SPEECH TO SOCIETY OF CONSERVATIVE LAWYERS AND CONSERVATIVE MEDICAL SOCIETY ON THE TOPIC OF MEDICAL NEGLIGENCE

1. A warm welcome to this joint meeting of the Society of Conservative Lawyers and the Conservative Medical Society. Can I say a special thank you to Dr. Tony Clarke, Chairman of the Conservative Medical Society for his help in organising this meeting.

2. Our topic is the highly topical subject of medical negligence, or as it is sometimes called, clinical negligence within the NHS, its extent, the heavy burden which it places on budgets, the way that it is handled today, and the way it might be improved in the future. The Government has issued consultation documents on the subject, the Secretary of State has promised a White Paper early in 2002 (!) and in the summer of 2001 Alan Milburn in his equally typical way spoke of a "plan for the biggest overhaul that the system of NHS clinical negligence compensation has ever seen". The Chief Medical Officer, Professor Liam Donaldson went out to consultation under the rather more open title "any ideas?"

3. We have three speakers tonight, myself, Dr Roger Clements a Fellow of the Royal College of Obstetrics and Gynaecology and enormously experienced as an expert medical witness who has been directly involved in a host of such cases over very many years; and Mr Arnold Simanowitz the Chief Executive of AVMA, the Association for Victims of Medical Accidents, who has been closely involved in his subject for some 20 years. We also have amongst our audience as guest of our member Richard Foster, a partner in the solicitor's firm of Weightman Vizards, Mr Steve Walker formerly of Municipal Mutual Insurance Company and for the past five years Chief Executive of the NHSLA that is the National Health Service Litigation Authority, a body set up by Ken Clarke when he was Secretary of State for Health in 1990 and which has more recently taken on overall responsibility through a number of selected firms of lawyers for the handling of all cases by patients against the NHS.

4. Most important for us as conservatives Liam Fox as Shadow Secretary for Health issued our own consultation document as long ago as last December 2001 which has received some 40 replies from all the major organisations which are currently being considered. I know that Oliver Heald MP of our Shadow Health team is taking a particular interest in this whole subject.

5. As to the structure of this meeting I intend to speak only comparatively briefly to set the scene and put it in the context of the 10 issues identified in our own conservative consultation paper. I shall then ask Arnold Simanowitz and Roger Clements to let us have their thoughts on the nature of the problem and sensible solutions. And then as soon as they have spoken we will throw the subject open to the floor. Among others I will ask Steve Walker if he would care to say a few words.

6. SUMMARY OF ISSUES

(a) The scale of the problem. It is important to understand this and get into perspective. Newspaper reports and indeed some Government documentation have mentioned a overall liability by the NHS arising out of the clinical negligence for which health trusts are responsible for as much as £4.4billion. This it must be remembered is not an annual figure but a cumulative figure bearing in mind that the average time for handling such cases – a problem in itself – is some 5½ years; and the £4.4billion represents the amount that would have to be paid if all such claims were successful.

(b) The second point that we must remember, particularly when ideas such as removal of legal aid, denial of monetary compensation, substitution by a so-called "no fault" compensation system, and fixed tariffs for particular injuries are concerned, is that what we are dealing with is the rights of individuals. We are talking about injuries suffered by individuals as a result of negligence, that is incompetent treatment by the health service, whether it be doctors or nurses or administrators or a combination of the two, negligence which has caused in many cases very serious injury to those individuals.

(c) When we approach these problems we as Conservatives must not forget our belief in those fundamental conservative notions, the importance of the individual, the concept of responsibility and the dangers of the present Government's constant striving for evermore centralisation and control, often to the reduction or elimination of the rights of individual citizens. We must always keep in mind, as Liam Fox rightly spelt out at the conference, importance of choice, of the recognition of professionalism within the health service and the power of the medical profession to handle cases in the way that they believe is in

the best interests of their patients. So that as Liam put it, all our citizens can get "the health care they deserve".

7. SIZE OF THE PROBLEM

This should not be exaggerated. Roger Clements will expand on this but the total cost is still well under 1% of annual health budgets and of course a very high proportion in cost is for long-term health care for those who tragically have suffered brain injuries or a combination of brain and physical injuries which means that they have to be cared for for the rest of their lives.

8. Openness, mediation and a swifter more friendly way of resolving what are often comparatively small claims where compensation is not the primary objective or necessity or where, if the system is inflexible, legal costs can easily equal or outweigh any amount of compensation awarded.

LIAM FOX'S 10 ISSUES

Just to remind you these cover the following topics:-

(i) Conciliation/mediation – which has much to recommend it
(ii) The effect of the Woolf reforms? Have these speeded up claims? I am personally much in favour of the idea that a judge or tribunal chairman should be available to take a grip of a case from a comparatively early stage if the combination of a complaints system, conciliation and mediation are not making progress.
(iii) Should there be a tribunal for claims under £50k?
(iv) Should there be some new law on clinical negligence – could we improve on the bolam test i.e. "care is not negligent if it is 'in accordance with a practice accepted as proper by a responsibly body of medical opinion'".

(v) Should there be compensation through the complaints system? – yes some melding of the complaints system and conciliation/mediation might be very sensible.
(vi) Handling of staff during investigations – very important, anyone can make a mistake and long periods of suspension are highly undesirable.
(vii) Should there be no fault compensation schemes?
(viii) What would be the implication for other fault cases if there were no fault introduced into clinical negligence? I am very doubtful indeed about the whole question of no fault compensation. It goes right back to the Pearson Report of the late 60's and has failed in Sweden and New Zealand. It

does not get rid of the question whether the injury is caused by a medical accident not does it get rid of the problems of the wider problems of causation.

(ix) Periodic payments for future loss – already been pioneered by the courts and sensible in some cases

(x) Fixed tariffs for general damages for pain and suffering and loss of amenity – rough and ready solution with little, in my view, to recommend it. If we get experienced professionals handling complaints and claims in the right way.

9. NL's PRELIMINARY SUGGESTIONS

(i) Openness and conciliation. Patients who have suffered a medical accident or adverse outcome are usually lost and confused, badly in need of help and guidance. Likewise the doctor, nurse or help professional who is involved and may have fallen short of the required standards also needs guidance and support. Suspension may be necessary but it should be avoided if possible. The fact is that many adverse procedures result from practitioners working at or sadly beyond the levels of their competence. Better monitoring and in-service training also have an important part to play in reducing the likelihood of mistakes and adverse outcomes. But openness, clear explanations and prompt availability of notes and records; and constructive remedial treatment where possible, are all likely to reduce trauma and anxiety and militate against a serious claim. But both sides, doctors and patients, need support. The system set up by Ken Clarke which removed the need for doctors to insure themselves and which meant that the NHS itself carries both risks was a big step forward. Nevertheless, loss of face, loss of promotion, or fear of loss of job, all encourage undesirable cover-ups unless proper support systems are in place.

(ii) Good conciliation will be likely to reduce the number of claims particularly the less serious ones. But the next step is proper monitoring and control of claims themselves. Along Woolf lines, an experienced judge or tribunal chairman should have responsibility for controlling claims from an early stage. Mediation should be an early option where possible with an experienced mediator.

(iii) Likewise more serious claims should be handled and controlled by judges experienced in the field. We should follow the example of the commercial court, and the

technology and construction court, where expert judges have control of a case from an early stage.

(iv) On the administrative front the NHS Litigation Authority has made big steps forward. The aim is not to do down the patient who has been significantly injured but to reach a fair and prompt outcome.

(v) No fault compensation is not a sensible option. I was saddened to see it recommended, yet again, in very inchoate form by the Kennedy Report i.e. the report on the Bristol Child Surgery. Sweden tried it, New Zealand tried it, modified it and never produced a very good result. It still required detailed questions as to whether the adverse result was caused by a medical accident or simply by the problems inherent in the patient's own illness or condition. It does not overcome the difficulties arising from fear of admitting professional shortcoming, which I have already mentioned. There is not enough money in the world to compensate everybody for everything. In the end what is required is that those who have been seriously injured are compensated in a way which will enable their lives to be as full and as well organised as reasonably possible.

(vi) Referring to the remainder of Liam Fox's 10 issues, many of these overlap. Tribunal for claims under £50k may make sense but I would suggest that it be in the context of a hierarchy of judicial control. Many complaints will be satisfactorily dealt with with explanation and apology. The next level which could be dealt with by the first level of judge may require both the resolution of the complaint and some compensation, possibly as high as £50k. The next stage is a full-blown case with an experienced judge in control. As to periodic payments for future loss the problem here is for the insurance companies. Insurance is a contract and insurers need to know where they stand. So does the patient. I should be interested to hear further views.

(vii) Finally fixed tariffs. I am opposed to these as being unnecessarily rough and ready. The courts as well documented by the law courts and up-to-date legal text books are expert in putting the right figure on to individual injuries and I see little merit in a crude system which is unlikely to leave anybody really satisfied.

Dr Roger Clements FRCOG pointed out that while the financial cost of claims totalled less than 1% of the annual health budget (the £4.4billion included claims over several years) one also had to consider the damage to the system and disfunctional performance by any health professional who feels they have made a serious mistake or is accused of doing so. He agreed with my point that medical staff in this position need strong support from their hospital and the State generally. They suffer a serious dent to their perception of self work.

Furthermore while the monetary costs should not be exaggerated, the seriousness of the problem was greater than that indicated by the number of actual claims. There were 7 times as many negative events as claims and some 3.7% of all hospital cases involve some degree of negligence.

He urged strongly that "honesty is the best policy". There should be rigorous "adverse outcome reporting". Dr Clements also opposed no-fault compensation as having proved unsatisfactory wherever it had been tried.

Arnold Simanowitz OBE the Chief Executive of AVMA also opposed no-fault compensation which he described as no real compensation at all. He pointed out that in New Zealand it was still necessary to show that the adverse event had been caused by medical error or mishap and patients were usually short-changed about the system.

On the contrary he was much in favour of a pre-action protocol so that everybody involved should get together at the earliest possible stage.

This was endorsed by Mr Steve Walker the Chief Executive of the NHSLA who before his appointment had been claims manager for the Municipal Mutual Insurance Company. He too was much in favour of all parties getting round the table at the earliest possible stage, putting their cards on the table, and seeking to reach a settlement as soon as was reasonably possible. It was no part of the NHSLA's policy to deprive those who had genuinely suffered of proper compensation. He did complain that sometimes legal advisers seemed unduly resistant to attempts to settle the case. A strong controlling line from an experienced judge from an early stage in the case ought to overcome such problems.