IHCA SUBMISSION TO THE EXPERT GROUP TO REVIEW THE LAW OF TORTS AND CURRENT SYSTEMS FOR THE MANAGEMENT OF CLINICAL NEGLIGENCE CLAIMS

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1. Introduction

The IHCA represents around 90% of all hospital consultants working in Ireland's acute hospital and mental health services. It welcomes the opportunity to present its views to the Expert Group reviewing the law of torts and current systems for the management of clinical negligence claims. As a preliminary matter, it should be noted that the comments and views submitted below have not been reviewed or approved by the Association's National Council as the next meeting of the Council will not take place until September.

All hospital consultants in public and independent hospitals are required to be indemnified against claims for medical negligence as a condition of their employment or practice rights and this is now a statutory requirement. In recent years, the Association has consistently highlighted the fact that escalating clinical indemnity costs are driving up the cost of providing care in public hospitals and jeopardising private practice in surgical and other specialities, forcing consultants to cease practice and emigrate. Indemnity costs more than doubled in most specialties, and in some specialties quadrupled, between 2012 and 2015. Furthermore, the average cost increases in 2016/2017 and 2017/2018 have been in the order of 4.5% per year with increases of up to 10% impacting some consultants and specialties in private practice in 2017/2018. In recent years Ireland has experienced an increase in the size and number of clinical negligence claims borne by the State and by medical defence organisations. The Medical Protection Society (MPS) acknowledges that this is not attributable to a deterioration in clinical standards but rather reflects a generally more active claims environment. In short, the indemnification increases have been attributed to a higher frequency of claims in Ireland, increased awards in the courts and lack of progress in reforming the law as it applies to clinical negligence claims.[1]

2. UK Reforms

The cost of indemnification for Consultants in Ireland is a multiple of that charged in the UK and other jurisdictions. This is primarily due to the fact that the UK engaged in significant tort law reform over a decade ago to address the issues which were driving up their costs. Similar actions have been taken in other jurisdictions. In broad terms, the UK measures were derived from:

- The 1999 'Woolfe' reforms which centred around two features: pre-action protocols to regulate activity prior to the filing of a claim, and a set of rules to tighten activity once a claim had been made.

[1] MPS 'Challenging the cost of clinical negligence– the case for reform'

- The 2010 'Jackson' reforms which centred on the introduction of fixed recoverable costs in some personal injury cases up to the value of £25,000 and costs budgeting in all cases above £25,000, with the latter being controlled by the court.

3. Australian Reforms

The current situation in Ireland is not dissimilar to that which pertained in Australia in 2001. At that time, one of the country's main medical defence organisations entered administration as it was unable to meet its liabilities. Nearly all reinsurers withdrew from the Australian market as a consequence of court awards that were perceived to be excessively high. Clinical indemnity premiums for certain specialities perceived as high risk became unaffordable. As a consequence, tort law reforms were introduced in every state along broadly similar lines, although not identical.

These included:

(a) Reducing the limitation period allowed for bringing claims,

(b) An approximate 50% reduction in the awards for the largest and most serious claims;

(c) A requirement for permanent disability before being eligible for general damages;

(d) Capping the maximum loss of earnings claim to a multiple of the national average wage, i.e. awards for loss of earnings and earning capacity are limited typically at a multiple of two or three times average weekly earnings.

Following these tort law reforms, the number of claims fell by more than 50% and the average value of claims fell by 20%.[2]

4. US Reforms

The history of tort law reform in the United States has followed a similar trajectory with similar outcomes to the Australian experience. The following list outlines the most common reforms that were introduced:

a) Cap on non-economic damages introduced in 33 states. Limits on non-economic damages can range from $250,000 in California to $750,000 per incident in Tennessee and Wisconsin.
b) Overall cap on damages introduced in 6 states. Some states place limits on both noneconomic and other damages together, such as Virginia where the limit is $2.15m.

[2] Tort law reform for personal injury claims – is it needed and does it work? An international perspective – Tony Mason, Former CEO Medical Protection Society, 29th September 2017

c) Reduced limitation periods introduced in most states of between 1 year (Tennessee) and 3 years (California).
d) Restrictions on plaintiff legal fee recovery introduced in 16 states.

5. Irish Reforms

In Ireland, some limited reform measures have been advanced including the adoption of pre-action protocols, the introduction of Periodic Payment Orders and requirements for Open Disclosure and these are to be welcomed. However, implementation is awaited having specific regard to pre-action protocols. Further reforms are also required in Ireland similar to those that have been implemented in other jurisdictions. The Association's specific views in this regard are outlined below according to headings (a) to (e) of the Expert Group's terms of reference.

(a) Law of Torts: Review the law from the perspective of the management of clinical negligence and personal injury claims in order to assess the effectiveness of the legal framework and to advise on and make recommendations on what further legal reforms or operational changes could be made to improve the current system.

Issues around the effective and efficient resolution of clinical negligence claims affect a range of stakeholders including patients, medical professionals, health service providers and legal professionals. It is vital from the perspective of these stakeholders that the legal framework is designed with the aim of reducing costs and increasing the efficiency and effectiveness of procedures. All affected parties must be facilitated in their attempts to settle issues between themselves without the necessity to commence legal proceedings or, where proceedings are unavoidable, to facilitate the early and efficient exchange of information relevant to the claim.

(i) Pre-Action Protocol

The Association supports reasonable measures aimed at facilitating the early and efficient exchange of information relevant to a claim. Part 15 of the Legal Services Regulation Act 2015 ("the 2015 Act") was signed into law on 30 December 2015 and has paved the way for the introduction of a new Pre-Action Protocol ("the Protocol"). However, the relevant commencement orders have not yet been made. **The Protocol should be implemented without further delay.**

The Protocol stipulates that a health service provider, including a hospital, must forward requested records within a period of 11 weeks. There is a concern, however, that existing administrative systems, supports and staffing levels in acute hospitals are overstretched especially at the frontline and that there may be difficulties complying with the relevant time period for the provision of records.

Accordingly, the Department of Justice should, in conjunction with the Department of Health and the HSE, consider measures that will facilitate health service providers in this regard and ensure that there is no administrative or other impediment to the release of requested records within the specified timeframe.

While acknowledging that a plaintiff is precluded under the enabling legislation from initiating legal proceedings until such time as he or she can demonstrate active engagement with the Protocol, the Association is concerned that the provisions regarding non-compliance may potentially be ineffective. As currently provided, it is envisaged that in circumstances where one party does not comply with a requirement of the Protocol, the other party will be relieved of his or her obligations thereunder. **Instead, the Protocol should make provision that the Defendant is entitled to make an ex parte application to the Courts for an order, direction or declaration to compel a non-compliant Plaintiff to properly engage in and abide by the Protocol.**

(ii) Limitation Periods

The IHCA appreciates that the law governing limitation of actions must ensure that a balance is struck between the competing rights of plaintiffs and defendants while having due regard to the public interest. While it is important to safeguard the rights of patients who have a legitimate cause of action in terms of of access to the courts and the right to litigate, this must be balanced against the right of doctors and their indemnifiers to fair procedures and their capacity to raise a defence that is not prejudiced by the passage of time, the unavailability of key records or witness accounts. **Accordingly, the Association supports and recommends the implementation of the Law Reform Commission's 2011 review of limitation periods which would provide for a 2 year basic limitation period for clinical negligence actions, consistent with the current period for general personal injury claims.**

(iii) A reduced limit on general damages and on claims for future earnings

The level of general damages and special damages awarded in Irish Courts tends to be higher compared with other jurisdictions.[3] Together with legal costs, this a key driver in terms of the cost of resolving claims and consequently a key driver in terms of the increasing cost of clinical indemnity for Consultants in Ireland. In the United States, nearly all of the rigorous empirical analyses conducted since 1990 has found that malpractice premiums are lower in the presence of damages caps.[4] In its current form, the Irish courts system facilitates relatively high awards that can be granted for personal injury including cases of clinical negligence. Since the State, through the Clinical Indemnity Scheme,

[3] MPS 'Challenging the cost of clinical negligence– the case for reform'

[4] Nelson L, Morrisey M, Kilgore M. Vol. 85. The Milbank Quarterly; 2007. Damages caps in medical malpractice cases

underwrites the costs associated with serious clinical negligence cases in public hospitals, the same pressures that have arisen in the USA, UK and Australia for tort law reform have not arisen in this jurisdiction. It is the Exchequer that bears the cost of public hospital clinical indemnity cases. However, in the independent hospital sector, it is clear that the escalating cost of indemnity has undermined the provision of private obstetric and maternity care. There is a growing risk that the provision of other specialist services will become unviable if clinical indemnity costs are not addressed urgently.

There is scrutiny in all other areas of public expenditure with regard to how the State expends tax revenue. However, there is no such obligation in the courts to consider whether the State or the Exchequer can afford the awards that are made. **Against that background, it would be prudent and in the public interest generally to ensure that fair and sensible limits are introduced and observed by the Courts in terms of the level of damages that may be awarded in any particular case having due regard to the circumstances of genuine litigants and the requirements for fairness and equity in any particular case. It may be of assistance to the Courts if a Book of Quantum for clinical negligence claims was devised similar to that pertaining to personal injury claims in the Personal Injuries Assessment Board (PIAB), together with a legislative requirement that the Courts must have regard to the Book of Quantum in determining the level of general damages in clinical negligence cases.**

(b) Alternative mechanisms: Consider whether there may be an alternative mechanism to the court process for resolving clinical negligence claims, or particular categories of claims, particularly from the perspective of the person who has made the claim. To do this, the Group will examine whether a mechanism could be established which would deal more sensitively and in a more timely fashion with catastrophic birth injuries, certain vaccine damage claims, or with claims where there is no dispute about liability from the outset. It will also examine whether an alternative dispute resolution mechanism or a no-fault system would be effective in some cases;

Every citizen has a constitutional right to rely on legal action to seek justice and redress. A patient who suffers an adverse outcome is entitled to seek redress which should be appropriate and be forthcoming within an acceptable timeframe. Any proposals made by the IHCA regarding alternatives to the current adversarial legal route are made having regard to this constitutional right.

(i) Mediation

Most medical negligence cases are settled by way of negotiation between plaintiff and defendant legal teams, acceptance of a formal offer to settle under the relevant court rules, withdrawal or

discontinuance by the plaintiff, or by way of settlement at the court door. The vast majority of all clinical negligence claims are resolved outside the court, with fewer than 3% of claims resolved through the court.[5] This fact alone would suggest that there are alternative mechanisms that could be employed to resolve medical negligence claims fairly at an earlier stage with greater efficiency and reduced legal costs.

The benefits of mediation as an alternative to litigation and the courts process are well known having particular regard to reducing the costs and delay associated with the resolution of disputes. While the Association is aware of its limitations, mediation should be afforded serious consideration as a means of avoiding protracted and expensive court proceedings in circumstances where both sides to the dispute are likely to have sufficient information available by the end of the mediation process to form a sound view as to whether settlement is appropriate (and bearing in mind that the mediation process itself offers a forum for the exchange of that information). **In particular, mediation could be triggered by the conclusion of the pre-action protocol process, when there has been disclosure of records and an exchange of views. Certainly, it should be seriously considered immediately before proceedings are issued in any given case.**

(ii) No fault compensation

The Association proposes consideration of a no fault compensation scheme, in discussions with the State Claims Agency, having specific regard to catastrophic birth injuries. The Association believes that a scheme of this nature would speed up the delivery of awards to the parents of babies who acquired brain damage either before or at birth while reducing the legal costs associated with the litigation of such cases. Given the level of media attention that these high profile cases attract, there may be a misconception that the prevalence of cerebral palsy in Ireland is high or very high in comparison with other developed countries but this is not the case. Around six to 10 babies a year are born with cerebral palsy in Ireland each year and this rate is generally the same throughout the developed world. There has been no major change in this rate for 50 years. While agreement does not exist among medical experts, the majority view is that cerebral palsy develops prior to birth rather than as a result of any complications during the actual birth. In any event, there should be no necessity for the parents in such cases to undertake a stressful and expensive course of legal action to ensure that a fund is created to provide for the medical and other needs of the child during his or her lifetime. This represents one of the strongest arguments for major reform in how these cases are resolved as between parents on the one hand and the State on the other.

[5] Joint Committee on Health and Children - Report on the Cost of Medical Indemnity Insurance June 2015

(c) Role of the HSE: Examine the role of the HSE in addressing the problems encountered by persons involved in clinical negligence claims and addressing the health needs of persons affected by clinical negligence, with consideration given to whether particular care packages could be made available for persons with specific injuries, e.g. cerebral palsy following birth;

(i) Resources

Firstly, in terms of prevention and reducing the incidence of clinical negligence claims, there is clearly a role for the HSE and health services management to ensure that the resources required to provide sage, high quality care are in place. This is not always provided due to capacity and front line resource deficits. Secondly, the structures for reporting (potential) Adverse Incidents and Risk Management Programme must be greatly improved. It must be noted that indemnifiers continually emphasise the crucial importance of properly maintaining and recording comprehensive contemporaneous medical notes for all patients. Indemnifiers frequently highlight the fact that the absence of such documentation has hampered the defence of some claims and, in some instances, has led to an admission of liability.

(ii) Resourcing record keeping

While it is most desirable to propose improved incident reporting systems and the establishment of proper risk management policies, the burden of implementing these policies, cannot and must not be placed solely on Consultants. It is unfair and unacceptable to burden Consultants with accountability while their employers disregard the advice available regarding medical standards and indeed compromise patient safety in the process due to insufficient acute hospital resourcing to enable hospitals to provide timely, high quality, safe care to patients.

(iii) Governance

Similarly, there is a real need for improved governance and accountability within the health services. The absence of appropriate governance and management of structures in public hospital and mental health services in Ireland has undermined the trust of patients, consultants and other healthcare staff. **Substantial improvements in governance are required to restore that trust and to ensure that high quality safe, timely care can be provided.** This is a fundamental prerequisite to ensuring effective use of adequate resources and improved service delivery which, in turn, will assist in reducing the incidence of poor patient outcomes and claims arising from clinical negligence.

(iv) Care Packages

With regard to the provision of particular care packages by the HSE for persons with specific injuries, the Association fully supports the expansion and availability of health services to patients and their families in circumstances where they have incurred a poor outcome in the public health system, whether as a direct consequence of clinical negligence or otherwise. However, any such expansion of services must be properly resourced bearing in mind that our public health service is already severely overstretched. The lifetime provision of health care packages to patients who suffer a catastrophic event or serious illness as a consequence of clinical negligence can only be provided effectively in the long term if the system is properly resourced having regard to day to day spending, capital investment and the required number of Consultant posts.

(d) Role of the State Claims Agency: Examine the role of the State Claims Agency in managing clinical negligence claims on behalf of the HSE to determine whether improvements can be made to the current claims management process.

The SCA performs a vital role in terms of (a) the provision of clinical indemnity in the public health system on the basis of enterprise liability and (b) the operation of the indemnity caps for Consultants who engage in off-site private practice. The Association understands that reports have been submitted to the Minister for Health with regard to the lowering of the indemnity caps and the provision of indemnity on a commercial basis by the SCA. **Both of these measures, if implemented, would assist in alleviating the difficulties currently being experienced by Consultants in practice as a result of spiralling indemnity costs.**

(e) Current Tort Legislation: Consider the impact of current tort legislation on the overall patient safety culture, including reporting on open disclosure.

The Association and its members support the adoption of a National Policy and Standards on Open Disclosure and have been engaging constructively since May 2013 with the HSE's National Advocacy Unit and the State Claims Agency in this regard.

Unfortunately, in the provision of care adverse outcomes will occur for a small proportion of patients, especially where the services are overstretched due to under-resourcing. **In some cases the adverse outcome arises as part of the normal risk of complications associated with therapy, surgery, and other procedures. In a more limited number of cases mistakes and errors may occur.** Naturally the risk of mistakes and errors is exacerbated where care is being provided in a health system that is under resourced and overstretched. **When things do go wrong, it is important that communication is conducted with patients and their families in an open, honest and transparent manner.** However

we must also recognise and cater for the needs of the greater number of patients, and their relatives, who encounter a recognised complication of therapy, not related to deficient care, but which is nonetheless disabling and distressing for those involved.

It is noted that much of the detail around Open Disclosure will be contained in standards to be set out by HIQA and the Mental Health Commission. **We note however that the legislation includes a definition for "*patient safety incident*" which, as currently drafted, extends to events where no actual injury or harm has occurred. This is a more expansive definition in light of the current National guidelines which define an "*adverse event*" as an incident which results in *actual* harm.** The Association considers that adoption of this definition is important. Contemporary medical care must take account of individual variation in response to therapy and allow for patient specific therapy. That variation in patient care should be acceptable (and even encouraged) without being regarded as safety incident. This approach should be adopted to take account of the normal process involved in the provision of health services in circumstances where the patient as an individual has provided meaningful and fully informed consent.

The Association welcomes the inclusion of provisions such that an apology made in connection with an allegation of clinical negligence will not constitute an express or implied admission of fault or liability and such that evidence of an apology will not be admissible in any associated court proceedings. Nonetheless, while the Association supports Open Disclosure there remains a concern that it could potentially have a negative impact in terms of increasing the number of clinical negligence claims in the courts.

Accordingly, while welcoming the introduction of the legislation on Open Disclosure, the Association would also welcome the introduction of more extensive legislation to address the concerns in this area. In particular the Association considers that the Open Disclosure legislation would be enhanced if the legislation also provided for a mediation service. Such a mediation service would ideally help to resolve the concerns of patients and their families without recourse to an adversarial litigation process, and would benefit both patients and their doctors.

Conclusion

The Association would welcome an opportunity to meet with the Chairman and members of the Expert Review Group.

25th July 2018