**Urological litigation trends and successful claims in the National Health Service (NHS):**

**An analysis of 20 years of claims in Urology from United Kingdom**

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Surgical specialities accrue some of the highest litigation claims and costs1 due to their invasive nature. Although urology continues to have some of the fewest claims, their associated costs are still rising. This paper aims to look into the urology litigation trends and successful claims in the National Health Service (NHS) over the last 20 years.

To investigate current litigation numbers, costs and causes for claims, we requested data from NHS Resolutions under the Freedom of Information Act. NHS resolutions is a dedicated litigation department to help manage claims and collaborate with associated services. It facilitates learning from clinical negligence claims by supporting local systems with their responses, sharing, learning and carrying out early liability investigations.

*Data collection*

The data collected from NHS resolutions included the number of claims dating from 1996-2019, the total sum of damages paid out each year for urology 1997-2017 and the causes for our claims dating from 2009-2019. The information was provided as two separate documents. The first covered the years 1996-2017 and outlined the number and cost of claims and is correct as of the 31 Dec 2017. The second document contained the causes for claims from 2009-2019. Causes with under 5 claims were masked with a ‘#’ in accordance with data protection guidelines. The second document is correct as of 31 Aug 2020.

*Trends of claims and cost of damages*

Figure 1A demonstrates the rising number of claims coded as urology over the last 20 years. In total, urology received 2585 claims in 20 years. Claim numbers remained relatively stable until 2007/08 when they rose sharply. The largest increase was between 2010/11 and 2013/14 when claims numbers rose by 48 and 50 respectively over 2 consecutive financial years. Over the course of 20 years the number of claims has increased almost 7-fold. Figure 1B demonstrates the amount paid in damages. As illustrated, the cost of damages has increased roughly in line with the number of claims. An anomaly year was 2007/08, whilst there were only 81 successful claims in urology, a staggering £7,801,400 was claimed. One can assume that as this is not in line with an increase in the number of claims that it is due to one or several costly successful claims.

NHS resolutions also provided data regarding the different causes of claims over the last 10 years. Causes which account for less than 5 claims over this period have not been included in analysis due to the difficulty in quantifying them and their lack of relevance due to their rarity over the last 10 years. The full data set can be found in Appendix 1.

*Non-operative claims*

Table 1 outlines the number of non-operative related claims. They account for 1210(…%) claims, which was the majority of successful claims. The largest subset of these claims were for ‘the failure to diagnose and/or treat’ (n=639, 53%). This is understandably a common cause for litigation, as delays in diagnoses can have detrimental effects on outcomes and are more likely to make a claim.2,3 Patients who received unnecessary treatment accounted for 346(29%) claims . Additionally, there have been 88 (7%) successful consent related claims over the last 10 years.

*Intra-operative claims*

There were 226 intraoperative related claims received over the last 10 years. We do not have full details of the majority of these claims, with NHS resolutions recording majority of them (61%) as ‘intra-operative problems’. Wrong site surgery, a never event, accounts for 8 claims. Of interest, 6 successful claims have been made against urologists for failing to supervise juniors.

*Post-operative claims*

There were 1134 successful claims post-operative claims during the last 10 years. 370 (33%) of these claims are due to the damage of structures; bladder, bowel, nerve damage etc. Retained foreign body or instrument accounts for 71 (6%) claims. NHS resolutions has coded 104 claims related to cancer, however the data received does not elaborate it further.

*Meaning of this paper and other research in this area*

This paper supports other evidence that litigation costs in surgery has increased every year.1,4 A study undertaken by the Kings Fund analysed possible causes of this increase5 and concluded the following reasons for this linear change. The first is a change in the doctor patient relationship, moving away from the paternalistic relationship where the doctor dictates a treatment course. Patients have a right to be involved in decision making and those who consequently feel misinformed, could be more likely to make a claim. Secondly, more patients research their symptoms prior to attending clinics or outpatient appointments, making them more informed about their choices. These are both positive changes and encourage patients to feel autonomous about decision making with regard to their health. Therefore, clinicians should continue to appreciate that communication is vital in supporting patients during treatment considerations. Finally, in recent years many solicitors offer Conditional Funding Arrangements (CFA), most commonly associated with the phrase ‘no-win, no-fee’, leading to patients having increased access to litigation and legal representation.6 The results provided by the Kings Fund concurs with this analysis, as depicted in Fig.1, with a notable increase in litigation claims from 2007/2008.

*Role of GIRFT in litigations*

Over the last 3 years, the number of claims has begun to stabilise. This could be in part due to the implementation of the national ‘Getting it right first time’ initiative.7 This initiative was formed based upon a national review of urology services, starting in 2017. It models aspects of excelling centres and works with others to implement national recommendations into local practices, thus improving standards of care. Examples from the 2019 programme included focusing on improving sub-specialist services and increasing the effectiveness of resources and procurement of equipment.

*Meaning of the study and areas of improvement*

The breakdown of the causes of litigation provides an insight into the areas of our practice which carry the most risk, and therefore where improvement in services is needed. It is important to note that NHS resolutions collect information primarily as a claims management tool, rather than for risk management or research purposes. Therefore, some of the information provided is limited.

Non-operative claims accounted for the highest number of urological claims, and failure to diagnose or treat encompasses nearly half of these. This is not unique to urology and is reflected in many other surgical specialities. Ford et al. quoted that 19.7% of all successful claims during the years 2004-2014 across 11 surgical specialities related to a failure or delay in treatment. Oncological targets set out by the government could protect trusts from litigation if patients were treated within the 62 definitive treatment window. 8 However, arguably it is the more insidious symptoms or patients who are labelled ‘failure to follow up’ due to an administration error who come to harm.

There have been 88 successful claims related to consent over the last 10 years. This is despite the importance of informed consent and assessing patient capacity, something taught extensively throughout medical training. A study by Veerman et al. looked at the intricacies of the consent process and found a disparity between the expectations of patient and the surgeon. While surgeons believed that patients desire more information on the cause, affect and prognosis of their disease, in fact many patients wanted more information on the characteristics of the operation and risks or complications rates of that specific surgery.9,10 Many hospitals now give patients a patient information leaflet prior to consenting for a procedure, which allows individuals time to process risks of procedures prior to being consented on the day of surgery.11 British Association of Urological Surgeons (BAUS) have procedure specific consent forms which can be used as a part of the consent process. As litigation claims for inadequate consent continue to make up a significant proportion of pre-operative claims, one could suggest that a more robust consent process, such as the distribution of patient information leaflets or a two-stage consent prior to elective surgery should be a mandatory activity, rather than simply good practice.

Intraoperative related claims represent a small proportion of the overall claims in surgery. However, arguably these could be some of the most avoidable through training and mandatory pre-operative checks. Wrong site surgery still accounted for 8 claims despite it being a listed as a ‘never event’.12 Correct implementation of pre-operative marking and the WHO checklist should prevent wrong site surgery, however it is important to note that human factors play a considerable role in never events.13,14 This fact highlights the critical role of the entire theatre team to engage with surgical checklists and adherence to procedures to prevent these mistakes. It also brings into account the importance of non-technical skills as a part of the surgical training.

Whilst damage to structures during routine surgery is rare, the data shows that incidents where this does occur accounts for a large proportion of the post-operative complications and subsequent claims. For example, BAUS suggest that when consenting for ureteroscopy, the risk of damage to the ureter is quoted as less than 0.1%, but due to its severity, should always be included on consent forms.15 Medicolegal challenges can arise when a patient experiences an adverse outcome but there is no evidence to refute the claim that they were unaware of the risk, making documentation of informed consent vital. A study in the US found a strong association with delayed ureteral repair and claim amount,16 making early identification of complications essential. Furthermore, the same study identified that if the cause of damage was due to failing to supervise a trainee, the claim amount increased significantly.16

Inadvertent damage to structures in some operations could be classed as ‘unavoidable’. For example in surgery to remove bilateral goitre damage to the recurrent laryngeal nerve injury is a permissible complication yet, bilateral RLN injury would be classed as negligent unless there was firm documentation to demonstrate that the nerve had been identified and spared.17 A key takeaway for urologists from this is to ensure that operation notes are clear, and every precaution has been taken to minimise damage to structures.

Retained foreign body or instrument accounted for 71 claims over the last 10 years. In urology, ‘the forgotten stent’ is a preventable and potentially lethal complication, with encrusted stents presenting an increased risk of infection and requiring operative management.18 Many trusts have now implemented a stent registry, some of which automatically notify patients of the need for stent changes or removals. 19,20

Urology is no different to other surgical specialities, in that the number and cost of claims is generally increasing year on year. This paper has highlighted some of the key areas and categories that these claims reside and analysed the micro-trends within the data. Whilst some elements of human factors and unpreventable damage can be tolerated, there is still the need for continual improvement to patient care, surgical training, counselling, informed consent and early management of complications. The evidence reviewed in this paper suggests that the best approach to this is the combination of rigid adherence to and re-enforcement of common surgical guidelines, supported by low-level initiatives to combat local trends.

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