

THE RISING COST OF CLINICAL NEGLIGENCE WHO PAYS THE PRICE?

CLINICAL NEGLIGENCE COSTS
STRIKING A BALANCE



CONTENTS

- 3** FOREWORD
- 4** EXECUTIVE SUMMARY
- 9** ABOUT MPS
- 10** THE RISING COST OF CLINICAL NEGLIGENCE
 - 11** Clinical negligence claims – an increasing trend
 - 13** Impact on the health and wellbeing of healthcare professionals, and the way that they practice
 - 13** Drivers of claims of clinical negligence – predisposing and precipitating factors
 - 16** Recent legal reform and the case for further action – the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO)
- 17** RECOMMENDATIONS
 - 17** Preventing claims
 - 18** Legal reform to tackle the cost of claims
- 25** CONCLUSIONS
- 26** ANNEXES
- 37** REFERENCES



FOREWORD

As the leading provider of professional protection to more than 300,000 doctors, dentists and healthcare professionals worldwide, the Medical Protection Society (MPS) has a unique insight into the nature of clinical negligence claims.

These are undoubtedly challenging times for all our members. In recent years the cost of clinical negligence has increased significantly for many. As a responsible not-for-profit organisation, we have an obligation to ensure that we collect sufficient subscription income to meet the expected future costs of claims against our members so we can be in a position to defend their interests long into the future. For this reason, we have had to reflect the rising costs of clinical negligence in membership subscription fees.

The Lord Chancellor's decision to reduce the Personal Injury Discount Rate to minus 0.75% is going to make this situation even worse. This significant decision will cost the public purse an extra £1.2billion each year¹ as the cost of claims will be substantially larger as a result.

I know that increases in the cost of membership subscriptions are unwelcome, and have a significant impact on some. At MPS we share our members' concerns and want to work with the government and others to help stem these spiralling negligence claims costs.

Alongside our concerns about the direct impact on our members, we are also troubled by what it means for the NHS and the public purse. NHS Resolution (formally the NHS Litigation Authority) estimated last year that the provision for future clinical negligence costs, relating to claims arising from incidents that have already occurred, stands at £56.1billion.² To pay for this, the NHS is diverting a significant amount of its funding away from front-line patient care towards claims. At a time when the NHS is facing tough financial pressures and must make difficult decisions about how it allocates its limited and precious resources, there is an urgent need to review the money spent on compensation for clinical negligence.

Finally, we are also concerned about the impact the fear of being sued is having on dentists and doctors' health and wellbeing and the way that they practise. In this paper we make recommendations that could help to address some of the factors contributing to the current claims environment, both to help prevent adverse incidents and claims, and also to better manage the cost of claims when they occur. Of course there are likely to be many other reforms that could have a positive impact on clinical negligence costs. We see our proposals as a starting point for government to consider further reforms, and we look forward to being part of these discussions. In order to fully understand the issue, it is also useful to look at the experience of other countries such as Australia and the US; and we have outlined these in the annexes of this paper.

I recognise the important role MPS must play as well. We will continue to support our members and promote safe practice in medicine and dentistry by helping to avert problems in the first place. Crucially, we will continue to advocate open disclosure.



Simon Kayll
CEO, MPS

June 2017

1. Office for Budget Responsibility, Economic and Fiscal Outlook, March 2017
2. NHSLA Report and Accounts 2015/2016

EXECUTIVE SUMMARY

Under current law, patients who have suffered avoidable harm as a result of poor medical care can bring a clinical negligence claim against the healthcare professional who caused the harm, whether the treatment was provided by the NHS or by a private healthcare provider. The money sought through a claim may be to compensate the patient for physical or psychological harm, and may also include a claim for the cost of care required as a result of the harm and loss of earnings.

Medicine is not an exact science and sometimes adverse incidents do occur. It is important that there is reasonable compensation for patients following clinical negligence, but this must be balanced against society's ability to pay. If the balance tips too far, the risk is that the cost becomes unsustainable.

NHS Resolution estimated last year that the provision for future clinical negligence costs, relating to claims arising from incidents that have already occurred, stands at £56.1billion.³ Expenditure on clinical claims by NHS Resolution increased by 72% (11.5% a year on average) over the five years to 2015/16.⁴ Should this trend continue it risks becoming wholly unsustainable for the NHS and wider society, which ultimately pays for these cost. Last year alone, nearly £1.5billion was spent and, put into context, this equates to the cost of training over 6,500 new doctors.⁵

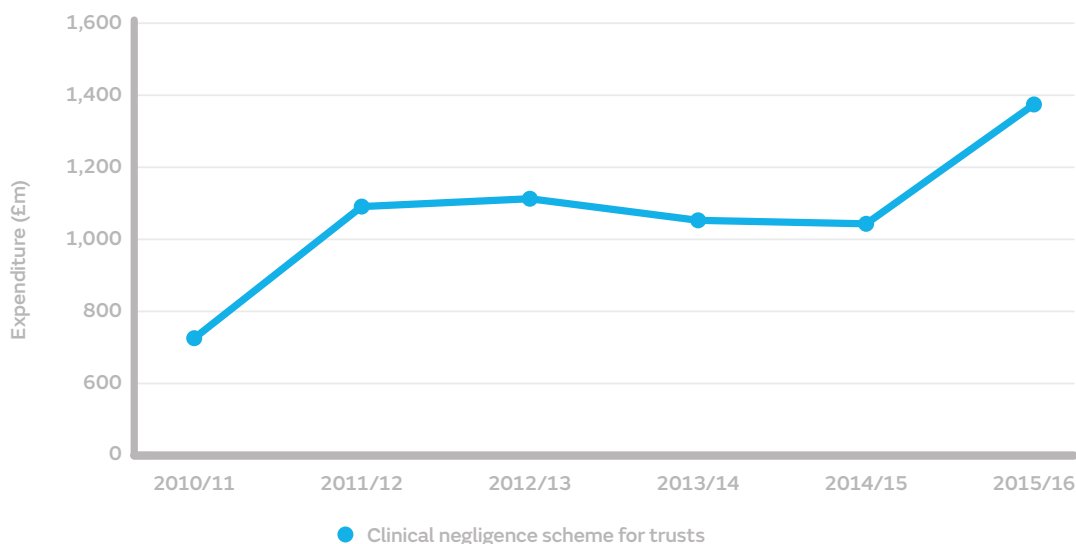
This is only set to increase as the Lord Chancellor announced on 27 February that the Personal Injury Discount Rate will be reduced from 2.5% to minus 0.75%. This decision, which took effect on 20 March 2017, will significantly increase the cost of settling awards for clinical negligence against the NHS, and these increases will need to be picked up by the public purse.

Soon after the discount rate changed it was reported in *The Guardian* that an NHS Trust nearly tripled an injury pay-out from £3.8million to £9.3million as a result.⁶ This is a significant amount of public money and was reflected in Office for Budget Responsibility papers published with the March 2017 budget which stated that an extra £1.2billion a year will be needed to meet the expected costs to the public sector.⁷

To illustrate the impact on claims, consider a 21-year-old woman requiring long-term care, but with a normal life expectancy, resulting from a GP's failure to diagnose a sub-arachnoid haemorrhage. A claim of £1million prior to 20 March (comprising of £700k of future care costs and £300k of other claims costs) would now, at the new discount rate of minus 0.75%, cost £2.3million. A similar claim at £5million would now cost £12.8million.

MPS is deeply concerned by the unsustainable increase in the cost of clinical negligence for a number of reasons. Firstly, it means the NHS is diverting a significant amount of its funding away from front-line patient care towards claims. At a time when the NHS is facing tough financial pressures and must make difficult decisions about how it allocates its limited and precious resources, there is an urgent need to review NHS spending on compensation for clinical negligence and legal fees.

Secondly, many of the spiralling costs are invariably paid for directly by frontline primary care professionals. Staff shortages in the NHS are already an issue, with one third of GP vacancies remaining unfilled.⁸ We are worried that the fear of litigation and the rising cost of clinical negligence could exacerbate this problem if not addressed.



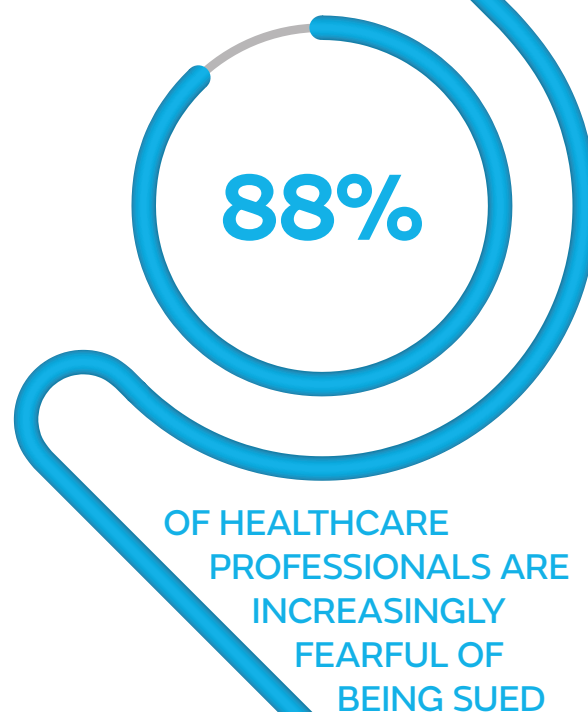
Thirdly, the fear of being sued is affecting the way doctors practise, their health and wellbeing, and how they see their future in the profession. In an MPS survey, we found that 88% of healthcare professionals are increasingly fearful of being sued, with 72% saying the fear has caused them stress or anxiety. This fear can lead to more defensive behaviour, with 75% reporting that it has resulted in them ordering more tests or making more referrals. Most significantly of all, 64% reported that the fear of being sued has made them consider their future in the profession.⁹

Finally, it is vital to note that these costs are rising even though “no material deterioration in the quality and safety of primary care in recent years”¹⁰ has been found. This means that costs are rising without a corresponding decline in professional standards.

We know from our research that 79% of the public surveyed are concerned about how the rising cost of clinical negligence is impacting on the NHS, and 86% of healthcare professionals tell us that if the cost of clinical negligence claims continues to increase at the same rate, they think it will threaten the sustainability of the NHS.¹¹

The majority of the public surveyed (73%) and healthcare professionals (86%) support changes to the legal system to tackle the issue. Fundamentally, there is agreement that difficult decisions are made about spending in healthcare every day, and how much society pays for clinical negligence must be one of them.¹²

In this paper, MPS urgently advocates a package of legal reforms to control the spiralling costs of clinical negligence claims to the NHS and health professionals in England and Wales to help promote a sustainable future. Alongside recommendations to tackle the cost of clinical negligence once a claim is brought, we also consider ways to prevent both the causes of adverse incidents and the drivers of clinical negligence claims.



3. NHSLA Report and Accounts 2015/2016
4. Figure 6 in the NHS LA's 2015/16 report and accounts, showing expenditure of £729.1m + £134.3m = £863.4m in 2010/11 increasing to £1,378.2m + £27.7m + £82.5m = £1,488.4m in 2015/16.]
5. Calculated using figures that it costs £230,000 to train a doctor. £1.5billion/£230,000 = 6,521.7 doctors according to fullfact.org/health/cost-training-doctor
6. The Guardian online, NHS trust triples injury payout to £9.3m under controversial new rules, theguardian.com/business/2017/mar/20/nhs-trust-injury-payout-health-service-insurance-ogden-formula viewed on 3 April 2017
7. Office for Budget Responsibility, Economic and Fiscal Outlook, March 2017
8. British Medical Association, *One third of GP vacancies remain unfilled*, December 2016. Available via: bma.org.uk/news/2016/december/one-third-of-gp-vacancies-remain-unfilled
9. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157.
10. Department of Health and NHS England, GP Indemnity Review, July 2016. Available via: england.nhs.uk/wp-content/uploads/2016/07/gp-indemnity-rev-summary.pdf
11. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).
12. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).

MPS RECOMMENDATIONS INCLUDE:

PREVENTION

- **Increase understanding of clinical negligence drivers**

If we want to reduce litigation we need to understand what the drivers are. Otherwise, we are reliant on assumptions about what will reduce negligence claims. Although these are well informed by international research, current locally based research is limited.

- **Increase understanding of specific risks**

We will seek to work with other organisations in the NHS and the wider healthcare system to raise awareness of the high value claim risk around conditions such as cauda equina syndrome, meningitis/encephalitis, missed cancers, peripheral ischaemia and chronic disease management. Fundamental to raising such awareness will be exploring 'red flag' symptoms and when to take urgent action.

- **Increase focus on education and risk management**

We would like to encourage an increased focus on education and risk management in both primary and secondary care.

- **Improve culture and systems for dealing with concerns**

For many years, MPS has supported an open, learning culture in healthcare and we encourage healthcare professionals to be open and honest with patients when things go wrong. MPS has a crucial role supporting and advising members to embrace open disclosure. All bodies involved in healthcare should work together to tackle cultural and environmental barriers to openness and resolution of concerns.

- **Expectations of healthcare services**

We would like to work with NHS England, the Department of Health, patient groups and others to consider ways we can build a common understanding of what we can and cannot reasonably expect from modern healthcare services.

LEGAL REFORM

SPECIAL DAMAGES

- **A limit on future care costs, based on the realities of providing home based care – a tariff would be set for annual care costs, dependant on injuries, with an overall cap.**

This would ensure consistency, fairness, and avoid the enormous differentials between costings proposed by care experts working for the claimant, and the defendant. The unpredictability about the size of awards makes it difficult to settle cases quickly and can result in long and expensive disputes, so this reform would also result in cost savings and quicker resolution for all.

- **A limit on future earnings which recognises national average weekly earnings**

This reform will introduce greater consistency in the size of awards claimants receive. Currently damages awarded are based on the claimant's weekly earnings and this means that for a similar claim, higher earners can receive more from the NHS in compensation than lower earners. Other countries, such as Australia, have introduced such limits.

GENERAL DAMAGES

- **Consideration of a minimum threshold for cash compensation for pain, suffering and loss of amenity (PSLA) in clinical negligence claims**

Introducing a threshold for claims relating to minor injuries and inconveniences would help achieve a better balance between ensuring that the ever-increasing liabilities for clinical negligence against the NHS are affordable to the public purse, and paying compensation to those who have suffered as a consequence of clinical negligence. Those who have suffered as a consequence of clinical negligence should be reasonably compensated. But where only very minor injuries or inconveniences are sustained, it is right to question whether society should shoulder the extra burden that the cumulative cost of these damage pay-outs result in.

LEGAL COSTS

- **Introduction of a system of fixed recoverable costs (FRC) for all clinical negligence claims up to a value of £250,000**

This scheme presents an opportunity to create a more proportionate, fairer system while generating substantial savings to the NHS. The government has proposed a fixed recoverable costs scheme to help stop lawyers charging excessive legal costs. In 2015/16, The NHS paid out £1.5 billion in clinical negligence costs, with legal costs accounting for 34% of that bill.¹³ The Department of Health has suggested an FRC system for claims up to £25,000; we believe this needs to include a wider pool of claims and should include claims up to £250,000.

- **Reform to rules relating to claimant expert reports covered by after the event insurance**

These reforms would bring about greater transparency and cost savings. Currently if a patient is successful in their claim for clinical negligence, the defendant – the NHS for example – may have to pay the cost of the claimant’s expert witnesses. They may also have to pay the cost of the premium for any After the Event (ATE) Insurance that the claimant solicitors/claimant took out to protect themselves from paying the costs of expert witnesses if they lose.

The regulations do not provide for a limit on the number of expert reports covered by the insurance premium or a cap on the experts’ costs. This can mean that the defendant is left to pick up a large bill for an insurance premium for an unlimited amount with next to no transparency behind why the cost is what it is.

- **Consideration of methods to reduce expert fees**

Looking at ways to reduce the fees paid to experts will help to ensure costs are in proportion to the damages. Introducing a cap on the number of experts instructed in the pre-action protocol stage of claims would also generate significant savings. Any system of capped or fixed expert fees must strike a balance so it is reasonable and fair and maintains an adequate pool of quality experts.

LIMITATION PERIODS

- **The introduction of an ultimate limitation period of ten years between the date of an adverse incident and when a claim can be made (but with judicial discretion in certain circumstances)**

This would help to achieve a balance between the rights of claimants and defendants and a public interest in ensuring that claims are pursued as quickly as possible. It is not unusual in England and Wales

to see late notification of claims. Late notification of a claim means that records may have been lost or destroyed, medical staff may have retired, died or cannot be traced or may have little recollection of the facts. The longer the delay between the incident and the claim, the greater the opportunity there is for claims to inflate and damage levels to increase.

A SMALL CLAIMS TRACK FOR CLINICAL NEGLIGENCE

- **An increase in the small claims track threshold for clinical negligence claims up to £5,000**

In our extensive experience, many low level clinical negligence claims are straightforward and could easily be managed within the small claims track, with the court having discretion to move a claim to another track if there are any particularly complex issues involved. We have considered what potential impact a small claims track for clinical negligence claims, with a limit of £5,000, would have on claims against our members. We think that such a proposal could be beneficial in reducing the cost of low value claims, and particularly dental claims.

QUALIFIED ONE-WAY COSTS SHIFTING

- **Qualified one-way costs shifting (QOCS) provisions should be amended so that the claimant is required to seek the court’s permission to discontinue less than 28 days before trial**

This reform could save on the considerable costs that are incurred when a claimant discontinues a case very near to the trial date, at the expense of the defendant – the NHS for example. While fundamental dishonesty is rarely a feature in clinical negligence claims, late discontinuation of a claim is not infrequent, and withdrawing comes at no cost to the claimant. The exchange of expert evidence takes place at least 12 weeks prior to trial, so discontinuance so close to trial should never be necessary. This would provide an incentive to ensure those bringing claims dishonestly, or bringing claims with poor prospects, do not run cases to the doors of court, only to withdraw them at the last minute once it becomes clear that the defendant will not settle.

¹³. Introducing fixed recoverable costs in lower value clinical negligence claims; a consultation, January 2017

Of the recommendations we make, individually we think the most effective in terms of stemming the increase in costs would be limits on special damages awards and an effective FRC regime for all claims up to £250,000. However to achieve the desired impact, changes need to be implemented with care to avoid unintended consequences and an increase in adverse behaviours.

We believe the whole package of reforms is necessary if we are to tackle the root of the problem.

We think there is a growing recognition of the need for reform to tackle the ever increasing cost of clinical negligence. In the 2016 NHS England/Department of Health GP Indemnity Review, there was a commitment to consider longer-term action to reduce costs:

“The Department of Health recognises the pressures that growing indemnity costs are placing on the whole NHS, and has already committed to exploring action to fix the amounts that can be recovered in costs by legal firms in certain cases. A further deep dive will be carried out to better understand the options for constraining litigation costs in primary and secondary care.”¹⁴

NHS Resolution also recognises the need for reform. Its new strategy to 2022 *Delivering fair resolution and learning from harm*, states:

“This [compensation costs] is unsustainable, particularly given the financial challenges facing the NHS. It is also to a degree, unavoidable, without significant law reform.”¹⁵

Alongside tackling the cost of clinical negligence once a claim is brought, we also need to consider both the causes of adverse incidents and the drivers of clinical negligence claims.

Evidence suggests that the link between adverse incidents and subsequent litigation or complaints is not as strong as might be supposed, and that many people sue even though there was no clinical error.¹⁶

By building our understanding of the factors that motivate people to initiate claims, and what they are hoping to achieve by doing so, all routes to effectively reducing claim numbers can be explored.

In this paper we consider what might help to improve the quality and reliability of care delivery, as well as what might prevent patients from wanting to bring claims of clinical negligence.



The Department of Health recognises the pressures that growing indemnity costs are placing on the whole NHS

14. Department of Health and NHS England, GP Indemnity Review, July 2016. Available via: <https://www.england.nhs.uk/wp-content/uploads/2016/07/gp-indemnity-rev-summary.pdf>
15. NHS Resolution, *Delivering fair resolution and learning from harm: our strategy to 2022*, April 2017
16. References 1 - 8 (references can be found on page 37)

ABOUT MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support together with the right to request indemnity for any complaints or claims arising from professional practice.

Our highly qualified, in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, e-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

MPS AND CLINICAL NEGLIGENCE CLAIMS

Along with other medical defence organisations (MDOs), MPS manages claims for clinical negligence brought against GPs, dentists and private doctors, whilst NHS Resolution manages claims arising in the NHS hospital sector. In Scotland, claims are managed by the Central Legal Office (CLO) in conjunction with the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) and in Wales, the Welsh Risk Pool provides a similar function.

Our claims handling philosophy aims to provide an expert, supportive and efficient claims handling service to members who are faced with claims. Where there is no defence and it is clear that a claim will be pursued, MPS will try to effect settlement on fair terms as early as possible. Where there is a good defence to a claim, MPS is robust in pursuing it. Many claims do not withstand detailed legal scrutiny and are successfully repudiated, and MPS successfully defends a significant proportion of claims.

MEMBERSHIP WITH MPS

MPS offers 'occurrence-based' membership to doctors and dentists in the UK. This allows them to request assistance with a claim or complaint that was caused by an incident that occurred during their time as a member - even if they only became aware of it much later and after their membership ended. This is important for doctors because the nature of negligence claims means that it can often be years before a case is brought and fully resolved.

We respond to this in how we calculate membership subscriptions. We undertake detailed and robust actuarial work to assess trends in the size of claims and the likelihood of claims for each membership type. We use this information when we set membership subscriptions so that we set aside sufficient funds to meet future claims.

THE RISING COST OF CLINICAL NEGLIGENCE

More people are suing for clinical negligence, and are seeking greater sums of money. In a recent survey of the public, 65% of those surveyed said it has become easier to make a claim of clinical negligence than ever before.¹⁷

As a country we need to take a three pronged approach to dealing with the unsustainable increases in cost occurring as a result of this long-term trend.

1 Improve patient safety and the quality and reliability of care delivery.

Preventing medical error where possible, and limiting its impact is clearly essential.

Medicine is not an exact science and sometimes adverse incidents happen. While we do not believe that the deteriorating claims environment comes as a result of a corresponding decline in professional standards, there are clearly improvements that can and should be made.

At MPS our ethos is about seeking to prevent problems from occurring in the first place and supporting our members with risk management. We run education programmes that seek to enhance patient safety and reduce risk through prevention and mitigation of individual and system errors.

Creating an open learning culture in healthcare is also crucial to ensure that lessons are learnt from mistakes to prevent them happening again. MPS has long advised and supported its members with open disclosure and learning from events, and will continue to advocate for an open and learning culture in healthcare.

However, it is simplistic to assume that a singular focus on improving patient safety and enhancing the quality and reliability of care delivery will alone result in a significant reduction in clinical negligence claims and complaints.¹⁸ It is also crucial we tackle the drivers of claims and significantly, from a cost and sustainability perspective, tackle the cost of claims when they are brought.

2 Increase our understanding of the drivers of clinical negligence claims to help inform prevention strategies.

There is a clear difference between the causes of clinical negligence or an adverse incident, and the drivers of a claim for clinical negligence. We know that on many occasions, there may be little or no link between the two.

High quality, in-depth qualitative research is needed to understand the drivers for clinical negligence claims in the UK. There is considerable international research on the topic, which is very helpful. However, it is important to have an up to date understanding as to why patients and their families in this country take legal action and what they are hoping to achieve through litigation, especially in cases where no negligence is found.

There are education programmes, including a number developed by MPS, which seek to address some of the likely factors which drive claims. These include courses which focus on communication, dealing with complaints and adverse incidents, and promoting the benefits of openness. We see these programmes as an important way of improving both the patient and healthcare practitioners' experience, as well as decreasing the likelihood of claims and complaints. By understanding the drivers more clearly we can increase and better target prevention strategies.

3 Introduce a comprehensive package of legal reforms to ensure that when claims do occur they are dealt with in a fair and proportionate manner, and are affordable to the NHS and society.

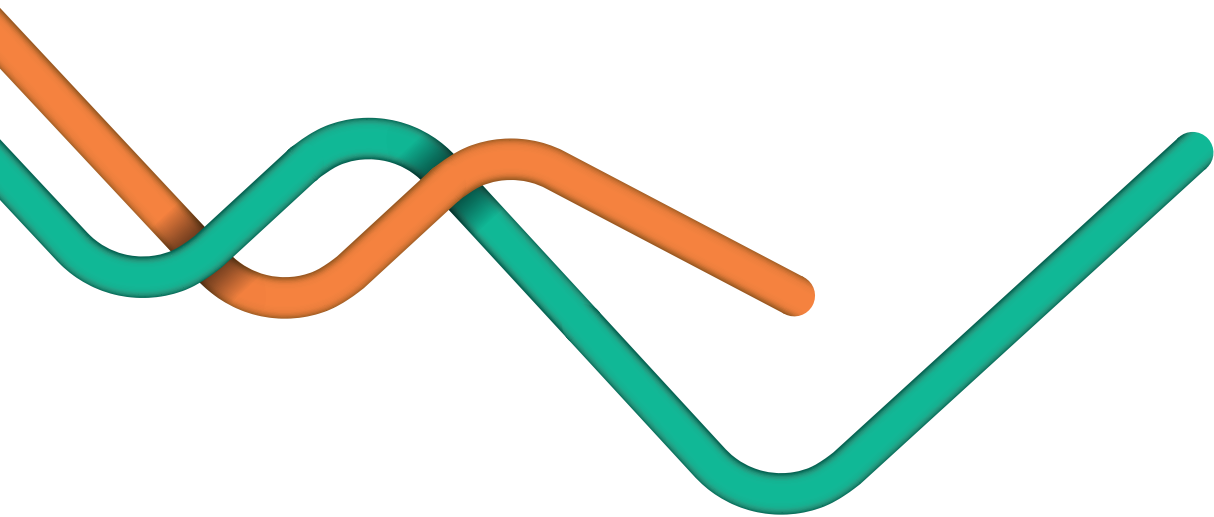
The most expensive claims are those where damages for lifelong care are awarded. However, even claims that are found to have no merit cost money to defend. The NHS successfully defended nearly 5,000 claims in 2015/16,¹⁹ which highlights the scale of unmeritorious claims that are brought against the NHS.

In its 2015/16 annual report, NHS Resolution estimated that £56.1 billion is the current amount needed to cover known and future claims for clinical negligence for past patient care.²⁰ Expenditure on clinical claims by NHS Resolution increased by 72% (11.5% a year on average) over the five years to 2015/16. We can only expect this figure to increase and legal reform is therefore desperately needed to prevent the bill to the NHS becoming unsustainable.

This is even more important in light of the recent change to the Personal Injury Discount Rate which has served to exacerbate matters. Difficult decisions about spending in the NHS are made every day and full consideration around ways in which claims can be made more affordable should be at the forefront of our thinking.

To effectively deal with the deteriorating claims environment, all three elements listed above must be addressed. And we cannot delay. We need to act fast to stop these increases becoming unsustainable for the NHS and society.

17. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).



CLINICAL NEGLIGENCE CLAIMS – AN INCREASING TREND

Our analysis of claims demonstrates that a full-time GP is expected to be twice as likely to receive a claim for clinical negligence than just nine years ago. A full-time GP can now expect to receive two clinical negligence claims over a typical career. The picture is similar for dentists. A full-time dentist is nearly twice as likely to receive a claim for clinical negligence than just ten years ago, and a full-time dental GP can now expect to receive two clinical negligence claims over a typical career.

GP claims can also cost significant amounts of money. While some claims will run into thousands of pounds, others will involve millions, which far outstrips the amount a GP will pay for professional protection over the course of their entire career. The highest paid claim to date against an MPS GP member was settled for over £5.5million.

We anticipate that we will begin to see more claims of this magnitude; indeed we have a number of open GP claims exceeding £5million that have not yet been resolved. These are now likely to be even larger as a result of the changes made to the Personal Injury Discount Rate.

It is not just the successful claims that cost money; NHS Resolution also reported that they “continue to receive, and defend, a significant number of unjustified claims and successfully defended nearly 5,000 claims in 2015/16”.²¹ Managing and defending such claims also costs money.

With NHS Resolution’s potential liabilities currently at £56.1billion,²² and with pressures on public funding increasing, spending of this magnitude on clinical negligence is clearly a concern for society as a whole, and not just healthcare professionals.

NHS Resolution shares our concerns about the ever increasing cost of clinical negligence claims stating that:

“ ” The NHS in England has experienced an increase in the costs associated with clinical negligence claims in recent years. This means increased costs to NHS trusts and less money available to care for patients.²³

There are likely to be a number of complex and interrelated causes of the increase in the frequency and size of claims against GPs in recent years. These could include:

- increasing patient expectations and changes in attitude
- greater desire for patient involvement and less tolerance of preventable harm
- an increase in the number of patients and the complexity of the issues they present with
- time and workload pressures on GPs
- disproportionate claimant legal costs
- increases in life expectancy and the cost of care packages
- greater awareness of the ability to, and knowledge of how to, make a claim or complaint
- a shifting focus of care from secondary to primary
- advertising by claimant legal firms
- recent economic experience
- increased patient access to online diagnostic tools, ‘best practice’ guidelines and patient review websites.

18. Reference number 8

19. NHSLA Annual Report and Accounts 2015/16

20. *ibid*

21. NHSLA Annual Report and Accounts 2015/16

22. *ibid*

23. NHSLA Annual Report and Accounts 2014/15

In its 2015 report, NHS Resolution shared the following thoughts about what lies behind the increasing negligence costs that the NHS has experienced:²⁴

- an increase in the number of patients being treated by the NHS
- an increase in the number of reported incidents - this may indicate an increasing and positive reporting culture and so is not necessarily reflective of an increase in incidents occurring
- an increase in the number of patients claiming compensation as a proportion of reported incidents
- an increase in the number of patients who claim but who do not recover compensation
- an increase in the number of lower value claims
- excessive claims for legal costs from some claimant firms
- rising lump sums and annual costs (usually for care), over and above inflation, for high value claims.

There are also growing concerns about the impact that workload and time constraints are having on the standard of care. For example, a recent survey run by the Royal College of Physicians found that over half of respondents believe patient safety has deteriorated over the past 12 months and highlighted that “doctors (are) overwhelmed by rising need in hospitals running at such high occupancy levels.”²⁵ While MPS is not in a position to comment on this and has no direct evidence that this is a factor, these concerns clearly need to be considered and addressed where possible.

MPS does not believe that the deterioration in the claims environment is as a result of a deterioration in professional standards and we can look to a number of examples of improved healthcare outcomes to support this.²⁶ The 2016 Department of Health and NHS England GP Indemnity Review found “no material deterioration in the quality and safety of primary care in recent years”²⁷ and evidence suggests that there have been impressive increases in quality, safety and improved health outcomes over the last 30 years.²⁸ We must therefore acknowledge and celebrate the dedication and commitment of so many healthcare professionals who work to improve the quality and safety of healthcare delivery in the UK.

KEY THEMES REGULARLY ASSOCIATED WITH CLAIMS

Understanding the causes of errors that may lead to claims is also important. From experience we know that there are a number of key themes regularly associated with claims:

- a. failure to diagnose
- b. delayed diagnosis
- c. failure to refer or seek a second opinion
- d. failure to act on tests and results
- e. medication incidents and prescribing errors
- f. failure to meet patient expectations resulting in dissatisfaction
- g. surgical technique.

Claims become more difficult to defend where:

- h. there is poor record keeping
- i. consent was not adequately sought or documented.

In 2016, we undertook research using our own GP claims data and found that the top five errors that led to the most expensive claims were:

- failure/delay in diagnosis of cauda equina syndrome
- failure/delay in diagnosis of meningitis/encephalitis
- failure/delay to diagnosis and delayed treatment/ referral of cancers
- delayed/missed diagnosis and inadequate treatment of peripheral ischaemia
- deficiencies in chronic disease management.

In addition, a final cost driver comes as a result of the Lord Chancellor’s decision on the 27 February 2017 to reduce the Personal Injury Discount Rate for personal injury awards from 2.5% to minus 0.75%; significantly increasing the cost of awards for claims of clinical negligence. The government has pledged to ensure that NHS Resolution has appropriate funding to cover changes to hospitals’ clinical negligence costs and to work closely with GPs and MDOs to ensure that appropriate funding is available to meet additional costs to GPs. However, the reality is that this move will drive up the cost of claims. This is a cost all taxpayers will bear.

24. NHSLA Report and Accounts 2014/15

25. rcplondon.ac.uk/news/physicians-worried-about-future-patient-safety-whistleblowing-and-rotas-gaps

26. Cancer survival in the UK has doubled in the last 40 years, cancerresearchuk.org/health-professional/cancer-statistics/survival
GMC FTP figures do not demonstrate a drop in clinical standards. Since 2006, enquires to the GMC have risen by almost 90%, however the number being referred to panel has actually declined. With regards the outcomes of panel hearings, these appear to be remaining stable.

27. Department of Health and NHS England, GP Indemnity Review, July 2016. Available via: england.nhs.uk/wp-content/uploads/2016/07/gp-indemnity-rev-summary.pdf

28. Reference 29, Health Expectancies at Birth and at Age 65 in the United Kingdom: 2009-11 ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2014 and Avoidable Mortality in England and Wales: 2013 ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2015-05-20, Avoidable Mortality in England and Wales: 2013 ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2015-05-20

IMPACT ON THE HEALTH AND WELLBEING OF HEALTHCARE PROFESSIONALS, AND THE WAY THAT THEY PRACTICE

As well as the financial impact of the cost of clinical negligence to the NHS, we are also concerned about the impact that the fear of being sued may have on healthcare professionals, both in terms of 'defensive medicine' and on their health and wellbeing.

There is international evidence to suggest that defensive medicine is a cost to healthcare systems.²⁹ However, UK evidence about the extent to which this is a factor in the NHS appears to be limited. When we surveyed our members we found that many indicate that defensive medicine may be an issue. For example, 88% of healthcare professionals say that they are concerned about the impact that working in a more litigious society is having on their welfare and the way they practise and 77% believe that the fear of being sued impacts on the services they feel able to offer. We believe that further research is needed to understand the potential cost in the UK.³⁰

Our members also tell us that the fear of being sued is impacting on their health and wellbeing.

In an MPS survey we found that:



88% of healthcare professionals are increasingly fearful of being sued



72% of healthcare professionals report that the fear has caused them stress or anxiety



64% of healthcare professionals reported that the fear of being sued has made them consider their future in the profession

A survey conducted by YouGov on our behalf found that the public share these concerns, with 74% reporting that they are concerned about the impact that working in a more litigious society is having on welfare of doctors and the way they practise.³¹

29. Rothberg et al, The Cost of Defensive Medicine on 3 Hospital Medicine Services, JAMA Internal Medicine, September 15, 2014, Studdert et al, Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, JAMA, June 1 2005

30. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157.

DRIVERS OF CLAIMS OF CLINICAL NEGLIGENCE – PREDISPOSING AND PRECIPITATING FACTORS

With over 125 years of experience supporting our members in this field, and drawing on international research, we believe that there is likely to be a number of complex, multifactorial and interrelated drivers behind the increase in the number and size of claims. These include factors relating to the patient, the doctor, the performance of clinical teams, society and the context and systems in which they work.

What constitutes an adverse outcome or patient safety incident also appears to be evolving, and may be viewed from different perspectives by the patient and the doctor. The patient's view may include disappointment in outcomes, poor doctor-patient interactional experience, service and quality, while doctors can tend to focus on whether medical error occurred.³²

Existing evidence tells us that there is not a strong correlation between clinical error and claims or complaints,³³ and that many people sue even when their case has no merit.³⁴ Indeed, we believe that there would still be claims for alleged clinical negligence (though unsuccessful) even in a world with no medical error. MPS successfully defends a high proportion of claims and pre-claims it receives, often because no negligence has actually occurred. By confusing the causes of clinical negligence and the drivers of clinical negligence claims we may not effectively reduce claim numbers.

31. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).

32. References 9-11

33. References 1, 7, 8

34. NHSLA Annual Report and Accounts, 2014/15 'The NHSLA currently resolves over 4,000 clinical negligence claims annually, for no payment of damages. In 2014/15 it saved over £1.2 billion for the NHS in rejecting claims which had no merit. In 2014/15 the NHSLA saved over £1.2 billion in rejecting claims which had no merit.' 'We continue to receive, and to defend a significant number of unjustified claims. More than 46% of clinical claims concluded in 2014/15, were resolved with no damages payment.'

UNDERSTANDING WHY PATIENTS SUE THEIR DOCTOR IS AN IMPORTANT FIRST STEP

It is likely that many doctors leave medical school with a traditional view of what causes litigation; namely that if they treat a patient, for whom they are responsible, outside acceptable standards of care and as a consequence the patient comes to harm, then they might be sued.

However, a number of studies undertaken over the last 25 years,³⁵ starting with the seminal Harvard Medical Practice Study published in 1991³⁶ suggest that the relationship between medical error and litigation may be more complex.

The drivers of clinical negligence claims and complaints are multifactorial and often interrelated. While there is a wide body of evidence which informs us about what the factors are most likely to be and how improvements can be made, there remains an information gap regarding the most recent UK experience.

It is therefore important to understand some of the motivating factors as to why patients initiate claims against doctors and what they are hoping to achieve by doing so. This will help give some indication as to how claims might be prevented and how desired outcomes might be achieved without resorting to litigation. This dynamic can be usefully considered in terms of predisposing and precipitating factors.³⁷

We know that the experiences of many patients who take action against their doctor include unmet expectations, poor communication and deficient interactional skills, witnessing poor teamwork and inter-professional communication, lack of information and involvement in relation to decision making and consent, as well as a lack of empathy.³⁸ These factors predispose a patient to make a claim should a precipitating event such as a diagnostic, medication or system error occur.

Evidence suggests that poor handling of an adverse outcome increases the likelihood of patients taking action and that effective responses stabilise or reduce the likelihood of patient action.³⁹

THE EXISTING EVIDENCE BASE

As previously highlighted, evidence indicates that there is not a strong correlation between clinical error and claims or complaints.⁴⁰ According to one study, 2% of GP consultations were associated with a patient safety

incident⁴¹. Despite this, only a very small proportion of adverse outcomes result in a patient bringing a complaint or claim, and many complaints and claims arise when there has been no error or negligence suggesting other drivers are also involved.⁴²

A 2004 review of the original Harvard Medical Practice Study highlighted that around 80% of claimants of clinical negligence did not actually suffer a negligent injury.⁴³ However, it is important to remember that very few of these claimants will be 'chancing a claim' in order to gain financial reward; many will be disappointed with the outcome of their care and may be seeking information or an apology. Research also demonstrates that most claimants bringing a claim genuinely feel that there was a problem with the care that they received.⁴⁴

PRECIPITATING FACTORS

Analysis of claims tends to revolve around the precipitating clinical factors, such as a delay in diagnosis, incorrect surgical technique or medication incidents as well as the individual and system errors that might have contributed to them.

Precipitating factors refer to the incident itself that results in patient harm, reflecting individual and/or system error. This is the actual event that causes harm such as:

- adverse outcomes and iatrogenic injuries (caused by medical treatment)
- inadequate or incorrect care
- system and process errors relating to, for example, test results, repeat prescribing or continuity at interfaces of care
- slips, lapses and mistakes
- medication errors
- missed or delayed diagnoses.

PREDISPOSING FACTORS

However, the risk of complaint and litigation appears to have much more to do with predisposing factors such as communication skills, manner and attitude, decision making and consent, sensitivity to patient needs and management of expectations than the complexity of the patient's condition, patient characteristics or technical and clinical skills.⁴⁵ These factors predispose a patient to claim should a precipitating clinical adverse event occur.

Many patients who take action report having experienced some of the following:⁴⁶

- delays
- inattentiveness
- apathy
- lack of empathy and compassion
- arrogance
- rudeness
- poor communication including not listening
- lack of information
- desertion
- lack of respect
- exclusion of family
- not being taken seriously
- not being listened to
- feeling devalued.

Research findings suggest that precipitating factors alone, in the absence of predisposing factors, are less likely to lead to a claim.⁴⁷ So for two doctors who have been involved in identical adverse outcomes, their relative risk of litigation will depend on the relative quality of their interactions with the patient before and after the event.

Perhaps not surprisingly, negative communication behaviour increases litigious intent,⁴⁸ while some communication behaviours appear to be associated with fewer complaints. This includes providing explanations and giving information, offering emotional support, being well informed about the patient, involving the patient and checking their understanding.⁴⁹

There are a number of further considerations around predisposing factors including:

- 1 Patients often use interpersonal competence as a proxy marker for clinical competence.

Many patients assess clinical competence in a different way to doctors and to the legal system. This may influence their decision about whether to take action should an adverse outcome occur.⁵⁰ From our experience, we suggest that at times patients may consider the quality of the interaction as the 'de facto' standard of clinical competence. If the quality of that interaction is low, patients may infer the quality of clinical care is low as well.

2 Patient disappointment and dissatisfaction – 'the expectation gap'

If a patient has an experience that is very different from what they were expecting, including witnessing poor teamwork or experiencing poor inter-professional communication between the clinicians providing their care, these unmet expectations may lead to an expectation gap. This can be a powerful 'predisposing factor' in a decision to take some sort of action. While a patient's perception of the outcome or experience may be very different from the doctors - or even reality - it is the patient's perception that matters in terms of dissatisfaction. In commercial terms, this is equivalent to 'over-promising and under-delivering'.

Unmet expectations across a range of issues are usually the cause of patient dissatisfaction, and there appears to be a strong link between patient dissatisfaction and complaints.⁵¹ Any patient disappointment following an episode of healthcare can turn to frustration or anger, which can then lead to blame and then possibly a claim.

It is of course imperative to do everything possible to minimise precipitating factors and prevent, trap or mitigate error to enhance patient safety and increase reliability of healthcare delivery through effective clinical governance and risk management. This will involve consideration of latent system risks that have contributed to the event including issues around leadership, teamwork and communication and whether there is a culture orientated towards patient safety and quality. Consideration of human factors is important, as these may well contribute to any error or under-performance.

SUMMARY

Although we are well informed by international research, current UK based research is limited. We need to update and increase our understanding of these issues in the UK in order to have a complete understanding of how to manage the drivers of clinical negligence claims and not just the causes of clinical negligence.

35. References 1 - 8
36. Reference 4
37. Reference 12
38. References 13-21
39. References 23-28 and 36-42
40. Reference 1
41. Reference 30
42. References 2-7
43. Reference 8

44. Reference 31
45. References 13-21
46. References 14 and 21
47. Reference 12
48. Reference 32 and 33
49. References 19, 20 and 34
50. Reference 35
51. Reference 22
(references can be found on page 37)

RECENT LEGAL REFORM AND THE CASE FOR FURTHER ACTION – THE LEGAL AID, SENTENCING AND PUNISHMENT OF OFFENDERS ACT 2012 (LASPO)

The 2012 LASPO Act introduced a number of reforms which sought to better manage civil claims and introduce greater proportionality between the size of damages and the legal fees that solicitors are able to earn. MPS supported many of the reforms to the civil justice litigation system contained in this Act, but unfortunately this Act has not yet been as effective as we might have hoped.

It has been argued that we are yet to see the impact of LASPO and we must wait for these reforms to embed before making further changes. However, we are concerned that even when we review cases that are subject to the post-LASPO rules, the fees that claimant lawyers seek are still disproportionately higher than the damages the patient receives.

When considering medical claims that we settled between 2012 and 2016, almost three quarters (73%) of those that are subject to pre-April 2013 CFA agreements had claimant costs agreed at more than the damages awarded. When considering claims that are subject to post-April 2013 CFA Agreements, two thirds (66%) had claimant costs agreed at more than the damages awarded. This evidence indicates that the effect of the Jackson reforms on proportionality of claimant costs appears to be quite limited on medical claims, based on the data that we have available.

Not only has the intended impact been less than we would have hoped for, there were also unintended consequences that we have had to manage. We experienced a large number of claims notified to claimants' solicitors just prior to the new rules on recoverability of additional liabilities on 1 April 2013. We believe that this was due to claimant solicitors aggressively marketing for clinical negligence claims to take advantage of the more generous pre-April 2013 costs rules. We are only beginning to see the end of the consequences of this spike in claims. This suggests that when further legal reform is made, it must be done in such a way as to avoid incentivising claimant legal firms to seek to bring new claims before any statutory deadline.

Finally LASPO did not seek to address all of the factors that drive an increase in the cost of clinical negligence, such as damages. It is time to consider a more comprehensive package of reforms.



RECOMMENDATIONS

PREVENTION

1 Increase understanding of clinical negligence drivers

We need greater awareness of why patients choose to sue. To do this we recommend that government undertakes high quality, in-depth qualitative research to understand the drivers for clinical negligence claims in the UK.

It is important to have an up to date understanding as to why patients and their families take legal action and what they are hoping to achieve through litigation. This is particularly true for patients in primary care who have litigated, as the majority of existing research focuses on the hospital setting.

If we want to reduce litigation we need to understand what the drivers are. Otherwise, we are reliant on assumptions about what will reduce negligence claims. Although these are well informed by international research, current locally based research is limited.⁵²

2 Increase understanding of specific risks

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place.

Part of this involves drawing on our experience and expertise to raise awareness of the causes of high value claims, the medical conditions behind these, and how tragedies can be prevented.

We will seek to work with other organisations in the NHS and the wider healthcare system to raise awareness of the high value claim risk around conditions such as cauda equina syndrome, meningitis/encephalitis, missed cancers, peripheral ischaemia and chronic disease management. Fundamental to raising such awareness will be exploring 'red flag' symptoms and when to take urgent action.

We also recommend that the Department of Health undertakes a review to assess and seek to mitigate the specific risks that occur in unscheduled care/out of hours.

3 Increase focus on education and risk management

We would like to encourage an increased focus on education and risk management in both primary and secondary care.

Specifically, education and risk management initiatives to limit predisposing factors and the issues that make it harder to defend a claim. This includes training which seeks to ensure effective doctor-patient communication skills, consent and record keeping.

In addition, it is important to assess the potential for reducing precipitating factors through risk management by managing individual or system errors that can lead to a claim such as misdiagnosis or a medication error. Consideration of human factors training is also important.

4 Improve culture and systems for dealing with concerns

For many years, MPS has supported an open, learning culture in healthcare and we encourage healthcare professionals to be open and honest with patients when things go wrong. MPS has a crucial role supporting and advising members to embrace open disclosure.

We do not believe that legal requirements and tick-box exercises are the best way of changing the fundamental culture change that is required. MPS continues to play its part in supporting members and offering education and advice. However, we believe that there is more that can be done and that all bodies involved in healthcare should work together to tackle cultural and environmental barriers to openness and resolution of concerns. Action should be taken to:

- encourage incident reporting and learning from events
- encourage widespread use of regular staff surveys on the safety culture within general practice, such as those used by MPS
- promote a culture of speaking up
- encourage a culture that prioritises safety, quality, learning and improvement
- manage behaviour that undermines a culture of patient safety
- move away from a 'blame and shame' culture to one that promotes openness, transparency, candour and fairness.

5 Expectations of healthcare services

We would like to work with NHS England, the Department of Health, patient groups and others to consider ways we can build a common understanding of what we can and cannot reasonably expect from modern healthcare services.

52. It is important to note that this research is different from establishing the clinical aetiology of claims (what went wrong and why).

In our experience, and as evidence would suggest, patient expectations are increasing and this is making it even more likely that expectations will not be met. We know that unmet expectations are a driving factor for claims.

As a society we need to have an honest conversation about the inherent risks involved in healthcare, understand that it is not an exact science, and discuss what we can reasonably expect – while of course ensuring poor care is dealt with effectively.

LEGAL REFORM

While it is clearly important to take action to prevent claims from occurring in the first place, through improvement in patient safety and by addressing both precipitating and predisposing factors, there will still be claims and the cost of these is increasing.

Ultimately, NHS Resolution paid out £1.5 billion of tax payers' money to compensate patients for clinical negligence claims in 2015/16⁵³ – money that could be spent on frontline care. It is for this reason that we propose a package of legal reforms that we believe will begin to stem the increasing cost of claims.

'SPECIAL' DAMAGES – FUTURE CARE COSTS AND EARNINGS

Personal Injury Discount Rate

The recent reduction in the Personal Injury Discount Rate from 2.5% to minus 0.75% will have the impact of significantly increasing claims for future loss. The rate is currently based on the assumption that claimants will only invest in Indexed Gilts (ILGS) until redemption, and we would strongly urge the Lord Chancellor to reform the methodology on which the rate is based.

Future care costs

In our experience damages, and in particular future care costs and earnings, have increased in recent years. These costs are set to increase even more dramatically as a result of the Lord Chancellor's decision to reduce the Personal Injury Discount Rate to minus 0.75%. To illustrate, consider a 21 year old woman requiring long-term care, but with a normal life expectancy, resulting from a GP's failure to diagnose a sub-arachnoid haemorrhage. A claim of £1 million prior to 20 March (compromising of £700k of future care costs and £300k of other claims costs) would

now, at the new discount rate of minus 0.75%, cost £2.3 million. A similar claim at £5 million would now cost £12.8 million.

While MPS is robust in investigating special damages claims, doing so can involve delay and incur additional costs, for example, necessitating the instruction of forensic accounting experts.

While it is important that claimants with meritorious claims receive an award that provides them with the care they need, there can be enormous differentials between costings proposed by care experts for the claimant, and the defendant. We also have very little knowledge of how claimants choose to arrange for their care once they have received compensation.

For example, an award may be based on qualified nursing care but the claimant may opt to employ unqualified carers at lower cost or employ two carers instead of three. Whilst it is right that claimants should be free to utilise their awards in any way which best meets their needs, there is a question of unfairness if in fact they are over compensated.

If public resources were unlimited, it would be ideal if all those who have complex and lifelong care needs could be provided with every possible treatment, therapy, home adaptation and other provisions which allow them to lead a comfortable and full life. But the reality is that the public purse is not bottomless and every pound that is spent by the NHS on a compensation payment is a pound that could be spent on frontline care. It is a question of sustainability, and reasonable compensation must be at the heart of all awards.

- MPS recommends a limit on future care costs, based on the realities of providing home based care
- MPS suggests that a tariff for annual care costs, dependant on injuries, with an overall cap would work well.

We believe that such reforms will result in a more consistent and sustainable approach to awarding damages for future care costs. This would also be fairer and prevent sudden and unexpected increases in the cost of damages.

53. NHSLA Annual Report and Accounts 2015/2016

54. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157

55. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).



A survey of our members' revealed that 73% support a limit on the amount of money a patient can claim for future care costs.⁵⁴



A survey conducted by YouGov on our behalf found that 49% of the public surveyed also support a limit on the amount of money a patient can claim for future care costs.⁵⁵

There is currently a large degree of unpredictability about the size of awards which makes it difficult to settle cases quickly and can result in long and expensive disputes. It also increases the chances of over-settlement, which in the long-term drives up costs further.

Such a tariff would clearly need reviewing at set periods and developing in collaboration with care specialists, specialist lawyers and judges. The damages range should also be reviewed annually to take into account inflation and wage increases.

Future earnings

There is a significant issue of fairness relating to future earnings as high earning claimants are often able to claim more in damages than lower earners. Ultimately, this means that higher earners can receive more from the NHS in compensation than lower earners.

- MPS recommends a limit on future earnings which recognises national average weekly earnings

We believe there should be a limit on future earnings and earning capacity. This could be an important tool for lowering costs in the system, and to introduce greater parity in the size of awards claimants receive.



A survey of our members revealed that 83% support a limit on the amount of money a patient can claim for loss of future earnings.⁵⁶



A survey conducted by YouGov on our behalf found that 57% of the public who were surveyed also support a limit on the amount of money a patient can claim for loss of future earnings.⁵⁷

Other countries have introduced such limits. Mark Doepel, Adjunct Associate Professor at the University of Notre Dame Australia and eminent Australian lawyer, notes in Annex A that in Australia awards for loss of earnings and earning capacity are capped (typically, at a multiple of two or three times average weekly earnings). This means that awards for high earning plaintiffs are reduced by way of a formula that is not susceptible to manipulation.

'GENERAL' DAMAGES – COMPENSATION FOR PAIN, SUFFERING AND LOSS OF AMENITY

Minimum threshold

We noted with interest the recent Ministry of Justice proposals in the 'Reforming the Soft Tissue Injury Claims Process'⁵⁸ consultation, specifically relating to minor injuries sustained in car accidents (RTA) and the removal of cash for compensation, pain, suffering, loss of amenity (PSLA).

In this consultation, the government recognised the need for reform in RTA claims whereby the compensation paid is out of proportion to the injury suffered, and that in some quarters it has become culturally acceptable for claims to be made for very low level injuries.⁵⁹

The consultation went on to state that the costs paid as a result of the high number of RTA injury claims has a wider costs to motorists through increased motor insurance.

While the government has since decided against a minimum threshold in favour of a tariff for PSLA damage for claims relating to injuries with duration between 0 and 24 months,⁶⁰ we believe that this is an important point. Where only very minor injuries or inconveniences are suffered, it is not beneficial to society to shoulder the extra burden that the cumulative cost of these pay-outs result in.

Consider the important balance between ensuring that the ever-increasing liabilities for clinical negligence against the NHS are affordable to the public purse, and paying compensation to those who have suffered as a consequence of clinical negligence. It seems fair

56. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157

57. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).

58. Reforming the Soft Tissues Claims process; A consultation on arrangements concerning personal injury claims in England and Wales, November 2016

59. *ibid*

60. Part 1 of the Government response to: Reforming the Soft Tissues Claims process; A consultation on arrangements concerning personal injury claims in England and Wales, February 2017

to question whether it is reasonable to pay damages where an injury sustained, or inconvenience caused, is minor, whereas the cumulative cost impact on the public purse would be significant.

In some Australian states there are minimum thresholds for general damages, as explored by Mark Doepel in Annex A of this paper. For example, in New South Wales, a patient will not be able to successfully sue for compensation for non-pecuniary loss if the general damages sought are less than 15% of the most severe injuries sustained (as defined by an agreed scheme of injuries). However, they are still able to sue to recover special damages for treatment or care and loss of earnings.

Should a minimum threshold not be pursued, we would welcome consideration of a tariff for damages in the same way as is proposed for RTA claims. For example, where there has been a prescription error or delayed diagnosis leading to a short period of discomfort for the claimant, which has been resolved or been treated within a few months.

- MPS recommends consideration of a minimum threshold for cash compensation (PSLA) in clinical negligence claims

CLAIMANT LEGAL FEES

Fixed Recoverable Costs (FRCs)


It is not unusual for claimant lawyers' costs to exceed the damages awarded to claimants in lower value clinical negligence claims even where claims are settled at an early stage.


MPS supports the introduction of fixed recoverable costs (FRC) for claims of clinical negligence, as recently proposed by the Department of Health. FRCs increase transparency and proportionality for all parties, and this will help ensure more informed decision making in regards to a legal action. We also believe that FRCs would benefit both parties financially, as it would no longer be necessary to prepare and then agree or dispute budgets in claims that fall under the regime.


We are pleased that government has listened to MPS's calls for such a system and is seeking to introduce FRCs, but are disappointed that these proposals do not go far enough.

We undertook a survey of our membership and found that 86% of members surveyed agree with proposals for FRCs so that legal costs are not higher than compensation payments.⁶¹

Working with YouGov, we also sought to understand the public's perspective on the cost of clinical negligence and whether they support FRCs. The survey of the public found that:⁶²

 82% disagree that lawyers should receive more money in legal fees than the patient does in compensation for clinical negligence claims against the NHS

 75% agree the UK government should do more to reduce the amount of money lawyers are able to claim from the NHS in legal cost / fees in relation to clinical negligence claims

 81% support fixed costs so that legal costs are lower than compensation pay outs

With the need to tackle ever increasing costs in mind, we support a system of FRC up to a value of £250,000. We would strongly urge government to reconsider setting the threshold for FRCs at £250,000. Otherwise, while this is a step in the right direction, it would be a wasted opportunity.

NHS data demonstrates that disproportionate claimant legal fees are still a significant issue even in higher cases. When looking at claims with damages payments between £50,001 and £100,000 in 2015/16, the total defence costs were 19% of the damages - whereas the claimant costs were 99%. For claims between £100,001 and £250,000 the total defence costs were 15% of the damages, whereas the claimant costs were 72%.⁶³

Whilst the most disproportionate claims are observed in the cases where damages fall between the bracket of £1,000 to £25,000, the highest levels of costs on an individual case basis paid out would be in cases in excess of the £25,000 figure. Therefore we might assume that the financial benefits to the NHS and the taxpayer would increase if the threshold were set at a higher level. Whilst we understand the arguments for not introducing FRC's for the most expensive and complex of claims, in our experience it would remain appropriate and viable to include claims up to £250,000.

- MPS recommends the introduction of a system of fixed recoverable costs for all clinical negligence claims up to a value of £250,000

61. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157

62. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).

63. Fixed recoverable costs in lower value clinical negligence claims; a consultation, Annex E: Additional data, prepared by the Clinical Negligence Policy Team

SOME RECENT EXAMPLES (ISSUED POST-LASPO) INCLUDE:

Claims with damages settled below £25,000

- A recent delayed diagnosis claim which settled for £4,000, yet costs of £35,263 were sought. Following our challenge, ultimately costs were agreed at £19,000.
- Another recent delayed diagnosis claim which settled within six months from the letter of the claim, and damages agreed at £7,000. Costs were claimed at £12,200, however, following our challenge, costs were ultimately settled for £4,750.
- Another straightforward dental negligence claim which settled for £3,500 within three months of the letter of claim saw costs claimed at £11,201.70. Ultimately costs were agreed at £5,000 - still in excess of the damages paid.

Claims with damages settled above £25,000

- A case where damages settled for £75,000 with a Bill of Costs which claimed £90,704 was ultimately reduced through negotiation to £70,000. This was a case which related to delayed diagnosis. Whilst the case was litigated, it was resolved early, before procedural steps were taken.
- A case where damages settled for £32,000 with a Bill of Costs which claimed £37,663 was ultimately reduced through negotiation to £22,500. This was a case which related to negligent surgery. Whilst the case was litigated, it settled shortly after service and the case had settled within one year from receipt of the letter of claim.
- A case where damages settled for £50,000 with a Bill of Costs which claimed £83,102 was ultimately reduced through negotiation to £64,000, which was a figure which still exceeded the damages agreed. It should be borne in mind that there were two defendants, however this was a relatively straightforward claim for negligent dental treatment. Whilst the case was litigated, it did not proceed as far as the CMC stage.

CLAIMANT EXPERT REPORTS

If a claimant is successful in their claim for clinical negligence, the defendant may have to pay both the cost of the expert witnesses but also the cost of the premium for any After the Event (ATE) Insurance that the claimant takes out to protect themselves from paying the costs of expert witnesses if they lose.

After the Event (ATE) insurance

Unlike other personal injury cases, the LASPO reforms made an exception to allow ATE premiums taken out by claimants to cover the costs of expert witnesses to be recoverable without any limits, from unsuccessful defendants.

The regulations also do not provide for a limit on the number of expert reports covered by the insurance premium or a cap on the experts' costs. This can mean that the defendant is left to pick up a large bill for an insurance premium for an unlimited amount with next to no transparency behind why the cost is what it is. Below is a recent example of such a claim.

A recent claim was settled within 12 months from the letter of claim and damages were agreed at £1,550. Despite this, costs were claimed at £39,621 (including a post-LASPO ATE premium of £5,597). Again, due to robust challenge, ultimately costs were settled for £15,000. However, this is still a far greater sum than the damages paid.

- MPS recommends reform to rules relating to claimant expert reports covered by ATE insurance

In the first instance, the ability for claimants to recover the cost of ATE premiums for expert witnesses from losing defendants should be removed.

If the ability to recover premiums remains, reforms should be made to clarify what it can cover. For example:

- a limit on the number of expert reports that the claimant can commission to support a case – one breach expert and one causation expert
- a cap on the amount that can be spent on an expert witness (whilst achieving a balance between this and the need for a quality expert pool)
- greater transparency over the way in which the premiums paid by losing defendants are calculated.

We agree that there may be an argument for a provision for special dispensation in complex cases which could involve judicial discretion.

Fees for expert reports

We also believe that there is a need to reduce expert fees, which will assist in preventing disproportionate costs in comparison with damages. We also believe that it is right that there should be a cap on the number of experts instructed in the pre-action protocol stage of claims.

- MPS recommends consideration of methods to reduce expert fees, including a cap on the number of experts instructed.



A survey of our members revealed that **88%** supported a limit on the amount of money that can be spent on expert witnesses.⁶⁴

However, we recognise that, in order to maintain an adequate pool of quality experts, any system of capped or fixed expert fees must be reasonable and fair. We urge the government to consider how best to achieve this important balance.

LIMITATION PERIODS

It is not unusual in England and Wales to see late notification of claims. For example, MPS recently received notice of a claim involving the failure to diagnose a disease in a toddler in 1990. We were notified of the claim in 2015 when the claimant was 25 years old.

Late notification of a claim means that:

- records may have been lost or destroyed meaning that hospitals and other institutions are unable to provide records
- medical staff may have retired, died or cannot be traced
- medical staff may have little recollection of the facts of the case.

Late notification of claims contributes towards delay and higher costs. The longer the delay between the incident and the claim, the greater the opportunity there is for claims inflation to increase levels of damages.

There is a balance to be achieved between the rights of claimants and defendants and a public interest in ensuring that claims are pursued as quickly as possible.

64. Fixed recoverable costs in lower value clinical negligence claims; a consultation, Annex E: Additional data, prepared by the Clinical Negligence Policy Team

- MPS recommends the introduction of an ultimate limitation period of ten years between the date of an adverse incident and when a claim can be made (but with judicial discretion in certain circumstances)

MPS recognises the need for judicial discretion in certain circumstances, for example where the parents of a seriously injured child are unaware that the child might have a claim in negligence until many years after the incident date.



A survey of our members revealed that **83% of respondents agreed that claims should be invalid if they are brought more than ten years after the incident.**⁶⁵



A survey conducted by YouGov on our behalf found that **64% of the public who were surveyed agreed that claims should be invalid if they are brought more than ten years after the incident.**⁶⁶

We think this is an important reform as we are concerned about the inconsistent way in which Section 33 of the Limitation Act is applied. In our experience, there can be an extremely varied approach to when the date of knowledge is dis-applied, with some courts applying a great deal of discretion. Again, in practice, this means higher costs.

Other systems have similar such limitation periods. The General Medical Council, for example, is limited in what investigations they can conduct into allegations that are more than five years old due to the difficulty in security sufficient and reliable evidence.

We see this recommendation as introducing a ‘back stop’. Up until the ten year limitation period, the claimant could bring a claim within three years of the date of the incident date or date of knowledge. In circumstances where there was a period of negligence, for example a prescription error, the limitation period could start to run from the date of the last prescription, or date of knowledge of the error, subject to the ten year back stop.

SMALL CLAIMS TRACK

MPS welcomed the principle behind the recent government announcement that it intended to raise the small claims track limit for Road Traffic Accident (RTA) personal injury claims to £5,000.

We strongly agree that the previous £1,000 limit for personal injury claims is out of step with the small claims limit in other cases, and we note that it has not been increased since 1991.

The proposed increase in the small claims limit to £5,000 was restricted to road traffic accident claims alone (with the small claims limit for non-RTA personal injury claims increased to just £2000), as there is a distinct risk that this could lead to significant claims displacement into clinical negligence. We believe that the certainty of one limit for all personal injury claims, including clinical negligence claims, also has the merit of simplicity and transparency for all parties.

In the 2015-2016 Parliament, this proposal was included in the Prisons and Court Bill. The Bill, however, ran out of Parliamentary time. We hope that if the issue is being reconsidered, the government will commit to keeping this disparity under review. We strongly believe that the £5,000 small claims track limit should be consistent across all personal injury claims, with the potential to increase further over time.

In our extensive experience, many low level clinical negligence claims are straightforward and could easily be managed within the small claims track, with the court having discretion to move a claim to another track if there are any particularly complex issues involved.

- MPS recommends an increase in small claims track threshold for clinical negligence claims to £5,000

We have considered what potential impact a small claims track for clinical negligence claims, with a limit of £5,000, would have on claims against our members. We think that such a proposal could be beneficial in reducing the cost of low value claims, and particularly dental claims.

The small claims track limit should therefore be raised to at least £5,000. There is much scope for the increase to be fully in line with all other small claims (apart from housing disrepair claims), namely to £10,000.

MPS however recognises that a stepped increase, eventually to £10,000 over say two years, would allow an assessment of the impact of increased numbers of litigants in persons, and the Court Service’s ability to support them. This is an important consideration and one which we would welcome further discussion on.

65. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157

66. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).



QUALIFIED ONE-WAY COSTS SHIFTING

While fundamental dishonesty is rarely a feature in clinical negligence claims, late discontinuance of a claim is not an infrequent feature. It results in considerable expense to the defendant without any cost consequences for the claimant, who may have been pursuing a fundamentally hopeless claim.

The exchange of expert evidence in clinical negligence claims and the preparation of joint statements should give a sufficiently clear indication of the prospect of the claim to all parties. This exchange and expert discussions take place at least 12 weeks prior to trial, so discontinuance less than four weeks before trial should never be necessary and, when it does occur, should remove the claimant's qualified one-way costs shifting (QOCS) protection. This would provide an effective incentive to ensure claimants with claims that have poor prospects do not draw out a claim unnecessarily.

- MPS recommends that QOCS provisions should be amended so that the claimant is required to seek the court's permission to discontinue less than 28 days before trial.

We welcome proposals contained in the recently published consultation on 'Reforming the Soft Tissue Injury Claims Process', which seeks to discourage the late withdrawal of claims. By amending the provisions so that a claimant is required to seek the court's permission to discontinue less than 28 days before trial, fraudulent claimants should be dissuaded from running cases to the doors of court, only to withdraw them once it becomes clear that the defendant will not settle.

CONCLUSIONS

The current clinical negligence claims environment cannot be allowed to continue on its current trajectory. Expenditure on clinical negligence claims by NHS Resolution has increased by 72% over the last five years. Not only does it risk becoming unsustainable for the NHS from a financial perspective, but it is also placing undue burden on doctors and dentists, and the fear of being sued is clearly having an impact on the way many healthcare professionals practise. This is to the benefit of no one, including patients.

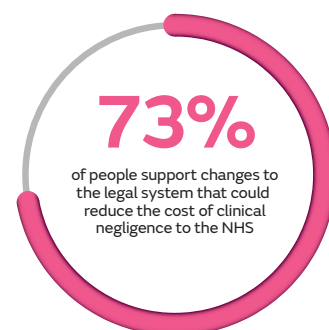
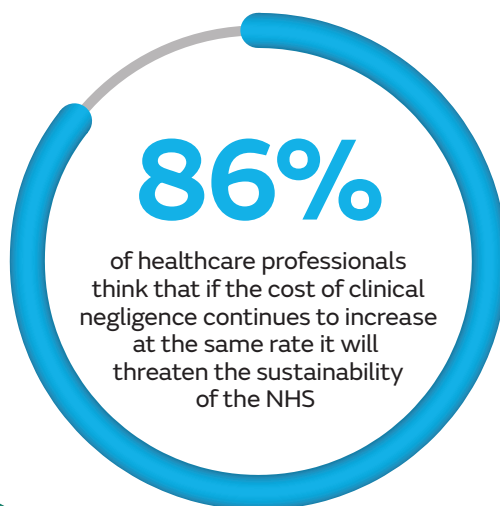
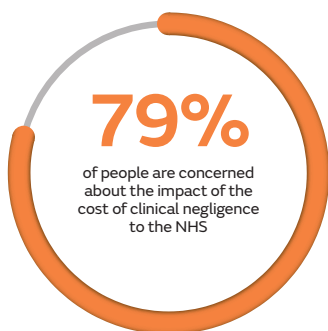
This situation has been exacerbated further by the recent announcement by the Lord Chancellor that the Personal Injury Discount Rate will be reduced from 2.5% to minus 0.75%. This significant and disappointing decision will dramatically increase the cost of settling claims, especially future care costs. This is an increased cost which the taxpayer will have to pick up.

To illustrate, consider a 21 year old woman requiring long-term care, but with a normal life expectancy, resulting from a GP's failure to diagnose a sub-arachnoid haemorrhage. A claim of £1million prior to 20 March (compromising of £700k of future care costs and £300k of other claims costs) would now, at the new discount rate of minus 0.75%, cost £2.3million. A similar claim at £5million would now cost £12.8million.

It goes without saying that there must be a clear focus on improving patient safety and the reliability of healthcare, but as we have explored in this paper, doing so alone is unlikely to address this problem. We also need to better understand why people bring claims and address these issues, and focus on a package of effective legal reforms to tackle the increasing cost of claims when they are brought.

We know from our research that 79% of the public are concerned about how the cost of clinical negligence is impacting on the NHS, and 86% of healthcare professionals tell us that if the cost of clinical negligence claims continues to increase at the same rate, they think it will threaten the sustainability of the NHS. The majority of the public (73%) and healthcare professionals (86%) support changes to the legal system to tackle the issue. Fundamentally, there is agreement from 83% of healthcare professionals, that difficult decisions are made about spending in healthcare every day, and how much society pays for clinical negligence must be one of them.⁶⁷

We have suggested a number of reforms that, if implemented effectively, will begin to tackle the cost of claims in England and Wales. Crucially we think the time for action is now, before we see the annual bill to the NHS increase any further. It is for the benefit of everyone to make the necessary changes before the increasing costs become unsustainable.



67. Survey of UK based Medical Protection Society members, conducted by the Medical Protection Society in February 2017. Sample size was 4157. Survey conducted by YouGov on behalf of the Medical Protection Society, between 9-10 February 2017. Sample size was 2034 British adults. Figures have been weighted and are representative of all GB adults (aged 18+).

ANNEX A

INTERNATIONAL EXPERIENCE – AUSTRALIA

A REVIEW OF TORT LAW REFORM IN AUSTRALIA AS AT SEPTEMBER 2014

By Mark Doepel, Partner, Sparke Helmore and tutor at the University of Sydney

INTRODUCTION

Australian tort law reform commenced in the early 2000s against the international backdrop known as the “liability crisis”. By 2002, the Chief Justice of New South Wales (NSW) was describing the law of negligence in Australia as “...the last outpost of the welfare state”.¹

The impetus for reform began in the health care sector. In 1999/2000, many Australian medical defence organisations were obliged to ask members to pay significantly more for their indemnity. The exponential rise in premiums – particularly for obstetricians – began to reduce the availability of some types of medical services.

Eventually, calls for reform percolated out to the broader community as liability insurance became less affordable and harder to obtain, particularly following the collapse of the HIH insurance group in March 2001. That group had been writing high volumes of liability insurance in return for unsustainable premiums and provided reinsurance to some Australian medical defence organisations. Many charities and community organisations could not obtain affordable liability insurance anywhere and began to cancel or curtail their public activities.

The Australian Federal Government established the Ipp Committee to examine possible reforms to tort law. The Committee released its two reports in August and September 2002, outlining 61 reform recommendations, chief amongst which was that all Australian jurisdictions should take a consistent approach to tort reform.

However, by November 2002 it was apparent that the Australian States and Territories would not be able to agree on a nationally consistent framework for tort law reforms. And so the governments of the eight Australian States and Territories each launched – separately – into tort law reform. This paper will examine those reforms and, almost a decade and a half on, look at how effective they have been, particularly with reference to the medical profession.

THE GENERAL AUSTRALIAN REFORMS

The table in (Annex b) summarises the main Ipp Committee recommendations, with the exception of those relating specifically to medical negligence (considered later), and the various Australian legislative implementations of tort reform.² Notably, the reforms enacted included some areas that were not amongst the recommendations in the Ipp Report:

- a. Apologies and expressions of regret. An apology does not now amount to an admission of (and may not be called as evidence of) liability or fault;
- b. Proportionate liability, which is now applicable in claims for property damage and economic loss, but not in claims for bodily / personal injury which were the sole concern of the Ipp Committee; and
- c. Procedural changes, particularly in relation to:
 - Personal injury claims. In Queensland, the Australian Capital Territory and the Northern Territory, the parties must now explore the possible resolution of claims before commencing litigation or face possible costs penalties. The Ipp Report recommended that advance notice of claims should be required before litigation but did not take procedural issues any further than that; and
 - Requirements for solicitors, when commencing any proceedings claiming damages, or any defence, to certify that, based on the information available at the time, there is a proper basis for the claim or defence. Solicitors who file such a certificate without proper basis may be required to pay the costs of the proceedings personally, without passing those costs onto their clients.

The main benefits that general tort reform was intended to bring to the medical profession lay in:

- a. Its efforts to clarify how questions of causation of loss should be approached, against a common law background where defendants were increasingly being found liable for very remote consequences of their own negligence. However, it remains to be seen whether the legislation has in fact clarified this difficult legal area;
- b. Reductions in limitation periods applicable to personal injury claims, so that the limitation period expires on the earliest of the following two dates (with exceptions for minors and those under other legal disabilities):
 - Three years from the “discovery date”, being a date 3 years after the plaintiff knew, or should have known, that:
 - death or personal injury had occurred;
 - it was caused by the defendant’s fault; and
 - it was sufficiently serious to warrant bringing proceedings for damages; or

1. Reynolds v. Katoomba RSL All Services Club Ltd (2001) 53 NSWLR 43 at [26]
2. Table A sets out the current state of the law in each jurisdiction. However, the reforms were not all introduced simultaneously so some have been in force in some relevant jurisdictions longer than others

- 12 years after the date of the act or omission occurred.

All but one of the Australian jurisdictions adopted these recommendations, although most did so in a modified form. As a result, Australian medical practitioners (with the exception of those in the Northern Territory) can be reasonably confident when treating a person aged 18 or more, that when 12 years have passed, there will be no further risk of a claim being made as a result of that treatment. The reforms also mean that most claims will be brought at a time when the defendant still has his or her records about the treatment and may still have a reasonable recollection of the relevant events;

- The capping of legal fees, providing a disincentive for lawyers to get involved in claims involving only minor injuries and an incentive for lawyers who do get involved to reach a prompt settlement, thus reducing both settlement and legal costs for defendants;
- The protection given to rescuers and “good Samaritans”;
- A reduction in higher-end awards of damages, mainly because:
 - Awards for loss of earnings and earning capacity are capped (typically, at a multiple of two or three times average weekly earnings) so that awards for high-earning plaintiffs are reduced by way of a formula that is not susceptible to judicial manipulation;
 - Awards of future damages (loss of earnings and / or medical care) are subject to a higher discount rate (5%) than the Ipp Committee recommended (3%). Although that will do much to curtail the large-end verdicts, it has given rise to criticisms that the higher discount rates adopted uniformly across Australia severely undermine the compensation paid to seriously injured plaintiffs. A push by plaintiff lawyer associations to reduce the discount rate is likely; and
 - Structured settlements are available to seriously injured plaintiffs requiring long-term care.

AUSTRALIAN REFORMS DIRECTED SPECIFICALLY AT MEDICAL INDEMNITY INCLUDING INSURANCE ARRANGEMENTS

The responses of each of the Australian jurisdictions³ to the Ipp recommendations about professional indemnity issues were slower than those relating to the general law of negligence. Most of the States and Territories began by introducing professional standards legislation that allowed members of specific occupational and professional groups to cap the civil liability of their groups’ members, but those reforms did not apply to claims for personal injury damages and were not applicable to the medical profession.

In November 2003 concerns were raised in the New South Wales Parliament that medical professionals were resorting to “defensive medicine” because they feared the legal consequences of making errors. That is, they were either performing unnecessary services to

assure patients that they had considered everything, or they were avoiding treating high-risk patients.

The main Australian tort reforms directed specifically at the medical profession were:

- The *Bolam* principle was returned to the law in most jurisdictions⁴, meaning that medical practitioners themselves, not the Courts, determine the appropriate standard of care, although the Courts can disregard medical opinion if it considers it to be irrational. However, the Northern Territory has not adopted this recommendation;
- The duty to inform patients of matters relevant to their decision to undergo treatment, including warnings, was reformed to some extent. However, there is little consistency between the various jurisdictions:
 - In New South Wales, Victoria, South Australia and Western Australia, the *Bolam* principle does not extend to failure to provide information / warn;
 - In Queensland patients must be informed about risks associated with medical treatment if:
 - a reasonable person would require it to make an informed decision about the treatment; and / or
 - the doctor knows or should know that he or she expects the advice to be given; and
 - In Tasmania, medical practitioners are protected if they need to act promptly to avoid serious risk to a patient’s life or health;
- Public health authorities now have immunity from suit for matters arising from the exercise of their “special statutory powers” unless they are exercised so perversely as to miscarry. Whilst the term “special statutory powers” is undefined in this context, the immunity would almost certainly apply to situations like a decision to detain (or not to detain) a person under mental health legislation; and
- New South Wales and Victoria legislated to preclude the recovery, in actions for wrongful birth, of damages to compensate the plaintiff for the cost of raising the child and/or income lost whilst so doing.

3. Although the reforms were enshrined in a number of enactments in each jurisdiction, the main Act(s) which comprised those reforms were: in the Australian Capital Territory, the Civil Law (Wrongs) Act 2002; in New South Wales, the Civil Liability Act 2002; in the Northern Territory, the Personal Injuries (Civil Claims) Act 2003 and the Personal Injuries (Civil Claims) Act 2003; in Queensland, the Personal Injuries Proceedings Act 2002 and the Civil Liability Act 2003; in Victoria, amendments to the Wrongs Act 1953; and in Western Australia, the Civil Liability Act 2002

4. Not in the Northern Territory and, in South Australia, in a modified form

THE AUSTRALIAN EXPERIENCE SINCE TORT REFORM

The most obvious difficulty with the Australian reforms is the lack of any national consistency – and indeed, the substantial diversity – between them. Whilst most of the States and Territories have models that are at least superficially similar, the devil lies in the detail of their differences. Queensland, the Australian Capital Territory and the Northern Territory adopted a completely new procedural approach to personal injury claims. Entities with an interest in tort issues nationally, including liability insurers, must therefore modify their approach to the extent of their duty of care and to any alleged breaches thereof differently in different jurisdictions.

The reforms appear to have had an impact on the number of Court filings. However, the early statistics may have been skewed by reason of a rush by plaintiff lawyers to file proceedings in advance of law reform, meaning that filings were up immediately prior to reforms and down immediately after them. The Australian Competition and Consumer Commission publishes an annual report into its monitoring of public and professional liability insurance issues and reported an 11% decrease in the average size of claims between about December 2003 and June 2004. However, the ACC reported that the average size of professional indemnity claims increased by 21% in the same period, indicating that much more remained to be done to reform the law of professional negligence.

Some of the reforms do not appear to be working in the manner intended. In particular:

- a. General damages in most jurisdictions are subject to a cap at their upper end (see item 11 in Table A). Anecdotal evidence suggests that:
 - Some Judges approach the scale of general damages by determining what figure they wish to award and then assessing the injury as the corresponding percentage of the worst case, rather than approaching the question from the opposite direction; and
 - Some plaintiff lawyers have become particularly innovative in their pleadings with a view to bypassing the cap. For instance:
 - There were efforts to plead cases under the Trade Practices Act 1974 (Cth), although the Federal Government curtailed that practice by making modifications to the Act to prevent it giving rise to civil actions for damages for personal injury; and
 - Some plaintiff lawyers have included nervous shock damages claims in cases that may previously have been conducted on the basis of pure physical injuries, with a view to increasing the plaintiff's percentage assessment;
- b. There is an apprehension that Judges will increase verdicts so as to avoid the cap on legal fees. Some defendant lawyers believe that it may be impossible to settle small claims for less than the

applicable threshold without also agreeing to pay something towards legal fees, so that claims which should have been settled are proceeding to trial;

- c. Plaintiffs' solicitors may initially have been more careful about the allegations made within pleadings when certifying that they had a reasonable basis for those pleadings, but there have been relatively few cases in which solicitors have been found personally liable for costs as a result of an inappropriate certification, and those cases have received relatively little publicity.⁵ Even when a Judge does not believe a plaintiff's evidence about the basis for a case, it may be difficult for a defendant to satisfy the Judge that the plaintiff's solicitor should also have disbelieved it from the outset. The apparent return to imaginative pleadings referred to above suggests that the threat of personal costs orders is having relatively little impact.

Other of Commissioner Ipp's recommended reforms are not working, simply because they have not been adopted, or have been too substantially modified by those jurisdictions that did adopt them.

For instance:

- a. Only one Australian jurisdiction introduced a threshold for non-economic loss awards in the way recommended;
- b. None of the jurisdictions capped non-economic loss awards at the number recommended; and
- c. The cap on legal fees in small claims was only introduced in half of the Australian jurisdictions. Each that did introduce it substantially modified the recommendation.

Looking more specifically at the medical indemnity field:

- a. One of the most important planks of the professional indemnity reforms related to the introduction of proportionate liability, so that a wrongdoer could only be found liable for a loss to which various wrongdoers contributed to the extent just and reasonable. However, those reforms did not apply to claims for personal injury and are of no assistance to medical practitioners who will still be jointly and severally liable for the whole of any loss to which they contribute, albeit with rights to claim contribution from other wrongdoers;
- b. There is some room for optimism in relation to the duty to inform / warn, following a 2013 decision by the High Court of Australia⁶ which exonerated a neurosurgeon from any liability to a plaintiff who, in the primary Judge's findings, would have undergone surgery even if he had been warned of the relevant risk. That case reversed an alarming earlier trend in claims for failure to warn:
 - In 1992, the High Court found an ophthalmic surgeon responsible for the plaintiff's loss of vision in her left eye by reason of his failure to warn her of a remote risk (1 in 14,000) which in fact materialised⁷, notwithstanding a body of professional evidence to the effect that no warning was necessary in the circumstances;

- In 1996, the District Court of Western Australia found an orthopaedic surgeon responsible for the results of the plaintiff's surgery, because it found that the warnings understated the magnitude of the risk⁸; and
 - In 2000, the High Court found a dental surgeon responsible for surgical complications despite recognising that it is difficult to accept a plaintiff's retrospective evidence that he or she would not have undergone the surgery if properly warned, when the problem which the surgery was designed to address was acute and the risk was remote⁹; and
- c. In 2013 the New South Wales Court of Appeal exonerated a radiologist from the consequences of failing to detect an aneurysm during a 2003 scan. The aneurysm was detected 3 years later and ruptured during surgery to remove it. Had it been detected earlier, the surgical intervention required would have been substantially less risky. The radiologist was not liable because:
- The harm suffered was the result of the materialisation of an "inherent" risk (that is, the risk of intra-operative rupture), being one that could not be avoided by the exercise of reasonable care and skill (including the care and skill of those who later treated the plaintiff);
 - The risk was unavoidable, even if the harm that manifested was not;
 - The radiologist did not perform the surgery which led to the rupture and there was no good reason of public policy to extend his liability to cover the consequences of surgery performed by someone else. It was not the radiologist's role to avoid the risk created by the later surgery;
 - Even though earlier surgery would have been less risky, it would not have been entirely without risks so that early diagnosis would not of itself have avoided the risk; and
 - Duties in relation to diagnosis are not analogous to duties to inform / warn and should not be expanded by reference to notional decisions patients might have taken not to undergo proposed treatment.

However, it is alarming to note that a survey conducted in 2009, albeit on the basis of a relatively small sample size¹⁰ concluded that many medical practitioners in New South Wales remained unaware of tort reforms some 7 years after they were enacted and continued to practice defensive medicine with a view to protecting themselves against litigation. Without better understanding of the reforms by the medical profession, they will not achieve their important aim of improving the standard of and access to medical care in Australia without compromising the interests of those responsible for providing it.

As we approach a benchmark of 15 years since the reforms began to be introduced, we see that a great deal of good legislative intent may have gone awry due to the haste of the various Australian jurisdictions to introduce their own tort reforms, rather than waiting to explore the possibility of national consistency, due to discrepancies between the Ipp recommendations and the regimes introduced in each Australian State and

Territory, and due to some liberal judicial interpretation of the reforms in lower courts. There can be no doubt that the reforms were of benefit to those who may be defendants in negligence actions, including professional negligence actions, but it is very difficult to conclude that they went far enough to address the imbalance which led to their enactment.

OTHER COMMON LAW JURISDICTIONS CONSIDERING TORT REFORM WOULD DO WELL TO CONSIDER WHAT WE HAVE LEARNED IN AUSTRALIA:

- a. In any federated country, national consistency must not be sacrificed in a race to introduce reforms;
- b. Professional negligence – and particularly medical negligence – has its own issues which must be addressed in the framework of broader negligence law reform. Legislation should enshrine professionals' right to be assessed on the basis of accepted peer conduct at the relevant time and should extend that assessment to issues of failure to provide information / warn;
- c. Legislative reform must apply comprehensively to all statutes that may confer individual rights of action for personal damages to avoid imaginative pleadings by plaintiff lawyers;
- d. Similarly, although the availability of personal costs orders against plaintiff lawyers who falsely certify a case's prospects is a useful tool, defendants must make judicious but regular use of the tool if they want the reform to have any effect on the commencement of speculative or unmeritorious cases; and
- e. Whilst caps on damages for economic and non-economic loss and on the ability to recover legal costs in small claims is very helpful in restricting settlement costs for defendants, legislation should be drafted with an eye to avoiding the possible future benevolent interpretation of thresholds by sympathetic judges;

5. For a rare example, see: *Lemoto v. Able Technical Pty Ltd* (2005) 63 NSWLR 300
 6. *Wallace v. Kam* (2013) 297 alr 383
 7. *Rogers v. Whitaker* (1992) 175 CLR 479; 109 ALR 625
 8. *Roberts v. Hardcastle* [2002] WADC 149
 9. *Rosenberg v. Percival* (201) 178 ALR 577
 10. *Defensive medicine in general practice: Recent trends and the impact of the Civil Liability Act 2002 (NSW)*, Omar Salem and Christine Forster, (2009) 17 JLM 235

ANNEX B

TABLE A – THE MAIN IPP REPORT RECOMMENDATIONS

Tort reform area	Australian responses							
	NSW	Qld	Vic	SA	WA	ACT	NT	Tas
<p>Duty and standard of care</p> <p>A person is not negligent for failing to take precautions against a foreseeable risk unless:</p> <p>a. it is “not insignificant” and</p> <p>b. a reasonable person in the same position would have taken precautions, with regard to the probability and likely seriousness of the risk, the burden of taking precautions and the social utility of the risk-creating activity.</p>	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
<p>Obvious risks</p> <p>A person is not liable for failure to warn of any risk that is obvious to a reasonable person, including matters that are patent or matters of common knowledge. A risk may be obvious even if it is of low probability.</p>	Yes	Yes	Modified	Modified	Modified	No	No	Modified
<p>Professionals</p> <p>The standard of care required of persons who hold themselves out as possessing a particular skill should be determined by reference to what could reasonably be expected of a person professing that skill as at the date of the alleged negligence, unless the Court considers that professional opinion as to those reasonable expectations is irrational.</p>	Yes	Yes	Yes	Yes	Modified (health care professionals only)	Modified	No	Yes
<p>Recreational Services</p> <p>There should be no liability for personal injury or death for the manifestation of an obvious risk.</p>	Yes	Yes	Modified	Modified	Yes	Modified	No	Modified
<p>Contributory negligence</p> <p>The test should be whether a reasonable person in the plaintiff’s position would have taken precautions against the risk of harm, having regard to what the plaintiff knew or reasonably knew taking into consideration the:</p> <p>a. probability of harm</p> <p>b. seriousness of harm</p> <p>c. burden of taking precautions and</p> <p>d. social utility of the activity in question.</p> <p>Courts should be entitled to reduce damages on account of contributory negligence by up to 100%</p>	Yes	Yes	Modified	Yes	Modified	Modified	No	Yes

Tort reform area	Australian responses							
	NSW	Qld	Vic	SA	WA	ACT	NT	Tas
<p>Causation</p> <p>The plaintiff bears the onus of establishing both:</p> <p>a. factual causation; and</p> <p>b. the scope of liability (including both legal and “common sense” causation, foreseeability and remoteness).</p>	Yes	Yes	Yes	Modified	Yes	Yes	No	Yes
<p>Proportionate Liability</p> <p>Joint and several liability should be retained for personal injury claims.</p>	Modified	Modified	Modified	Modified	Modified	Modified	Modified	Modified
<p>Liability for Mental Harm</p> <p>There should be no liability unless the mental harm is a recognised psychiatric illness. It must have been reasonable to foresee mental harm in a person of normal fortitude, with reference to:</p> <p>a. whether the injury arose from witnessing a shocking incident or its aftermath</p> <p>b. whether there was a pre-existing relationship between the plaintiff and the defendant and</p> <p>c. the nature of the relationship between the plaintiff and the person who was injured or killed in the incident.</p>	Modified	No	Yes	Yes	Yes	Yes	No	Modified
<p>Limitation period</p> <p>A nationally consistent limitation period should be introduced, being a period of 3 years with a long-stop 12 year period, discretion to extend and extended period for minors. Time should commence from the date on which the plaintiff knew or should have known that an injury had occurred, the cause of which was attributable to the defendant and that the injury was sufficiently serious to warrant proceedings.</p>	Yes	Modified	Modified	Yes	Yes	Modified	No	Modified
<p>Thresholds for non-economic loss awards</p> <p>No general damages should be payable unless the injury is equivalent to 15% of a most extreme case and general damages should be assessed as a percentage of the capped maximum award.</p>	Yes	No	Modified	Modified	Modified	Modified	Modified	Modified

INTERNATIONAL EXPERIENCE – UNITED STATES

In the United States, the debate about tort reform, both in relation to medical negligence and other areas of civil liability, grew rapidly in the mid-1980s and again in the early 2000s.

The 2012 Republican Party Platform said that it is committed to aggressively pursuing tort reform legislation to help avoid the practice of defensive medicine, to keep healthcare costs low, and improve healthcare quality. This reform would include state and federal legislation to cap non-economic damages in medical malpractice lawsuits.¹¹

“A reform in these laws would encourage patient safety, as providers would be more willing to admit mistakes, and therefore patients would be better able to seek appropriate compensation.”¹²

Doctors’ organisations, such as the American Medical Association (AMA), are of the same view and AMA stated that it continues to pursue legislative solutions at both the federal and state levels.¹³ They argue that the broken medical liability system remains one of the most vexing issues for doctors today and that it places a wedge between doctors and their patients:

“It forces physicians to practice defensive medicine. It puts them at emotional, reputational and financial risk, and it drains resources out of an already financially strapped national health care system – resources that could be used for medical research or expanded access to care for patients. Now more than ever, AMA is committed to improving the medical liability system for both patients and physicians.”¹⁴

In the absence of a federal medical liability reform, many US states have implemented tort reform in different ways. More than 30 states have some form of cap on damages in clinical negligence suits. California and Texas are the most advanced and successful states with regards to medical liability reform. Despite legal challenges, California’s landmark legislation, the Medical Injury Compensation Reform Act (MICRA) of 1975, was upheld again in November 2014, keeping a \$250,000 cap on non-economic damages in medical liability lawsuits.

In 2003, for the first time since Reconstruction in 1877, the citizens of Texas elected a Republican majority to the Texas House of Representatives. Many of them were interested in reforming the state’s tort system.¹⁵ Discussions evolved around House Bill 4 (HB4), which limited the award of noneconomic damages in medical malpractice cases to \$250,000 against all doctors and health care practitioners and a \$250,000 per-facility cap against health care facilities such as hospitals and nursing homes, with an overall cap of \$500,000 against health care facilities, creating in effect an overall limit

of noneconomic damages in medical malpractice cases of \$750,000.¹⁶

Prior to enacting this bill, Texas was in the midst of a medical malpractice crisis. Pay-outs per claim were sky-high, medical tort insurance premiums rose uncontrollably and doctors left the profession or fled the state.¹⁷

Ten years of tort reform have provided at least the following positive changes in Texas:

1. By the end of 2013, 10 years and three months after the effective date of HB4, the number of licensed doctors in Texas had almost doubled.
2. Since the tort law was adopted, the increase in growth of the number of doctors in Texas is twice the population growth.
3. After the reform, Memorial Hermann Hospital System added – in one year – 26 pediatric subspecialists; a normal year previously would only count just one or two.

The Wall Street Journal, *The New York Times*, the Texas Trial Lawyers Association, and the American Medical Association have all agreed that HB4 did achieve its goals.¹⁸

The most significant and common areas of reform are statutes of limitations, limits on (non-economic) damages, limits on Attorneys’ fees and pre-litigation panels.

1. STATUTE OF LIMITATIONS

In all states there is a limited amount of time within which a patient can make a medical malpractice claim against a medical professional.

Courts may take different views on when the statute of limitations begins to run in medical malpractice cases. To some extent, the difference in these views is a reflection of the wording in the statutes. The difference also reflects the courts’ views on the relative merit of protecting injured parties versus protecting medical providers by enabling them to defend themselves when records are still in existence and memories are still fresh.

11. MedicalMalpracticeLawyers.com: What Is President-Elect Donald Trump’s Position on Medical Malpractice Tort Reform? 16 November 2016
12. republicanviews.org/republican-views-on-health-care/ viewed on 15 February 2017
13. wire.ama-assn.org/practice-management/how-medical-liability-reforms-will-be-advanced-challenged-2016 viewed on 30 January 2017
14. American Medical Association (AMA) “Medical Liability Reform – NOW!” 2016 Edition, 1
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16. atra.org/state/texas/ viewed on 31 January 2017
17. American Academy of Pediatrics (AAP News): “Texas’ medical liability landscape improves after tort reform enacted”, Volume 31, Nr 5, May 2010
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In some states, the time for filing a claim begins to run upon the *occurrence of the act* or omission the plaintiff claims constituted malpractice. Other states say that the time begins running when the act or *omission results in injury*. Another approach is that the time begins to run when the plaintiff *discovered or should have discovered* he or she was injured. A fourth option is that the time begins to run when the treatment concludes.¹⁹

2. LIMITS ON (NON-ECONOMIC) DAMAGES

Currently 33 US states have placed damage caps, or limits, on the amount of money that a patient can receive in a medical malpractice case on non-economic damages, while six states placed a cap on total damages. However, the policy of capping in these states varies by amount, exceptions and causes of action covered. The most recent cap was enacted in Missouri in May 2015 with a statutory \$400,000 cap on noneconomic damages and a higher cap of \$700,000 for catastrophic personal injury or death.²⁰

Not only California and Texas are front-runners when it comes to capping. Colorado and Kansas have also enacted a cap on non-economic damages (\$250,000-\$300,000). Colorado is one of the only states to have upheld both a hard cap on non-economic damages and a hard cap on total damages. In addition, premiums are low and they have advanced expert witness reforms in place that include that experts must be in the same speciality as the defendant, and they must be licensed in Colorado.²¹

Litigation in the above-mentioned states has significantly decreased over time and annual malpractice premiums for doctors remain low. Following close behind are Indiana (which implemented a \$1,25 million cap on total damages and a pre-litigation screening panel process) and Alaska, North Carolina, North Dakota, South Dakota (which all have implemented caps on non-economic damages of \$500,000 or lower). The majority of these states have some of the lowest medical malpractice pay-outs per capita.²²

In Illinois, New York, DC, Pennsylvania, New Jersey and Delaware, litigation happens more often, they have some of the highest malpractice pay-outs per capita and discussions on tort reform are practically absent. The implications on the overall malpractice pay-outs are visible here.²³

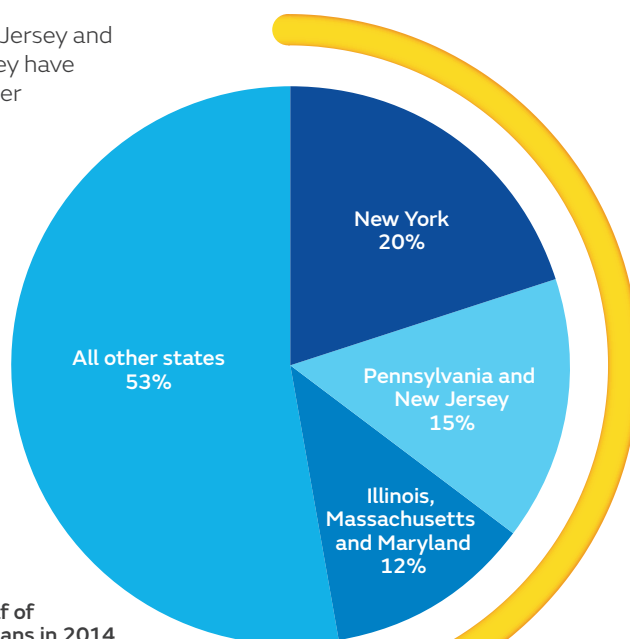
If implemented proportionately, the caps on damages are generally seen as a measure that contains costs. Insurers say their business has benefited from those state laws, and they would welcome tort reform at a national level.²⁴ Caps are not considered as the only factor in keeping the premiums down and they are not always recognised as an effective measure. In states such as Virginia and Nebraska, the caps on total damages worth \$2 million and \$1.75 million respectively (increased annually), are simply too high to be effective²⁵ Caps can be controversial; eight states have had their state supreme Courts rule such caps as unconstitutional.²⁶

3. LIMITS ON ATTORNEY'S FEES

Although there have been several recent attempts to enact federal legislation that would limit the amount attorneys can recover in medical malpractice cases, there currently is no federal statute on the matter. However, states have enacted a variety of different statutes that deal with limiting attorney's fees. There are currently two main types of regulation: percentage limitations on attorney's fees and granting courts review and approval authority.

Sixteen states currently have a statute or court rule that establishes a specific limit or sliding scale on contingency fees attorneys may charge clients who file a medical malpractice claim. In some states, courts can determine the reasonableness of the attorney's fee on the basis of issues such as skill requisite, the amount involved and obtained, the nature of the lawyer's relationship with the client etc.

These fees are thought to incentivise lawyers to take on a large number of cases that have a limited chance of success, to subsidise unsuccessful cases with the successful ones.²⁷



Six States that accounted for nearly half of all malpractice payments against physicians in 2014

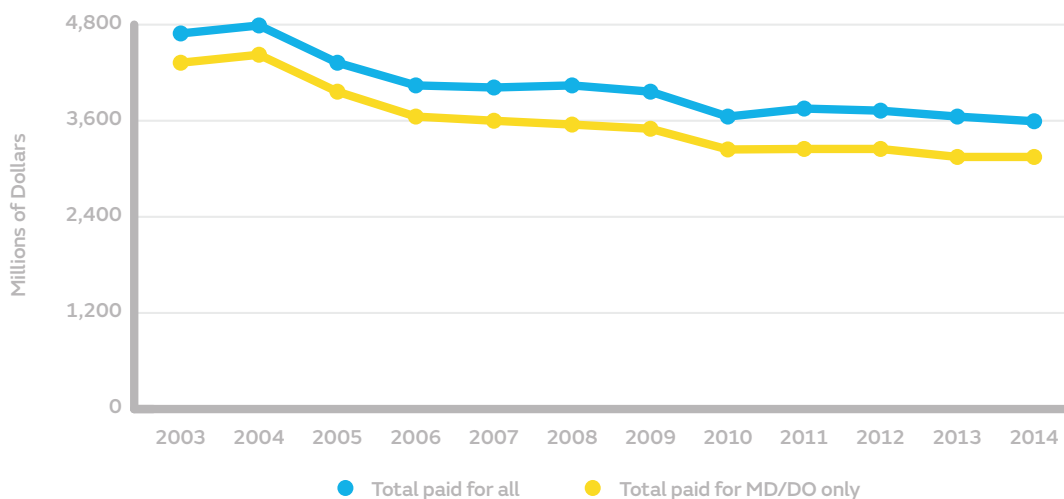
4. PRE-LITIGATION PANELS

Nineteen states currently make use of a pre-litigation panel review process (mandatory in 14 states, optional in 5). These panels are often made up of doctors and lawyers. This law is meant to be effective in weeding out frivolous claims and encourage early settlement. However, most states still allow cases to move forward in the courts despite a panel ruling in favour of the defendant, and in other states, the panel findings are not admissible in court.²⁸ This type of reform receives criticism as it can take a very long time for the panel to come to a decision, which can negatively impact both the patient and the doctor involved.

The reforms in Texas are a glaring example of the benefits of tort reform, but it is generally difficult to draw firm conclusions about the impact tort reform has had. In principle, states with tort reform should see a decrease in litigation and ultimately a decrease in malpractice premiums. Statistics prove that over the last twelve years there has been an unquestionable drop in the total number of paid medical malpractice claims against health care professionals including doctors in the US. For example, there were just over 15,000 paid medical malpractice claims against MDs and DOs in 2003 in the US. By 2014 that number had dropped to below 8900 which is more than a 40% drop in twelve years. The cost of indemnity payments for these claims has dropped significantly as well.²⁹

The graph below shows that the total Amount Paid for All Medical Malpractice Claims from 2003-2014 for All Health Care Practitioners and DO/MDs³⁰ in the United States is decreasing gradually.³¹

The influence of the state's culture on the litigation



environment should not be underestimated, says Dr Greg Roslund. In Minnesota, for example, there is a complete lack of tort reform; yet, doctors pay some of the lowest malpractice premiums in the country. Florida, on the other hand, has tort reform fairly high on the agenda, but is considered to be a 'judicial hellhole' with doctors actually paying some of the highest premiums in the country.³²

People in Minnesota do not sue. Their behaviour is called 'Minnesota Nice' to describe the 'social glue' that holds the people together. The cultural characteristics of "Minnesota Nice" include a polite friendliness, an aversion to conflict and confrontation, a tendency towards understatement, a reluctance to make a fuss or stand out, emotional restraint, self-deprecation, passive-aggressiveness and resistance to change. There are even companies in Minnesota that offer workshops helping outsiders adjust to the notorious 'Minnesota Nice' culture, both in the workplace and in private life.³³

In Florida, the medical malpractice environment is driven by a number of factors, including the fact that patients and lawyers are willing to run with the malpractice claims. "Basically, Florida is one of the most litigious states in the country," explains Giselle Lugones, executive vice president of Aon Risk Solutions. "A little bit of money behind it results in an overburden of frivolous claims."³⁴ Not only are the plaintiffs lawyers in Florida aggressive, they are extremely skilled. "As a result of having this strong plaintiff community, you have a more educated potential of plaintiffs where they pursue claims and are more apt and willing to take on the litigation aspect of medical malpractice," Lugones said. In a climate where there are more willing claimants, it's logical that the number of claims which result in a payment goes up.³⁵

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 21. Dr Gregory Roslund, "Medical Liability and the Emergency Physician: A State by State comparison – Part I", AAEM NEWS, August 2013
 22. Ibid
 23. Source: National Practitioners Databank
 24. The Washington Post: "Top Republicans say there's a medical malpractice crisis. Experts say there isn't" 30 December 2016
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 27. Ibid, 38

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 30. A doctor of osteopathic medicine (DO) is a fully trained and licensed doctor who has attended and graduated from a U.S. osteopathic medical school. A doctor of medicine (MD) has attended and graduated from a conventional (allopathic) medical school
 31. Source: National Practitioners Databank
 32. Dr Gregory Roslund, "The Medical Malpractice Rundown: A Stat-By-State Report Card", Emergency Physicians Monthly, 21 July 2014.
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 34. Aon Risk Solutions is a global provider of risk management, insurance brokerage and reinsurance brokerage.
 35. Nina Lincoff, Florida's culture of medical malpractice claims isn't good for health care, South Florida Business Journal, 23 October 2015

EXAMPLES OF STATE ENACTMENTS OF SELECTED CARE LIABILITY REFORMS³⁶

State	Limits on non-economic damages	Limits on attorney's fees	Statute of Limitations
California	\$250,000 cap on non-economic damages UPHELD Civ. §333.2 (1975)	Sliding scale: 40% of first \$50,000, 33,3% of next \$50,000 and 15% of anything over \$600,000 §6146 (1987)	3 yrs or 1 yr FD ³⁷ ; max of 3 yrs; 1 yr FO ³⁸ §340.5 (1975)
Colorado	\$300,000 cap on non-economic damages, \$1m cap on total damages § 13-80-102.5 (2013)	None	2 yrs FD, max of 3 yrs; 2 yrs FO §13-80-102.5 (1998)
Florida	\$500,000 cap on non-economic damages per physician/claimant;\$1 million max \$750,000 cap on non-economic damages per entity/claimant. EXCEPTIONS - \$150,000 cap on non-economic damages per emergency provider/claimant; \$300,000 max. §766.118 (2003) Ruled unconstitutional by Supreme Court in wrongful death cases involving multiple claimants (3/2014)	30% of first \$250,000, 10% of anything over \$250,000; Florida Const. Art. I, Sec. 26 (effective 11/2004)	2 yrs or 2 yrs FD; 4 yrs max. §95.11 (1975)
Hawaii	\$375,000 cap on physical pain-and-suffering damages, but no cap on non-economic damages that are not physical in nature (e.g., emotional distress) §663-8.7 (1986)	Court approval §607-15.5 (1986)	2 yrs FD; 6 yr max. §657-7.3 (1986)
Idaho	\$250,000 cap on non-economic damages (adjusted annually for inflation based on the average annual wage as of 1/7 2004) §6-1603	None	2 yrs; 1yr FO §5-219 (1971)
Indiana	\$250,000 cap on total damages per provider; \$1.250,000 cap on total damages for all providers and state fund: UPHELD §34-18-14-3 (1999)	Fee may not exceed 15% of any award that is made from Patient's Compensation Fund §16. 9(5). 51 (1999)	2 yrs FD or act; §34-18-7-1 (1999)
Kansas	\$250,000 cap on non-economic damages: UPHELD §333, 757 2d 251 (1988)	None	2 yrs. FD; 4 yr max. §60-513 & 515 (1994)
Louisiana	\$100,000 cap per provider/ incident, and a \$500,000 cap on total damages (difference paid by PCF), plus future medical costs 40:1299.42 (1991)	None	1 yr FO; 1 yr FD; 3 yrs max. UPHELD 9:5628 (1975)
Nevada	\$350,000 cap on economic and non-economic damages: NRS §41A.035 (2004)	Sliding scale: 40% of the first \$50,000 33,3% of the next \$50,000 ; 25% of the next \$500,000 ; 15% of anything over \$600,000; §7.095 (eff 11/23/2004)	3 yrs from date of injury; 1 year FD §41A.097 (eff 11/23/ 2004)
Ohio	Greater of \$250,000 or 3 times economic damages up to max of \$350,000/plaintiff, \$500,000/occurrence (\$500,000/plaintiff and \$1 million/occurrence in catastrophic cases) §2323.43 (2003)	Capped at amount of non-economic damages unless otherwise approved by the court §2323.43 (2003)	1 year FD; 4 yrs max. §2305.113 (eff 4/7/ 2005)
Tennessee	\$750,000 cap for noneconomic damages UPHELD §29-39-102 (eff for injuries occurring after 10/01/2011)	Fee may not exceed one third of recovery UPHELD §29-26-120 (1976)	1 yr FD; 3 yrs max.; §29-26-116 (1967)
Texas	\$250,000 cap on non-economic damages per doctor/claimant as well as per institution §74.301 (2003)	None	2 yrs FD; 10 yrs max. § 74.251 (2003)

36. Available at piaa.us/wcm/Advocacy/Government_Relations/wcm/_Advocacy/Government_Relations.aspx

37. From Discovery

38. Foreign Object exception

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