

The examining medical practitioner will visit the claimant at home, conduct a medical examination, and complete a form which summarises the claimant's needs for attention or supervision, as described by the claimant or a carer. It also includes a checklist of activities which the claimant can and cannot do. The evidence of the claimant and the carer is crucial to the report, and they are well advised to make a list of all the attention and supervision needed before the doctor's visit, to ensure nothing is forgotten. Equally important is evidence from the family doctor, health visitor, or nurse, confirming the patient's need for help.

The delegated medical practitioner makes a decision based on the examining doctor's report and any other evidence the claimant submits. In borderline cases it may be worth the claimant writing out a statement of needs, which can then be confirmed as accurate by a general practitioner or consultant. Attendance allowance can be awarded for life or for a shorter period. For a child the award will always end on the 16th birthday, after which a new claim must be made.

If the delegated medical practitioner refuses attendance allowance, or awards only the lower rate, the claimant can ask for a review of the decision by writing to the attendance allowance unit within three months. Reviews can also be requested at any time if there is a change in circumstances, such as a deterioration in the patient's condition, or if the original decision was taken in ignorance of, or based on a mistake about, a material fact. The claimant will then be examined again by a different doctor, and additional evidence can be sent in, including, for example, a diary kept over a few weeks detailing all the attention or supervision required.

The review procedure can be long and complex and can place a tremendous strain on the claimant and the carer. Doctors can help by being aware of the possibility of reviews, being able to direct patients to competent advisers (such as advice centres or law centres) for help, and being prepared to give their opinion about their patient's needs for attention. In 1988, 72% of people who sought a review after an initial

refusal were subsequently awarded attendance allowance.

Patients to look out for

Attendance allowance is currently paid to people with a wide range of medical conditions. What is important is not the condition but the loss of function that it causes. Mentally ill claimants often have a more difficult time qualifying than physically ill claimants, but many do, and it is often worth a claim. Deaf children who need an interpreter also often get attendance allowance. Children suffering from diabetes or metabolic diseases which require closely supervised diets have been awarded attendance allowance, as have people suffering from asthma, heart disease, arthritis, and multiple sclerosis. Among elderly people, senile dementia and arthritis commonly give rise to the attendance needs which qualify them for attendance allowance. As a general rule, anyone who appears to satisfy the attendance conditions, whatever the medical diagnosis, should be encouraged to claim.

Attendance allowance and other benefits

Attendance allowance can be received along with any other benefit and is tax free.

- Someone receiving attendance allowance is treated as 80% disabled for the purposes of severe disablement allowance (see article on incapacity benefits).
- In calculating income support and housing or community charge benefit attendance allowance acts as a "passport" to the disabled child premium and to the disability, severe disability, and higher pensioner premiums.
- If the disabled person has a carer he or she can claim invalid care allowance at £28.20 a week providing that he or she:
 - cares for at least 35 hours per week
 - does not earn more than £20 a week
 - is not in full time education
 - is under 65 when first claiming.

For Debate

Compensation for medical accidents

Brian Capstick, Peter Edwards, David Mason

Recent publicity has continued to bring the question of compensation for victims of medical accidents into the public eye. The perceived problems are, firstly, that the expense of awards is an intolerable strain on health service resources; secondly, that there is an inequity between those who get nothing under a tort system and the fortunes—sometimes in excess of £1m¹—awarded to the winners; and, thirdly, that there is an incipient public health problem of litigation deterring doctors from entering obstetrics, once a popular specialty.

Although the debate is often conducted in terms that refer to medical malpractice litigation generally, the present concern has arisen largely out of the single issue of those obstetric claims in which cerebral palsy is said to have been caused as the result of birth asphyxia. In 1988 we began a study of 100 such claims, which comprised a statistical survey of origins and outcomes,² an analysis of the medical and legal issues (*Obstetric Malpractice Claims*, forthcoming), and the present outline³ of the options that exist to control the cost of these and, to some extent, other claims.

The no fault option

No fault compensation is increasingly mooted as a means of compensating the victims of medical accidents, and a private member's bill introduced by Mrs Rosemary Barnes proposing such a scheme is due to receive its second reading in the House of Commons on 1 February. We therefore considered the extent to which a no fault scheme would be likely to overcome the three problems of cost, equity, and the threat to public health to which we have referred above, both generally and in the context of the cases of brain damaged babies that we studied.

FAIRNESS FOR ALL?

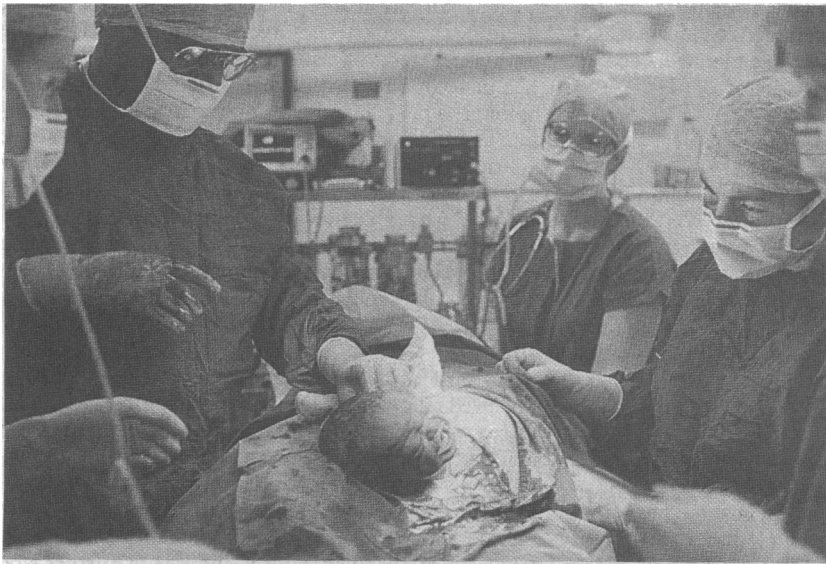
The class of beneficiaries is the first matter that any no fault scheme has to define, and it goes straight to the issue of fairness.

The most cautious type of no fault scheme is that which permits claims only by a narrowly selected group of patients, such as the Vaccine Damage Payments Act 1979 or the scheme operating in the state

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Is the threat of litigation causing doctors and midwives to desert obstetrics?

D. WIDMAIER/NEWSPORT SURVEY

of Virginia, which compensates infants neurologically impaired through mechanical or hypoxic problems during labour, delivery, or neonatal management.⁴ Schemes of this nature suffer from the drawback that there is no reason on grounds of equity to treat victims of cerebral palsy, for example, more favourably than the victims of spina bifida, or to treat victims of accidents in general more favourably than the victims of disease or any other affliction.

Cost considerations have confined most no fault schemes to injuries caused by an accident. In New Zealand, where the largest existing no fault scheme is administered, eligibility is based on damage resulting from "personal injury by accident" which, in the medical context, has been interpreted by the Accident Compensation Corporation to mean "a medical error or medical mishap."

The requirement for injury by accident means that once the medical error or mishap has been established it must be shown to have caused or contributed to the subsequent injury. The aetiology of many medical conditions is complicated, and most medical treatment is given to patients already suffering from some injury or illness, so proving causation can be just as much an obstacle to compensation under a no fault scheme as under the tort system. In the circumstances of the leading legal case on causation, *Wilsher v Essex Health Authority*,⁵ the unfortunate claimant would have had to establish precisely the same case under a no fault scheme as he failed to do under the law of negligence.

Most devastatingly, a scheme that requires a causal link would fail to overcome the problem of the infant cerebral palsy cases that have played such a major part in focusing attention on the shortcomings of the current system of compensation. They could be resolved only with the same complex examination of the causal link between birth hypoxia and cerebral palsy as is currently conducted, and most cerebral palsy sufferers whose handicap is congenital would continue to get nothing.

COST CONSIDERATIONS

In addition to the problems of how a no fault scheme would operate there is the question of how much it would cost. If the tort system is deficient because the requirement of proving fault excludes too many claims then it is implicit that any alternative system would seek to compensate more claimants. However, as Sir Donald Acheson recognised in his 1990 William Power memorial lecture, the cost of malpractice litigation is increasing dramatically and if the trend continues it will soon become unaffordable. The 1500 or so

children who are born each year with cerebral palsy would very nearly account for the entire budget of a regional health authority if each of them was awarded damages at current maximum levels.

The major component of current awards in obstetric malpractice litigation is the cost of providing future nursing care, accommodation, special education, and transport requirements. A no fault scheme would have to continue to pay for these very expensive components or forsake the principle of compensation in favour of what seems in so many cases to be mere consolation.

Advocates of a no fault scheme are therefore faced with a dilemma: if they seek to compensate a greater number of claimants at the current rates they are in danger of bankrupting the system; but if the rates are reduced to the levels that are normal with such schemes the integrity of the scheme is in danger of being undermined. It is unlikely that claimants or their representatives would welcome a system similar to that established in Sweden, which pays out an average of only £3200 to some 2500 claimants each year, or that they would forgo their £1m awards for the £20 000 presently paid for catastrophic injury under this country's existing no fault scheme set up under the Vaccine Damage Payments Act.

This problem of cost would be further compounded by the continued existence of the tort system. If patients retained the right to sue for negligence, then those with the prospect of a substantial award would have little incentive to settle for a lesser payment under the no fault scheme. Thus there would be a risk that the system would make compensation payments only to those claimants who would either not have brought proceedings under the tort system at all or whose claims would have failed. The overall cost of claims would then consist of old style damages awards plus the no fault payments and would therefore be a greater drain on resources than it is now. Conversely, if the implementation of a no fault scheme extinguished the right to sue in tort but did not provide for compensation commensurate with that currently available it would be regarded as more iniquitous than the present system.

Neither the BMA's bill nor, it is understood, Mrs Barnes's bill was prepared to extinguish the patient's right to a tort claim, with the result that these schemes would exist alongside the tort system and not in place of it. That seems to many people to comprise the worst of both worlds from both a cost and an equity point of view.

PUBLIC HEALTH CONCERNS

The first public health concern, as the chief medical officer pointed out in his lecture, is that (by analogy with the American experience) the threat of litigation is causing doctors and midwives to desert obstetrics in such numbers as to precipitate a crisis in the provision of the service. But the American experience is not comparable with our own. The defection to other specialties is brought about largely by the prospect of prohibitively high insurance premiums for obstetricians, a factor which, since the introduction of crown indemnity, affects only private practitioners in this country. Moreover, the litigation picture here is not so bad that it should determine career decisions. Although the number of claims has been rising for some years, the number that succeed is still fairly low.²

The no fault solution to the recruitment problem would also raise public health concerns of its own. Chief among them is that no fault schemes do nothing to reduce the number of accidents that occur and the human cost of these accidents. If anything, no fault schemes create a climate in which there is no incentive to improve the accident record by taking advantage of

the many measures—including incident reporting, practice protocols, audits, and modern claims management techniques—open to hospitals to cut the cost of claims and reduce the risk of accidents.

Law reform

Many of the problems that we identified in no fault schemes do not have obvious solutions. We therefore looked at alternatives that would assist the health service in the short term to cut the cost of claims and in the medium term to reduce the risk of the accidents that give rise to claims.³ This included a programme of law reform that is necessary to correct certain anomalies.

LIMITATION PERIODS

One problem with medical malpractice litigation is the length of time that often passes between the date of the accident and the date when the hospital hears that there is to be a claim. We found that a quarter of obstetric claims did not come to the attention of the health authority until more than seven years after the event. Medical malpractice claims are prejudiced by delays of this kind to an unusual degree because, in contrast with accidents in other contexts, one party—the patient—is likely to have a very vivid memory of the treatment while the other—the doctor—is likely to have forgotten what may have appeared to him or her as an entirely routine episode. The matter is most acute in the case of the law that permits brain damaged infants a lifetime in which to bring claims; here the case for reform is overwhelming. Very stale claims cannot be fairly adjudicated, and now that minors are assessed for legal aid by reference to their own resources rather than those of their parents there is no longer any need to wait until they are theoretically independent of their parents' means in order to pursue their claims.

We recommend that the time limit for bringing a medical malpractice claim should be 18 months from the date the patient (or, in the case of minors, the parent or guardian) becomes aware, or should have become aware, that he or she may have a claim against the hospital. We also recommend that the latitude given to the courts to extend these limits should be much more tightly restricted.

THE LEGAL PROCESS

Another area that could usefully be reviewed relates to the legal process itself. In ordinary personal injury actions arising from road traffic accidents or accidents at work lay people can easily understand the processes that cause accidents, and it is usually obvious whether the injury complained of was caused by the accident or not. In medical cases, on the other hand, the processes are often complex and issues of liability and causation often require the evidence of expert witnesses. The result is that medical malpractice claims are usually more complicated than others, and changes to the rules of procedure are required to allow defendants time in which to prepare a defence.

Similar considerations have given rise to calls for trials to be conducted by a panel of two medical people and a judge. The idea is attractive from the point of view that such a panel should be able to get to the bottom of the matter more quickly than a judge alone. There is a risk, however, that such a panel would

become an arbiter of medical practice instead of deciding the issue of liability merely by reference to the traditional test of whether the practice followed was in accordance with a responsible body of medical opinion. This principle is a bulwark against an explosion of litigation in Britain, and we should be wary of deviating from it.

The objective of more efficient trials could equally well be accomplished by publications designed to extend lawyers' understanding of the more common types of claim and by the appointment of a specialist panel of judges to try medical claims.

THE COST OF CARE

A third area where the law might usefully be reviewed relates to the legislation that permits plaintiffs to recover the full cost of private care even if health service care is available as an alternative.⁶ We recommend the repeal of this legislation so as to allow judges to take into account the availability of care in the health service when assessing awards of damages. There is also a view that law reform should go further and prohibit any award of damages for future care in claims arising out of treatment in the health service, so that the plaintiffs would be obliged to return to the health service for care unless they chose to pay for it privately.

PRIVILEGE

A final area where reform of the existing law is required relates to the question of compulsory disclosure of documents, including documents prepared as part of a quality assurance or risk management programme, unless they were prepared predominantly for the purpose of defending legal proceedings. The possibility of compulsory disclosure makes every such document a hostage to fortune and is a powerful disincentive to the quality assurance programmes that are so urgently required in the health service. We recommend active investigation of the possibility of giving protection from disclosure to documents prepared in the course of a quality assurance or risk management programme or the clinical complaints procedure.

Conclusion

We concluded that the immediate response to the burgeoning cost of medical malpractice claims should be a reform of the existing law to remove the worst of the anomalies, coupled with a programme of quality assurance to cut the cost of claims and reduce the risk of accidents. We were heartened by the tremendous enthusiasm for such measures that we found among clinicians after the introduction of crown indemnity. Although we would be the first to accept the many imperfections of the tort system, we did not find that the no fault schemes were likely to deliver the promise of a more just or economical use of the resources used to compensate the victims of medical accidents, either generally or in relation to the victims of cerebral palsy whose interests we considered specifically.

1 *Almond v Leeds Western Health Authority*, 1 Med LR 370.

2 Capstick B, Edwards P. Trends in obstetric malpractice claims. *Lancet* 1990;336:931-2.

3 Capstick B, Edwards P. *Quality counts!* London: Capsticks, 1991.

4 Code of Virginia, Ss 65.1-164 to 65.1-179, 1987.

5 *Wilsher v Essex Area Health Authority* [1988] 1 All ER 871.

6 Law Reform (Personal Injuries) Act 1948, S.2(4).