

Litigation matters: a claimant lawyer's perspective on NHS claims

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In the first of a new series, Edwina Rawson presents an analysis of the clinical negligence litigation process from a claimant lawyer's viewpoint.

It may be difficult for trust managers and medical practitioners to accept that there is a common goal between them and claimant litigation lawyers, but there is. Nobody wants to be the subject of a claim for compensation, but looking at the bigger picture, there is an argument that litigation, and the threat of it, improve and maintain standards. The steps involved in bringing a claim are simple to express although litigation can be complex. Swift resolution can keep costs down and help patients to move on.

It's not just about the money

Patients who have concerns about the treatment they receive often tell us that litigation is not about the money, but is a result of wanting to ensure that something similar does not happen to others. It is, they say, "a point of principle". Obviously, financial compensation is a factor especially if the person has ongoing care needs or is unable to do the job they were doing before the treatment, but it is often not the dominant one.

Not surprisingly, many patients want an apology and some recognition that they have been wronged, and considerable anger can stem from being denied these. Obviously, the practitioners and trusts should not accept legal responsibility unless there is fault, but from my own experience it is surprising how many cases settle despite the trust not apologising and not making an admission of liability at the complaints procedure or early in the court proceedings. Early admissions have the benefit of keeping legal costs to a minimum, but often claimants have to fight even strong cases which warrant an admission at an early stage.

No doubt all practitioners and trusts are aware of the advice from Stephen Walker, chief executive of the NHS Litigation Authority (NHSLA), in a letter dated 1 May 2009 to NHS chief executives and finance directors, which provides that:

"It is both natural and desirable for clinicians who have provided treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives; to express sorrow or regret at an outcome; and to apologise for shortcomings in treatment. It is important to patients that they or their relatives receive a meaningful apology. We encourage this, and stress that apologies do not constitute an admission of liability."

Whilst the emphasis on the importance of an apology is welcome, from a patient's perspective the approach is disappointing. We can, of course, appreciate that an apology does not necessarily indicate an admission of liability, but it should do so at least in cases where there have been "shortcomings in treatment". If apologies are necessarily

without any admission of liability, it is difficult to see how they can be regarded as "meaningful" and sincere. In any event, in my experience, it is still unusual for a client to receive an apology at an early stage.

Impact of negligence and the complaints procedure

It is trite to say that the impact of being the victim of medical negligence is huge and, as lawyers, we bear witness to this, probably more than the practitioners or the trusts. Bearing in mind that we are talking about treatment which has been so bad that no reasonable practitioner could have done it in the same way (see below), it is not surprising that people find this crushing and many of our clients suffer psychiatric problems as a result. In addition, people struggle with something bigger than the details of their own treatment – they find it difficult to come to terms with the loss of their inherent faith and trust in the medical profession generally.

The complaints procedure often fails to deliver a fair and proper assessment of the position. It is clear from the patients who come through our door that they often feel they were not listened to and/or that the trust did not give an accurate portrayal of events. If the complaints procedure was truly effective, there would be a correlation between cases which result in the patient being told there were no failings in treatment, and the cases that fail in litigation. However, this has not been our experience. It is, without doubt, better for everyone if liability is admitted early.

Steps in litigation

Clinical negligence cases can be extremely complicated. However, the actual steps involved in bringing a claim are surprisingly simple to express, as follows.

Funding

The basic rule is that the loser of litigation pays the winner's legal fees. At the outset of being instructed, an appropriate funding arrangement needs to be entered into. The options are:

- Public funding (formerly known as legal aid): this is only available in a small number of cases, in which a merits and a means test are satisfied. It is treated as a loan and if the case succeeds, the legal costs will be paid by the defendant trust and the Legal Services Commission will be reimbursed. Cases on behalf of children are usually funded this way.
- Before-the-event insurance: this is where the cost of legal fees is covered under "legal expenses insurance" on an insurance policy. Most clients find it bizarre (and I can understand why) that, say, their home insurer will pay the legal fees in relation to a medical negligence claim!

- Conditional fee agreements: these are sometimes referred to as “no win no fee” agreements, and have been subject to much media controversy. Under a conditional fee agreement, the solicitor agrees that he or she will not be paid anything at all if the claim does not succeed, but can charge a percentage uplift or success fee to the losing party if the claim does succeed. The justification for the success fee is that it covers the losses incurred in the claims that do not succeed. Many cases are pursued on this basis.
- After-the-event insurance: this is usually taken out in relation to the risk of losing the case and having to pay the trust’s legal fees, and in relation to own disbursements (that is, expenses such as the expert’s fee for providing a report). A common funding arrangement is for the solicitor and barrister to enter into conditional fee agreements, backed by after-the-event insurance to protect the client against losing and having to pay the trust’s fees.
- Private: clients could pay their own legal fees.

Investigation

The “investigation” is into whether there was negligence and whether the negligence caused injury which the patient would not have suffered in any event.

The test for negligence was established in the case of *Bolam v Friern Hospital Management Committee 1957*, and is whether the doctor concerned provided treatment to the standard required of a reasonably competent practitioner in that specialty at the relevant time. To put it colloquially, the treatment must have been so unreasonable that no reasonable doctor would have done the same. Under the *Bolitho v City and Hackney Health Authority 1997* principle, it is open to the court to decide that a particular practice is “illogical” and therefore unreasonable even if supported by a body of medical opinion. However, not surprisingly, this is rare.

Contrary to the view that we live in a compensation culture, the test for negligence is difficult to meet. Rightly, it protects practitioners and trusts against liability for mistakes that could have happened even in the best hands and only serious mistakes fall within the net. The practical reality is that in many cases there may have been mistakes, but these are not of sufficient gravity for the case to proceed. The law takes account of reasonable human error. This is something that members of the public and medical practitioners sometimes fail to appreciate.

If it can be established that the failings amount to negligence, in addition to this it has to be shown that there is “causation”, that is, on the balance of probability (over 50% likelihood) the negligence caused injury that the patient would otherwise not have suffered.

The first steps the solicitor will do in the investigation are to take a full witness statement from the client, obtain copies of medical records and to prepare a letter of instruction (which will set out the history and the particular issues that the independent medical expert needs to address), and identify an expert in the appropriate specialty to prepare the report.

After receipt of the independent medical expert’s report, and assuming that it supports a claim going forward, the pre-action protocol referred to in the Civil Procedure Rules should be complied with. The patient’s solicitor will write a letter, known as a letter of claim, to the defendant setting out the history, the allegations of negligence, details of causation of injury, and details of financial and other losses incurred as a result of the injury. The trust will then have three months in which to undertake its own investigation and to provide a letter of response. Assuming there

is no admission of liability at this stage, there will be a conference (meeting) with counsel (barrister), attended by the client, solicitor and the medical experts acting in the case. The purpose of the conference is to explore the issues, and to decide whether the case is sufficiently strong to proceed further.

Resolution

If the case is sufficiently strong, the next steps will be to issue and serve court proceedings. Thereafter, the case will be governed by a timetable which will cover service of a defence, exchange of witness statements relating to liability, exchange of reports prepared by the independent medical experts on behalf of the claimant and defendant, a meeting of the liability experts, investigation into quantum (the value of the claim in light of the claimant’s condition and prognosis), preparation of a claimant’s schedule of loss and future damage which provides details of the losses arising from the injury (such as the cost of appropriate care and loss of earnings), preparation by the defendant of quantum and a counter-schedule (setting out how the defendant views, for example, the claimant’s care needs and loss of earnings), and meetings between the quantum experts.

In many cases, usually after the defendant has received the claimant’s schedule of loss and future damage, there will be a round-table meeting to see if settlement can be reached. Only about 2% of cases reach the courts, with the remaining 98% either being abandoned or settled out of court.

Learning from litigation

Many doctors do not want to act as experts in litigation, and I have heard various reasons for this including a reluctance to criticise another doctor on the basis that “there but for the Grace of God go I”, and because there is an assumption that the doctor would have been doing his or her best and therefore should not be sued. Whilst this is understandable, the doctors who do act as experts report considerable benefits from doing so, including that the mistakes of others inform and improve their own practices and that they can report lessons to management at their trusts so that steps can be taken to avoid similar things happening.

Trust managers and medical practitioners also find it beneficial to read relevant case reports, which provide useful insight into the kinds of mistakes that are made and therefore the pitfalls that need to be avoided. In cases that reach the courts, it is helpful to know which failings a judge has found to have been negligent, and in cases that do not it is helpful to know which failings have resulted in the NHSLA settling rather than defending the claim.

Moving on

A downside of litigation is that it does keep “the problem” very much alive for the patient and is traumatic for the practitioners accused of mistakes. No matter how much we advise clients not to let the case become too much of a significant feature in their lives and not to expect to receive compensation, for many clients the claim does dominate. It is usually only after it has concluded that the client can really begin to move on from what happened and put both the treatment and the litigation behind them.

There is no doubt that medical litigation – like other areas of professional litigation – is here to stay. It is hoped that trusts will adopt a pro-active approach to giving apologies and, where appropriate, make admissions of liability at an early stage. Costs will be reduced and, more importantly, the patient will be in a position to move on sooner.

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