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Do PATIENTS WANT and EXPECT COMPENSATION following HARM?

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Recent research in Australia on the Open Disclosure of adverse medical events suggests that patients want reparative gestures following an adverse event.[1]

Having now interviewed close to 150 patients and relatives involved in hospital-caused harm, we know that the principal gestures that patients expect are: an apology; timely and honest communication and information flow; acknowledgement of the error and for responsibility to be taken; reassurance that the incident will not happen again and that the service seeks to improve as a result of the incident; and emotional support. One other important expectation is *financial* support. Where reparative gestures are predominantly communicative in nature, financial support has, besides a communicative dimension (as gesture), also a material dimension (as resources, for example, money).

Deciding what is appropriate financial compensation is challenging for a number of reasons. Australian health services, by and large, tend to shy away from offering compensation outside of a finding of legal liability. This may be because the service's insurer refuses to repay the service for monies paid in this way. It may also be because the service lacks the necessary bureaucratic-administrative mechanisms for making money available to patients who are harmed, or for determining amounts to pay for non-hospital-related costs. Or it may be that the service's lawyer advises against awarding payments lest they be converted into attributions of legal liability under our fault-based system of compensation.

In some states – for example, Queensland – public system monies have now been made available by the health bureaucracy to allow services to make limited *ex gratia* payments. Findings from our Open Disclosure studies indicate that both clinicians and patients want a better method of providing compensation, including *ex gratia* payments, for expenses incurred as a result of adverse incidents.

HOW BEST TO PROVIDE COMPENSATION FOR HOSPITAL-CAUSED HARM?

The debate on the best method of achieving compensation has intensified recently as a result of the introduction of a National Disability Insurance Scheme (NDIS) and the proposed National Injury Insurance Scheme (NIIS) in Australia.[2] It is therefore timely to examine the issue of compensation following medical error in the Australian context in more detail. To date, the debate has focused on what is the best legal and administrative structure for providing compensation.[3] While our previous studies have touched on the question 'what are patients' and relatives' views on compensation?', we have not yet systematically investigated the question 'how should patients be compensated for hospital-caused incidents?' The starting point for this debate should not be the structure or form of the compensation scheme, but what clinicians, patients and relatives say about what needs to be done following an unexpected outcome or incident.

Following on from our 2008 interview study,[4] we interviewed an additional cohort of patients and relatives about incidents and their disclosure between 2009 and 2011 (the '100 patient stories study'). Interviewees were 39 patients and 80 family members involved in high-severity healthcare incidents (leading to death, permanent disability, or long-term harm) and incident disclosure.[5] Recruitment was via national newspapers (43 per cent), health services where the incidents occurred (28 per cent), two internet marketing companies (27 per cent), and consumer organisations (2 per cent).

Responses often touched on issues of compensation. Specifically in relation to the issue of *ex gratia* assistance, patients and relatives from our sample would have wanted accommodation and travel for family members, any parking fees covered, and waivers of further medical fees for treatment necessary to remedy the hospital-caused problem. When this was not offered, patients and relatives felt that the health service had failed to take appropriate responsibility for unexpected, adverse outcomes resulting from clinical intervention.

One would expect that such assistance following harm would of course be determined with reference to the circumstances of the injury, but also the particular financial resources required for the patient to deal adequately with that injury, the extra care needed, and the resources needed

by relatives to assist and accompany the patient. Admittedly, such determinations are by no means easy, particularly when the causes of the incident remain contested, when the degree of assistance needed remains unclear, or when the extent of the harm is not fully known or appreciated (by either the service or the patient).

Nonetheless, it is certainly significant that most people in the 100 patient stories study did not want to litigate, even in cases where the service was evidently at fault. Those who litigated did so because they required financial resources to deal with the injury, as the following quotes demonstrate:

> "...Oh I had to move. I had to move from the country to Adelaide to be closer to a hospital because of it. I actually had to uproot my whole life... But you know, the funniest part about it was actually the doctor who told me to sue... They actually told me to sue." (patient; failure of medical-surgical procedure)

> "I mean this has necessitated us to now sell our residential home. So not only is he trying to get better and we've now had to sell our house because we can't afford the mortgage." (wife of deceased patient; delayed and incorrect treatment)

Aside from our 100 patient stories study (published in 2011) and our earlier evaluation of the Open Disclosure pilot (published in 2008), little is known in Australia about the incidence and amount of compensation including *ex gratia* payments offered to patients following adverse events. Anecdotal evidence suggests that some Australian health service-providers do have in place disclose-and-early offer models.[6] However, the application and success of these models have been neither researched nor reported. Australian Medical Indemnity Insurers know when a reserve is set aside to fund a potential claim, the amount of that reserve, and the final amount of the claim. Analysis of this data would inform the debate about improving models of compensation, including how to reduce the time between setting reserves and finalising claims.

In addition, the Australian model of Open Disclosure differs from the vast number of models in place in the US, being a disclosure-only model, not a disclosure-and-early-offer-of-compensation model. In the US, and particularly in states such as New Hampshire, the outcomes of these models, particularly those that impose significant legal constraints on patients accepting early offers, are by no means clear and guaranteed. Given our reliance on American literature on the topic of Open Disclosure, it is surprising that the ramifications of early-offer models have not been addressed in Australia.

Instead, the debate in Australia appears to be focused on the legal and administrative structures governing disclosure information provision and *ex gratia* assistance. For example, a recent article in the Ethics and Law section of the *Medical Journal of Australia (MJA)* argues that the introduction of the NDIS and NIIS is a 'missed opportunity to achieve the needed comprehensive reform of the compensation system in Australia'.[7] Furthermore, the authors recommend that prior to taking any action on the NIIS, 'the Productivity Commission should be asked to conduct an inquiry into the merits of moving to a no-fault system for dealing will all medical injuries'.[8]

This argument downplays the advantages of the tort system as a deterrent to sub-standard care, instead focusing on the disadvantages of the time-consuming and costly business of mounting and proving claims. But in allowing anyone who is harmed to lodge a claim, no-fault injury compensation schemes potentially generate cost blow-outs, as well as shifting financial responsibility from healthcare professionals to the public. This may produce further unforeseen barriers and restrictions, resulting in new injustices and dilemmas. Where do we turn?

A NO-FAULT COMPENSATION SCHEME

The Productivity Commission's 2011 report into long-term care and support for Australians with disability has triggered intense debate about compensation. The report recommended an NDIS to provide all Australians with insurance for the costs of support if they acquire a disability, and the establishment of a NIIS to provide lifetime support for people acquiring a catastrophic injury as the result of an accident. The NIIS appears to cover all causes of *catastrophic* injury or disability, including those due to medical 'accidents'.[9]

Some commentators argue strongly for the introduction of an NIIS no-fault scheme.[10] Numerous nations, including New Zealand, Sweden and Denmark, have moved towards adopting no-fault or mixed-compensation schemes. In addition, Scotland plans to introduce a no-fault scheme for medical injury based upon the Swedish scheme, and England has legislated for a compensation scheme for medical negligence, although it has yet to be implemented in practice. Such schemes are varied in their approach to the issue, showing that this is not a one-size-fits-all matter. Some nations build into their strategy a broad range of remedies. This may include non-financial reparation such as an apology, an explanation, and reassurance that steps have been taken to prevent recurrence. Others include financial compensation without denying victims the option of civil proceedings. Again, others navigate between these two extremes, adopting a variety of positions.[11]

The argument to move away from a fault-based legal system is predicated on the view that no-fault and mixed schemes reduce the uncertainty experienced by victims and providers under a fault-based scheme. No-fault or even mixed schemes are seen to limit uncertainty about legal costs, length of proceedings, and the adversarial and often defensive intent motivating questions about causation.[12]

Research suggests, however, that the no-fault and mixed-fault schemes currently in existence are not without problems. For example, although about 9,000-10,000 cases are processed under the Swedish system annually, compensation is paid in barely half of these cases, suggesting that a good number of legitimate claims may be denied, even under a no-fault system.[13] The limitations of New Zealand's system have been well-documented.[14] A recent article outlines the challenges posed by any such scheme in Australia: reconciling the different goals of the tort-based system and a no-fault system, the financial costs of implementing and >>

maintaining a no-fault scheme, and the implications of such a scheme for, and its impact upon, professional conduct cases and clinical practice improvement generally.[15]

SO...?

Preventable medical errors harm a large number of people per year. Any discussion of compensating for medical negligence that does not touch on reducing preventable medical errors ignores this fundamental problem.

Rather than holding the taxpayer financially responsible, as the NIIS is slated to do, the civil justice system holds doctors, hospitals and insurance companies financially accountable. To date, it has been this accountability that has driven the development of patient safety systems and practice improvement, insofar as they exist. Were a no-fault system to be introduced in the form of an NIIS, whether modelled on the New Zealand system, the Scandinavian system, or any other system, the transfer of the costs of health service-caused harm to the taxpayer must be accompanied by a rigorous and publicly controlled mechanism for holding healthcare to account for avoidable harm inflicted on patients.

Were the NIIS' costs to rise, for example, due to a rise in compensable harm, the public should have the right to insist on new monitoring approaches, new accreditation standards, new training initiatives, and perhaps more comprehensive public participation models. Further, under an NIIS, clinicians' insurance fees should continue to be collected to contribute to funding such new approaches, standards, initiatives and models. Were compensation payouts to drop, and the insurance pool to grow, researchers could be encouraged to seek funding for studies targeting the safety of healthcare processes with the close involvement of public, professional and health service management representatives.

Important in this regard is that the most recent Australian compensation amounts for litigious claims are generally not high. More than half (58 per cent) of closed claims in 2009-10 were settled for less than $10,000, including 17 per cent where no payment was made. Just 6 per cent were settled for $500,000 or more. In addition, two-thirds (67 per cent) of closed claims were finalised within three years of being opened, compared with 14 per cent which took more than five years to be settled. Just 3 per cent of closed claims were finalised through a court decision, compared with 51 per cent through a negotiated settlement with the claimant. The remaining 46 per cent were discontinued (for instance, following the claimant's withdrawal of the claim).[16] The question that arises here is to what degree (if at all) these figures are indicative of what might happen under an NIIS.

Given the lack of openness about current compensation models in operation and the dearth of research into patient experiences of those models, it is too early to argue that a no-fault system is the preferred model to achieve reform. This is particularly true if the other side of the equation – more stringent and publicly transparent approaches to quality and safety improvement – is not embraced at the same time.

Equally, there may well be ways of tweaking the current model(s) to achieve appropriate compensation for victims of adverse medical events, and more forthcoming attitudes on the part of services having to consider *ex gratia* assistance for patients harmed as a result of unplanned outcomes. Arguably, and considering again the findings from our patient/relative interview studies and current litigation trends, the answer to the problem of how best to compensate patients following an adverse incident may not require a major overhaul of the current compensation system. By enabling services to adopt a 'service culture' and reject the conventional 'deny and defend' approach, it might be possible to meet both clinicians' and patients' expectations without introducing a no-fault scheme. This involves trialling methods that allow for earlier offers of compensation after a reserve has been set, or trialling and evaluating some of the disclose-and-early-offer models that are in operation internationally.[17]

CONCLUSION

While our research suggests that patients do want various forms of assistance and compensation following an adverse event, further empirical research is needed to identify what kinds of compensation are currently used in Australia, what patients' and relatives' experiences are, and what might be the most appropriate system(s) for providing compensation, especially financial compensation. Were we to conclude that these systems are inadequate and settle on a no-fault system, such a decision must be accompanied by measurable and tangible progress towards safer healthcare for patients.[18] Inevitably, and given that they might be expected to foot the bill, a critical development should be that the public be granted a greater role and enhanced right to sit in judgement on progress towards quality and safety, and to collaborate closely with health professionals in designing strategies and processes for ensuring that patient safety is enhanced, not sacrificed. ■

Notes: **1** R Iedema, S Allen, K Britton, C Grbich, D Piper, A Baker, et al, 'Patients' and family members' views on how clinicians enact and how they should enact Open Disclosure – the "100 Patient Stories" qualitative study' (2011) *British Medical Journal* 343; R Iedema, N Mallock, R Sorensen, E Manias, A Tuckett, A Williams, et al, 'The National Open Disclosure Pilot: Evaluation of a Policy Implementation Initiative' (2008) 188 *Medical Journal of Australia* 397-400. **2** Productivity Commission (2011) *Disability Care and Support*, Report No. 54, Canberra. **3** J Rait 'How best do we compensate for accidental medical injuries? A new medical injury scheme will require realistic costing, careful planning and gradual implementation' (2012) 197(5) *Medical Journal of Australia*, 299-300; D Weisbrot & K Breen, 'A no-fault compensation system for medical injury is long overdue' (2012) 197(5) *Medical Journal of Australia* 296-98. **4** R Iedema, N Mallock, R Sorensen, E Manias, A Tuckett, A Williams, et al, 'The National Open Disclosure Pilot: Evaluation of a Policy Implementation Initiative' (2008) 188 *Medical Journal of Australia* 397-400. **5** Incidents resulted in 50 deaths or permanent disability; 12 injuries; 9 hospital-caused diseases; and 27 cases of ongoing suffering: R Iedema, S Allen, K Britton, C Grbich, D Piper, A Baker, et al, 'Patients' and family members' views on how clinicians enact and how they should enact Open Disclosure – the "100 Patient Stories" qualitative study' (2011) *British Medical Journal* 343. **6** A Wu (2009) Professor of Health and Policy Management at the John Hopkins Bloomberg School of Public Health, personal communication with Geoffrey Hirst, Director of Surgical Services, Mater Health Services, South Brisbane, cited in NPSA (2009) *Patient Safety Alert: NPSA/2009/PSA003* available at: <http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=65171&>, accessed 6 March 2013). **7** D Weisbrot & K Breen, see note 3 above. **8** *Ibid*, at 296. **9** Productivity Commission, see note 2 above.

10 D Weisbrot & K Breen, see note 3 above. **11** AB Kachalia et al, 'Beyond negligence: avoidability and medical injury compensation' (2008) 66 *Social Science & Medicine*, 387-402. **12** A Corbett 'Regulating compensation for injuries associated with medical error', (2006) 28 *University of Sydney Law Review*, 259-96. See, also, T Cockburn and W Madden, 'Establishing causation in difficult cases: Can material contribution bridge the gap?', *Precedent*, issue 105, July/August 2011, pp24-8. **13** H Johansson 'The Swedish system for compensation of patient injuries', (2010) 115(2) *Upsala Journal of Medical Sciences* 88-90. **14** K Wallis & S Dovey, 'No-fault compensation for treatment injury in New Zealand: identifying threats to patient safety in primary care', (2011) 20 *British Medical Journal Quality & Safety* 587-91. **15** J Rait, see note 3 above. **16** Australian Institute of Health and Welfare (2012), *Public and private sector medical indemnity claims in Australia 2009–10. Safety and quality of health care series No. 12*. Cat. No. HSE 120, Canberra: AIHW. **17** SK Bell, PB Smulowitz, AC Woodward et al, 'Disclosure, apology, and offer programs: stakeholders' views of barriers to and strategies for broad implementation' (2012), 90 *Milbank Q*, 682-705. **18** JM Gilmour, *Patient safety, medical error and tort law: An international comparison (final report)*, (2006), Toronto, Ontario, Canada: Osgoode Hall Law School, York University.

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Who's really doing the ambulance-chasing?

LEX AND THE CITY

By Lexi Legis

Tell me... if you are in a social setting talking to another lawyer who works in the corporate world, do you admit you are a personal injury lawyer? Or do you say something more vague and general like, "I specialise in civil litigation"? Or a new one I heard the other day: "I'm a human rights lawyer"? I must confess, I used to. I was completely sick of other lawyers who live in the world of the six-minute unit, and who regularly wine and dine their clients on their corporate credit cards, calling me an 'ambulance-chaser'. Now I'm proud to say I am a personal injury lawyer and quickly explain to those other lawyers how rewarding my work is. It is about helping people when they are at their most vulnerable. That feeling of knowing that your client sees you as their lawyer, psychologist, financial planner, marriage counsellor, and confidante; all wrapped into one. There is no better feeling than achieving a great result for a person whose life has been devastated by injury, and literally seeing the relief and feeling of financial strain lift from their shoulders. I always wish I could wave my magic wand and heal them. I can't, but at least knowing that they will be able to pay for much-needed treatment or care, or respite for a tired spouse who spends their day changing their partner's colostomy bag, is a great feeling. I am sure my friend who is a GST specialist cannot describe the same feeling on sending an advice to a company about their GST liability.

Another thing that really irks me because of the inequality between different areas of law is the advertising restrictions on personal injury law. Why should a family lawyer be able to advertise and offer their assistance to 'ditch the bitch', and a criminal lawyer can advertise they can 'get you off', but I can't advertise that people whose livelihoods have been taken away by injury, negligently caused by someone else, have a lawful right to claim for their losses? For example, one of the most long-standing 'special categories' of duty owed to other members of the public is the duty owed to another road-user. If you are injured by the negligence of another driver, you have only six months to lodge a claim form on the insurer of the other vehicle, which is strictly enforced. But how do most members of the public know this? 'Late claims' take up so much time and valuable resources (payable by the community through our green slips). Why not just allow personal injury lawyers to advise the community of their rights and any time limits and reduce this expense? I cannot see any legitimate and justified reason why personal injury is the only area of law that cannot be advertised to the public.

Anyway, back to meeting other lawyers in social settings. I often go on to ask whether they charge their corporate clients for every minute of time spent talking to them, emailing them or quickly perusing a one-line email from them. "Absolutely", they respond. They wouldn't dream of doing a second of work 'pro-bono'. I then explain to them the concept of no-win, no-fee. "So you mean you can act for a client for years and they lose their case and you get paid nothing? You don't send them a monthly bill?" "Yep", I respond, "and not only that but I write off the tens of thousands of dollars I've spent on reports and court-filing fees in bringing their claim." Suddenly, the level of respect rises a little. Having gained their attention, I then briefly tell some stories of complex litigated matters; juicy cross-examination; and the different damages regimes, procedural requirements and causes of actions we need to be alive to, to really give a flavour of how complex and interesting personal injury law is. Suddenly, their work reviewing contracts seems a little dull.

Admittedly, when personal injury claims are legislated out of existence I may have to start thinking about other areas but, right now, there is no other area of law I would want to specialise in, despite the constant challenges the government throws my way. ■