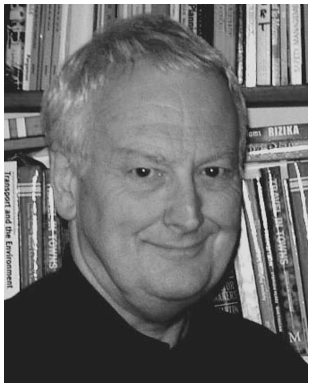
Do we have enough 'injidents'?

John Adams



Introduction

On 2 June 2001, the *British Medical Journal* published an editorial with the title "*BMJ* bans 'accidents'". The authors — Barry Pless, editor of *Injury Prevention*, and Ron Davis, North American editor of the *BMJ* — explained: "most injuries and their precipitating events are predictable and preventable. That is why the *BMJ* has decided to ban accidents".

What word would they use in its stead? After considering and rejecting a number of alternatives they say "… the English language may simply fail us here. Perhaps we should coin a word to refer collectively to the incidents that may produce injury (injidents?)".

Their principal objection to the use of the word 'accident' is that it deflects blame: "when we use 'accident,' we exonerate from blame the person injured, the parent, the manager, the facility, the company, or 'the system'". They should perhaps have pondered longer on why a language as rich and ancient as English should lack a word adequate to their purpose. Their proposal loads the word 'accident' with a bias that it does not have in common parlance. In everyday usage it is blame-neutral: it is simply an unfortunate, undesired and *unintended* event. They would replace it with a word that is blame-loaded: every undesired outcome must be someone's fault. (While they say 'most' injidents are predictable and preventable, they are prepared to exonerate only those for which preventive or avoiding measures are impossible — perhaps asteroid impacts.) They may protest that their new word is neutral, but words, especially new words, acquire their meanings from the contexts in which they are used, and the editors make clear in the manifesto with which they launch it that they want a word that attaches blame to events that were predictable and that should, therefore, have been prevented.

Figure 1 shows a sevenfold increase over five years in successful claims against the NHS for clinical negligence and illustrates the recent success enjoyed by those seeking to attribute blame and to connect it to financial compensation. By March 2000 the value of outstanding claims, plus the estimated liability for claims for negligent episodes not yet received, had reached £3.9 billion. Is this explosive growth in financial liability associated with a parallel growth of medical negligence? Unlikely. Much more likely, I propose, is that Figure 1 tracks the rise of the risk-blame-litigation-compensation culture — the injident culture. How might this rise be explained, and what are the likely consequences?

Three framing devices

I begin my attempt at an answer by introducing three devices for framing debates about risk management. (For a more extensive discussion of these framing devices see: Adams J. *Risk*. UCL Press, 1995. http://www.adamsmith.org.uk/policy/publications/pdf-files/risky-business.pdf)

Types of risk

It is important to be clear about the type of risk one is dealing with. *Directly perceptible risks* are dealt with instinctively and intuitively. We do not undertake a formal probabilistic risk assessment before crossing the street. Risks perceived through science, such as cholera, require microscopes to see them and a scientific training to understand what is observed. Other disciplines, ranging from physics and engineering to epidemiology and statistics, have also proved their value in managing risk. *Virtual risks* are culturally constructed: when the science is inconclusive people are liberated to argue from pre-established beliefs, convictions, and prejudices. When virtual risks — sometimes called unconfirmed hypotheses — get mistaken for risks about which science has clear and useful advice to offer, much confusion results.

Doctors and their patients encounter all three types of risk routinely. Patients have directly perceptible symptoms that lead them to the doctor. People with headaches, stomachaches, fevers, rashes, lumps, fractures, etc. regularly present themselves for treatment and often what needs prescribing is obvious to the doctor who has seen it many times before. At other times, the symptoms are ambiguous, and blood tests, X-rays, and other scientific diagnostic tools are invoked as tests for GPs' hypotheses. But often these tests are inconclusive; science can provide no clear, uncontentious answers. Here we are in the realm of virtual risk,

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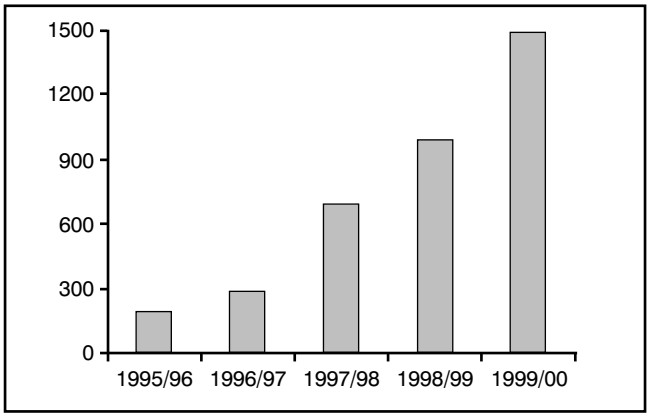

Figure 1. Total charges to income and expenditure accounts for provisions for clinical negligence, in £millions. Source: Handling clinical negligence claims in England, Report by the Comptroller and Auditor General, HC 403 Session 2000-2001: National Audit Office, 3 May 2001.

where science can generate hypotheses but cannot provide convincing confirmation. Figure 2 presents these three different types of risk as a Venn diagram with overlapping circles to make the point that the boundaries are not always clear. Cholera, for example, began as a virtual risk with its cause lurking in a miasma. As science acquired a firm grip on the disease it has become possible to make it visible — by means of warning signs on polluted water supplies — and ultimately treatable. As patients become better informed by their doctors or educational campaigns about the aetiology of conditions such as allergies, they learn to perceive directly risks that were previously invisible.

Risk management is a balancing act

Figure 3, the Risk Thermostat, characterises risk management as a form of cost–benefit analysis without the money. Rewards for risk taking come in a great variety of incommensurable forms: money, power, love, glory, food, sex, rushes of adrenaline, etc. and the greater the perceived rewards associated with a particular risk, the greater the propensity to take it, and the higher the setting of the thermostat. The potential adverse consequences of risk taking are also many and varied. The model described by Figure 3 proposes that when perception and propensity get out of balance there will be a behavioural response that seeks to restore the balance. An important corollary of this model is that risk taking in the aggregate, by definition, leads to accidents; it is behaviour that carries with it a probability of an adverse outcome. A further corollary is that the goal of preventing all accidents (or injidents), implies reducing the propensity to take risks to zero, which requires eschewing all the rewards of risk taking.

The rewards foregone in the pursuit of zero accidents, what economists call 'opportunity costs', can be large. The advice given recently by a teachers' union to its members not to supervise school trips is an example. As the perceived legal and career risks associated with schools trips have grown, the incentive to take them has been correspondingly reduced, and a valuable part of education is lost. This sort of bottom-loop bias is a common characteristic of institutional risk management. The institutional risk manager is

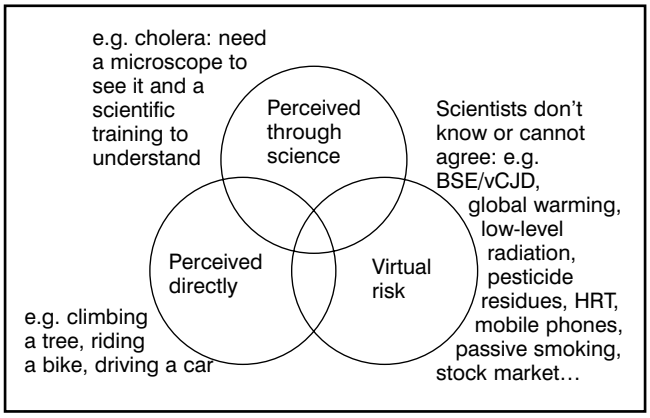

Figure 2. Three types of risk.

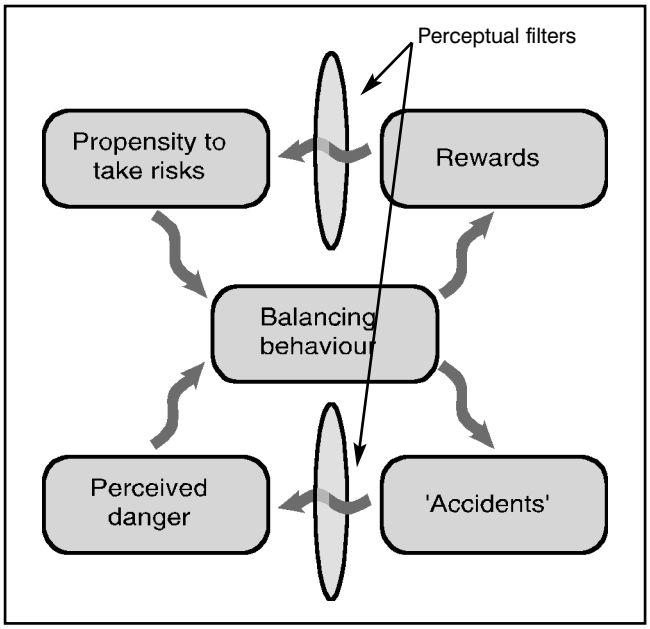

Figure 3. The Risk Thermostat.

enjoined not to have his judgement about safety compromised or corrupted by contemplation of the rewards of risk taking. The injident culture fosters bottom-loop bias and promotes the growth of defensive medicine.

Perceptual filters

Risk is inescapably subjective. It is a word that refers to a future state that exists only in the imagination. The less conclusive the science, the less trammelled the imagination and the more influential become the imaginative filters through which future risks and rewards are perceived. Figure 4 presents, in cartoon form, four commonly encountered filters. In brief:

- *Egalitarians* are fearful and risk averse: if you can't prove it's safe then you should assume it's dangerous and invoke the precautionary principle. In environmental debates they argue that nature should be obeyed and respected and interfered with as little a possible. They are participatory democrats, hostile to big business, big government, and the forces of globalisation. In medical

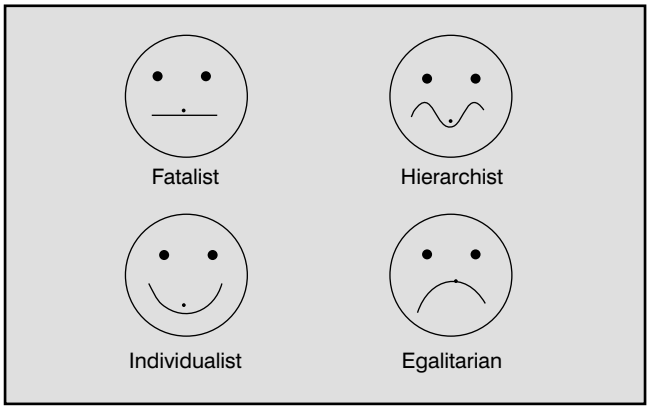

Figure 4. Perceptual filters.

debates they can be expected to be concerned about the fairness of provision, to be suspicious of bureaucrats and unelected quangos, to favour 'natural' or 'alternative' remedies, and to promote the consumption of muesli.

- *Individualists* are optimists and pragmatists focused more on the rewards of risk: if you can't prove it's dangerous assume it's safe. The natural environment is something to be exploited for human benefit. In an uncertain world one's best defence is to be rich and powerful with as much control over nature as possible. They are staunch defenders of freedom — to drink, to smoke, and drive without a seat belt — and prefer private health insurance to the welfare state. They are self-confident with a strong belief in their own abilities; a personality trait shared, I am told, with some consultant surgeons. They eat steak and drink fine wine.
- The *fatalist* buys lottery tickets and ducks if he sees something about to hit him — otherwise, *que sera sera*. He feels, usually realistically, that he has little control over the forces that buffet his life. He has low expectations, smokes, drinks, eats junk food, and is generally resistant to the blandishments of the promoters of safe sex and healthy living. He endures his fate, but resents it. Should a litigation specialist offer him the possibility of untold riches if he can think of someone to blame for something, he is likely to grasp it with alacrity.
- *Hierarchists* view risk as a scientifically manageable problem. They employ scientists, accountants, actuaries, and cost–benefit analysts to assist them. They are very uncomfortable in the presence of virtual risk. Their initial response to any new scare for which science has no confident answer is to reassure the public that everything is safe and under control and then to commission more research that they fervently hope will support their reassurance. Their management style is top down, and they favour large-scale, centralised provision of medical services.

And therefore?

What insights might these three framing devices offer by way of helping to understand the steep rise in litigation and compensation? In the limited space available here, I will propose three.

First, advances in science are making more conditions treatable. It is noteworthy that a field of medicine — obstetrics and gynaecology — that has contributed enormously to the increase in average life spans over the past century by hugely reducing perinatal mortality, is the field associated with the largest share of payouts for clinical negligence. The capture by science of misfortunes that were previously mysterious 'acts of God' has moved them out of the realm of fatalism and into the realm of the hierarchist: the legislator, the regulator, the hospital trust, the doctor. It has made them manageable, and in so doing created a target for litigation whenever management is less than completely successful — God is more difficult to sue.

Secondly, there has been an erosion of trust in traditional authority (the hierarchy) from which the medical profession is not exempt. The man from Whitehall no longer knows best. Government (including the Chief Medical Officer) and big business (including the pharmaceutical industry) now command extraordinarily low levels of public trust (Figure 5). The filters through which risks and rewards mediated by the hierarchy are perceived have been transformed. Consider the recent MMR debacle. A dissident scientist armed with a virtual risk (Dr Wakefield has argued that the triple vaccine *might* cause autism) has persuaded a large number of parents that this virtual risk outweighs the reward of protection against the well-established risks associated with measles, mumps, and rubella. It appears that attempts to reassure by established authorities — ranging from the WHO and all the Royal Colleges to large numbers of independent scientists — are now construed as evidence that they must be trying to cover up something dreadful.

The distribution of levels of trust displayed in Figure 5 reflects imputed motives, and most people now impute unworthy, self-interested, ones to government and big business. The high level of trust still commanded by GPs indicates that most people believe that their doctor will exercise his or her judgement in their best interest, independently of government pressures. This belief was threatened by the imposition on GPs of vaccination quotas accompanied by financial sanctions, that created the possibility in the minds of some that advice about the MMR vaccine might be self-interested. Trust was further undermined by the Prime Minister's refusal to assure the public that he practiced what he preached.

Mistrust generates conflict and litigiousness. If my neighbour and good friend accidentally injures me, my first instinct is not to sue him. His remorse, embarrassment, and acceptance of responsibility are likely to move me to reassure him that I bear him no ill will, and he in turn is likely help me in any way he can. But official expressions of remorse and acceptance of responsibility for medical accidents are discouraged, if not forbidden, by the insurers and lawyers whose job it is to limit legal and financial liability. The National Audit Office inquiry into the handling of medical negligence claims in England reports that they were told by the Department of Health that "they do not see it as the business of the NHS to advise patients that there might, on the face of it, be grounds to believe an adverse medical event may have been due to negligence, or suggest patients seek legal advice, or admit liability." There is an extremely fine line

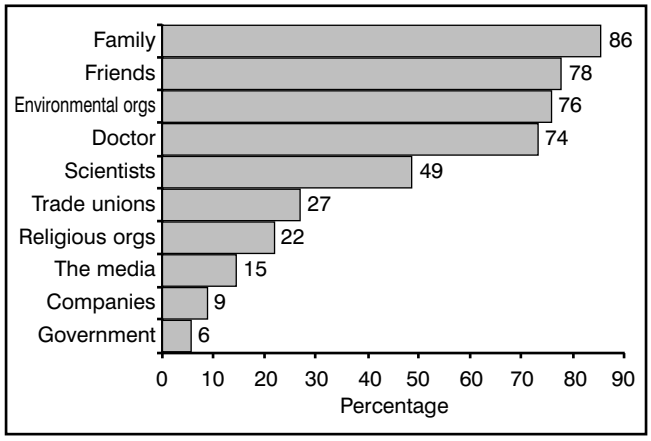

Figure 5. Whom do you trust? Percentage of responders who said they would trust an institution 'often or always' to tell them the truth about risks. Source: Marris C, Langford I, O'Riordan T. Integrating sociological and psychological approaches to public perceptions of environmental risks, *CSERGE, University of East Anglia, 1996.*

to be drawn between expressions of regret and acceptance of responsibility. 'Sorry' is a word that embraces both. If you type it into the Google internet search engine you get 11 million hits; it would appear to be a concept that makes many people anxious. A risk-averse culture is likely to shy away from any ambiguity that hints at the possibility of liability, and in so doing is likely to generate antagonisms that provoke litigation.

Until relatively recently, litigation was a luxury that few could afford. Most people, while benefiting enormously from medical advances, were still obliged to accept occasional failures with a fatalistic shrug. The advent of Crown indemnity, conditional fees (no win, no fee), insurance to cover the costs of failed litigation, and the alacrity with which the legal profession and insurance industry have grasped these opportunities, have democratised access to litigation. While this has undoubtedly benefited many deserving people, it has also radically altered the perceived risks and rewards of a number of actors in the legal/medical drama.

Rewards for lawyers have increased, and the 'downside' can mostly be covered by insurance. The insurance industry has moved into a lucrative new market.

Numerous fatalists, who previously had to grin and bear their misfortunes, have been empowered. If the risks of litigation are covered by insurance and the potential rewards are enormous, why not sue? The temptation to exaggerate one's misfortune (what the insurance industry calls 'moral hazard') doubtless proves irresistible to some, justifying further increases in the costs of insurance.

The medical professions respond by becoming more risk averse. More time is spent on the worried well, more diagnostic tests are ordered, more risk assessments are done, more defensive medicine is practiced, and more clinical negligence insurance is purchased.

And the patient? Many who have been victims of negligence or malpractice are now compensated. Others may benefit from the powerful new incentives for the medical profession to be more careful. But far more are likely to be suffering the opportunity costs of all this compensation and induced caution. The extremely risk averse regimes governing the development of new drugs increase their costs and delay their arrival. After a product is launched, the pharmaceutical industry's risk aversion is self-imposed. Most new drugs are accompanied by leaflets with long lists of rare side effects, to fend off litigation. My own GP reports spending/wasting more time on a reverse placebo effect; i.e. if a placebo were prescribed with one of these leaflets, many patients would present with one or more of the symptoms listed.

The billions of pounds that have been spent on the bureaucratic support structures of the blame-and-claim industry is money that could have been spent on more doctors, nurses, beds, and medicines. As potential liability increases the cost of insurance increases, costs which will be passed on to the patient; in some cases an inability or unwillingness to bear insurance costs is reducing the numbers of doctors prepared to enter, or remain in, certain specialities. Further, endemic mistrust and fear of litigation are wasting significant resources on unnecessary, and sometimes dangerous, diagnostic procedures, and on risk assessments that have nothing to with increasing safety and everything to do with anticipatory blame shifting.

Risk management, as described by Figure 3, is a balancing act; one cannot have the rewards without taking risks, and one cannot take risks without having accidents. The bottom-loop bias of those who would consign 'accidents' to the Orwellian memory hole is transforming the way that the medical profession performs this act. It is possible to have too few accidents. An obsession with eliminating accidents by finding someone to blame for everything that goes wrong will incur large opportunity costs in the form of rewards foregone. A more complete examination than has been attempted here of the way in which the profession is now constrained to manage risk would, I suspect, come to the conclusion that it does not have enough injidents.