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Introduction

Internationally the costs of litigation are large and increasing, to a level that places a drain on precise health care resources and affects the way medicine is practised. The costs of litigation are huge, NHS Resolution, formerly the NHS Litigation Authority, in England estimates that for the whole of the NHS in 2016/17 the costs were £1.7 billion (1) and they are increasing. The costs in the United States of America are estimated at 1.66 of GDP, which is 2.6 times higher than the rate in Europe. The liability costs in European countries such as Germany and Denmark have been calculated as increasing by 13% and 25% per year since 2008 (2).

Further, the nature of the claims are changing, with the number of claims in Clinical Negligence below £3,000 having increased by 26%(3). The increase in the volume of smaller claims leads to a disproportionate increase in legal costs, as there are certain legal costs that are unrelated to the size of the claim. Surgery is one of the principle areas attracting an increase in both claims volume and damage costs within the NHS (4).

We examined the costs associated with litigation within the NHS, using Trauma & Orthopaedics as a case example and consider whether a change to a non-fault legal system would lead to reduced costs and improved patient care.

The existing system in the UK

Currently for a patient to succeed, they have to establish that the action or inaction taken by the clinician was negligent. In England and most other jurisdictions, in order to succeed in a claim for clinical negligence, the patient has to establish three factors; the doctor owed them a duty of care; the doctor's actions were negligent and the injury suffered by the patient was caused by the doctor's negligence. The first of the factors is often automatic, as the doctor is

employed to treat the patient, and courts have been slow to apply a relationship when the doctor is out socially and gets involved in helping someone who acutely becomes unwell, a good Samaritan act (11). The critical question is what constitutes negligence, the second factor, and thus has the doctor breached the duty of care they owed to their patient. This is breached when their treatment falls below the standard expected of them, being judged at the level of ordinary skill rather expecting them to be miracle workers or possessing the highest expert skill (12). A court assessing independent medical evidence on the doctor's actions and whether a responsible body of medical opinion supports them at the time when the incident occurred. (13). The third test is whether the established negligence lead directly to the harm suffered by the patient, with the harm being actual harm rather than potential harm that occurred coincidently at the time of the established negligent actions by the doctor. The three factors need to be established by the patient on the balance of probabilities, namely more probable than not (51%). Then a court makes an assessment of the harm and consequential loss, making an appropriate award.

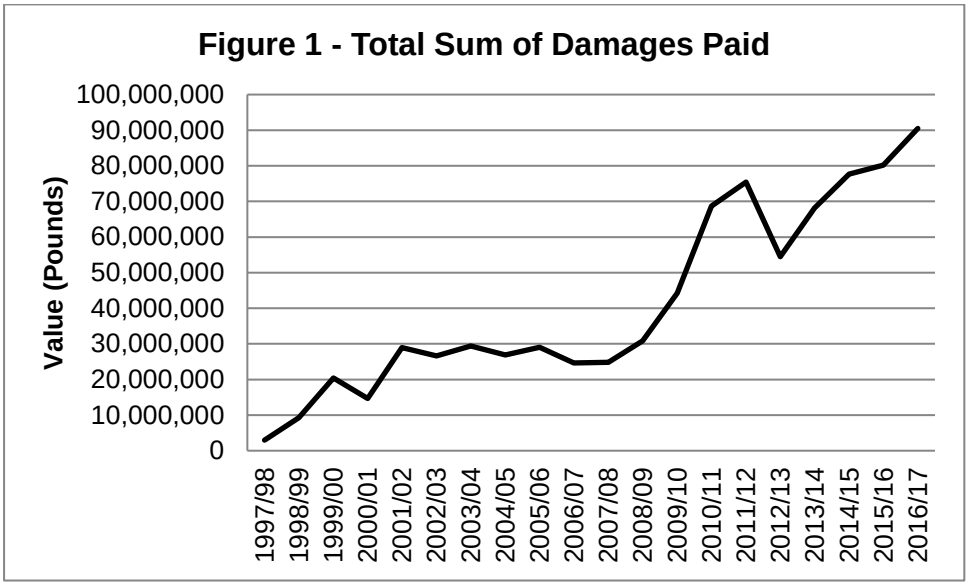
The winning party to the trial will have their costs paid by the other side; the court, at the conclusion of the trial will make sure that the claimed costs are reasonable, usually assesses these. There has been extensive legal reform in personal injury including clinical negligence within the English jurisdiction, with one of the principle aims being to reduce costs (5).

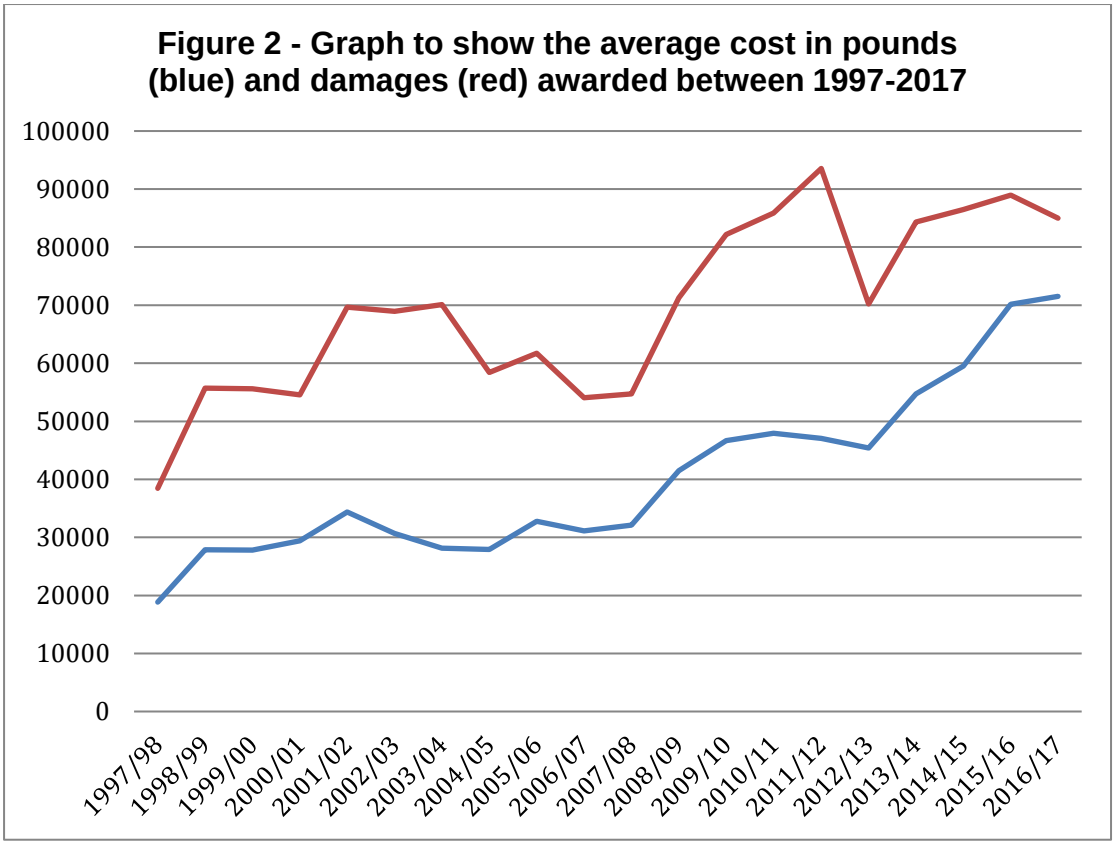
A case study – Orthopaedic & Trauma Surgery within the NHS

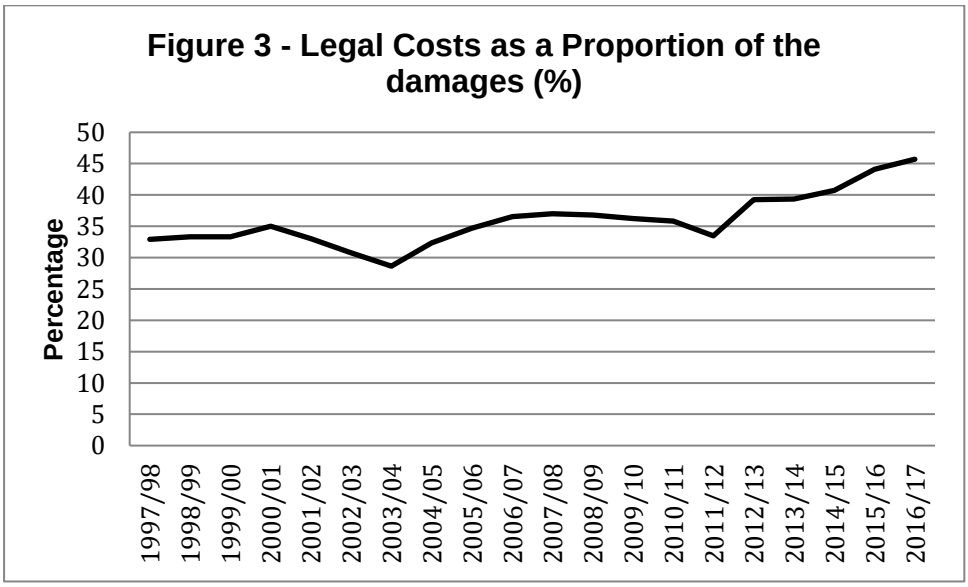
Trauma and Orthopaedic (T&O) surgery accounts for 48% of legal claims against the surgical arm of the NHS, which is the largest proportion of claims of all surgical speciality within National Health Service (NHS) (14, 15). A freedom of information request (16) was made to NHS Resolution, seeking details of claims within T&O over the last 20 years. This data was distilled into a number of successful claims (settled before or after a civil trial), amount of damages, the amount of both defence and claimant costs, Figures 1-3. NHS Resolution is a not-for-profit arm of the NHS that is responsible for the indemnity scheme

operated on behalf of the Secretary of State for Health that covers clinical negligence claims against the NHS.

The number of legal cases involving T&O has increased dramatically over the last 20 years, with a 1,283% increase in the number of claims. The cost of the damages awarded/paid by NHS Resolution in the last financial year was in the region of £90.5 million pounds, which represents a 2,956% increase over the 20-year time frame, Figure 1. These amounts, Figure 2, demonstrate an upward progression of both the average damages secured and the average overall costs of the actions. Even more troubling is the increase in the proportion of the damages which are received by the lawyers on either side, Figure 3, in 1997/98, the cost of the litigation accounted for 33% of the damages, where as in 2016/17 this had risen to 46%. The cost of the overall litigation in the year 2016/17 amounted to approximately £76 million, versus the damages awarded to patients of £90.5 million.







What is no fault litigation?

Currently in order for a patient/claim to be successful, it has to be established that the action or inaction taken by the clinician was negligent. In a non-fault system the focus shifts to the link between the action and/or inaction by the

clinician and the harm resulting from it. The primary objective being rehabilitation, rather than financial compensation, although money remains an important feature. The British Medical Association has supported the idea of a no fault system in the past, when the idea was being canvassed by the Scottish Government (24). Non-fault schemes already operate in England on a very narrow basis, for example the Criminal Injuries Compensation Scheme, which compensates those injured as a result of criminal actions. This scheme has a minimum threshold of £1,000 damages and thus small injuries are excluded(25).

The advantages of the non-fault system are large, patients would obtain compensation quicker as there would not be the necessity to establish fault; the award would be made by an administrative mean or tribunal rather than by an adversarial process and if implemented well there would be cost saving in reduced legal fee pay outs. In this environment, there could be a complete paradigm shift, as it would encourage transparency between clinicians and patients. The desire to work in medicine comes from a calling to help people, thus without a constant fear of “being sued”, there will be change to learn more deeply from adverse events and lead more readily to their disclosure.

Currently, there are two national schemes that operate in New Zealand and Sweden, with small local schemes operating for birth-related neurological injuries in Virginia and Florida in the United States. The scheme in New Zealand applies to all type of personal injury, including medical negligence, whereas, the Swedish scheme applies to medical injury only. The system in New Zealand when it was applied to medical treatment, was aimed at promoting a focus on learning from medical error and developing a system of reporting that was underpinned by concern over patient safety rather than attributing blame to individual clinicians (26, 27). Fundamentally, in order to fall within the scheme the patient has to establish that the injury “is caused by treatment; and is not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including the person's underlying health condition at the time of the treatment; and the clinical knowledge at the time of the treatment” (28). The Accident Compensation

Corporation, the body responsible for administering the scheme, unless the claim is high-cost or borderline, the claim is investigated by them and a decision made within 2 months. For those claims of higher value or borderline there are strict time limits in which decisions have to be made which are within the region of 9 months. These are of course small time frames compared to the average time a case takes to be litigated in the UK. Do we have a time frame? The funding of the scheme met by the state, in 2017 cost in the region of £8,3984,400 (7). If the patient is unhappy about the decision, then there is an appeal to an independent review body.

In 1975 Sweden made the move to a non-fault scheme in medical negligence, which was then followed by Finland, Denmark and Norway. The motivation for the change in the system was along similar social and legal goals to New Zealand. The eligibility criteria under the Swedish scheme is centred on the concept of 'avoidability', namely, a patient receiving compensation if they have suffered injury that could have been avoided. The right in Sweden to take the matter to civil court still exists, although this is only exercised in 15% of patients (29, 30). The scheme is funded by a combination of regional income tax, which operates like a quasi-medical injury insurance company.

In 2003, it was estimated the introduction of the non-fault scheme in England would cost in the region of £973.5 million for clinical negligence and £1.25 billion across the whole civil system. This would be in the medium term offset against the inevitable reduction of the payment of legal costs, when the legal costs associated with one surgical speciality of orthopaedics amount to £76 million.

Discussion

The increase in costs for damages and the associated lawyer cost has dramatically increased, in Trauma and Orthopaedics alone in 2017, damages cost the NHS 90 million, in addition to 76 million in costs. However, It has been established that, rather than financial compensation, in response to a medical error, the primary aim of the injured patient is a desire for the doctor to make a meaningful apology, provide an explanation and employ measures to stop it

reoccurring (7, 8). In an adversarial system where the patient has to establish liability there is a tension between fulfilling this need and the health care provider admitting liability.

Many medical regulatory bodies throughout the world encourage a spirit of openness and transparency. In England, there is a duty of candour on Doctors, Nurses and Midwives to timely speak to a patient if something has gone wrong, apologise and report the error (9). This is modelled on the approach to error in the aviation industry(10). In practice, the spirit of candour fails to translate into a genuine apology. The apology, in the authors experience, if it is forthcoming, fails to be meaningful with phrases like “I am sorry you feel your treatment was inadequate” being employed and is often supervised by Hospital lawyers for fear of clinicians increasing the legal exposure. Stifled by this tension, the explanation neither satisfies the patients’ desire of genuine apology or the regulatory requirement of candour.

The introduction of a non-fault system into England would introduce a level of transparency and openness that cannot exist in the current landscape. The cost of introduction into medical error alone would reduce the estimated costs considerably. Further, although more individuals would fall within the system, this could be off-set with a minimum tariff, i.e. £3,000. If a patient’s damages amounted to less than £3,000, then the individual would not be entitled to any compensation. It would reduce the number of claims and involve an individual patient acceptance that when using a free state provided health system that it does not represent an opportunity to recover damages unless the harm was substantial. The calling to practice medicine and supervising medical bodies’ regulation leads to good patient care, rather than the threat of being sued. The fact it may be difficult to initially develop a system that includes private medicine and other independent contracts, does not mean that a system cannot be developed.

Although governing bodies, such as the General Medical Council, encourage candour, there remains the tension of an adversarial system, which focuses on fault. For there to be genuine apologies and investigation of medical error, the

focus on fault needs to be removed, which could be achieved by the introduction of a non-fault scheme in medicine.

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Research ethics

This was not required for this research.

Data

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