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EDITORIAL

The ugly face of medical negligence: where has justice gone?

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In the year ending 31 March 2013, the NHS Litigation Authority (NHSLA) has seen a rise in claims of almost 11 % on the previous year [1]. Expenditure on clinical negligence claims in 2012/13 shows that of the £1.258 billion spent, £275 million was paid to claimant solicitors. Catherine Dixon, Chief Executive of the NHSLA reports that this is due primarily to the availability of no-win no-fee agreements which enable claimant's lawyers to charge up to 100 % uplift on their costs which has significantly increased the number of claims and the amount the NHS has had to pay for its claims. New legislation will change this.

Of more concern, the NHSLA reports that it has seen a significant rise in the number of claims suggesting negligent care has been delivered when it has not. These speculative cases hope to attract an out of court settlement, where the NHS to limit overall costs, will accept the lesser of the two financial evils. The surgeon is also advised to accept these settlements to limit their stress or uncomfortable exposure to adverse publicity.

According to this same 2013 review by the National Audit Office (NAO) in the NHS, a fifth of maternity services funding is spent on insurance against malpractice.

The report found the NHS in England spent £482 m on clinical negligence cover in the last year for obstetrics—the equivalent of £700 per birth. The sum for NHS spine surgery has been requested.

There are no declared figures for cost per spine surgery, case, but it is likely to be in the order of £300 per case. For a lumbar discectomy one of the most common spinal surgeries, which reimburses privately for £741, a malpractice claim can be a six or seven figure number. Is this commercially viable or fair?

Medical malpractice litigation is a major concern for most British spine surgeons. We obviously do not want to do harm to our patients. The majority of surgeons will have entered medicine with the ideals of helping people. We do not set out to do harm, but the judiciary system supporting charges of manslaughter in a few high profile cases and truly massive settlements against surgeons would make a reasonable individual to believe otherwise.

Most doctors would hopefully have a sense of fair play and if they had committed a medical error that had harmed their patient would accept a reasonable financial settlement. But has it all got out of control—in the same way as whiplash injuries? Is there a naive view that this is all virtual money where the tax payer or insurance company picks up the tab?

Legally, negligence is defined as conduct that falls below the standards of behaviour established by law for the protection of others against unreasonable risk of harm. A person has acted negligently if he or she has departed from the conduct expected of a reasonably prudent person acting under similar circumstances. Common language use would define negligence as being careless or sloppy. Are all these cases we hear about really due to carelessness? I doubt it very much.

To establish negligence as a cause of action under the law of torts four criteria must be satisfied. A plaintiff must prove that the defendant had a duty to the plaintiff, the defendant breached that duty by failing to conform to the required standard of conduct, the defendant's negligent conduct was the cause of the harm to the plaintiff, and the plaintiff was, in fact, harmed or damaged.

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This all sounds very reasonable and logical. However, if we speak to our colleagues about malpractice cases against them we can often hear stories of very reasonable surgical behaviour and decision making. The complication is often part of "the perfect storm".

Has surgeon and patient bad luck, combined with poor outcome now become reasonable excuse to seek financial redress?

As a medical profession we are keen to blame the lawyers (so called 'ambulance chasers'). We may castigate them for financial zeal. The popularity of Conditional Fee Agreements (CFAs)—where lawyers take on cases for a proportion of the final settlement rather than for up front fees—is one factor in the growth in litigation. However, they are also motivated to get the best for their client. We would expect the same of our own legal teams in other areas of civil or criminal law, but how far do they push matters to achieve success? Is this a system that is inherently flawed? Does the best legal team usually win? How much can they understand complex medical or surgical issues?

There is a common football cliche when a striker is scoring a goal, that "the finish was clinical". However, clinical matters are rarely black and white. There are even more than 50 shades of Grey! Invariably the more one knows as a doctor the more confusing spinal decision making can be. It takes 5 years of medical school and several years of subspecialty training. Therefore, is it reasonable to expect this sophisticated knowledge and apprenticeship to be transferred to legal teams working in many areas of malpractice? Is it possible for a judge to divorce himself from the tragedy of a suffering patient sitting in front of him, particularly if there is a paralysed or handicapped child involved?

Such was the volume of attempted litigation in the USA that several surgical groups took out retainers on the services of in-house attorneys. Even malpractice cases that fizzled out attracted significant legal costs. The citizens of Texas passed Proposition 12, an amendment to the state's constitution which limits non-economic damages in a medical lawsuit to $250,000 to arrest the exodus of surgeons unable to practice in the state due to economically non-viable expenses. Since then, insurers have cut their rates almost a third.

Doctors bear some responsibility for the increasing burden of malpractice suits. A casual comment when seeing a patient for a second opinion can lead to litigation. It is important to be humble and respectful to other colleague's work. A surgeon must strive not to make one-upmanship comments implying that he could have done things better and differently. This may boost his ego for a few minutes at best.

Invariably lawyers are dependent on the medical expert advice provided to them. This is another area where we might be found lacking. Who are these experts and what qualifies them for this role? This is where we, as a profession, need to examine ourselves.

Most of us would expect these experts to be practising spine surgeons or recently retired practitioners. It would also be expected that they hold expertise in spine surgery, rather than brain surgery, or general orthopaedics and trauma. The ethics of an expert opinion are complex. How do we as a medical profession deal with an articulate doctor who is acting outside their remit of expertise? Some have called for a register but this would be difficult to police. A policy of asking legal teams to confirm with BASS that their expert is indeed a spine specialist is a basic and easy step forward. There are definitely surgeons giving opinions that they are not qualified nor experienced to give.

How can we reduce the human and financial burden of malpractice? We can practice sensible defensive medicine. Although the term is often used in a pejorative manner; we would practice most other aspects in our adult life in a defensive and conservative manner whether they are financial or our own health issues. The consent process is a key to gaining patient trust. A well-documented consent process will also close the door to many legal fishing trips. Once surgery has been decided, I have found that scheduling a consent clinic very helpful. This is another visit to go over the surgery itself, and allows the consultant surgeon to re-check symptoms, indications and for contemporary radiology. In the meantime, the patient is asked to review written or web-based materials on their anticipated surgery. Seeking written consent on the morning of surgery may compromise its validity with the patient stressed by the prospect of going under the knife. Once in theatre, the WHO checklist has some merit but is somewhat deficient for levels. It needs refining for spine surgery.

We should be made aware of all the spinal malpractice cases where the plaintiff is successful. In my role as president of BASS I have sought collaboration with the NHS litigation authority and the major indemnity societies. Clearly, it is in everyone's interest to identify common themes, so the mistakes of others are not repeated again and again. This will benefit patients, surgeons and the medical indemnity insurance companies. The latter have not been as forthcoming as they should, despite written requests.

The NHS Litigation Authority has been more helpful, and their data have been previously analysed by Quraishi et al. [2]. Childs and Khatri have presented their findings to BASS in Norwich 2013. They found the data collected by the NHS to have significant flaws making detailed analysis problematic.

In emergency cases, Quraishi found missed fractures (42 %) and caudal equina injuries (24 %) accounted for $^2/_3$ of litigation. In elective practice, the top three categories were damaged to spinal cord (20 %), post-operative care (15 %) and infection (11 %). There are 30 cases completed settlements per year on behalf of the NHS LA [2].

The key point that he also noted was that more than 60 % of all claims for acute spinal diagnoses were directed at non-surgical specialties. Are we as spinal surgeons paying for our medical colleagues errors? It does, however, highlight the vital and ongoing need for education regarding spinal disorders across the breadth of medical professionals.

For private practice, we probably have to accept that the annual indemnity fee is high because settlement awards are expensive. In theory, there will be competitive forces, which will increase with new insurance companies competing against the traditional indemnity societies. However, the legal process is still reassuringly expensive! The ball is in our court to improve matters; after all we are the alleged perpetrators.

Education and raising standards must be the key. We presume that most surgeons who have a critical number of surgical cases are usually more adept than the occasional surgeon. We would also reasonably expect that a surgeon who attends meetings and courses to improve and update their knowledge is desirable. BASS, as our professional society, is keen to support this educational role to reduce potential damage to patients and legal damages awarded. We need to identify cases where compensation has been sought. The role of a bi-annual confidential update on causes of litigation presented at our BASS meetings will be instructive. Learning points from each specific case can be collated, so that the wider spinal community learns from the specific event.

A continuous internet database to collect and present data to BASS members at our annual meetings will hopefully raise our game. The British Spine Registry is a valuable tool to aid this data collection. NHS data have limitations (personal communication Khatri 2013) and the indemnity societies are regrettably reluctant to share their data. We must be in control of this collection as a professional society.

The concept of a BASS-certified surgeon who contributes to our speciality by attending meetings, participating in the spine forums, and committing to updating their practice has also been discussed by our executive. In the long run, these BASS-certified surgeons will hopefully attract less litigation and private indemnity costs—if private spinal surgery still exists.

Conflict of interest None.

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