



**Tithe an  
Oireachtais  
Houses of the  
Oireachtas**

**Tithe an Oireachtais**

**An Comhchoiste um Shláinte agus Leanáí**

**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**

**31HHCN20**





**Tithe an  
Oireachtais  
Houses of the  
Oireachtas**

**Tithe an Oireachtais**

**An Comhchoiste um Shláinte agus Leanáí**

**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**



## Table of Contents

<b>CHAIRMAN’S PREFACE .....</b>	<b>5</b>
<b>31<sup>st</sup> Dáil Members of the Joint Committee on Health and Children .....</b>	<b>7</b>
<b>Summary .....</b>	<b>9</b>
<b>MAIN CONCLUSIONS AND RECOMMENDATIONS .....</b>	<b>15</b>
<b>1. Introduction .....</b>	<b>18</b>
<b>2. Overview of medical indemnity insurance and the State’s Clinical Indemnity Scheme (CIS) .....</b>	<b>20</b>
<b>3. The challenge of rising medical indemnity insurance costs and the impact on healthcare in Ireland.....</b>	<b>25</b>
<b>4. What can be done to make medical indemnity insurance more affordable? Actions considered by stakeholders .....</b>	<b>32</b>
<b>5. Patients’ concerns regarding medical negligence claims .....</b>	<b>47</b>
<b>Appendix 1 References .....</b>	<b>49</b>



## CHAIRMAN'S PREFACE



The Joint Committee on Health and Children identified medical indemnity insurance costs as a strategic challenge for the health sector. It has been suggested that the cost of medical indemnity insurance is becoming prohibitively expensive for many medical consultants, causing them to leave full-time private practice. Adverse medical events are traumatic for patients, families, and medical professionals alike. The costs involved could also be better spent on improving patient services.

For this reason, our Committee took evidence from stakeholders to assess the potential impact of rising costs on future provision of services. It examined international best practice to look at ways to improve the patient experience and to reduce the cost of medical negligence. It heard from patients and advocates who underlined the need to prioritise patient safety. The report places a strong emphasis on open disclosure in the health service. It makes a number of broad recommendations to improve the treatment of patient complaints. This, in turn, should help to reduce levels of avoidable claims and associated costs.

Following meetings with stakeholders, and having considered secondary research by the Houses of the Oireachtas Library & Research Service, the Committee prepared this report. Written submissions were also received from members of the public, whose input helped to inform the debate.

## Joint Committee on Health and Children

I would like to thank the following stakeholders who contributed to Committee discussions:

- The Medical Protection Society
- The Law Society of Ireland
- The Bar Council of Ireland
- The Irish Hospital Consultants' Association
- The State Claims Agency
- The Medical Injuries Alliance
- The Irish Medical Organisation

This Report is based on Committee hearings held in January 2015. However, it should be noted that a number of recommendations on patient safety and the handling of complaints also take into account more recent Committee hearings held in May 2015.

Given the nature of the topic discussed, it is inevitable that the report considers a number of legal matters. In order to avoid a 'siloes' approach to policy, a number of general comments on legal issues are included in the Committee's recommendations for further progression elsewhere. The Committee will forward a copy of this report to the Ministers for Health and Justice and Equality, and to the Joint Oireachtas Committee on Justice, Defence and Equality, for consideration.

On behalf of the Committee I wish to re-iterate my support for the hard-working staff of the Irish health service. There is also a strong need to learn from the patient experience as outlined to this Committee, to improve patient safety and health outcomes in general.

I would also like to express my appreciation to the Members of the Joint Committee, and for the support of the Oireachtas Library and Research Service, and the Committee Secretariat for their ongoing assistance.



---

**Jerry Buttimer, T.D.**  
**Chairman**  
**Joint Committee on Health and Children**



## Joint Committee on Health and Children

### 31<sup>st</sup> Dáil Members of the Joint Committee on Health and Children

			
<b>Catherine Byrne TD</b> (Fine Gael)	<b>Ciara Conway TD</b> VICE CHAIR (Labour)	<b>Regina Doherty TD</b> (Fine Gael)	<b>Clare Daly TD</b> (Independent)
			
<b>Peter Fitzpatrick TD</b> (Fine Gael)	<b>Seamus Healy TD</b> (Independent-WUAG)	<b>Billy Kelleher TD</b> (Fianna Fáil)	<b>Eamonn Maloney TD</b> (Labour)
			
<b>Sandra McLellan TD</b> (Sinn Féin)		<b>Michael McNamara TD</b> (Labour)	
			
<b>Mary Mitchell O'Connor TD</b> (Fine Gael)	<b>Dan Neville TD</b> (Fine Gael)	<b>Caoimhghín Ó Caoláin TD</b> (Sinn Féin)	<b>Robert Troy TD</b> (Fianna Fáil)

## Joint Committee on Health and Children

			
<b>Senator Colm Burke (Fine Gael)</b>	<b>Senator Thomas Byrne (Fianna Fáil)</b>	<b>Senator John Crown (Independent)</b>	<b>Senator John Gilroy (Labour)</b>

	
<b>Senator Imelda Henry (Fine Gael)</b>	<b>Senator Jillian Van Turnhout (Independent)</b>

## Summary

### Medical indemnity insurance in Ireland

Medical indemnity systems serve three related purposes:

- Covering the liabilities of medical practitioners and health organisations;
- Compensating victims of injuries sustained from medical procedures; and
- Deterring medical malpractice.<sup>1</sup>

Through the Clinical Indemnity Scheme (CIS) the State Claims Agency (SCA) manages all clinical negligence claims taken against healthcare enterprises, hospitals and healthcare practitioners covered by the scheme. Consultants working in whole-time private practice are not covered under the CIS. These consultants typically obtain medical indemnity insurance from medical defence organisations, such as the Medical Protection Society (MPS).

In recent years Ireland has experienced an increase in the size and number of clinical negligence claims borne by the State:<sup>2</sup> The SCA told the Committee that they currently have 2,840 current clinical claims under management, with an estimated contingent liability of €1.159 billion in respect of those claims.

---

<sup>1</sup> Toh et al. (2009). Medical indemnity - who's got the perfect cure? Accessed on 19<sup>th</sup> March 2015 at [http://www.actuaries.asn.au/Library/ACS09\\_Paper\\_Toh%20et%20al..pdf](http://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf)

<sup>2</sup> Source: Statistics provided by Medical Protection Society and State Claims Agency.

### 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.

The SCA point out that the large increase in the number of claims is affected by the lag effect of 2,500 consultants, whose claims were previously handled by medical defence organisations, coming into the claims system.

The trends outlined above are also attributed to several factors including: resource constraints; an increase in legal fees; an increase in the cap on general damages from €325,000 to €450,000 for catastrophic injuries; and claims of a defensive culture in the health sector.

In recent years, medical indemnity costs for Irish private consultants working in high-risk specialities such as obstetrics, orthopaedics and neurosurgery have risen dramatically. MPS report that actuarial estimates of the cost of indemnity per member are increasing by more than 90%.<sup>3</sup>

MPS claim that these cost increases are due to the rate at which hospital consultants are being sued, and the scale of compensation claims paid out.

---

<sup>3</sup> Medical Protection Society, "*Challenging the Cost of Clinical Negligence: the Case for Reform*", 2.

## Joint Committee on Health and Children

However, the Committee was not provided with sufficient evidence to conclusively examine the linkage between litigation cases and premia charged.

The cost of subscriptions has meant that, in some specialities, it is no longer affordable to work in private practice. In Ireland, more than 40% of all non-emergency operations are carried out privately each year. **There is a concern that if private consultants close their practices, there will be knock-on effects for the public system, as it absorbs these extra patients.**

Other jurisdictions faced similar problems. Australia and the USA both introduced reforms aimed at curbing the rise in medical indemnity insurance costs. These reforms consist of changes in tort law, combined with transparency measures and increased use of alternative dispute resolution mechanisms (ADR).

Of course, reforms appropriate for one country may not be appropriate for another. Nevertheless, it is appropriate for the Health Committee to consider whether various reforms would be effective in an Irish context.

Some patients and the Medical Injuries Alliance (MIA) also wrote to the Committee to express dissatisfaction with a protracted legal process and with the level of information available to them, where a medical error is thought to occur.

In examining medical negligence, it is important to acknowledge the difficult task facing doctors, nurses and midwives. In certain areas of medicine, the likelihood of a problem occurring with a procedure, or clinical treatment, are quite high. As Professor Duffy pointed out in Committee hearings, mistakes can occur without intentional negligence on the part of medical teams:

*“Rarely is harm due to wilful misconduct. Most often, harm is due to systems failure or unintentional human error... Fear of litigation is a major barrier to frank apology and communication with patients following an adverse event, and health care staff are often the second victims of such events... Rather than focusing on apportioning blame, open disclosure policies should support patients and doctors and focus more on learning from adverse events in order to reduce harm and improve patient safety.*

## Joint Committee on Health and Children

For patients, adverse medical events can be traumatic, but it should be recognised that the litigation process is difficult for both sides, and can also have an extremely negative impact on medical staff.

A summary of proposed actions is provided in Table 1 (page 12). Some actions, such as the adoption of pre-action protocols, the introduction of a statutory duty of candour and Periodic Payment Orders, were recommended by most stakeholders. Others, such as tighter limitations periods on claims for personal injuries and placing a cap on damages, proved more divisive.

Groups representing patients and doctors stated that full implementation of an open disclosure policy would reduce the number of negligence claims, as it would allow medical practitioners to give patients the answers they require, without having to resort to the courts. Both patient advocates and medical professionals were also in favour of a greater use of alternative dispute resolutions, such as mediation.<sup>4</sup>

Recent Committee sessions (held on May 19<sup>th</sup> 2015) to examine patient safety in maternity services in Portlaoise highlighted the lack of a national advocacy service, and patient dissatisfaction with the manner in which complaints were handled. During the discussions, Deputy Kelleher stated that:

*“This committee has previously discussed the question of developing transparent policies for dealing with patients who have had adverse interactions with the HSE. These policies do not seem to be progressing.”*

The Committee also noted the Ombudsman’s report, *Learning to Get Better*<sup>5</sup>, which stresses the need to improve how the health service handles complaints:

*“No organisation serving the needs of the sick, can afford not to listen, and listen carefully, to the experiences of their patients and their families. This is partly a matter of recognising the rights of patients and in part a necessity for any effective running of the service. Modern healthcare has to be a genuine partnership between patients and those who provide them with the help they need.”*

---

<sup>4</sup> <http://www.irishexaminer.com/ireland/fees-must-reflect-the-financial-era-judge-315235.html>

<sup>5</sup> <https://www.ombudsman.gov.ie/en/Publications/Investigation-Reports/Health-Service-Executive/Learning-to-Get-Better/Learning-to-Get-Better.pdf>, p. 1.

## **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).

### **OVERALL**

- Patients and advocate groups highlight the lack of an advocacy service and difficulties accessing medical information in a timely manner.
- Some proposals, particularly those which relate to tort law reform, are divisive, with doctors and insurers on one side and patients and legal professionals on the other.
- Most stakeholders support a statutory duty of candour/open disclosure as a means of creating a better relationship between doctors and patients and reducing the incidence of legal action.

## Joint Committee on Health and Children

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

<sup>6</sup> However MPS recommend that this should be further researched.



## MAIN CONCLUSIONS AND RECOMMENDATIONS

The Committee identified a number of key concerns and recommendations for the Oireachtas, the Ministers for Health and Justice, the HSE and other stakeholders. The Report also highlights strategic issues which may also need to be addressed. These may require an inter-departmental approach, or possible legislative changes.

### Rising Costs

1. The Committee is concerned with evidence confirming the extent of rising cost of medical indemnity cover for consultants in private practice.
2. For example, the Committee is aware of cases where the combination of significant premium increases and reduced private treatment payments in certain specialties render private practice unviable.
3. The Committee also received evidence of significant increases in malpractice premium for consultants moving to full-time private practice upon retirement. By way of example, in two cases the premium increased by 239 per cent and 400 per cent respectively, in spite of significant reductions in workload and risk profile.
4. As a result of increased costs, it is likely that consultants required to retire at the age of 65, will choose not to continue in private practice. It is also suggested that a younger cohort of consultants may find that it is not financially tenable to practice in Irish private hospitals.
5. The long-term implications of this trend would be significant difficulties in replacing medical expertise in certain private hospitals, with a consequent transfer of workload to public hospitals.

### Insurance Premia

6. There is no evidence to date that a consultant with a strong risk profile (or lower rate of malpractice cases) benefits from lower premium charges, or that conversely, a consultant with a history of malpractice cases is charged a higher premium. This suggests that the current structure includes a strong element of cross-subsidisation.
7. The Committee has not received a sufficiently detailed breakdown of medical indemnity premia to fully examine whether they are linked to risk levels.
8. As a general principle, the Committee is of the view that medical indemnity premia should be designed to incentivise learning, and the elimination of medical errors.

## Joint Committee on Health and Children

9. The Committee is of the view that the Minister for Health, the Irish Medical Organisation and the Medical Protection Society should consider examining ways to achieve objective 8 above by linking premia to data on consultant performance, and accredited standards of medical institutions.

### Health Service

10. The Committee noted evidence that the ratio of consultants, and general resource levels, play a contributory role in the incidence of errors.
11. A recent survey of HSE employees found that, in the last month, 45% of HSE staff witnessed workplace errors that could have hurt patients / clients.<sup>7</sup> This data underlines the need for patient safety to be made a key priority for the health service.
12. A *duty of candour* should be regarded as absolute for Irish health professionals. However, some medical professionals perceive that they may be constrained, as a result of legal and administrative interventions, from openly discussing mistakes with patients. The Minister for Health, the Minister for Justice and the Medical Council should consider measures to introduce stand-alone legislation placing an onus on health service staff to inform patients when mistakes or errors occur.
13. Allied to this, an open disclosure culture should be considered as a key reform of medical negligence in Ireland. Since 2013, the HSE has piloted an open disclosure policy in a small number of hospital sites. The Committee recommends that consideration be given to accelerating implementation of an open disclosure policy at all public hospitals.

### Legal Recommendations (for referral to the Minister for Justice, Defence and Equality)

14. Consideration is needed to implement Periodic Payment Orders (PPOs) on a priority basis. PPOs can ensure that the needs of patients requiring lifelong care are met at an early stage, improving their health outcomes. The Committee welcomes the recent publication of the heads of the Civil Liability (Amendment) Bill 2015.
15. The Committee notes the increase in medical claim costs between 2008 and 2014, which significantly exceeds the pace of inflation. The Committee is also concerned with the increase in the *average* legal costs involved.

---

<sup>7</sup> IPSOS/MRBI Survey, *Have your Say, 2014: Health Service Employee Survey*.  
<http://www.hse.ie/eng/services/news/media/pressrel/employeesurvey.html>. Accessed 17/04/2015.

## Joint Committee on Health and Children

16. The Committee recommends that consideration be given to introducing sanctions on legal representatives in cases where there is evidence of inappropriate joining of parties to medical negligence cases.
17. The Committee recommends that the Department of Health consider reducing the medical indemnity lower cap to €250,000 and reducing the higher cap to €500,000, in order to alleviate pressure on private consultants.
18. **Pre-Action Protocols:** The Government could consider working with the Medical Protection Society, the Law Society, and the Bar Council to ensure Pre-Action Protocols apply to all medical negligence cases.
19. **Alternative Dispute Mechanisms:** The Committee believes that a significant number of litigants are not seeking redress, but seek to understand what happened to them, and to ensure that problems do not re-occur. The Government could consider measures requiring parties to consider mediation at an early stage in the process in medical negligence cases. In line with the Ombudsman's recommendations<sup>8</sup>, the Health Service Executive may also need to consider how it can introduce a standardised complaints resolution service.

---

<sup>8</sup> <https://www.ombudsman.gov.ie/en/Publications/Investigation-Reports/Health-Service-Executive/Learning-to-Get-Better/Learning-to-Get-Better.pdf>

## 1. Introduction

The Joint Committee on Health and Children held meetings on the 22<sup>nd</sup> and 27<sup>th</sup> January 2015 to discuss the increasing costs of medical indemnity insurance.<sup>9</sup> The Committee is concerned that, **without action, the increasing costs of medical indemnity insurance would threaten the financial viability of private consultants working in private practice.**

Given that over 40% of all non-emergency operations are carried out privately each year, such a scenario would have **serious implications for the public health system which would need to absorb these patients.**

The Committee received written submissions from seven stakeholder groups representing doctors, patients, legal professionals and insurers as well as private correspondence from six individuals. Their contributions will be referenced throughout this Report.

The Report is structured as follows:

- **Background:** This section provides an explanation of the system of medical indemnity insurance in Ireland. The section also provides an explanation of the Clinical Indemnity Scheme (CIS) and how Indemnity Caps operate in Ireland. Finally it examines the progression of a typical clinical negligence claim.
- **The challenge of rising medical indemnity insurance costs and the impact on healthcare in Ireland**  
This section examines trends in clinical negligence claims in Ireland. It also considers the implications of rising medical indemnity insurance costs to healthcare in Ireland.

---

9

<http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/H EJ2015012200003?opendocument#C00100> and <http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/H EJ2015012200003?opendocument#C00100>

## Joint Committee on Health and Children

- **What can be done to make medical indemnity insurance costs more affordable?**  
This section discusses key stakeholder recommendations as outlined to the Committee and also looks at international approaches, particularly in the area of tort law reform.
- **Patients' concerns regarding medical negligence claims**  
This section summarises key concerns around clinical negligence claims raised by patients and patient advocates.
- **Conclusions and Recommendations**  
Taking the available evidence into account, this section provides a range of Committee recommendations for consideration by policy-makers.

## 2. Overview of medical indemnity insurance and the State's Clinical Indemnity Scheme (CIS)

### 2.1 Medical indemnity insurance in Ireland

Medical indemnity systems essentially serve three related purposes:

- Covering the liabilities of medical practitioners and health organisations;
- Compensating victims of injuries sustained from medical procedures; and
- Deterring medical malpractice.<sup>10</sup>

Since 2004, hospital consultants in public practice are covered by the State's Clinical Indemnity Scheme (CIS) which is managed by the State Claims Agency (SCA) in respect of alleged incidents of clinical negligence occurring on or after 1 February 2004 in a public setting. The CIS is the largest of the SCA schemes dealing with clinical claims and was established in 2002 for two main reasons:<sup>11</sup>

- the commercial insurance market was no longer willing to provide insurance cover in the field of obstetrics, due to escalating court awards and costs; and
- the previous system for resolving medical claims featured multiple legal teams and was considered to be costly, time consuming, and adversarial.

---

<sup>10</sup> Toh et al. (2009). Medical indemnity - who's got the perfect cure? Accessed on 19<sup>th</sup> March 2015 at [http://www.actuaries.asn.au/Library/ACS09\\_Paper\\_Toh%20et%20al.pdf](http://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al.pdf)

<sup>11</sup> As noted in the Comptroller and Auditor General 2012 Annual Report which reviewed the CIS scheme. See <http://www.audgen.gov.ie/documents/annualreports/2012/report/en/Chapter29.pdf>

## Joint Committee on Health and Children

Through the CIS, the State assumes responsibility for the indemnification and management of clinical negligence claims arising from the diagnosis, treatment and care of patients in public healthcare enterprises.

The SCA is reimbursed on a monthly basis from the Department of Health Vote (formerly the HSE vote) for its payouts under the CIS. Hospital Consultants working in the private sector are covered by the Medical Protection Society (MPS), a not-for-profit organisation owned by members.

Prior to February 2004, all hospital consultants purchased indemnity from medical defence organisations; mainly the Medical Defence Union (MDU) or MPS. However, when hospital consultants in the public sector migrated to the State-run CIS in February 2004, these companies were left with a reduced income stream to meet future claims, thereby increasing the cost of subscription rates for consultants in whole-time private practice.

### **2.2 Withdrawal of MDU from the market**

The Government stated that the CIS scheme would not have retrospective effect; therefore medical defence organisations would retain liability for any future claims in respect of incidents that occurred prior to 1<sup>st</sup> February 2004.

However in 2004 the MDU withdrew its cover for Irish consultants in private practice and refused to provide indemnity cover to hundreds of consultants facing malpractice law suits, arguing that the Department of Health should cover these liabilities under the CIS scheme.<sup>12</sup>

The Department of Health responded by implementing new arrangements in October 2004, whereby clinical negligence claims against consultants were handled by independent solicitors, nominated by the Irish Hospital Consultants Association (IHCA) and the Irish Medical Organisation (IMO).<sup>13</sup> The solicitors were entitled to apply to the Minister for Health for ex-gratia assistance in respect of settlements and related costs. An on-going dispute

---

<sup>12</sup> <http://www.irishexaminer.com/archives/2004/0520/ireland/anger-over-medical-defence-union-decision-to-stop-consultant-cover-902984900.html>

<sup>13</sup> Comptroller and Auditor General Annual Report 2012. See <http://www.audgen.gov.ie/documents/annualreports/2012/report/en/Chapter29.pdf>

## Joint Committee on Health and Children

between the Department of Health and MDU was settled in 2012 with MDU paying €45 million to the Irish State with regard to its historic liabilities in Ireland.<sup>14</sup>

Presently MPS is the main provider of indemnity cover for hospital consultants working in the private sector. MPS has more than 16,000 members in Ireland working as healthcare professionals.

### 2.3 Indemnity caps

To offset the rising costs of medical indemnity caused by the movement of public consultants to the CIS, the Government introduced indemnity caps. These caps mean that the State will cover (through the CIS) any claim against private consultants for incidents occurring after 1 February 2004 in private hospitals, above a certain ceiling.<sup>15</sup> The caps reduce the risk to the insurer and consequently the premiums being charged to private consultants. When the caps were introduced it was agreed that they would be reviewed after seven years.<sup>16</sup>

In 2011 PricewaterhouseCoopers (PwC) were commissioned by the SCA to carry out a review, namely to find out whether the State was getting value for money from the Caps scheme and to advise on the optimal approach to the indexation of these caps. The review concluded that the Exchequer was getting good value-for-money.

The report also recommended that the Caps be moved in line with the CPI Sub-Index for Health so long as premiums for higher-risk specialities were relatively constant over time, as regards the cost of the Caps arrangement to the CIS. The formal review in 2011 resulted in an indexation factor of 13% (representing the increase in the CPI from 2004-2011) being applied to the Caps.<sup>17</sup>

In July 2013 the Government agreed to continue to provide the cap scheme for another five years and adjust the caps annually from July 2014, in line with the consumer price index.<sup>18</sup>

---

<sup>14</sup> Ibid.

<sup>15</sup> Seanad Debate 25/6/14

<sup>16</sup> Written submission by the SCA to the Joint Committee on Health and Children.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.



**Box 1: Current indemnity cap rates**

The caps rates since 1 July, 2014 are:<sup>19</sup>

- Consultant obstetricians, neurosurgeons, and orthopaedic surgeons undertaking spinal surgery - €590,425 per claim as well as an annual aggregate limit of €1,771,275 per consultant;
- For all other specialties the limit is €1,180,850 per claim with no aggregate limit.

**2.4 The normal progression of a clinical negligence claim**

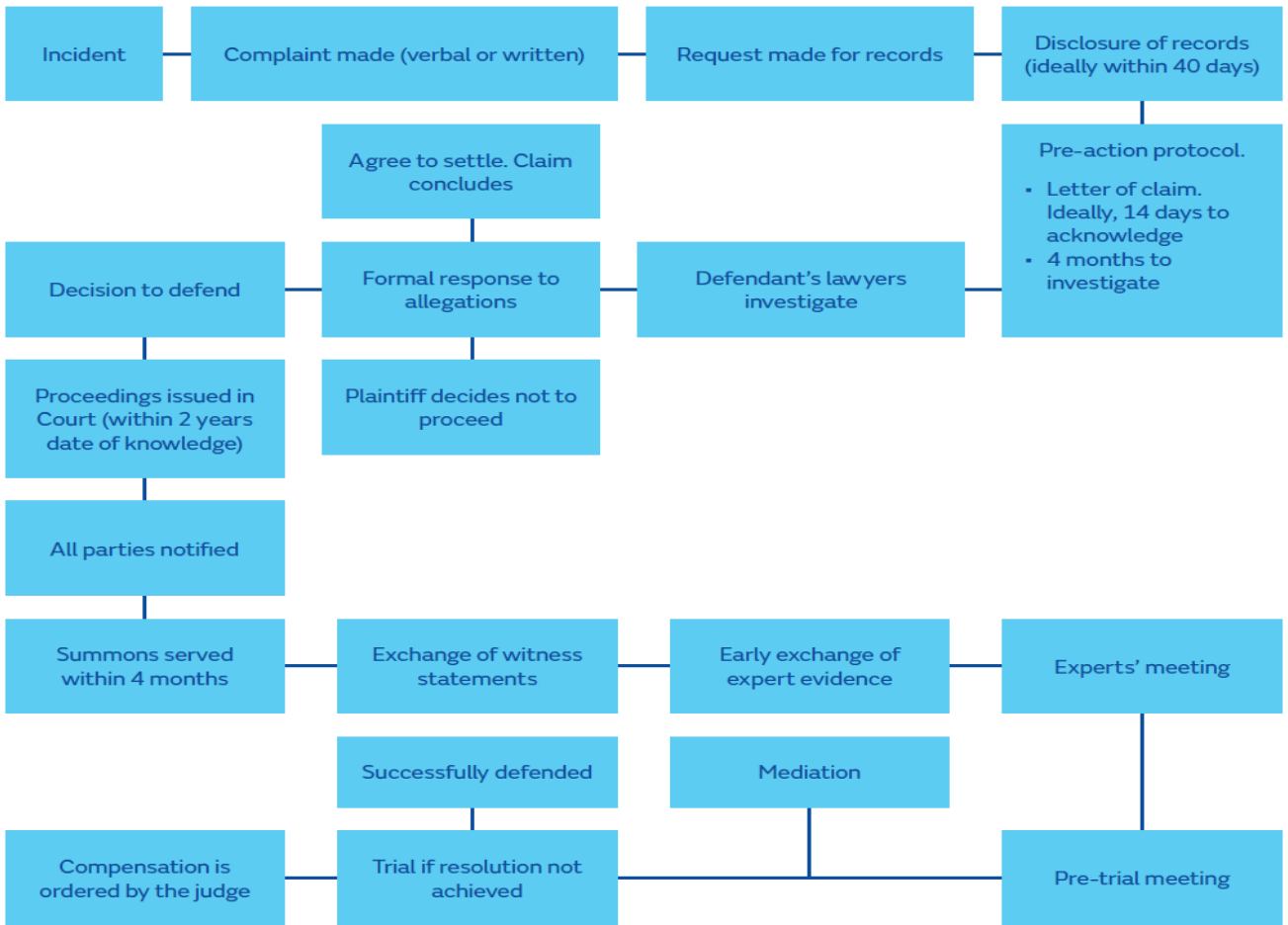
MPS outlines the 'ideal journey' of a claim in Ireland, as outlined in the chart below, while noting that this process can be interrupted and delayed with deleterious effects for both the defendant and the plaintiff.

---

<sup>19</sup> Reply to PQ [32828/14]. See <https://www.kildarestreet.com/wrans/?id=2014-07-17a.1996>

## Joint Committee on Health and Children

**Figure 1: Progression of a clinical negligence claim in Ireland**



Source: MPS

### 3. The challenge of rising medical indemnity insurance costs and the impact on healthcare in Ireland

#### 3.1 Number and size of clinical negligence claims

The SCA told the Committee that they currently have 2,840 current clinical claims under management, with an estimated contingent liability of €1.159 billion in respect of those claims. The number of CIS claims under management by the SCA has increased by more than 45% between 2008-2012.<sup>20</sup> The average cost of personal injury (clinical) claims resolved in 2014 was €140,000 compared with €67,000 in 2009. The SCA claim that the lag effect of 2,500 consultants joining the CIS in February 2004, is mainly responsible for increased claims.

There is a considerable cost to the State as a result of clinical negligence claims. The *Irish Times* reported on the 30<sup>th</sup> March 2015 that the HSE paid out almost €67 million in compensation for medical malpractice during birth procedures over the last five years; while overall €165 million was paid out as a result of incidents which occurred in HSE-run hospitals.<sup>21</sup>

The SCA's submission to the Committee contained the following table, which presents the total costs of CIS claims resolved from 2008-2014. The table shows what the Comptroller Auditor General Report (2012) also found, that the average level of legal fees paid by the SCA per resolved case has been rising over recent years. The size of awards has also been increasing. The total cost of all claims resolved has increased from €21.7 million to €69.7 million and the average cost per claims resolved has increased from €73,000 to €141,000.

---

<sup>20</sup> Comptroller and Auditor General 2012 Annual Report which reviewed the CIS scheme. See <http://www.audgen.gov.ie/documents/annualreports/2012/report/en/Chapter29.pdf>

<sup>21</sup> <http://www.irishtimes.com/news/health/childbirth-malpractice-cost-hse-67m-over-five-years-1.2157876>

**Table 1: Total cost of CIS claims resolved from 2008-2014**

Cost Element	2008	2009	2010	2011	2012	2013	2014
	€'000	€'000	€'000	€'000	€'000	€'000	€'000
<b>Cost for all Claims Resolved</b>							
Awards/Settlements	10,995	12,836	33,786	33,512	35,357	37,440	44,437
Legal Fees - SCA	4,385	4,327	7,848	7,090	8,595	9,840	9,331
Legal Fees - plaintiff	5,464	4,427	12,370	12,527	12,964	16,029	14,684
Other	844	355	897	845	961	1,303	1,231
<b>Grand Total</b>	<b>21,688</b>	<b>21,945</b>	<b>54,901</b>	<b>53,974</b>	<b>57,877</b>	<b>64,612</b>	<b>69,683</b>

	€'000	€'000	€'000	€'000	€'000	€'000	€'000
<b>Average Cost per Claim Resolved</b>							
Awards/Settlements	37	39	99	104	101	107	90
Legal Fees - SCA	15	13	23	22	24	28	19
Legal Fees - plaintiff	18	13	36	39	37	46	30
Other	3	1	3	3	3	4	2
<b>Grand Total</b>	<b>73</b>	<b>66</b>	<b>161</b>	<b>168</b>	<b>165</b>	<b>185</b>	<b>141</b>

Source: SCA (2015), Submission to the Joint Committee on Health and Children, data correct as of 31/12/14,.

**The reasons (given by stakeholders) for the increasing size and volume of clinical negligence claims include the following:**

- In 2009 the High Court increased the cap on general damages from €325,000 to €450,000 for those who have suffered catastrophic injuries (MPS);<sup>22</sup>
- General damages, special damages and legal costs tend to be higher in Ireland than elsewhere (MPS);
- The economic downturn in Ireland may have pushed some claimant lawyers to seek an alternative source of income (MPS);
- An inefficient and lengthy legal process makes final costs more expensive as the cost of settling a claim increases as time goes on (IMO, MPS);
- The level of market penetration that MPS has in Ireland compared with other territories and how this impacts on its exposure (LSI);

<sup>22</sup> General damages refer to compensation for pain and suffering as a result of an injury and do not include compensation for out of pocket expenses which are covered by special damages.

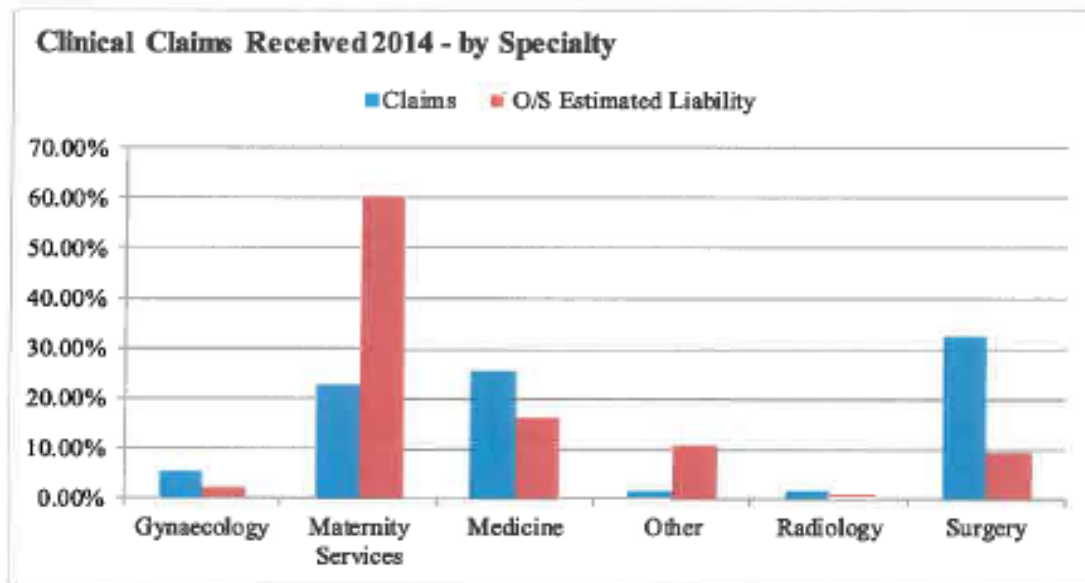
## Joint Committee on Health and Children

- The fact that medical negligence occurs (LSI);
- A perceived defensive culture exists in the health service, the SCA and MPS (MIA)
- An expanding range and complexity of medical procedures carried out by MPS members in recent years has resulted in a higher risk profile (LSI).
- The lack of an efficient and predictable legal process – no judge-led case management or pre-action protocol (MPS).
- The lack of a speedy and transparent system creates pressure to settle claims in circumstances where MPS would not do so elsewhere in the world (MPS).

### 3.2 Clinical negligence claims by speciality

Figure 2 shows the percentage of claims received by speciality in 2014. In total, the SCA received 609 new clinical claims in 2014. *Of these maternity services accounted for 23% of all new claims and 61% of the estimated liability of all new claims.*

**Figure 2: Clinical claims received by the SCA in 2014**



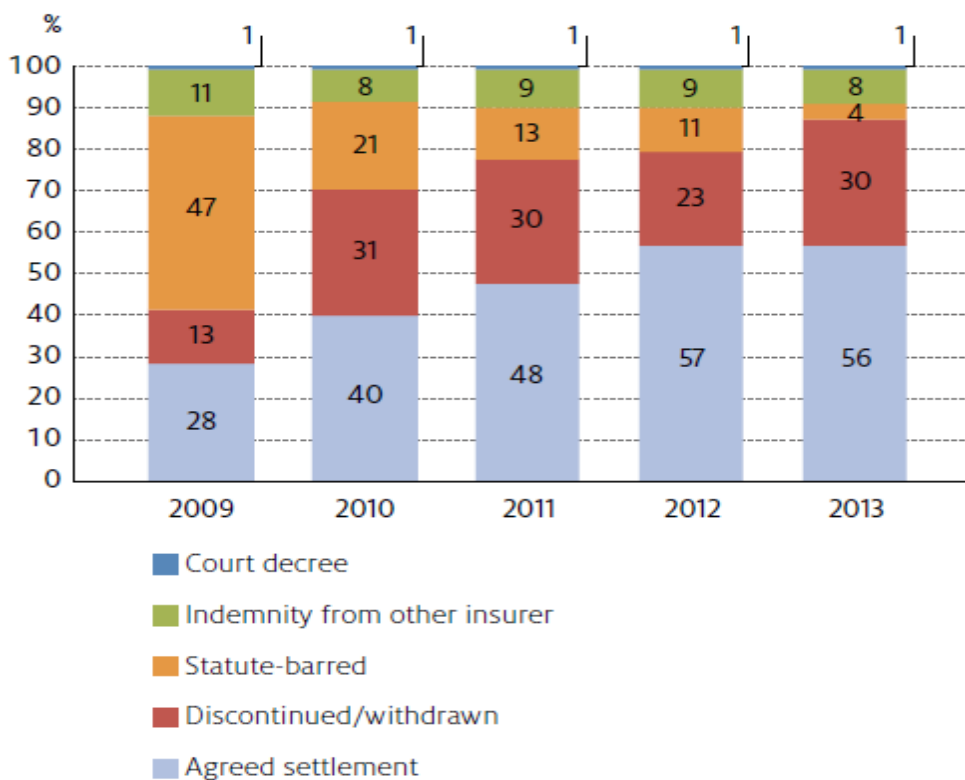
Source: SCA (2015), submission to the Joint Committee on Health and Children

**3.3 How clinical negligence claims are resolved**

The vast majority of all claims are resolved outside the court, with fewer than 3% of claims resolved through the court. Cases which go to court tend to involve infant cerebral palsy or other catastrophic injuries.<sup>23</sup>

Figure 3 shows how CIS claims were resolved from 2009 to 2013. The figures are taken from the NTMA Annual Report 2013. The chart shows an increasing trend for cases to reach an ‘Agreed Settlement’ and in 2013, 56% of CIS cases were resolved in this way.

**Figure 3: How CIS claims were resolved from 2009-2013**



Figures may not total due to rounding.  
Source: NTMA

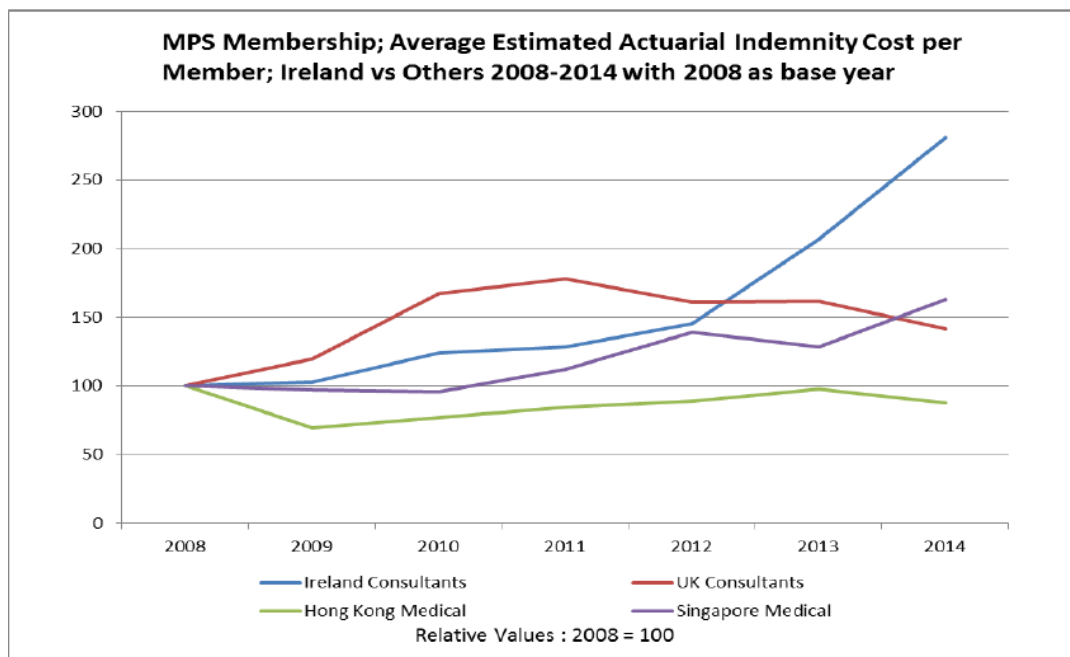
<sup>23</sup> <http://www.audgen.gov.ie/documents/annualreports/2012/report/en/Chapter29.pdf>

### 3.4 Rising costs of subscription rates for private consultants

As previously stated, consultants working in whole-time private practice are insured by medical defence organisations such as MPS. On 22<sup>nd</sup> January 2015 MPS told the Committee that there was a “deterioration in the claims environment” and that Ireland has experienced a rapid increase in claims, especially in the past two years. MPS cite actuarial estimates that between 2009 and 2014 “...the cost of indemnity for claims per member had increased by over 95%.”

MPS provide a chart (Figure 4) comparing the experience of Ireland with the UK, Hong Kong and Singapore. The chart shows that while the average estimated actuarial indemnity cost per member has increased in Ireland, the UK and Singapore, it has increased far more dramatically in Ireland.

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



Source: MPS (2015)

## Joint Committee on Health and Children

In 2014 MPS hiked their membership subscription fees by an average of 42% for off-site practices.<sup>24</sup> MPS say that they have had to increase their subscription rates as a consequence of the escalating number and size of clinical negligence claims and that, unlike the SCA, MPS must fund itself on a pre-funded basis, i.e. collect money now for incidents which occur that year but for which claims may occur in the future.

The IHCA told the Committee on 22<sup>nd</sup> January 2015 that the cost of clinical indemnity for private hospital consultants in some specialities has doubled in the past two years and that obstetricians face the most expensive medical indemnity insurance, at €337,000. *In fact there are no longer any obstetricians working in whole-time private practice as this is not affordable.* The IHCA also told the Committee that indemnity charges have now reached unaffordable levels. Mr. Martin Varley of the IHCA said:

*“The cost of indemnification for consultants in Ireland is a multiple of that charged in the UK and other jurisdictions. This is primarily due to the fact that the UK reformed the law over a decade ago to address the issues which were driving up their costs and similar actions have been taken in other jurisdictions.”*

**Table 2 shows the approximate annual charges for consultants in private practice**

Annual charge	Speciality
€337,000	Obstetrics
€104,000	Neurosurgery and Spinal Surgery
€97,500	Bariatric Surgery, Gynaecology, Orthopaedics (excluding spinal surgery), Plastic Surgery and Refractive Laser Surgery
€77,000	Cardiothoracic Surgery, General Surgery (excluding bariatric), Ophthalmology (excluding Refractive Laser Surgery), Otorhinolaryngology, Urology and Vascular Surgery

Source: IHCA (2015), submission to the Joint Committee on Health and Children

---

<sup>24</sup> Irish Medical Times. (2014). *Indemnity in crisis: the case for tort reform*. December 4<sup>th</sup> 2014.



### 3.5 The implications of rising medical indemnity insurance costs for healthcare in Ireland

In Ireland more than 40% of all non-emergency operations are carried out privately each year.<sup>25</sup> Some stakeholders have expressed concern that the rising costs of medical indemnity insurance for private hospital consultants make their practices unsustainable. If these consultants pull out of private practice it will put further pressure on the public health system.

“...a growing number of patients seeking care in public hospitals at a time when these hospitals do not have the capacity to treat more patients due to a lack of frontline resources and an insufficient number of consultants.”<sup>26</sup>

An increase in patients entering the public system could also lead to an increase the number of clinical negligence claims dealt with by the SCA, as noted by MPS in their written submission to the Committee.

Another consequence for healthcare in Ireland is the phenomenon of doctors practicing “defensive medicine.” This was brought to the Committee’s attention by Professor Trevor Duffy of the IMO. Professor Duffy said:

“...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.”

A further concern is that consultants will pass the cost of increasing premiums to patients, leading to higher health insurance premiums.<sup>27</sup>

---

<sup>25</sup> <http://www.irishexaminer.com/ireland/private-health-cover-set-to-rise-again-273670.html>

<sup>26</sup> <http://www.irishtimes.com/news/health/bill-to-set-minimum-indemnity-cover-for-doctors-1.1885423?mode=print&ot=example.AjaxPageLayout.ot>

<sup>27</sup> <http://www.irishexaminer.com/ireland/private-health-cover-set-to-rise-again-273670.html>

## 4. What can be done to make medical indemnity insurance more affordable? Actions considered by stakeholders

Any actions/policies which reduce the size and/or number of clinical negligence claims should reduce the costs of medical indemnity insurance. This section looks at actions considered by stakeholders who made presentations to the Committee and also considers the findings of the Working Group on Medical Negligence Litigation and Periodic Payments. Many of the actions covered in this section did not receive a consensus among stakeholders.

### 4.1 Reduce the indemnity caps

MPS and the IHCA recommended that the State reduce indemnity caps, in order to achieve lower indemnity charges for consultants.

On 17 July 2014 in reply to a Parliamentary Question on the issue of medical indemnity costs for hospital consultants the Minister for Health, Dr. Leo Varadkar T.D. reported that:<sup>28</sup>

“The State Claims Agency commissioned an actuarial assessment of any proposed decrease in the caps rates, which, while of benefit to private consultants, would incur more costs for the State and this issue is being examined by my Department in conjunction with the State Claims Agency.”

The Department of Health requested the SCA to look at three scenarios and their likely cost to the State.<sup>29</sup> These scenarios were:

**Scenario 1** – reduce the lower cap to €250,000, reduce the higher cap to €500,000

**Scenario 2** – reduce the lower cap to €250,000, leave the higher cap at current level

**Scenario 3** – reduce the lower cap to €250,000, establish a medium cap at €500,000, leave higher cap at the current level.

**Table 3** illustrates the liability incurred by each of these scenarios. The table shows that from 2014-2019, the estimated additional liability under scenario 1 is €49.45m, while under

---

<sup>28</sup> PQ 32828/14

<sup>29</sup> See submission to the Committee by the SCA. Currently the lower cap is €590,425 per claim and the higher cap is €1,180,850 per claim.

## Joint Committee on Health and Children

scenario 2 it is €9.97m and scenario 3 is €20.95m. The second scenario is therefore the least expensive option for the State.

Commenting on any proposals to reduce the Caps rate in July 2014, Minister Varadkar said:<sup>30</sup>

“At a time of huge financial pressure on the public health system any change to the caps arrangement must be carefully considered and a Government decision would be needed to effect such a change.”

**Table 3: Additional liability incurred as a result of changes to indemnity caps - three scenarios**

Incident year	Estimated additional liability incurred under scenario 1 €m	Estimated additional liability incurred under scenario 2 €m	Estimated additional liability incurred under scenario 3 €m
2014/15	8.42	1.72	3.58
2015/16	9	1.81	3.81
2016/17	9.69	1.97	4.12
2017/18	10.65	2.14	4.51
2018/19	11.69	2.33	4.93
Total	49.45	9.97	20.95

Source: SCA 2015

### **4.2 Provide indemnity cover to private hospital consultants through the State Claims Agency**

The IHCA recommend that the SCA provide medical indemnity cover for private hospital consultants. However, they advised that this option should be further examined in a committee with representatives from the Department of Health, the SCA and the IHCA.

### **4.3 Adopt Pre-action protocols**

Pre-action protocols were recommended by the Working Group on Medical Negligence Litigation and Periodic Payments and were also recommended to the Committee by the LSI, Bar Council, IMO, IHCA, MIA and MPS. As such they are favoured by almost all stakeholders that met with the Committee.

---

<sup>30</sup> PQ 32828/14

## Joint Committee on Health and Children

Pre-action protocols are procedural requirements which must be met before commencing litigation. The general aim is to encourage settlement or, if this is not achieved, to focus the issues in dispute, thereby facilitating a more efficient and cost-effective trial process.<sup>31</sup> Pre-action protocols were established in the UK in 1999, following Lord Woolf's *Access to Justice* report (the Woolf Report) in 1996.<sup>32</sup>

In February 2015 MPS released proposals for pre-action protocols which aim to promote openness and transparency between all parties, reduce the length of time it takes for resolution to legal action against medical professionals and reduce the cost of making clinical negligence claims in Ireland.<sup>33</sup>

MPS suggest that before any legislation is introduced to enforce mediation between parties, the protocols should be trialed voluntarily. Emma Hallinan, Director of claims at MPS said:

“We recognise the important role that the MPS must play, and have committed to trialling procedural reform before it is introduced in statute. We are in the process of writing to plaintiff lawyers with large medical negligence practices to request that they work with us to pilot this.”

MPS propose that during this trial a tariff of general damages would be used, similar to the UK's Judicial College *Guidelines for the Assessment of General Damages in Personal Injury Cases*. The idea of such a tariff is that it would achieve greater predictability and reduce the chances of over-settlement by providing a scale of compensation for specific physical injuries caused by clinical negligence. This would range from dental damage to life-changing brain injuries. However general damages as well as special damages for the costs of hospital negligence would still have to be resolved by negotiation.

---

<sup>31</sup> <http://www.alrc.gov.au/publications/5.%20Alternatives%20to%20Discovery/what-are-pre-action-protocols>

<sup>32</sup> [https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot\\_rcd#IDAVJ0HC](https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/prot_rcd#IDAVJ0HC)

<sup>33</sup> <http://www.irishmedicalnegligence.ie/news/cost-of-making-clinical-negligence-claims/>

### 4.4 Introduce a no-fault claims system

As noted by Toh et al. (2009) common-law countries traditionally rely on the tort system to handle medical malpractice cases, while many Nordic European Countries (Sweden, Denmark, Norway, Finland) have a no-fault system in place. Such a system allows compensation to the injured parties without finding fault or negligence.<sup>34</sup>

The Irish Medical Organisation (IMO) recommends that the Government consider the introduction of a no-fault claims system. The IMO argue that while this was rejected in the UK for fear that it may increase the number of claims, no-fault claims have been in operation in New Zealand and Scandinavia since the 1980s.

New Zealand is the only common law country with a comprehensive no-fault system.<sup>35</sup> Under the New Zealand system, patients who sustain an avoidable medical injury can apply, without a lawyer, for compensation, regardless of whether their injuries can be attributed to the negligence or other wrongdoing of a medical professional.<sup>36</sup>

The IMO also state that since the introduction of a no-fault system in France, clinical negligence court proceedings have been reduced to one third. Toh et al. (2009) note that the French system is a hybrid system where a no-fault system is in place for injuries resulting in invalidity of at least 25%.<sup>37</sup>

MPS however do not advocate the use of a no-fault system, writing:

“...no fault schemes do not incentivise improvements in patient safety, may result in lower compensation levels, and may impose significant costs on the taxpayer.”

---

<sup>34</sup> <http://www.irishexaminer.com/ireland/the-obstetrician--i-knew-what-i-did-was-the-right-thing-for-the-patient-257418.html>

<sup>35</sup> Toh et al. (2009). Medical indemnity - who's got the perfect cure? Accessed on 19<sup>th</sup> March 2015 at [http://www.actuaries.asn.au/Library/ACS09\\_Paper\\_Toh%20et%20al..pdf](http://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf)

<sup>36</sup> Douglas, T. (2009). Medical Injury Compensation: Beyond 'No-Fault'. Accessed on 18<sup>th</sup> March 2015 at <http://medlaw.oxfordjournals.org/content/17/1/30.full>

<sup>37</sup> Toh et al. (2009). Medical indemnity - who's got the perfect cure? Accessed on 19<sup>th</sup> March 2015 at [http://www.actuaries.asn.au/Library/ACS09\\_Paper\\_Toh%20et%20al..pdf](http://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf)

Box 2 lists the common arguments for tort system, versus arguments for no-fault systems.

**Box 2: Arguments for tort vs no-fault system**

Arguments for a tort system are that:

- It provides a clear process for determining whether the physician provided the expected standard of care, and therefore acts as a deterrent for malpractice;
- Appropriate compensation levels can be determined by the Courts for individual cases;
- It is a socially acceptable means of airing the retributive feelings of injured patients; and
- Costs may be lower than for no-fault systems as a result of its more restrictive coverage, particularly in eliminating more minor cases that may be put off pursuing a claim by the prospect of litigation.

The arguments in favour of no-fault schemes, on the other hand, are that:

- Compensation is more uniformly applied, without a potentially lengthy and stressful legal battle with uncertain outcomes;
- Consequently the time to receipt of compensation is shorter;
- More funds go directly towards the patient's care rather than to expensive litigation (court fees, lawyers' fees, paid expert witnesses) and administration;
- Benefits are mostly provided in the form of ongoing care, rather than as lump sums, with its associated risks of mismanagement and subsequent insufficiency to meet future medical and related costs;
- The criticism against no-fault schemes not providing sufficient deterrence for poor medical practice can be overcome by the establishment of a separate physician accountability framework and deterrence mechanism (separate from the compensation function); and
- The evidence is not straightforward that the fear of liability alone under the tort system is a sufficient deterrent.

Source: Toh et al. (2009)

### 4.5 Promote alternative dispute resolution (ADR) mechanisms

ADR may include mediation, arbitration or collaborative practice. Where collaborative practice takes place there is a commitment by the patient, their family, health care professionals, solicitors and insurers to an open and transparent resolution to the claim, without going to the court.

The IMO, and the Bar Council recommend that ADR mechanisms be used to a greater extent. The Medical Injuries Alliance (MIA)<sup>38</sup> is also in favour of a better use of ADR, preferably early on. Speaking to the Committee on 27<sup>th</sup> January 2015, Mr. Michael Boylan of MIA said:

“My experience is that mediation takes place much too late in the process, generally in the month before trial when patients and their lawyers and legal teams have incurred great expense and experienced much stress. Mediation is usually viewed as an alternative to settling a case and can create a further delay and more expense.”

### 4.6 Better resource the health service

The IMO told the Committee that between 2008 and 2014 health service funding has been reduced by 27% (€4BN), with an 11% reduction of staffing levels (almost 13,000 WTE) since peak levels in 2007. The IMO also cited a reduction in the number of acute hospital beds in the system at a time when demands on the hospital system have increased.

Senator John Crown also raised under-resourcing as an issue when he said:

“For most specialties we have approximately one fifth or one sixth the number of specialists per head of population when compared with countries in continental Europe.”

Speaking to the Committee on 27<sup>th</sup> January Mr. Ernest Cantillon of LSI agreed with this point and said that the consequences of slashing resources is that inevitably, more patients will be injured.

### 4.7 Introduce tighter limitation periods for personal injuries

The Statute of Limitations for personal injury compensation claims in Ireland is the time limit within which an injured party can issue proceedings according to the *Courts and Civil Liability Act 2004*. In most cases involving adults, this Act reduced limitation in personal

---

<sup>38</sup> The Medical Injuries Alliance was established in 2011 to advocate for patients.

## Joint Committee on Health and Children

injuries claims from three years to two years from the date of knowledge.<sup>39</sup> Where an injury has occurred to a child, the Statute of Limitations does not take effect until they reach the age of 18, so they will have two years from their 18<sup>th</sup> birthday to make a claim.<sup>40</sup>

In their paper, *Challenging the cost of clinical negligence: the case for reform* (2014), MPS argue that this reduction did not have the expected effect of reducing the number of claims as there is no requirement to serve a personal injury summons for one year after it is issued. In effect MPS argue, this means that plaintiffs have at least three years to investigate their claim.

Professor Trevor Duffy of the IMO, cited the Law Reform Commission's recommendation that tighter limitation periods for commencing legal proceedings could reduce the cost of insurance.

The Bar Council of Ireland disagree with any proposal to reduce limitation periods, emphasising that they have already been reduced from 3 to 2 years. LSI also caution against any reduction in limitation periods and in their written submission to the Committee write:

“The rights and circumstance of the patient should be carefully considered in any discussion on reducing periods.”

The MPS paper makes two recommendations around limitation periods:

- full implementation of the recommendation of the 2011 Law Reform Commission review on limitations.
- an ultimate limitation period of ten years, beyond which no proceedings could be brought.

This latter proposal was criticised by MIA who wrote in their submission:

“Were a final limit of 10 years imposed after which no proceedings could be brought at all, it would deny access to justice and redress for families and patients who were misled by unscrupulous doctors or simply never given a proper explanation for the

---

<sup>39</sup> In general the date of knowledge is the date on which the injury was suffered, or the date at which the person becomes aware of the injury. See Section 2 of the Statute of Limitations (Amendment) Act, 1991.

<sup>40</sup> <http://www.personalinjuryireland.ie/injury-claims-statute-of-limitations-ireland/>



## Joint Committee on Health and Children

events which resulted in their being severely injured. Further brain injured children who could never know what had caused their injuries would be denied justice.”

The LSI also disagree with the ten year limitation period and told the Committee:

“With regard to the ten year position, the MPS advocated that once ten years had elapsed from an event irrespective of any mitigating circumstances, it should be out the door and one should not be able to claim, irrespective of its merits. Certainly from the Law Society’s point of view and, as I understand, from Bar Council’s point of view, they see the unfairness of this.”

Ms Sarah Moorehead of the Bar Council of Ireland told the Committee:

“With regard to the ten year limit for a brain injury... in the early years of many cases parents are so overwhelmed by the nature of what they are dealing with that the last thing they are speaking about is taking action.”

### 4.8 Periodic payment orders (PPOs)

Most stakeholders strongly recommend the introduction of PPOs. PPOs are awards/settlements in catastrophic injury cases which are paid out on a periodic basis and would typically involve the payment of a lump sum followed by annual payments over the course of the claimant’s life to provide for future care and/or medication. Payments will continue until the claimant’s death.<sup>41</sup> PPOs should lead to an initial cash saving as a large upfront payment is not required.

On the 18th February 2010, the President of the High Court established a Working Group on Medical Negligence Litigation and Periodic Payments. The group found that where a plaintiff has been catastrophically incapacitated and will require ongoing care and medical treatment in the future, the single lump sum award is inadequate and inappropriate. As an alternative the group recommend period payment for when the care, treatment and equipment is actually required.<sup>42</sup> The Working Group report notes that PPOs are used in Germany, Belgium, Italy, Sweden, Australia, USA and Canada. In Germany an annuity is paid monthly; a lump sum may be payable as an alternative only “if a serious reason exists”. The Working

---

<sup>41</sup> <http://www.audgen.gov.ie/documents/annualreports/2012/report/en/Chapter29.pdf>

<sup>42</sup> Full report can be read at this link

[http://courts.ie/Courts.ie/library3.nsf/\(WebFiles\)/5CEEA19C4A5959BC802577DC0055C9F4/\\$FILE/Medical%20Negligence%201.pdf](http://courts.ie/Courts.ie/library3.nsf/(WebFiles)/5CEEA19C4A5959BC802577DC0055C9F4/$FILE/Medical%20Negligence%201.pdf)

## Joint Committee on Health and Children

Group recommended the introduction of legislation to empower the courts to make consensual and non-consensual PPOs in cases where long term care will be required due to catastrophic injury.<sup>43</sup>

The current Programme for Government includes a commitment to introduce legislation to facilitate courts making provision for structured settlements in circumstances where lump sums are currently awarded as a consequence of individuals suffering catastrophic injury because of the negligence.<sup>44</sup> In 2013 the Government approved the drafting of the Heads of a *Civil Liability (Amendment) Bill* to implement the recommendations contained in the High Court Working Group Report on Periodic Payments Orders and agreed that the extension of any such scheme to non-State defendants would be examined further in consultation with the Department of Finance.<sup>45</sup>

In April, 2014, the Department of Justice and Equality established an inter-departmental working group to work through the technical aspects of PPOs and to devise the elements of the periodic payment scheme for the proposed legislation. More recently, the Heads of the legislation have been published, with the intention to enact the legislation in 2015.

### 4.9 Duty of candour/open disclosure

A number of stakeholders during the Committee's debates advocated that there be "duty of candour" in cases where something goes wrong. The Medical Injuries Alliance define duty of candour as:<sup>46</sup>

"...an obligation on all health care professionals and administrators to reveal at the earliest possible opportunity when a medical accident takes place."

Duty of candour is often called 'open disclosure' and it enables a medical professional to admit wrongdoing to a patient without it being used in court against them.

During the Committee's deliberations, evidence was cited which suggested that where patients were dealt with fairly and honestly, the number of clinical negligence claims reduced.<sup>47</sup>

---

<sup>43</sup> Ibid.

<sup>44</sup> PPQ 48162/14 on 16/12/14.

<sup>45</sup> Reply to PQ dated 25<sup>th</sup> February 2015. See <http://www.justice.ie/en/JELR/Pages/SP15000056>

<sup>46</sup> <http://www.medicalinjuriesalliance.ie/pressrelease/>

## Joint Committee on Health and Children

At a Committee meeting on 27 January 2015, Mr Ernest Cantillon of the Law Society of Ireland told the Committee about the University of Illinois, which has introduced a duty of candour under penalty:

*“If a doctor does not admit he has had an adverse event, he may have six months’ salary deducted or may be held back if he is in the progression from junior doctor to senior doctor. This approach has resulted in the number of adverse incidents being reported multiplying. However, while the number of adverse incident reports may have increased from perhaps 100 to 1,000 per annum, the number of claims has declined because patients were dealt with fairly and honestly. In addition, those patients who proceeded to litigation were easier to deal with and settled their cases easier.”*

The UK legislated for duty of candour in November 2014 on foot of the Francis Inquiry into failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009.<sup>48</sup> The new regulations mean that a failure to be candid on the part of NHS bodies is a crime.<sup>49</sup>

There is no statutory duty of candour in Ireland, but the HSE's National Open Disclosure Policy, developed with the SCA, was launched in November 2013. The Policy defines Open Disclosure as:

*“An open, consistent approach to communicating with service users when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the service user informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.”*

(Open Disclosure, Candour and the Patient, Medico-Legal Journal of Ireland 2013, Asim A. Sheikh)

The Bar Council propose that there would be a statutory duty of candour in Ireland which would allow doctors to “come clean at the very beginning” without prejudicing the defence of any case. A consultation paper published by the Law Reform Commission in 2008 also recommended that:<sup>50</sup>

---

<sup>47</sup> Research by Dr. Timothy McDonald of the University of Illinois.

<sup>48</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/295773/Duty\\_of\\_Candour\\_Consultation..pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295773/Duty_of_Candour_Consultation..pdf)

<sup>49</sup> <http://www.hsj.co.uk/resource-centre/supplements/duty-of-candour-what-new-regulations-mean-for-trusts/5077462.article>

<sup>50</sup> Law Reform Commission (2008). Consultation Paper on Alternative Dispute Resolution. Accessed on 12 March 2015 at <http://www.lawreform.ie/2008/consultation-paper-on-alternative-dispute-resolution.186.html>

## Joint Committee on Health and Children

"...a statutory provision be considered which would allow medical practitioners to make an apology and explanation without these being construed as an admission of liability in a medical negligence claim".

In February 2015 the Minister for Health, Dr. Leo Varadkar, T.D. told the Joint Committee on Health and Children that doctors failing to live up to their duty of candour was the equivalent of a motoring *'hit and run'*. The Minister said that he intended to legislate to make open disclosure a legal requirement. The Minister also said that if more doctors were open about making mistakes there would be less lawsuits.<sup>51</sup> He stated that:

*"..., the HSE is moving very firmly towards a change in culture - in hospitals and health care settings - to one of open disclosure. The evidence is very strong that people are less likely to sue, and are less likely to be awarded big damages, if health care professionals are upfront and honest about what happens when things go wrong. Unfortunately, that has not been the culture across our health service in recent years. We have seen a number of very distressing examples where staff have not been willing to tell patients and their families the truth about what happened. I think if they had done so not only would the outcomes have been better for the families and patients concerned, the cost to the taxpayer would have been lower. That is a big change that can happen without legislative reform..."*

It is anticipated that legislation to underpin a duty of candour will be included as part of the Health Information Bill.<sup>52</sup>

---

<sup>51</sup> <http://www.irishtimes.com/news/politics/doctors-must-tell-patients-of-errors-under-new-varadkar-law-1.2092525>

<sup>52</sup> Reply to PQ, 42785/14 on 11/11/14

### 4.10 Tort law reforms

A number of stakeholders including MPS and the IHCA recommend a change to tort law and the legal process, MPS told the Committee on 22<sup>nd</sup> January 2015 that they launched a campaign for procedural and tort law reform, in particular recommending: a tariff on general damages, a limit on general damages, and a realignment of legal fees in proportion to the size of claims.

The IMO make similar recommendations but also recommend a certificate of merit be introduced to ensure that only cases with merit are brought forward. It should be noted that the Minister for Health also supports tort reform, stating that:

“...There is the bigger issue. I think tort reform is required in this country. In terms of payments for medical negligence, in many cases these are not cases of medical negligence at all and can be biological events in some cases. Health care, by its very nature, is risky and there will always be a certain level of claims even against good physicians and good surgeons. A lot needs to be done when it comes to tort reform. Our legal costs and awards are very high. I intend to engage directly with the Minister for Justice and Equality on the matter in 2015. However, law reform is slow and I doubt it will produce savings in 2015...”

The Bar Council is against a reduction in general or special damages, writing:

“...there already exists a judicially determined cap on general damages in this jurisdiction. A call for a reduction in the level of compensation to be paid to catastrophically injured patients following a negligently inflicted adverse event would be grossly unfair to injured patients.”

### 4.10.1 Effect of Tort reform on medical indemnity insurance costs: international experience

This section looks at measures taken to reduce medical indemnity costs in a number of other countries.<sup>53</sup>

#### Australia

Australia experienced a continued rise in the size and number of medical negligence claims throughout the 1980s and 1990s and the cost of premiums also rose considerably. In 2002 the largest provider of medical indemnity, United Medical Protection, went into provisional liquidation, raising the possibility that many doctors would be unable to find alternative cover.<sup>54</sup> As a result, the Commonwealth Government introduced premium subsidies for doctors in high-risk specialty categories; government assistance for medical indemnity providers; and placing the industry within a new regulatory framework.

The Australian Government began progressively reforming tort law in 2001; major reforms include:

- caps on damages for economic loss and non-economic loss;
- minimum thresholds of impairment to access damages for non-economic loss;
- changes in the limitation periods and
- increases in discount rates that apply to claims payouts.

The Australian Government set up a Medical Indemnity Policy Review Panel which found that the medical indemnity measures introduced by the Government contributed significantly to the viability of the medical indemnity industry as well as the affordability of medical indemnity premiums.

---

<sup>53</sup> It should be noted that the section provides a cursory overview and a more in-depth analysis is available within the studies cited. It is also worth considering that, as stated by Toh et al. (2009), the solutions appropriate for one country are likely to differ for another.

<sup>54</sup> Medical Indemnity Policy Review Panel (Australia). (2007). Achieving stability and premium affordability in the Australian medical indemnity marketplace. Accessed on 18<sup>th</sup> March 2015 at [http://worldaidsday.org.au/internet/main/publishing.nsf/Content/852BD73CC15FF78DCA257BF00020A957/\\$File/MI%20Policy%20Review%20Panel%20Report%20FINAL.pdf](http://worldaidsday.org.au/internet/main/publishing.nsf/Content/852BD73CC15FF78DCA257BF00020A957/$File/MI%20Policy%20Review%20Panel%20Report%20FINAL.pdf)

## USA

The USA recently experienced its third medical malpractice insurance crises, characterised by a:

“...deterioration in insurer financial performance, a significant increase in premium levels, and often a corresponding decrease in coverage availability”.<sup>55</sup>

**(i) Reforms which limit damages:** In terms of limiting damages, the most common reform is to put a cap on noneconomic damages (pain and suffering). Ambrose and Carroll (2007) found that that these measures do not always result in lower premiums:

“There is some evidence that non-economic damage caps reduce claims payouts...but evidence of the effect of non-economic damage caps on premiums is mixed... insurers could be exercising market power by retaining the savings as profit rather than passing these savings on to policyholders in the form of lower premiums.”

**(ii) Contingency fee limits:** The idea behind placing limits on attorney contingency fees is to curtail the number of smaller and/or marginal claims litigated. Insurers’ costs should eventually fall because they will have fewer claims to defend. However, the evidence does not show that limiting these fees has any effect on premiums (Ambrose and Carroll, 2007).

**(iii) Reforms of the legal process:**

Alternative dispute resolution- whether by means of pre-trial screening, arbitration, or mediation on either a voluntary or, in some cases, a mandatory basis. ADR has been found to be associated with reduced premiums.

### 4.10.2 Universal objectives for a successful medical indemnity scheme:

Toh et al. (2009) reviewed countries around the world in order to find a ‘perfect cure’ for the problems of spiralling medical indemnity costs. The authors developed a list of universal objectives for any system of medical indemnity:

---

<sup>55</sup> Ambrose, J.M. and Carroll, A. (2007). Medical Malpractice Reform and Insurer Claims Defense: Unintended Effects? *Journal of Health Politics, Policy and Law*, Vol. 32, No. 5, October 2007.

## Joint Committee on Health and Children

- **Appropriate compensation.** A successful scheme should appropriately compensate victims. An ideal system would also minimise system transaction costs such as legal expenses.
- **Timely compensation.** Compensation should be provided as soon as possible after the discovery of the injury. Moreover, payments should be made as they are needed. More serious injuries should be compensated via periodic payments for specific needs, such as private nursing care.
- **Mandatory cover.** Cover should be mandatory for practicing medical professionals.
- **Available and affordable cover.** Cover should be available for all medical professionals who meet the required standard. The premiums should be affordable for the practitioner.
- **Accountability and encouragement of good medical practice.** Practitioners should be held accountable for injuries that they cause. Accountability should be separate from compensation and should be dealt with by the relevant profession.
- **Facility for apology.** It should be possible for the practitioner to apologise without admitting fault.
- **Encourage good monitoring.** The system should actively encourage a trusted system of feedback and reporting of errors, so as to help prevent repetitions of the mistake.



## 5. Patient's concerns regarding medical negligence claims

The Committee received correspondence from a number of stakeholders who expressed concern that patients are not adequately represented in Ireland. The following concerns were most commonly expressed by patients in their correspondence with the Committee.

Ms. Deirdre Courtney claimed that a defensive approach is taken by doctors which she maintained did not lead to honesty and candour. At a Committee meeting on 27<sup>th</sup> January 2015, the Medical Injuries Alliance also claimed that:

“...there is a widespread culture of defend and deny which has the undesirable effect of poisoning the doctor-patient relationship.”

Other patients complained that error was not admitted voluntarily and that it was only when their solicitors received documents through Discovery<sup>56</sup> that they got the answers they were looking for.

Patients pointed out that the adversarial approach forces all parties to go through the courts which is an expensive and lengthy process for all involved. Patients felt that if doctors were more open about mistakes, this could be avoided.

Furthermore, some patients argue that the costs involved in clinical negligence claims are exacerbated by (a) delays by the defendants, e.g. in handing over documents and (b) defending cases in spite of clear evidence that injuries were caused by clinical negligence.

Some patients complained that hospitals were placing patients under unnecessary hardship by defending cases for years before reaching a settlement in the days leading up to a court appearance, or even on the day of a court appearance. In these circumstances patients felt settlement should have been reached far earlier.

---

<sup>56</sup> The "discovery of documents" is a process regulated by Rules of Court which enables litigants in civil cases to have access to "relevant" documentary evidence in limited circumstances. See <http://www.lawreform.ie/fileupload/Issues%20Papers/ip5Disc.pdf>

## Joint Committee on Health and Children

Medical practitioners have highlighted a number of cases where medical teams admitted an error at an early stage, but where admission of liability and settlement have taken a number of years as these cases have been dealt with at an administrative / legal level.

In submissions to the Committee, the MIA suggests the following ways to improve access to justice:<sup>57</sup>

- Encouraging members of the medical profession in Ireland to provide objective clinical opinions for injured patients, as happens in other countries. For victims of medical negligence based in Ireland, obtaining expert reports and second opinions on medical negligence matters is extremely time consuming and expensive as medical experts have to be brought to Ireland from other countries to take part in cases.
- That a clear set of rules be established by the Courts to promote the earliest possible exchange of information and settlement of valid claims.
- That the system of legal aid be expanded to ensure access to proper experienced legal advice and an effective system of legal aid for patients.
- That an independent audit of hospital care and treatment be performed following litigation so that lessons can be learned and to avoid a similar medical error being repeated in the future.

---

<sup>57</sup> <http://www.medicalinjuriesalliance.ie/pressrelease/>

**Appendix 1 References**

**Links to Transcripts of Committee Hearings**

[Meeting held on Thursday 22<sup>nd</sup> January 2015](#)

[Meeting held on Tuesday 27<sup>th</sup> January 2015](#)

**Links to Opening Statements / Submissions to the Committee**

**22 January 2015 - Joint Committee on Health and Children**

[Irish Hospital Consultants Association Opening Statement](#)

[IMO Opening Statement](#)

[State Claims Agency Opening Statement](#)

[Medical Protection Society Opening Statement](#)

**27 January 2015 - Joint Committee on Health and Children**

[Bar Council of Ireland Opening Statement](#)

[Ms. Deirdre Courtney Opening Statement](#)

[Law Society of Ireland Opening Statement](#)

**Reference to publication by the Office of the Ombudsman**

Learning to Get Better: An investigation by the Ombudsman into how public hospitals handle complaints (2015).

<https://www.ombudsman.gov.ie/en/Publications/Investigation-Reports/Health-Service-Executive/Learning-to-Get-Better/Learning-to-Get-Better.pdf>





