make a complaint. However the study suggested that advice was not always readily available or there was a lack of awareness how to access advice.

Making a claim

Interviews with pursuers suggested that their primary motivation was the desire for validation of their explanation of what had gone wrong. Pursuers also wanted to protect other patients from a similar experience. Most pursuers claimed that financial compensation was not the main motivation for suing, although medical professionals tended to believe that financial motivation was a key factor.

While the number of adverse events is relatively high in the UK, the proportion of claims is very small. Previous research has suggested that there are a range of factors which influence whether someone pursues a claim. These include for example the seriousness of the injury, whether the other side had taken action. Patients are also less likely to sue if they do not know a medical error has occurred, and if they cannot locate or pay for legal representation. Some of the factors would persist regardless of the nature of the medical negligence scheme. However if a compensation scheme was introduced that lifted the barrier of finding legal representation as well as the need to prove negligence then an increase in claims would be expected.

Analysis of data on closed cases provided by the Central Legal Office suggests that settlement is more likely to occur when the pursuer is represented by a firm experienced in medical negligence claiming and the larger the financial 'value' of the claim. Relatively 'small value' claims appear less likely to result in settlement. The data also showed that there are considerable costs involved in currently settling small claims below £20,000. There are also significant costs to the public purse of unsettled claims.

Expenditure implications of No-fault scheme

The study explored the potential expenditure implications of a no-fault scheme based on the analysis of CLO data on closed cases since 2004. Estimates were calculated based on a range of assumptions about the potential increase in claims; the level of award for the additional successful claims; the lower cost of processing claims. The estimates used for actual awards settling under the proposed scheme are based on the average awards for settled claims made under the current system between the period 2004 and 2009. It is important to note that the estimates produced are not predictions of what a no-fault scheme will cost in the future but are estimates of what public expenditure would have been in a typical year over the recent past for cases handled by the CLO had the proposed no-fault scheme been in existence.

Both lower and upper estimates are provided. Compared to the typical annual cost of the present scheme of £18,057,455, an upper figure of £27,014,275 and a lower figure of £18,357,455 have been estimated. The proportionate increase in public

expenditure represented by the upper estimate is considerably lower than that previously estimated for the introduction of a no-fault scheme in England.

Conclusions

Suing a medical professional is the final step in a process that commences with the patient having a grievance. Grievances, complaints and even claims, were not necessarily related to a specific clinical event. Instead, patients' grievances were tied to problems of communication breakdown, staff attitude, perceptions of inadequate resourcing, and poor general care. Many of the findings arising from this study have suggested the need to improve the complaints procedure in order to give complainants a greater sense that they were being listened to and that steps would be taken to ensure individuals and institutions learned from their complaint.

The study suggested that the settlement of a claim is influenced by a range of factors: level of experience of pursuer's solicitors in dealing with such claims and the financial value of the claim. There are also considerable costs involved currently in settling small claims. On this basis, small claims might be better dealt with in a development of the complaints system which permitted a moderate level of financial payment in some claims.

Estimates (relying on a number of assumptions) of what expenditure would have been had the proposed No-fault compensation system been in place in recent years suggest levels of public expenditure ranging from that of the current system to an increase of around one half. These estimates are sensitive to the assumptions made.

For pursuers, an optimal system provides for appropriate compensation, timely resolution of claims, and access to ongoing care, support and rehabilitation as needed.

For scheme providers and their members, costs of claims need to be contained, and while savings can be made by minimising costs associated with litigation, such as excessive legal fees and expert reports, the most significant cost driver is the number and extent of claims.

Fault-based schemes focus solely on the need to prove negligence and it has been argued that this does little to improve the quality of care, produces defensive medical practices, discourages error reporting and institutional learning, and blocks transparency. While it has been argued that no-fault schemes may address some of these problems, the primary goal should be to prevent errors from occurring in the first place.

References

Fenn, P. T., Diacon, S. R., Gray, A., Hodges, R., and Rickman, N. (2000) The current cost of medical negligence in NHS hospitals: analysis of claims database, *British Medical Journal*, 320, 1567-71.

National Audit Office (2001) *Handling Clinical Negligence Claims in England*. Report by the Comptroller and Auditor General, Session 2000-2001, HC 403.

Studdert, D. M. and Brennan, T. A. (2001) No-fault compensation for medical injuries: the prospect for error prevention *The Journal of the American Medical Association*, 286(2), 217-223.

Symon, A. (2000) Litigation and defensive clinical practice: quantifying the problem *Midwifery*, 16(1), 8-14.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: <http://www.scotland.gov.uk/socialresearch>. If you have any further queries about social research, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131-244 7560.



Social Science in Government