

Patient Safety and Tort Litigation: Two Solitudes?

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Patient Safety Frames the Issues

- Underlying systemic factors play significant causal role in most adverse events and near misses in health care;
- Analysis shouldn't be limited to "sharp end";
- Information about errors & injuries is essential to future prevention;
- Inaccurate & counter-productive to blame individual practitioners for patient injury.

Law Frames the Issues

- Legal liability as a means to hold wrongdoer to account;
- Individualized focus on personal responsibility and fault / deficiencies;
- Law forms backdrop to decisions & actions of health care providers, institutions, patients & regulatory bodies; this affects uptake of patient safety approach.

The Study

- “Patient Safety, Medical Error and Tort Law: An International Comparison”, online at: http://www.osgoode.yorku.ca/faculty/Gilmour_Joan_M.html
- 5 country review: Can., U.S., Eng., Aus., N.Z. Why these? All common law (except Que.) & similar currency of patient safety approach;
- Goal: Assess tort reforms & “fit” with pt. safety.

Findings (Patient Safety)

- Common themes, tensions & solutions across countries; generally value external oversight (eg. error reporting), but not via legal proceedings;
- Common critiques of tort system & law: (i) inappropriate individual blame; (ii) chills disclosure;
- BUT lack of public acceptance of patient safety prescriptions; concerns re accountability & preventing self-protectionism;
- Unresolved tensions: individ. & systemic accountability.

Findings (Tort Law)

- Tort system achieves none of its 3 primary goals (compensation, accident avoidance, corrective justice) well;
- BUT support for medical liability system continues in some quarters, including public;
- Prospect of tort liability has on occasion acted as effective incentive to improve safety.

Tort Reform and Patient Safety

- Tort reform has largely aimed at reducing size & risk of judgments, not improving patient safety (tho' see now UK - *NHS Redress Act*);
- Some qualified privilege legislation (i.e. protecting information from disclosure in legal proceedings) is aimed at both; little empirical evidence of effects.

Canada

- Significant incidence of adverse events (AE's) causing patient harm (R Baker, P Norton et al., *CMAJ* 2004; 170: 1678-89);
- Not all AE's = negligence; some do;
- Medical malpractice litigation remains infrequent and declining in Canada;
- Access to civil justice system problematic, but little impetus for significant reform.

Canada (con't.)

Have been some developments:

- Wider acceptance *must* disclose harm to pts.;
- Some law reform (provinces vary), eg.
 - Qualified privilege legislation (all; terms vary);
 - Mandatory reporting critical incidents (eg. Sask., Man., Que.);
 - Complaints processes mandated for health authorities (eg. Alta., B.C., Que.);
 - Apology laws.

Making Litigation Count for Patient Safety: Working Within the System

- Use info from legal proceedings as learning resource; disseminate;
- Tie expansions in qualified privilege to demonstrated compliance with error reporting & pt disclosure requirements; sunset clause;
- Enterprise liability (align incentive to take care with organization having power to make changes).

Law Reforms That Go Further

- Expanded complaints mechanisms as an alternative to litigation (internat'l models, eg. Aus., England *NHS Redress Act*);
- Capacity to address complaints about system of care, not just individual providers;
- Leverage existing governmental subvention & tie to patient safety participation by MDs, hospitals, institutions.

Moving to a New System: Considering No-Tort or No-Fault

- Examples exist, eg. NZ (30+ years with comprehensive no-tort system); or (limited) Que., US, UK (vaccine); Fla & Va (birth injuries); Can. (tainted blood);
- Need to determine goals, scope, benefit levels; eligibility; funding; costs;
- Reasons for underclaiming & undercomplaining in NZ even with no tort?

Patient Safety and Accountability

- Whether fault-based or no-fault, MUST ensure accountability for (i) safe, quality care, and (ii) adequate compensation;
- Professional regulation will be increasingly important;
- New challenges posed by collaborative care;
- Include patients in solutions; public trust in safe, quality care & adequate compensation for preventable injuries are key to acceptance of reduced focus on fault.

Concluding Observations

Cautionary notes:

- Highly politicized nature of health care system affects commitment to systemic analysis;
- Especially when harm is serious, neither patients nor politicians necessarily accept systemic analysis;
- Empirical evidence that patient safety advocates' prescriptions are effective is lacking;
- Little political will for radical law reform.
