

Why do parents litigate and what does it do for the family?

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It is reported that the annual cost to the National Health Service from litigation rose from £456 million in 2008 to more than £1 billion in 2012. The greatest single proportion of this is paid as compensation to successful claimants in brain damage at birth litigation.¹ When considering the question of why parents litigate my perspectives are first those of a paediatric neurologist who has a special clinical interest in childhood disability, and second those of an expert witness who advises claimants and defendants in clinical negligence and personal injury litigation.

I have undertaken this latter role for approaching 40 years, in combination with my clinical and academic commitments, and I have prepared about 5000 expert reports. The majority of these have been concerned either with detailing the likely causation of brain damage and disability, or with detailing the likely prognosis, care needs and life expectation of disabled children and young people.

As part of my practice I examine most of the children on whom I report and, as part of my evaluation, I enquire, whenever I perceive it is reasonable and appropriate to do so, why the litigation is being brought. I cannot claim that this is in any way a rigorously scientific approach. Rather, a clinical impression has been obtained and this appears to be relatively stable and consistent in terms of the information that is provided. Informal conversations with colleagues who undertake medicolegal practice indicate that they have similar impressions as to the reasons why parents litigate.

Against this background, it is appropriate to make clear that there is a significant tension with respect to the paediatrician's role in conventional clinical neurodisability practice when this is contrasted with medicolegal practice.

In the former situation paediatricians offer initial and continuing support to parents as they go through the stages of understanding and adapting to an

appreciation that their child is likely to have a long-term disability that will adversely affect his health, development and future independence. By contrast a medicolegal report is prepared ultimately for the Court and, unsurprisingly, may include unpalatable information so far as parents are concerned, for example, the likely degree of cognitive impairment in their child or an estimate of life expectancy, especially if these are given relatively early in the life of a disabled child. As is discussed further below this raises the possibility that an expert opinion in litigation can alter family functioning and adjustment.

There is an absence of published work that describes why parents litigate on behalf of their children. A review of the literature has not identified any articles that specifically address this topic. There are however a small number of papers that have touched on this area. These include those of Neale² who undertook a clinical analysis of 100 medicolegal cases, Raine³ who analysed successful litigation claims in children in England, and Sen *et al*⁴ who analysed successful litigation claims in childhood deaths in England. However none of these examined the motivations of parents who undertook litigation. By contrast MacLennan,⁵ when discussing no-fault compensation, suggests that litigation can also have adverse effects on the family with a child with cerebral palsy. Similarly there is no published work which evaluates the stress that litigation places on parents, although, in my experience, they universally express relief when the process, whether successful or not, is completed.

Ultimately, from the legal perspective, any personal injury claim is concerned with obtaining compensation in order, so far as is possible, to place a successful claimant in the position that he would have had if not been for the injuries. It is my perception that this is not always understood or consistently applied by some lawyers and by some expert witnesses. Indeed, for children who have sustained irreversible brain damage, it is difficult to see how this can be achieved. This point is made within the context that, in my medicolegal role, I always do my best to ascertain from parents why they are bringing a claim on behalf of

their child. It is unsurprising therefore that no parent has ever told me that they are trying to place their child in the position that would have been the case had the alleged negligence not occurred!

Instead their reasons fall into a number of partially separable groups and indeed many parents when asked to think about this identify more than one reason. This is unsurprising as their reasons for litigating need to be seen within the serial contexts of establishing breach of duty, that is, whether or not fault can be demonstrated, establishing causation, that is, did the fault cause the damage, and thereafter quantifying a successful claim.

In order of frequency and with respect to my own experience the initial reasons are provided in [box 1](#) below.

Each of these is examined in detail below.

In addition and as their litigation proceeds some parents, possibly influenced in part by their legal team, are then increasingly motivated and even encouraged to maximise quantum, that is, the amount of compensation they will receive.

WHAT HAS HAPPENED TO CAUSE THE BRAIN DAMAGE IN OUR CHILD?

This is the most common declared reason and I estimate that this is why some 25–35% of parents initiate their medicolegal enquiries. It is most frequently seen following presumed brain damage at birth. In the largest part this is because it is often the case that the reason why this has happened has not been able to be identified in the detail that parents require by the treating clinicians. It is wholly legitimate and indeed of the greatest

Box 1 Parental reasons for litigation

- To find out what has happened to cause the brain damage in their child
- To stop this happening to other children
- To ensure that their child has all appropriate provisions
- To provide long-term care in adult life
- To obtain retribution against perceived offenders
- Pressure from extended family or other agencies
- Following unexpected discovery of possible fault
- To obtain financial compensation

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importance for parents to understand how their child's brain damage has occurred. Indeed this is an appropriate and major remit of the treating clinical services.

However if cerebral palsy is taken as an example of brain damage causing neurological disability its cause in any individual case can be obscure and unidentifiable even after all appropriate investigations including brain MRI, genetic studies when they are indicated, and searches for unusual or rare conditions have been undertaken.

If at the same time there is continuing parental concern that there may have been poor midwifery or obstetric care and that this concern has not been satisfactorily addressed by the treating clinical services it is not surprising that recourse to litigation can be the next step.

Experience suggests that under this circumstance it is possible that the forensic medicolegal process may help in clarifying causation. It is however equally likely that this will not be the case.

It follows that litigation is not always successful when it is initiated for this reason.

From my paediatric perspective I would regard recourse to litigation when this is undertaken and whether successful or not, as a component of the parental adaptation process. Many parents confirm this and indicate how difficult it is for them to 'move on' until they have as full an understanding as possible of how their situation has come about.

If this point is followed through it could be argued, as an alternative to the medicolegal process, that if careful, comprehensive and sensitively conveyed further clinical opinions, perhaps provided by appropriate specialist services, were available to provide parents with relevant aetiological information, this could well reduce the number of claims that are ultimately made.

Clearly such independent opinions could make it clear in some cases that a claim on behalf of the child should be made. It might be considered however that that would be a price worth paying.

Within this context it may also be that the increasing use of mediation could, albeit possibly in the longer term, reduce the number of claims that are made on behalf of children.

THE DESIRE TO CHANGE OBSTETRIC, MIDWIFERY OR NEONATAL PRACTICE

This reason for commencing litigation is seen most frequently in children with presumed 'brain damage at birth' when parents or other family members identify

perceived fault in the mother's care during the antenatal period, or during the course of labour and delivery. Occasionally perceived fault with respect to neonatal resuscitation is the trigger. I estimate that in round terms some 10–20% of families initiate their litigation because of presumed obstetric, midwifery or neonatal fault. It is also of interest that fathers—"who were there and powerless to act"—are frequently the initiators of this approach.

The initial motivation in this circumstance may not be about obtaining compensation. Rather it is concerned at least at the beginning with ensuring so far as is possible that similar events do not affect other families.

It has been remarkable in my experience how frequently presumed faulty midwifery and obstetric care is clearly down to there having been ineffective communication between the staff and the family. This is not to exclude the occasions when there also has been an inappropriate standard of care. The use of serious untoward incident examination procedures together with the use of complaints procedures appears to have helped a number of parents appreciate that some maternity units can effectively consider and change their practices.

A form of whistle-blowing may trigger this parental approach. This occurs when a member of the maternity unit staff can suggest to parents that they should obtain legal advice.

It is often the case that when the wish to change practice is the trigger for commencing litigation that this comes early during the disabled child's infancy. Very often this is at a time when there is only an incomplete appreciation on the part of the family of the likely extent of the disabilities and functional impairments that will ultimately be seen. Once parents are more aware of this it is frequently the case, if fault is demonstrated, that parental motivation changes during the course of the litigation.

Occasionally under this circumstance families then move on to a sense of dissatisfaction with the ongoing services and provisions that are available to their child. It is of interest that instead thereafter of campaigning for improved paediatric services that it is more usual for them to look towards non-statutory provision for remediation and rehabilitation.

It might be considered that this represents, at least to an extent, a failure of adaptation on their part. However it is sometimes the case that articulate parents who may have a professional background and who have been scarred emotionally

by perinatal and neonatal events are demonstrating a degree of realism if, in their perception, statutory resources for disabled children are limited in the area in which they live.

THE WISH FOR IMPROVED PAEDIATRIC PROVISION FOR THEIR CHILD

This reason for bringing a legal claim is usually seen in the parents of somewhat older children, that is, beyond the age of 2–3 years. By this time it may be known that liability is likely to be established or it has been indicated that liability will not be contested.

I estimate that this comprises some 10–15% of the families referred to me.

Superficially this motivation appears to be relatively straightforward if it is thought that what is being looked for is more physiotherapy, speech and language therapy, occupational therapy, aids and appliances, specialised educational provision or technology.

However the issue is more complex than the philosophy of 'more is better' and there needs to be an awareness of the potential differences between the use of evidence-based or clinically reasoned practice on the one hand and the beliefs and sometimes prejudices of some parents and of a few professionals on the other. Unfortunately there is in general a paucity of literature on evidence based practice in paediatric neurorehabilitation and this has left the field open to what may be perceived as exploitation at some levels. It is encouraging therefore that the National Institute of Health and Care Excellence in the UK is contributing to guidance on how services may be developed for example, with its guidelines on spasticity management⁶ and with respect to its past work on selective dorsal rhizotomy⁷ and its planned work on cerebral palsy.

In successful claims the extent of the provisions that are sometimes deemed to be necessary by a child's legal and specialist advisers can be very extensive indeed. They may occasionally be the subject of contested Court hearings as in the reported case of Whiten and St George's Healthcare National Health Service Trust.⁸ The need for there to be reasonable and proportionate compensation is detailed in this judgement.

In addition, for many parents who have this motivation, that is, to litigate in order to improve provision of services for their child, a component, which may be covert, is their search for a cure for their child's brain damage. It follows that treatments such as the use of stem cell therapy, hyperbaric oxygen and other heterodox approaches may be sought or used. It is

important that treating clinicians and also those preparing medicolegal advice have an awareness of this. If there is a failure to do so then inappropriate expectations can be reinforced and ultimate failure of one or both parents to adapt emotionally may occur.

Within the medicolegal context and when recommending provisions for disabled children the roles of expert witnesses in relation to quantification requires comment. My experience has been that, in spite of the Civil Procedure Rules for litigation, some experts fail to distinguish between independent expert opinion and advocacy when providing their advice; indeed they may be led into this by lawyers acting for one side or the other. There is much to be said for the use of jointly instructed experts on quantum issues so long as their reports and opinions can then be rigorously tested.

LONG-TERM CARE PROVISION

I estimate that around 10% of the families whom I see describe this as their principal motivation. It is related to the parental wish for improved services for the disabled child but also includes the recognition, which is likely to be realistic, that their offspring's need for care and support will continue beyond the time when they will be able to provide this.

This involves complex societal issues and it is wholly understandable that individual families will attempt to produce their own tailor-made solution.

One commonly stated subsidiary motive that comes within this heading is a parental wish that their disabled child will not be a long-term responsibility of healthy siblings.

Within this context it is relevant that there are well-documented data that detail the increasing life expectation for children and adults with neurological disabilities.^{9 10} This clearly has implications for the total compensation that may be paid in individual cases, and here the increasing use of periodic annual payments, particularly in the English courts, has major attractions. This largely removes the risks of all of the compensation being spent during the disabled person's lifetime or, alternatively, very large sums being left after unexpectedly early death.

RETRIBUTION

Rarely, there is a sometimes vehemently expressed wish on the part of a small minority of parents to punish and humiliate the perceived offender or offenders who has damaged their child. I have been made aware of this motivation in around

5% of the families I have seen. For health professionals this is quite the most disturbing motivation that they see in parents who are litigating on behalf of their disabled child. On rare occasions in my experience this has been so extreme that I have had to take advice on whether an unsuspecting clinician needs to be informed or protected.

More usually the parental attitude that is seen when retribution is the motive is one where it is anticipated that punitive damages will be obtained and that the individual whom they perceive to be at fault will be disciplined or dismissed.

Clearly in this circumstance the claimant's legal team has a very important role in advising and, if possible, refocusing parental attitudes. From my paediatric clinical perspective I regard this parental stance as a possible indication of a significant failure in their adaptation so that there is a clear need to assist them.

Conversely, it is also relevant that regulatory bodies, including the General Medical Council, are prepared to investigate documented concerns by families about individuals' professional practice, and that sanctions are available. This has happened occasionally in my experience.

FAMILY AND OUTSIDE PRESSURES

This uncommon reason for commencing litigation is seen most usually in very young or single parents.

When litigation has not been initiated by a child's parents this may be an indication that they anticipated, or would have preferred, getting on with meeting the evolving challenges for themselves. It is important in this circumstance however that treating clinicians and also the professionals involved in the medicolegal process are aware of the influence of the outside parties, for example, grandparents, and, with appropriate consent, be prepared to discuss matters with them.

FOLLOWING UNEXPECTED DISCOVERY OF LIKELY FAULT

This may be seen in later childhood for example, when a child with disabilities has asked his parents to ascertain the reasons for these and the relevant records have then been scrutinised.

From the family functioning perspective this may raise complex issues involving blame with the litigation then offering one aspect of restitution.

TO OBTAIN COMPENSATION

In my experience it is unusual that this is the primary motivation for initiating

litigation. However it may be seen particularly in speculative claims. While a small minority of lawyers and other agencies seem to encourage this approach in personal injury litigation following trauma, for example, in road traffic accidents, the difficulties and costs of obtaining supportive expert evidence in litigation involving children are likely to be significant restricting factors.

Nevertheless, as successful litigation proceeds the amount of financial compensation that is to be obtained becomes increasingly important and can become a significant driving force for many and possibly most families. It is here that the legal profession has a responsibility for ensuring that compensation is reasonable and proportionate.⁸

CONCLUSIONS

Paediatric neurodisability practice provides a complex template in which relevant issues include an understanding of the cause of the neurological impairment, an understanding of prognosis, the need for the provision of relevant support and services and, and in favourable circumstances, long-term parental and familial adaptation.

The recourse of a small minority of parents to litigation has to be seen within the above context, and the process when it is successful may help with respect to resource provision.

Inevitably however parents find the process to be stressful and, whether successful or not, the frequent comment following its conclusion is that they are glad it is over.

There are nevertheless obvious gaps in the information that is available. Given that litigation is so demanding of emotional and financial resources it would be helpful if relevant bodies including those that represent both defendants, for example, the National Health Service Litigation Authority and the medical defence organisations, and also claimants, for example, Action against Medical Accidents could work together to provide a more solid foundation for research in this field.

Competing interests I receive payment for preparing medicolegal reports.

Provenance and peer review Commissioned; externally peer reviewed.



To cite Rosenbloom L. *Arch Dis Child* 2014;**99**:1065–1068.

Leading article

Received 6 May 2014
 Revised 29 June 2014
 Accepted 30 June 2014
 Published Online First 17 July 2014

Arch Dis Child 2014;**99**:1065–1068.
 doi:10.1136/archdischild-2013-304139

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Arch Dis Child 2014 99: 1065-1068 originally published online July 17, 2014

doi: 10.1136/archdischild-2013-304139

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