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Weaknesses of the Clinical Negligence System in a Patient Safety and Learning from Error Context

In four key ways, the tort of negligence is currently too narrow and self-selecting a tool to contribute to learning from error in a meaningful way:

1. The tort of negligence focuses on the fault of an individual tortfeasor and the effects of this on an individual patient. Its enquiry does not go beyond the actions of the clinician involved, whether this reached the required professional standard, and whether this failure to meet the standard caused the injury concerned. It is unlikely therefore to be able to provide meaningful contributions to the question, for example, of why injuries to women and babies are so widespread in maternity care. Furthermore, questions of clinical culture in different organisations, as well as organisational or systemic issues are not the focus of a clinical negligence case but, if explored, could add significantly to our understanding about why and how errors are made.
2. Studies have shown that patients want redress for such harm to go beyond this narrow focus, and their wishes accord with the aims of an open healthcare culture which ensures that lessons are learned from harm. There is long-standing evidence that what patients want goes well beyond, although certainly can include compensation. The findings of Vincent et al[1] which showed that patients also want an explanation, an apology, accountability and assurances that other patients will not suffer from the same error, were notably replicated in 2018.[2] Despite this, in clinical negligence litigation, it is only compensation that is a guaranteed outcome of a successful claim, thus denying many patients and their healthcare providers the improvements in safety that is the desire of all of them.
3. It is only error caused by fault which is the focus of the enquiry of clinical negligence litigation. This is a flawed outcomes-based approach[3] to error which can mean that errors which do not fall below the required standard of care, but nevertheless have or could have caused harm are not learned from within this system. One of the key tropes around criticisms of clinical negligence litigation is that it can lead to defensive medicine, i.e. tailoring decisions around treatment with the fear of legal consequences in mind. However, defensive medicine in this sense is a 'jaded cliché'[4] and evidence that it even exists is 'weak at best'[5]. As such, the Committee's question, '[t]o what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?' risks leading it along a line of enquiry which is based on a fallacy.

[1] Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. Lancet. 1994 Jun 25;343(8913):1609-13

[2] Behavioural Insights Team and NHS Resolution, 'Behavioural insights into patient motivation to make a claim for clinical negligence' (August 2018)

[3] Merry and Brookbanks, Merry and McCall Smith's Error's, Medicine and the Law (Cambridge: Cambridge University Press) (Second Edition, 2017)

[4] Paula Case, 'The jaded cliché of "defensive medical practice": from magically convincing to empirically (un)convincing?' *P.N.*2020, 36(2), 49-77

[5] van Dijck G, 'Should Physicians be Afraid of Tort Claims? Reviewing the Empirical Evidence' *Journal of European Tort Law*, vol. 6, no. 3, 2015, pp. 282-303. https://doi.org/10.1515/jetl-2015-0017

Having fault (and its concomitant, blame) at the centre of negligence enquiry however can lead to defensiveness in the aftermath of error and a reluctance to contribute to or engage with learning from error. The fear of legal repercussions may have a negative impact on the willingness of clinicians to engage in processes to maintain safety and learn from error. The inquiry report into the actions of Ian Paterson, the now jailed surgeon who carried out unnecessary and unrecognised breast surgery[6] stated that the power of the prevailing culture, including bullying and fear of repercussions around reporting concerns, meant that some of Paterson's colleagues were deterred from engaging with patient safety reporting systems. While clinical negligence may not impair patient safety in the form of defensive medical treatment then, the prospect of claims being brought, which have blame at their centre, may deter reporting concerns and therefore learning from error. As the Public Accounts Committee have noted, '[t]he NHS's culture when things go wrong appears to be predominantly defensive, rather than candid and transparent, which limits its ability to learn lessons.'

4. The clinical negligence system receives information about harm caused by healthcare which is skewed, partial, and contingent on other, wider factors which are not always of relevance to the aim of learning from error. For example, despite often being criticised for participating in a 'compensation culture', those who sue the NHS often do so reluctantly, and may require the prompt or support of an advocate such as a family member, friend or healthcare practitioner to embark on bringing a claim.[7] While alarm is often expressed about the numbers of clinical negligence claims, currently only 4% of harmed patients bring a claim[8] and so information provided by these cases is by no means representative of the scale or nature of patient injury being experienced across the NHS. Whether their claim is taken on by solicitors and investigated, including being referred to NHS Resolution, can be context dependent and contingent upon whether the patient harmed has the personal or financial resources to withstand the rigours and stresses of the litigation process.[9]

It is evident then that the current clinical negligence litigation system can only ever, at best, make a partial contribution to learning from error and improving quality of care. In my view therefore, legislative reform is required.

Reform

It is right that patients who have sustained harm during the course of their medical treatment receive redress for that harm. In its review of clinical negligence litigation, it is vital that the Government ensure that in any reforms:

1. The (currently missing) link between harm caused in the course of the provision of healthcare, and learning from that event, is built in to any system of redress.
2. There are a number of systems which currently have elements which can and do contribute to learning from error, and have the potential to contribute to larger scale learning, but which currently act in isolation from each other, or connect in disjointed or inconsistent ways, or operate on a small scale. These include the Duty

[6] James G, *Report of the Independent Inquiry into the Issues raised by Paterson*, (February 2020) HC 31
[7] Anne- Maree Farrell and Sarah Devaney, 'When Things Go Wrong: Patient Harm, Responsibility and Disempowerment' in C Stanton, S Devaney, AM Farrell and A Mullock (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015) 103-115
[8] Public Accounts Committee Managing the costs of clinical negligence in hospital trusts, (2017) HC 397 [5]
[9] Lewis, R. 2018. 'Humanity in tort: Does personality affect personal injury litigation?' *Current Legal Problems* 71(1), pp. 245-278.

of Candour, NHS Resolution's commitment to learning from negligence cases, the Getting it Right First Time initiative, the National Reporting and Learning System and the NHS Complaints System. These should be better connected in a new combined redress and learning from error system;

3. A new combined redress and learning from error system should contain the elements which patients have consistently said they want to see after sustaining harm as part of their healthcare, ie an apology, an explanation, assurances that the incident will be prevented from being repeated, accountability and compensation where appropriate.
4. The requirement of proof of fault (i.e. a breach of the standard of care) should be removed. Our report to the Scottish Government on no fault schemes[10] highlights that the advantage of no fault systems is that they can build in the elements which it is decided, on the basis of principle, should lie at their core. A reformed system should as a minimum include those elements (set out above) which patients wish to see in formal responses to the causing of harm through healthcare, including a requirement that information about errors be shared and learned from. Legislation would be required to establish such a scheme, to set out how and by whom it would be administered, and the key requirements of its scope such as eligibility and disability threshold requirements.

[10] Farrell A-M, Devaney S and Dar A, 'No-Fault Compensation Schemes for Medical Injury: A Review' Commissioned by the Scottish Government (2010) file://nask.man.ac.uk/home$/Downloads/SSRN-id2221836.pdf