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**MAIN ARTICLE**

# Litigation trends and costs in otorhinolaryngology

C W METCALFE[1], S J MUZAFFAR[1], C J COULSON[2]

[1]*Department of Otolaryngology, City Hospital, Birmingham, and* [2]*Department of Otolaryngology, Queen Elizabeth Hospital Birmingham, UK*

## Abstract

*Background*: Litigation in surgery is increasing and liabilities are becoming unsustainable. This study aimed to analyse trends in claims, and identify areas for potential risk reduction, improved patient safety and a reduction in the number, and cost, of future claims.

*Methods*: Ten years of retrospective data on claims in otorhinolaryngology (2003–2013) were obtained from the National Health Service Litigation Authority via a Freedom of Information request. Data were re-entered into a spreadsheet and coded for analysis.

*Results*: A total of 1031 claims were identified; of these, 604 were successful and 427 were unsuccessful. Successful claims cost a total of £41 000 000 (mean, £68 000). The most common areas for successful claims were: failure or delay in diagnosis (137 cases), intra-operative problems (116 cases), failure or delay in treatment (66 cases), failure to warn – informed consent issue (54 cases), and inappropriate treatment (47 cases).

*Conclusion*: Over half of the claims in ENT relate to the five most common areas of liability. Recent policy changes by the National Health Service Litigation Authority, over the level of information divulged, limits our learning from claims.

**Key words:** Jurisprudence; Otolaryngology; Access To Information

## Introduction

The National Health Service (NHS) Litigation Authority was established in 1995 to provide indemnity cover for negligence claims against the NHS.[1] Its current duties were established by the National Health Service Act 2006; these include the handling of negligence claims on behalf of NHS organisations and independent sector providers of NHS care in England who are members of the NHS Litigation Authority's schemes.[1]

Despite the modern emphasis on patient safety, there has been a steadily increasing trend of litigation claims pertaining to clinical negligence in recent years. The NHS Litigation Authority paid out over £700 million back in 2008/2009, a figure that has risen to £1.2 billion per year since 2011/2012.[2] As of March 2014, it is estimated that the NHS Litigation Authority has potential liabilities of £25.7 billion relating to clinical negligence claims.[2]

Whilst obstetrics and gynaecology contributes the highest total value of litigation costs, the largest number of claims arises in surgical specialties.[3] Within this broader surgical bracket, all subspecialties have shown a large increase in claims over the past five years.[4] This is occurring despite the introduction of initiatives such as the World Health Organization (WHO) 'Safe Surgery Saves Lives', a widely implemented scheme which aims to reduce errors and adverse events surrounding surgical procedures.[5]

The importance of litigation and patterns of claims has become increasingly recognised in recent years for a number of surgical specialties. Within orthopaedics, the landmark 'Getting It Right First Time' report by Professor Tim Briggs recognised that litigation and the NHS Litigation Authority's potential liabilities were becoming unsustainable.[6]

Otorhinolaryngology, despite being smaller than general surgery or orthopaedics in terms of consultant numbers,[7] still attracts significant litigation; however, this has only been recognised by a small number of papers in the literature. It has already been observed that litigation costs are changing rapidly. It is therefore important that any evidence relating to litigation patterns is continually updated to best inform current practice, improve patient safety and reduce the number, and cost, of future claims.

This paper aimed to identify the scale and financial cost of claims to the NHS Litigation Authority in ENT over a 10-year period. Any trends in claims were identified. These areas were highlighted for

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TABLE I
TOTAL AND MEAN COSTS BY CLAIM CATEGORY

| Claim category | Successful cases (*n*) | Total cost (£) | Mean cost per case (£) |
|---|---|---|---|
| Failure or delay in treatment | 66 | 8 million | 120 000 |
| Intra-operative problems | 116 | 8 million | 72 000 |
| Failure or delay in diagnosis | 137 | 9 million | 67 000 |
| Inappropriate treatment | 47 | 2 million | 45 000 |
| Failure to warn – informed consent issue | 54 | 2 million | 36 000 |

potential risk reduction, improved patient safety and a reduction in the number, and cost, of future claims.

## Materials and methods

A Freedom of Information request was made to the NHS Litigation Authority for data on all claims to the NHS Litigation Authority from fiscal year 2003 to 2013, covering all locations and cases.

Summary data were provided in table format, and were re-entered into a spreadsheet and coded for analysis. Claim codes used by the NHS Litigation Authority were retained for our analysis. A number of cases had more than one claim code and are therefore included in multiple subgroups in the results.

## Results

A total of 1031 claims were identified within the study period. Of these, 427 were unsuccessful and 604 were successful. Successful claims led to payouts of £41 million (mean, £68 000). The most common areas were: failure or delay in diagnosis (226 cases, 61 per cent successful), intra-operative problems (196 cases, 59 per cent successful), failure or delay in treatment (138 cases, 48 per cent successful), failure to warn – informed consent issue (95 cases, 57 per cent successful), and inappropriate treatment (71 cases, 66 per cent successful).

The most costly areas overall were: failure or delay in diagnosis (£9 million), failure or delay in treatment (£8 million), and intra-operative problems (£8 million). Failure or delay in treatment was the most costly on a case-by-case basis, with a mean cost of £120 000. Wrong site surgery was cited as a basis for 11 successful claims, with a total cost of £78 000 (mean, £7000). The 12 successful claims related to a foreign body left in situ were comparatively more costly, at a total of £430 000 (mean, £36 000). Improper delegation to a junior or failure to supervise was cited in only three successful cases; however, these resulted in large payouts, at a mean of £52 000 per case. Mean costs by subgroup are summarised in Table I.

## Discussion

The NHS Litigation Authority database is an important tool for the documentation and analysis of all claims made against the NHS. It allows us to recognise patterns of litigation proceedings, with a view to modifying future practice, improving patient safety and reducing the financial burden of future litigation.

The frequency of claims within ENT is relatively low in comparison to other specialties, such as orthopaedics, which had over 6000 claims between 2008 and 2013.[4] The authors are aware of two previous papers that investigated litigation in ENT as a whole. The first, from 2006, used data from the Medical Defence Union in addition to data from the NHS Litigation Authority database.[8] Findings from this study were consistent with ours in that failure or delay in diagnosis was the commonest cause of litigation for both NHS Litigation Authority and Medical Defence Union databases. The second, more recent study was limited to adults and found 363 settled cases between 2000 and 2008; however, only 284 of these were deemed to have enough detail for analysis.[9] This paper also highlighted failure of diagnosis as an issue attracting significant litigation. These previous studies had access to greater individual case information than is currently available via the NHS Litigation Authority.

There has been a recent change in policy made by the NHS Litigation Authority because of concerns over identifiable case information breaching patient confidentiality. As a result, only coded claim categories and costs are available, without information on each individual case. The authors were advised that providing individual case information could lead to the identification of the individuals who had made the claims, and therefore this information was exempt under Section 40 (personal information) of the Freedom of Information Act, 2000. This 'Freedom of Information Privacy Clause' places considerable limits on the quality and depth of any analysis, and attenuates any conclusions drawn from the data.

Learning from litigation is an important process for improving future practice. Unfortunately, use of the NHS Litigation Authority database is now more limited in that regard. It is important, for the continual improvement of future practice, to review the ongoing need for limitations on data divulged. A brief case synopsis with no identifiable information is unlikely to breach confidentiality. There may be an argument for allowing medical practitioners a higher degree of access to this information, as the principle of confidentiality is already an absolute responsibility for those practising medicine.

Other limitations of the NHS Litigation Authority database include data not being available by year, which prevents analysis of changing trends over time, and the lack of information on patient demographics, the type of centre involved or the grade of the clinician who provided the claimant's care. It should also be

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noted that this is a legal database maintained by non-clinicians, and therefore the coding of claims cannot be verified by the authors.

The results from our study, and evidence from previous studies, show that failure or delay in diagnosis still contributes the largest volume of claims in ENT surgery. This is a broad category of claim; however, the finding suggests that responsibility for reducing future litigation in ENT surgery extends beyond the remit of ENT surgeons alone, and involves any healthcare professional referring to ENT services. This is of particular importance for general practitioners, for whom 15 per cent of consultations involve the upper respiratory tract, and head and neck.[10] Accurate recognition of signs and symptoms that require specialist input allows prompt referral, and will reduce the likelihood that a definitive diagnosis is delayed. The same applies to assessment in an ENT out-patient setting, where surgeons should be aware of their limitations, and be willing to seek a second opinion or refer to a tertiary service if necessary.

After failure or delay in diagnosis, intra-operative problems contributed the largest number of claims. It is difficult to analyse these claims without knowing the nature of the problems; however, this finding shows that intra-operative problems, which are severe enough to result in litigation and compensation for the patient, are not uncommon.

Our results also show that wrong site surgery, despite being a National Patient Safety Authority 'never event', still occurs, and actually results in a lower mean payout than other categories of litigation. One could postulate that the type of wrong site surgery which occurred had relatively minor effects on the patients concerned, and the reason more costly wrong site surgical procedures are not seen is because the surgeon is more likely to re-check the site if the perceived negative outcomes of wrong site surgery are more severe.

Another 'never event', retained foreign body post-operation, was accountable for a similar number of claims as wrong site surgery, but the mean cost of each case was five times higher. This shows that, despite the introduction of tools such as the WHO checklist, serious and preventable adverse events still occur around surgical procedures.

It should also be noted that three claims were attributed to improper delegation to a junior, with high mean payouts of over £50 000. Although these were rare cases, it demonstrates the importance of trainees practising within their competencies and being able to identify when senior support is needed.

Finally, failure to warn (an informed consent issue) was coded as the cause for 54 claims. Valid, informed consent is an important part of the surgical process in competent adult patients, and failure to inform patients of complications pre-operatively can result in litigation when problems occur. It is a commonly accepted principle in surgical practice that any complication with an incidence of 1 in a 100 should be mentioned to the patient, along with any potentially serious complications (no matter how small the odds).[11] It has been observed that many patients will not have informed themselves about the surgery prior to the consent process,[12] and therefore adequate consent is vital for fully informing the patient about the surgery. Realistic patient expectations may reduce the likelihood of claims post-operatively. On an individual level, auditing and reflecting on a surgeon's consent process could act as a straightforward method for reducing the risk of litigation. Those who routinely take consent should be made aware of recent updates to the UK law on consent,[13] which now include a requirement to ensure that the patient is aware of alternative management options, in addition to the treatment being proposed. The importance of clear documentation should be emphasised.

The recurring theme with these results is that successful claims in ENT can be attributed to the five most common areas of litigation (i.e. failure or delay in diagnosis, intra-operative problems, failure or delay in treatment, and inappropriate treatment) in well over half of the cases. Even without individual case information (following the NHS Litigation Authority constraints), these areas should serve as guidance for surgeons as to where their practice can improve and how they can reduce the likelihood of future litigation.

In conclusion, claims within ENT are relatively infrequent, but potentially very costly. Whilst the cause of claims is varied, over half of claims are related to the five most common areas of liability, and these should serve as a guide for improving future practice. Focusing on the early diagnosis of ENT pathology with subsequent referral to specialist services may go some way to reducing the most common and costly area of litigation.

- **Litigation claims in surgery are increasing, and National Health Service Litigation Authority liabilities are unsustainable**
- **Litigation data can be used to improve patient safety and reduce the number, and cost, of future claims**
- **Over half of ENT claims relate to five common areas of liability; these should guide future practice**
- **Recent policy changes limit learning from litigation claims; these changes should be reviewed to allow improvements in current practice**

Further detailed exploration of individual claims may provide more insight into avoidable pitfalls that could reduce future claims. Recent policy changes by the NHS Litigation Authority over the level of information divulged severely limit our learning from litigation

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claims. These changes should be reviewed to allow improvements in current practice.

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Address for correspondence:
Dr Christopher Metcalfe,
Department of Otolaryngology,
City Hospital,
Dudley Road,
Birmingham B18 7QH, UK

E-mail: c.w.metcalfe89@gmail.com



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