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IMO Submission to the Interdepartmental Working Group on Rising Cost of Health-Related Claims - July 2023

Rising Cost of Medical Negligence Claims

The rising cost of medical negligence claims has been a concern for the IMO for a number of years now.

Under the Clinical Indemnity Scheme, the State Claims Agency (SCA) manages negligence claims taken against hospitals, medical practitioners, and other healthcare professionals covered by the scheme. The cost incurred in 2021 of resolving and managing ongoing claims was €486.5m, up €81.8m (20.2%) from €404.7m in 2020.[1] Further, the 2021 costs signal relatively high legal costs as a proportion of medical claims, with legal and other administrative costs accounting for just under a quarter of overall costs. While there has been an increase in both the quantity and size of settlements in recent years, attributed to a variety of factors, an inefficient and lengthy legal process contributes to the high cost of claims.

In addition to the financial cost, the current adversarial system of litigation following an adverse event has broader consequences in terms of the human cost including the emotional stress experienced by both plaintiffs and defendants of lengthy court proceedings as well as the cost to the wider health system in terms of the practice of defensive medicine and the contribution of a litigious culture to difficulties retaining medical staff in high-risk specialties.

IMO Recommendations:

A wide range of measures are needed to address the culture of litigation following an adverse event. Over the past number of years the IMO has made a number of submissions on the rising cost of indemnity insurance and open disclosure which are summarised as follows:

[1] NTMA Annual Report 2021 - State Claims Agency Extracts https://stateclaims.ie/news/ntma-annual-report-2021-state-claims-agency-extracts

Tort Reform

More than a decade ago the Working Group on Medical Negligence and Periodic Payment Orders, published recommendations on pre action -protocols and case management rules and greater use of periodic payment orders. While legal provisions have been made to support these reforms, on-going barriers preventing the acceleration of these key reforms must be identified and addressed.

Courts as a last resort

Recourse to the courts to resolve clinical negligence claims should be considered only as a last resort, after all other alternatives have been explored. Since the implementation of the Mediation Act 2017, Mediation must be offered, and SCA figures shows that there has been some increase in the number of claims resolved through this mechanism.[2] While this is to be welcomed, efforts must continue to promote resolution of disputes through alternative mechanisms.

No Fault Claims Systems

The IMO is of the view that further consideration should be given to the introduction of a No-Faults Claims system for certain cases.

No-Fault Claims mechanisms can provide timely and efficient access to compensation for injured parties without recourse to the courts and have been in place in New Zealand and Scandinavian Countries since the 1980s.. While there are concerns that No Fault Claims systems may increase the number of claims or could lead to lessons not being learnt, however, experience from France shows that following the introduction of No-fault Claims system in 2004, court proceedings for clinical negligence fell by a third, while appropriate reporting mechanisms and analysis of patient safety incidents can ensure appropriate learning from adverse events.

Under No- Fault Claims systems it is no longer necessary to prove clinical negligence but patients do have to prove that the treatment or medical process caused them harm. There is generally some guidance on compensation payments and in some countries the system is limited to certain types of injury, for example in US States of Florida and Virginia a no-faults system applies to birth injuries only.

While there is no “one-size fits all” model, detailed assessment of No-Fault Claims Systems and their implementation in different jurisdictions could address concerns and ensure the development of a no-faults claim system that is fit for purpose.

[2] NTMA opcit

Open Disclosure

The IMO supports Open Disclosure and the Promotion of a Just Culture following an adverse event however IMO doctors are concerned that a "blame culture" persists within the health sector. In a detailed submission on the Draft Policy Framework for Open Disclosure in the Irish Health Service, the IMO raised concerns around the simplistic narrative in public discourse that patient safety incidents are solely the result of clinical mis-management while ignoring the multiplicity of factors that may contribute to the adverse event.

In order to support Open Disclosure and a Just Culture the IMO called for:

- Recognition of the systemic and resourcing issues that contribute to patient safety incidents - Factors such as hospital overcrowding, insufficient allocation of resources, understaffing, all contribute to patient safety incidents. All non-medical contributing factors such as resource issues, understaffing, systems failures must be ascertained and included in the disclosure process.
- Sufficient resources within the hospital including adequate resourcing of psychological supports for patients and staff, risk management departments and recognition that open disclosure, incident investigation, risk management all take time away from clinical duties
- The process for Open Disclosure must be fit for purpose - the IMO has raised concerns that the prescribed statements as laid out in the Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018, are onerous, require legal support and are not conducive to an open and honest conversation with a patient or their family
- The IMO also highlighted that clinicians must have confidence in the Open Disclosure and Risk Management Processes. - Where an incident relates to an item that has previously been flagged on a HSE Risk Register, that fact must also be disclosed to the patient along with the length of time that item has been on the risk register.
- A system whereby senior decision makers and budget holders are held accountable in the same way as the medical profession.

Greater focus on prevention

The IMO is concerned that there is insufficient focus on prevention of patient safety incidents. IMO members have repeatedly expressed their concerns about inadequate staffing levels, insufficient hospital capacity, overcrowding and growing waiting lists for outpatient and elective care. The largest barrier to patient safety in the country is the low number of medical specialists per head of population and the inadequate distribution of resources based on medical or social need. Our health services are significantly over-stretched and clinicians are dealing with a constant stream of emergency patients without time or resources to adequately engage in audit and patient safety and quality improvement initiatives. It is imperative that all

clinical services operate with sufficient minimum financial and manpower resources necessary to provide safe, quality, evidence-based care.

In addition, the IMO are concerned that potential risks to patient safety are identified and highlighted on HSE risk registers yet often no further action is taken to mitigate risk.

Automatic Entitlement to Health and Social Services for People with Disabilities

People with disabilities should have automatic entitlement to health care and social supports including access to community therapy services so that patients and their carers are not required to take legal action to secure appropriate long-term care and support.