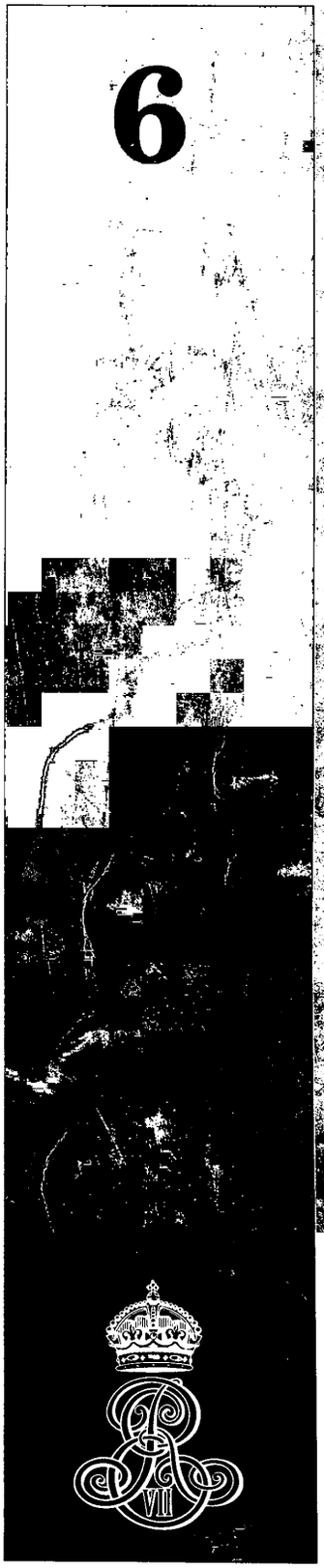
BRIEFING PAPER

6

MEDICAL NEGLIGENCE

COMPENSATION AND ACCOUNTABILITY

CHRIS HAM
ROBERT DINGWALL
PAUL FENN
DON HARRIS



CENTRE FOR
SOCIO-LEGAL STUDIES, OXFORD

KING'S FUND INSTITUTE

No 6 in a series of briefing papers on current health policy issues.

ISBN 1 870607 08 2

Published by the King's Fund Institute
126 Albert Street, London NW1 7NF

Copies are available at £5.95

J7608 / DESIGN & PRINT / REDESIGN / 01-533 2631

MEDICAL NEGLIGENCE

COMPENSATION AND ACCOUNTABILITY

CHRIS HAM

KING'S FUND INSTITUTE

ROBERT DINGWALL
PAUL FENN
DON HARRIS

CENTRE FOR SOCIO-LEGAL STUDIES, OXFORD

CONTENTS

TABLES AND FIGURES

ACKNOWLEDGEMENTS

We are grateful to the large number of individuals and organisations who have provided us with information and commented on earlier drafts of this Paper. Figures 1 and 2 are reproduced with permission of the Medical Protection Society and Figure 3 with permission of the Medical Defence Union. Tables 1, 2 and 5 are reproduced with permission of the Controller of Her Majesty's Stationery Office. Tables 6 and 7 are reproduced with permission of the New Zealand Department of Health.

SUMMARY

In recent years, there have been significant increases in the number of claims of medical negligence made against doctors and in the damages awarded to patients. As a consequence, the subscriptions paid by doctors to the medical defence societies have risen sharply. The medical profession has expressed concern at the rising costs of these subscriptions. At the same time, health authorities have drawn attention to the impact of increasing awards for damages on cash limited budgets. In the light of these developments, it has been suggested that the UK may be about to experience a malpractice crisis along the lines of that which has occurred in the US. To avoid such a crisis occurring, various proposals for reform have been put forward, including the introduction of a no-fault compensation scheme and the development of more effective procedures for maintaining high standards of medical practice.

This Paper reviews the available evidence on medical negligence and analyses the options facing policy makers. The Paper shows that claim rates in the UK are much lower than in the US. Differences between the two countries in legal, health care and social insurance systems mean that it is highly unlikely that levels of litigation in the UK will reach those of the US. Furthermore, the subscriptions paid by doctors to the defence societies are not high compared with those paid by other professions.

The argument that the threat of litigation is leading to defensive medicine cannot be substantiated using available evidence. The application of tort law to cases of medical negligence involves doctors and not lawyers determining what are reasonable standards of care. There is thus no legal reason why doctors should practise medicine defensively. The claim that the UK is experiencing a malpractice crisis is therefore exaggerated and must be treated with caution.

Insofar as there is a malpractice crisis, it concerns the difficulties facing patients and their relatives in bringing a claim against doctors. The main shortcomings of existing arrangements for dealing with negligence are:

- the procedures involved in pursuing a claim for damages are lengthy and expensive for patients, doctors and health authorities
- only a small proportion of people suffering medically-related injuries obtain compensation
- the emphasis on establishing fault and cause and effect turns the tort system into a lottery: similar cases of injury giving rise to similar needs are compensated totally differently according to the circumstances surrounding their cause and the completeness of the evidence
- those making a claim may find it difficult to obtain the services of a solicitor with relevant expertise and of doctors willing to act as expert witnesses
- the legal process is adversarial and causes those involved to close ranks. Consequently, patients and their relatives are often not given adequate explanations or apologies when things do go wrong and doctors may be distressed by the apparent hostility and ingratitude of their patients
- the deterrent effect of the law is weakened by the availability of insurance coverage.

There are also weaknesses in the arrangements for maintaining high standards of medical practice. These include the variable interest shown by doctors in medical audit and peer review, and the limitations of complaints and disciplinary procedures as mechanisms for ensuring professional accountability.

The Paper identifies a range of options available to policy makers contemplating reform. Particular attention is paid to three possibilities: modifying the existing system and strengthening professional accountability; introducing a no-fault compensation scheme; and providing compensation through social security. The Paper argues that there is a good case for reform because the shortcomings of existing arrangements are formidable.

The proposals that deserve most serious consideration in the *short-term* are those that aim to modify the existing legal system and strengthen professional accountability. This would involve:

- providing potential claimants with a means of identifying solicitors with appropriate skills in medical negligence cases
- giving greater publicity to legal services through advertising and other means in order to increase public awareness of the general possibility of claiming for damages
- modifying fee-splitting arrangements among lawyers to create greater incentives for solicitors to pass on cases to specialists
- making access to legal aid easier
- developing a system to enable health authorities to pool their risks in order to cope with a larger number of successful claims
- developing arrangements for medical audit by requiring doctors to demonstrate that they routinely review the quality of their work and by introducing procedures for the reporting of surgical and other incidents on a confidential basis
- extending and simplifying disciplinary procedures against doctors. This applies both to the GMC's procedures and to the procedures followed by health authorities. The aim should be to ensure that adequate arrangements are in place for handling all cases where concern about professional conduct and competence arise, not just those involving the most serious consequences
- implementing the recommendations of the Davies Committee on hospital complaints in order to establish independent investigating panels to examine complaints about clinical matters.

If these proposals were adopted, then many of the weaknesses of existing arrangements would be overcome. In particular, the proposed changes would help to deter doctors from acting negligently, and they would assist patients and their relatives to obtain an adequate explanation when things go wrong. However,

the adversarial nature of the legal system would remain, and it would still be difficult for patients and their relatives to obtain compensation. Hence, at the same time as these changes are implemented, serious consideration should be given to the introduction of a no-fault compensation scheme in the *longer term*.

In designing a no-fault compensation scheme for the UK, it should be possible to learn from experience in Sweden and New Zealand. This would mean examining carefully the definition of accidents for which compensation would be paid, ensuring equity in the treatment of accident victims and the sick and disabled, and developing procedures to prevent accidents, monitor standards of care and encourage rehabilitation. As overseas experience has demonstrated, these issues need to be clarified before radical changes to the system of providing compensation are introduced.

Also in the longer term, policy makers should consider introducing procedures for disciplining doctors based on Sweden's Medical Responsibility Board and including significant lay participation. At the same time, they should examine the desirability of fundamentally reforming complaints procedures in order to establish one point of contact whatever the nature of a patient's complaint and to guarantee that those hearing complaints are genuinely independent.

1 HOW EXISTING ARRANGEMENTS WORK

Medical negligence occurs when there is a breach of duty to use reasonable care and as a consequence there is injury to a patient. What is reasonable care is in practice defined by doctors. Reasonable care reflects customary standards and practices in the relevant part of the medical profession. When there are differences of view on customary standards, the doctor is deemed to use reasonable care if a group of medical peers accept that what was done was reasonable. English law does not require doctors to practise medicine to any absolute standard. The expectation is that any individual doctor will apply an ordinary level of skills. There is not negligence if injury results from the normal risks associated with that particular branch of medical care, nor if an accident occurs. Distinguishing between accidents and negligence is often difficult and gives rise to lengthy arguments among doctors and lawyers.

Actions for negligence are brought under the civil law of tort (wrongdoing). This general body of law has a number of objectives (Harris *et al.*, 1984; Danzon, 1985). The most important in the context of this Paper are:

- to compensate persons injured as a result of negligence
- to deter people from acting negligently

In addition, the law serves:

- to provide retribution for the injured person against the person who caused the injury
- to initiate an inquiry into the cause of the mishap.

If a patient, or the surviving relative of a deceased person, considers that there has been negligence, an action may be brought against the doctor responsible. NHS patients may also bring an action against the health authority in whose clinic or hospital the incident occurred. Where the claim relates to the actions of a general practitioner or a doctor consulted privately, the matter rests purely between the patient and the doctor. A health authority, however, is vicariously liable for the acts of its employees, including doctors. If a plaintiff can show that a named doctor was negligent in the course of his or her employment, compensation can be recovered from the health authority. In theory, the authority could then sue the negligent doctor for its outlay in costs and damages.

As crown bodies, health authorities do not take out insurance against damages and legal expenses but meet these costs from their budgets. Doctors, however, obtain cover through membership of one or other of the three defence societies operating in the United Kingdom: the Medical Defence Union, the Medical Protection Society and the Medical and Dental Defence Union of Scotland. These organisations are not insurance companies but are mutual aid associations run by doctors for doctors. Although most of their income is absorbed by negligence cases, the societies provide a wide range of legal services to their members, including representation at inquests, public inquiries, General Medical Council (GMC) hearings and other disciplinary proceedings. Health authorities require doctors to belong to a defence society as a condition of their employment. There is no specific compulsion for GPs to join a defence society but it is normally a condition of partnership agreements.

Following discussions between the defence societies and the Ministry of Health in the early years of the NHS it was recognised that litigation to establish the allocation of liability between a doctor and his employer would impose an unnecessary burden on both health authorities and the defence societies. The resulting accord, set out in circular HM(54)32, provided for the coordinated defence of negligence cases and a sharing of damages in proportion to the contribution of each party to the incident. Where agreement could not be reached, the costs would be divided equally between the parties found to be liable. Both parties waived their right to take legal action against the other, except in rare circumstances.

The Pearson Commission

The Royal Commission on Civil Liability and Compensation for Personal Injury (the Pearson Commission) published a report reviewing the operation of the law on personal injuries in 1978. The Pearson Commission undertook a wide- ranging inquiry and examined arrangements made for providing compensation for injuries in a number of fields including employment and transport. The Commission estimated that at the time of its inquiry approximately £800 million a year was spent on compensation for personal injury. Over 50 per cent of these costs were met from the social security system, the remainder being divided equally between tort awards and other sources such as occupational sick pay and occupational pension schemes. As the Pearson Commission emphasised, social security payments such as sickness benefits and industrial injuries benefits, together with the provision of services like the NHS, were the most important source of compensation. The Commission took the view that this should continue to be the case and that tort awards should be retained to supplement the social security system. No fundamental change in the law was therefore proposed, although it was suggested that duplication of compensation should be ended by offsetting social security benefits against tort awards.

As far as no-fault compensation was concerned, the Commission emphasised that no-fault already played a part in the provision of compensation for injuries. For example, both social security benefits and services like the NHS were provided regardless of whether anyone was at fault in causing an injury. In terms of extending no-fault arrangements, the Commission recommended that a no-fault scheme should be introduced for road injuries but not in other areas. In the exceptional case of children suffering injury as a result of vaccine damage, the Commission proposed a special scheme of compensation funded by the state.

As Table 1 shows, on the best estimates available to the Commission, medical negligence cases represented a tiny proportion (0.2 per cent) of all personal injury claims. The Commission reported that around 700 claims concerning medical services (that is claims on doctors, dentists and pharmacists) were made each year. As Table 2 shows, using information supplied by

Table 1 · Annual numbers of tort claims and payments for personal injury or death by type of claim. United Kingdom.+

	Claims		Payments	
	'000s	%	'000s	%
Employers' liability				
Injury	114.7	46.0	90.5	42.0
Disease	2.9	1.2	1.7	0.8
Motor vehicle	102.2	40.9	98.3	45.7
Other transport	1.1	0.4	0.9	0.4
Products and services (excluding medical services)	2.2	0.9	1.7	0.8
Medical services*	0.7	0.2	0.3	0.1
Occupiers' liability	12.2	4.9	10.8	5.0
Other	14	5.6	11.2	5.2
Totals	250	100	215.4	100

* Claims on doctors, dentists and pharmacists
\+ Estimates in round numbers for 1973

Source: Pearson Commission

the medical defence societies, the Commission found that the societies received 500 claims of *medical* negligence each year on average. Over 60 per cent of these claims were abandoned, some 34 per cent were settled out of court, and only 5 per cent ended up in court. Of the court cases, the majority (20 out of 25) were won by the defendant. The Commission noted that medical negligence cases were unusual in the low rate of success of court cases and also in the low percentage of successful claims overall: 30-40 per cent compared with 86 per cent in other personal injury cases according to Pearson's estimates.

Table 2 · Claims on medical defence societies. United Kingdom.+

	Annual Averages
Number of negligence claims referred to legal advisers	500
Number of claims abandoned	305
Number of claims settled out of court	170
Number of claims going to court	25
Total value of compensation	£1,000,000

\+ Estimates in round numbers based on data for 1974 and 1975

Source: Pearson Commission

Despite the growing number and size of claims, the evidence the Commission received from the medical profession favoured the retention of the tort system. As the Commission noted in summarising this evidence, doctors argued that:

> *liability was one of the means whereby doctors could show their sense of responsibility and, therefore, justly claim professional freedom. If tortious liability were abolished, there could be some attempt to control doctors' clinical practice to prevent mistakes for which compensation would have to be paid by some central agency . . . This could lead to a bureaucratic restriction on medicine* (p. 287).

The Commission noted that some of its members felt these views were overstated. Furthermore, the Commission made the point that the deterrent effect of the law was mitigated by the growth of insurance coverage. An additional consideration was that cases of gross negligence were settled out of court with little publicity whereas cases receiving much publicity were often those where the doctor had a good defence. Although recognising the importance of these considerations, the Commission did not favour a change in existing arrangements, even though it reviewed the experience of no-fault systems in New Zealand and Sweden. However, it concluded that:

> *the progress of no-fault compensation for medical accidents in New Zealand and Sweden should be studied and assessed, so that the experience can be drawn upon, if, because of changing circumstances, a decision is taken to introduce a no-fault scheme for medical accidents in this country* (p.291).

The Position Today

In the decade that has passed since the Pearson Commission reported, the position in relation to medical negligence has changed significantly. The number of successful claims has risen (see below) and there have been increases in the damages awarded by the courts. These developments have given rise to fears that the UK might be following the example of the USA and may be about to experience a malpractice crisis.

Table 3 · Defence Society Subscription Rates 1978-88

Year	Rate £	Annual Increase %
1988	1,080	87
1987	576	71
1986	336	17
1985	288	17
1984	264	35
1983	195	44
1982	135	13
1981	120	26
1980	95	36
1979	70	75
1978	40	–

In response, the defence societies have increased their subscription rates substantially. As Table 3 shows, subscription rates rose from £40 in 1978 to £1,080 in 1988. The increase in subscription rates was 71 per cent in 1987 and 87 per cent in 1988. This has created particular difficulties for junior doctors. Although concessionary rates are available to newly qualified doctors (see Table 4) and those on limited

Table 4 · 1988 Defence Society Subscription Rates+

	£
Full rate	1,080
Concessionary rates available to members who join within three months of qualification	
1st year	180
2nd year	240
3rd year	396
4th year	492
5th year	600
6th year	744
Non-clinical membership	132
Limited income concessionary rates	
Income ceiling of £6,230	360
Income between £6,231 and £12,460	720

+ Subscription rates from January 1 1988 for the Medical Protection Society and the Medical Defence Union.

incomes, a junior doctor is required to pay the full rate seven years after qualifying. Until the introduction of new arrangements following the 1988 pay award (see below), this meant that subscription rates could amount to the equivalent of a month's salary. As a result of these pressures, the medical profession has reconsidered its position and has called for a review of existing arrangements.

At the same time, health authorities have expressed their concern at the impact of increasing awards on cash limited budgets. As well as the cost of awards themselves, health authorities are worried that the threat of legal action will lead to more defensive medicine. By increasing the use of diagnostic tests and procedures, and by producing greater caution on the part of doctors, it is feared that defensive medicine will add to the pressure on health authority spending, particularly in the acute hospital services.

In parallel with the concern of health authorities and the medical profession, organisations representing patients and their relatives have drawn attention to the shortcomings of the tort system (ACHCEW, 1987; Simanowitz, 1987). First, there is the lengthy and expensive procedure involved in pursuing a claim for damages. This means that cases are often brought only by the rich or those able to obtain legal aid. Cases take a considerable time to work their way through the courts: the average time for settling a claim is four years.

Second, the legal process is by definition adversarial. As such, it may cause doctors and health authorities to close ranks and not offer an adequate explanation to patients and their relatives when things go wrong. In addition, the legal process may itself be distressing in providing a constant reminder of painful or unhappy events.

Third, the emphasis on establishing fault and cause and effect in injury cases turns the tort system into a lottery. Compensation is based not on need but on the ability to prove that somebody was at fault. The rules of the legal process which put the burden of proof on those bringing a claim may create significant difficulties for plaintiffs. As a consequence, similar cases of injury may be compensated quite differently. For example, a child suffering brain damage after contracting encephalitis will receive no compensation, a child suffering brain damage as a result of vaccine damage will receive £20,000, and a child suffering brain damage following traumatic birth delivery may receive hundreds of thousands of pounds compensation (BMA, 1987).

Fourth, only a small proportion of people suffering medical injuries are compensated through the tort system. This may mean that the losses incurred as a result of injury are inadequately compensated, although other sources of compensation are available.

Underlying these criticisms is a concern that the arrangements for maintaining high standards of medical practice and holding doctors to account for unacceptable standards of practice are inadequate. Action for the Victims of Medical Accidents (AVMA), established in 1982, has highlighted these issues, and has argued for much greater openness and accountability on the part of the medical profession in dealing with the consequences of accidents. One of the points emphasised by AVMA is that most people who suffer medical injuries are not seeking compensation but want an explanation of what went wrong. An adequate system for dealing with injuries needs to provide for this as well as to offer financial compensation.

Before considering these points more fully, it is worth noting a number of other criticisms levelled at the tort system as it applies to medical injury cases. These are:

- those making a claim may find it difficult to obtain the services of a solicitor with relevant expertise
- there may be difficulty in obtaining the services of doctors willing to act as expert witnesses for patients
- the legal process causes distress and expense to doctors and health authorities as well as to patients
- the availability of legal aid may result in legal action being initiated in inappropriate cases, that is cases where those making a claim have little chance of success (Hawkins and Paterson, 1987).

It is against this background that alternatives to existing arrangements have again come under scrutiny. One widely canvassed option is a no-fault compensation scheme. This has found favour with the British Medical Association (BMA) and the Association of CHCs in England and Wales (ACHCEW). Other possibilities include the introduction of differential premiums for doctors to reflect the risks involved in their work; shifting the cost of providing compensation to the NHS (Harvey and Roberts, 1987); reforming the tort law to overcome some of the shortcomings identified; providing more support to medical injury cases through the social security system; and extending first party insurance cover.

The view of AVMA is that a change in the existing arrangements is required but it is not clear what that change should be. The view of the Government is that the case for change remains not proven (Warden, 1988). To shed more light on this debate, we now

consider in more detail the available evidence on the present system and assess whether there is indeed a case for reform.

2 WEIGHING THE EVIDENCE

Before accepting too readily the claim that the UK is experiencing a malpractice crisis, it is important to review the available evidence to establish whether this claim is justified. Ideally, this evidence would include:

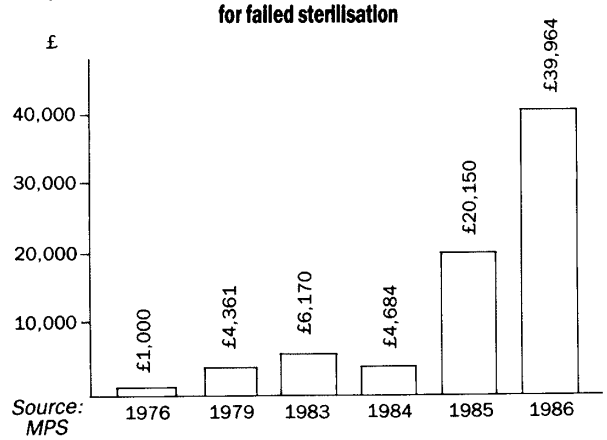
- trends in the number of medical accidents occurring expressed as a proportion of patients treated
- trends in the number of medical accidents which result from negligence
- trends in the number of claims made expressed as a proportion of patients treated
- trends in the number of successful claims made expressed as a proportion of patients treated
- trends in damages awarded, including total damages awarded each year, the size of the biggest award and the size of the mean award.

In practice, only some of this information is available. It is not possible to identify either the number of accidents occurring or the number of accidents which result from negligence because this information is not collected routinely. Information is available on claims and damages through the defence societies. The Medical Protection Society (MPS) has published some information on trends in awards (Figures 1 and 2) and has informed us that the number of claims received by the Society increased from around 1,000 in 1983 to over 2,000 in 1987 (personal communication). Similar trends are reported by the Medical Defence Union (MDU): the frequency of claims paid more than doubled between 1984 and 1987, and the average value of damages awarded also doubled in the same period (personal communication). The MDU has published a graph (Figure 3) showing changes in the highest sum awarded in medical negligence cases. More detailed data are not made public because the societies consider that this information is commercially sensitive and might be used by insurance companies seeking to enter the medical insurance market.

Health authorities also collect information on claims and damages but again this has not been fully analysed and published. The DHSS only receives information from health authorities on awards over £100,000 and the Department is currently seeking to improve the quality of this information. The DHSS also collates information on the total payments for losses and compensation made by health authorities. In 1986-7 a total of £9.3 million was paid out by health authorities (Hansard, 24 November, 1987, col. 162) but this covers a range of cases including compensation for unfair dismissals and losses due to theft. There is no information held centrally on the proportion of these payments spent on compensation for medical negligence (DHSS, personal communication).

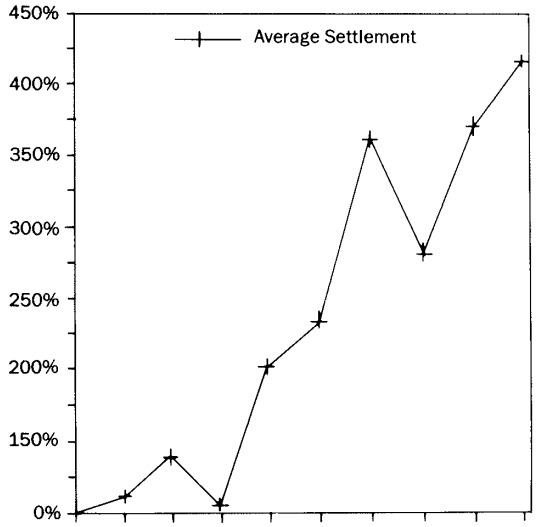
In view of the limited information held by the DHSS, we approached RHA legal advisers for assistance and received detailed replies from six regions. The experience of claims opened in these regions in the most recent available year is shown in Figure 4,

Figure 1 · Maximum awards paid by the Medical Protection Society for failed sterilisation



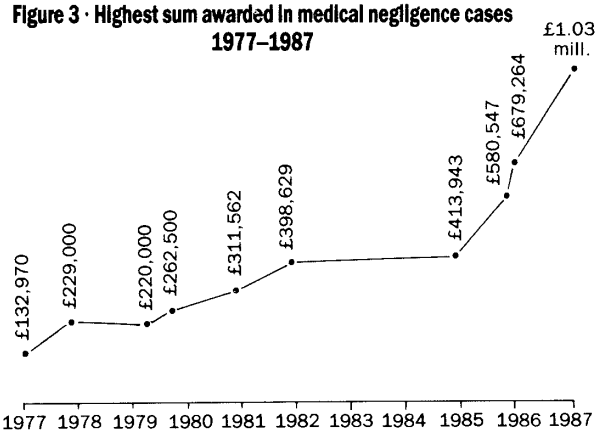
Source: MPS

Figure 2 · Average costs of settlements. Percentage increase from January 1976.



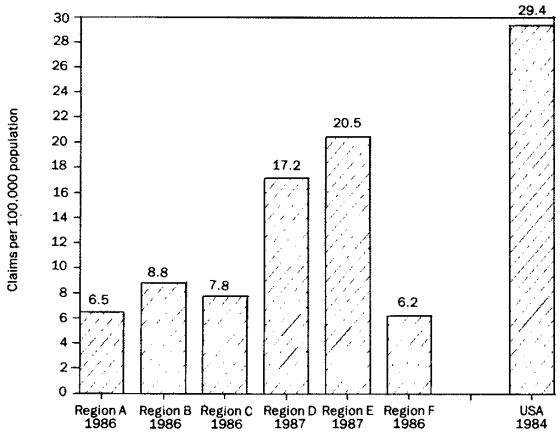
Source: MPS

Figure 3 · Highest sum awarded in medical negligence cases 1977–1987



Source: MDU

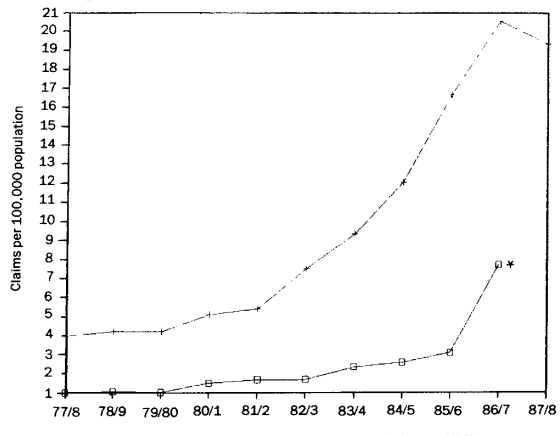
Figure 4 · Annual Claim Rates: Selected English Regions and USA



Sources: RHA solicitors and US General Accounting Office

together with the US rate for 1984. The variation within the UK is striking: most regions had an annual rate of around 8 claims per 100,000 population between 1986 and 1987, but two adjacent regions had annual rates which were more than double this. Time-series data were readily available for only two of the six regions. Figure 5 shows that Region E has always tended to have a high rate of claiming. As the Figure demonstrates, there is a clear upward trend in the number of claims since 1979/80, but with some indication of a levelling off in 1988.

Figure 5 · Claim Rates for two English Regions 1977–87



It is difficult to go beyond these global figures to examine the experience of authorities in managing claims and to identify their specific origins. The most useful published data can be found in a study of 100 cases taken at random from the files of the West Midlands RHA (Hawkins and Paterson, 1987). An audit of these cases found that at the end of three years, 73 actions had been withdrawn, 12 settled out of court and 1 lost in court. Fourteen cases were pending and the authors estimated that nine of these fourteen cases were likely to reach court.

In the context of the Pearson Commission's data, these figures do not suggest that the proportion of claims which are successful is increasing. Indeed the rate at which claims are abandoned would appear to have increased. On the other hand, it would appear that the proportion of claims going to court or likely to go to court is increasing.

Evidence we have obtained from another health authority confirms that the rate at which claims are abandoned has increased. In this authority, 75 per cent of claims were abandoned in the 1980s compared with around 50 per cent in the 1970s. There is no evidence from this authority that the severity of the claimants' injuries has reduced over time. However, the higher proportion of claims which are abandoned may mean that some claims are being pursued on weaker grounds than they were previously.

The claims experience of this health authority also revealed some interesting patterns in relation to the nature and sources of medical negligence claims. Most claims resulted from temporary injuries, with conditions like iatrogenic infections, fractures caused by mishandling or lack of supervision, and missed diagnosis of fractures being typical. There is some evidence that claim-provoking incidents in hospitals are most likely to occur on the wards rather than in the operating theatre. Moreover, claims arising from events in operating theatres seem rather more likely to be abandoned. All specialties attract claims, although some attract more claims than others. High risk specialties appear to be obstetrics and gynaecology, anaesthetics, accident and emergency, orthopaedics and neurosurgery.

The evidence from the West Midlands and elsewhere points to a picture in which there is a diversity of claims, many of which arise from relatively minor injuries, with little indication of any systematic variation in the incidence of claim-provoking occurrences. This diversity is reflected in a wide distribution of settlement amounts around a fairly modest average figure. In 1986 prices, the average settlement over the years 1981-86 would appear to be in the region of £15,000 with a standard deviation of £27,000. In addition, health authorities incur legal costs, even where cases are eventually abandoned. Again in 1986 prices, the legal costs of one authority varied between a mean of £210 for abandoned cases, through £1,200 in cases where some payment was made, to £3,000 in cases which were successfully defended in court. Where the authority was required to pay the plaintiff's costs as part of a settlement or award, the mean payment was £2,000.

The Impact of Subscriptions on the Medical Profession

As we have noted, a major cause of current concern with compensation arrangements is the impact of increases in defence society subscription rates on the medical profession. In considering this issue, it is worth noting that general practitioners' subscriptions are fully reimbursed by the Government as expenses.

As far as hospital doctors are concerned, the increase in defence society subscriptions was taken into account by the Review Body on Doctors' and Dentists' Remuneration in making recommendations on salary levels in 1987.

The Review Body went a stage further in its 1988 report, proposing that two-thirds of the medical rate of subscriptions should be reimbursed as an expense to all whole-time employed practitioners or part-time employed practitioners working wholly for the NHS, with effect from 1 January 1988 (Review Body on Doctors' and Dentists' Remuneration, 1988). The Review Body argued that doctors should continue to bear part of the cost of subscriptions in order to maintain involvement in the handling of claims.

The aim of this proposal, which was accepted by the Government, was to put doctors employed by health authorities on the same basis as they were in 1986. The Review Body emphasised that this was an interim measure that should apply until a better long-term solution had been achieved. In effect, then, the full costs of GPs' subscriptions and two-thirds of the costs of subscriptions paid by doctors employed whole-time by health authorities are met by the Government. This is likely to relieve much of the pressure from the medical profession for change, at an overall cost to the taxpayer of the order of £50 million in England alone.

The subscriptions paid by doctors should also be viewed in the context of those paid by other professions. It is difficult to make straightforward comparisons between professional indemnity insurance in medicine and that available to other professions because of the prevalence of risk-rating and variations in the amount of cover offered. Risk-rating means that the premium charged is weighted by reference to factors like the nature of the business handled, its location and the insured's previous claims record. In a profession serving a private clientele, variations in risk can be expressed as variations in charges to clients. In the NHS, they would either lead to variations in residual income which produced recruitment problems in high-risk specialties, or, more probably, pressure for differential rewards through the Review Body system. The result would almost certainly be far more costly to administer. Since almost all medical and dental premiums are ultimately paid by the NHS, there seems little to be gained from such a change.

The rates actually paid by doctors appear to be towards the lower end of the range of professional liability premiums. A telephone survey of insurers revealed the following:

Lawyers

Solicitors are required to pay into a mutual fund administered by the Law Society according to a complex scale varying from a minimum of 3.3 per cent of gross fee income below £30,000 in total for a practice to 0.1 per cent of gross fee income above £220,000 per partner, weighted to reflect the ratio between partners and assistant or unqualified staff and the nature of the work being undertaken. This buys £500,000 of cover for each and every claim. Larger practices dealing with high value commercial work obtain top-up cover on the commercial market.

The Bar set up its own mutual fund from 1 April 1988. This groups barristers into four categories depending upon the mix between civil and criminal work in their practice. The fund's directors expect to develop more sophisticated risk-rating in future years. The lowest contribution, for a barrister mainly engaged in criminal work, is 0.3 per cent of gross fee income with a minimum of £20 and a maximum of £390. The highest contributions, from barristers engaged mainly in civil work, are 0.7 per cent of gross fee income up to a maximum of £910 per annum. Coverage is offered in five bands, depending upon the premium paid, from £250,000 up to £2 million for each and every claim. £1 million of cover on this basis would cost between £300 and £499. Practitioners may raise their cover by voluntarily increasing their premium. Leading counsel handling tax cases would need to top up their cover in the insurance market to as much as £10 million but it is unlikely that anyone would pay more than one per cent of their gross fee income.

Financial Services

Chartered accountants do not as yet have compulsory insurance although this is under active discussion within their institute. About 60 per cent of them, mostly in small firms, with an average of 3 partners, are covered under the institute's policy with a commercial insurer. The minimum coverage allowed is 3 times annual gross fees or 30 times the gross income from the largest single source, whichever is greater. The lower limit is fixed at £50,000 for a 1986/7 premium of £385. The maximum currently available under the scheme is £1 million. All coverage is on an aggregate basis. Premiums paid vary between 1 and 3 per cent of a practice's gross fee income depending upon size and claims history. The 'Big Eight' international firms have set up their own mutual fund. In this sector, the highest premiums appear to be paid by insurance brokers where they can go up to 20 per cent of gross income.

Construction

About 40 per cent of architects are not insured at all, either by deliberate choice or as a result of falling behind with premiums during the recent recession in their industry. There is also a particular uncertainty about the position of architects employed in the public sector who do not normally carry their own insurance but whose employers, mostly local authorities, have not accepted liability on their behalf. Those who are insured are mostly covered by a scheme administered by the RIBA.

Current premium rates vary between 4 and 15 per cent of a practice's gross fee income with a minimum of £1,000 per partner. The average is about 7 per cent or around £14,300 per annum at 1987 prices. Rates are influenced by the nature of the business, claims experience and the amount of cover required. Most insured practices carry between £150,000 and £250,000 for each and every claim. Cover of £1 million would cost a typical practice about £80,000 per annum at current rates. Again, the largest firms have formed their own mutual scheme to cover their high-value work.

Chartered engineers pay upwards of £1,000 per head for £250,000 aggregate cover in the commercial market. Much depends on the nature and location of their work, so that anything involving a risky material like water or high value like oil rig design might lead to premiums of up to 8 or 9 per cent of a partner's gross income.

Other Health Professions

Veterinary surgeons are covered by a defence fund very similar in its operation to the medical defence societies, except that premiums are related to cover, with each practitioner determining his or her own needs. The minimum cover is £50,000 for each and every claim which costs £102 per annum. Practitioners involved in high value work such as racehorses or major intensive husbandry may seek up to £4 million worth of cover at a cost of £2,500 per annum. The package includes £750,000 for incidental injury to humans irrespective of the indemnity selected for liability in respect of animals.

Most independent retail pharmacists are covered by the Chemists' Defence Association which provides up to £3 million in respect of each and every claim. The premium forms part of their annual subscription to the National Pharmaceutical Association, currently £225 plus VAT, and it is not possible to disaggregate this component. The larger chains, such as Boots and some Co-operative societies, make their own arrangements for employed pharmacists. NHS-employed pharmacists are covered by a policy arranged at Lloyds by the Pharmaceutical Society which covers them for £500,000 aggregate at an annual premium of £32.50.

The great variation in the nature of the cover provided and the methods of calculating premiums make it difficult to translate these figures into direct comparisons with the rates paid by doctors. If, however, we were to attempt an estimate of what a typical professional would pay for £1 million cover on each and every claim, which is broadly the benefit offered by the defence societies, then we would come up with a figure in the range of £1,500 to £5,000, with at least some paying a good deal more and a few paying rather less. This compares with the 1988 subscription of £1080 for defence society membership and makes the new arrangements with two-thirds reimbursement to doctors working exclusively for the NHS appear a positive bargain.

As a proportion of income a registrar will pay about 2.75 per cent of gross salary once the concessionary rate for junior doctors expires after six years in practice and a senior consultant with an A plus award will pay about 0.5 per cent of gross NHS salary. Again, both seem to be at the lower end of the range for professionals. Insofar as there is a continuing problem, it would seem to be one of equity between practitioners at different stages in their careers with different earning capacities. There are ways of dealing with this short of a fundamental reform of the tort system. A BMA Working Party, for example, has suggested that the concessionary rate might be available for twelve years after qualification with a consequent increase in the full rate subscription to increase the element of cross-subsidy.

Defensive Medicine

A further cause of concern is that the increased likelihood of litigation will result in more defensive medicine. This claim is made regularly by the BMA and the defence societies. The argument most frequently articulated is that rather than risk legal action doctors will err on the side of caution by requesting additional diagnostic tests which may be clinically unnecessary. Lord Pitt recently summarised this argument:

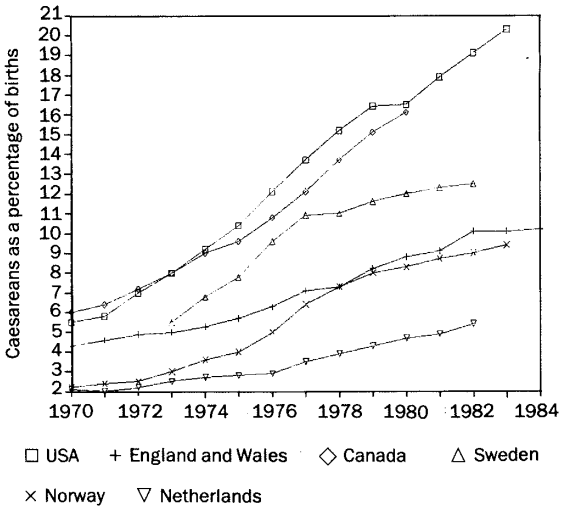
> *If doctors are to face these awards of severe damages they have to make sure of their defence. You are always better off in the witness box if you can say that you have done all the tests that are considered necessary . . . That means that one is wasting resources. We must therefore face the fact that if we are going to pursue the course that we are now pursuing we shall find an increase in defensive medicine with an alarming waste of resources* (Hansard, House of Lords, 10 November 1987, cols. 1350-51).

In fact, there is little hard evidence that defensive medicine is on the increase. A comprehensive American review of medical malpractice questioned the claim that doctors in the United States were becoming more defensive and noted that if more tests were carried out there could well be benefits for patients (Danzon, 1985). It is also worth reiterating that in the eyes of the law standards of reasonable care in practice are defined by doctors. There is therefore no obligation on doctors to carry out tests and procedures other than those considered reasonable by the profession.

Against this, Harvey and Roberts (1987) have questioned whether doctors will see this as providing them with sufficient protection. These authors maintain that even where clinical guidelines exist doctors may still judge that tests are needed as a defence against possible litigation. However, Kennedy (1987) argues that what is required is for doctors to be better informed of the legal position and to not feel constrained to practise in a way that is inappropriate. Similarly, Carson (1982) has maintained that changes in clinical practice involving reductions in the use of tests need not increase legal liability if the changes are discussed within the profession and receive the support of a responsible body of doctors. These arguments apply not only to tests but also to other areas of clinical practice, such as obstetrics, where it has been suggested that defensive medicine is also on the increase.

One of the most widely cited examples of defensive practice is the rise in caesarean section rates. This is, however, a phenomenon experienced by many countries with very different patterns of litigation (see Figure 6). The trend seems to be much better explained by other factors. These include changes in the perceived risk/benefit ratio following improvements in anaesthetic technology; changing clinical indications; the preference for conducting further deliveries by repeat caesarean; time management benefits for doctors and patients; and, for a time in the US, greater reimbursement for caesarean sections. Many of these

Figure 6 · Caesarean rates for selected countries 1970–84



Derived from Macfarlane and Mugford (1986).

factors are reflected in the rising British rates, independently of any concern over the risk of litigation (Yudkin and Redman, 1986).

Explanations

Various explanations have been proposed for the growth over the last decade in litigation arising from medical accidents. As we discuss below (chapter 4), we do not think it is plausible simply to attribute the increase in litigation to a direct copying of American experience. Three other types of explanation have been put forward: a real increase in negligence; easier access to legal representation; and a change in the propensity of patients to sue following an adverse outcome.

It is really quite impossible to determine whether rates of medical error have changed in the last ten years. Litigation rates are affected by so many factors that they cannot be treated as a reliable proxy for actual medical behaviour. However, the timing of the increase and the lag between events and claims tend to discount the suggestion that the recent squeeze on the real resources available to the NHS has put excessive pressure on staff and caused higher rates of error. The rates began to rise in relation to incidents occuring in the mid 1970s which predate the most acute stringency in health service resources, although it is not impossible that this is a factor in the recent acceleration of the trend.

A more important observation, though, is that this phenomenon is not unique to the medical profession. Almost without exception, other professions' liability insurers report a similar trend over a similar time scale. In the case of architects, for example, there was one claim for every 7 policies in 1979 and 7 for every 10 in 1987. Claims against veterinary surgeons doubled between 1981 and 1987. The real value of paid and reserved claims against accountants increased by 82 per cent between 1979 and 1984. It seems highly improbable that all professionals have simultaneously become more prone to error.

There have certainly been important changes in the market for legal services since 1979. A number of medical commentators, as well as insurers for retail pharmacists and veterinary surgeons, have argued that legal aid has become more freely available and that this has encouraged a proliferation of trivial claims. The statistical basis for this latter statement is uncertain. In the case of medicine, it is certainly not substantiated by any of the figures currently available to us.

What is clear is that the capital and income limits for civil legal aid have consistently lagged behind inflation in the last ten years and the proportion of the population eligible for assistance has decreased. It is possible that the changing nature of the market for legal services, especially the growth of specialisation among solicitors, has improved the presentation of applications so that more are likely to be granted. It is also likely that the liberalisation of access to clinical records in recent years has increased the willingness of Legal Aid Committees to support the initial stages of an action because they know that information will be available at a reasonable cost. They can then take a considered decision on whether the action is worth supporting further.

Both of these developments would tend to facilitate more claims from a smaller pool of eligible claimants. This might be experienced by defendants as a growth in 'trivial' claims because many of them will inevitably prove insubstantial once the documents have been studied. Again, though, these developments must be put in the context of the general increase in litigation over the supply of professional services, which is as marked among those serving corporate customers as among those serving individuals. In architecture, for example, the highest risk of litigation arises from work for housing associations. Accountancy cases almost invariably involve company liability.

The most likely explanation, then, relates to claims consciousness, the awareness among victims of the possibility of legal redress and their readiness to pursue this route. The more active marketing of legal services and the efforts of a number of statutory and voluntary bodies like CHCs, Citizens Advice Bureaux and AVMA may well have had some impact, both in terms of public education and of practical support. If, however, we are dealing here with a particular case of a general phenomenon, more general explanations would be needed.

One possibility is that there may have been a cultural change towards a greater insistence on the right to be compensated for life's misfortunes and an increased distrust of the assumed skill and honour of professionals. Clients may be less ready to accept that adverse outcomes are intrinsic to the uncertainties of professional work and to insist that some dereliction of duty must underlie any failure. In this limited sense, there may be something to be said for the 'Americanisation' thesis.

3 PROFESSIONAL ACCOUNTABILITY

One of the most important issues involved in medical negligence is that of professional accountability. As Kennedy has stated

> *suing doctors in court alleging negligence is merely one way of seeking to hold them accountable for their conduct* (1987, p.52).

As we have noted, the issue of accountability lies at the heart of the criticisms voiced against tort law by organisations representing patients and their relatives. The argument advanced by these organisations is that doctors are accountable to patients only in a weak sense and that changes are needed to ensure that adequate explanations are given when things go wrong and that appropriate action is taken against the doctors concerned.

There are various ways of ensuring accountability apart from through the courts. The two most important are professional self-regulation and procedures for holding doctors to account to the public or the public's representatives. The UK has traditionally relied most heavily on self-regulation. Like all professional groups, doctors have argued that responsibility for setting and maintaining standards should lie with the profession. We have noted already that what is defined as reasonable care in a legal context is determined by doctors, and more generally doctors take it upon themselves to ensure that the quality of care provided is satisfactory. The medical defence societies contribute to this through their educational activities. These activities take a number of forms: published reports warning doctors of the risks associated with different aspects of clinical practice; films and tape/slide programmes; and seminars and lectures given by staff of the societies. The aim of these activities is to warn doctors of well-known pitfalls and to improve standards of care.

Medical Audit

To the extent that the profession actively monitors standards it does so on an informal basis by means of medical audit and peer review. This involves doctors regularly assessing their practice in discussion with colleagues. In the main, initiatives for audit in the UK have been organised locally by the doctors in a hospital department or the general practitioners in a group practice. In addition, there are examples of more formal mechanisms which are part of a national interest in audit. These include the Health Advisory Service, the National Development Team for Mentally Handicapped People, the Confidential Enquiry into Maternal Deaths, and the Confidential Enquiry into Peri-operative Deaths. All of these mechanisms involve an element of independent professional assessment of standards.

Despite the interest shown in audit both locally and nationally, Sir Raymond Hoffenberg (1987) has argued that the medical profession has shown considerable resistance to the concept of audit. Hoffenberg contends that the profession should welcome greater scrutiny of clinical competence, for only in this way will public confidence be maintained and the threat of external regulation avoided.

The General Medical Council

The accountability of doctors to the public is discharged principally through the various procedures that exist for handling complaints. Doctors are closely involved in these procedures, most obviously in the case of the GMC. The GMC is an independent statutory body charged with maintaining a register of doctors, overseeing medical education, and handling disciplinary matters. The GMC is made up mainly of doctors and it investigates allegations of serious professional misconduct. Approximately 1,000 complaints are handled each year and these arise from criminal convictions as well as from the public and the professions. The complaints considered by the GMC include matters of professional etiquette such as advertising and the abuse of personal relationships with patients (for example, entering into a sexual relationship) as well as the neglect by doctors of their professional responsibilities to patients. It is this last category of complaints that includes examples of medical negligence.

Complaints are carefully screened and in the vast majority of cases the Council decides that no question of serious professional misconduct arises and hence no action is taken. Investigation of the remaining cases may result in a letter of advice or admonition to the doctor concerned, or reference to the professional conduct committee. This committee considers approximately five per cent of all cases received by the Council. Approximately one-third of these cases concern the professional responsibilities and clinical competence of doctors. The committee operates like a court and can impose a range of penalties, including in extreme cases striking a doctor off the register. A recent analysis of the work of the GMC concluded that, in comparison with Sweden and the United States, the Council's disciplinary procedures exhibited 'an extraordinary degree of control' (Rosenthal, 1987, p.128) by doctors themselves of professional conduct.

Complaints

Apart from the GMC, separate arrangements exist for handling complaints in the hospital and community health services and the family practitioner services. The detail of these arrangements is complex but the basic principles are as follows. In the case of family practitioner services, complaints about breach of contract are heard by service committees of family practitioner committees. These usually comprise three lay members, three medical members and a lay chairman. A complaint normally has to be made within eight weeks of the event which gave rise to it (soon to be extended to 13 weeks). The remit of service committees is limited to breach of terms of service and excludes criticism of a doctor's manner or matters such as the efficiency of appointments' systems.

In a study conducted in the early 1970s, Klein (1973) found that the most common types of complaint concerned failure to treat a patient in an emergency, failure to provide a proper surgery, failure of deputising services, and improper demands for fees. Complaints involving the clinical judgement of GPs

were also considered by service committees but these were in a minority. In the case of complaints about clinical judgement, Klein found that service committees relied heavily on the assessment of their medical members in determining whether doctors were in breach of their duty to provide proper and necessary treatment.

It is worth noting that the number of formal complaints against family practitioners, including GPs, is small: in 1983, 1,313 complaints were investigated in England and practitioners were found to be in breach of their contracts in 341 cases (26 per cent). In the same year, there were around 190 million consultations with family doctors and 30 million courses of dental treatment (DHSS, 1984).

Complaints concerning hospital and community health services are investigated by health authorities following procedures set out in circular HC(88)37. Again, the number of written complaints received is small: 25,336 in relation to hospital services in 1985 in England, or around 3.5 complaints for every 1,000 in-patient and day cases. In the same year, 3,649 written complaints were received concerning community services (DHSS, personal communication).

Complaints About Clinical Judgement

Special procedures exist for handling hospital complaints in which issues of clinical judgement arise. These procedures involve the consultant in charge of the case initially investigating the complaint and seeking to satisfy the complainant. If this fails, the complaint is referred to the regional medical officer who may ask for an independent professional review to be conducted by two senior doctors. This is invoked in the case of serious complaints only and is intended as an alternative to legal action. A review conducted by regional medical officers early in 1984 (Scott, 1985) indicated that the officers involved believed they were providing a useful service to complainants but various proposals were made for speeding up and improving the procedures.

The procedures for handling complaints concerning clinical judgement are particularly relevant to our interests. This is because a major concern of the committees and organisations that have analysed these procedures in recent years has been to create a system which satisfies complainants who have the option of taking a case to court but who choose not to do so. It can be argued that if an adequate system can be devised for handling complaints concerning clinical judgements then patients and their relatives will be less likely to pursue a legal remedy. Against this, organisations representing the medical profession have argued that the option of taking a case to court should preclude other methods of independent review.

In addressing this question, the Davies Committee (1973) proposed the establishment of investigating panels of professional and lay members to conduct investigations into hospital complaints concerning clinical judgement. This proposal was not acceptable to the profession and was not implemented. A different stance was taken by the Select Committee on the Parliamentary Commissioner for Administration (1977) which argued that the Health Services Commissioner or Ombudsman should be empowered to look into clinical complaints as well as other complaints incapable of being resolved by a health authority. This too was unacceptable to the profession.

Following lengthly negotiations, the government secured the agreement of doctors to introduce in 1981 the procedures described above. These procedures place responsibility for investigating complaints about clinical judgement firmly in the hands of the profession and do not provide for the sort of lay and independent involvement envisaged by the Davies Committee and the Select Committee. The reason for this is the reluctance of the profession to relinquish control over the handling of complaints. This reluctance stems from the perceived threat to clinical freedom and the risk of double jeopardy if patients decide to go to court after using the independent review process. In fact, the evidence suggests that few complainants do initiate legal action following independent professional reviews. An analysis of complaints dealt with in this way between 1981 and 1983 found that in only 3 out of 94 completed inquiries was a civil action for damages started (Scott, 1985).

The Health Service Commissioner

The only other source of redress available to patients is the Health Services Commissioner. However, the Commissioner's remit is limited to complaints concerning injustice or hardship suffered by members of the public as a result of a failure in a service provided by a health authority or a failure of an authority to provide a service which it was its duty to provide. Cases outside the Commissioner's jurisdiction include those involving clinical judgement and cases where legal action is proposed. As Table 5 shows, there has been a steady increase in the number of complaints received by the Commissioner but many of these complaints are either rejected or referred back. The largest category of rejected cases (30 per cent in 1986-7) are those involving clinical judgement.

Table 5 · Health Service Commissioner Analysis of Activity 1977-1986. England

Year	Complaints Received	Rejected or Discontinued	Referred Back	Results Reports Issued
1977/78	494	267	59	94
1978/79	590	426	67	101
1979/80	484	334	58	90
1980/81	556	398	83	98
1981/82	586	419	95	89
1982/83	658	460	96	101
1983/84	770	520	145	96
1984/85	711	387	195	104
1985/86	807	407	238	116

Source: DHSS 1986

The Case for Reform

The various complaints procedures that exist play a part in holding doctors accountable but the evidence suggests they are weighted in favour of the medical profession (Klein, 1973; Rosenthal, 1987). Also, despite changes introduced in the last decade, they remain complicated and fragmented. This is one of the reasons why the number of formal complaints made is small in relation to the number of patients treated.

The defects in the complaints procedure have been acknowledged by Hoffenberg (1987) who has argued for strengthened and improved arrangements to be introduced. More radically, Kennedy (1983) has called for the establishment of a Code of Professional Standards of Competence supported by appropriate procedures for supervising adherence to these standards. This would include an independent professional inspectorate and a professional standards review tribunal made up of a majority of lay members. In a similar vein, ACHCEW has emphasised the need for appropriate arrangements to be made for identifying professional mistakes and unacceptable clinical practices and taking appropriate action. ACHCEW has suggested that this might involve setting up clinical responsibility boards, along the lines of Sweden's Medical Responsibility Board (see below), to investigate complaints about clinical care.

Thus, whatever arrangements are made for providing financial compensation for the victims of medical accidents, there is a clear case for strengthening the procedures for enquiring into the cause of accidents, maintaining high standards of medical practice and holding doctors to account for their actions. Central to these procedures should be a genuinely independent review process for complaints involving clinical judgement. As a number of commentators have argued, the profession's fears of double jeopardy are almost certainly exaggerated (see the report of the Davies Committee, and evidence to the Select Committee on the Parliamentary Commissioner for Administration (1977) from regional health authority chairmen and nurses) and those closely involved in the existing system of independent review have acknowledged its weaknesses (Rue, talk to the Royal Society of Medicine, January 1988; Health Service Commissioner, 1988). Above all, there is a need for a system of independent review separate from courts of law. We return to discuss these issues further in chapter 6.

4 MEDICAL LIABILITY: THE US EXPERIENCE

Some of the current anxiety over medical negligence litigation is provoked by the fear that American experience could be repeated in the United Kingdom. In fact, there are good institutional reasons why this is unlikely, unless the institutions themselves change considerably (this chapter draws heavily on Quam *et al.*, 1987a and b and 1988).

Malpractice suits were uncommon in the United States until the late 1960s. Since 1970, claims reported by the St. Paul Company, the largest insurer, have increased from 4.3 per 100 insured physicians to 18.3 per 100 in 1986. Nevertheless litigation is still rare in relation to admissions. Most studies suggest that 1 to 2 per cent of hospital admissions lead to some injury by a negligent act. Danzon (1985), in the most comprehensive study, concluded that only 10 per cent of potential negligence cases led to claims, of which only one-half received any compensation. Although a number of very high awards have attracted considerable media attention, most independent studies have found that court awards and settlements closely reflect the actual economic losses of the plaintiffs.

The point is that in the US, with very little social insurance and a reliance on private health and welfare provision, these can be very large. While the rate of inflation in claim severity, the cost to insurers of each case, exceeded that of general retail price inflation in the 1970s, it kept closely in line with the price index for medical goods and services. Since the proportion of doctors' gross income spent on medical insurance remained more or less constant between 1975 and 1985, it can plausibly be argued that the rising cost of malpractice reflected rather than caused the rising cost of health care. Conversely, the attempts to contain health care costs in the 1980s have done much to precipitate the current crisis, since it is no longer possible simply to pass on rising insurance premiums in charges to patients, insurers or the government.

The most commonly noted implications of the malpractice experience of the United States are in the practice of defensive medicine and the distribution and activities of doctors. It can, however, also be argued that it is at least partly responsible for the more aggressive approach to quality assurance and risk management which is observable in US hospitals.

Defensive Medicine

Most of the evidence on defensive medicine is anecdotal. The proliferation of unnecessary tests is better explained as a function of a fee-for-service payment system. It is also found in other countries like West Germany with such systems. Conversely, the spread of prospective payment schemes and standardised DRG reimbursements in the US seems to be reducing the volume of tests despite the professed concern over litigation. In any case, 'defensive medicine' may look very different from the point of view of the profession and the patient. If one response is a greater concern for record-keeping, for example, this may be considered burdensome by doctors but benefit patients. Some support for this view is found in a 1983 American Medical Association survey of 1,240 doctors which found 57 per cent of respondents claiming to keep better records (AMA 1984). The American College of Obstetrics and Gynaecology 1985 survey of 1,646 obstetricians and gynaecologists reported claims by 58.8 per cent of respondents to be monitoring patients more closely. 44.2 per cent of the respondents said that they consulted medical colleagues more frequently over the progress of a case (ACOG 1985). If these replies reflect genuine changes in behaviour, then they could be taken as evidence of an appropriate response to tort litigation's deterrent message.

Distribution and Activities of Doctors

The working environment of US doctors has been undergoing considerable changes. The population is ageing and there is considerable internal migration from the North and East to the West and South. Also, the US has an oversupply of physicians and hospital beds and there has been a gradual replacement of fee-for-service by prospective payment. It is difficult to isolate the effects of recent malpractice experience from these developments. There have been particular problems with specialties like obstetrics in rural areas. Here, however, malpractice and insurance are just two factors in the historic decline of population and prosperity which has made all medical care marginal because people lack the resources to pay for it. The phasing out of GP obstetrics was envisaged ten years ago on policy grounds, before malpractice was ever an issue. In many rural areas, there are too few births for a general practitioner to maintain the currency of his or her skills but a withdrawal of the service, for whatever reason, creates much greater access barriers than in the UK, because of the very low population densities and the distances that these dictate between specialist centres.

Quality Assurance

Quality assurance is partly related to the notion of defensive medicine but deserves highlighting separately. One of the virtues of the tort system is claimed to be its deterrent effect. While this is attenuated for individuals by insurance, it remains a potent source of collective pressure on hospitals and the profession. While the combination of an oversupply of doctors and hospital beds with price restrictions creates conditions which favour quality competition, this is also stimulated by the possibility of containing insurance costs. The costs may be a small item of the budget but represent an item which can be contained by personal or organisational initiative, unlike, for example, the costs of a new drug therapy. Moreover, the avoidance of litigation may have a positive return in the avoidance of adverse publicity, a useful gain under present market conditions. Corporate medicine may have a stake in its public image which the corner-shop practitioner did not. Certainly, the positive collaborative response of the profession, the hospitals and the insurers, through improved physician and risk management programmes, suggests that the quality-promoting aspects of the tort system should not lightly be dismissed.

Differences in Legal Systems

The extent to which the American experience is likely to be repeated in the UK depends upon factors in the legal, health care and social insurance systems. The UK and the US share a common legal tradition, but have developed rather different systems and responses to medical claims. Access to lawyers is easier in the US, with roughly twice as many per million population as in the UK. Moreover, fee-splitting arrangements encourage generalist lawyers to refer medical cases to specialists in this field. In the UK, it is more a matter of chance whether plaintiffs will find their way to a personal injury specialist, let alone one who is expert in medical litigation. The effect of the contingency fee system should not be overstated. In the US, lawyers who work on this basis will only accept claims which are likely to be successful and profitable so that cases which do not receive the support of the firm's medical advisers or seem unlikely to yield enough damages to cover the firm's costs are turned away. In fact about 85 per cent of prospective plaintiffs are rejected for one reason or another. On the other hand, plaintiffs can shop around without having to face the monolithic decision of a legal aid committee.

In the past, it has been much more difficult to assemble the papers for a case in the UK. This is changing with greater access to records and pre-trial disclosure following recent judgements and changes in the Rules of Court. However, experienced personal injury practitioners are divided about the likely results. Some take the view that the obligation to disclose medical reports will actually weaken the plaintiff's position in pre-trial bargaining, since it will be harder to bluff defendant insurers about the strength of the case.

American legal doctrine is generally more favourable to plaintiffs than its equivalents in the UK, with the possible exception of Northern Ireland. In theory, the same test is applied in each country: was the standard of care such that it would be recognised as reasonable by other members of the profession? In practice, American juries seem to have been more willing to extend this to sins of omission as well as of commission, especially allegations of failure to diagnose. Nevertheless, these cases are still harder than others to pursue successfully. There is a particular difference in the position on informed consent. In Britain and most American states, the standard is set by reference to what a reasonable doctor would tell a patient and is determined in relation to evidence from other doctors. A few American states have, however, shifted to setting the standard by reference to what a reasonable patient might want to know, which is determined by the court itself. There is, though, little evidence that this makes any real difference in actual litigation.

A major difference between US and UK litigation lies in the relationship between doctors and hospitals. In the US this can give rise to extensive cross-litigation as the potential defendants seek to allocate liability between themselves. In the UK, such litigation is restricted by the provisions of circular HM(54)32 (see chapter 1).

Another notorious difference between the two legal systems is in the use of juries. This is a constitutional right in the US but has long been obsolete in the UK, except in Northern Ireland and, to a more limited extent, Scotland. It has been claimed that juries are responsible for high awards in the US. In fact, they have been shown to be quite well-informed about the costs to plaintiffs. Juries assume about the right amount in contingency fees and then calculate awards on a realistic assessment of health care costs, lost earnings and future expenses. If awards are discounted by removing the legal costs, which are quoted separately in the UK, and the present and future health care costs, which would be met by the NHS, and if the wage rates are adjusted to their real value in each country, much of the difference evaporates. In individual cases, American juries may award substantial general damages (for pain and suffering) or punitive damages which are seldom available in the UK. However, taking the system as a whole, neither of these payments is sufficiently large or common to affect the overall calculations.

Differences in Health Care Systems

If the NHS contains the cost of successful claims, there is also reason to think that it may act as a deterrent. Patients who have paid directly for their own care seem more inclined to sue than those who have not. The division of labour between GPs and specialists under the NHS also seems likely to prevent claims by encouraging the development of long-term relationships between patients and GPs and protecting patients from the more aggressive interventions of specialist medicine without a clear justification. Moreover, litigation in the US is undoubtedly fuelled by the sheer cost of extra care and the necessity to provide for the future. An iatrogenic injury may not only be expensive in itself to repair but may compromise a patient's future eligibility for health insurance or HMO membership. In such circumstances provision may have to be made for a lifetime's medical bills.

The crucial point is that American patterns of litigation reflect the experience of a society with minimal levels of public provision. They represent a private alternative to the welfare state. Insofar as the higher level of public provision in the UK is reduced, we might expect litigation to increase.

5 MEDICAL ACCIDENTS: THE EXPERIENCE OF NO-FAULT COMPENSATION

New Zealand

The New Zealand scheme of no-fault compensation came into operation in 1974. The scheme was introduced following the recommendations of the Woodhouse Commission which reported in 1967. Prior to the introduction of the scheme, New Zealand provided compensation for personal injury on a similar basis to the UK. The Woodhouse Commission argued that tort law was deficient in various respects and it proposed the establishment of a comprehensive scheme of no-fault compensation covering injuries from all accidents, including medical accidents. This proposal was accepted by the Government and the Accident Compensation Corporation (ACC) was set up to administer the scheme. Tort action has been abolished in respect of injuries covered by the scheme.

The fundamental principle underlying the scheme is that the community has a responsibility to protect all citizens from losses sustained through personal injury by accident. There is therefore comprehensive entitlement for all injured people and the scheme is financed by the community. The scheme has three main aims: to provide realistic financial compensation; to promote rehabilitation following injury; and to prevent the occurrence of accidents. The Woodhouse Commission emphasised that efficient administration was an important principle behind the scheme, the objective being to ensure that compensation is paid quickly and that administrative costs are kept to a minimum.

The scheme is organised into three funds: one for those injured in employment, another for people involved in motor vehicle accidents, and a third for other people suffering accidents. Income derives from a levy on employers and the self-employed, a motor vehicle owners levy, general taxation, and interest on investments. The proportion of income obtained from these sources is illustrated in Table 6. Payments made under the scheme include:

- compensation for loss of earnings (accounting for 48 per cent of payments in 1987-88) amounting to a maximum of 80 per cent of previous income and paid on a periodic basis
- compensation through lump-sum payments for the permanent loss or impairment of a bodily function and for the loss of enjoyment of life and pain and suffering (accounting for 21 per cent of payments in 1987-88)
- compensation for medical costs (accounting for 14 per cent of payments in 1987-88).

The remainder of the Accident Compensation Corporation's expenditure is allocated to administration (7 per cent) and other items such as accident prevention and rehabilitation (Law Commission, 1987). In order to limit costs and concentrate resources on the more serious cases, the Corporation does not pay compensation in the first week after an accident. For people in work, the costs of accidents at work in this period are met by employers.

The definition of accidents is an important and keenly debated aspect of the scheme. In the case of medical accidents, the Accident Compensation Act includes in its definition of personal injury by accidents, 'medical, surgical, dental or first aid misadventure'. The key elements of an accident under the Act are that it should be unexpected and that it should not be self-inflicted. Excluded from the Act are losses which result from disease, infection or the ageing process. Also excluded are accidents which occur as part of the normal and expected risks associated with medical treatment (for fuller details of the scheme see Accident Compensation Corporation, not dated).

Table 6 · Source of receipts for Accident Compensation Corporation 1974–1988 (percentages)

Year Ended 31 March	Levies			Investment Income		TOTAL
	Employer	Motor Vehicle	Government Contribution	Employer	Motor Vehicle	
1975	67.0	26.1	3.6	2.4	0.9	100
1976	66.2	21.8	5.4	5.1	1.7	100
1977	65.1	19.5	7.0	5.1	3.4	100
1978	62.2	17.4	8.5	7.1	4.8	100
1979	62.4	16.2	9.0	7.3	5.1	100
1980	64.0	13.8	7.8	8.9	5.6	100
1981	61.6	12.3	8.3	11.7	6.1	100
1982	61.6	10.6	9.4	11.6	6.8	100
1983	60.4	9.1	11.3	13.7	5.5	100
1984	62.4	8.0	10.8	13.1	5.7	100
1985	51.7	13.5	14.3	14.9	5.6	100
1986	50.6	12.1	17.6	14.8	5.0	100
1987	47.3	24.3	17.4	6.9	4.1	100
1988	71.2	12.8	8.5	6.7	0.8	100

Source: Law Commission (1987 and 1988)

Medical misadventure as defined by the Act includes unexpected mishaps resulting from medical intervention as well as medical errors, that is a failure to observe a reasonable standard of care. This definition is wider than that of medical negligence but it should be emphasised that *it does not include all medical accidents*. Although the range of accidents is broadening as new cases arise, important exclusions remain including accidents which result from omission to treat a patient (Smith, 1982). The approach taken to medical accidents differs in this respect from the approach taken in the case of non-medical accidents where a more liberal definition is adopted (Vennell, 1987). As a consequence, difficulties arise in determining whether a medical accident can be compensated through the scheme and it is still necessary to demonstrate that injury was caused by medical intervention.

These difficulties notwithstanding, the scheme as a whole has widespread public support in New Zealand and there is no suggestion that the arrangements it replaced should be revived. On the other hand, the scheme has encountered financial problems. Table 7 illustrates trends in income and expenditure between 1975 and 1988. After adjusting for inflation, income has increased by 122 per cent and expenditure by 313 per cent. As the table shows, income exceeded expenditure until 1984, but in the following three years expenditure exceeded income.

The levy paid by employers and the self-employed was reduced by approximately 30 per cent in 1985 following pressure by employers and this helps to account for the change in the Accident Compensation Corporation's financial position. At the same time, expenditure has continued to increase significantly, and the Corporation had to use its reserves to fund the deficit. This had the effect of reducing the reserves from $396 million at 31 March 1984 to $89.2 million at 31 March 1987. In response, the Corporation introduced a 300 per cent increase in the levies paid by employers and the self-employed. As a result, in 1988 income again exceeded expenditure. The increase in levies was unsuccessfully challenged in the courts but the attendant publicity gave added impetus to a review of the scheme being undertaken by the Law Commission.

Table 7 · Accident Compensation Corporation Income and Expenditure 1975-1988 ($ million)

	Income	Expenditure	Income adjusted for inflation	Expenditure adjusted for inflation
1975	81.3	32.7	81.3	32.7
1976	93.8	59.2	80.0	50.5
1977	110.4	81.3	82.8	61.0
1978	127.8	102.8	83.7	67.3
1979	141.9	114.1	84.0	67.6
1980	174.1	121.9	87.2	61.1
1981	201.6	149.4	87.5	64.8
1982	242.4	192.3	90.9	72.1
1983	283.6	252.9	94.4	84.2
1984	325.3	284.6	104.7	91.6
1985	300.2	340.1	85.3	96.6
1986	342.5	454.5	86.0	114.1
1987	425.8	578.3	90.3	122.6
1988	926.5	693.2	180.7	135.2

Source: Law Commission (1987 and 1988)

An interim report published by the Commission in October 1987 emphasised that the general form of the scheme was sound and should be retained (Law Commission, 1987). The financial difficulties that had arisen did not reflect weaknesses in the scheme's concept but in its administration. The reduction in levies in 1985 had failed to take account of the fact that the scheme would take a number of years to mature as payments made in earlier years accumulated.

The report argued that there were no grounds for radical changes, such as compulsory first-party private insurance. Rather it proposed a series of modifications. These included: extending the waiting period for eligibility from one week to two; allocating part of the duty paid on road transport fuel to the scheme; and levying a single rate contribution on employers and the self-employed instead of a rate based on the estimated risks of different industries.

The Commission's final report, published in May 1988, reiterated these proposals and also recommended the abolition of lump-sum payments for loss or impairment of a bodily function and for the loss of enjoyment of life and pain and suffering (Law Commission, 1988). In place of these payments, it was suggested that periodic payments should be introduced for people with significant permanent disabilities. Furthermore, the Commission argued that greater emphasis should be put on the prevention of accidents and the rehabilitation of accident victims, and it recommended that designated ministers should be charged with responsibility for these functions.

Another key proposal was that the sick and disabled should be entitled to the same benefits as people suffering accidents and should be included within the scheme by stages. Associated with this proposal, the Commission recommended that the definition of medical accidents should be extended to encompass cases where injury occurred as part of the normal and expected risks associated with medical treatment. This was designed to introduce greater consistency in the eligibility of those suffering injury from different types of accident.

In parallel with the Law Commission's review, the operation of the scheme has been examined by the New Zealand Royal Commission on Social Policy as part of a wide-ranging analysis of social security provision. In a working paper published in March 1988, the Royal Commission endorsed the underlying principles of the scheme but called for substantial modifications to be made to its operation. More specifically, the Royal Commission suggested that: the waiting period for eligibility should be extended to four weeks; earnings-related compensation should cease after two years and should be replaced by a flat-rate benefit; lump-sum

payments for non-economic loss in respect of pain and suffering and enjoyment of life should be eliminated and in place of these payments the Accident Compensation Corporation should pay for care directly; and an allowance paid periodically should replace lump-sum payments for loss of a bodily function. In its analysis, the Royal Commission drew particular attention to the more generous compensation available to victims of accidents compared with the sick and disabled. The Royal Commission argued that in the long term there was no justification for this difference and it should be eliminated.

Against a background of support for the principles of the scheme yet concern about rising costs, it is possible to identify a number of strengths and weaknesses in the New Zealand arrangements. On the positive side, the scheme provides universal entitlement for victims of accidents who come within the scope of the scheme. Claims are settled quickly and at little administrative cost. Victims of accidents do not have to prove negligence, although there is a need to establish that injury was caused by an accident as defined by the scheme. Insurance company profits and lawyers' fees are eliminated, the adversarial features of the tort system are avoided, and those injured by accidents do not have to meet legal expenses. At the same time, the demands made on the legal system are much reduced.

On the negative side, the following points are worth noting:

- the loose definition of accidents in the scheme opens up the possibility of abuse and makes it possible for compensation to be claimed for injuries caused by incidents other than those included in the scheme. Much depends on the integrity of GPs who effectively act as gatekeepers in determining whether injuries come within the scheme but who may also benefit if an accident victim requires the continuing services of a GP
- the exclusion of some medical accidents and of individuals suffering from disease, congenital conditions and other forms of illness creates inequities. Accident victims receive income-related earnings, free or low cost health care in the public or private sector, and in some cases lump-sum payments. These benefits are not available to the sick and disabled, although social security benefits at lower levels are
- the removal of the deterrent effect of tort law has reduced some of the pressure to maintain high standards within the medical profession. The Accident Compensation Corporation has a role in accident prevention but has no power to monitor standards of medical care. In New Zealand as in the UK, responsibility for standards rests principally with the medical profession. There has been concern recently about the lack of accountability of doctors in the absence of tort litigation, although the effectiveness of the law as a means of holding doctors to account is acknowledged to be limited
- the scheme has increased demand for health services. Furthermore, by lowering or removing costs for accident compensation recipients, the scheme has contributed to the growth of private sector provision. Associated with this has been a drain of scarce personnel such as physiotherapists and orthopaedic surgeons to the private sector
- while the scheme is generally effective in providing compensation, it does not overcome the difficulty experienced by victims of medical accidents in obtaining an explanation of why an accident happened. This appears to be as much of a problem in New Zealand as in the UK even though the threat of legal action is removed
- the scheme as a whole contains few incentives to improve safety. If the Law Commission's proposed single rate contribution by employers is accepted, incentives will be reduced still further.

A final point to emphasise is that medical accidents are only one small element in the scheme. While there has been considerable debate in New Zealand about the handling of sports injuries and workplace accidents, much less attention has been paid to the effectiveness of the scheme in compensating victims of medical accidents. Several informants have emphasised that the scheme is less easily mobilised to compensate the victims of medical accidents than other accident victims.

Sweden

The Swedish scheme of no-fault compensation for medical accidents came into operation in 1975. A second scheme to provide compensation for injuries resulting from drugs was introduced in 1978. The arrangements for medical accidents go under the name of the Patient Insurance Scheme. The scheme is organised on a voluntary basis by the county councils, the bodies responsible for providing health services in Sweden. The county councils currently pay a sum equivalent to 70 pence per inhabitant each year into the scheme. Claims and payments are handled by a consortium of private insurance companies. Those suffering injury as a result of negligence may still sue under tort law but few do so.

Like the New Zealand system, the Swedish scheme provides compensation for loss of earnings, loss or impairment of a bodily function, pain and suffering and medical costs. Eighty four per cent of the budget is spent on compensation and 16 per cent on administration. Unlike New Zealand, the bulk of payments for compensation are for non-economic losses such as pain and suffering; about 70 per cent of the compensation paid out is for this purpose, with 14 per cent allocated for loss of earnings and 13 per cent for medical costs. The level of payments is intended to match what would have been paid under tort law. The average cost of an accepted claim in 1987 was around £3,200 (Oldertz, personal communication).

In interpreting these figures, it is important to bear in mind the generous social security arrangements that exist in Sweden. The benefits available through social security are taken into account when compensation is awarded through the Patient Insurance Scheme, as is the existence of a health service largely free at the point of use. The scheme is therefore a means by which those suffering injury and

loss as a result of medical accidents can supplement the benefits to which they are entitled through social security. Its awards are more closely comparable to the 'pain and suffering' component of tort damages than to the overall sums recovered by successful plaintiffs.

As in New Zealand, not all injuries are included within the scheme. The basic principle underlying eligibility is that there should be a direct link between an injury and medical intervention. This is intended to exclude those injuries which are self-inflicted or which would have occurred as part of the natural progression of an illness. Also included are injuries which could not have been avoided even if the doctors had been fully aware of the nature of a patient's condition. Five categories of injuries are included in the scheme:

Treatment Injuries
These are injuries resulting from medical interventions which could have been avoided if the treatment had been applied another way.

Diagnostic Injuries
These are injuries which result from investigations such as angiography of the brain where damage may be caused by the investigation. Compensation is paid both if injury could have been avoided and if injury was unavoidable but the original condition of the patient was not serious.

Incorrect diagnosis
Compensation is paid if a doctor fails to use a reasonable level of skill, defined as that expected of a specialist, and as a result makes an incorrect diagnosis. Compensation is also paid if diagnostic equipment is faulty.

Accidental Injuries
These injuries include unexpected incidents such as a patient falling out of bed or slipping on a hospital floor. The accident must be related to the care received and excludes incidents which could have occurred in the patient's home.

Infection Injuries
These are injuries which result from infections which occur during care. Compensation is not paid if infection is an expected and unavoidable part of the illness. Where it is difficult to establish the real reason for an infection, compensation is normally paid.

As these categories make clear, included within the scheme are acts of omission, such as the failure to make a correct diagnosis, as well as acts of commission.

There are a number of exclusions in the scheme. One of the most important is complications which are considered to be unavoidable. Also excluded are injuries which follow from life-sustaining and emergency treatment. To simplify administration and to reduce costs, minor injuries are excluded. To be eligible for compensation, a person must have been ill for more than 30 days, or have been in hospital for more than 10 days, or suffered permanent disability or died. Compensation is not paid for psychological injury which does not have an organic base. Injuries caused by cosmetic surgery may be included, although in some cases the risks of infection are considerable and in such cases injuries are not compensated.

The total number of injuries registered with the scheme by the end of 1987 was 48,167 (Oldertz, 1987). Currently, the scheme receives around 5,000 reports regarding the county councils each year. Approximately 50 per cent of claims are accepted for compensation (Oldertz, personal communication). Claimants dissatisfied with the decision of the insurance consortium can appeal, and if still dissatisfied they can take their claim to arbitration. The number of claims received compares with an annual rate of 10 legal claims before the introduction of the scheme, indicating the much greater coverage achieved under the no-fault arrangements.

It should be emphasised that the aim of the scheme is to provide compensation. Separate arrangements exist for handling complaints against doctors and for pursuing disciplinary matters. These centre on the Medical Responsibility Board, a government agency that receives complaints and reviews cases concerning doctors and other health service personnel. The Board is made up mainly of lay people and concentrates on cases involving clinical judgement.

As Rosenthal (1987) has noted, Sweden has a greater degree of lay involvement in the handling of complaints than the United Kingdom and places greater emphasis on the need to hold doctors to account. Nevertheless, as she also emphasises, the need for technical judgements on matters of clinical competence inevitably still gives the medical member of the Board a significant influence on the outcome. Although the Medical Responsibility Board dismisses most of the complaints it receives, far more complaints are sent to the Board in relation to the size of the population and the number of doctors in practice than to its UK equivalent, the GMC. The Board also accepts a higher proportion of cases for investigation than the GMC. In contrast, the Board appears less willing than the GMC to impose the most severe sanction, striking a doctor off the register or recalling his certificate to practice.

One other point to note about Sweden is that both the Patient Insurance Scheme and the Medical Responsibility Board feed back information on cases they receive to the medical profession in order to educate doctors about risks and to assist the promotion of high standards of care.

In summary, the Patient Insurance Scheme has many of the same benefits as the New Zealand no-fault arrangements. These include speed, simplicity, low administrative costs, the elimination of legal costs, and removal of the adversarial features of the tort system. The scheme also removes the need to establish negligence. As a voluntary arrangement, the scheme has been able to evolve in the light of experience and has been modified to take account of changing needs. Furthermore, it has not encountered the same financial difficulties as the New Zealand scheme. Three factors which have contributed to this are:

- the more limited focus of the Swedish scheme, with its emphasis on medical accidents rather than all accidents
- the existence of a comprehensive social security system in Sweden, casting the Patient Insurance

Scheme in the role of a supplementary source of finance, and

- the more rigorous exclusion of minor injuries in Sweden.

A further difference between the two countries is the stronger arrangements that exist in Sweden for holding doctors to account, investigating complaints, and promoting high standards of practice.

6 OPTIONS FOR REFORM

We began this Paper by noting that existing arrangements for dealing with medical negligence have come under increasing critical scrutiny. Our analysis of the evidence has shown that in recent years there has been a marked increase in the number of legal claims against doctors and in the size of awards made in court cases. As a consequence, the subscriptions paid by doctors to the defence societies have risen significantly, and health authorities have expressed concern at the impact of increasing awards on cash limited budgets.

Despite these developments, the evidence we have reviewed indicates that the UK is not experiencing a malpractice crisis. As we noted in chapter 2, claim rates in the UK are much lower than in the US. Furthermore, as we argued in chapter 4, differences between the two countries in legal, health care and social insurance systems mean that it is highly unlikely that levels of litigation in the UK will reach those of the US. For these reasons, some of the criticisms levelled against existing arrangements for dealing with medical negligence need to be interpreted cautiously.

Nevertheless, our analysis has demonstrated that tort law is deficient in a number of respects. In relation to the two main objectives of the law — compensating people injured as a result of negligence, and deterring doctors from acting negligently — the following shortcomings have been identified:

- the procedures involved in pursuing a claim for damages are lengthy and expensive for patients, doctors and health authorities
- only a small proportion of people suffering medically-related injuries obtain compensation
- the emphasis on establishing fault and cause and effect turns the tort system into a lottery: similar cases of injury giving rise to similar needs are compensated totally differently according to the circumstances surrounding their cause and the completeness of the evidence
- those making a claim may find it difficult to obtain the services of a solicitor with relevant expertise and of doctors willing to act as expert witnesses
- the legal process is adversarial and causes those involved to close ranks. Consequently, patients and their relatives are often not given adequate explanations or apologies when things do go wrong and doctors may be distressed by the apparent hostility and ingratitude of their patients
- the deterrent effect of the law is weakened by the availability of insurance coverage.

We have also emphasised the weaknesses of other arrangements for maintaining high standards of medical practice. These include the variable interest shown by doctors in medical audit and peer review, and the limitations of complaints and disciplinary procedures as mechanisms for ensuring professional accountability. Our analysis has demonstrated that the tort system is one element in a package of measures by which the medical profession is held accountable to the public. Any proposals for reform must consider the law's role in ensuring accountability and promoting high standards while recognising its shortcomings as a means of providing compensation.

Against this background, we now consider the range of policy instruments which are, in theory, available to those contemplating reform. Some of these instruments are concerned primarily to deter negligence, while others aim to provide compensation. The instruments may be used singly or in combination. We begin by outlining options for deterring doctors from acting negligently, and then consider methods of providing compensation. In the first part of the chapter, the menu of options is described briefly, and this is followed by more detailed analysis of those options which in our view merit most serious discussion.

Deterrence

There are three main options for deterring doctors from acting negligently. These are legal liability, regulation backed by statute and self-regulation.

Legal Liability

Legal liability for medical accidents can take a number of forms. Doctors can be held strictly liable for all the adverse consequences resulting from medical treatment, or only for the adverse consequences resulting from their negligence. Those held liable can be either individual practitioners or groups of individuals acting collectively. Figure 7 sets out the possibilities.

Figure 7 · Deterrence through liability rules

What is the basis of liability?	Who is liable? Individual doctor	Who is liable? Doctors as a group
Cause	**STRICT LIABILITY**	**NO-FAULT LIABILITY**
Fault	**NEGLIGENCE LIABILITY**	**VICARIOUS LIABILITY**

Strict liability exists when individual doctors are held responsible to patients for all the adverse outcomes of medical treatment. *No-fault liability* imposes liability on doctors as a group. The group might be the whole profession or only those doctors involved in the treatment which gave rise to the adverse outcome. *Negligence liability* is the current rule. Under this rule, only those doctors whose standard of care is deemed inadequate by the courts are held liable for the adverse consequences of their actions. The NHS already assumes *vicarious liability* for most of its employees. Under this liability rule the fault of an individual employee renders the employer

liable for the adverse consequences resulting from the employee's actions.

All these possibilities can in theory create appropriate incentives for doctors to avoid injuring patients, although in practice the incentives may not operate effectively. Moreover, it is, in principle, possible for patients to contract with individual doctors, hospitals or health authorities in order to agree on a different set of incentives to take care, although again the practical problems of this option may be considerable.

One other possibility should be mentioned, namely that there should be *no liability*. This would shift the entire responsibility to the patient to take his or her own measures to ensure the safety of the care received.

Regulation backed by statute

A second approach to deterrence is to give a regulatory body the power to monitor the adverse consequences of medical intervention. Such a body would receive reports of medical accidents, which would be required by law, and would determine appropriate action to be taken. This would include the power to levy a fine or injury tax. A body of this kind might develop out of the General Medical Council and would combine its regulatory role with oversight of registration and medical education. If this option were to be pursued, there would be a need to ensure that the regulatory body were genuinely independent and accountable to Parliament. This approach relies on a structure of incentives similar to those generated by the various liability rule options discussed above. Figure 8 illustrates the possibilities.

Figure 8 · Deterrence through regulation

What is the basis of the regulation?	Who is regulated? Individual doctor	Who is regulated? Doctors as a group
Cause	**INJURY TAX ON INDIVIDUAL**	**INJURY TAX ON GROUP**
Fault	**DISCIPLINARY PROCEDURES**	**REGULATION OF PROFESSIONAL STANDARDS**

The first option identified in Figure 8 is the payment of an *injury tax by individual doctors*. This would not imply any direct payment by a doctor to a patient. Patients could seek compensation elsewhere, but each doctor would be subject to a regular audit and the payment of a levy corresponding to the estimated social costs of adverse outcomes from his or her interventions.

An alternative would be for the *injury tax to be levied on groups of doctors* or the profession as a whole. Estimates of harm could be based on sampling and aggregate analysis of injuries. A third option is to deter negligence through *disciplinary procedures*, as happens at present. This requires an agreed procedure for investigating complaints and imposing penalties on individual doctors. Penalties might be either professional or financial but need not be linked to the losses of individual patients.

Finally, the option of *group regulation* might be considered. Rather than having an independent regulatory agency involved with the review of individual doctors, the profession as a whole might be set specific standards of safety and effectiveness and left to develop its own systems of control. The effective santion here is the risk of losing the privileges of the occupation's protected position in the delivery of health care. The incentive is the concern of colleagues to protect the profession's reputation and maintain public confidence.

Self Regulation

A third approach to deterrence avoids using either the civil or criminal law to impose financial incentives on doctors and instead relies on market-based incentives. Even where no-one is held liable, there may be powerful incentives in a market situation for providers to maintain standards, simply as a way of ensuring commercial viability. In the NHS the incentives operate differently, relying more on the concern of the professions and health authorities to protect and improve their reputations. This is again an important element of the present system, although it does not always operate effectively.

Compensation

There are three main options for compensating those injured in medical accidents. These are liability insurance, first-party insurance and social security.

Liability Insurance

Any system of legal liability could provide compensation for patients selected by the liability rules as long as those held responsible have the means to pay the damanges awarded. Effectively this implies that arrangements must exist for the pooling of liabilities through insurance. Of course, under a system of group liability, it is possible that some groups will be large enough to bear their own liability losses without insuring. For smaller groups and individuals, third-party liability insurance is a necessary adjunct to civil liability if the latter is to be an effective means of providing compensation.

First-Party Insurance

If doctors are not held legally responsible for the adverse consequences resulting from medical treatment, either because it is held that no-one should be liable, or because only those accidents caused by negligence are compensated, then the burden of loss arising outside the liability system falls directly on the injured patients. Those at risk may therefore choose to insure against the prospective losses, either directly, by means of an income replacement or medical expenses policy with an insurance company, or

indirectly, by means of a negotiated sick pay scheme through which employers meet such losses up to a maximum as part of a wages and conditions package. The payments under such schemes are made without necessary reference to the fault or causation of any other party.

Social Security

Each of the above insurance options for spreading losses could be made compulsory by a government which was concerned about the possibility of uncompensated losses. Alternatively, government could itself provide social insurance financed out of employee contributions, general taxation, and/or specific levies on goods and services. Entitlement to benefits under such a scheme could be based on the fact of a disability, and not on its cause. In addition, injured patients may be treated and cared for through the further provision of public health care and social services. Effectively, this would be a system of compensation in kind.

Whatever form of compensation is provided, there always remains, in principle, the opportunity for individuals or groups of individuals to contract with each other in order to arrive at an alternative arrangement. For example, patients could agree to waive their rights to compensation through the courts in return for lower cost treatment. Equally, individuals covered by a social insurance fund may be permitted to contract-out in order to obtain preferable cover under a private insurance policy. In practice, however, people may be barred from restricting their coverage beyond a certain point or from completely opting out of compulsory contributions to a common insurance pool because of possible adverse selection problems.

The Agenda for Reform

Given the range of options available, it is possible to pursue the objectives of compensation and deterrence separately. As an illustration, doctors could be deterred from acting negligently through regulation by an independent agency with the power to levy an injury tax, while compensation could be provided by first-party or social insurance. However, separating the objectives in this way may be inefficient, in that it undervalues the role of the patient in providing information about negligence. This option may also deprive the patient of the satisfaction of securing an improvement in the circumstances which led to his or her injury and it reduces the opportunities available to victims to obtain psychological redress. Although the effectiveness of the tort system in serving these purposes should not be exaggerated, this element of the system may well be significant in some cases in helping to resolve events through the public attribution or exoneration of responsibility for harm.

The medical litigation system in the UK combines negligence liability and disciplinary procedures initiated by complaints with third-party liability insurance for doctors and self-insurance for health authorities. This system gives the individual patient a key role in the process of deterring negligence and obtaining compensation. However, as we have emphasised, the system has a number of shortcomings.

Many of the other options we have identified also have shortcomings. To give some examples, an injury tax levied on individual doctors would be cumbersome and costly to administer; disciplinary procedures may be ineffective as a form of deterrence if they are invoked only in the most serious cases; and self-regulation depends for its effectiveness on a strong commitment by health authorities and doctors to promote high standards through medical audit and quality assurance programmes. This commitment may not always be present.

Market-oriented solutions such as no liability and voluntary first-party insurance place an unreasonable burden on the patient in terms of assessing the quality of the services available. In extreme cases, the patient may be dead before the inadequacy of the care becomes apparent. This may deter others, but is little consolation to the victim. The marked imbalance in information between patients and doctors is thus a major weakness of market-oriented options.

What then are the policy options which deserve serious consideration in reviewing how the shortcomings of existing arrangements might be overcome? In our view three options merit further analysis. These are:

- the modification of the tort law system and the strengthening of professional accountability
- the introduction of a no-fault compensation scheme, and
- the abandonment of the tort system in favour of providing compensation through social security.

We have selected these options for analysis as they represent different points on the agenda of change facing policy makers. Modifying the existing system and strengthening professional accountability involve incremental reforms, many of which could be introduced at little or no cost. There are obvious attractions in this option to a government committed to tight control of public expenditure. Furthermore, in view of the government's stated position that the case for major reform remains not proven, it may be through a series of minor changes that the best prospects for improvement lie.

No-fault compensation, as we have noted, is an option favoured by a number of organisations active in the field of medical negligence, including the BMA and ACHCEW. There is also relevant overseas experience on which to draw and from which to learn (see chapter 5). If there should be a further increase in the number of legal claims against doctors and in the size of court awards, the feasibility of this option may come under closer scrutiny. There is therefore merit in assessing the costs of introducing such a scheme in the UK and the measures that would need to be taken to strengthen professional accountability in the context of no-fault compensation.

Abolishing the tort system in favour of providing compensation through social security — our third option — is a fundamental change which is best viewed as a long-term possibility. Nevertheless, it is an option that deserves analysis, if only to highlight the important part played by social security in supporting

those suffering injuries. The issue of income support for disabled people is a major area of analysis in its own right, and in this chapter we are able only to illustrate its potential role in the case of medical negligence.

Changing the Existing System

Changes to the existing system fall into three categories. These are increasing access to the courts, transferring negligence liability from individual doctors to health authorities while at the same time strengthening the accountability of doctors, and introducing differential insurance premiums for doctors. We now consider each in turn.

Increasing access to the courts

One set of reforms would seek to increase access to the legal system so that patients could more easily obtain compensation and more cases would result. Specific proposals have recently been put forward by the Citizens Action Compensation Campaign and by the report of the Review Body on Civil Justice to the Lord Chancellor. Both express sympathy for the development of contingency fees in Britain and the Civil Justice Review also discusses at length methods by which legal proceedings could be accelerated.

Our view is that contingency fees and the acceleration of legal proceedings are of limited relevance to medical negligence cases. While it is understandable that both litigants and legal personnel are frustrated by delay in establishing liability and determining compensation, its causes are poorly understood. The pace of litigation towards trial or settlement is determined largely by the plaintiff's solicitor. It may be slowed down in order to establish exactly how serious someone's injuries are so as to calculate what would be an appropriate level of compensation. It may be necessary to wait until a victim can be examined by one of the relatively small number of doctors who are skilled in the preparation of expert evidence for civil cases. If the findings are uncertain or the clinical evaluation is contentious, further time may elapse before other specialists can accommodate the patient. Once a case is prepared, a solicitor may wish to have it presented by a specialist barrister who is fully aware of the complexities of the area. In short, there may be good reasons for delay.

Contingency fees have attracted attention as a possible private alternative to legal aid. In fact, their main virtue is that they substitute the judgement of individual solicitors for the monopoly of the local legal aid committee. The American evidence shows that contingency fees are far from representing a poor person's route to justice. Lawyers will not take on cases unless the certainty of winning and the likely profit are sufficient to justify the risk. Thus, they will take relatively low-value cases arising from road traffic accidents, which are cheap to run and have a highly predictable outcome: they are reluctant to take low-value cases in other areas, including medical malpractice, because the return is insufficient to cover their costs. Moreover, medical malpractice is seen as a particularly risky area, because of the intrinsic uncertainty of causation, so that the lawyer has a strong incentive to reject all but those cases on which his own medical advisers give him strong support. The comparative irrelevance of contingency fees in the British context can be seen from the limited use of speculative actions in Scotland. These are not pure contingency, in that lawyers are only allowed to charge on the basis of the work they have done rather than taking a percentage of the eventual recovery, but they are conditional on the outcome of the case.

A more important consideration is that cases should be handled by solicitors skilled in medical negligence work. Plaintiffs are particularly vulnerable because medical litigation is classically conducted by local law firms with limited knowledge and experience in complex personal injury work. They are opposed by a small group of highly specialised firms with great experience of representing defendants. The real requirement is for a means of identifying and certifying solicitors who are competent to handle such cases on behalf of plaintiffs. AVMA and a number of community health councils have developed panels of solicitors to whom they steer cases and whose effectiveness they attempt to monitor. AVMA has devoted particular effort to the development of a monitoring system in an attempt to improve the effectiveness of their panel members. It would be open to the Law Society to build on these initiatives , as they have done with practitioners in child care and mental health law.

If this change were to be fully effective, it would have to be accompanied by a number of other modifications to the present system. One would be greater publicity for legal services in general, either by encouraging solicitors' own marketing of their services or through the development of schemes like the Law Society's Accident Legal Advice Service (ALAS) initiative which has tried to heighten public awareness of the possibility of claiming for damages. These initiatives might be accompanied by a liberalisation of the rules governing the advertising of legal services to enable members of the public to identify more easily solicitors accredited in medical negligence work and to be better informed about the benefits of approaching a specialist.

It would also be desirable to modify the present rules on fee-splitting, so that generalist, High Street firms had a greater incentive to pass complex cases on to practices with a more appropriate level of skills in return for an introduction fee or a proportion of the eventual profit on a successful case. Some attention would have to be given too to the access barriers represented by the current means testing on civil legal aid. At present, the rewards are too low to encourage specialist firms to develop medical negligence work and the eligibility levels are so restricted as to prevent a considerable section of the population from obtaining redress.

If access to legal aid were made easier, an increase in the rate at which claims are made and pursued would be likely to occur. This might accentuate some of the problems of predicting the financial burden for health authorities. One way of responding would be to pool the risks on a national or regional basis, creating

in effect an internal insurance scheme as already happens in some places.

Transferring liability to health authorities and strengthening accountability

A second possible change to the existing system would be to transfer negligence liability from individual doctors to health authorities and family practitioner committees. This would put doctors on the same basis as most other NHS staff, with their employer assuming vicarious liability. Such a change would certainly imply a more active role for health authorities and family practitioner committees in promoting high standards of clinical practice and reducing mistakes. As we emphasised in chapter 3, interest in medical audit in the NHS has been uneven, and there are grounds for arguing that a more systematic and rigorous approach is needed.

Health authorities could give a lead by requiring doctors at the appropriate level (firm, department, group practice) to demonstrate that they routinely review the quality of their work. The recent report of the Confidential Enquiry into Perioperative Deaths (Buck *et al*, 1987) recommended that clinicians should assess themselves regularly and that surgeons and anaesthetists should actively audit their results. This recommendation applies with equal force to other branches of medicine.

There is increasing evidence that doctors themselves recognise the importance of audit, both as a form of continuing education and as a means of avoiding mistakes. Thus, several of the royal colleges have taken the initiative recently to encourage doctors systematically to assess their work and to discuss their results with colleagues. Equally, at the local level, a number of enthusiastic individuals have demonstrated what can be achieved when doctors set aside time to gather information about their practice and analyse differences in approach. It should be possible to build on this experience in the future to ensure that audit develops with the support of the profession.

There may also be lessons to learn from developments in the United States in risk management, in particular in encouraging reports of adverse events. Drug reactions, for example, are already monitored by the Yellow Card scheme. Hospitals might introduce similar arrangements for the reporting of surgical or other incidents on a confidential basis, rather in the same way as airline pilots are encouraged to report near misses. One incentive for this might be to impose a collective responsibility on the medical and nursing team for the care of a patient.

Modern health care depends so much on the contribution of a number of specialists in different aspects of any particular case that it is questionable whether the concept of individual liability remains entirely appropriate. If one person makes a mistake which others ignore or cover up, then, at least morally, they would seem to be just as responsible for the adverse outcome. An example might be of a surgeon who commits an error during a common procedure. It is argued by risk managers in the United States that anaesthetists and the theatre nurses should feel an obligation to challenge the surgeon as he makes the mistake and to record their dissent if he persists. If they do not, they should be equally vulnerable at law and to professional sanctions. The medical profession, however, see this as a recipe for clinical anarchy. Individual liability, it is claimed, is the proper corollary of clinical autonomy.

As well as strengthening arrangements for medical audit in these and other ways, changes could be made to both disciplinary procedures and complaints procedures to ensure that doctors are held accountable for their clinical competence. In the case of disciplinary procedures, the GMC currently investigates cases of serious professional misconduct but other cases do not fall within its remit. Furthermore, as we have noted, the GMC's procedures are professionally dominated. Proposals are currently under discussion designed to enable the Council to consider less serious examples of misconduct, and this would mean that a wider range of cases could be investigated. But more radical change, involving the setting up of procedures similar to those that exist in Sweden (see chapter 5), may be needed if the public is to be reassured that disciplinary procedures are adequate for their purpose.

At the local level, disciplinary procedures against hospital doctors concerning matters of professional competence are set out in circular HM(61)112 and involve an investigation by a panel under a legally qualified chairman. These procedures have been criticised as complex, expensive and lengthy, and their operation is under review by the DHSS and the medical profession. This review provides a timely opportunity for change to be introduced to ensure that adequate arrangements are in place for handling all cases where concern about professional conduct and competence arise, not just those involving the most serious consequences.

Turning to complaints procedures, we noted in chapter 3 that the existing complaints machinery is complex, fragmented and slow. A case can be made for improving this machinery independently of concern about medical negligence. A starting point would be to implement the proposals of the Davies Committee on hospital complaints. It is in this area that complaints procedures are most open to criticism, particularly as far as complaints about clinical judgement are concerned. If the Committee's proposals for independent investigating panels were implemented it would become easier for patients and their relatives to pursue complaints about clinical matters and to have confidence that these complaints would be thoroughly and rapidly investigated. This in turn might reduce the number of legal claims brought by patients seeking an explanation of what went wrong rather than financial compensation.

In the longer term, the aim should be to simplify the complaints procedures to establish one point of contact whatever the nature of the complaint (clinical or non-clinical; hospital, community health services or family practitioner services) and to guarantee that those hearing complaints are genuinely independent.

Differential premiums for doctors

A third way of reforming the existing system, and an alternative to the transfer of negligence liability to health authorities, would be to change the incentive structure facing doctors by introducing differential insurance premiums. As we noted in chapter 2, such risk-rating is common in professional liability insurance and is applied to doctors in the United States. Where professional services are privately provided, there may be some merit in this arrangement. Differential risks can be reflected in differential fees so that there is no direct impact on recruitment to specialties. Doctors can be left with comparable post-premium incomes, or at least, incomes which vary only sufficiently to adjust for the non-pecuniary penalties of a high risk of litigation. Both patients and doctors are given appropriate indications of the hazards associated with different areas of medicine and an incentive either to safe practice or careful selection of doctor.

In the NHS, however, doctors are paid on a uniform scale. Individual effort and initiative are rewarded to an extent by merit awards or list sizes but there are no systematic differences between specialties in terms of the basic income available from NHS practice. In the absence of any variation, it is hard to imagine that recruitment to high-risk specialties would remain unaffected by differential premiums. Moreover, for practitioners working full time for the NHS, the introduction of such premiums would involve little more than an accounting exercise as the government would bear the major share of the cost through its policy of reimbursing two-thirds of the cost of defence society subscriptions.

The one exception to this argument concerns those doctors combining NHS work with private practice. The potential awards to a victim of negligent private treatment are larger than for those to NHS patients because private patients would be able to obtain damages based on the assumption of future private care, whereas this might be disputable for NHS patients. It is debatable whether the NHS should in effect cross-subsidise private practice, although whether this happens in practice is difficult to estimate. In global terms, any subsidy is unlikely to be large, and is in any case roughly corrected by the recently announced arrangements which confine reimbursement of the major portion of defence society subscriptions to those doctors working exclusively for the NHS. It is also possible that the risks of private practice are less because of the different case-mix in that sector. Nevertheless, it remains possible that the public payments may be slightly larger than they would be if private medical practice formed a separate pool for insurance purposes.

Moving to No-Fault

The term no-fault compensation refers, strictly, to all schemes which abandon the rule that an injured patient has to show that someone was negligent in order to obtain redress. However, there is an important distinction between those schemes which still require patients to identify an individual responsible for their condition and those which do not. The former, of which Sweden and New Zealand are examples, share with the negligence system the advantage of being able to make constructive use of the desire of injured patients to obtain redress. Adverse outcomes can be attributed to individual doctors and, at least potentially, used as a basis for promoting high standards. Those schemes which sever the link between victims and the agents of their injuries must find alternative ways of achieving this objective.

The extent to which this is a serious problem depends on the ability of individual doctors to avoid accidents. If it is believed that accidents are better understood as a result of organisational failures, rather than personal mistakes, then the attribution of responsibility to individuals is unnecessary. All that is needed is sufficient information to demonstrate that the patient's injury arose from medical treatment together with a means of referring that information to the appropriate manager or health authorities. Information on claims for compensation might be fed back to those responsible for service delivery at the local level and be used in national reviews to alert all care providers to common problems.

Whether a no-fault scheme is based on proof of individualised causation or not, there is likely to be a need for some form of risk-spreading. Health authorities are large enough to self-insure, although the unpredictable impact of awards at a time of scarce resources suggest that this may not be the most efficient means of managing their budgets. There may therefore be a case for pooling risks on a regional or national basis, as happens in Sweden. If causation is placed on an individual basis, then doctors would need to continue to obtain some form of insurance and this could be provided by a consortium of the defence societies.

The potential cost of a no-fault scheme varies greatly according to the assumptions that are made about the rate of claiming and the size of awards. At present, there are roughly ten claims relating to hospital treatment per 100,000 population in England each year. Approximately three of these claims are compensated and the average award is around £15,000. The total cost of the system, including both damages payments and legal expenses, is estimated to be £75 million, of which £65 million is attributed to the NHS, either directly or through the cost of subscriptions to the defence societies out of NHS employees' income.

The Swedish scheme generates about 60 claims per 100,000 population from all health care contacts, although, in practice, almost all of these seem to relate to hospital treatment. Fifty per cent of these claims receive compensation, averaging £3,200 at current exchange rates. If we assume that a Swedish style system were introduced in the UK, at the same rates of claiming and payment, the estimated cost for England alone would be of the order of £50 million per year (see Table 8). This would appear to represent a substantial saving.

However, given the more limited nature of the

Table 8 · Estimated costs of a no-fault compensation scheme

A. CURRENT SYSTEM (ENGLAND 1988)	£ mill
Estimated health authority costs:	15
Assumptions: claim rate = 10 per 100,000 population abandonment rate = 70% average settlement = £15,000 administrative costs = 30% defence society contribution = 50%	
Estimated defence society costs*:	60
Assumptions: income generated from doctors practising in England based on a) subscription rates for 1988 as in MPS/MDU annual reports b) breakdown of medical manpower in England as published by DHSS.	
Total	75

B. SWEDISH STYLE NO-FAULT SYSTEM	£ mill
Estimated cost if Swedish system replicated	50
Assumptions: claim rate = 60 per 100,000 population abandonment rate = 50% average settlement = £3,200 administrative costs = 15%	
Estimated cost with average settlement £15,000	235
Estimated cost with average settlement £7,500	117

** This includes a sum for legal and administrative costs other than those related to negligence cases.*

British social security system compared with Sweden, it would also represent a substantial degree of under compensation. As we noted earlier, the Swedish scheme is designed to top-up other payments in recognition of the pain and suffering involved, and is not the sole source of income replacement or service purchase. If a similarly accessible scheme were introduced in England, the lower barriers to access might allow the rate of claims to rise to Swedish levels. If these claims were compensated at current English rates, the overall cost would rise to £235 million per year. On the other hand, one might expect that the average payment per claim would fall, since an increase in the number of claimants is likely to be associated with a reduction in the average severity of claims. In this case, £235 million should be treated as an upper limit. If the average payment per claim were halved, the cost would be around £117 million per year. While this is certainly well above the present cost of tort litigation, it might be thought that the price were justifiable if the shortcomings of the tort system we have identified were overcome.

For this to happen, it would be important to learn from the experience of New Zealand and Sweden. In particular, careful consideration would need to be given to:

- the definition of accidents to be included in the scheme
- the procedures to be used to prevent accidents, to monitor standards of care, and to encourage rehabilitation
- the importance of ensuring equity in the treatment of accident victims and the sick and disabled
- the means by which doctors would be held accountable and patients would receive an explanation of why an accident happened.

In relation to the last of these points, our proposals for reforming the existing system by extending medical audit and strengthening complaints and disciplinary procedures (see above) would have equal relevance under a no-fault scheme.

The issue of equity of treatment for accident victims and the sick and disabled is more complex. As recent developments in New Zealand have demonstrated, the establishment of special schemes for accident compensation can create distinctions which are difficult to defend. It is for this reason that proposals are now under discussion to reduce the benefits available to accident victims in New Zealand. One of the aims of these proposals is to enable the sick and disabled to be eligible for the same benefits as people injured during accidents. In Sweden, this issue is handled through the social security system which provides a generous level of benefits on the basis of need, with accident compensation supplementing these benefits. This suggests that a further radical option for reform is to introduce a general disability income. We now consider this in more detail.

A General Disability Income

The replacement of tort by social security is both radical and potentially expensive. As such, it is probably best viewed as a long term possibility. The advantage of a general disability income is that individuals would receive support on the basis of the fact of their injury and its consequences, and would have to establish neither fault nor cause. The payment of benefits periodically rather than as a lump-sum would also remove much of the present uncertainty about whether a sum of money would be adequate to meet future expenses, and would also permit a continuing review of the victim's circumstances.

The principal advantages of social security as a means of providing compensation lie in its relative accessibility and simplicity. As a result, a large number of beneficiaries can be compensated at a low level of administrative expense. However, these advantages are the product of a generalized, rule-based approach to deciding the appropriate amount of compensation. Benefits may be payable in relation to a schedule of impairments, and/or proof of incapacity for work, without any specific tailoring of payments to the individual's circumstances, as happens under tort law.

The generosity of the social security system is constrained by the extent to which the payment of benefits affects the recipients' recovery, and, where relevant, their return to work. This is a particular concern when disability benefits are payable to those who are permanently, but partially, disabled, and who therefore retain some capacity to work. Designing a set of rules governing the determination of benefits without penalising the decision to return to work for this group of claimants is a task of considerable difficulty (Fenn and Harris, 1987; Berkowitz and Burton, 1987).

Two possible solutions are to make awards conditional upon the severity of impairment alone, or to make the assessments irreversible or lump-sum. Either way, this would ensure that subsequent decisions to return to work would not result in a withdrawal of benefit. However, this kind of solution would exaggerate still further the inequities between different types of claimants noted above. The New Zealand approach to this problem has been to limit income replacement to 80 per cent of previous earnings, and to give the Accident Compensation Corporation additional responsibilities for rehabilitation. It is difficult to ascertain the extent to which this has been successful (Ison, 1980). Clearly, the adoption of a general disability income scheme would not avoid difficult choices between equity and efficiency of the kind which bedevil the tort system.

Moreover, if this option were pursued, a considerable weight would be thrown on the adequacy of other arrangements for monitoring medical standards. Again, this brings into play our proposals earlier in the chapter for extending medical audit, and strengthening complaints and disciplinary procedures. As the New Zealand experience has demonstrated, agreement must be reached on how to deter malpractice before radical changes are introduced.

Conclusion

Faced with these options, how should policy makers proceed? In our view there is a good case for reform, because of the considerable shortcomings of the existing arrangements. On the other hand, it is hard to argue strongly for any particular policy option on the basis of present information. Nevertheless, we can broadly summarise the policy choices in relation to both compensation and deterrence.

It is far from clear that the possibilities have been exhausted for improving the tort system as a means of obtaining compensation. As we noted earlier in the chapter, there are a number of ways in which the system could be changed. In summary, the key measures worth pursuing are:

- providing potential claimants with a means of identifying solicitors with appropriate skills in medical negligence cases
- giving greater publicity to legal services through advertising and other means in order to increase public awareness of the general possibilities of claiming for damages
- modifying fee-splitting arrangements among lawyers to create greater incentives for solicitors to pass on cases to specialists
- making access to legal aid easier, and
- developing a system to enable health authorities to pool their risks in order to cope with a larger number of successful claims.

While these changes would overcome some of the weaknesses of the present system, there would still be a basic inequality between defendants, represented by a small group of experienced and specialised lawyers, and plaintiffs, represented by a dispersed, heterogeneous group of lawyers with infrequent involvement in medical negligence cases. It would also remain difficult to prove fault given the intrinsic uncertainties of human biology and medical technology. In the longer term, then, the inadequacies of the tort system as a method of compensation seem likely to encourage its replacement by a more equitable alternative. If a general disability income is ruled out on grounds of expense, serious consideration could be given to the development of a no-fault scheme.

A no-fault scheme would overcome many of the shortcomings we have identified in the present system: the expense and time involved in pursuing a tort claim; the strong element of lottery; the small proportion of injured patients who receive compensation; and the adversarial nature of the legal process. But, as we have seen, neither the Swedish nor the New Zealand schemes offers a model which could be imported directly into the United Kingdom. Each has developed under a particular set of institutional conditions which are not reproduced here. Both also illustrate some of the inherent problems of no-fault schemes, such as the question of equity between people disabled as a result of different sorts of mishap and the means by which claims can be mobilized and screened.

The New Zealand experience also demonstrates the greatest weakness of no-fault schemes, namely the reduction in whatever deterrent effect the tort system may exert. The tort system has the unique feature of presenting the victim of negligence with a financial incentive to pursue a claim against the person believed to be responsible. But, given the difficulties of pursuing claims and the intervening effect of insurance, this is inadequate by itself as a method of preventing accidents.

For this reason, consideration needs to be given to a range of other policy options designed to encourage high quality medical care. In the short term, the most promising options worth pursuing are those which aim to strengthen professional accountability. As we have

emphasised throughout this Paper, regardless of whether or not a system of no-fault compensation is introduced, a strong case can be made for improving complaints procedures, reforming the procedures used to discipline doctors, and encouraging the extension of medical audit. To summarise the discussion earlier in this chapter, this would involve:

- developing arrangements for medical audit by requiring doctors to demonstrate that they routinely review the quality of their work and by introducing procedures for the reporting of surgical and other incidents on a confidential basis
- extending and simplifying disciplinary procedures against doctors. This applies both to the GMC's procedures and to the procedures followed by health authorities. The aim should be to ensure that adequate arrangements are in place for handling all cases where concern about professional conduct and competence arise, not just those involving the most serious consequences
- implementing the recommendations of the Davies Committee on hospital complaints in order to establish independent investigating panels to examine complaints about clinical matters.

At the same time, careful consideration should be given to two further changes for implementation in the longer term. These are:

- the introduction of procedures for disciplining doctors based on Sweden's Medical Responsibility Board and involving significant lay participation, and
- the reform of complaints procedures to establish one point of contact whatever the nature of the complaint and to guarantee that those hearing complaints are genuinely independent.

If implemented, these measures would help to deter doctors from acting negligently and would assist patients and their relatives to obtain an adequate explanation when things go wrong.

In conclusion, further research would help to clarify the policy choices we have mapped, but even more important is a political commitment to consider carefully ways in which improvements can be brought about to the benefit of all those involved with medical negligence. Above all, what is now required is an informed debate of the issues and the options, a debate which recognises the need both to provide compensation and to promote deterrence.

REFERENCES

Accident Compensation Corporation (not dated), *Unintentional Injury*, Wellington.

ACHCEW (1987), *When Things Go Wrong in the NHS: Compensation and Investigation*, Unpublished paper.

American College of Obstetrics and Gynecology (1985), *Professional Liability Insurance and Its Effects: Report of a Survey of ACOG's Membership*, ACOG, Washington DC.

American Medical Association (1984), *Professional Liability in the 1980s Special Task Force on Professional Liability*, AMA, Chicago.

M. Berkowitz and J.F. Burton (1987), *Permanent Disability Benefits in Workers' Compensation*, W.E. Upjohn Institute, Kalamazoo.

British Medical Association (1987), *No-Fault Compensation Working Party Report*, London.

N. Buck, H.B. Devlin and J.N. Lunn (1987) *The Report of a Confidential Enquiry into Perioperative Deaths*, The Nuffield Provincial Hospitals Trust and the King's Fund, London.

Davies Committee (1973), *Report of the Committee on Hospital Complaints Procedure*, HMSO, London.

D. Carson (1982), 'The risk headache', *Health and Social Service Journal* XCII, 4822, 1346-49.

Department of Health and Social Security (1984), *The Health Service in England Annual Report 1984* HMSO, London.

Department of Health and Social Security (1986), *The Health Service in England Annual Report 1985-1986* HMSO, London.

P. Danzon (1985), *Medical Malpractice* Harvard University Press, Cambridge.

P.T. Fenn and D.R. Harris (1987), 'Disability in the UK: Incidence, Social Security Benefits and Labour Market Effects', in H. Emanuel (ed.), *Disability Benefits: Factors Determining Application and Awards*, JAI Press, Greenwich.

D. Harris *et al.* (1984), *Compensation and Support for Illness and Injury*, Clarendon Press, Oxford.

I.M. Harvey and C.J. Roberts (1987), 'Clinical Guidelines, Medical Litigation, and the Current Medical Defence System' *The Lancet*, 1, 3525, 145-147.

Health Service Commissioner (1988), *Selected Investigations Completed November 1987-March 1988*, Fourth Report for Session 1987-88, HC 511, HMSO, London.

C. Hawkins and I. Paterson (1987), 'Medicolegal audit in the West Midlands region: analysis of 100 cases' *British Medical Journal*, 295, 1533-36.

R. Hoffenberg (1987), *Clinical Freedom*, The Nuffield Provincial Hospitals Trust, London.

T.G. Ison (1980), *Accident Compensation*, Croom Helm, London.

I. Kennedy (1983), *The Unmasking of Medicine*, Granada, London.

I. Kennedy (1987), 'Review of the Year 2. Confidentiality, Competence and Malpractice', in P. Byrne (ed.) *Medicine in Contemporary Society*, King's Fund, London, 40-63.

R.E. Klein (1973), *Complaints Against Doctors*, Charles Knight, London.

Law Commission (1987), *The Accident Compensation Scheme*, Report No. 3, Wellington.

Law Commission (1988), *Personal Injury: Prevention and Recovery*, Report No. 4, Wellington.

A. Macfarlane and M. Mugford (1986), 'An Epidemic of Caesarians' *Journal of Maternal and Child Health*, 11: 38-42.

C. Oldertz (1987), *Compensation for Personal Injuries: First-Party Insurance or Third-Party Liability? The Swedish Alternative*, Paper prepared for colloquium at the University of Ghent.

Pearson Commission (1978), *Royal Commission on Civil Liability and Compensation for Personal Injury*, Cmnd 7054, Report Vol. 1, HMSO, London.

L. Quam, R. Dingwall and P. Fenn (1987a), 'Medical Malpractice in Perspective 1: The American Experience', *British Medical Journal*, 294 : 1529-32.

L. Quam, P. Fenn and R. Dingwall (1987b), 'Medical Malpractice in Perspective II: The Implications for Britain', *British Medical Journal*, 294 : 1597-1600.

L. Quam, R. Dingwall and P. Fenn (1988), *Medical Negligence: A Review and Bibliography*, Centre for Socio-Legal Studies, Oxford.

Review Body on Doctors' and Dentists' Remuneration (1982), *Eighteenth Report 1988*, Cm 358, HMSO, London.

M. Rosenthal (1987), *Dealing With Medical Malpractice*, Tavistock, London.

J. A. Scott (1985), 'Complaints arising from the exercise of clinical judgement', *Health Trends*, 17, 70-72.

Select Committee on the Parliamentary Commissioner for Administration (1977), *Independent Review of Hospital Complaints in the NHS*, First Report, Session 1977-78.

R. Smith (1982), 'Compensation for Medical Misadventure and drug injury in the New Zealand no-fault system: feeling the way' *British Medical Journal*, 284, 1457-59.

A. Simanowitz (1987), 'Medical Accidents: The Problem and the Challenge' in P. Byrne (ed.), *Medicine in Contemporary Society*, King's Fund, London, 117-130.

M. Vennell (1987), 'Informed Consent or Reasonable Disclosure of Risks: The Relevance of an Informed Patient in the Light of the New Zealand Accident Compensation Scheme', *Recent Law*, 160-175.

J. Warden (1988), 'Prime Minister's mind not closed on medical defence', *British Medical Journal*, 296, 221.

P. L. Yudkin and K.W.G. Redman (1986), 'Caesarean section dissected 1978-1983' *British Journal of Obstetrics and Gynaecology*, 93, 135-144.

KING'S FUND INSTITUTE

The Institute is an independent centre for health policy analysis which was established by the King's Fund in 1986. Its principal objective is to provide a balanced and incisive analysis of important and persistent health policy issues and to promote informed public debate about them.

Assessing the performance of health care systems is one of the Institute's central concerns. Many of its projects focus on trying to determine whether health care systems achieve their objectives. The Institute is also concerned with health policy questions which go wider than health services proper. These centre on the scope of public health policy and on social and economic determinants of health.

The Institute's approach is based on the belief that there is a gap between those who undertake research and those responsible for making policy. We aim to bridge this by establishing good relations with the scientific community, and by gearing our work towards making the most effective use of existing data. One of our key objectives is to undertake informed analyses and channel them to politicians, civil servants, health managers and professionals, authority members and community representatives.

The Institute adopts a multidisciplinary approach and seeks to make timely and relevant contributions to policy debates. A high priority is placed on carefully researched and argued reports. These range from short policy briefings to more substantial and reflective policy analyses.

The Institute is independent of all sectional interests. Although non-partisan it is not neutral and it is prepared to launch and support controversial proposals.

Other publications from the King's Fund Institute

Healthy Public Policy: A Role for the HEA Briefing Paper No 1, Virginia Beardshaw. £2.00.

Public Expenditure and the NHS: Trends and Prospects Briefing Paper No 2, Ray Robinson and Ken Judge. £3.95.

Promoting Innovation in Community Care: From Small Scale Developments to Mainstream Provision Briefing Paper No 3, David Hunter. £3.00.

Community Physicians and Community Medicine Research Report No 1, Sarah Harvey and Ken Judge. £4.95.

Health Finance: Assessing the Options Briefing Paper No 4, Ray Robinson et al. £4.95.

Griffiths and Community Care: Meeting the Challenge Briefing Paper No 5, David Hunter and Ken Judge. £3.95.

Health Care Variations: Assessing the evidence Research Report No 2, edited by Chris Ham. £6.95.

Last on the List: Community Services for People with Physical Disabilities Research Report No 3, Virginia Beardshaw. £7.95.

Further details about the Institute and its publications can be obtained from:

Su Bellingham
King's Fund Institute
126 Albert Street
London NW1 7NF
Telephone: 01-485 9589