The urological Damocles

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The contents of my Presidential Address represent my personal views and not the official views of the Medical Defence Union (MDU) on whose Council I have had the privilege to serve over the past 16 years.

The MDU was formed just over 100 years ago in response to 2 cases in which medical practitioners who had not been negligent in any way had been sued by patients. Defending these cases proved very expensive and one of the doctors had spent some months in jail. It was decided to form an association of doctors (and later dentists) to protect the interests of both individual practitioners and the profession at large.

After a faltering start, the MDU has grown steadily and now has over 120 000 members, providing advice and assistance for doctors and dentists worldwide except in the USA and Canada. Rather like the University of Oxford, there was an early 'breakaway group' which formed what is now the Medical Protection Society and the Scots, as always, have their own organization.

Legal actions and claims for damages are on the increase everywhere in the free world and the amounts awarded by the courts, particularly in cases of medical negligence, are also rapidly escalating. Much has been said of the 'contingency fee' basis for lawyers' charges in the USA, but it is less well appreciated that in the UK the system of legal aid gives virtually free rein (once a certificate has been obtained) to litigate, and even when a doctor has been totally vindicated in court, the defence organization has to pay the, frequently substantial, legal costs.

These and other factors have inevitably led to rapidly increasing subscriptions over the past few years, and I can see no end to that trend. Colleagues may draw some comfort by comparing their lot with other professions, for we are still a long way behind solicitors, architects, engineers, etc. It is a sad fact that litigation for negligence is becoming a major problem to all professions and many colleagues in other fields are seriously worried by the future prospects.

Most other professions seek indemnity insurance through commercial insurance companies and our organization is the envy of many of them. At the moment the Law Society, representing solicitors, is setting up its own organization on MDU lines because commercial insurers have proved unsatisfactory. It is not often that doctors are 100 years ahead of the lawyers!

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Compensation

Under the present system to obtain compensation for loss, a patient must prove the following three elements. There must be a duty of care, as in a doctor-patient relationship; a breach of that duty by omission or commission and damages must flow from that breach of duty. Because of the nature of the legal system, such actions are inefficient and time-consuming and litigants may have to wait years for compensation.

To overcome this problem, New Zealand has introduced a no-fault system of compensation for damages caused by accidents. The definition of an accident is difficult and the amounts of compensation awarded are small compared with those made in British courts; those with high earnings are advised to take out additional individual insurance. The scheme is funded by contributions from employers, employees, motor licenses and the Government.

In the UK a Royal Commission on no-fault compensation, headed by Lord Pearson, deferred consideration of medical accidents until further experience of schemes in New Zealand and Sweden had been gained. However, it is very doubtful if such a scheme is likely to be introduced in the UK in the near future.

Personally I would like to see applications for legal aid submitted to an independent panel containing a doctor, rather than - as at present - being decided by a lay committee on the basis of an (often misleading) report from the plaintiff's nominated expert. This might prevent some worthless cases coming to court wasting everyone's time and money. Small mediation panels consisting of a lawyer, a doctor and a layman have been tried in several states in the USA, but are really only worthwhile if their findings are binding on patient and doctor. If not, they merely make the legal process longer and more complex.

The standard of care imposed by the courts is extremely high and the problem is that the courts take little notice of the fact that we have a National Health Service (NHS). They do not recognize that the NHS is seriously underfunded to meet the ever-increasing demands of the public. The gap between what is possible in medicine and what is available to all NHS patients is ever widening, but the courts take little note of this. Long waiting lists for outpatient and inpatient treatment, large busy clinics, hurried consultations, bed shortages, hospital strikes and the non-availability of the latest advances in medicine all create medicolegal problems. The sums awarded to patients are very high and, perversely, when damages are awarded they are on the basis of continuing *private* care, despite the fact that most patients continue to use the NHS. Large damages are awarded on an 'estimated' prognosis, but these patients often die sooner than anticipated, leaving the relatives having effectively won the football pools.

It is an unpalatable fact that the NHS has never, is not, and will never be funded sufficiently well to provide universally the standard of care expected by our courts of law. At present the medical profession - through its professional indemnity organizations - is left paying for the difference between public expectations and realizations. This inevitably will lead to ever-increasing subscriptions, which will represent an increasing proportion of medical salaries. General practitioners have their defence subscriptions reimbursed by the Government as part of their practice expenses and it would not be unreasonable to ask the Government to do the same for hospital doctors, for at least a large proportion of the subscriptions, particularly as it has been the hospital service which has suffered most through recent financial stringencies.

Urological pitfalls

The following two areas in the field of urology illustrate some of the problems we face.

Ureteric injuries

A computer search of 35 000 files over a three-year period revealed a total of 38 cases of ureteric damage, the majority following gynaecological surgery. This must represent only a small fraction of the total in the country, and at a meeting of the Section of Urology in May 1986 I emphasized the importance of the consultant dealing personally with the problem, of transferring the patient to the urological ward and repairing the damage satisfactorily in a single subsequent operation; my personal preference in high ureteric injuries is for transuretero-ureterostomy. If the facts of the case are fully explained to the patient, injury to a single ureter will not usually be regarded as a negligent surgical act. However, to paraphrase Lady Bracknell, 'to injure two ureters looks like carelessness!'.

Vasectomy

The field of male sterilization has always been full of legal pitfalls. For many years the operation of vasectomy for sterilization was thought to be illegal, although this has never been the case in Britain. Vasectomy is publicized by the enthusiasts as a safe, simple and effective method of sterilization and, while this is usually the case, the potential complications of the procedure should be carefully explained to the patient and that explanation recorded. Haematoma occurs to a significant extent in around 5% of cases and may lead to further operation and prolonged time off work. The effectiveness of the operation is judged by the production of two aspermic semen specimens, but it is well recorded that occasional positive sperm counts occur after two negative counts.

Early recanalization (where two counts never become negative) and late recanalization (persistent positive counts occurring after two negative counts) occur in approximately 0.5% and 0.05% of cases respectively. The former is usually diagnosed on postoperative sperm counts, but the latter all too frequently by pregnancy in the spouse. Such occurrences cause serious marital disharmony until the sperm count proves positive and the anger is then turned upon the vasectomist. The condition of late recanalization has only recently been well documented, but since the paper by Philp *et al.*[1] in 1984, it is essential to warn all patients of its possibility and it is recommended that such a warning is included in the consent form using such wordings as 'I understand that there is a possibility that I may not become or remain sterile'.

It must be clear to anyone who practices in the field of sterilization that this doubt will cause much worry to some couples and it is regrettable that such defensive medicine is necessary in today's legal climate.

Conclusion

The medicolegal world is a fascinating one but is avoided by many doctors as it is strange, time-consuming and occasionally frightening. However, patients who have sustained damage deserve a good medical opinion and do not always get one. When writing a medical report, it is important that the opinion expressed is sustainable, preferably both by personal experience and by the literature. Appearing as an expert witness in court can be a worrying experience and, though likened by some doctors to *viva voce* examinations, it is as well to remember that the 'examiner' (the opposing counsel) relies for his reputation and ultimately his income on his ability to fail the candidate!

The future for the medical profession in the present legal system in the UK is grim. A different system should be adopted to deal with dispensation of legal aid and binding arbitration should be considered as an alternative to the courts. Other avenues such as no-fault compensation deserve serious consideration, although their financial implications make early implementation unlikely.

Finally, I would like to finish with a quotation from Lord Denning, who 35 years ago in the case of Cassidy *v.* Ministry of Health, said: 'Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risk. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Doctors, like the rest of us, have to learn by experience: and experience often teaches the hard way'.

Reference

1 Philp T, Guillebaud J, Budd D. Late failure of vasectomy after two documented analyses showing azoospermic semen. *Br Med J* 1984;289:77-9

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