Irish Medical Journal
Established 1867

Issue: Ir Med J; Vol 114; No. 3; P288

Medical Malpractice: Paying Twice for Patient Care

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Recently published data[1] from the UK reports that the NHS has paid 2.8 billion Euro in clinical negligence claims in 2018-19. This equates to 2% of the entire UK health budget. It is forecast that into the future the quantum will rise to 4%. Ireland is experiencing similar surges in legal claims. The number of claims is increasing at a faster rate than the numbers being resolved. The rate of growth in outstanding liabilities is 15% per annum since 2010. The cost of a baby delivery is 3,324 Euro but when indemnity is factored in the cost is doubled[2]. Every Euro spent on lawsuit settlements is a Euro that cannot be spent on medical care.

Christine Tomkins, MDU chief executive, stated that the health services haven't become less safe[3]. 'The problem is that we have a medical negligence system that is unfair and unsustainable. A balance has to be found that is fair and affordable'.

It has been pointed out by many commentators that the modern public health care systems are very different to the original structures. The current services have to provide a much wider range of care. The commitments vary from screening programmes, clinical care, complex radiology, laboratory investigations, treatment, and communication. The delivery of this wide-ranging complex care system is challenging. All elements have been the subject of medico-legal claims in recent years.

Clinical negligence is the breach of a legal duty of care to a patient which directly caused harm to the patient. Over time the bar has been set higher for professional performance and patient expectations are greater. Health services have been criticised for not responding in an effective manner. They have been accused of admiring the problem rather than taking decisive action[4].

The rising malpractice costs over the past decade are due to three factors, 45% are due to the rise in claims, 34% are due the rise in damages awarded, and 21% are due to a rise in the claimants' legal costs.

The UK National Audit Office[5] has examined in some detail why increasing numbers of patients are suing their health services. It appears that one of the reasons is that they now have greater access to the legal system. This includes no-win-no-fee agreements and claims management companies. There is little to suggest that clinical care has become less safe or overall patient satisfaction is lower.

While a lawsuit may follow any type of clinical activity, there are a number of readily recognisable patterns. The common reasons are; failure or delay in performing a treatment 22%, failure or delay in diagnosing a condition 17%, incorrect treatment 7%, and operative complications 6%. Long waiting times following a GP referral are another adverse factor. They increase patient dissatisfaction and decrease tolerance for any subsequent perceived errors in their care.

In addition to the individual cases, there is the issue of mass action claims. Recent examples include the Pandemrix-Narcolepsy, the transvaginal implants, the symphysiotomy, and the cervical screening actions[6].

Maternity claims consistently occupy the headlines. They account for 10% of the claims but 50% of the total pay-outs. The issue is birth injury with the catastrophic effects over the child's lifetime. It is clear that any suite of measures being considered to tackle rising litigation costs should look at ways to support the obstetric services.

While there is no magic bullet, there are approaches at the clinical interface that may contain or reverse the current rising number of claims. Consent remains an important issue. The patient information must be both clear and comprehensive. It must avoid jargon. If the patient can't understand what they are consenting to, it is not informed consent. Communication between professionals is key for patient safety. Important moments include shift handover, the involvement of other clinical teams, the transfer of the patient to another ward, ICU, or another hospital. Another important measure is the early recognition of complex cases. This includes patients with multiple co-morbidities, often accompanied with a complex psycho-social history.

The diagnostic processes must be well structured. There needs to be a clear pathway built into the ordering of a test, its performance, the receipt of the result, and the appropriate action if required. Good clinical monitoring must be built into the care pathway of every patient. It is key to the timely identification of the deteriorating patient. Some obstetric units are using the 'fresh eyes' procedure, where the midwife looking after a patient in labour may at intervals ask a colleague to review the CTG.

The follow-on step is the escalation of the case. Knowing when to escalate is based on training, knowledge, and experience. Story telling by senior staff about previous cases is helpful. Staff must feel empowered to escalate when they are concerned. An over-call can easily be stood down, while failure to call can lead to serious consequences for the patient.

Health services must fully appreciate that investment in high quality health care pays dividends. It is the best way to reduce litigation rates. The four pillars set out by Yau et al[1] are staff, infrastructure, equipment, and IT.

Understaffing is a frequent problem. The common causes are lack of recruitment, lack of retention, and lack of funding. We now have a better understanding about why staff don't come and why they don't stay. Much has been learned from organisations that have good staffing records. Staff like to be properly trained for the tasks that they are doing. A skills facilitator plays an important role. Staff like to feel both clinically and psychologically supported. It is appreciated when senior staff are readily approachable and available. Good organisations have a well-structured safety culture that all the staff can contribute to and feel part of. Staff like to be mentored and given advice and evaluations on their career progression. Staff should feel both listened to and appreciated. They should be encouraged to develop and participate in quality improvement initiatives.

Infrastructure is a major problem. A lot of hospitals are old, and replacement is a slow process. Cramped, overcrowded clinical spaces are distressing for both staff and patients. They create difficulties in the delivery of care. The key points about medical equipment is that staff must be fully trained in its use. In order to avoid confusion, the same brands should be used throughout the hospital. Any malfunctioning items should be removed from clinical use and promptly repaired or replaced by clinical engineering.

IT systems have a great potential in improving patient care. They provide immediate access to the patient's record. Case notes are always available. The other strengths are the access to the radiology and lab reports. It makes prescribing safer. It speeds communication with GPs and other community staff.

In addressing the challenge of rising litigation, we need work out our best strategies and implement them.

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