

Medical injury, patients' claims and the effects of government responses in Anglo–American legal systems

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Almost no one is happy with malpractice liability, the traditional Anglo–American system for dealing with complaints about medical injury. To its more trenchant critics it is inefficient, ineffective, inaccurate and, what matters most, it is structurally inconsistent with the fundamentals of quality improvement and future patient safety.¹ It is, in all, something only a trial lawyer could love.^{2 3}

Efforts at reform are in place almost everywhere. New Zealand has effectively barred malpractice litigation entirely⁴; Australia has curbed it by offering parallel, commission-based procedures⁵; Canada and England have relatively lower claiming rates due to disincentives built into law and insurance practices⁶; while in the USA the process remains troublesome. Many hospitals and some liability insurers have initiated disclosure and early intervention programs to prevent disappointments from turning into legal claims,⁷ but the legal environment in the USA remains largely unchanged. Some states in the USA limit recoveries through the imposition of 'caps' on damages such as 'pain and suffering', but more fundamental reforms are few.⁸

Dissatisfaction with the process among patients is particularly notable. Traditional litigation

provides only money, and then only infrequently, slowly and at considerable emotional and psychological expense. Injured patients, however, report the need for other things^{9 10}: restoration (more broadly than cash); sanction (accountability for erring providers); communication (disclosure, explanation, apology); and, perhaps most significantly, correction (steps taken to assure the error is not repeated).¹¹ Money is a poor surrogate for these other concerns. Australia and New Zealand have responded to that fact by creating health complaint commissions, agencies empowered to deliver a broader and more responsive array of remedies. Many of us in the USA who are considering the shape of comprehensive reforms there have been looking at these models for inspiration and experience. The experience, however, is mixed. Even in Australia and New Zealand patient dissatisfaction is still significant.⁵

Bismark *et al* hypothesise in the accompanying article⁵ that this dissatisfaction flows from a 'gap' between what patients want from these commissions and what they receive. Analysing a subset of complaints (those alleging inadequate informed consent) and using as their analytical scheme the four desiderata just discussed, the authors compare what patients said they wanted from the process with what the commissions' conciliators reported they received. Measured in that dichotomous, non-qualitative way, they found the gap they

predicted in three of the categories: fewer than 1 in 10 who sought sanctions achieved it; about a third of those seeking restoration received that; and, again most significantly, correction was achieved for fewer than 1 in 5 of the many complainants who reported that as among their goals.

The study has a number of limitations, all the more important of which are explicitly discussed by the authors. For one, the incidents studied are a selected subset of a distinctive type of medical complaint, viz only those complaints defined as a 'case' that allege inadequate informed consent. Whether the study's findings are generalisable is therefore a significant but unanswerable question. For another, little is known about the qualitative aspects of either the complaints or the remedial outcomes. That is to say, the existence of a gap is dichotomous. And—although this is something the authors' data did not allow—it is not possible in these findings to determine the legitimacy of the patients' demands. If, for example, a patient demanded that a provider be sanctioned but that did not happen, was that because the care was in fact not sanctionable? I return to the importance of this question below.

There are a number of other interesting questions raised by the study by Bismark *et al* and its results that are somewhat less obvious. Students of the sociological sciences, for example, will recognise at least one additional body of work with which the study's findings might be linked: there is little that is intrinsic or inevitable about peoples' needs and expectations following an injurious event. What people want and expect is as much a function of environmental variables as it is of objective injury, loss, or pain. Professor Sally Lloyd Bostock, one of the most published expositors of this view, developed what she termed an 'attribution theory' to link injury

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with behaviour, specifically so claiming behaviour.¹² An individual's journey from the fact of injury to the making (or not making) of a claim is an untidy psychological process, though in outline it can be described as a cascade of perceptions and decisions: first, recognising that one has been injured; second, realising that the injury was caused by someone else; third, assessing that cause as a matter of fault or wrongdoing on the actor's part; next, concluding that some sort of accountability is called for; and from there sorting through all of the permutations of seeking satisfaction by selecting a remedy. How each of these decisions comes out is affected by the culture, by the people surrounding the subject and their voiced guidance and expectations, by the grid of social support and, of course, by the remedial pathways known to be available.

There is a converging legal literature, begun as long ago as the 1960s by the lawyer–psychologist Robert Redmount¹³ and carried forward by numerous commentators since.¹⁴ A client, Redmount opined, is like 'putty in a lawyer's hands'. What the client decides to do is shaped by the lawyer's explicit counsel and by the lawyer's own tacit and often unrecognised predispositions about what a client like this ought to do in a situation like this. The meaning and importance of a perceived gap between expectation and response needs to be assessed carefully in light of these more subtle processes.

This also suggests caution in extrapolating studies from one country to another, even where all of the locations are Anglophonic. In Australia, for example, the authors report that lawyers seldom take on a malpractice case until after the Commission process has concluded. In Canada (and elsewhere) the hospitals' responses have shown a powerful influence. And in the USA access to members of the trial bar is

almost entirely unchecked. In short, we don't know much a priori about how the fourfold expectation set is modulated in any particular clime, and less so in any particular case. Whether the patients' expectations that form one of the bookends of the reported gap are authentic is therefore more than a philological question. It is also a pragmatic one in the design of reformed post-injury systems. What, one might ask, would patients who are iatrogenically injured want or need in the absence of external influences, or in the presence of those if deliberately changed?

Taking the sociological and the legal–psychological together has led to a richer understanding about the seeming authenticity of injured parties' expectations and needs. What we have learnt in recent years about the effects of early disclosure and apology support it: patients' perceptions are malleable, as well as their behaviours.¹⁵ A fault-based liability system that turns every adverse encounter into a win–lose contest between conflicting views of the truth creates a universe of expectations, operatives and signs that inform and support the very adversarial behaviour necessary to access the system. One might wonder then, as I do, whether the adversarial nature of the Anglo–American system isn't the cause of the adversarial behaviour that makes it, in the world of medical error, so very ineffective. It would be very interesting to conduct a study contrasting patient attitudes in Australia, where tort liability exists alongside the Commission process, with those in New Zealand, where liability for these kinds of matters no longer exists. (And possibly with Canada, the USA and the UK.) There would of course be the usual difficulties in conducting crosscultural comparisons, but the results would be illuminating in any case.

Those questions lead to another. Bismark and colleagues, having

verified the gap between demand and response, offer two solutions for narrowing it. One, in consonance with the preceding notes, is to correct expectations with, in the argot of mediation, reality training. The other is to design the systems to deliver more of what complainants seek. The prescription for the latter invites additional pause. To put it starkly, how much should such a gap matter?

The authors' answer includes some of the more important consequences of disappointment with remedial systems: relations between patients and providers may be worsened; and, though they do not describe the mechanism, opportunities for corrective action may be lost. To that one could add, simply, that governments are supposed to deliver what their constituents want and value, or from a social solidarity point of view we ought to be about feeling and easing our fellows' pain. Some might say that what 'the system' does in the aftermath of medical care is a part of the care itself, and that all medical care must be compassionate, including its bitter end.^{16–18}

The question could, however, be approached from a different starting point. What objectives, exactly, should a legal system seek to achieve in the aftermath of an adverse medical event? Is satisfaction with remedial outcomes one of them?

Many believe, as I do, that the principal objectives should be three, not coincidentally redolent of the authors' four-factor catalogue: restoration of the patient to a pre-event condition as nearly as may be, accountability for individual and institutional providers when they err, and learning—using today's adverse outcome to help prevent tomorrow's. But how should these be measured? Each has at least two components: the subjective expectations of the patient, and the objective measures in the medico-legal system.

The authors are likely right that subjective dissatisfaction may impede full participation in medicine's efforts at improvement; but in a world in which not everything worthy can be had without cost to something else, would a system that produced accountability, learning and objective restoration—but without perfect subjective satisfaction—be a bad one? As a matter of public policy should we assess the adequacy of governmental responses solely from a utilitarian perspective? Or from a base in egalitarian or communitarian values?

To put it most pragmatically, should we continue, as we do in the USA, with fault as the basis of compensation? Or is the link between fault and payment forged by deeply felt but too often dysfunctional drives for accountability and, let's use the word, revenge? It is difficult to explain the persistence of the Anglo-American fault-based tort system as anything other than its having been built on an atavistic foundation of retributive, rather than distributive, justice. Revenge might be very satisfying. Should the legal system continue to suborn it?

This is, of course, very far beyond the scope of the undertaking reported in the authors' study. But then, it is in praise of the work to say that it raises as many interesting questions as it answers. I, for one, am not the least discouraged by the

findings. While critics of fault-based liability have assailed that system as not responding to patients' richer needs, that criticism remains valid even if the alternatives essayed so far show something, though much less, of a similar lack. The alternatives in Australia and New Zealand address many of the economic and legal inefficiencies of the Anglo-American tort system, even if some work remains to be done in redressing the non-monetary aspects of patients' grievances. What matters at least as much, however, is the contribution the legal process makes to quality and safety. All we know suggests that the traditional systems are ineffective.¹⁹ We await with considerable hope similar studies from the Antipodes of their gains in quality and safety.

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