Medico-legal claims: current challenges

DAVID BADENOCH

David Badenoch argues that there needs to be a better balance between providing proper compensation for the patient who has been negligently damaged and the rapidly increasing number and value of medical claims.

Doctors face a challenging medico-legal environment. An increasing number of claims are brought against medical practitioners, including urologists, in both the public and private sector. An increasing number of cases are also brought to the General Medical Council (GMC) and there are coroners’ inquests to face.

WHY ARE CLAIMS INCREASING?

There are many reasons for this increase in claims. Both patients and doctors may have raised or even unreal expectations of medical standards. One of the most significant driving forces behind the increase in claims, however, is the desire on behalf of the claimant to achieve a financial reward for whatever has been perceived to have gone wrong, linked to the year-on-year growth in the values of awards made by the courts over the past few years (at 10 per cent per annum).

It is now an established fact that not only the number, but also the value of medical claims has been going up rapidly year-on-year. The inflation associated with medical claims even outweighs that of house prices, excluding central London (Figure 1). The first £1 million-plus damages claim was awarded in 1988 and was met with utter astonishment. Today, claims for babies damaged at birth may cost up to £6 million.

Ironically, the rise in the size of settlements at 10 per cent per annum has in part been driven by the improvements in care, with longer life expectancy in particular and better health, certainly partly as a result of improved medical advances. This is compounded by a reduction in expected future investment returns because of the recent relatively poor state of the British and world economies. The levels of awards are related in part to the improvement in life expectancy.

One fundamental reason why the size of settlements has been rising is that common law requires the cost of future care in such cases to be calculated on the basis that it would be provided privately rather than through the NHS. This rule was established under the Law Reform

---

David Badenoch, MA, DM, MCh, FRCS(Urol), FEBU, Consultant Urological Surgeon, London Urology Group; member of council of the Medical Defence Union

---

Figure 1. Claims inflation, 1990–2010. Source: Medical Defence Union
(Personal Injuries) Act 1948, just as the NHS was being established. This was perhaps understandable back in 1948 when no one knew how long the NHS might last or indeed how comprehensive a service it could deliver. Now, however, it no longer makes sense, as the NHS always delivers some, if not all, of the care; the provision of NHS care should not therefore be disregarded in calculating the size of a settlement.

There can also sometimes be a considerable discrepancy between the claimant’s and the defence costs, and there may be a disproportion in the sums going to the damaged patient and those going to the lawyers.

For the future, in order that doctors can practise good medicine, in both the private and public sectors, there must be a stop to this claim inflation of 10 per cent per annum. Although the patient who has been negligently damaged must be properly compensated for future care and loss of earnings, these high awards from the courts must be balanced against the affordability of those damages and the financial constraints upon those who are expected to fund them, ie doctors as members of the defence organisations and the NHS itself.

The NHS currently faces an annual bill in the region of £18 billion and rising.

PROOF OF NEGLIGENCE

Turning to the concept of clinical negligence, in order to succeed, the claimant (usually patient) has to prove to the court that the doctor against whom the claim is made owed a duty of care, that there was a breach of that duty (a failure to treat with a reasonable skill and care), and that as a result of the breach of duty, harm followed: in legal terms ‘causation’ is established. It is essential that a causative link is proved in order for the patient/claimant to recover damages: to succeed in such a claim, this has to be made on the balance of probabilities (ie with a greater than 50 per cent likelihood).

During the course of managing a patient, it is possible for a negligent act to occur that does not alter the outcome, ie the natural process is unaffected. In these circumstances, the patient/claimant would be unable to prove on the balance of probability that a causative link was established. At its most basic, causation involves asking a simple question: ‘but for the doctor’s negligence, would the patient have suffered the damage of which he or she now complains?’ This is the so-called ‘but for’ test.

If the patient would have suffered exactly the same injury of which he now complains, the claim will fail, no matter how gross or obvious any breach of duty may be. It may nonetheless warrant a referral to the GMC but not to a court. The patient must also prove his case on causation rather than the doctor disproving it.

UROLOGY CLAIMS

The Medical Defence Union (MDU) is notified of approximately one new clinical negligence claim arising out of private urological practice every month: this represents approximately half the urological activity of the MDU. Urology is comparable to other specialities with reference to claims settled, approaching 30 per cent.

Urologists are twice as likely to receive claims as dermatologists, half as likely as general surgeons, a third as likely as orthopaedic surgeons and a tenth as likely as plastic surgeons. It is interesting to note that scrotal, groin and penile surgery, as well as misdiagnoses, has a relatively high notification compared with other areas of urology (Figure 2). It is perhaps not surprising that in numerical terms, although claims in transgender surgery are small, as these represent procedures that are carried out relatively rarely, the risk is higher than that in other areas of urology. Although these procedures are classed as urology, they are not all performed by urologists and it is of note that two areas of particular high claim, namely vasectomy and missed testicular torsion, frequently involve non-urologists in urological areas.

Although there is a general trend for increased numbers of claims and increased levels of awards made for successful claims, which fuel these claims, this must...
be set against an increasing number of doctor–patient episodes and indeed numbers of doctors overall and urologists in particular; thus the true risks may be skewed. Nonetheless there are increased numbers of claims against practitioners after more than 20 years of claim-free membership. This is likely to be indicative of the environment of litigation in which we live as much as falling competence, but also perhaps reduced trust in us as doctors, stimulated by the well-publicised problems encompassing the Bristol, Shipman and Mid Staffordshire scandals.

PREVENTING CLAIMS

How do we prevent claims? Fundamentally, we need to prevent negligence occurring in the first place. There are bound to be times when, as doctors, we perform at below our normal level, which may result in an adverse outcome. Clearly it behoves us all to try to prevent this occurring in the first place by good clinical practice, performing in areas in which we are fully trained, with the support of other doctors and health specialists. It is vital at all times:

• to show compassion for our patients, and particularly so where there is an adverse outcome to any condition or procedure
• to concentrate on providing an even better level of care than might be standard
• never to back off from a problem arising out of one's actions
• to be quick to involve the additional opinions and care of suitable colleagues.

It is important not only for the patient but also for the doctor to feel properly supported when things do go wrong, as they inevitably will at some time. It is impossible to perform medicine and surgery without making errors, but it is the early identification of these, and their rapid and effective correction with the patient's full knowledge, that generally will reverse not only a difficult clinical situation but also the potential medico-legal claim.

Defence of the claim is impossible where there are no or inadequate clinical records, and this still remains a problem, in spite of significant prompting from the GMC and other bodies. Once the claim has been made, or even if the doctor believes there may be a claim in the pipeline, it is important to consult the medical defence body early, fully and honestly. It can be difficult to be impartial in recognising one's own failings: self-criticism, honesty and a degree of humility are important in handling any claim brought against oneself, but with the expert help of a defence organisation, support and expertise should be properly provided.