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Celebrating 50 years: MBRS 1968 – 2018

Mr. Justice Charles Meenan,
The High Court,
Four Courts,
Dublin 7.

Copy

October 26th 2018.

Dear Judge Meenan,

Re: Expert Group on Reform of Medical Negligence

I read with great interest your interim report on the issue of reform of the tort system in the area of medical negligence with particular reference to the recent cervical check controversy. I note that your Group will be issuing your final report in early 2019 on the issue more generally.

There has been a great deal of expert work done in this general area in Ireland over the past decade or so, particularly by your colleagues in the Judiciary, Mr. Justice Quirke, Ms. Justice Irvine, Mr. Justice Kearns and Mr. Justice Kelly, some of which is ongoing.

I sat as a member of the *Advisory Group on No-Fault Compensation* established by the then Minister for Health in the early 2000s to look at the issue of no-fault compensation in birth hypoxia injury. That Group was on the threshold of publishing its final report when, for whatever reason (constitutional or financial), the final meeting to sign off on the report never occurred. I wrote to a number of Ministers in 2008 through 2016 thereon but the Group was never informed as to its abolition or otherwise.

I believe that a great deal of work was completed by that Group and write to ensure that your Expert Group is aware of the near completed report arising therefrom which might be of assistance to you. I am therefore enclosing copies of the related correspondence to assist in tracing any relevant research and documentation from our Advisory Group which might be applicable to your current work. I also enclose a diagrammatic representation of a suggested model I submitted in 2008 for consideration based on my experience as a member of the Personal Injuries Assessment Board 2004-2012. I also enclose a copy of an article published in the Lancet Journal in 2000 which may be of both historic and current interest. Finally, I enclose a copy of some media reports I found recently concerning the Group.

May I wish you and your Expert Group the very best in the challenging task set you in addressing this long overdue reform of tort law as it applies to medical negligence cases in particular. I look forward to reading your final report in 2019.

With Kind Regards.

Yours Sincerely.

Denis A. Cusack

Professor Emeritus Denis. A. Cusack.

29th September 2016.

DAC/dm

Mr. Simon Harris T.D.,
Minister for Health,
Hawkins House,
Hawkins Street,
Dublin 2.

Dear Minister,

Re: Advisory Group on No-Fault Compensation and Reform of Medical Negligence Process.

I note your very encouraging comments to the Joint Oireachtas Health Committee on the issue of adverse outcomes in maternity hospitals.

I have written to your predecessors, Dr. Leo Varadkar, Dr. James Reilly and Ms. Mary Harney in this matter since 2007 and in relation to the above mentioned Advisory Group of which I was (and believe still am) a member. I enclose a copy of that correspondence, which, I believe, speaks for itself. I also enclose a copy of an old article from the medical journal The Lancet of 2000 and a copy of an article from the Irish Examiner of November 12th 2013.

It appears that everybody is in agreement that the current system of dealing with adverse events and adverse outcomes in maternity hospitals is wholly inadequate and you have described it as "quite shameful".

As you will see from the correspondence, I have found it a very discouraging and disappointing experience being a member of the Advisory Group and seeing that nothing came of the group's work and that very little has changed. I was encouraged by your remarks and I ask you to look at this correspondence which is sent to you in a positive spirit and in support of the necessary reforms to which the draft report of the Advisory Group could contribute if updated and brought to completion. This may of course also require liaison with your Ministerial colleague, the Minister for Justice and Equality.

I am also copying this correspondence and this covering letter to Dr. Michael Harty, Chair of the Oireachtas Health Committee.

Thank you for taking the time to read this correspondence and I look forward to hearing from you by way of substantive reply. Please be assured of my support in this matter.

Yours sincerely,

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Professor Denis A. Cusack,
Head of Subject in Forensic & Legal Medicine.

Encl:

cc: Dr. Michael Harty

Letters/harris290916

9th September 2014.

DAC/bmcc

Dr. Leo Varadkar T.D.,
Minister for Health,
Hawkins House,
Hawkins Street,
Dublin 2.

Dear Minister,

Re: Advisory Group on No-Fault Compensation and Reform of Medical Negligence Process.

I wrote to your predecessor, Dr. James Reilly, most recently in April 2012 regarding the above.

The last meeting of the Advisory Group took place on the 12th May 2008. It was my understanding that further work was done to finalise the report of the Advisory Group and on which I believe all of the members had signed off and that a final meeting was to be called so that report could be submitted to the Minister for Health. There has been no communication since to the members of the Group regarding any further meetings and, more importantly, as to whether or not the work done by the Group will be brought to a conclusion in the form of a report and/or recommendations to the Minister in the near future. Indeed, I have informally heard that for whatever reason the work of the Group has come to a complete halt and may not be followed up by the Department.

However, there are also developments in two other areas related to the consideration of No-Fault Compensation Schemes and also reform of the medical negligence litigation process. The first of these areas relates to the success of the Personal Injuries Assessment Board (of which I was a member from April 2004-2012). The second is the report from the Working Group on Medical Negligence and Periodic Payment Orders chaired by Mr. Justice Quirke, the work of which has been continued by Ms. Justice Mary Irvine.

I believe that these three strands of: No Fault compensation for hypoxic injury babies at birth (Ref: Department of Health and Children); medical injuries assessment board process (Ref: PIAB/Injuries Board and Department of Enterprise, Trade and Employment); and a move to periodic payments rather than lump sum payments (Ref: Department of Justice and Law Reform) are critical issues in this specific area of medical negligence litigation and for medical negligence generally.

I enclose a draft copy of a potential No Fault Scheme which I circulated for consideration to the Advisory Group on 7th April 2008 which although now outdated may still be of assistance as a basis for progression.

In all of the circumstances, I would ask you most earnestly to review the issue of medical negligence having regard to the elapse of time so that it might be progressed and in particular a decision about the Advisory Group be made which may be that it is formally extinguished. I believe that a ministerial decision on this would be both timely and welcomed.

Yours sincerely,

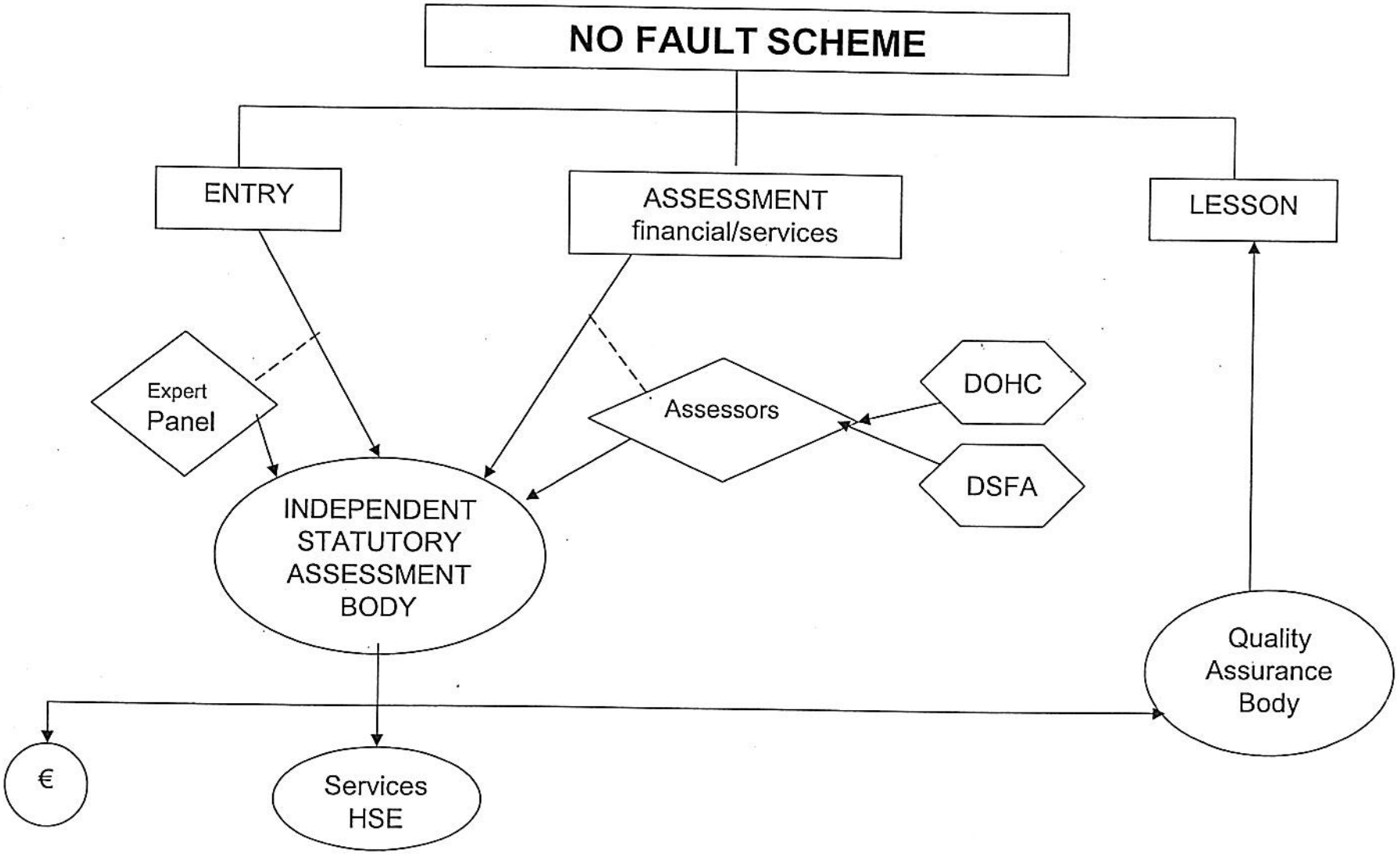
Professor Denis A. Cusack,
Head of Subject in Forensic & Legal Medicine.

Encl:

Letters/varadkar99

DRAFT

Circulated by Prof. Cusack at the No Fault Group Meeting of the 7 April 2008



Medicine and the law in Europe

Ireland: breakdown of trust between doctor and patient

Denis A Cusack

By European standards Ireland experiences a very high level of medical litigation. The possible reasons for this are numerous but not yet determined with any certainty. The consequences are quite clear with negative effects on medical practice, on the psychological health of doctors and patients alike, and on finances of the state. There are different patterns of medical litigation throughout Europe. Ireland may be merely anticipating the emerging increase in such actions elsewhere in the region. The present adversarial basis for medical litigation is not wholly without merit and has contributed to professional accountability. Nevertheless, a change in the present system ensuring accountability and fair compensation is required, together with a striving to ensure that trust is rebuilt between doctors and patients.

The level of medical litigation in Ireland today has earned this country the epithet "51st state of the [US] Union" and the dubious distinction of being the most litigious country in Europe. Medical indemnity subscription rates for obstetricians in Ireland are between €55 000 and €87 000 per annum (1€ is about $US1). The total cost of medical indemnity to the Irish (population 3·7 million) will be about €41 million in 2000. A doctor in Ireland is four times more likely to be sued than a colleague in the UK and awards by Irish courts and out-of-court settlements are several times higher than elsewhere in Europe.

Is this a peculiarly Irish malaise, explicable by patients in Ireland expecting too much of doctors; by doctors being reluctant to explain the limitations of medicine; by patients being greedy and too eager to litigate; by doctors in Ireland practising a lower standard of care than elsewhere? Could this loss of trust in doctors merely be a symptom of a more general malaise in a society that is rapidly becoming more secular and prosperous? Or do we have an overintrusive legal system feeding on the legitimate litigious nature of the Irish people? Or is the medicolegal situation in Ireland an early sign of a pan-European epidemic?

Medical law and medical ethics are inextricably bound. A society's laws reflect the *mores* of that society and should also reflect the ethical principles of that society, even though sometimes the two will diverge. The ethical bases for the doctor-patient relationship are the Hippocratic oath and its modern successor declarations of Geneva, Helsinki, Tokyo, and Lisbon, the professional codes of statutory regulating bodies, and the individual doctor's conscience. The legal bases for that relationship are international instruments (including the European Convention on Human Rights); fundamental rights expressed in written or unwritten national constitutions; public health statutes; and criminal and civil codes or case law developing from the laws of tort (civil wrongdoing) and contract. In addition, there is usually a triangular relationship of patient, doctor, and healthcare institution. These medicolegal fundamentals are present throughout Europe so what, if anything, is unique to Ireland?

Lancet 2000; **356:** 1431–32

Division of Legal Medicine, Department of Forensic Medicine, National University of Ireland, Dublin, University College Dublin, Dublin 2, Ireland (Prof D A Cusack FRCPI barrister-at-law)
(e-mail: legal.medicine@ucd.ie)

Currently, there are three major medically related inquiries underway in Ireland. A judicial inquiry into infection with HIV and hepatitis C of persons with haemophilia follows an earlier inquiry into the Blood Transfusion Service Board and the infection of patients by HIV contaminated blood and blood-related products. A second inquiry is reviewing post-mortem examination policy, practice, and procedure since 1970, particularly as it relates to organ removal, retention, storage and disposal. It was set up following the discovery that organs of children had been retained and disposed of after necropsy without the consent or knowledge of parents. A third group of inquiries, undertaken by some of the regional health boards, is examining the clinical standards of several specialist consultants, utilising peer-review panels drawn from the Royal Colleges. The substantive issues of all of these inquiries are not peculiar to Ireland. However, they exist on a background of a rising level of mistrust of, or at best a diminution of confidence in, the medical profession with calls for an end to self-regulation by the profession and for greater accountability of doctors.

However, medicine is not alone. There is a serious loss of trust in public institutions and professions generally. This loss of confidence is reflected in Ireland's many inquiries into corporate activities and alleged evasion of taxes facilitated by banking institutions; in official inquiries investigating possible connections between bribes to public officials and politicians and planning and political decisions; in allegations of institutionalised child abuse dating back some decades, some involving religious orders; and even in the conduct of certain members of the judiciary.

The maintenance of trust between doctor and patient encompasses the need for accountability on the part of the profession. Patient autonomy, or the right to self-determination and involvement in decision-making, has gained strength in the past decade. There must be a recognition of both rights and duties on the part of patient and the doctor. Yet there is an uneasy relationship between medicine and law. Medical care is based on trust, albeit in a relationship of unequals, while the adversarial litigation process is based on a healthy and necessary mistrust. Therein lies the intrinsic tension even though both medicine and the law strive to serve the "best interests" of the patient.

Two central issues in Irish medical law illustrating this tension are the definitions of the proper standard of medical care and of what constitutes informed consent. In

the 1999 case of Collins *vs* Mid Western Health Board and Another, Supreme Court Judge Keane stated: "ultimately, the courts must reserve the power to find as unsafe practices which have been generally followed in a profession". In Walsh *vs* Family Planning Clinic and Others (1992), it was stated, in relation to an elective procedure, "that the risk . . . however exceptional or remote . . . of grave consequences . . . should be explained in the clearest language". The paternalism and deference to the medical profession evident in the so-called Bolam test are truly dead as legal tests in Ireland. These issues are two major battlefields in the war over medical negligence litigation. Irish doctors now fear that judges set the parameters of medical practice. Yet these principles, enunciated by Irish courts, find expression in courts throughout the world.

Another recent development is the liberal and far-reaching Freedom of Information Act 1997 and its application to Irish health boards and hospitals. Patients now have full access to all written records held by public healthcare providers. This has added to the unease of doctors keeping such records and to increased defensiveness in the practice of medicine in Ireland because the documentation of clinical standards and of consent procedures is now readily scrutinised.

A further evolution which may complicate the doctor-patient relationship is the awareness of human rights in medicine. Topical issues in Ireland here include informed consent; the state's obligation to provide healthcare and care facilities for vulnerable children; mental health law and the law on criminal insanity; and, as in the UK, incorporation of the European Convention on Human Rights into national law. These human rights issues will be grafted onto the existing medical negligence crisis in Ireland. The "crisis" affects both patients and doctors, and the difficulties encountered are satisfactory for neither. There is a price to pay for any systemic mistrust between doctors and patients, and Irish society may not be fully aware of the significant cost to the caring nature of medicine and the excellent relationship between most individual doctors and patients.

Can any of the foregoing explain "the Irish malaise"? Are these problems in the medicolegal relationship between patients and doctors unique to Ireland? The answer is that they are not, but they have found expression in an Irish tradition of protecting personal rights through the justice system as reflected in high level of personal injury litigation generally. There is some evidence for an increase in medical litigation in other parts of Europe. The experience of Nordic countries is different, in part due to different legal systems and more generous social security compensation systems. Nevertheless, we do seem to be witnessing the emergence of a pan-European weakening of the doctor-patient relationship accompanied by unrealistic expectations of medicine.

Proposed reforms to the law on medical negligence in Ireland include active management of cases, pre-action protocols, early exchange of expert reports, procedures to deal with small claims, structured settlements, and the introduction of tables of awards for injuries for judicial guidance. Alternatives to legal action have also been mooted, including efficient complaints procedures, clinical risk management programmes, alternative dispute resolution (mediation and arbitration), enterprise (rather than individual practitioner) liability schemes, no-fault compensation (particularly for children injured through brain hypoxia at birth), and pre-litigation screening to exclude any with no *prima facie* merit. A Department of Health and Children circular of August, 2000 (94/2000) has set out proposed changes for medical indemnity, beginning in July, 2001. However, none of these changes addresses the basic question about what has happened to trust.

Solutions lie not only in reform and partial replacement of the tort system but also in a positive education programme for doctors, patients, lawyers, judges and the media in the principles of legal medicine. Greater professional accountability, continuing professional education, and reaccreditation procedures will also have a role. Rationalisation of arrangements for compensating victims of medical accidents is also required. Only thus can a fair and balanced approach to transparency and accountability of professionals be achieved whilst maintaining a caring and competent delivery of healthcare with a rebuilding of trust.