

Litigation and neurodisability

The desire to obtain explanations and redress for the impairments that are a consequence of neurological disability is unsurprising, and so far as the parents of disabled children are concerned is a component of their adaptation.

One manifestation of this seen frequently in North America, Britain, and Australia but less extensively elsewhere, is that legal claims for damages are made by parents on behalf of their offspring. Individually these run into millions of pounds or dollars and their cumulative total, if it were satisfied, comprises a significant proportion of national health care budgets.

Whilst it is an understandable view of some health professionals that they have no wish to be involved in any way in medico-legal practice it is, nevertheless, a fact of western life that litigation will not go away; hence, we need to be aware that there are resulting implications both for practice in general and also for individual children and their families.

If cerebral palsy (CP) is considered at the individual level the first implication has to be that if, as is generally accepted, 80 to 85 per cent of children with CP do not have a perinatal derivation for their disability, then 15 to 20 per cent do, and that therefore this is the group which is primarily the source of 'brain damage at birth' litigation.

The analysis of liability (whether there were appropriate standards of professional care) and aetiology (now called causation by the lawyers) are the core elements in establishing whether a suit for damages is viable. Moreover, and whether health professionals like it or not, the legal test here is what is termed the balance of probability, i.e. to determine whether it is more than 50 per cent likely that particular events or actions occurred. This sits very uncomfortably indeed with the concept of scientific or statistical certainty and is a major source of conflict between lawyers and doctors, including those who are liability and causation experts. It should be emphasized however, that it is wholly legitimate for medical experts when reporting to lawyers to conclude that the cause or timing of an individual child's disabilities is unidentifiable, even on balance of probability in the present state of knowledge.

It is nevertheless impressive that the scrupulous quality of enquiry brought by many lawyers to individual cases is now spreading to perinatal risk management practice, although it is hitherto very far from universally applied even in tertiary units in Britain. How helpful it would be to the parents of many children who are subsequently demonstrated to have disabilities if, for example, very high risk groups of children, e.g. those who are of very low birthweight and those who have sustained a neonatal encephalopathy, were routinely analyzed within a multi-professional context? In a minority of such circumstances, culpable fault would be found but this might be an appropriate price to pay for beneficial modifications of practice.

Whether or not a successful claim for damages is brought on

behalf of a child with CP the costs of the child's future long-term care need to be calculated and it is these which form the bulk of the quantum of damages. Moreover, and as is well known, the longer the affected individual is expected to live the more expensive the claim.

This produces a number of paradoxes. The first is the contrast in costs of care for successful litigants which are very much greater than the resources that are available for the remainder of the population.

Unfortunately there is no published study on how settlements have been used by successful child litigants. Possible solutions to this unsatisfactory state of affairs include no fault compensation but this has enormous disadvantages, for example, in determining eligibility. I personally prefer an approach that would provide a system of agreed annual payments. This at least would circumvent the nonsense of lawyers accepting that doctors (or statisticians or epidemiologists) know how long individual children with CP will live and then offering compensation accordingly.

Given the reality that litigation is here to stay and that it will do so within a climate where blame and perceived fault on the part of doctors is likely to persist, the resulting processes can provide opportunities and it is important that at least some of these are taken.

For example, the promotion of adaptation to disability and its long-term consequences for children and their parents can be facilitated by appropriate and meticulous enquiry into what has happened and, thereafter, by the provision of longer term support. It should not be only the minority of successful litigants who benefit from this. Rather this pattern of investigation should be available for all children with disabilities.

Secondly, and at least in Britain, there are clear opportunities for bodies that represent either side of the litigation process to be encouraged to work more effectively together in clarifying the place of litigation. Here it is encouraging that the Department of Health in Britain has prepared a paper¹ and set up a working party to consider the broader issues of clinical negligence and the need for reform. This would, however, appear to be a broad brush approach and there is a need that specific attention be paid to the place of litigation within the overall context of the prevention and amelioration of childhood disability. There is a recognized role for expert advice within this approach; perhaps the message to the readership should be that given that litigation is with us, there are potentially generalizable benefits which need to be identified and worked towards.

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Reference

1. Clinical Negligence: what are the issues and options for reform? Department of Health UK. www.doh.gov.uk/clinicalnegligencereform/