Why do people sue doctors? A study of patients and relatives taking legal action

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Summary
To examine the reasons patients and their relatives take legal action, we surveyed 227 patients and relatives who were taking legal action through five firms of plaintiff medical negligence solicitors.

Over 70% of respondents were seriously affected by incidents that gave rise to litigation with long-term effects on work, social life, and family relationships. Intense emotions were aroused and continued to be felt for a long time. The decision to take legal action was determined not only by the original injury, but also by insensitive handling and poor communication after the original incident. Where explanations were given, less than 15% were considered satisfactory. Four main themes emerged from the analysis of reasons for litigation: concern with standards of care—both patients and relatives wanted to prevent similar incidents in the future; the need for an explanation—to know how the injury happened and why; compensation—for actual losses, pain and suffering or to provide care in the future for an injured person; and accountability—a belief that the staff or organisation should have to account for their actions.

Patients taking legal action wanted greater honesty, an appreciation of the severity of the trauma they had suffered, and assurances that lessons had been learnt from their experiences. A no-fault compensation system, however well intended, would not address all patients’ concerns. If litigation is viewed solely as a legal and financial problem, many fundamental issues will not be addressed or resolved.

Lancet 1994; 343: 1609–13
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Introduction
Litigation for medical negligence was estimated to cost the UK National Health Service more than £60 million in 1990/91 and the cost has been rising steadily since.1 In the USA there are eight times as many instances of negligence as claims for compensation and fourteen instances of negligence for every successful claim for compensation.2–4 Because many claims are made in the absence of negligence, the chance of a doctor being sued after a negligent event was only one in fifty. Even in the comparatively litigious USA, there is a potential for more litigation than is currently experienced.

The true costs of injury to patients are greater than the immediate costs of litigation and compensation; any such injury affects the patient both physically and emotionally, which will often lead to an increased use of hospital resources.5 Hospital staff may be affected both by the original incident and by the process of litigation.6,7 Feeling responsible for injuring a patient appears to be one of the main sources of stress for over-worked juniors, and litigation can be a distressing and damaging experience.8

Attempts to cope with the increase in litigation for medical negligence have tended to concentrate on the efficient handling of claims or changes to the system of compensation.1,9,10 However, if litigation is to be reduced it is important to understand both why the original incidents occur and why patients turn to litigation when something does go wrong. A person who decides to take legal action for negligence must be extremely determined and prepared to endure a long and often frustrating legal process.

In some cases the need for compensation may be the over-riding reason for litigation; eg, if a child is seriously injured, the financial burden for a lifetime’s care is colossal. Even when compensation is vital, the motivation for litigation may not be exclusively financial but determined by the way the original incident was handled by the staff concerned. Did a senior doctor give an apology, an explanation, and begin immediate reparative treatment? Or did the staff simply keep quiet and hope nothing would come of it?

Some authors have suggested that patients may sue primarily to receive an explanation of what has gone wrong or in the hope that staff may be disciplined or called to account.11 There is little research on the needs of patients injured during their treatment or the factors that lead to litigation. This study examines the impact of medical injury on patients and their relatives and their reasons for taking legal action after such incidents.

Subjects and methods
Five firms of medical-negligence solicitors took part in the study in 1992. Solicitors wrote to those of their clients currently involved in a medical negligence claim setting out the aims of the study. Closed
an analysis was done to reveal those that clustered together (tended to receive similar ratings). A principal components analysis with varimax rotation was carried out to reduce the 13 reasons to a smaller number of clearly interpretable factors. Initial analyses revealed three factors with eigenvalues of greater than 1·00 and one at 0·95, but the scree test showed a break in the series of eigenvalues between factors four and five: the four-factor solution offered a clearer interpretation and a more parsimonious solution.12

### Results

Solicitors wrote to 466 clients, and 301 (64·5%) replied agreeing to take part. 227 subjects returned fully completed questionnaires, a final response rate of 48·7%.

**Patients suing on their own behalf**

There were 92 women and 41 men (69%/31%), average age 41·7 (range 18–72), 80 (60%) were married or living together. Only 26% were in full-time or part-time employment.

**Relatives**

72 were relatives, generally of a child. In 52 instances the original incident had taken place at birth (37) or in the first months of life; in 13 the patient had been under 18. At the time of the study, 25 of the patients were under 5 years old, 19 between 5 and 10, 9 between 11 and 18 years old, and the rest were adults.

**Bereaved**

22 subjects were relatives of patients who died. 11 had lost a spouse, 8 a child, 2 a mother, and 1 did not specify the

### Box 1

**Patients' descriptions of incidents**

Hysterectomy left me in pain and incontinent... later I had ovaries and bladder repair op... unable to empty my bladder completely as my urethra had been stitched almost closed... major bowel problems and left with life-threatening condition and completely incontinent.

A swelling on my cheek was diagnosed as a malignant tumour and part of my jaw and extensive tissue removed without my consent. The laboratory test showed that it was not a tumour, malignant or benign.

Failed to diagnose polycystic ovary disease which led to lot of pain... two operations involving an ovary and fallopian tube being removed. I was told the pain was in my mind.

Attending GP on and off for years... treated eczema or psoriasis when in fact I had skin cancer, increasing fast.

Two cardio-respiratory arrests caused by undiagnosed upper airway obstruction... the second arrest caused irreversible brain damage because it was prolonged by attempted resuscitation with too large a tube.

Son attending hospital for 18 months, limping and suffering severe pain in his back and legs. Consultant insisted nothing wrong with him; said we were neurotic parents. We were all sent to a psychiatrist. Insisted on second opinion... spinal tumour diagnosed.

Child ill... on third day referred to A & E... given a cursory examination and sent home—that night she was seriously ill with meningitis and is now brain damaged.

Husband had breathing difficulties. GP admitted him to Casualty, having forewarned them. They were unprepared and incompetent—eg, the anaesthetist failed to respond to pager as he didn't know how it worked. Nobody knew how to open the oxygen cylinder.

Operation for gall stones ended with losing pancreas, most of stomach, small bowel, spleen. They stitched through the mesenteric artery and failed to give a proper diagnosis in the beginning before they operated (patient died).
Box 2

Patients' and relatives' views of their care

I felt as though the medical authorities were clamming up as soon as I expressed my concern over the way I looked... So much evidence has come to light (after seeing a solicitor)... If nothing else comes from all this, I have the satisfaction of knowing that it wasn't just my imagination or me simply making a fuss.

Since it has been known that I have taken legal action any decisions/actions I or my carer take in my treatment is received with a disclaimer of all responsibility on the part of the medical team. I am unable to trust any medical people now.

However when I asked my solicitor to ask for a written apology they said "No way". They have admitted negligence, they have offered compensation, they want to make amends—but they won't give me an apology—"Yes, we did it but we're not sorry!" sums up their attitude.

If I were to use a couple of words they would be accountability and justice. To be more explicit, there seems to be an all pervasive attitude that doctors are somehow above and beyond the normal restraints the rest of humanity have to abide by.

The obstetrician said by way of an explanation "It was just one of those things". (after death of grandchild) That's not good enough—people need more than that. ... I feel no need for vengence, witnessing the grief of my son and daughter-in-law hurt me so much and I felt desperate for them—I hope they get the answers they need.

The most important reason for me is because (daughter) can't do this herself and I'm sure she would if she was able to... I think people should see just how this affects the rest of the family and not just the person who suffers the rest of her life.

The lawyer has just sent me a negative report which may terminate any possible case but this kind of careful and detailed report could have avoided many years of anguish if supplied soon after my reaction to the news of my daughter's damage.

Nature and effects of incidents

The nature of the original incidents, as classified by the respondents, is shown in table 1. Some examples of the incidents, in the subjects' own words, are given in box 1. Details have been changed to preserve anonymity.

The people involved in the incident (according to the patient or relative) were general practitioners (22), surgeons (68), obstetricians (16), other or unknown medical specialties (59), midwives (11), nurses (8), and other unspecified members of staff (21). No answer was given by 32 respondents to this question.

Over 70% of respondents described themselves as having been severely affected by what had happened. Table 2 shows the effects of the incident. Over 50% had been severely affected financially. Overall 71% were severely affected physically, 46% emotionally or mentally, and 83-8% in terms of life overall.

Reactions to incidents

Feelings of anger were expressed by 90%, bitterness by 80%, betrayal by 55%, and strong feelings of humiliation by 40%. Some examples of the ways patients and their relatives felt, taken from accounts of their experiences written in the questionnaire, are shown in box 2.

Explanations after the incident

Respondents often had difficulty in finding out what had happened. In 48 cases, an explanation was given within a few days of the incident, in 28 within a few weeks, 37 within a year, and in 15 over a year later (14 did not specify a time); 85 people said that they never received any explanation.

Where an explanation was given (128 cases), a consultant or senior registrar gave it in over 70% of cases and a doctor of unknown grade in 9%. However, in 7 cases (5%) the person giving the explanation was the house officer or senior house officer, and in 4 a nurse (3%). On 49 (44-5%) occasions a relative or friend was present when the explanation was given, on 32 (25-0%) the patient or relative was alone, and on 30 (23-4%) with other hospital staff but no friend or relative. The remaining patients did not specify who, if anyone, was with them. 42 people (32-8%) had no opportunity to ask questions.

Where explanations were given, many respondents were dissatisfied. Table 3 shows that explanations were given sympathetically in under 40% of cases, and the majority were felt to be unclear, inaccurate, and lacking information. Responsibility for what had happened was fully or partly accepted on only 30 occasions (13% of total sample), and a
those who did not, but no significant differences were found made between subjects who wanted compensation and motivation for about 40% of people. A comparison was many patients and relatives, but was not an important was less important for the bereaved—who in any case was not reflecting the importance of that factor to the respondents. To assess the relative importance of each of these four major reasons for litigation: standards of care extended well beyond the original incident. Patients and relatives considered that sub—standard care contributed to a decision to take legal action.

Four main factors were identified in the analysis of reasons for litigation. Factors and loadings, the strength of the association between each reason and the underlying factors, are shown in table 4. The four factors were accountability—wish to see staff disciplined and called to account; explanation—a combination of wanting an explanation and feeling ignored or neglected after the incident; standards of care—wishing to ensure that a similar incident did not happen again; and compensation—wanting compensation and an admission of negligence.

The number of questions loading onto each factor does not reflect the importance of that factor to the respondents. To assess the relative importance of each of these four major themes to each group of subjects, factor scores were calculated by averaging individual item scores for the relevant questions. Mean scores below 3.00 were taken as disagreement and above 3.00 as agreement (as in the original scale). The results are shown in the figure. Standards of care and explanations are important for all groups.

Compensation was usually a determining factor for those suing on behalf of a relative (often a dependent child), but it was less important for the bereaved—who in any case receive small damages. Accountability was important for many patients and relatives, but was not an important motivation for about 40% of people. A comparison was made between subjects who wanted compensation and those who did not, but no significant differences were found on their views on accountability, standards and explanations.

Preventing litigation
A final question asked whether "once the original incident had occurred could anything have been done which would have meant you did not feel the need to take legal action?" 94 (41.4%) respondents replied yes to this question and gave reasons, which are shown in table 5. Some people gave two reasons and so the total number shown is greater than 94.

Discussion
The incidents that gave rise to litigation were of a serious nature and had, in many cases, profound effects on the lives of the patients involved and their families. Long-term effects on work, social life, and family relationships were common. Strong emotions were aroused and both patients and relatives were often still distressed years after the original incident. Patients and relatives considered that sub—standard care was often the main problem that contributed to a decision to take legal action.

Four main themes emerged from the analysis of reasons for litigation: standards of care—both patients and relatives wanted to prevent similar incidents in the future; explanation—to know how it happened and why; compensation—for financial losses, pain and suffering or to provide care in the future for an injured person; and, accountability—considering that an individual or organisation should be held responsible. The legal system is being used therefore for a variety of reasons, some of which it is not intended to serve. Patients and relatives are hoping for more than compensation when they embark on a legal action.

The present UK civil system provides compensation for medical negligence, although usually only after a long and tortuous process; disadvantages which have often been discussed. The system does exercise a form of indirect accountability, in that clinical staff may occasionally have to account for their actions in a court of law. The process of achieving this can be humiliating and distressing for both patients and doctors. Many of these incidents are in any case not due to a single negligent act or omission, but to a chain of smaller errors and unfortunate circumstances—there is little point in calling a junior doctor to account if the real cause of the mishap is shortages of senior staff that mean junior doctors have to work unsupervised.

Complaints about the lack of clear, sympathetic explanations point to deficiencies in communication, and a failure to appreciate that in some circumstances the
emotional needs of patients may be as important as their physical state. Communication assumes a special importance when things have gone wrong. Patients often blame doctors not so much for the original mistakes, as for a lack of openness or willingness to explain. A valued feature of the civil system, much appreciated by patients, is that if they successfully proceed beyond the initial stages of litigation, their case is reviewed by an independent expert instructed by their solicitor. Unlike the complaints procedures, the patient sees the clinical report, has access to the notes, and may be able to discuss their case with the expert. Many patients, after reading such reports, experience a feeling of relief that their suspicions were confirmed and that they were not wrong to persist in their complaints. Equally, where they have misunderstood what happened, an independent expert may be able to clarify matters for them. Either way, it is unfortunate that such independent experts cannot be brought in at an earlier stage, perhaps without incurring the emotional and financial costs (for both sides) associated with litigation.

Most injured patients and their relatives feel strongly that they want to ensure that what happened to them is not repeated. Fenn has pointed out that the present system, whatever its faults, does give patients an incentive and a means to provide information on sub-standard care. However it is doubtful if litigation currently has many beneficial effects on standards of care. As injury to patients, whether negligent or not, is seldom followed by litigation the effects of litigation on patient care are bound to be unpredictable and hard to quantify. Only if health-care providers introduce programmes of risk management, aimed at reducing injury to patients rather than just reducing payments for negligence, is litigation likely to produce any benefits for patients generally.

That patients and relatives wish to prevent future incidents can be seen both as a genuine desire to safeguard others and as an attempt to find some way of coping with their own pain or loss. The pain may be ameliorated if they feel that, because changes were made, then at least some good came of their experiences. For this reason it is important to take patients’ and relatives’ views on clinical matters seriously, even though they might seem to be going beyond their knowledge and expertise. Patients may also have something useful to contribute as well as simply having a right to be heard. Just as clinical reviews of accidents provide valuable insights into quality of care, so may the accounts of injured patients. Accidents provide valuable insights into quality of care, so may the accounts of injured patients. Any organisation matters seriously, even though they might seem to be going beyond their knowledge and expertise. Patients may also have something useful to contribute as well as simply having a right to be heard. Just as clinical reviews of accidents provide valuable insights into quality of care, so may the accounts of injured patients. Any organisation may be as important as their physical state. Communication assumes a special importance when things have gone wrong. Patients often blame doctors not so much for the original mistakes, as for a lack of openness or willingness to explain. A valued feature of the civil system, much appreciated by patients, is that if they successfully proceed beyond the initial stages of litigation, their case is reviewed by an independent expert instructed by their solicitor. Unlike the complaints procedures, the patient sees the clinical report, has access to the notes, and may be able to discuss their case with the expert. Many patients, after reading such reports, experience a feeling of relief that their suspicions were confirmed and that they were not wrong to persist in their complaints. Equally, where they have misunderstood what happened, an independent expert may be able to clarify matters for them. Either way, it is unfortunate that such independent experts cannot be brought in at an earlier stage, perhaps without incurring the emotional and financial costs (for both sides) associated with litigation.

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