Episode 4 Transcript

Topic: Clinical Negligence Claims: Learning vs Costs

Hosted by: Professor Anne-Maree Farrell

Guest: Dr Sarah Devaney

This transcript has been edited for clarity

00:01
Welcome to 'Mason Institute Investigates,' a podcast series produced by the Mason Institute, funded by the Edinburgh Law School. In each episode we investigate current national and global issues involving ethics, law and policy in health, medicine, and the life sciences.

00:20
Welcome to our series on Current Issues in Health, Law, and Bioethics, sponsored by Edinburgh Law Schools, Mason Institute and the Centre for Social Ethics and Policy at the University of Manchester.

00:35 Professor Farrell:
Hello, my name is Professor Anne-Maree Farrell and I'm based at Edinburgh Law School. I was a practicing lawyer focusing on clinical negligence litigation and other litigation in the areas of medicine and health, and I worked in Australia and Ireland and I'm now an academic based in the UK. I'd like to introduce my colleague Dr. Sarah Devaney, off you go.

00:58 Dr Devaney:
Hi, I'm Sarah Devaney. I'm a health care lawyer as well with a background in clinical negligence practice representing patients: people bringing claims in relation to harms that they'd sustained during their health care. I'm now based at the University of Manchester, where I lecture both law students and medical students on a variety of issues relating to health care law, in particular clinical negligence claiming and forms of redress.

01:33 Professor Farrell:
Thank you, Sarah. As Sarah pointed out, both of us are engaged in teaching a range of students that are interested in the study of health and medical law and bioethics and Sarah and I, we both used to work together and based on our backgrounds as well, we're

both interested in broader questions around patient safety and patient redress and how that works in the context of the NHS in the UK. So, we thought it would be a good idea to get together and have a chat about some current topics in the area, and particularly, some proposals for reform that have recently gone up the political agenda. Sarah, would you like to introduce the background to that?

02:17 Dr Devaney:
Well, it's funny because we've heard that there are reviews ongoing at the moment of the clinical negligence system. But we've got very few details about what that's actually going to cover. We don't have a sense of that, although Nadine Dorries has said that there are serious reviews ongoing. I think it might be looking at compensation and levels of compensation, which suggests to us that this review might follow reviews that have been undertaken in the past and the recent past, which were very much looking at the costs that are involved in clinical negligence claiming. Because any money that is paid out in compensation to patients and for injuries that they've sustained as part of their health care and to their legal representatives, comes out of the NHS pot.

03:11 Professor Farrell:
Costs seems to be the focus of the current proposals or the current round of reforms. Now you and I have been working in this area for quite some time, both as practitioners and as teachers in the area. This is not new for us in terms of understanding the dimensions and the impetus for reform over many decades in the UK. This is what I would suggest is the latest iteration of how we should approach reform of the clinical negligence litigation system. It is primarily focused on England, but likely to have impact in the devolved administrations, particularly Scotland and Wales, debatable in Northern Ireland. But certainly, we're looking at England being the front runner in this regard. So, as you and I both know, often the impetus for these sorts of rounds of reforms, is preceded by a report from the National Audit Office, about the dimensions of claiming under the clinical negligence litigation system, and particularly burgeoning costs in the area. So, I suppose when I think about the costs in the area it's interesting, a lot of it is based on, quite rightly, on figures produced by bodies such as NHS Resolution. They arere predicted, we need to look at the predictions, but also take a longer view. We look at over 5 to 10 years: what have been the actual payouts? The actual costs in the area, and break that down around claimant costs, defendant costs, as well as costs to the institutions as well. I know that one particular area has been of long concern to policymakers in the area, which is claimant costs. So, you were specifically practiced in that area and in English context, perhaps you'd like to talk about that some more.

05:00 Dr Devaney:
There has always been a bit of bad press relating to claimant lawyers costs in in the clinical negligence arena, but there are reasons why that can be significantly higher than defendant costs. So, one of those is that the burden is on the claimant to establish that each of the tests that makes up a successful clinical negligence claim has been established. So, they have to frontload lots of costs relating to investigations and obtaining expert witness reports and so on, in order to be able to establish whether or not the claim has a prospect of succeeding and should continue. Secondly, defendant costs have been under quite some pressure in recent years, so defendant firms often work on contract to the NHS and the terms of those have been constricted over time, so that the amounts that they charge have been pressed down, so there can be this disparity between the two parties. But really I think what we would like to do is to change the focus of the debate a little bit from an almost exclusive focus on costs in some arenas, which, while obviously very important, doesn't quite fit into the focus that we're really committed to as well, which is linking clinical negligence claims on what we learn about how harms happen, to patient safety and trying to learn from and prevent subsequent harms being caused.

06:33 Professor Farrell:
So how do you understand patient safety and sort of the parameters of the debate and how perhaps we need to reframe the current understanding of what reform means, which is simply about costs? I suppose what you're saying is that that's an element, but really, where do we want to go? And even why are we being forced to a situation of contemplating clinical negligence litigation when it really should be about systems learning and patient safety? And this is really your area so I would defer to you in this regard.

07:05 Dr Devaney:
I do think there should be a connection between the two, and all credit to NHS Resolution, which is the regulator that receives and defends many claims that are made against the NHS for clinical harms, which has said that it wants to be a learning organisation. They know that they're sitting on this vast body of data in relation to clinical harms and are trying to both use that and engage with other organisations and initiatives that look at learning from where error has occurred and using that to prevent a future error as well. And we would like to see a much stronger link between individual claims which focus very much on the harm, caused that patient and wider systemic learning and prevention and clinical negligence claims are a really valuable source of data, but there are very small sorts of data, so the level of claiming, it hasn't really in numbers terms, increased over the past ten

years, and that's pretty steady and people are generally fairly reluctant to bring claims against the NHS.

08:27 Professor Farrell:
I mean certainly, all the empirical data that is available shows that there is remarked reluctance to bring a claim. It's often at the end of a series of attempts on the part of patients and their families to seek patient redress and that would be again noted in the empirical research in the area. It's about wanting to know what happened to them, where they did suffer harm, get an explanation, apology, financial compensation where appropriate, and that may be where clinical negligence comes in. But also, that there are systems learning and professional accountability to ensure that what happened to them and their families, doesn't happen to anybody else. We need to take, in any concept of reform, an account of what the data tells us, firstly about the rate of claiming and whether we are dealing with a crisis or not. The data doesn't show that. But secondly, what do we want to do with the data that's being collected to engage with what the literature also tells us about what patients want when things go wrong. So, my view is, unless you propose a reform agenda that takes account of redress and specifically focuses on the patient safety agenda, you're not likely to achieve the results you want in terms of our functioning NHS that is responsive to patients, respects and looks after treating health care professionals. In that context, you're going to get a partial approach that's focused on costs that is, perhaps serving of the institutions. But they also need to be at the service of patients and families as well as those employed by them.

10:17 Dr Devaney:
Absolutely, and I think as part of that you know there needs to be an engagement by the NHS and NHSR with patient groups and initiatives such as AvMA.

10:31 Professor Farrell:
We need to explain what AvMA sort of stands for.

10:33 Dr Devaney:
So, this is another charity that has been representing patients for many years: Action against Medical Accidents. AvMA supports patients both individually but also as a group in trying to get learning from error, much more high up on the agenda of the NHS and they have a variety of initiatives looking at the harmed patient, which you know NHSR could really engage constructively with, to helpfully understand the patient experience and use it as a learning resource much more fully, and the result of all this, as well as better outcomes for patients, would of course be a reduction in costs, which was our starting

point, and the issue of cost. If you are learning and you're putting in measures to prevent incidents that you know will happen when certain circumstances exist, then you're inevitably going to have that downward pressure on costs overall.

11:57 Professor Farrell:
And it's interesting with any reform agenda or a move towards a partial or full no-fault system for medical injury, which often accompanies calls for reform to clinical negligence litigation in the NHS. If we look to comparative systems that may operate, for example in New Zealand, what we're seeing is a collection of data around the rate of avoidable or negligent adverse events, but the question is what do you do with it? As you say, if we if we address it at the at the coalface so to speak, you bring the rate of negligent events down. You bring down the rate of clinical negligence litigation claims. But the ultimate outcome needs to be patient safety for patients and families, but also they're treating healthcare professionals, to be enabled to feel good, to feel safe in that environment, and that's where I think we would both agree the focus needs to be and that simply proposing reform, whether on a cost basis or even abolishing the system, is not really going to the heart of it, in terms of addressing that need for systems learning and patient safety. It's interesting that sort of learning process for patient safety. You can also see an evolution over time for looking at avoidance of a blame system to systems learning to perhaps creating a just culture, and that seems to be high on the agenda now. Do you have any views on whether that is more of the same? Are we seeing a shift in systems learning and patient safety for the benefit of all?

13:41 Dr Devaney:
I think there are real shifts and real promising policy and learning initiatives in relation to patient safety. Cultures are so important because what we learn from the major inquiries into harm that's been caused on a large scale, whether it's a particular trust or by a particular practitioner, it's often that there's been a culture around that person or around that area of specialism, which is afraid to point out that what is happening is not good for patients. It's harmful and in a variety of ways whether it is not giving patients dignity and respect right through to causing them serious physical harm. So, cultures are so important and there's been a really important step in the implementation of the duty of candour, which places organisations and individual professionals under a duty to be open and honest with patients where something has gone wrong or could have gone wrong but could have caused them harm; it's quite a low threshold. I think there needs, in order for that to really achieve its aims, there needs to be credible support in place for practitioners to enable them to feel that they can engage in being open and transparent without feeling

that they're then going to be hung out to dry from a professional regulation perspective, or during the course of the clinical negligence claim.

15:20 Professor Farrell:
I agree with you that culture is so important. For example, even where you've got statutory protections or even non legally binding protections for health care professionals to be open and honest, to apologise, to explain; you aren't seeing that shift in culture, even with that degree of quasi or full legal protection. And I would agree with you, it comes to broader concerns around the culture in which healthcare professionals are operating, particularly in austere or austerity time, that we also need a broader understanding of the pressures that they're under. I know the just culture agenda was in part a response to the fallout from the Bawa-Garba litigation too. But the whole idea of no blame but also learning, but also understanding that there are a range of issues facing health care professionals when things go wrong, that are both systemic as well as down to them as professionals, but particularly in an austerity driven environment, a feeling that a just culture involves a broader understanding of the issues that are driving mistakes or problems or resourcing issues that may lead to mistakes, shall we say even when they negligently occur.

16:39 Dr Devaney
And I think we could have a perhaps a much more nuanced understanding of risk in healthcare from the perspective of patients. An understanding of what we're going into and what we're being exposed to, and both amongst patients and professionals perhaps we could be better at tolerating the fact that things might go wrong and having a much better response to that. So rather than looking for blame, within that being able, between patients and professionals and regulators, to really being able to find out why that has happened and what can be done to get the best outcomes out of that, which is meant to try and prevent that happening to anybody else where it's possible.

17:36 Professor Farrell:
Certainly, the empirical data does say that patients and their families are not interested in wanting to assign blame. They really value good relationships with their treating health care professionals. After all, they're in a situation of vulnerability in relation to their bodies or their physical or mental health; they want the support; they want that good relationship from their treating healthcare professionals, as well as the environment in which they're receiving treatment. But equally they want, where harm has occurred, for that to be openly acknowledged as part of that reciprocal relationship with their treating health care professionals, so it can't be one way, it needs to be reciprocal, but equally appreciating the

downward and upward pressures faced by healthcare professionals in a difficult environment in which many of them now have to work where there's not a lot of resources. They're often overwhelmed. They're operating in teams as well, rather than just being on their own, but often the law, for example, focuses solely on the individual doctor in question. Is the law fully capturing the dynamics of that patient-doctor relationship? Perhaps where problems do occur; where harm is caused and focusing on one aspect of that relationship where it's broken down; focusing just on costs, is never going to fully address the complexities. It's an easy political win, but it's never going to focus on the complexities of empowering patients, respecting health care professionals, and ensuring that the health system delivers.

19:15 Dr Devaney:
For me really, the main message is this has just all got to be tied up with patient safety. You can't have developments in an initiative in improving patient safety and then a complete silo of claiming, which doesn't tie into it. So, NHS Resolution is saying that they want to be a learning organisation from the claims that come to them, so those are the good sort of messages at the moment, but I think we need to be saying that any reform of the clinical negligence system can't just be focusing on the issue of costs. I think that's a great place to end it.

19:49
Thank you for listening to Current Issues in Health Law, and Bioethics. This has been a production of Edinburgh Law School at the University of Edinburgh.

20:08
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