EDITORIAL

Medicolegal aspects of accident and emergency medicine

The inaugural symposium of the section of Accident and Emergency Medicine was held on 19 January 1987 at the Royal Society of Medicine. It was devoted entirely to the topic of medicine and the law. That victims of accidents deserve compensation is never in dispute. That victims of medical accidents must first prove negligence is the source of much dispute. The ritualization of this is, no doubt, profitable for those who practice law but not for those who practice medicine. It is not always very rewarding for those who seek redress.

Establishing fault, or the absence of ‘reasonable’ skills, fixes and apportions blame. Much judicial time is spent in determining what is or isn’t ‘reasonable.’ Professor Atiyah of Oxford University reassured the audience that ‘reasonable’ did not mean perfection or even absence of mistakes. He could not, however, give a precise definition. Medical expert witnesses are usually called to establish reasonable practice and the case weighed against this. Damages are then awarded for potential loss of earnings, costs incurred and a sum for pain and suffering. In this way, the legal system resembles motor insurance. You establish whose fault the accident was, then claim your damages. All right, perhaps, for motor cars but, surely, not good enough for people. Sweden and New Zealand have taken the step of introducing a ‘no fault’ compensation scheme. You get your money without fixing or apportioning blame—this can be done elsewhere, if appropriate. Professor Atiyah endorsed this development and looked forward to its inception in the UK.

Harvey & Roberts (1987), writing in the Lancet, also endorse such a development but doubt it will be introduced in the UK in the foreseeable future. A Royal Commission has already rejected it (Pearson, 1978) and they feel the BMA are still less than enthusiastic. They carry the arguments further. Health authorities must, at least, be, in part, responsible for the actions of all their employees and, in fact, are for all except doctors. Nurses, for example, are not required to be members of defence societies and health authorities carry the burden of any litigation. This should extend to doctors, they argue, and if health authorities continue to insist that membership of a defence society is a condition of employment, they should pay the now not-inconsiderable annual fee. In order to attract physicians to emergency departments, many hospitals in the USA already pay malpractice insurance as a condition of employment in the emergency room.

Dr Youell of the American University of the Caribbean gave what might be a glimpse of the UK future, as portrayed by the startling present of the USA. From 1976 to 1984, malpractice suits increased from 2.5 per 100 to 25 per 100. The average award in a similar period increased from $420 000 to $888 000. The picture appears somewhat inflated as 50% of all suits are dismissed by the courts and only 10% go to
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trial. Furthermore, half of all the settlements are reduced on appeal. What is more, only 19% of the final settlement ends up in the patient’s hand: The remainder goes in expenses, the largest of which is the lawyer’s fee: 40–50%! In spite of these caveats, the burden of litigation is growing heavier. A neurosurgeon in Florida, for example, is required to pay $170,000 a year in malpractice insurance. It does vary between specialties: a family practitioner in the same state will pay only $15,000.

Whatever the burden to the physician, the weight is ultimately shifted to the patient. Doctors’ fees rise with the cost of litigation and physicians distance themselves from situations where litigation is most likely. Some neurosurgeons, apparently, will no longer take calls from emergency rooms. Such ‘opting out’ is not an option for the NHS practitioner, of course. The doctor/patient relationship has clearly deteriorated and both parties share the blame. Dr Youell also pleaded for the ‘no fault’ compensation scheme for the USA.

There were other contributions, equally informative, and the day bodes well for the future of the section. My personal reception of the messages being transmitted was that ‘you pays your money and you takes your choice.’ When you sue your doctor, you change your relationship with doctors. You also may not achieve ultimately what you really wanted. Perhaps, if we were to find out what patients really want when they start grievance procedures, much unnecessary litigation might be avoided. Financial recompense is only a part and should be provided ideally by a ‘no fault’ scheme. A genuine curiosity about what went wrong and an assurance that no-one else will suffer in the same way are higher in patients’ minds than doctors often think. Maybe patients would, most of all, want a doctor to simply say that he’s sorry. This, unfortunately, is often thought to be an admission of guilt, but need not be. As stated at the beginning, medical litigation is too often settled like a motor accident claim. Insurance companies counsel you against such utterances. But medical claims are surely different and expressions of genuine sympathy must never be suppressed for the sake of legal expediency.

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REFERENCES

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