An alternative to the clinical negligence system

Richard Furniss and **Sarah Ormond-Walshe** analyse the NHS Redress Act and compare it with the current system

The current system for patients to obtain compensation after medical error has been much criticised. It is seen as complex, slow, and costly, both in terms of legal fees and time of clinical staff. Patients are said to be dissatisfied with the lack of explanation and apologies, and the system is believed to encourage defensiveness and secrecy in the health service.¹ After publishing a consultation document in 2003 that recommended reforming the way in which allegations of clinical negligence in the NHS are handled,¹ the government passed the NHS Redress Act 2006 last November. We examine its likely effects.

Claims under the new act

The act introduces a scheme for redress without recourse to the civil law. The scheme will apply to England and Wales and covers only hospital care. It makes provision for investigation, assessment of liability, and remedy for the complainant. This remedy might include an apology, explanation, or award of financial compensation up to a ceiling of £20 000. The scheme is an alternative to (although not a substitution for) proceedings in the civil courts.

The scheme will not be launched before April 2008 and the regulations providing procedural detail will be promulgated in 2007, but the broad process for making a claim is given. The applicant (usually the aggrieved patient, but perhaps a representative of a dead patient) would initially complain to the NHS trust. The NHS Litigation Authority, which currently deals with clinical negligence claims on behalf of NHS trusts, will oversee all trusts. The trust will investigate the claim using methods that seem to be the same as under the existing complaints procedure. As a consequence of the investigation, the patient may get an apology, explanation, or offer of compensation. The same test, and standard, of fault will apply as for clinical negligence claims.

Current system

The typical clinical negligence claim does not, of course, begin with the delivery of a writ to an NHS trust. A potential claimant will often have first written a letter of complaint. The trust is likely to have responded to the complaint in detail. Sometimes, the trust provides an acceptable explanation or apology, which brings an end to the matter, as in this example:

A woman who was a practising nurse was in hospital for childbirth. She recognised that she was developing symptoms of pre-eclampsia and

Richard Furniss, barrister,
Sarah Ormond-Walshe,
barrister, Lincoln's Inn, London
WC2A 3UP
Correspondence to:
Sarahow@22ob.com

told a junior doctor that the baby needed to be delivered as soon as possible. The junior doctor dismissed her concerns. A consultant recognised shortly afterwards that she was correct, and the baby was delivered by emergency caesarean section. There was no lasting harm to mother or baby. A letter of complaint resulted in an investigation, and the junior doctor was spoken to about her future conduct. No further action was taken.

If claimants remain dissatisfied, they will instruct a solicitor, normally an expert in medical claims—classified as expert because of the public funding rules. Claimants whose cases have little merit are unlikely to find a solicitor to continue with the claim. This is because someone has to pay the solicitor's costs. A case will be publicly funded only if the claimant has limited means and the case has sufficient prospects of success and is proportionate when the likely costs are set against the likely damages.

Other methods of funding include through trade unions or insurers, a "no win, no fee" agreement with solicitors, and the claimant's private funds. Trade unions and insurers will decline to fund an unmeritorious case, and solicitors are unlikely to take on cases where there is a high risk of not getting a fee. Very few claimants wish to spend their own money on a difficult claim. Consequently, only a minority of prospective claims that are considered by solicitors progress any further.

If a claim is taken up, the next step is usually to obtain a report from an independent medical expert. If the report supports the claimant's case, a formal letter of claim will be sent to the NHS trust. The trust (or the NHS Litigation Authority, which may take over the conduct of the case) will have three months in which to investigate and respond. This will include an interview with the accused clinicians and perhaps others in the department, and the trust may instruct a separate expert. The trust may admit fault in a formal letter of response or give reasons why it does not consider that the clinician was at fault. If dispute remains, the claimant will issue a claim and start formal legal proceedings.

Will the redress scheme improve on current system?

The first criticism of the present situation is that it is complex and slow. But clinical negligence claims are, necessarily, more complex than many other types of case (such as personal injury claims). This is because of, for example, the sophistication of some medical

procedures, the application of the legal test of the standard of care (the Bolam/Bolitho test), and the complexity of medical causation:

A diabetic man attends a hospital podiatrist for treatment of a sloughy and malodorous ulcer on his toe. He is not referred to the diabetic team but discharged into his general practitioner's care. The lesion becomes gangrenous, and his forefoot needs to be amputated. There is obvious negligence, which is immediately admitted. However, it is unclear whether earlier referral to the diabetic team would have saved the forefoot. Expert evidence is required.

The redress scheme is intended to allow smaller value cases to be settled more quickly. An expert need not be consulted for the claim to be settled.

As the redress scheme is simpler it should also be less costly for claimants. Currently, although claimants may draft an initial complaint without recourse to a lawyer, they are unlikely to be able to instruct an expert or draft a formal letter of claim.

The savings on experts are less clear as the scheme will use them in some circumstances. If the NHS does not offer redress, a medical expert may be instructed to consider the case on behalf of both parties. Many have hoped that, in order to preserve a measure of independence, experts will be commissioned in all but the simplest cases. If, as expected, jointly instructed experts are the norm, the scheme is in danger of being seen as part of the NHS:

A claimant complains that a leading hand surgeon has performed a procedure negligently. Expert opinion is required to determine whether there has been a breach of duty. Obviously, the claimant cannot identify a suitable expert. The operators of the redress scheme ask another hand surgeon. She is unable to help but recommends a third leading hand surgeon, who provides an opinion unfavourable to the claimant. All three surgeons necessarily know one another fairly well. The claimant suspects a conspiracy.

The scheme will provide free independent legal advice to applicants when there is joint instruction of experts or to assess the acceptability of compensation offers.

Those claimants who are prepared to accept the redress scheme may be satisfied, and indeed receive monetary compensation, with limited lawyers' fees incurred. However, a claimant who could use the redress scheme is unlikely to be granted public funding for a negligence claim. There is also concern about claimants who reject an offer of £20 000 under the scheme because they believe their case is worth £30 000. The difference between the sum offered and the sum sought may be considered so small that litigation is disproportionate. In such a case, the claimants

PHOTOS.COM

The NHS redress scheme will allow negligence claims to be made without going to court

will be forced to accept less money than they are entitled to.

It is more difficult to see how the redress scheme will avoid clinicians being diverted from their duties. We hope that claims under the scheme will be investigated with the same rigour as current clinical negligence claims. This is essential for the protection of clinicians. Clinicians against whom a claim is made will still be required to meet and discuss it with an investigator.

Explanations, apologies, and preventive action

The only remedy provided to the victims of negligence by the legal system is monetary compensation. Undoubtedly, some claimants want an explanation, apology, or a reassurance that steps have been taken to prevent a recurrence. Although these are often given under the current system, they are not a matter of right.

The redress scheme is likely to be more useful to,

SUMMARY POINTS

The NHS redress scheme will allow negligence claims to be made without court involvement

Redress may include an apology, explanation, or compensation up to £20 000

The scheme may be seen as less impartial because NHS trusts make the decision

It may result in more cases because claims for small amounts of compensation or an apology are not currently publicly funded

and used by, those who have no grounds for monetary compensation because they have suffered no loss:

A clinician negligently fails to diagnose a claimant's cancer. As a result of the consequent delay in diagnosis, the claimant's chances of survival are reduced from 42% to 25%. On the balance of probabilities (the legal standard of proof), the claimant would not have survived in any event. Consequently, the claimant has suffered no loss and is entitled to no monetary compensation.

Under the redress scheme, however, the above claimant would (if breach of duty is established) be entitled to an explanation, an apology, and a reassurance about the future. The scheme will therefore fill a gap in the present system. It may therefore produce more, not fewer, complaints.

Defensiveness and secrecy

The government has decided not to make the scheme independent of the NHS. The presumed rationale is that the NHS is better able to own any mistakes if it identifies them itself. The difficulty is that the public is unlikely to perceive the scheme as impartial if the trusts carry out the investigation.

We are aware of no evidence to support the allegation that clinicians and trusts are defensive or secretive or that claimants currently believe that the NHS is defensive or secretive when mistakes have been made. Some claimants may consider that the NHS has something to hide if it does not immediately admit the fault alleged against it. And as a matter of human nature, some clinicians are unable to accept fault even when they have obviously made a mistake. Of course, if a NHS body makes the decisions under the redress scheme these problems will not go away. A claimant who is rebuffed by the redress scheme is as likely to accuse the NHS of secrecy as he or she is under the current system.

More claims

The redress scheme will therefore complement the present system in some cases. It is unusual to obtain public funding for a clinical negligence claim worth less than £20 000 (because it is disproportionate to incur legal fees for such a modest amount) and claims for an apology cannot be made. For this rea-

The redress scheme is intended to allow smaller value cases to be settled more quickly

son, many, if not most, of the claims that are initially brought under the redress scheme will be claims that could not have been brought in the present system. Consider the following case:

A 60 year old man has neurosurgery and a small incision is initially made on the wrong side of his head (because the radiograph was misplaced on the illuminator). He has no third party funder and cannot pay costs himself. There are no special damages (financial loss) and damages for pain, suffering, and loss of amenity will be no more than about £5000. Public funding is unavailable because of the low value of the claim compared with the likely legal costs.

This case would not result in a negligence claim but could be considered under the redress scheme. The redress scheme may, therefore, create more complaints against clinicians that require formal investigation. Overall costs could rise because of the extra cases, and more clinicians will be diverted from their duty as part of the investigations.

If the scheme is widely used it will undoubtedly be extended by raising the limit of financial compensation. If claimants were permitted to recover compensation of up to, say, £50 000, the scheme would deal with many of the claims that are currently brought under the present system. The NHS might then save on the cost of litigation. However, currently the scheme seems likely to give rise to more complaints, many without merit, and the way in which it deals with them may be less satisfactory than at present.

Contributors and sources: The authors are barristers specialising in clinical negligence law, acting for both claimants and hospital trusts. Both have experience in clinical negligence actions in a wide range of medical disciplines.

Competing interests: None declared.

- 1 Department of Health. Making amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS. London: DoH, 2003. www.dh.gov.uk (search for: 32260).

Accepted: 27 November 2006

CORRECTIONS AND CLARIFICATIONS

What is heterogeneity and is it important?

Some technical glitches at final proof stage led to the phrase " χ^2 test" being mangled in this article by John Fletcher in the "Clinical epidemiology notes" series (*BMJ* 2007;334:94-6, 13 Jan, doi: 10.1136/bmj.39057.406644.68). In the caption to figure 1, the part in parentheses should start, "P for χ^2 test..." In figure 2, the chi symbol is also missing at the bottom of the left hand columns (test for heterogeneity) in each of the two sections. These errors occurred in the printed *BMJ* and in the pdf on bmj.com.

Minerva

We tripped up over a vowel when we miss-spelt neurapraxia as neuropraxia (*BMJ* 2007;334:162, 20 Jan, doi: 10.1136/bmj.39093.672697.801).

We have already published these corrections on bmj.com.