Patients, Politics, Medicine and the Law

IMO

Rhona Mahony MD,
Ireland East




CLAIMS PORTFOLIO AT END 2018

3,196
Clinical Claims

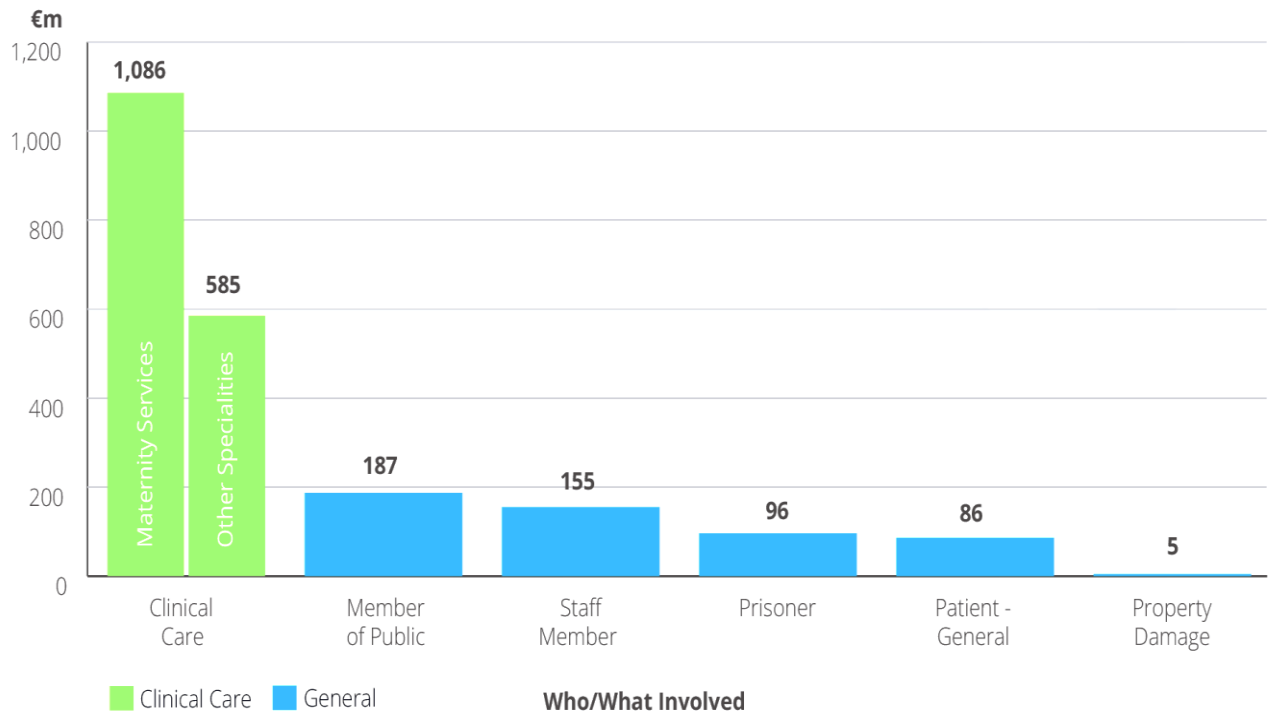
7,462
General Claims

€2.33bn
Clinical Claims - Est. Outstanding Liability

€0.82bn
General Claims - Est. Outstanding Liability

5 *The Court of Appeal held that the RRR in respect of the calculation of future care-related special damages should be 1%. It also held that the RRR in respect of all pecuniary losses should be 1.5%. The RRR used previously to calculate the estimated outstanding liability was 3%.*

Breakdown of Estimated Outstanding Liability for Active Claims at End-2016



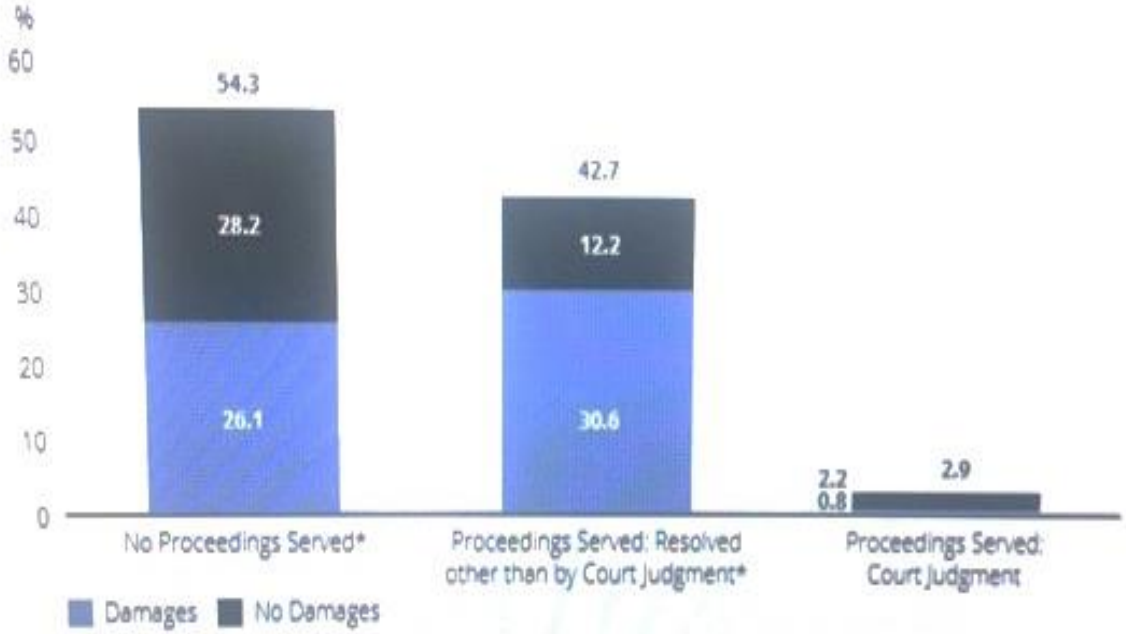
Cost of Claims Resolved 2012-2016

Clinical Claims	2012 €000	2013 €000	2014 €000	2015 €000	2016 €000
Cost for All Claims Resolved					
Awards/Settlements	35,357	35,974	44,726	44,467	53,018
Legal Fees - SCA	8,637	9,503	8,861	8,712	8,635
Legal Fees - Plaintiff	12,964	15,410	13,853	15,592	17,633
Other	963	1,247	1,188	1,511	1,707
Total	57,921	62,135	68,628	70,283	80,993

COSTS OF CLINICAL CLAIMS RESOLVED

	2017 €	2018 €	Change %
Awards/Settlements	87,984,249	179,906,664	104
Legal Fees - Plaintiffs	28,007,666	41,197,915	47
Legal Fees - SCA	15,634,410	21,725,989	39
Other	2,887,984	4,068,869	41
Total	**134,514,309**	**246,899,438**	**84**

CLAIMS RESOLVED 2018



*Includes cases settled, cases discontinued or claim statute barred, and indemnity received.

Figures may not total due to rounding.

Tithe an Oireachtais

An Comhchoiste um Shláinte agus Leanaí

Tuarascáil ar an gCostas a bhaineann le hÁrachas Slánaíochta Liachta

Meitheamh 2015

Houses of the Oireachtas

Joint Committee on Health and Children

Report on the Cost of Medical Indemnity Insurance

June 2015

CIS Claims resolved from 2008-2014.

- The total cost of medical legal claims increased by 221% (from €21.7m to €69.68m)
- Total awards paid out increased by 304% (from €10.99m to €44.43m)
- Legal costs for the State Claims Agency increased by 113% (from €4.3m to €9.3m)
- Legal costs for claimants during the same period increased by 169% (from €5.46m to €14.6m)
- **The average award paid out increased from €37,000 to €90,000 in the same period**
- Average legal fees for the State Claims Agency increased from €15,000 in 2008 to €28,000 in 2013, falling to €19,000 in 2014
- Average Plaintiff legal fees increased from €18,000 in 2008 to €46,000 in 2013, falling to €30,000 in 2014.

KEY ISSUES

MEDICAL INSURANCE

- The number of Irish clinical negligence claims and size of awards to victims have been increasing over recent years.
- The costs of purchasing medical indemnity insurance have also risen dramatically. If this trend continues it is likely that more consultants will leave whole-time private practice, putting added pressure on the public system.
- There is a need to ensure the sole remaining medical insurer for Irish consultants remains in the Irish market for the foreseeable future.
- This issue represents a strategic risk for the healthcare system.

LEGAL ISSUES NOTED

- The *adversarial* nature of the Irish medico-legal system.
- Relatively high legal costs as a proportion of medical claims.
- Undue delays in processing medical negligence claims.
- The cause of the increase claims in Ireland is disputed by stakeholders, but all agree that a faster resolution of claims is preferable, less costly and better for the healthcare system.
- There is some common ground between stakeholders, namely in placing greater emphasis on alternative dispute resolution mechanisms, pre-action protocols and periodic payment orders (PPOs).

Obstetric Medical Negligence

Cerebral Palsy

Everything Else

“A group of permanent disorders of the development of movement and posture, causing activity limitation that are not attributed to progressive disturbances that occurred in the developing fetal or infant brain”

Rosenbaum et al 2006

The Dunne Case

Little WJ. (1862) “On the influence of abnormal parturition, difficult labours, premature birth and asphyxia neonatorum on the mental and physical condition of the child.”

Freud. (1897) “Infantile cerebrallhmung”

The major cause of cerebral palsy and mental retardation was

intrapartum “ brain damage”

What is the contribution of Asphyxia to Cerebral Palsy in Term Infants?

Causation of Cerebral Palsy- The legal explanation

Cerebral Palsy often results from hypoxia, which is effectively starvation of oxygen/oxygenated blood, causing damage to the brain and consequently physical and sometimes intellectual disabilities.

Whilst Cerebral Palsy may occur without negligence, it is certainly true also to say that in many instances a mother's pregnancy, labour and delivery or the baby's immediate post natal care can be handled poorly by Obstetric and Midwifery staff or Paediatricians.

Examples of such common complications include failure of medical personnel to deal competently with an abnormal CTG trace (which shows the baby's heart rate and the mother's contractions)

In those circumstances, the injury to the baby's brain could often have been avoided completely, or at least very significantly reduced, had competent medical treatment been given.

A certain Irish solicitors website 10.04.2019

Contribution of Labour and Delivery to Cerebral Palsy	CP
Obstet Gynecol. 2013 Oct;122(4):869-77. **Antecedents of cerebral palsy and perinatal death in term and late preterm singletons.** McIntyre S[1], Blair E, Badawi N, Keogh J, Nelson KB.	small
Clin Obstet Gynecol. 2008 **Causative factors in cerebral palsy.** Nelson KB.	12.6%
J Obstet Gynaecol Can. 2008 May;30(5):396-403. **How often do perinatal events at full term cause cerebral palsy?** Menticoglou SM	0.55/1,000
Am J Dis child 1991;145:1325-31. **How much of encephalopathy is due to birth asphyxia .** Nelson and Leviton.	Small
Paediatr Perinat Epidemiol. 1995 Apr;9(2):156-70. **Assessing the contribution of birth asphyxia to cerebral palsy in term singletons.** Yudkin PL[1], Johnson A, Clover LM, Murphy KW	20%
Clin Perinatol. 1989 Dec;16(4):995-1007. **Relationship of intrapartum and delivery room events to long-term neurologic outcome.** Nelson KB	Small

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Prenatal Factors in Singletons with Cerebral Palsy Born at or near Term

Karin B. Nelson, M.D., and Eve Blair, Ph.D.

2015 NEJM

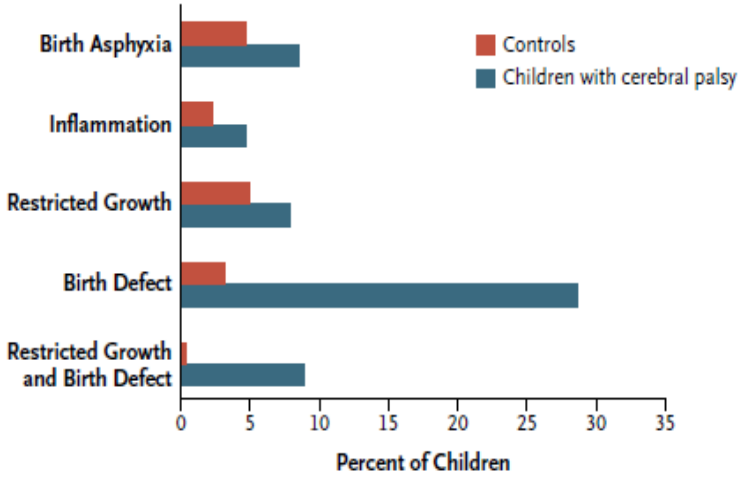
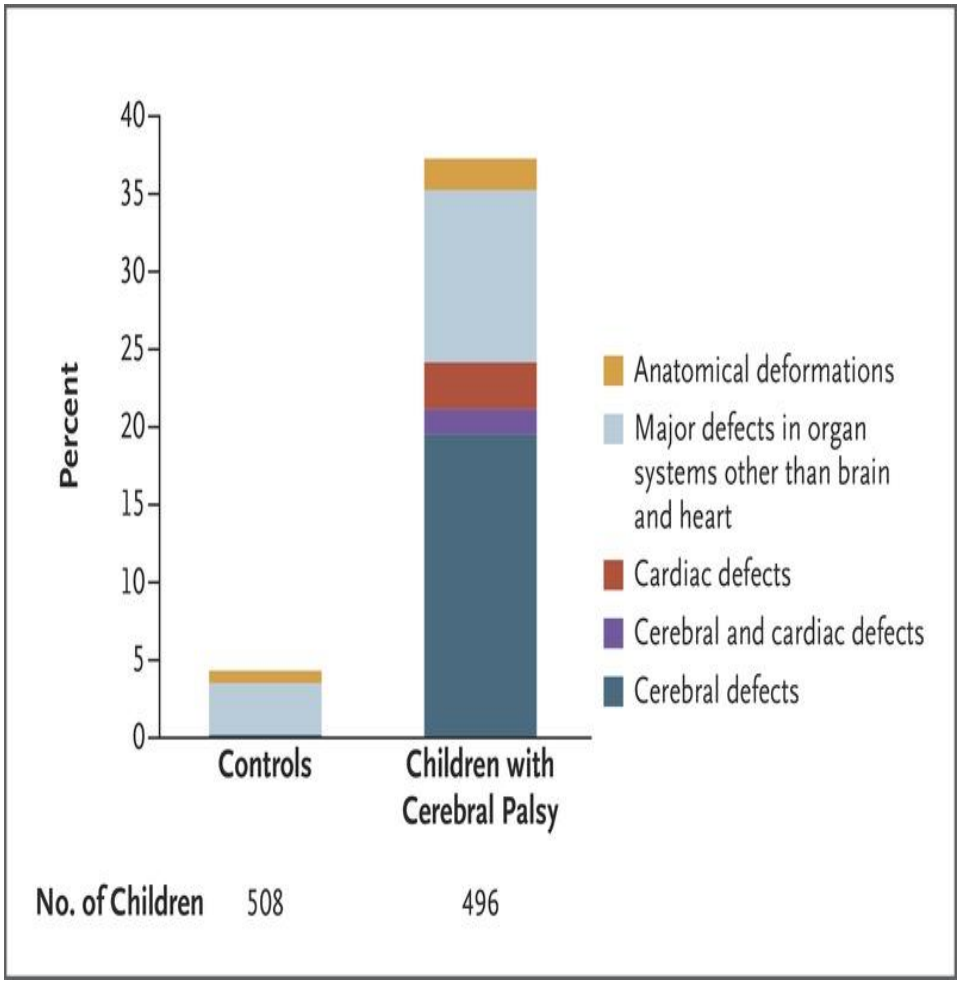


Figure 2. Distribution of Four Major Risk Factors in Singleton Children with Cerebral Palsy Born at a Gestational Age of at Least 35 Weeks, 1980–1995.

Data are from a study of 496 children with cerebral palsy and 508 controls. The four risk factors were a potentially asphyxiating intrapartum event, evidence of inflammation, fetal growth restriction (defined as a birth weight that was more than 2 SD below the optimal weight for gestation, sex, maternal height, and parity, or a neonatal diagnosis of fetal growth restriction), and a major birth defect. Data shown are for one or more of these risk factors in at least 2% of children with cerebral palsy or controls. Major birth defects were the most frequently occurring risk factor in children with cerebral palsy, and when combined with fetal growth restriction, they were associated with the highest relative risk.


40
35
30
25
20
15
10
5
0
Percent
Controls
Children with Cerebral Palsy
Anatomical deformations
Major defects in organ systems other than brain and heart
Cardiac defects
Cerebral and cardiac defects
Cerebral defects
No. of Children
508
496

Aetiology of CP

- **Disordered developmental processes**

- Birth Defects: Cerebral and cardiac anomalies most frequent associations. Congenital microcephaly is the commonest associated structural anomaly.
- Fetal growth restriction
- Thrombotic states
- Placental conditions
- Genetic factors

Nelson, 2015, NEJM

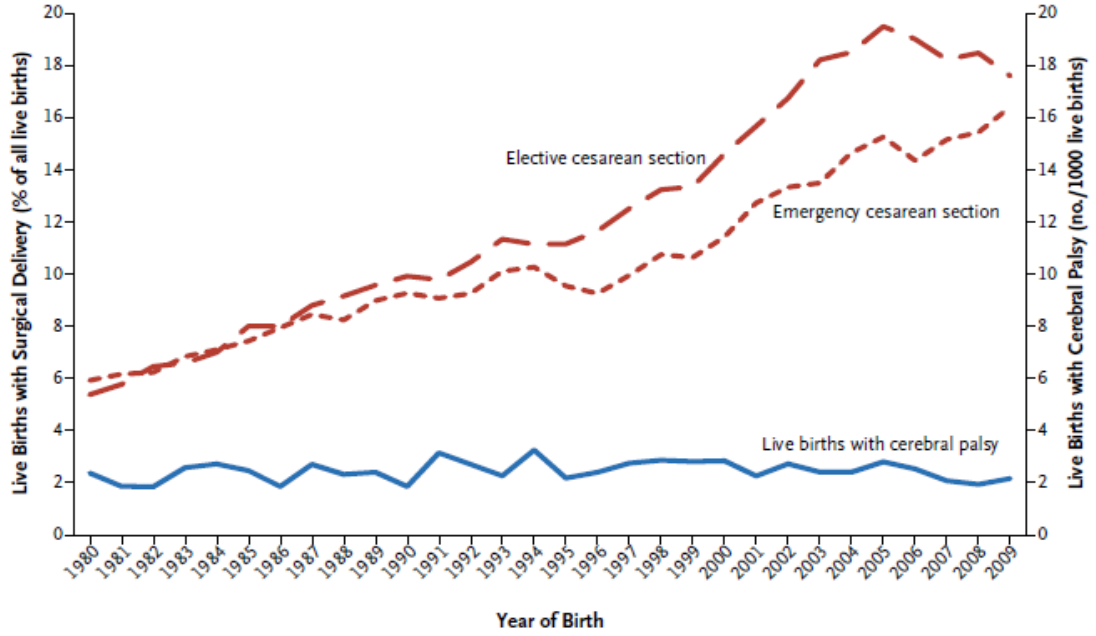
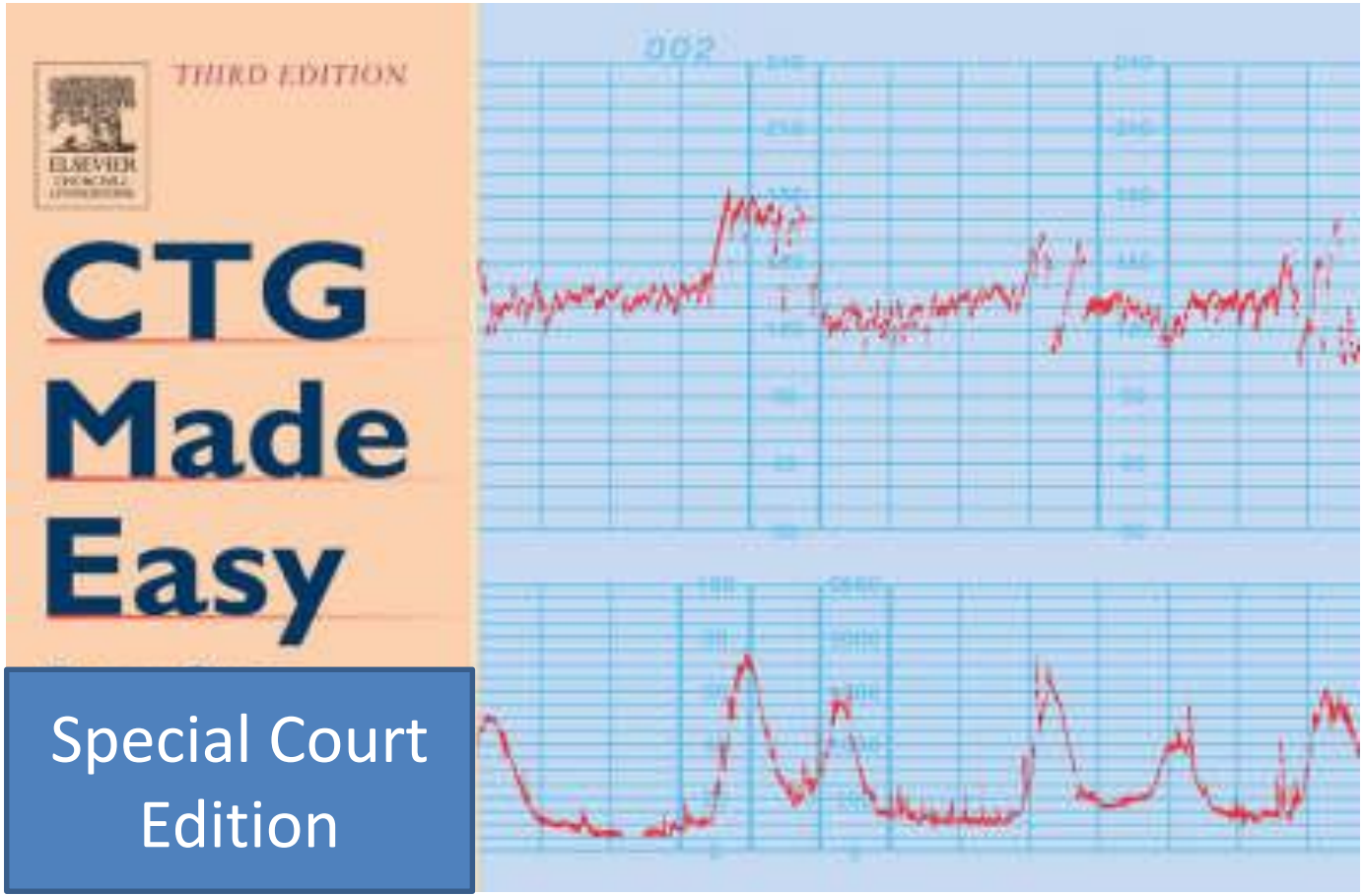
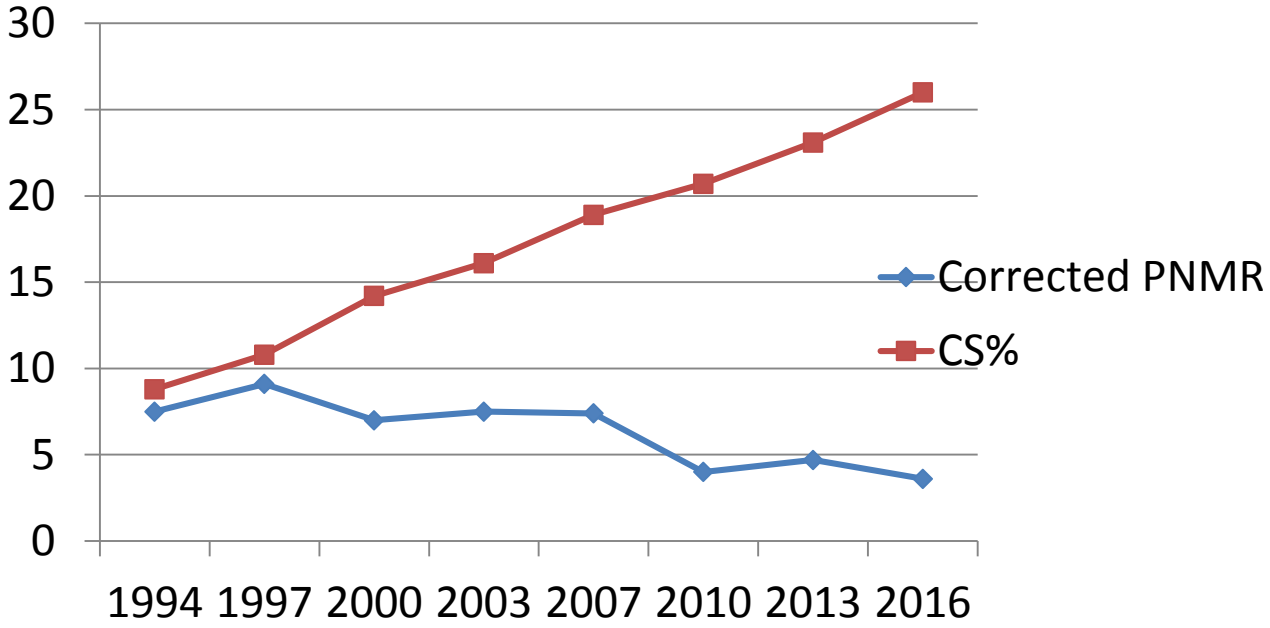


Figure 1. Elective and Emergency Cesarean Sections and Live Births with Cerebral Palsy in Western Australia, 1980–2009.

Shown are the proportions of live births with delivery by elective cesarean section before the onset of labor or membrane rupture and without induction, live births with delivery by emergency cesarean section (with the timing determined by an arising complication), and all live births with cerebral palsy. The increasing proportions of both elective and emergency cesarean deliveries since 1980 have not been accompanied by any change in the proportion of live births with cerebral palsy.


THIRD EDITION
CTG
Made
Easy
Special Court
Edition



Corrected PNMR vs. Rate of Caesarean Section (CS) 1994-2016

No change in prevalence of term CP

Temporal and demographic trends in cerebral palsy-fact or fiction

"No data exist in the entire medical literature to demonstrate that intervention based on any single or combination of FHR patterns reduces the risk of CP"

Clark and Hankins Am J Obstet Gynecol 2003;188:628-33

Temporal and demographic trends in cerebral palsy-fact or fiction

“ A test leading to an unnecessary major abdominal surgery in more than 95% of cases should be regarded by the medical community as absurd at best”

Clark and Hankins Am J Obstet Gynecol 2003;188:628-33

In the past, assumptions about an asphyxial cause of cerebral palsy have led to an increase in surgical deliveries, harmed maternity services,[80] and blinkered research. It is now evident that in advantaged countries, most cases of cerebral palsy in term or near-term neonates must have other explanations. Clinical investigations allied with research in genetics and genomics, teratology, and developmental neuroscience are likely to lead to a greater understanding of cerebral palsy and other neurodevelopmental disorders.

“The American College of Obstetricians and Gynecologists, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Society of Obstetricians and Gynaecologists of Canada have acknowledged that there are no long-term benefits of EFM [electronic fetal monitoring] as currently used.” 2014

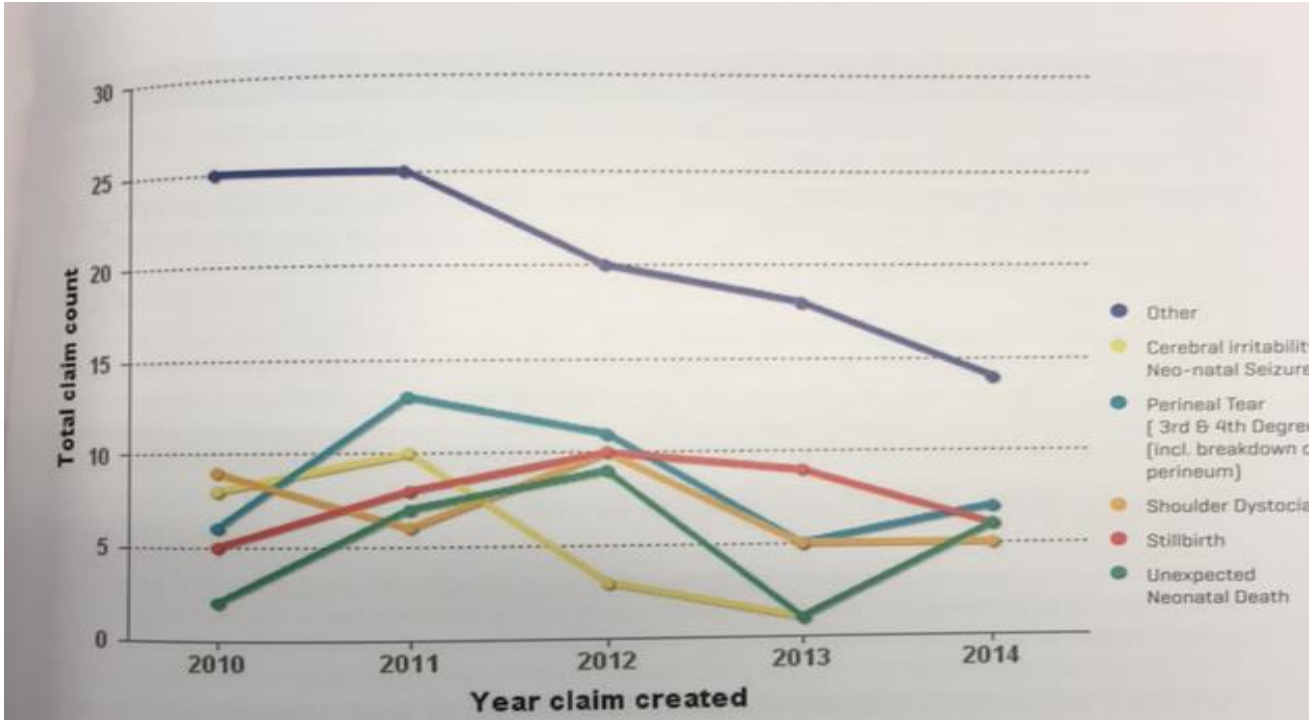
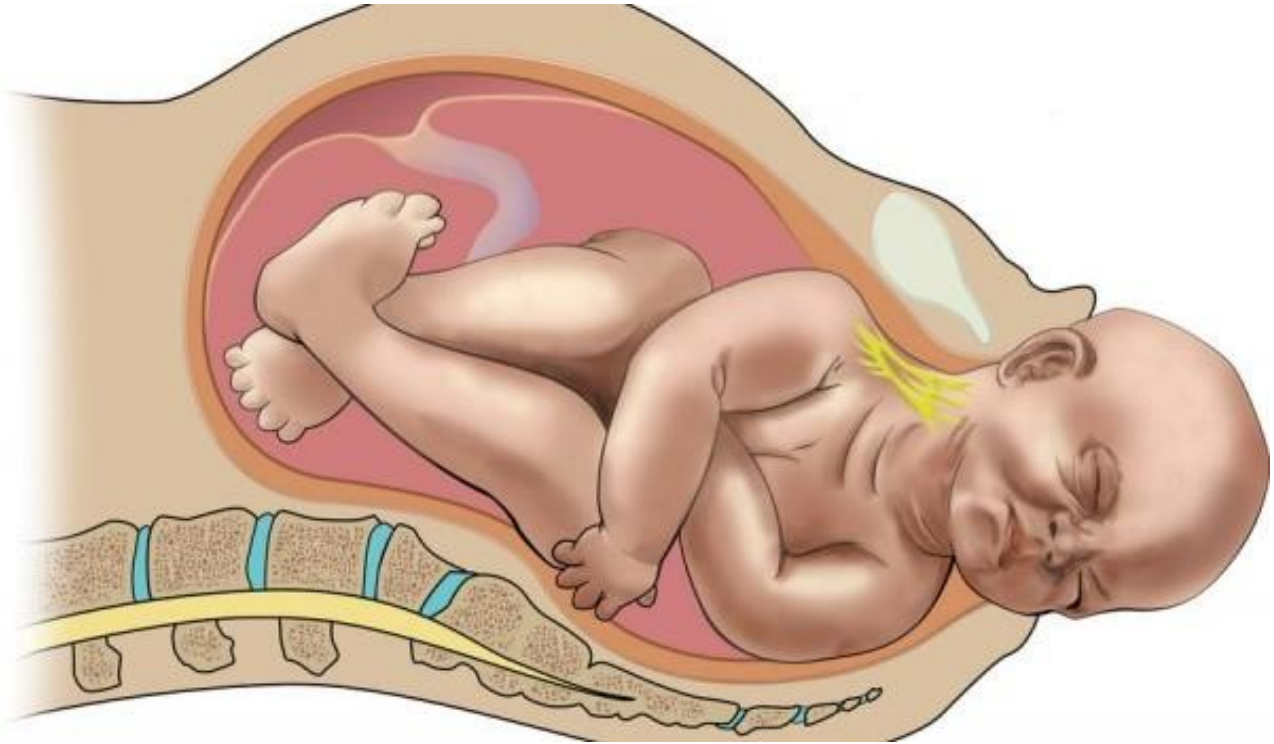
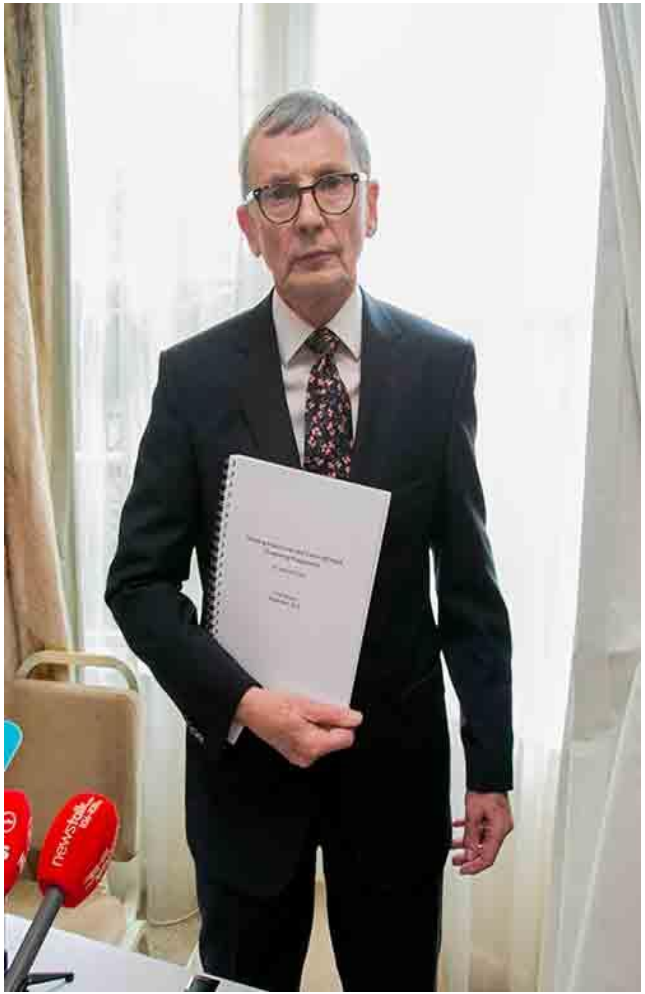


Figure 14: Six most common claims created in Maternity services tracked over 5 years 2010-2014 inclusive, categorised by claim type, excluding mass actions




CervicalCheck
THE NATIONAL CERVICAL SCREENING PROGRAMME




National Patient Experience Survey
RTÉ

15 Summary of Recommendations

Method of Approach

1) The Department of Health and the HSE should revise their policies in respect of document management. This should ensure that good quality records are created and maintained which are authentic, reliable, and complete in searchable format. They should be protected and preserved to support future actions and ensure current and future accountability.

Listening to the Voices of the Women and Families Affected

2) The Minister for Health should give consideration to how women's health issues can be given more consistent, expert and committed attention within the health system and the Department of Health.

3) The Department of Health should examine the current arrangements for patients to have access to their hospital

THE HIGH COURT

BETWEEN:

THE NATIONAL MATERNITY HOSPITAL
Applicant

AND

THE MINISTER FOR HEALTH
Respondent

AFFIDAVIT OF RHONA MAHONY

The Human Cost

Human Error

System Failure

Wilful Misconduct

"...the consequence of an adversarial litigious system is that doctors will often practise defensively, such as ordering more diagnostics or treatment than necessary, or they may avoid treating certain high-risk patients."

Professor Trevor Duffy IMO

Figure 1: Progression of a clinical negligence claim in Ireland

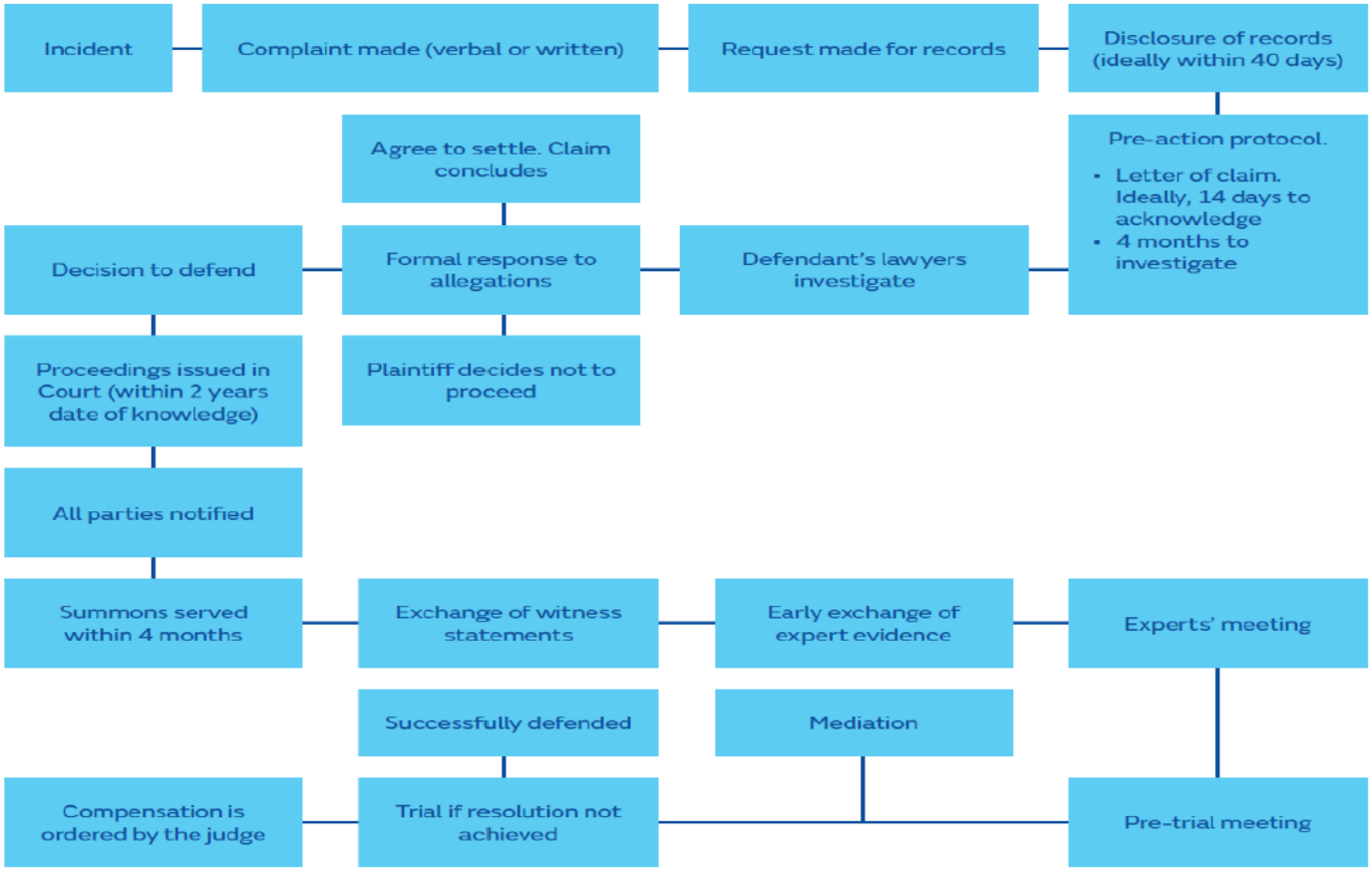
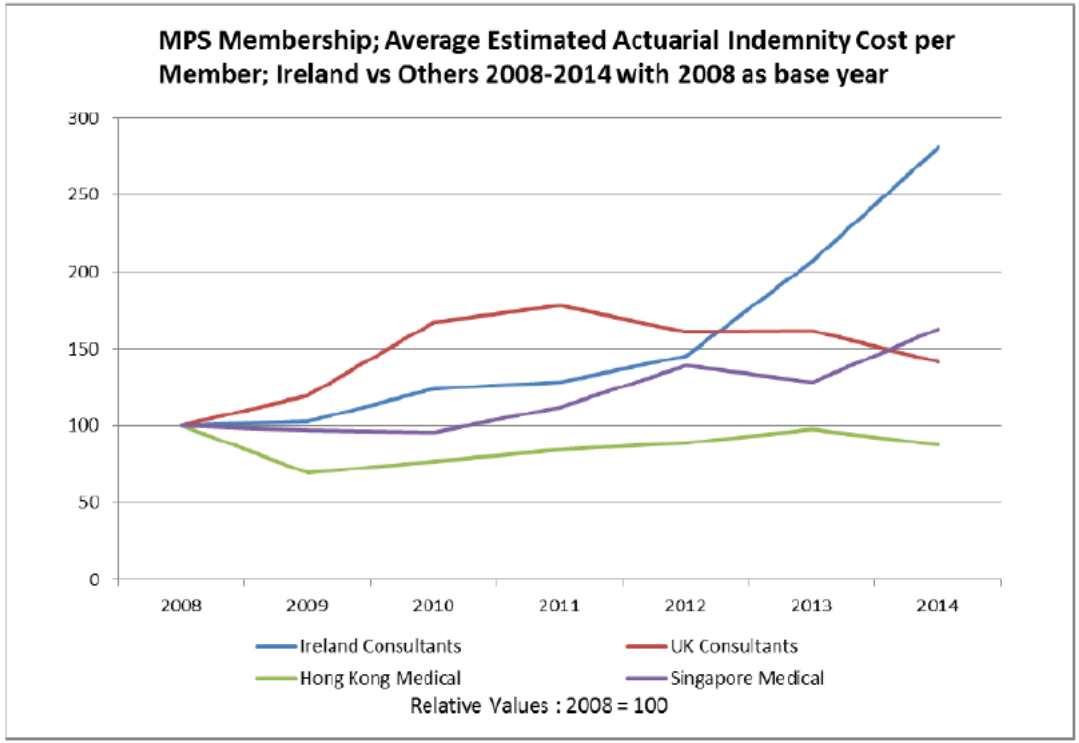


Figure 4: Average estimated actuarial indemnity cost per member: Ireland, UK, Hong Kong and Singapore



Source: MPS (2015)

World J Surg
DOI 10.1007/s00268-013-2324-y

World Journal of Surgery

Shortage of Doctors, Shortage of Data: A Review of the Global Surgery, Obstetrics, and Anesthesia Workforce Literature

Marguerite Hoyler · Samuel R. G. Finlayson · Craig D. McClain · John G. Meara · Lars Hagander

Abstract

Introduction The global surgery workforce is in crisis in many low- and middle-income countries (LMICs). The shortage of surgery, obstetrics, and anesthesia providers is an important cause of the unmet need for surgical care in LMICs. The goal of this paper is to summarize the available literature about surgical physicians in LMICs and to describe ongoing initiatives to supplement the existing surgical workforce data.

Methods We performed a systematic search and literature review of the English-language literature regarding the number of surgeons, obstetrician–gynecologists, and anesthesiologists practicing in LMICs.

Results Literature describing the number of surgeons, obstetricians, and anesthesiologists practicing in LMICs represents a small minority of LMICs, and indicates consistently low levels of surgical physicians. Our literature search yielded comprehensive data for only six countries. No national data were found for 23 of the 57 countries considered by the World Health Organization (WHO) to be in health workforce 'crisis.' Across LMICs, general surgeon density ranged from 0.13 to 1.57 per 100,000 population, obstetrician density ranged from 0.042 to 12.5 per 100,000, and anesthesiologist density ranged from 0 to 4.9 per 100,000. Total anesthesiologist, obstetrician, and surgeon density was significantly correlated with gross domestic product (GDP) per capita ($r^2 = 0.097$, $p = 0.0002$).

Conclusion The global surgery workforce is in crisis, yet is poorly characterized by the current English-language literature. There is a critical need for systematically collected, national-level data regarding surgery providers in LMICs to guide improvements in surgery access and care. The Harvard Global Surgery Workforce Initiative and the WHO global surgical workforce database are working to address this need by surveying Ministries of Health and surgical professional organizations around the world.

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Introduction

A lack of trained surgical providers is among the most significant barriers to essential surgical care worldwide [1–5]. Indeed, the World Health Organization (WHO) has determined that 57 low- and middle-income countries (LMICs) are in dire healthcare human crisis [6, 7], and research indicates that surgeons, obstetricians, and anesthesiologists tend to be particularly scarce [8–10]. In sub-

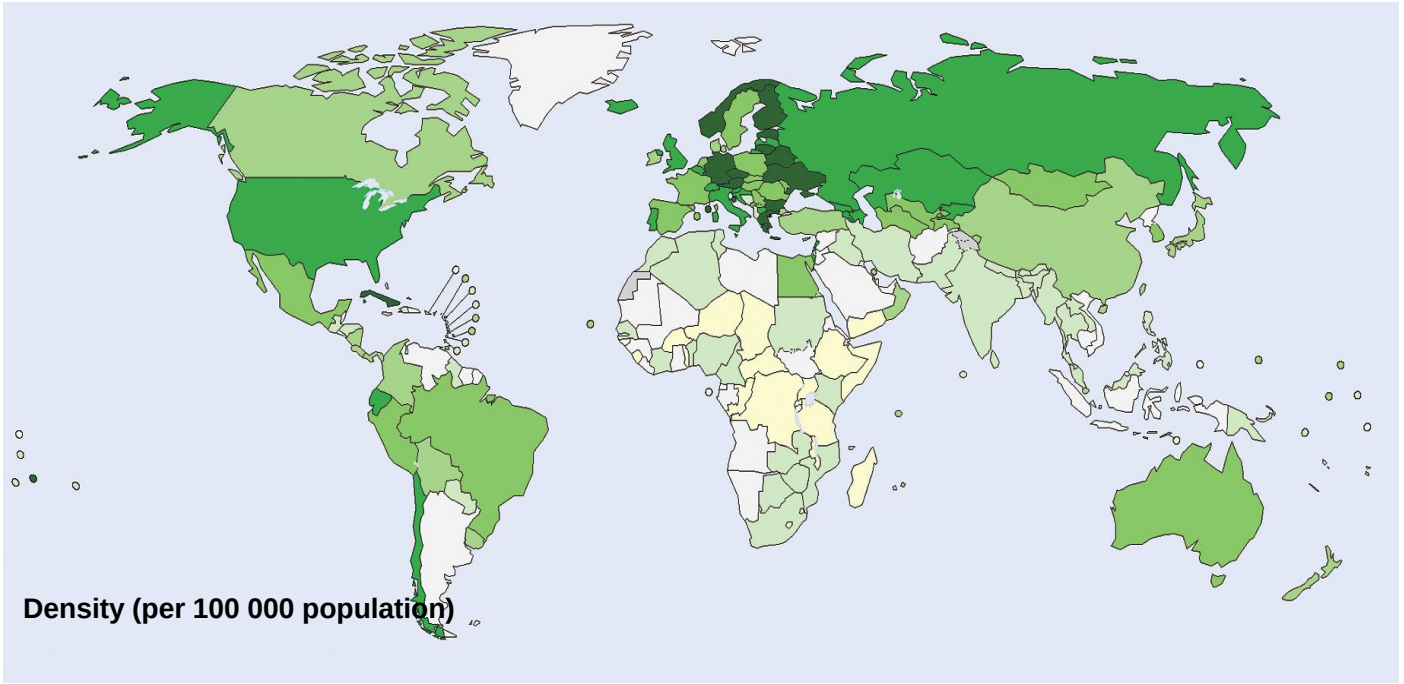

Figure: Global distribution of surgeons, anaesthesiologists, and obstetricians, per 100 000 population

TABLE 1: Summary of actions proposed by stakeholders to address rising medical indemnity insurance costs

ACTION	Groups who recommend this	Stakeholder groups that disagree with proposed actions
Reduce indemnity caps	IHCA, MPS	
Provide indemnity cover to private hospital consultants through the State Claims Agency	IHCA (subject to prior consultation)	
Adopt Pre-action protocols	LSI, Bar Council of Ireland, IMO, IHCA, MIA and MPS	
Introduce a no-fault claims system	IMO	MPS[6]
Promote alternative dispute resolution (ADR) mechanisms	IMO, Bar Council of Ireland, MIA	
Better resource the health service	IMO, LSI	
Introduce tighter limitation periods for personal injuries	MPS, IMO	Bar Council of Ireland, LSI, MIA
Introduce periodic payment orders (PPOs)	Bar Council, LSI, SCA, MIA	
Introduce a statutory duty of candour/open disclosure	IMO, Bar Council of Ireland, LSI, MIA, MPS, SCA	
Place a tariff on general damages	MPS	MIA
Place a cap on general and special damages	MPS	Bar Council of Ireland, LSI, MIA
Realign legal fees in proportion to the size of the claim	MPS	
Introduce a certificate of merit	MPS, IMO	Bar Council of Ireland MIA

Stakeholder key: *Irish Hospital Consultants Association (IHCA), Irish Medical Organisation (IMO), Law Society of Ireland (LSI), Medical Injuries Alliance (MIA), Medical Protection Society (MPS), State Claims Agency (SC*