

Patient Safety instead of Adversarial Medicolegal Claims

Abstract:

In the UK the annual cost of claims has risen to 1.5 bn annually. Similar increases have been encountered in Ireland. Clare Dyer¹, an experienced legal correspondent, questions the value and effectiveness of the current tort systems. It doesn't appear to be making the patient safer. The present arrangement is expensive both in time and money. The court costs are substantial and a sizeable portion of any award goes to legal team rather than to the patient. Large amounts of money are being lost to the health service annually. The process is very challenging for doctors. The majority undergo periods of emotional distress during the lengthy, intrusive litigation process. One of the possible reasons that doctors react so adversely to litigation is that most of them are self-critical from the outset. Their distress is compounded by the fact that in tort law fault must be found in order for compensation to be paid. A feeling of being out of control pervades the experience². In the US being sued is now considered the price of practising medicine. The stakes are both personal and very high. By age 65 years 75% of doctors in low risk and 99% in high specialties will have encountered personal litigation³. The term medical malpractice stress syndrome (MMSS) is increasingly being used to describe the commonly experienced array of psychological and physical symptoms including anxiety, depression, negative self-image, poor appetite and exacerbation of pre-existing medical problems. Downstream consequences include stopping seeing certain types of high risk patients, taking early retirement, discouraging others from entering medicine.

There are alternatives. No-fault schemes were again considered in the UK in 2011 but ultimately rejected. Although they would save on legal fees, it was felt they would increase the number of claims being filed and reduce the quantum for individual injured patients. Despite this setback the no-fault approach remains on the table and has been adopted in many developed countries. In the no-fault programme patients don't have to prove that hospitals or health care professionals were negligent but they do have to demonstrate that the treatment or medical process caused them harm. It has been in place in New Zealand, Sweden, Norway, Denmark and Finland since the 1980s. In France and Germany there are high rates of settlement without going to court. In the US, Florida and Virginia have introduced no-fault compensation for birth injury cases.

Another approach is to cap compensation amounts. This appears to be practical especially for smaller claims. Parts of the UK have a redress claims scheme for amounts less than £20,000.

Over the past 30 years the approach to real or perceived medical mishaps is based on the triad of blame, litigation and punishment in the form of monetary payment and/or sanctions. Don Berwick⁴ US Institute for Healthcare Improvement has recently challenged this approach. In a Report addressing the issues surrounding the excess deaths in Mid Staffordshire he sets out a different model for improving patient safety and reducing harm. He was requested by the UK government to provide an 'outside opinion' on the Francis report which ran to 1700 pages and 290 recommendations. Berwick has taken a very different stance to other commentators. He advises to abandon blame as a tool and place more trust in the goodwill and good intentions of the staff. Fear is toxic to both safety and the environment. Recrimination and demoralisation must be resisted. The vast majority of staff wishes to do a good job, to reduce suffering and to be proud of their work. In most cases the cause of the mishap is the systems, procedures and the environment rather than the individual health care worker. The Guardian newspaper⁵ commenting on the report described it as 'not so much a breath of fresh air as an exhilarating blast'. It also notes his most sparing use of the law.

There are three types of harm- harm due to error, harm due to system failure and more rarely harm due to wilful misconduct. Most mishaps take place in situations where well-intentioned staff is doing their best to care for their patients. Human error is common but unintended. The only constructive option is to record it, discuss the causation and learn from it. Managements that place an emphasis on blame and disciplinary measures simply drive errors underground and as a consequence safety improvement will not happen. In the occasional, rare case where there has been wilful or reckless harm, strong disciplinary action must of course be implemented.

Safety provision for patients needs to be proactive rather than reacting to an injury that has occurred. While 'zero harm' is probably unattainable, continual reduction should be the goal of all health organisations. Good leadership is required to provide clarity and consistency to the culture of safety. In addition to diagnosis and treatment, safety must be part of every patient's care.

Management can jeopardise patient safety in a variety of ways and instances. It may place targets and costs centre stage rather than the patient as happened in Mid Staffordshire. The voicing of bad news or criticism by staff is deemed unwelcome. There may be a failure to understand that not all problems can be solved within the organisation and within the existing budget. Some issues require outside expertise and innovative solutions. Some organisations have unclear responsibility structures and when safety issues arise staff is

unclear as to who is in charge. Staff may be treated with lack of respect and operational changes implemented without consulting or informing them. Management needs to constantly be mindful of the best scientific evidence on staffing ratios. There is now clarity that for a general medical-surgical ward there should be no fewer than one registered nurse per 8 patients plus the nurse in charge. When this staffing level is breached, patient safety risks rise significantly.

Berwick specifically addresses doctors. He acknowledges that working in a publically funded health service such as the UK or Ireland, places one under the spotlight of constant scrutiny. Every clinician knows what it is like to be involved in an error even despite one's best efforts. The system can fail in so many ways. Common examples are the mislaid important scan report, the drug dose miscalculation when the unit is understaffed and fatigued and the patient who acquires a hospital infection. Education and commitment to safety is more important than rules and regulations. The avoidance of error is so important because mishaps undo all the good work and reputation of the organisation.

Two guiding principles emerge. The patient must feel and be safe from harm and the healthcare worker must feel safe from blame and sanction when carrying out his/her duties in an appropriate manner.

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Editor

1. Dyer C. Fault lines: resolving clinical negligence claims. *BMJ* 2013;347:13-14
2. Charles SC. Coping with a medical malpractice suit. *West J Med* 2001;174:55-58
3. Studdert DM, Mello MM, Atul A et al. Claims, errors and compensation payments in medical malpractice litigation. *N Engl J Med* 2006;354:2024-33
4. Berwick D. A promise to learn- a commitment to act. Improving the safety of patients in England. 2013. NHS England
5. The Guardian newspaper editorial. Berwick report on the NHS: a fine institution. 6th Aug 2013

Comments: