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David Chacko

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David Chacko

School of Medicine, University of Pennsylvania
<dchacko@mail.med.upenn.edu>

Abstract

The frequency and severity of medical liability litigation in the United Kingdom have increased since the middle of the twentieth century. Recent estimates of settling outstanding negligence claims hover around at least 10 percent of the National Health Service's total annual budget. This paper argues that the frequency and severity of these claims have increased as patients have been increasingly dissatisfied with the established complaints procedures and regulation of physicians and as doctors have seen their influence in the doctor–patient relationship decrease. The current litigation situation compared to the past is three pronged: doctors are being sued more often; when sued, they are more likely to lose; and when losing, the claims awarded against them are increasing in size. As patients become increasingly aware that doctors are more likely to lose when sued and that the courts are more likely to award larger settlements, the frequency with which doctors are sued will almost certainly escalate. This paper concludes by discussing no-fault compensation as an alternative to litigation that would likely reduce physicians' susceptibility to litigation.

1: Introduction

Since the middle of the twentieth century, the medical profession has endured growing scrutiny from the legal system, most clearly demonstrated by the increase in the incidence and severity of medical liability lawsuits. Some feel that this rise in litigation is useful because learning from errors makes healthcare safer for the entire community and holds physicians accountable for their actions.[1] However, opponents believe that litigation is unnecessary to maintain health standards and is needlessly costly, asserting that 'nothing could be more damaging to the future of medical care than the suggestion that patients sue their doctors'.[2] According to the Department of Health (DoH), medicine is unlike many other professions in that it relies on people, rather than machines, to make risky and complicated decisions with potentially severe and lifelong consequences.[3] Adverse outcomes, opponents emphasize, are often an inherent risk of medical care and do not necessarily reflect poor treatment. This paper will examine the growth in medical liability litigation in the United Kingdom over the past half century and provide reasons for this increase to further understand the current state of litigation. Importantly, it is widely accepted that the rise in litigation is not due to an increasing incidence of clinical negligence, but rather 'the increasing tendency [of patients] to seek legal redress and the rising costs of such legal settlements'.[4] The Medical Legal Committee of the British Medical Association (BMA) reports that 800 medical mistakes are committed daily in British hospitals.[5] Autopsy studies show that doctors misdiagnose fatal illnesses 20 percent of the time.[6] As the number of claims currently litigated represents only a small fraction of medical error cases, the courts could potentially face an enormous volume of medical malpractice cases in the future if patients are increasingly likely to seek legal redress. Thus an understanding of the public's growing motivation to utilize the legal system is crucial in averting a litigation crisis. This paper will focus on the reasons why people are more likely now than in the past to pursue legal action and why the size of claims has been increasing.

In the UK, the National Health Service (NHS) is legally responsible for all medical liability claims directed at its physicians and health authorities. The NHS provides funding to defend the claim, pay legal fees, and compensate plaintiffs.[7] Until recently, the UK paid little attention to the costs of medical litigation.[8] In fact, in 1996, Lord Woolf declared in his Access to Justice report that publicly available information was

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[1] Department of Health, *Making Amends* (2003), p. 8.

[2] Kennedy, Ian, *The Unmasking of Medicine* (1981), pp. 128–129.

[3] Department of Health, *Making Amends* (2003), p. 7.

[4] National Audit Office, *NHS (England) Summarised Accounts 1995–1996* (1997–1998), p. x.

[5] 'Doctors Want No Fault Compensation', *BBC News* (6 July 1999).

[6] Leonhardt, David, 'Why Doctors So Often Get It Wrong', *New York Times* (22 February 2006).

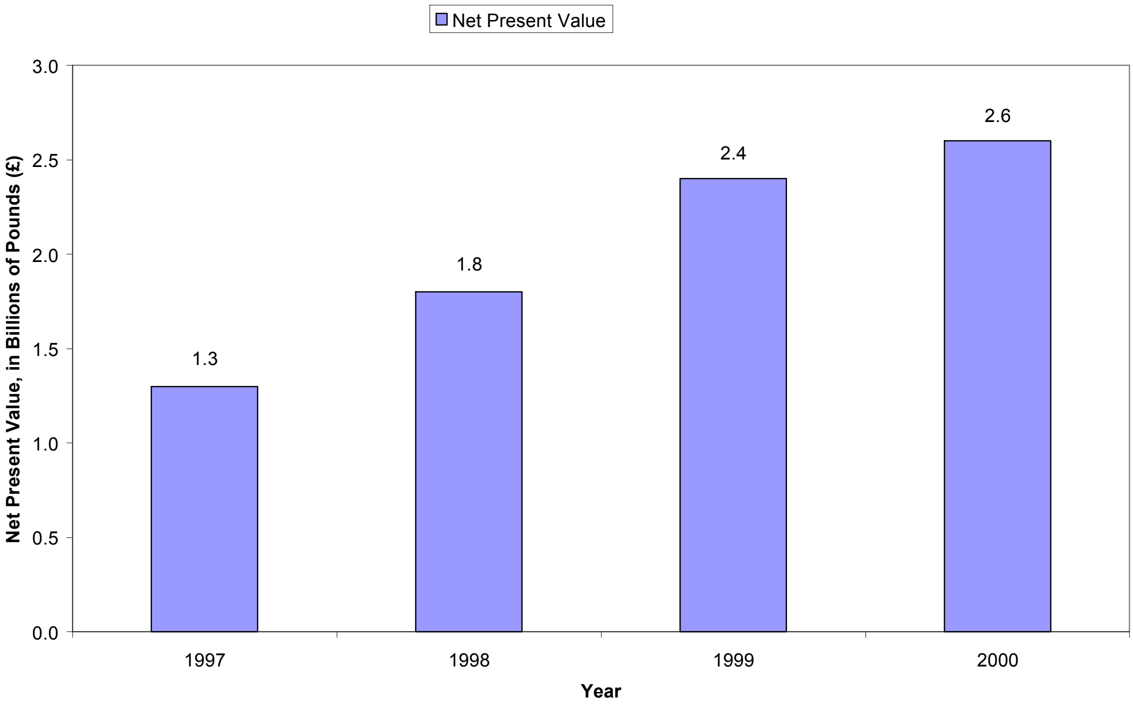
[7] National Audit Office, *Handling Clinical Negligence Claims* (2000–2001), p. 1.

[8] Department of Health, *Making Amends* (2003), p. 8.

lacking on claims and on whether the claims process was cost effective and efficient.[9] However, as claims-related expenses have continued to grow and because the government directly pays these expenses, political leaders have become more concerned about the costs of settling these claims.

It is important to also understand the extent of the problems. First, what is the scale of medical liability claims? Second, and perhaps more importantly from an historical and policy perspective, are claims increasing in number and monetary value? In response to the first question, the National Audit Office (NAO) determined that there were approximately 10,000 new claims against the NHS in 1999–2000.[10] The NHS Litigation Authority (NHSLA), which is a branch of the NHS with the authority to settle certain types of negligence claims and set up risk management protocols, estimated that the total cost of immediately paying all outstanding clinical negligence claims in 2004 (including claims on incidents that have occurred but have not yet been reported) was £7.78 billion.[11] Compared to the estimated budget of £61.3 billion for total NHS expenditure in the year ending 2004, this sum represents about 13 percent of the budget of the NHS – money that could otherwise have been put toward providing healthcare.[12]

Figure 1 - Net Present Value of Outstanding Claims on March 31



Source: National Audit Office (see p. 4 for full citation)

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[9] National Audit Office, *Handling Clinical Negligence Claims* (2001), p. 2.

[10] National Audit Office, *Handling Clinical Negligence Claims* (2000–2001), p. 1.

[11] NHS Litigation Authority, *About the NHS Litigation Authority* (2004).

[12] Department of Health, *Departmental Report 2004* (2003–2004), p. 35.

Regarding the second question above, there are three indicators that can be used to measure the increase in number and size of medical litigation. First, in general, the annual number of claims has been increasing. The NHSLA, which handles a fraction of total claims against the NHS, reported an increase in new claims from 2,411 in 1999–2000 to 4,115 in 2000–2001.[13] Second, the total expenditure on claims has also been on the rise. Looking at the recent past suggests that the problem is substantial. As shown in Figure 1, the net present value of outstanding claims (excluding claims on incidents that have occurred but have not yet been reported) on March 31, 2000, was £2.6 billion.[14] The comparable figures for 1997, 1998, and 1999 were £1.3 billion, £1.8 billion, and £2.4 billion, respectively.[15] This represents a significantly high compounded annual growth rate of 26 percent. Looking at a longer timeframe reveals that the issue has existed for a long time and has continued to grow. Clinical negligence expenditure in the NHS rose from £1 million in 1974–1975 to £446 million in 2001–2002. Even when corrected for inflation, this represents an increase of nearly 7,000 percent over a twenty-seven year period.[16] Third, the size of individual claims has increased. For example, the average amount paid out per filed claim rose from £57,000 in 2002–2003 to £68,000 in 2003–2004 to £90,000 in 2004–2005.[17] This growth in average payout suggests that the severity of individual claims has increased. Showing that the government has acknowledged that medical liability is an important issue that it must handle, the Comptroller and Auditor General of the NAO decided that 'provisions in respect of clinical negligence will now be shown separately from other provisions' in his annual reports.[18]

In trying to determine the causes for the increase in size and severity of medical liability litigation, one must consider a range of different possibilities. Perhaps the change was gradual with lawsuits increasing at a nearly constant rate. Or perhaps the change was punctuated by major policy changes. For example, the introduction of legal aid, in which a plaintiff could utilize state-sponsored lawyers to pursue his claims, led to an increase in litigation. In addition, litigation might have increased because alternative methods of resolution (like an apology) were not available.[19] In fact, many insurers believe that whether a patient likes his doctor is a better predictor of the likelihood of legal action than the occurrence of malpractice itself, with disliked doctors being sued more frequently.[20] Often, the consequences of poor treatment extend be-

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[13] National Audit Office, *NHS (England) Summarised Accounts 2000–2001* (2001–2002), p. R23.

[14] National Audit Office, *Handling Clinical Negligence Claims* (2000–2001), p. 3; National Audit Office, *NHS (England) Summarised Accounts 1997–1998* (1998–1999), p. xxxv; and National Audit Office, *NHS (England) Summarised Accounts 1998–1999* (1999–2000), p. R48.

[15] National Audit Office, *NHS (England) Summarised Accounts 1997–1998* (1998–1999), p. xxxv and National Audit Office, *NHS (England) Summarised Accounts 1998–1999* (1999–2000), p. R48.

[16] Department of Health, *Making Amends* (2003), p. 9.

[17] NHS Litigation Authority, *About the NHS Litigation Authority* (2004).

[18] National Audit Office, *NHS (England) Summarised Accounts 1996–1997* (1997–1998), p. xxvi.

[19] National Audit Office, *Handling Clinical Negligence Claims* (2000–2001), p. 5.

[20] National Center, *Reforming* (1994).

yond the physical problem: ‘The psychological and social impact can include anxiety, depression, fear of future treatment, [and] disruption to work and family life.’[21]

The current litigation situation differs from the past in three ways: doctors are being sued more frequently; when sued, they are more susceptible to losing; and when losing, the sizes of claims against them are increasing. Several causes have been proposed to explain the rise in medical litigation. This paper will consider two overarching factors that have contributed to the rise. As patients have become increasingly dissatisfied with the current complaints procedure (Section 2), they have had to decide whether they would be successful in court. The weakening prestige of doctors (Section 3) has convinced patients that they have an increased likelihood of winning these lawsuits compared to the past. The confluence of these related factors at approximately the same time has meant that the challenge to the medical profession by litigation has been much stronger. These factors have contributed jointly and severally to the rise in the incidence and severity of medical liability lawsuits. The final section of this paper discusses an alternative to litigation, known as no-fault compensation, which allows a patient who has been harmed in the course of medical care, whether through physician negligence or not, to collect compensation.

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[21] Department of Health, *Making Amends* (2003), p. 9.

2: Patient Response to Regulation of the Medical Profession

Beginning in the nineteenth century, the British medical profession was almost entirely self-regulated. Over the past several years, however, physicians have come under increased regulation and scrutiny. On the one hand, external intervention has been crucial for doctors because certain types of legislation add to the legitimacy of the profession. Statutes clearly delineate a legal entity of physicians and establish membership guidelines. Only those with the appropriate licences can legally practice medicine, thereby setting up barriers to entry into the profession. Thus, doctors gain credence because of intervention. Eliot Freidson describes this situation as a 'legally supported monopoly'.[22] On the other hand, not all intervention has been helpful to doctors. One obvious example of this is the increased scrutiny that has resulted from the rise in medical liability claims.

What is noteworthy about the growth in this type of litigation is that it did not need to occur. Surely doctors have always and will always make mistakes, but mechanisms exist in the UK to deal with these errors. First, for those patients who fear that a medical injury would render them less capable of working, thereby creating financial instability, the UK has a social safety net, which is designed to care for patients who can no longer provide for themselves. Second, research shows that the stated reasons that claimants pursue action are often non-economic reasons. For instance, 52 percent said they wanted to prevent something similar from happening to another patient, 44 percent wanted an apology, and 40 percent wanted physicians to understand their concerns. Another study showed that many patients who filed complaints did not want to sue their doctor, but simply wanted to voice a grievance.[23] For those patients who are seeking to prevent future mistakes, voice concerns, or receive an apology, there are established procedures for complaining. Thus medical liability litigation need not exist, except in extreme cases. That this type of litigation has increased in recent years is evidence of two trends that have developed in parallel. First, it has become easier for a patient to sue his doctor. And when a patient decides to sue, he is more likely to win the lawsuit. Second, patients are increasingly dissatisfied with the current complaints procedure and, more broadly, with the social safety net. This section examines this second trend in an attempt to understand why patients are displeased. At the same time, it will illustrate that most of the state's attempts at intervention and regulation have been reactive rather than preventative, and thus have been less effective in meeting patients' needs.[24]

From the mid 1800s to the mid 1900s, the medical profession regulated itself with little outside influence. The Medical Act 1858 empowered the profession to create and enforce its own professional standards.[25] Self-regulation clearly benefits the medical profession because it grants physicians autonomy to determine what constitutes proper treatment of patients and proper behavior of physicians. Through the concept of liberal corporatism, self-regulation can be valuable for the state as well. If

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[22] Freidson, Eliot, *Professional Dominance* (1970), p. 83.

[23] Mulcahy, Linda, *Disputing* (2003), pp. 94, 96.

[24] Hollingsworth, J. Rogers et al., *State Intervention* (1990), p. 197.

[25] Salter, Brian, *The Politics* (1998), p. 122.

the government convinces the public that, because of the highly technical knowledge needed to practice medicine, physicians can regulate themselves more effectively than the state can regulate them, then the state can legitimately divest the responsibility and costs of regulation.[26] The profession chose to establish the General Medical Council (GMC), which is financed by the profession but accountable to Parliament, as the form of self-regulation.[27] The GMC is charged with establishing a register of medical practitioners who are qualified to treat patients.[28] As part of discharging this duty, the GMC has the authority to discipline members whose actions are of poor quality and, if necessary, revoke medical licences. When the NHS was formed in 1948, the GMC had existed for nearly a century, making it an established body that could successfully negotiate with the state to ensure that under the government-controlled healthcare system, doctors would still enjoy self-regulation and autonomy. While the creation of the NHS created universal access to medical care, the functional autonomy of the medical profession was an important, though less stated, goal as well.[29] As stated by the Royal Commission on the NHS, 'The health and personal social services have always operated on the basis that doctors and other professional providers of services have individual professional freedom to do what they consider to be right for their patients.'[30] The widespread acceptance of clinical freedom made it difficult to challenge doctors during the early days of the NHS. In theory, the Council concerns itself with claims of 'serious professional misconduct', which, according to the GMC, 'means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession'. One might expect the GMC to review a wide range and large number of claims; however, it interprets this mandate narrowly. Because the GMC's primary role is maintaining the register, when considering its disciplinary role, it handles claims that it considers to question whether the physician is qualified to practice medicine.[31] For example, from 1970 to 1984, no doctor was struck from the register for failing to attend to a patient, but four were struck for sexual misconduct with patients. Margaret Brazier asks, 'has the G.M.C. got its priorities right in punishing the adulterer with greater vigour than the uncaring doctor?' The answer, she explains, is that serious professional misconduct is interpreted to consist not of negligence or failure to attend to patients, but rather of actions that disgrace the profession.[32]

The GMC increased the profession's legitimacy during the nineteenth century and first part of the twentieth century, but has come under increased public scrutiny since then. The growing public awareness of alleged scandals involving physicians acting unprofessionally has caused an increase in the number of investigations into these allegations. In many of these investigations, officials have found that the GMC has not listened to or analyzed the complaints, thereby questioning the ability of the profes-

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[26] Mulcahy, *Disputing* (2003), p. 10.

[27] Salter, *The Politics* (1998), p. 122.

[28] Brazier, Margaret, *The Regulation of Doctors* (1994), p. 6.

[29] Allsop, Judith, *Health Policy* (1995), p. 33.

[30] *Report of the Royal Commission* (1979–1980).

[31] Brazier, *The Regulation* (1994), pp. 10, 11.

[32] Brazier, *Medicine* (1987), pp. 11–12.

sion to regulate itself.[33] To save its credibility, the GMC needed to show that self-regulation worked. Recognizing this, its president Sir Donald Irvine said that the GMC's key issue was 'getting its image and relationship right with the outside world'.[34] To be successful at this aim, the Council needed to balance the public's need for greater accountability with the profession's wish to maintain a moderate level of autonomy.[35] Diminishing this autonomy too much would lead to doctors' lack of confidence in the GMC. On the other hand, too little questioning of doctors in response to complaints would diminish the public's confidence in the Council, and the public would be compelled to resort to other means, including litigation, to voice its grievances. Perhaps as a sign of a more patient-friendly approach, the GMC has responded to these scandals with recent attempts to provide effective monitoring of physicians' performance. These efforts represent 'substantial progress towards putting its house in order and [ending] its image as a closed shop protecting its own'.[36]

Concerned with the GMC's handling of complaints, the government initiated a standardized complaints procedure. The 1966 Health Memorandum published by the Department of Health and Social Security (DHSS) recommended adopting standardized complaints procedures. Of note, these guidelines suggested that complaints be handled by physicians and that it was unnecessary for most complaints to be considered by someone outside the medical organization.[37] This conflicts with one of the main principles of effective regulation – that it be conducted by independent agents.[38] In retrospect, it is likely that the DHSS suggestions did so little to improve the situation of complainants as to deem them of little worth. However, in an age when society held the medical profession in high regard, it was commonly assumed that physicians were motivated by a public service ethos and were working in the best interests of their patients. If a patient alleged that he was harmed by his physician's treatment decision, it was believed that the physician handling the complaint, who would also be driven by his desire to serve the patient's interests, would fairly and equitably determine whether the treating physician had been responsible for the patient's harm. Though the memorandum did little in the way of challenging a physician's right to review clinical claims, its accomplishment lies in its suggestion that complaints procedures be standardized. When such procedures are not standardized, a patient will find it more difficult to file a complaint. On the one hand, some would argue that non-standardized procedures might frustrate a patient to the extent that he becomes inclined to pursue litigation. But during the first few decades of the NHS, when doctors were still considered to be god-like, the likelihood of a patient suing his physician, even when frustrated, was much lower than in more recent times. Instead, the patient would generally accept his position, understanding that he could do little to improve his situation. With the standardized procedures recommended in the DHSS memoran-

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[33] Mulcahy, *Disputing* (2003), pp. 17, 18.

[34] Salter, *The Politics* (1998), p. 123.

[35] Salter, *The Politics* (1998), pp. 123–124.

[36] Lewis, Charles, *Clinical Negligence* (2001), p. 61.

[37] Mulcahy, *Disputing* (2003), pp. 29, 31.

[38] Walshe, Kieran, *Regulating Healthcare* (2003), p. 233.

dum, however, a patient was more likely to air his grievance. And as more patients filed complaints, the medical profession's contention that it could regulate itself became less defensible.

Clinical autonomy was further challenged during the 1970s by a series of government inquiries – including the Ely Inquiry (1969), Fairleigh Inquiry (1971), Whittingham Inquiry (1972), and Normansfield Inquiry (1978) – that suggested that a thorough review of hospital complaints procedures was necessary and that the GMC was failing to regulate effectively. The reports highlighted that certain vulnerable patient groups, like ethnic minorities and women, were being neglected, leading to substandard health outcomes for these patients.[39] The substandard health outcomes discussed in government inquiries were originally explained through natural causal mechanisms, such as by blaming genetic factors for the poorer health of ethnic minorities.[40] But by relying on genetic influences, those putting forth this explanation ignored the importance of health inequalities based on other social factors.[41] For example, in the 1970s and 1980s, mortality rates by occupational class were used to analyze the effects of social stratification on standards of health because it was known that poverty contributed strongly to poor health.[42] Mortality rates showed that people in each of the Registrar General's five occupational classes had a higher rate of death than those in the classes above them. Deaths from respiratory diseases and accidents, which are strongly correlated with socioeconomic class, show similar differences according to class.[43] Perhaps even more significant than the presence of these inequalities is the widely held view that social inequalities have been increasing.[44] The NHS was created, among other objectives, to reduce social inequalities by providing access to healthcare for every citizen. Thus, the presence – and more significantly, growth – of health inequalities based on social factors highlighted the fact that the main goal justifying the creation of the NHS had not been met. Therefore, society has begun looking beyond the medical profession to address health inequalities.

In response, the British government began emphasizing more external regulation, shifting away from the self-regulation model, in which the medical profession was regarded as fully competent, to a scenario involving external audits. Professional autonomy began to weaken during the early 1970s. The Davies Committee, which published its report in 1973 and was the first government-sponsored group to investigate the complaints procedure, recommended that the appropriate handling of complaints required external involvement.[45] There are two complementary explanations

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[39] Mulcahy, *Disputing* (2003), p. 32. Other views can be found in Coulter, Angela and Helen Magee (eds.), *The European Patient* (2003), p. 187, and in Mackenbach, Johan et al., 'Socioeconomic Inequalities', in Mackenbach and Martijntje Bakker (eds.), *Reducing Inequalities* (2002), p. 3.

[40] Jones, Helen, *Health and Society* (1994), p. 186.

[41] Mackenbach et al., 'Strategies to Reduce', in Mackenbach and Bakker (eds.), *Reducing Inequalities* (2002), p. 31.

[42] Benzeval, Michaela et al., 'Income and Health', in Graham, Hilary (ed.), *Understanding* (2000), p. 96.

[43] Jones, *Health and Society* (1994), p. 149.

[44] Graham, 'The Challenge of Health Inequalities', in Graham (ed.), *Understanding* (2000), pp. 8–9.

[45] Mulcahy, *Disputing* (2003), pp. 33, 34.

for the committee's departure from the idea that only doctors were capable of reviewing claims. First, the committee felt that the complaint review would be seen as more objective if it included a non-medical party: 'This improvement is in the interests of complainants, who have a right to expect that their complaints will be fully and impartially considered.'[46] Second, the committee recognized that doctors have professional biases that might promote the covering up of errors. One result of the Davies Committee report was the creation of the Health Service Commissioner (HSC), who investigates any matter related to the failure or maladministration of the health service that causes hardship or injustice. By statute, the commissioner cannot investigate claims 'taken solely in consequence of the exercise of clinical judgment'.[47] Nonetheless, this position reduced the scope of self regulation and gave more power to the public.[48] More significantly, it contributed to the gradual erosion of doctors' ability to regulate themselves, thereby making it likely that future changes in regulation would include clinical matters. In fact, some commissioners have broadly interpreted the clinical judgment clause of the act, thereby considering cases in which the doctors involved contend that the issue of complaint was clinical in nature. Recently, patients have expressed their approval of the HSC's work and their desire for his jurisdiction to be expanded to involve even more cases. The commissioner's 'investigations are regarded by many as fair, thorough and effective in correcting mistakes by health providers. With greater powers, a wider remit and jurisdiction over all complaints, it could be the beginning of something meaningful, rather than the, comparatively, meaningless NHS complaints mechanism currently in place'.[49]

In spite of physicians' decreased autonomy, some people believe that doctors still possess great influence in deciding what constitutes negligence for at least three reasons. First, it is argued that doctors are uniquely qualified because of their skills and training to evaluate when a mishap has occurred. This gives doctors a certain power over patients and allows them to assert that certain outcomes do not constitute negligence, but rather an expected risk of treatment. The distinction between an adverse outcome and a medical error is often murky, and doctors can influence their patients to believe that certain outcomes are not a result of negligence. For instance, the growing diffusion of technology has given physicians the ability to claim that certain iatrogenic illnesses are the inevitable price of state of the art treatments. Second, doctors can control, to some extent, the visibility of their errors and their patients' perceptions of mishaps. Third, in deciding legal cases, courts and lawyers rely on expert opinions, which often come from doctors, and thus negligence is still largely decided by the profession itself.[50]

A further inroad into self-regulation was seen in 1985 with the passage of the Hospitals Complaints Procedures Act. Michael McNair Wilson, a Member of Parlia-

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[46] Department of Health and Social Security, *Report of the Committee on Hospital Complaints Procedure* (1973), p. 56.

[47] *National Health Service Act 1977* (1977).

[48] Brazier, *Medicine* (1987), pp. 127, 128.

[49] Elder, John, *Who Cares* (1998), pp. 5–6.

[50] Mulcahy, *Disputing* (2003), pp. 58, 72.

ment, was hospitalized with renal failure and developed septicaemia due to his treatment. Feeling frustrated by the absence of an effective complaint mechanism, he initiated a bill that required each hospital to have proper complaints procedures and to adequately advertise those procedures to patients.[51] These requirements are crucial for two reasons. First, centralization of the complaints procedure shows the government's commitment to addressing patients' concerns and represents a renewed effort to ensure patient satisfaction. One would expect that these reforms would appease patients before litigation was pursued; however, as discussed below, patients have been dissatisfied with these reforms. The government's failed attempt to provide a proper complaints process has likely upset the public and pushed more patients to litigation than if such an effort had never been made at all. Second, the requirement that the complaints process be adequately advertised addressed McNair Wilson's concern that many aggrieved patients are not given information about the complaints procedure. In fact, one study found that only 2 percent of patients remembered receiving written information about the proper procedure.[52]

Despite efforts to create a complaints process that is in line with the needs of patients, the results have fallen short of what was hoped for. First, in 1993, the Audit Commission found that 45 percent of the hospital wards it surveyed did not have any posted or written information about filing a complaint. Some contend that this omission was intentional to prevent the filing of frivolous claims.[53] While advertising would almost definitely increase the number of unfounded claims, assuming that all potential claims would be frivolous – and therefore not providing any information about the complaints process – seems incorrect and excessive. Second, patients believe that the complaints procedure is biased in favor of health and medical practitioners and of the health service: 'Arguably the most powerful message coming through from patient support agencies and the complainants they represent is the one placing a big question mark against the impartiality of the NHS complaints procedure as a whole.'[54] This sentiment was echoed in the 1994 *Being Heard* report in which patients expressed their fear that 'professional loyalties [might] override fair play'.[55] What is important to note about this feeling is that whether the lack of impartiality is real or perceived is irrelevant. If a patient imagines a bias that is not actually present, attempts to convince him of the truth will likely fail. Finally, the lack of impartiality, especially in the handling of local complaints, has led some people to criticize the system by saying that 'you complain to the person you are complaining about' resulting in members of the medical staff attempting to hide the errors of other staff members and preventing patients from accessing relevant information.[56] As a result of this defensive approach to resolving complaints, patients feel that their grievances are not being dealt with appropriately. The combination of these three factors – the decision

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[51] Brazier, *Medicine* (1987), pp. 125, 126.

[52] Prescott-Clarke, Patricia et al., *Focus on Health Care* (1988), p. 143.

[53] Mulcahy, *Disputing* (2003), p. 43.

[54] Elder, *Who Cares* (1998), pp. 3, 43.

[55] Department of Health, *Being Heard* (1994), p. 49.

[56] Ham, Chris et al., *Medical Negligence* (1988), p. 5.

in certain settings to not provide basic information about how to file a complaint, the lack of an impartial review, and the defensive nature of the review with its associated secrecy – has led patients to be dissatisfied with the complaints process: 'With a dearth of confidence in the system, expectations about outcomes are not high…. Lengthy, unhelpful and biased is how some have expressed their views.... Between 80% and 90% had no confidence about getting a fair hearing – or result – through the complaints procedure.'[57] As mentioned previously, with the government's insistence on providing a proper complaints process and its failure to deliver such a system, patients' dissatisfaction with the current situation is likely stronger than if no system had been promised. As a result, because of this dissatisfaction, many patients have decided that the only option for ensuring a fair and open review is litigation. Therefore, the complaints procedure, which ideally would have settled a number of complaints before they reached the courtroom and thereby decreased the extent of litigation, has actually had the opposite effect. Until the government establishes a complaints procedure that reflects the wishes of patients and places regulation in the hands of the public, this form of litigation will continue to increase.

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[57] Elder, *Who Cares* (1998), p. 46

3: Threats to Professional Autonomy and Dominance

In 1970, Eliot Freidson discussed the concept of ‘professional dominance’ as related to the medical profession as the state in which the physician ‘has gained a status which protects him…from outside scrutiny and criticism and which grants him extraordinary autonomy in controlling both the definition of the problems he works on and the way he performs his work’.[58] For many years, because lay people could not easily replicate this success, they venerated physicians’ healing power and accepted a position of less power in the doctor–patient relationship. However, doctors have begun to lose some of this authority over the past few decades, and patients have become more powerful. This section intends to explore three theories that describe this transition and the resulting loss of physician influence. This transition has been seen on a global scale. Initiatives in the UK have led to similar changes around the world, and vice versa. Thus, while focusing on the UK, this section discusses these theories in relation to their worldwide impact. Focusing on the global impact sheds additional light on the situation of British doctors because ‘the same social, economic and technological forces have led doctors world-wide to feel (probably correctly) that they have less influence on health and health policy than they once had and less control over their own destinies’.[59] By exploring these theories, this section provides several interrelated reasons for the rise in medical liability litigation.

It is important to consider the diminishing power and influence of doctors within the broader context of societal changes. The rise in medical liability litigation coincides with a rise in general litigious behavior in the UK. The rise in general litigation indicates that people’s attitudes toward pursuing legal recourse have changed. Indeed, the latter part of the twentieth century has seen the rise of a ‘compensation culture’ in the UK and the rest of the Western world, and this has been seen particularly strongly in claims against professionals.[60] Of note, nearly all British professions have had their authority increasingly challenged by legal action over the past half century. Therefore, the phenomenon is partially a reflection of a more extensive process of social and cultural change.[61]

Commenting on physician’s professional powers, Freidson presents two interrelated aspects: autonomy, or the ability to control one’s work, and dominance, or the ability to control others in the division of labor.[62] In both dimensions, doctors’ power has diminished in the past several years, exposing them to increased litigation. One theory used to explain the loss of power – proletarianization – is based on the ideas of Karl Marx that professions that have been honoured in the past (including medicine) have been debased by capitalist expansion.[63] Eventually, all workers, including pro-

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[58] Freidson, *Profession of Medicine* (1988), p. 337.

[59] Smith, Richard, ‘Doctors and Health Policy’, in Day, Patricia et al. (eds.), *The State, Politics and Health* (1996), p. 126.

[60] Harpwood, Vivienne, *Negligence in Healthcare* (2001), p. 3.

[61] Dingwall, Robert, ‘Litigation’, in Gabe, Jonathan et al. (eds.), *Challenging Medicine* (1994), p. 50.

[62] Freidson, *Professional Dominance* (1970), pp. 135–137.

[63] McKinlay, John and John Stoeckle, ‘Corporatisation and the Social Transformation’, *International Journal of Health Services*, 18–2 (1988), p. 200.

fessionals, lose control over their work, thereby resulting in the proletarian worker replacing the autonomous professional.[64] Applied specifically to the medical profession, proletarianization is the process by which physicians are divested of control over location and content of work and are subordinated to the needs of capitalism. As Ellen Annandale points out, 'physicians are incorporated into large-scale bureaucracies [and] are gradually shorn of control over their work'.[65] The growth of capitalism and loss of autonomy are most clearly seen in the transition from solo private practices to salaried hospital employment. Because most physicians strive for autonomy, they seek self-employment.[66] The move from private practice to salaried employment in 'large-scale bureaucracies' represents a noteworthy decline in autonomy. While this argument is valid, it is also important to consider reasons other than capitalist expansion to explain the increase in salaried employment. For instance, as medical technology improves, some types of equipment are too expensive for a single physician (or small group of physicians) to purchase. Hospitals seem like the best alternative purchaser, and physicians align themselves with hospitals to use this equipment. Nevertheless, the concept of proletarianization is valid in explaining some of the profession's loss of power.

The second theory about doctors' loss of power, known as deprofessionalization, has been described as 'a loss to professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos, and expectations of work autonomy and authority over clients'.[67] In other words, the public of the past generally regarded physicians highly for three main reasons: physicians' control of knowledge, the public's perception that physicians work in the patient's best interest, and physicians' control of the decision making process. Regarding this first point, doctors have gradually lost their sole possession of medical knowledge. In the past, the physician 'was a distant and recondite figure with access to knowledge which transcended local concerns and was unavailable to ordinary people'.[68] Christopher Dede of the Harvard Graduate School of Education, speaking about university professors – though his argument applies equally to physicians – stated that deference to professors is driven by their status as 'infallible sources of deep knowledge', but this notion has been weakening.[69] The average length of formal education among the general public has increased. This, combined with growing access to information, especially through Internet websites like WebMD, has decreased the knowledge gap between patient and physician. With this greater level of information, patients are increasingly empowered to question physicians about their diagnosis and treatment.[70] In addition, patient self-help groups are part of a new social movement that has allowed

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[64] Oppenheimer, Martin, 'The Proletarianization', *Sociological Review Monograph* 20 (1973), p. 213.

[65] Annandale, Ellen, *The Sociology of Health and Medicine* (1998), pp. 225, 226.

[66] Freidson, *Profession of Medicine* (1988), p. 365.

[67] Haug, Marie, 'Deprofessionalization', *Sociological Review Monograph* 20 (1973), p. 197.

[68] Kelleher, David et al., 'Understanding Medical Dominance', in Gabe et al. (eds.), *Challenging Medicine* (1994), p. xii.

[69] Glater, Jonathan, 'To: Professor@University.edu', *New York Times* (21 February 2006).

[70] McKee, Martin et al., 'Pressures for Change', in McKee and Judith Healy (eds.), *Hospitals* (2002), p. 45.

patients to see their medical conditions differently and thus has resulted in a growing opportunity to challenge physicians.[71] Pharmaceutical advertising has created increased awareness among patients of various diseases and possible prescription cures, thereby leading some patients to demand certain treatments. Finally, the growing use of alternative medicine also erodes doctors' control of knowledge.[72]

Ideas regarding the second point above have also changed. In the past, doctors were

> part priest.... The patient looks to the physician ... as the comforter and healer who will make him well and happy; he has the learning and the magic that will bring relief from fear and pain. The patient, whether consciously acknowledging it or not, longs to be relieved or comforted. All this gives the physician a hierophantic status.[73]

But the public has been increasingly sceptical of whether physicians really do faithfully work in the patient's best interest. In some cases:

> the patient resents his dependence and is not averse to debunking the myth; a myth, be it noted, that he has himself created. This relationship is not entirely dissimilar to the emotional duality that a child feels towards his parents. In an age where the child has learnt that obedience to parents is not necessarily the norm, parental control is less and less effective, and for today's children anything is permissible, it is not surprising that the divine aspect of the medical profession has taken a beating.[74]

Regarding the third point, coinciding with the shift to salaried employment, the decision making process has also seen a considerable amount of change. Prior to the 1980s, paternalism, in which the doctor assumed the dominant role, was the most common form. The use of this method was based on four assumptions:

1. There is a single best treatment for a disease/illness and the doctor knows what that treatment is.
2. While not only possessing the knowledge of the range of possible treatment options, the doctor consistently applies the correct information in choosing among treatments.
3. Because of his clinical training and medical knowledge, the doctor is in the best position to evaluate the tradeoffs among different treatments to make the correct decision.
4. The doctor is vested in the treatment decision because of his concern for the patient's well being and thus makes his decision accordingly.[75]

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[71] Kelleher, 'Self-Help Groups', in Gabe et al. (eds.), *Challenging Medicine* (1994), pp. 115–116.

[72] Lupton, Deborah, 'Consumerism' (1997), in Bury, Michael and Gabe (eds.), *The Sociology of Health and Illness* (2004), p. 203.

[73] Lewis, *Clinical Negligence* (2001), pp. 1–2.

[74] Lewis, *Clinical Negligence* (2001), pp. 1–2.

[75] Charles, Cathy et al., 'Decision Making', *Social Science and Medicine* 49 (1999), in Bury and Gabe (eds.), *The Sociology of Health and Illness* (2004), pp. 230–231.

During the 1980s, people started to question these assumptions. There was a growing awareness that standards of care about a single best treatment based on cost and effectiveness did not exist for many illnesses.[76] As treatments became more technical and detailed, it was more difficult to know with certainty that one treatment option was better than another. In addition, people became more aware of small area variations – different treatments for similar conditions based not on clinical determinants, but on other factors including physician preferences in a particular region.[77] Patients also began to realize that since they had to live with the consequences of the doctor's medical decisions, they should participate in the evaluation of tradeoffs. Finally, as stated earlier, there was also growing concern about whether the doctor was really acting in the patient's best interest. Gradually, people demanded greater accountability from doctors.[78]

Because of these changes, other models of decision making emerged that attempted to correct the flaws of the paternalistic model. These models differ according to information exchange, deliberation, and treatment decision. Information exchange involves the amount and type of information exchanged between a physician and his patient and the nature of the directionality (i.e., one way vs. bidirectional and patient to doctor vs. doctor to patient) of the exchange. Deliberation refers to the process of evaluating various treatment options and concerns itself with the extent of participation by patients and physicians. During the last stage, the actual treatment decision is made, but the number of decision makers varies according to the treatment model used.[79] On one extreme, paternalism is the embodiment of physician dominance. It derives its name from the idea that parents know what is in the best interests of their child. Even if the child were to disapprove of a certain parental action, he would have no way to enforce his protest because it is assumed that parents act according to what they believe are the best interests of their child. Similarly, in the paternalistic decision making model, a physician is presumed to care for the health of his patient enough that he has the right to decide what treatment option is best. Accordingly, in the three metrics that differentiate the models, paternalism lies on one end of the spectrum. Information exchange is predominantly unidirectional from the patient to the physician. The patient provides his doctor with such facts as his lifestyle, health history, and symptoms. The doctor, on the other hand, communicates minimally with the patient. The physician then deliberates (possibly with other physicians) without patient influence about the tradeoffs of various treatments. Finally, the doctor implements the treatment option that he selects.[80] It is at this stage that the patient actually wields some power in that he can choose to decline a procedure or refuse to comply with a medication regimen.

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[76] Freemantle, Nick, 'Optimizing Clinical Performance', in McKee and Healy (eds.), *Hospitals in a Changing Europe* (2002), p. 256.

[77] Shi, Leiyu and Douglas Singh, *Delivering Healthcare in America* (2004), p. 497.

[78] Charles, 'Decision Making' (1999), pp. 230–231.

[79] Charles, 'Decision Making' (1999), pp. 233, 235, 238.

[80] Charles, 'Decision Making' (1999), pp. 233–238.

On the other extreme, informed decision making is evidence of the growing rights of patients. As its name implies, this model requires that the patient be educated about his medical problem and his options. Information exchange is again predominantly unidirectional, but the information flows from the doctor to the patient. Rather than assimilating information to make a decision, the physician serves as a medical encyclopedia, providing the patient with as much relevant information as possible. The doctor should provide background on the medical problem and the potential costs and benefits of various treatment options. During the deliberation stage, the patient and likely his friends and family consider various treatment options, seeking the physician's input only to clarify points of information. The weighing of all decisions is, in the end, conducted by the patient, which allows him to arrive at his desired treatment option.[81] Again, like paternalism, the less-involved party (in this case, the physician) has greater influence during this final stage than the other stages because he can refuse to perform a certain procedure or prescribe a certain medication. Yet, the majority of the decision making power lies in the patient's hands. David Eddy supports this new sense of patients' rights:

> Different people can properly have different preferences. There is no single correct answer, and there is no obligation that everyone agree.... The people whose preferences count are the patients, because they are the ones who will have to live (or die) with the outcomes.... What matters is what Mrs. Smith thinks... [because] in the end, it is the patient's preferences, not [the doctor's preferences], that count.... It is also quite possible that Mrs. Smith's preferences will differ from Mrs. Brown's preferences. If so, both are correct, because 'correct' is defined separately for each woman. Assuming that both women are accurately informed regarding the outcomes, neither should be persuaded to change her mind.[82]

Thus, this model gives a patient the right and responsibility to take care of his own health.

In the middle of these two, shared decision making retains aspects of both the paternalistic and the informed decision making models. Shared decision making, which has become increasingly popular, represents a synergistic compromise. The flow of information is bidirectional – the doctor shares medical information with the patient, while the patient shares personal and cultural information with the doctor. The presence of the medical information ensures that all treatment options are explored, while the presence of the personal and cultural information ensures that the treatment options are viewed in light of the patient's desires. Together, the doctor and patient evaluate the different alternatives.[83] This method has both advantages and disadvantages. While it allows the major stakeholders to participate in the decision making process, it is more time consuming and costly. In the final stage, the physician and

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[81] Charles, 'Decision Making' (1999), pp. 233–238.

[82] Eddy, David, 'Clinical Decision Making', *Journal of the American Medical Association* 263 (1990), p. 442.

[83] Charles, 'Decision Making' (1999), pp. 233–238.

patient decide upon a treatment plan. Because both parties participate in the entire process, the likelihood of compliance by both parties is higher.

This transition is also seen in the third threat to physicians: the rise of consumerism, which started to develop in the UK after World War II. A by-product of collective action and market forces, it led to the creation of laws aimed at providing greater protection to individual consumers. Applied specifically to British healthcare, the introduction of the NHS in 1948 led to a change in the attitudes of patients toward their doctors. Assisted by documentaries featuring medical malpractice and by lectures given by prominent citizens who criticized the then-current state of medical care, the nature of medical practice became a topic of public debate over the next several years.[84] Ian Kennedy, who delivered the Reith Lectures in 1980, described consumerism as the concern with protecting the legitimate interests of the patient against those who might attempt to hurt, injure, or exploit him or weaken his ability to make his own decisions. Thus, the goal of consumerism is to achieve a better balance of power between physician and patient. In addition, consumerism can help patients reclaim some of the authority that they had previously surrendered and can aid in reshaping medicine to meet the needs of those it seeks to help.[85] There are many ways that consumerism can affect the practice of medicine. The most significant challenge is seen in the daily practice of a physician. As the consumer of medical care, the patient has a right – and some would argue, a responsibility – to assert his interests in self-determination and participate in determining the course of his treatment. On the other hand, doctors emphasize their paternalistic role to demonstrate their professional status. In this sense, consumerism creates a standard to which the doctor must be held and provides a means for the patient to enforce the standards.[86] To establish this goal, the government has occasionally passed legislation aimed at increasing the rights of patients. Under Prime Minister John Major, the Patients Charter, which reflected the idea of an ‘empowered client’ as seen in the Citizens Charter, was enacted in 1991. Although this charter did not have the force of law, it encouraged patients to complain by asserting their healthcare rights.[87] It set out details of what patients could expect from the NHS, thereby establishing a standard by which doctors could be judged. In this respect, it has ‘significantly raised public awareness of ‘rights’ and standards and, as a consequence, precipitated a rise in the number of complaints’.[88] Thus it has encouraged healthcare providers to focus on the gap between perceived and actual levels of care.

In addition, the diffusion of medical technology is another area in which consumerism can present a challenge to medicine.[89] With medical research proceeding more and more rapidly, new procedures and medicines are quickly produced and adopted into medical practice before the public has a chance to critically evaluate their effi-

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[84] Harpwood, *Negligence in Healthcare* (2001), p. 3.

[85] Kennedy, *Unmasking Medicine* (1981), pp. 116–117.

[86] Kennedy, *Unmasking Medicine* (1981), p. 123.

[87] Harpwood, *Negligence in Healthcare* (2001), pp. 3, 4.

[88] Elder, *Who Cares* (1998), p. 57.

[89] Kennedy, *Unmasking Medicine* (1981), p. 119.

cacy, safety, and necessity. Indeed, the influx into the market of 'me too drugs' presents such an example. Pharmaceutical Company A develops a drug that is protected for a limited number of years by a patent; when this patent expires, sales of the drug often plummet immediately because of fierce competition from generic products, which are sold at a fraction of the price. In order to compete with these lower-priced drugs, Company A needs to lower the price of its previously patent-protected molecule. A way that the company can step around this problem is by producing a me-too drug – a drug that acts through a similar mechanism and targets a similar medical problem as the original drug. Through effective marketing, the drug company is able to advertise the newer product, which is protected by a new patent, as being a better choice than the previous product. This advertising leads consumers to believe that more recently developed medicine is better than older versions.[90] Thus, consumers tend to opt for this newer drug, consequently paying the higher prices associated with a patent-protected drug, rather than opting for the generic competitors of the older drug. But David Kessler, the former commissioner of the US Food and Drug Administration (FDA), asserts that only a small minority of these me-too drugs offer a clear clinical advantage over existing therapies and that 'for patients... [the marketing of me-too drugs] can mean misleading promotions, conflicts of interest, increased costs of health care, and ultimately, inappropriate prescribing'.[91]

Me-too drugs also enter the market when Pharmaceutical Company B wants a share of Company A's profits before Company A's patent expires. During the life of the patent, Company B is prevented from producing Company A's molecule. If Company B wants to enter the market, it must produce a different drug. Company B can do this by developing a me-too drug. Marcia Angell, a past editor of the *New England Journal of Medicine*, claims that the pharmaceutical industry has built itself on these me-too drugs. Between 1998 and 2002, 77 percent of the drugs approved by the FDA were classified, in the FDA's view, as me-too drugs. Most did not have different chemical compositions than their original versions.[92] Such an example is seen in the market for cholesterol-lowering statins, such as Zocor, Mevacor, and Lipitor. The value gained by the public of having an extra statin from which to choose is, some argue, relatively small: 'There is little reason to think one is any better than another…. But to get a toehold in the market, me-too statins were sometimes tested in slightly different patients, then promoted as especially effective for those uses.... If tested in the same kinds of patient, [they] would likely have shown the same effects.'[93] Maureen Dowd of the *New York Times* opinion staff indicts the drug industry in a similar way: 'Addicted to their billion-dollar sales, the [drug] companies have been sneakily repackaging old pills for new uses.'[94] However, for the pharmaceutical company, the molecule, if marketed properly, either will maintain Company A's high sales figures when the previously invented statin loses its patent protection or will allow Company

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[90] Harris, Gardner, '2 Cancer Drugs', *New York Times* (26 February 2004).

[91] Kessler, David et al., 'Therapeutic-Class Wars', *New England Journal of Medicine* 331–20 (17 November 1994), p. 1350.

[92] Angell, Marcia, *The Truth about the Drug Companies* (2004), p. 75.

[93] Angell, Marcia, *The Truth about the Drug Companies* (2004), p. 81.

[94] Dowd, Maureen, 'Aloft on Bozoloft', *New York Times* (3 July 2002).

B to profitably enter the market even while Company A's molecule is under patent-protection. The pharmaceutical industry asserts that me-too drugs are justifiable because the competition between Companies A and B keeps the prices down and because if one drug doesn't work for a particular condition, another one might. But, some assert, there is little support for either of these claims. First, there is no evidence of price competition among me-too drugs. When the first copycat drug comes to market, the price of the original version does not drop. Nor is the copycat ever promoted as being a cheaper version of the original.[95] In fact, most experts believe that the prices of the newer drugs are well above those of the older versions.[96] At most, aggressive marketing results in the drug companies dividing the market rather than competing on price.[97] Second, the scientific evidence does not support the claim that if one drug does not work, a virtually identical one will. Angell even calls on the drugs companies to prove their claim: 'The companies could easily test that proposition. They could test their me-too drugs in patients who have not done well on the first one. But they don't do that, probably because they don't really want to know the results.'[98] Questionable practices of the pharmaceutical companies undermine consumers' trust in the healthcare system. As the most visible members of the system, physicians face most of the backlash for patients' grievances about any aspect of healthcare. As stated by Kennedy, 'we, the ordinary citizens, have to all intents and purposes been overtaken, overwhelmed by such developments.'[99] Though it is the consumer who is directly affected by the developments, his voice is rarely heard. Indeed, Kennedy believes, 'if any of us should be bold, or naïve, enough to raise his voice and suggest we wait a moment before opening this particular Pandora's box, the scientific establishment reacts with wounded indignation. 'How dare you challenge the right to pursue knowledge, conduct research and introduce technical innovation?" '[100] Such questioning is viewed as standing in the way of progress. But clearly, there must be restrictions on what science can and cannot do. There are reasons, both ethical and practical, that medicine should not proceed beyond certain limitations. On the other hand, medical advancement is only possible through guarded experimentation. Therefore, a balance between these competing views must be reached. The goal of consumerism in this case is to advocate for the rights of patients to ensure that medical advancement does not impinge on these rights; these rights are even more important when the stated reason for the research – i.e., medical progress – and the possible underlying reason – i.e., heftier profits and larger bonuses for chief executives – do not match. To the extent that consumerism is successful in achieving this goal, the power of the medical profession over patients will diminish, thereby exposing the physician to an increased risk of being sued and an increased risk of losing the lawsuit.

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[95] Angell, *The Truth about the Drug Companies* (2004), p. 89.

[96] Harris, '2 Cancer Drugs', *New York Times* (26 February 2004).

[97] Goozner, Merrill, *The $800 Million Pill* (2004), p. 216.

[98] Angell, *The Truth about the Drug Companies* (2004), p. 90.

[99] Kennedy, *Unmasking Medicine* (1981), p. 119.

[100] Kennedy, *Unmasking Medicine* (1981), p. 120.

Overall, the relationship between a patient and his physician has changed considerably over the past few decades. The power of doctors associated with their professional autonomy and dominance has gradually weakened. This erosion has been explained by the concepts of proletarianization, deprofessionalization, and consumerism. The image of an idealized, infallible medical professional has undergone significant changes. From the days in which doctors were able to do little to help the sick, physicians have established themselves as being part of a life-saving, patient-oriented profession. Patients regarded physicians with god-like reverence as a result. But, over the past few decades, this position has been increasingly challenged. Compared with previous attempts at rejecting professional authority, the current ‘revolt’ of patients represents a concerted, rather than individual, effort to question professional autonomy and authority.[101] This challenging of physicians has allowed a patient to realize that his claim of medical negligence against his physician has a greater chance of succeeding in court than it did in the past. As a result, the use of this form of litigation has continued to grow during the last half century.

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[101] Haug, Marie and Marvin Sussman, ‘Professional Autonomy’, *Social Problems* 17–2 (1969), p. 155.

4: Conclusion

Most people have a view on whether medical liability litigation is overall good, bad, or somewhere in the middle. On the one hand, some argue that this type of litigation has been successful in compensating victims of medical mishaps and in holding doctors accountable for their actions, and has thereby contributed to an improvement in the standard of healthcare. On the other hand, people argue that litigation in its current state is unnecessary and costly and that healthcare has suffered as a result. What is evident from the data is that in the past half century, the number and severity of claims in the UK have increased significantly. The NHS currently receives more than 10,000 complaints per year. Estimates of settling outstanding claims vary, but tend to hover around at least 10 percent of the NHS's total annual budget. Expenditure on claims has increased, both in the recent past and over a period of decades, and the severity of claims has also risen. This trend likely reflects a generalized increase in litigation.[102]

Due to greater awareness of the rise in litigation, the government has taken a stronger interest in addressing its growth. To successfully address the issue, it is necessary to understand some of the major reasons that account for the growth. This paper has provided numerous reasons, which have been grouped into two categories. First, patients have become increasingly dissatisfied with the current complaints procedure. The inability of the medical profession to effectively regulate itself coupled with the government's failed attempts at intervening have left patients feeling that litigation is their only possible option of complaining about substandard care. The public has also realized that the social safety net designed to care for society's less privileged members has been ineffective in dealing with health issues. In the past, when people believed that the social safety net would provide for them if they were harmed through medical care, they had less financial incentive to sue physicians. However, as people have become more aware of societal inequalities, they have pursued litigation more aggressively.

Second, physicians of the past used to be held in high regard and were considered god-like and infallible. Today, although the medical profession still receives a great amount of respect from patients and the public, its status has declined. As explained by the theories of proletarianization, deprofessionalization, and consumerism, the power of the profession has been eroded both by other healthcare providers (e.g., nurses and physician assistants) and by the general public (including patients), leading patients to believe that they have a better chance of succeeding in litigation.

Litigation does have its merits as a form of dispute resolution. Perhaps the single best quality of litigation is that it seeks to identify a tortfeasor – an individual or group whose negligent actions resulted in harm to the patient. It holds doctors accountable for their decisions. Because no reasonable doctor wants to be found guilty of harming his patients, litigation – or rather the *threat* of litigation – encourages doctors to practice carefully. Thus, litigation, at least in theory, protects patients. However, it has serious drawbacks that are worth mentioning. First, the process is costly – the protracted nature of lawsuits and the expensive professional services of lawyers, expert wit-

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[102] National Audit Office, *NHS (England) Summarised Accounts 1999–2000* (2001–2002), p. R32.

nesses, and judges contribute to the enormous cost of litigation. In addition, when a case is legally aided, a lengthy trial requires significant public expenditure. It is also inefficient – the National Consumer Council found that, on average, 85 percent of a compensation award is spent on costs.[103] Third, the process is arbitrary in that similar cases of harm necessitating similar levels of need are often compensated differently.[104] Fourth, while litigation compensates – and sometimes overcompensates – a few badly-injured patients, it distinguishes between an adverse outcome and a medical error in that it allows compensation for the latter but not the former.[105] In either case, the patient has been harmed by undergoing medical care. Some consider it unfair that a patient, possibly one who is no longer able to move or work as he could before treatment, should not be compensated for his injury simply because it was deemed an inherent risk of medical care. Fifth, if physicians' service ethos is not enough motivation, the awarding of monetary damages is intended to deter poor treatment. But the availability of insurance coverage weakens this deterrent effect.[106] Finally, though litigation holds doctors accountable for their actions, it is an oppressive force in the doctor-patient relationship. Because the reputation of a physician is, as pointed out by Lord Denning, as dear to him as his body, the finding of fault is detrimental to a physician.[107] As such, the discovery and trial phases of the litigation process tend to polarize both parties, and physicians often become defensive and unwilling to provide information.[108] The adversarial nature of litigation further contributes to the time needed to reach a settlement, thereby adding costs.

As a result of mounting criticism of the tort system, the government formed the Royal Commission on Civil Liability and Compensation for Personal Injury in 1973. Also known as the Pearson Commission, its five-year study resulted in a number of recommendations. Among its medically-oriented recommendations, it advised against the outright elimination of the tort system for compensating personal injury claims. It also suggested that severely disabled children should be given compensation regardless of whether the handicap was attributable to someone's negligence; this suggestion was a precursor of the possible move to a no-fault compensation scheme. Though the commission decided against such a scheme for medical accidents, it noted in its report that some members of the commission saw the merits of the system and encouraged the government to review international models of no-fault compensation, such as those in Sweden and New Zealand.[109] About a decade later, the BMA emphasized its support of such a scheme.[110] In October 1999, the government, through the Health Select Committee, again expressed its interest in exploring the viability of a

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[103] Brazier, *Medicine* (1987), p. 143.

[104] Ham et al., *Medical Negligence* (1988), p. 5.

[105] Rosenthal, Marilynn, *Dealing with Medical Malpractice* (1987), pp. 15, 17.

[106] Ham et al., *Medical Negligence* (1988), p. 5.

[107] Denning, *The Discipline of Law* (1979), p. 243.

[108] Mulcahy, *Disputing* (2003), pp. 7, 75.

[109] Brazier, *Medicine* (1987), pp. 144–145.

[110] Carrier, John and Ian Kendall, *Medical Negligence* (1990), p. 68.

no-fault compensation scheme when it called on the DoH to review the matter and publish a consultation document on whether to introduce such a program.[111]

There are many advantages to a no-fault compensation system. First, it places an emphasis on aiding the patient: 'the social need to compensate those with disabilities from government funds is given precedence over the need to punish those who are responsible for the harm or make an example of them'.[112] Second, because harm caused by expected risks of treatment is not excluded, a greater number of claimants are able to collect compensation from a no-fault fund, and these claimants can use this money to assist in putting their lives back in order after a medical mishap.[113] Third, because it does not seek to establish whether the harm suffered by the patient was due to a risk of treatment or a medical mistake, the system, as its name implies, does not seek to assign blame. As a result, the adversarial dynamic between patients and physicians in litigation is not a significant issue under no-fault compensation. Instead, resolution of the conflict is a means of reaffirming the doctor-patient relationship and building trust.[114] Finally, the resolution process can occur much more quickly because there is no lengthy trial needed to establish causation and substandard care.[115]

One of the most serious drawbacks to no-fault compensation is that it destroys the link between a harmed patient and his doctor.[116] Eliminating this causal link between the victim and agent of harm introduces a type of moral hazard in that a physician becomes more willing to try a less-established, riskier treatment with the assurance that unless his actions are grossly unprofessional, he faces few, if any, consequences. Therefore, a no-fault scheme could unintentionally lower the overall standard of healthcare by providing doctors with seemingly limitless and unchecked clinical autonomy. However, this problem can be addressed through the creation of investigatory committees whose role would be to maintain high levels of clinical excellence.[117] In carrying out their function, they would seek to identify the cause of medical mistakes (as the current litigation system does), but the allocation of blame would not be tied to the payment of compensation. Because such investigations would engender a sense of organizational improvement rather than the assignment of fault, physicians would be more likely to openly participate in the process rather than assuming a defensive posture as seen in the current litigation system.

Additionally, many people believe that a no-fault compensation system would be too expensive to maintain for two reasons. First, the litigation system does not compensate patients for mishaps that are an expected risk of treatment. On the other hand, a no-fault system would provide financial aid in such situations. Therefore, the volume of cases handled by a no-fault scheme would be much higher than the volume

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[111] National Audit Office, *NHS (England) Summarised Accounts 1998–1999* (1999–2000), p. R51.

[112] Mulcahy, *Disputing* (2003), p. 76.

[113] Brazier, *Medicine* (1987), p. 146.

[114] Mulcahy, *Disputing* (2003), p. 75.

[115] Mann, Ronald, 'No Fault Compensation', in Mann and John Havard (eds.), *No Fault Compensation* (1989), p. 8.

[116] Ham et al., *Medical Negligence* (1988), p. 31.

[117] Brazier, *Medicine* (1987), p. 146.

dealt with by the litigation system. Second, patients might submit claims of dubious merit in the hopes of collecting compensation. However, these issues can also be addressed. The high costs of lawyers, judges, and expert witnesses would be saved through the use of no-fault compensation.[118] The expenses associated with the current litigation system could be put toward payment of those who are entitled to receive money. Payment rates for no-fault compensation could be adjusted to ensure that all who have a legitimate claim on the fund can collect money.[119] To prevent claims of insufficient merit being made on the fund, the government could prescribe guidelines that define the scope of accidents to be included in the program.[120] Standardization of the process of awarding compensation would prevent the awarding of money for claims of insufficient merit. At the same time, it would also address a major concern of patients regarding the secretive nature of the current complaints procedure by demonstrating the transparency of the no-fault compensation system.

Thus, discontent with the current litigation system has led some people to call for a new program to deal with complaints about medical care. The most promising alternative is a no-fault compensation scheme, which many believe would represent a significant improvement over litigation. The primary advantage of this scheme is its goal of providing financial assistance to all victims of medical mishaps regardless of whether their injury resulted from physician error or as a side effect of treatment. But it is also helpful for doctors because it does not attempt to blame physicians for the mishap. As a result, physicians can be more forthcoming in resolving claims and can work toward learning from mishaps with the goal of improving overall patient care. The successful introduction of a no-fault compensation system requires that certain aforementioned concerns be addressed. Under a no-fault system, almost all of the NHS's budget would be spent for health purposes. This, in many people's view, would be a significant advancement over the present situation. As this paper has argued, until such a system is introduced, it is likely, for the reasons stated in previous sections, that doctors will be increasingly susceptible to medical liability litigation. As a result, the incidence and severity of claims will almost certainly continue to rise.

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[118] Bolt, David, 'No Fault Compensation', in Mann and Havard (eds.), *No Fault Compensation* (1989), p. 94.

[119] Kennedy, *The Unmasking of Medicine* (1981), p. 138.

[120] Ham et al., *Medical Negligence* (1988), p. 32.

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