Medical Negligence Claims are not a Good Indicator of Poorly-Performing Doctors

I should preface our comments by stating that the MDU's view is that it is in the public interest, to prevent harm to patients and others, to identify poorly-performing doctors as early as possible. This is best done by monitoring their clinical performance at a local level with the aim of identifying concerns as early as possible. In the majority of cases it should be possible to remedy any problems at this stage, without the need to take more drastic action such as referral to the GMC or to begin disciplinary proceedings.

An effective monitoring system will need to include regular checks on doctors' performance, and analysis of whatever information they are required to provide. This can be achieved through a variety of tools such as regular peer review and audit, significant event analysis, appraisals and various other means. Our experience suggests it wrong to consider that claims against doctors are an indicator of poor performance; indeed it could be counter-productive to rely on such information, and in some cases work against the interests of patients who are suing for compensation.

Difficulty in defining what constitutes a claim

Many doctors may be involved in negligence claims as, for example, witnesses, experts, or because they were part of a team, but their own performance is never in question. It could not be construed in the public interest to require GPs to inform PCTs of such peripheral involvement.

With claims against GPs, one of the first difficulties is that of defining at what stage, if any, claims could be reported to PCTs. Since Lord Woolf's reforms in 1999, the MDU's experience is that about 70% of claims our medical members notify to us are discontinued, usually before proceedings have been issued, though the figure is higher if you look at GP claims alone. The majority of these claims go no further than initial exchange of information in the pre-action phase, if it is clear from this that there has been no negligence. Often claimants' solicitors do not tell us that, having seen the relevant information, their client

has decided not to pursue the matter. Therefore, it is not clear in many cases that they are not proceeding until they become time barred (the statute of limitations runs three years from the date of the incident or the date of knowledge).

It would be unfair to require GPs to report notifications of claims to their PCT at a time when they are first received because the allegations are untested and we cannot see how it would serve any useful purpose as 70% of cases are not pursued, but this may not be clear until much later on, often only when they become time barred.

Most of the remaining 30% of claims are settled out of court, with no admission of liability. Very few cases go to trial and, in those that do, the judgement is usually in favour of the doctor. It is difficult to understand, therefore, if and at what stage a claim could or should be reported.

There are other equally persuasive reasons why claims are not a useful indicator of concerns about a doctor's performance.

Time lag

There is invariably a time lag between the date of an incident and the date a claim related to it is made. In general practice this happens, for example, with missed diagnoses or failures to diagnose which only become apparent much later, when further tests are done or the patient's illness becomes more severe. Seventy per cent of medical claims are notified to the MDU within three years after the incident, and the average settlement period for medical claims is 3-5 years after notification, though in complex cases it can be much longer. Where the patient is suffering from a mental disorder or disability, or where children are involved, the notification and the settlement periods can be much longer since there is either no limitation period, or it only begins to run when the child reaches 18.

If there are problems with a doctor's practice, it is important that they are identified as soon as they arise and addressed immediately. Given that on average settled claims take 6-8 years from the date of the incident to settlement, it could not be suggested that they provide any useful information about a doctor's current performance.

Purpose/aim of the clinical negligence procedure

The purpose of any investigation related to a claim is not to look at professional competence of any healthcare professionals involved, nor is it to decide what lessons can be learnt so that future incidents can be prevented. It is about establishing whether and how much financial compensation should be awarded to a patient who alleges he or she has been negligently damaged. The case is only concerned with whether there was a breach of duty and whether that breach caused the damage sustained by the patient. It is not concerned with establishing whether any healthcare professional involved in the care of the patient had any performance problems.

It should also be noted that claims are brought for a number of reasons that are outside a doctor's control. For example, there are certain areas in the UK that have a high rate of claims against doctors and others where there is a low rate of claims – the north west of England being an example of the first category and Scotland being an example of the second. This is unrelated to the competence or otherwise of doctors practising in those areas, but relates more to local factors such as willingness of patients as consumers to make a claim if something goes wrong, and the means by which they may fund a claim. It may also reflect the availability and high profile in some areas of the country of firms of solicitors advertising their specialisation in clinical negligence claims.

The incidence of claims is also affected by other factors such as the specialty of the doctor and the pre-existing conditions or expectations of patients. GPs may be deterred from taking on additional activities if they may find themselves at higher risk of claims because they are offering secondary care type services that are considered higher risk, such as fitting intra-uterine contraceptive devices and certain types of minor surgery. Again, the competence or otherwise of the doctor is not a factor in this higher risk.

Possible disincentive to settlement

Claims are settled for a number of reasons and many of them are not related to a doctor's performance. For example, an expert may say that the treatment was indeed reasonable but the notes are missing; or there may have been a time lag and those involved may have no reliable memory of events; the clinical issues may not be clear either way; or a non-negligent doctor may ask us to settle because he finds the prospect of going into the witness box too daunting and extremely disruptive to his professional and personal life. And, with vicarious liability, the mistake may have been made by a practice nurse, or receptionist but the claim might be made against and settled on behalf of the GP.

Currently when we settle claims we usually do so without an admission of liability on the doctor's behalf because cases are rarely so clear that they warrant such an admission. It is a question of balancing the pros and cons of each case and, through negotiation, reaching a position that is acceptable to both the doctor and claimant. We are concerned that if a doctor knew that he would have to report such a settlement to a current or prospective employer, and that it might harm his employment prospects, he may be reluctant to agree to do so. To continue to defend a claim may result in a long delay in its eventual settlement, or may mean that it is defended successfully and that the patient does not receive compensation. Either way, the legal costs of the claim will increase substantially. None of this is in the doctor's interests, nor is it in the interests of the patient who brings the claim, and who might otherwise have received compensation. To introduce such a disincentive would be damaging to both.

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