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

e) consider the impact of current tort legislation on the overall patient safety culture, including reporting on open disclosure.

Patient Safety is defined as the practice of prevention and mitigation of errors and adverse effects to patients associated with the delivery of health care. This is achieved through Risk Management. Every effective Risk Management Strategy has a very strong focus on learning and preventative measures in relation to past events.

Dr. Tony Holohan CMO – Presentation to Oireachtas Health Committee 2018

‘Learning from adverse events is the bedrock of patient safety.’

Despite clear patient safety provisions in relation to learning from adverse events under the NTMA (Amendment) Act 2000, there is no evidence to suggest that it is a contributor to better patient outcomes and experiences. In fact, it can be strongly argued that the processes and practices in operation in Ireland are seriously compromising patient safety through facilitating repeat adverse events and a failure to acknowledge and mitigate known risks, as the apparent ignoring of law and the administration of cases is doing little to prevent further harm.

National Treasury Management Agency (Amendment) Act 2000

The Agency shall advise and assist the State authority ..... in relation to the measures to be taken to prevent the occurrence, or to reduce the incidence, of acts, omissions or other matters ....... including measures to identify sources of risk that may occasion such claims

(b) The advice under paragraph (a) may include advice for the purpose of preventing or reducing any such risk ..... and the assistance under that paragraph may include any one or more of the following:

(i) the provision ..... of information, instruction and training for the purposes of enabling them to ascertain whether any such risk exists and if it does, of increasing the awareness of its existence and encouraging the adoption by that authority of appropriate measures to counter any such risk,

(ii) the assessment of any such risk, including the determination of whether it could give rise to a serious hazard,
(iii) the evaluation of the adequacy of the measures adopted by such an authority to counter any such risk,

(iv) the provision to such an authority of safety audits, inspections and reviews

The prevalence of repeated similar cases strongly suggests that the above is not being carried out to any satisfactory degree.

It should also be noted that an incorrect interpretation of the Health Act was, until very recently, being used by the HSE as a means of actively not progressing systems analysis investigations into adverse event, thus seeing the law, facilitating repeat events via preventing learning.

The first and most important consideration in assessing if current tort law contributes to a patient safety culture is a review of repeat adverse events, i.e., is the pursuing of cases mitigating the chances of known incidents of harm recurring? The answer is a definite no. There appears to be practically no relationship between case law trends and an improvement in patient safety.

What happens in reality?

The primary functions of the State Claims Agency are:

1. To ensure that the State’s liabilities in relation to personal injury … claims, are contained at the lowest achievable level.

2. To implement targeted … risk work programmes to mitigate litigation risk …. in order to reduce the costs of future litigation against the State.

Case after case suggests that there is a disproportionate focus on item 1 above, with item 2 getting little attention in relation to adverse health events mitigation.

The most concerning product of the current system is it facilitates the containment of the facts of adverse events where the State bodies can essentially pay off claimants via settlement offers to ‘go away’ without the facts of the harm ever being admitted to the claimant and prevent practices being opened up to scrutiny and publicity in the courts. The publicity factor is discussed further below.

The unbalanced nature of the legal process sees claimant required to lay all cards on the table in terms of proving causation, while the defendant can hold back, in full knowledge of what actually occurred, and not engage in relation to the facts of the adverse event until the 11th hour, generally years after the harm. With, in excess of 90% of cases settled it must be accepted that causation in at least 90% of cases is eventually proven, again, generally at the latest possible moment. One would question how many similar adverse occurrences could be prevented if legislation was enacted, with functioning accountability mechanisms for non-compliance, that required the defendant to practice transparency from the outset, allowing mitigation measures to be put in place aimed at preventing potential future harm.
Even when settlements are reached, conflicting expert reports from both sides can remain on the table, each geared towards supporting their own desired outcome of the case but without any fully independent focus on the actual facts of the adverse event.

These reports are generally based on differing accounts from the practicing medical team and claimant, leading to further confusion and disagreement of the actual occurrence.

A further significant chasm in current legislation in relation to advancing patient safety is seen in the lack of any functioning sanction mechanisms in relation to misleading statements by medical teams after an adverse event has occurred, the ‘misplacement’ of elements of clinical notes and even fraudulent changing of medical records. The medical records in relation to my son’s death were changed weeks after his death, which an independent expert from outside of the State described as ‘for his own gain’. This was known to the hospital management at the MRHP, yet they provided the altered records to the Coroner, the HSE’s investigation team, An Bord Altranais, the Medical Council and my wife and I. Despite this, the Medical Council’s sanction was to tell him not to do it again.

Despite reservations from claimants, tendered settlement offers are regularly accepted through sheer exhaustion with the process and with the threat of full hearing costs to consider, despite a desire to establish the facts of the occurrences that caused the tort.

In all of the above situations, definitive conclusions as to the root cause of the adverse event are rarely disclosed and, it would appear, no further actions in relation to dealing with same takes place. Despite the obligations on the key stakeholders involved to establish this root cause and take actions to reduce or mitigate the chances of recurrence, the figures confirm, similar harm is consistently repeated.

What is equally worrying is the fact that even when a root cause is established via defendant’s expert reports or trial, it appears that actions to prevent the repeat of events are also limited.

The UK has recently introduced the fully independent Healthcare Safety Investigation Branch, whose function is to establish the facts of adverse outcomes in order to shape measures to prevent recurrence of similar events. This body does not act on behalf of patients or healthcare providers but in the interest of patient safety only.

Example: Birth Injuries.

My son’s death was caused by hypoxia, which was, among other issues, due to an inability to operate and read the CTG machine, the use of the drug syntocinon and a delay in escalating his care to consultant level. What is most notable about the tort law/patient safety relationship in relation to birth injuries in Ireland is the fact that these same causes of injuries and deaths continue to reoccur time and time again, many times prior to Mark’s death and many times since. Numerous previous cases in relation to birth injuries were known to the HSE & SCA prior to Mark’s death. Back in 2014/2015 when my wife and I were seeking the introduction of a National Patient Safety Office to collate all known data in relation to adverse events from all key State Stakeholders, it was confirmed to us that the SCA had concerns about Portlaoise prior to Mark’s death, yet no measures that may have prevented his death were put in place.
Dr McKenna, in his submission to the Group, cited approximately 10 cerebral cases annually. This is despite advances in technology and medicines, and a stable-declining birth rate.

Despite the knowledge of these repeated deaths and injuries, consistently over many years, known to the HSE, the SCA and the Courts, costing the State upwards of €200 million annually, their causes have been consistently ignored in the aftermath of every case.

In each case, consequences for individual health practitioners or the hospital involved in repeat events are practically non-existent, despite sometimes reprehensible behaviour to patients in the aftermath of the event and ultimately, the State repeatedly picks up the bill via the SCA.

There is essentially no incentive or stick associated with the operation of current tort law in Ireland that promotes a patient safety culture.

Patient safety measures aimed at preventing birth related injuries and deaths, have only commenced in recent years, largely as a result of the efforts of injured service users, and certainly not as a result of any function of tort law.

High Profile Cases.

In could be argued that high profile cases such as those related to the Portlaoise Baby Deaths and Cervical Check promote or, more accurately, force corrective action on health service providers. While this may well be the case, it is generally with a limited shelf life, and, is due to public outcry and political pressure rather than a factor of the operation of tort law.

In the aftermath of the death of Savita Halappanavar, a National Maternity Strategy was muted, however, it did not materialise until the maternity related issues were again highlighted by my wife and I after our son’s death. The National Maternity Strategy followed and was launched in 2017 after a full year of input from a working group of key stakeholders. 10 years of ring-fenced funding was announced as part of the Maternity Strategy Implementation aimed at improving obstetric outcomes in Ireland. However, the HSE’s 2019 budget slashed this ring-fenced funding from €7.6 million to €4.1 million diverting the funds to other services. As a result, a planned national CTG training plan which is aimed at targeting the single biggest contributor to adverse maternity outcomes in Ireland is not taking place.

This again highlights the lack of enforcement of the law as referenced under National Treasury Management Agency (Amendment) Act 2000 and any coherent joined up thinking in relation to recurring medical negligence cases in Ireland, or indeed actions of the service provider in relation to patient safety.
**Further Considerations.**

In relation to the argument that some learning may be derived from every case, it is worth briefly mentioning the presence of barriers to entry within the current tort law system.

These include:

**Financial:** Outlays of €3,000 upwards in order to commence a case, in particular from the perspective of those on lower wages or in the aftermath of an event that may have resulted in an extended period off work or resulted in unemployment can be prohibitive for many people, and, as a result, a case may never be pursued.

**Timing:** The current statute of limitation period of 2 years, within which many affected persons, particularly in the aftermath of a long-term recovery, permanent injury or the death of a loved one, may not have even considered pursuing a case or be emotionally ready to do so. When considered in relation to the workings of the amendments to the Civil Liabilities Act 2018, this limitation period is particularly short.

**Fear:** The complexity of pursuing a case and the constant media reporting of extended durations involved, the known psychological effects of the process, fear of giving evidence and anxiety in relation to personal information being made public also sees some potential cases not being pursued.

To summarise current Tort Law in relation to promoting Patient Safety, one can only conclude that the imbalance under current legislation in relation to case procedures and a failure to act in accordance with the risk mitigation intentions of the law utterly fails the ideals of patient safety and improving outcomes, with the facts and figures essentially speaking for themselves.

It is difficult to conclude anything other than the concentration on ensuring that the State’s liabilities in relation to personal injury claims are contained at the lowest achievable level is the only function being actively pursued by the SCA in the management of cases and the lack of any consequences for the HSE after consistent recurrence of same adverse events is facilitating continued negative outcomes. Certainly the health and consequences to future service users does not appear to receive any consideration in current case management.

So long as the SCA report year on year rising costs and reserves in relation to the settlement of Medical Negligence cases against the State, one has to question if legislation needs to be substantially strengthened as currently it is clearly not fulfilling any function in relation to improving Ireland’s Patient Safety Culture.

**Open Disclosure.**

I acknowledge the amendments to the Civil Liabilities Act 2017 in relation to Prescribed Statements on Open Disclosure and have been involved with the Dept of Health in the review of the procedures from a service user’s perspective.

These provisions, however, should not be viewed as a panacea to the Open Disclosure argument from a patient openness perspective. They are purely geared toward protecting, and most likely placating, clinicians in disclosing adverse events. They do not make it mandatory to disclose all events (within reason) to patients harmed by healthcare. In fact, the provisions
providing the disclosure from being used in the context of a medical negligence claim, may well create further difficulties in the progressing of cases.

The provisions in relation to the disclosure of SREs internally, if fully put into practice, could make a significant difference to patient safety. If the full facts are addressed early after an adverse event, the benefits to informing risk management and mitigation could be significant.

**Dr. Deirdre Madden - Commission on Patient Safety 2008:**

> Patients who are the victims of medical mistakes should be fully informed of what has occurred and how they have been affected

In terms of the current position, despite the duties set out under Medical Council Guide to Professional Conduct and Ethics, the HSE Open Disclosure Guidelines and repeated recommendations over the past decade, Open Disclosure is currently not in practice in Ireland and therefore it cannot be considered in the context of having any positive impact on a Patient Safety Culture. As the Taoiseach, then Health Minister, said in relation to the events at MRHP: ‘these people were lied to’ and ‘this is akin to a hit and run’.

At present, the lack of Open Disclosure has a huge negative effect on harmed service users, public perception and confidence in our health service. This leads to a mis-trust in the aftermath of an adverse event, which, by extension, leads to a maximising of litigation numbers. It is universally recognised that people who have been harmed in healthcare have a strong need to find out the facts of the adverse event. Studies have concluded that this need for information is one of the primary reasons for pursuing a case for medical negligence once the stone-walling process commences.

When Canada introduced and fully bought into Open Disclosure Guidelines in 2008, there was a significant reduction in the number of cases pursued against the State. The openness in relation to the actual causes of events satisfied many would-be litigants and no actions were commenced. This also served as a means of risk management targeting areas in need of improvement, thus mitigating repeat events.

There are concerns among some that a full transparency and openness in relation to adverse events will lead to a massive increase in actions against the State. This is an extremely narrow view and takes no account of the evidence from other countries in relation to the introduction of Open Disclosure or the derived learning that will accrue from this approach, which serves overall to reduce repeat events and harm.

An example of the safety benefits of full disclosure can be seen in the construction industry where injuries and deaths have fallen 85% in the past 40 years as a result of a full industry buy-in to 100% reporting of all injuries, however small, while also including reporting of ‘near-miss’ events, all backed up by strong legislation. Non-disclosure of any ‘lost-time’ injury, serious injury or death is against HSA legislation, where serious sanction are imposed for infringements of the law and concealing of even minor events would result in dismissal from work. The net effect of this open approach is a safer place of work for construction workers and the public in general affected by building works.
In practice, the lack of open disclosure in operation in Ireland and provision of misleading information is having a significant negative impact on people harmed by healthcare in Ireland. A patient safety culture has to be considered in the context of mental as well as physical health. It is notable that the tort of Intentional Infliction of Emotional Distress is also being increasingly pursued in relation to medical negligence cases as a direct result of the behaviour of the defendants in the aftermath of the event. At a time when injured parties should be wrapped in cotton wool, they are knowingly being subjected to this additional psychological torment. Many of the correspondences seeking engagement and answers in the aftermath of my son’s death were constructed and sent by my wife and I in the early hours of the morning as the frustration and attrition practices employed by the hospital and HSE in their limited responses to us lead to many nights of no sleep and constant anguish. I recognise this same distress in the many families who have sought help from us over the past number of years as they struggle with these same practices.

Families receiving admissions of liability and apologies after 5, 6 7 years of psychological torment and frustration, where much sought-after information is consistently withheld by agents of the State, regardless of the known impact that it is having on the affected service user, is a national disgrace and is certainly at polar opposites to a patient safety centred culture.

In the context of advancing the work of the Group, I believe it is imperative that we establish where this denial culture stems from and make recommendations in relation to addressing this abuse of position, which is clearly compounding the effects of medical harm and is an obvious obstruction to better service user outcomes and patient safety as a whole.

I believe that a recommendation should also be made that legislation in relation to Open Disclosure is reframed to benefit the service user rather than solely to encourage clinicians to disclose. This legislation needs to include clear sanction mechanisms for those who conceal and mislead patients in the aftermath of harm occurring.

Mark Molloy Feb 2019