Features

Chroniques

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Cost of malpractice protection on rise in UK, too

Caroline Richmond

In brief

As in Canada, medical malpractice premiums in the United Kingdom are on the rise. In recent years there has been a 15%–20% annual rise in the cost of claims, and litigation costs for the National Health Service are soaring. Now, reports Caroline Richmond, another surge of litigation may be on the horizon because a 1996 change makes it possible for lawyers to take cases on a contingency basis.

En bref

Comme au Canada, les primes d'assurance contre la faute professionnelle en médecine sont à la hausse au Royaume-Uni. Le coût des règlements a grimpé de 15 % à 20 % par année ces dernières années et les coûts des litiges grimpent en flèche pour le National Health Service. Caroline Richmond signale maintenant qu'une autre flambée de litiges s'annonce, car une modification apportée à la loi en 1996 permet aux avocats de prendre en charge des dossiers en cas d'urgence.

As in Canada, medical malpractice insurance premiums in the United Kingdom have been spiralling upward as patients demand higher standards of care and accountability. In recent years the cost of claims has risen 15%-20% per year. Between 1985 and 1988 the number of successful claims and the average award doubled, resulting in a fourfold increase in total costs.

The Medical Defence Union (MDU) was started in 1885 by 2 lawyers and 5 "gentlemen." Malpractice allegations were rare in those days, due in part to the outrageous strategy of counterclaiming for defamation. By 1905 the MDU had acted in only 48 defamation cases and won all but 3; of 267 malpractice cases only 4 were lost. There were also 701 cases involving members' problems with interpreting acts of Parliament, especially the Lunacy Acts, which gave rise to many actions for "wrongful certification."

The MDU's early history was turbulent, with allegations of irregularities and lack of accountability, and in 1892 a breakaway group formed the Medical Protection Society (MPS), which now indemnifies 45% of physicians.

In 1907 the MDU offered insurance for 7 shillings and sixpence a year (about 75 cents today) which covered members for up to £2000 in any single action. This level of protection was fine until 1924, when a court awarded £25 000 to a man wrongly detained by doctors under the Lunacy Act.

Further changes in the law led to increased costs. Between the 2 world wars it became possible to sue the estate of a deceased person, which meant that doctors could be sued posthumously; claims could also be made for loss of life expectancy. When the newly formed National Health Service (NHS) made medical care available to all in 1948, there were more patients to launch potential suits. Then, the introduction of legal aid meant that the poor could have redress under the law.

In 1949 the MDU's annual subscription doubled, from £1 to £2. Indemnity and legal payments, which had cost the organization £250 000 in the years up to 1947, were to cost it 3 times as much in the 15 years that followed.

The subscription rose to £3 in 1959, £6 in 1969, £70 in 1979 and £1080 in 1988. A year later differential rates were introduced by rival MPS, a move deplored by the British Medical Association and the MDU. (The Canadian Medical Protective Association [CMPA] introduced differential rates in 1984. — Ed.) The MDU had to

capitulate and follow the lead of the MPS; the new subscriptions were £1350 for hospital-based physicians and £775 for GPs. By 1996 these had doubled again.

GPs are regarded as independent contractors within the NHS, but they have always had their premiums reimbursed by the NHS as legitimate practice expenses. Hospital doctors were also obliged to carry insurance if they worked within the NHS, but by April 1988 their premiums were so high that the health service reimbursed two-thirds of every doctor's premium. Less than 2 years later, on Jan. 1, 1990, the government brought in NHS indemnity coverage. A doctor who now works solely within the NHS needs no separate insurance, but a high proportion still subscribe as they are otherwise not covered for advice on issues such as certificate signing, complaints to the General Medical Council, appearances at inquests or fatal-accident enquiries, and volunteer work.

Large cash reserves

Meanwhile, the defence societies are in much the same position as the CMPA, with increasing amounts of money in reserve. They argue that this might be needed for obstetric claims that are brought many years later. In 1995 the MDU's reserves stood at £240 million, up from £200 million the previous year; the MPS has £136 million in reserve.

Litigation costs for the NHS are soaring, from £53 million in 1990–91 to £125 million in 1993–94, the most recent data available. There is another surge of litigation on the horizon, for until recently launching suits had been impossible for those who were neither wealthy enough to pay their way nor poor enough to get legal aid. A 1996 change in the law made it possible for lawyers to take cases on a contingency basis; the number of cases may increase, but litigants will first have to persuade a lawyer to take their cases on an a no-win, no-fee footing.

In light of all this doctors are thanking their lucky stars that things aren't a great deal worse. As an Oxford GP recently wrote in the *British Medical Journal*: "When I qualified in 1959 I paid a subscription to the Medical Defence Union. It was £2 and with my receipt came a dire warning against the dangers of forgetting to renew punctually. Life membership was offered for £50 — actually £48 as I had already paid £2. Terrified that I might not be covered due to renewing my subscription a week late one year, I sent off a cheque for the then enormous sum of £48 and became a life member. Shortly afterwards life membership was abolished but as the subscription has risen from £2 to its present astronomical figure — as a general practitioner I would now have to pay £1740 — I have been somewhat complacent. I never failed to remind the secretary of the Medical Defence Union, who had been my fellow student, of my life status when we met."

Hepatitis B policy

The British Medical Association (BMA) has been campaigning since 1987 for a national hepatitis B policy for health care workers. Only 600 cases of hepatitis B are recorded in the United Kingdom each year, compared with 2000 in the mid-1980s. .

In August 1993, the Department of Health published guidelines to reinforce the existing but somewhat haphazard policies in place in individual hospitals and health care trusts. The departmental guidelines required "provider units" to immunize and check the immunity of all surgeons by the middle of 1994, and that of all staff involved in exposure-prone procedures by 1995. Health care workers who test positive are banned from performing exposure-prone procedures, instrumental deliveries and from anything requiring sharp instruments.

The guidelines indicate that workers from countries with a high prevalence of hepatitis B should be tested for past or current infection. Employers are expected to supply the vaccine and ensure that follow-up antibody testing is done. The BMA advises members that they need written evidence of vaccination. Staff should also be willing to give blood samples to confirm these findings, and be willing to accept a booster after 5 years. Pregnant women should be vaccinated if they are in high-risk work. All GPs are expected to be vaccinated, and it is mandatory if they are to perform minor surgery or obstetrics. Those who refuse are banned from doing work that includes exposure-prone procedures.

Some cases slip through the net. In 1996 a woman who had a hip replacement died from hepatitis B caught from a locum orthopedic surgeon who was a known carrier. Like a number of surgeons with the virus, the doctor was cleared as being safe to operate by a Department of Health advisory committee because he was considered to be "low risk."

In 1994 Dr. Umesh Gaud was jailed for causing a public nuisance by endangering health when he worked at hospitals in London and the southeast for 3 years, despite knowing that he had hepatitis. One patient died from hepatitis B after undergoing heart-valve surgery in which Gaud assisted. Gaud had deceived hospital authorities by submitting false blood samples for tests, and continued working in invasive medicine until his arrest in October 1993.

The Department of Health recognizes that about 10% of people will fail to respond to vaccination, and many of them will fear for their jobs. They can continue to practise without restriction provided they take extra precautions to avoid exposure and injury, and report any exposure to blood and sharps.

The NHS injury-benefits scheme provides temporary or permanent payments of up to 85% of salary for staff who can show that they acquired the disease at work. ?