MADS ANDENAS[1]

La responsabilità professionale del medico nel diritto anglosassone
(sintesi della relazione)

INCREMENTAL DEVELOPMENT IN THE CASE LAW AND LIMITATIONS IN STATUTE LAW REFORM

VERONA 21 APRIL 2006

1. Some basic issues

Liability for medical malpractice continues to be one of the most fertile areas of English law. Each court term offers new decisions developing the law, and there is a continuous parliamentary statute law reform activity.

Tort law is a field dominated by the incrementalism of the common law. The law develops incrementally, not by establishing a broad principle but by extending a rule through analogy. This is a facts based process and the extension by analogy can be blocked by policy concerns.

The case law shows that there is a search for principle but that this has not overcome the limitations of the facts based incrementalism or analogy.

There is a role of parliamentary intervention through legislation. The Department for Constitutional Affairs, aided by the Law Commission, has the responsibility for the field but legislation is usually devoted to issues on the margin. Two new bills can lead to more important changes, in particular the new NHS Redress Scheme. Both bills are presented against a background of rising costs of awards and litigation, and this is seen as indicative of a growing litigation culture.

The focus remains on the individual professional (medical doctor). The institutional context and parliamentary legislation

Insurance issues.

Public or private law distinctions. *Draon*[2]

2. Institutional liability

Focus in the case law is on liability for the individual doctor or other health professional. The issues relate to the standard of care, causation and economic loss. Doctors or other

---

[1] PhD (Cambridge); MA, DPhil (Oxford); Professor of Law, University of Leicester; Senior Fellow, Institute of European and Comparative Law, University of Oxford. General Editor of the International and Comparative Law Quarterly and of European Business Law Review. Former Director of the British Institute of International and Comparative Law, London and of the the Centre of European Law, King's College, University of London.

[2] 2005 decision by the European Court of Human Rights.

health professionals function within an institutional framework. This affects liability and insurance more than one may understand from the case law.

Imposing liability on the institution (hospital) takes the financial responsibility away from the individual professional. It is taken over by the institution providing the medical service. Legally, the employee/professional remains responsible to the patient when the institution is vicariously liable. The institution has an indemnity against the employee.

In practice, the institution will be sued and pay the damages (and the indemnity will not be made use of).

Until 1990, doctors employed in the National Health Service (NHS), had to subscribe to one of the medical defence organisations, The Medical Defence Union, Medical and Dental Defence Union of Scotland and the Medical Protection Society. After 1990 and the introduction of the NHS Indemnity Scheme[3] and later the Clinical Negligence Scheme for Trusts,[4] NHS authorities assumed responsibility for medical negligence claims. Doctors employed in the National Health Service (NHS), no longer have to subscribe to one of the medical defence organisations. This followed an increase in the subscription rates of the medical defence organisations in the 1980s. The outcome was a negotiated arrangement with the medical defence organisations.

The NHS has changed since the NHS indemnity[5] was introduced in 1990. NHS hospitals are organised as NHS Trusts with separate legal personality. A special health authority, the NHS Litigation Authority, manages all claims for clinical negligence against NHS employees. The NHS Litigation Authority also administers risk pooling schemes including the Clinical Negligence Scheme for Trusts established in 1995.

The NHS indemnity covers the vicarious liability of an NHS body for the negligence of staff acting in the course of their employment. No contribution is sought from the employee.

The NHS indemnity does not apply to private hospitals. Neither does it apply to private work undertaken by a consultant in an NHS hospital.

Private hospitals have to take commercial insurance cover. Doctors engaging in private practice (not covered by the NHS indemnity or private hospital commercial insurance), will normally be members of a defence organisation providing indemnity for professional negligence claims.

3. The NHS Redress Bill: A Major Initiative to Reforming the Approach to Clinical Negligence in the NHS

---

[3] HC (89)34, updated as HSG (96)48.

[4] National Health Service (Clinical Negligence Scheme) Regulations 1996, SI 1996/251, made pursuant to the National health Service and Community Care Act 1990, section 21.

[5] See A Grubb and J Laing *Principles of Medical Law* (2 ed OUP Oxford 2003) 542-545.

In a 2003 consultation paper[6] the Chief Medical Officer set out proposals for reforming the approach to clinical negligence in the NHS.[7] The concern was the growing costs of litigation[8] and damages awards.

The proposal is for a new NHS based system of redress (The NHS Redress Scheme). It would provide redress for patients 'who have been harmed as a result of seriously substandard NHS hospital care'. It will provide investigations when things go wrong, remedial treatment, rehabilitation and care when needed, and also explanations and apologies.

The proposed NHS Redress Scheme would have four main elements: (1) an investigation of the incident which is alleged to have caused harm and of the harm that has resulted; (2) provision of an explanation to the patient and of the action proposed to prevent repetition; (3) development and delivery of a package of care providing remedial treatment, therapy and arrangements for continuing care where needed; and (4) payments for pain and suffering, out of pocket expenses and care or treatment which the NHS could not provide.

Patients would be eligible for payment for serious shortcomings in NHS care if the harm could have been avoided and if the adverse outcome was not the result of the natural progression of the illness. Payment would be made by a local NHS Trust for reimbursement of the cost of the care leading to harm (or similar amount). Payment would be made by a national body for amounts up to £30,000.

Special provisions were envisaged for families of neurologically impaired babies. They would also be eligible for the new NHS Redress Scheme if the birth was under NHS care, the impairment was birth-related, and severe neurological impairment (including cerebral palsy) was evident at birth or within eight years (genetic or congenital abnormality would be excluded). A package of compensation would be provided in cash or kind according to the severity of the impairment, judged according to the ability to perform the tasks of daily living. It would comprise a managed care package, and a monthly payment for the costs of care (at home or in a residential setting) which cannot be provided through a care package (in the most severe cases this could be up to £100,000 per annum). There would be a one-

---

[6] *Making Amends – A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS.* A report by the Chief Medical Officer (June 2003).

[7] With the different jurisdictions in the United Kingdom, and the devolution process giving more autonomy to Wales, Scotland and Northern Ireland, the recommendations could only apply to England . The proposed changes to arrangements in England for care and compensation for severely neurologically impaired babies could have implications for the rest of the United Kingdom. It was stated in the report that these issues were discussed with the devolved administrations.

[8] See the interesting comparative study in P Fenn, A Gray, N Rickman, Y Mansur *The funding of personal injury litigation: comparisons over time and across jurisdictions* (Department of Constitutional Affairs London 2005). From their survey, it appears that conditional fee arrangements (CFAs) have recently become a significant source of funding for new clinical negligence cases, although still in the minority by comparison with those funded by legal aid and private hourly fees. The proportion of all cases that were legally aided (publicly funded) was 33%1. The remaining 67% were almost equally split between CFA cases and those funded in some other way (presumably by private hourly fee). An emerging feature is the increasing proportion of CFA clinical negligence cases referred by Trade Unions; 12% of all open CFA cases were referred by Trade Unions.

off lump sum payments for home adaptations and equipment at intervals throughout the child's life (in the most severe cases, this could be up to £50,000). There would also be an initial payment in compensation for pain, suffering and loss of amenity capped at £50,000.

The new NHS Redress Scheme would apply to NHS patients treated in hospital and community health settings. Only in the next stage would further consideration be given to redress for patients treated under NHS funding arrangements but by independent or voluntary sector providers in the United Kingdom or abroad.
It was also proposed that 'after a suitable period of operation and evaluation', it should be considered to extend the scheme to provide higher financial compensation and to encompass NHS primary care services.

A national body building on the work of the NHS Litigation Authority would operate the new procedures. In the case of the element of the scheme relating to neurologically impaired babies, a national expert panel would be responsible for determining whether the impairment was birth-related, reviewing the severity of impairment and other factors and reporting to the national body.

The new NHS Redress Scheme would not take away a person's right to sue through the Courts. It was indicated that there may be a duty to exhaust the application procedure under the scheme before turning to the court system. Those accepting packages of care and compensation under the scheme would be required to waive their right to go to court on the same case.

For cases that do not fall within the criteria of the scheme it was proposed that there would be an expectation that mediation would be used as a first step. Pre-action protocols would require mediation to be attempted in specified types of cases. Acceptance of a mediation package would be binding. There would be strong encouragement of the use of periodical payments in larger value cases including 'out of court' settlements. The costs of future care would no longer reflect the cost of private treatment. Specialist training would be provided to judges handling clinical negligence cases.

The Department for Health published *NHS Redress: Statement of Policy* in 2005 together with the NHS Redress Bill.[9]

Four 'key policy drivers' for the proposed reforms with the NHS Redress Scheme as its main element were identified:
(i) the current system is perceived to be complex and slow;
(ii) the current system is costly both in terms of legal fees and diverting clinical staff from clinical care; there is a negative effect on NHS staff morale and on public confidence;
(iii) patients are dissatisfied with the lack of explanations and apologies or reassurance that action
has been taken to prevent the same incident happening to another patient; and
(iv) the system is said to encourage defensiveness and secrecy in the NHS, which stands in the way of learning and improvement in the health service.

[9] The NHS Redress Bill, Explanatory Notes, and Regulatory Impact Assessment are available at www.dh.gov.uk/actsandbills.

The Department for Health stated in *NHS Redress: Statement of Policy* that the Bill for the NHS Redress Scheme will provide a genuine alternative to litigation for less severe cases where there is a qualifying liability in tort arising out of hospital treatment, removing the risks and costs of litigation from the patient. The scheme will aim to address the delays that are inherent in the current system and help reduce the general burden of litigation costs (which cost the NHS nearly half a billion pounds every year). Overall, the Department for Health expects that costs will increase in the short term: more patients may receive compensation as scheme members take an active approach to identifying eligible cases and providing redress. However, the Department for Health expects that these costs will be offset over time by a reduction in the amount of money spent on legal fees for litigated cases.

The Bill will enable the Secretary of State for Health to set up a redress scheme. This will be done by regulations. They will apply to cases involving liabilities in tort arising out of hospital care provided as part of the NHS in England (wherever that care is provided) and set out the detailed rules governing the operation of the scheme in secondary legislation. It is intended that the scheme will be reviewed three years after implementation. Placing these rules in regulations (secondary legislation) will allow the scheme to be more easily amended. It also ensures that there is the necessary flexibility to adapt the scheme in order to reflect the changing ways in which NHS services are delivered, and limits the technical and administrative detail that appears in primary legislation (parliamentary statute).

The 2005 *Statement of Policy* sets out in some detail how it is intended that the NHS Redress Scheme will work in practice, and how the powers taken in the primary legislation are proposed to be used in the secondary legislation. It is stated that this detail has been developed through extensive discussions with stakeholders as to how the scheme might most effectively work in practice. However, these details are not final; the intention is to work with stakeholders in drafting the secondary legislation and then to publish the draft regulations for further, more formal consultation. It is stated that this will ensure that the scheme works effectively on the ground. The draft regulations will be published for consultation by summer 2006.

The 2005 *Statement of Policy* states that there will be a single scheme scheduled to the regulations made under the powers taken in this Bill. When the scheme is first established, the regulations and scheme will be subject to affirmative resolution procedure in order to allow full parliamentary scrutiny.

4. The 2005 Compensation Bill

In 2005 the Government also introduced the Compensation Bill to Parliament which is likely to be adopted before summer 2005. It contains two parts, the first dealing a particular aspect of the test for negligence, and the second with so-called claims farmers.

Part I, Section1 deals with the deterrent effect of potential liability. It provides that:

> A court considering a claim in negligence may, in determining whether the defendant should have taken particular steps to meet the standard of care (whether

by taking precautions against risk or otherwise), have regard to whether the requirement to take those steps might -
(a) prevent a desirable activity from being undertaken at all, to a particular extent or in a particular way, or
(b) discourage persons from undertaking functions in connection with a desirable activity.

Section 2 provides that apologies, offers of treatment or other redress shall not be regarded as any admission of liability.

Part 2 sets out a regulatory scheme for so called claims farmers. The purpose of this scheme is to promote best practices. It is supposed to counteract the growth of a compensation culture.

5. Negligence and the Duty of Care

Standard of care.

Who is the duty owed to?

D V East Berkshire Health Authority [2004]QB 558

”In so far as the position of a child is concerned we have reached the firm conclusion that the decision in Bedfordshire cannot survive the Human Rights Act. Where child abuse is suspected the interests of the child are paramount – see Section 1 Children Act 1989. Given the obligation of the local authority to respect a child's convention rights, the recognition of a duty of care to the child on the part of those involved should not have a significantly adverse effect on the manner in which they perform their duties. In the context of suspected child abuse, breach of a duty of care in negligence will frequently also amount to a violation of Article 3 or Article 8. The difference of course is that those asserting that wrongful acts or omissions occurred before October 2000 will have no claim under the Human Rights Act. This cannot however, constitute a valid reason of policy for preserving a limitation of the common law duty of care which is not otherwise justified. On the contrary the absence of an alternative remedy for children who were victims of abuse before October 2000 militates in favour of the recognition of a common law duty of care once the public policy reasons against this have lost their force.
It follows that it will no longer be legitimate to rule that, as a matter of law, no common law duty of care is owed to a child in relation to investigation of suspected child abuse and the initiation and pursuit of care proceedings. It is possible that that there will be factual situations where it is not fair just and reasonable to impose a duty of care but each case will fall to be determined on its individual facts…….where consideration is being given to whether the suspicion of child abuse justifies taking proceedings to remove a

child from its parents, while a duty of care can be owed to a child, no common law duty of care is owed to the parents."

5. Dealing with Causation in the Case Law

Here we have a number of cases. The House of Lords judgment in *Chester v Afshar* [2004] UKHL 41 [2004] 3 WLR 927 is dealing with a particular causation problem. The surgeon had negligently failed to warn Ms Chester (the claimant) of risk of post-operative paralysis. The operation was conducted without negligence but paralysis occurring. Ms Chester would not have undergone operation at that time if she had been informed of risk (but probably at some later stage). The House of Lords held that the causal link remained between failure to warn of risk and claimant's injury.

The defendant, a neurosurgeon, advised the claimant to undergo a surgical procedure on her spine which, even if conducted without negligence, carried a small risk that the claimant would develop cauda equina syndrome. Ms Chester reluctantly agreed and the procedure was carried out shortly after the consultation. She subsequently developed cauda equina syndrome and brought an action against the defendant in negligence. The judge found that the defendant had negligently failed to warn Ms Chester of the risk of developing the syndrome, that had she been aware of the risk she would have sought advice on alternatives to surgery and the operation would not have taken place when it did, but that the defendant had not been negligent in its performance. The judge held that there was a sufficient causal link between the defendant's failure to warn and the damage sustained by Ms Chester and that the link was not broken by the possibility that the claimant might have consented to surgery in the future. He accordingly concluded that the defendant was liable in damages.

The Court of Appeal had dismissed the defendant's appeal. The judge at first instance had not found that, if properly informed, Ms Chester would never have undergone the operation and since the risk which eventuated was liable to occur at random irrespective of the skill and care with which the operation might be performed, the defendant's failure to warn neither affected the risk nor was the effective cause of the injury she sustained, so that, applying conventional principles, she could not satisfy the test of causation.

The majority in the House of Lords (Lord Bingham of Cornhill and Lord Hoffmann dissenting) saw it differently. The issue of causation was to be addressed by reference to the scope of the doctor's duty, namely, to advise his patient of the disadvantages or dangers of the treatment he proposed. Such a duty was closely connected with the need for the patient's consent and was central to her right to exercise an informed choice as to whether and, if so, when and from whom to receive treatment. The injury she sustained was within the scope of the defendant's duty to warn and was the result of the risk of which she was entitled to be warned when he obtained her consent to the operation in

which it occurred, the injury was to be regarded as having been caused by the defendant's breach of that duty. Justice required a narrow modification of traditional causation principles to vindicate the claimant's right of choice and to provide a remedy for the breach (para 101).

Lord Hope
"I would accept that a solution to this problem which is in Miss Chester's favour cannot be based on conventional causation principles…..Nor does it seem to me that an appeal to common sense alone will provide a satisfactory answer to the problem"

What are the principles governing causation? We look at some other recent decisions.

Gregg v Scott [2005] 2 AC 176 Lord Hoffmann (in the majority)
"A wholesale adoption of possible rather than probable causation as the criterion of liability would be so radical a change in our law as to amount to a legislative act. It would have enormous consequences for insurance companies and the National Health Service… I think any such change should be left to Parliament".

Lord Nicholls (in the minority)
"The law must strive to achieve a result which is fair to both parties in present day conditions. The common law's ability to develop in this way is its proudest boast. But the present state of the law on this aspect of medical negligence, far from meeting present day requirements of fairness, generates continuing instinctive judicial unease."

Lord Steyn in *McFarlane v Tayside Health Board* [2000] 2 AC 59

"It is possible to view the case simply on the basis of corrective justice. It requires somebody who has harmed another without justification to indemnify the other. On this approach the parents claim for cost of upbringing must succeed. But one may also approach the case from the vantage point of distributive justice. It requires a focus on the just distribution of burdens and losses among members of a society. If the matter is approached in this way, it may become relevant to ask commuters on the Underground the following question: should the parents of a healthy but unwanted child be able to sue the doctor or hospital for compensation….I am firmly of the view that an overwhelming number of ordinary men and women would answer the question with an emphatic "no"……My lords to explain decisions denying a remedy for the cost of upbringing of an unwanted child by saying there is no loss, no foreseeable loss, no causative link or no ground reasonable restitution is to resort to unrealistic and formalistic propositions which mask the real reasons for the decisions. And judges ought to strive to give the real reasons for their decision. It is my firm conviction that where courts of law have denied a remedy for the cost of upbringing an unwanted child the real reasons have been grounds of distributive justice."……The Court must apply positive law. But Judge's sense of the

moral answer to a question, or the justice of the case, has been one of the great shaping forces of the common law."

Lord Nicholls in *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32
"The present appeals are another example of such circumstances where good policy reasons exist for departing from the usual threshold "but for" test of causation. ..A former employee's liability to identify which particular period of wrongful exposure brought about the onset of the disease ought not in all justice to preclude recovery of compensation……
I would not use the phraseology of legal inference..the phraseology tends to obscure the fact that when applying the principle described above the court is not, by a process of inference concluding that the ordinary "but for" standard of causation is satisfied. Instead the court is applying a different and less stringent test. It were best if this were recognized openly".

Lord Bingham in *Rees v Darlington Memorial Hospital NHS Trust* [2004] 1 AC 309 "In McFarlane there were three solutions which the House could have adopted: (1) That full damages against the tortfeasor for the cost of rearing the child may be allowed subject to the ordinary limitations of reasonable forseeability and remoteness… (2) damages be recoverable with a deduction from the amount of such damages for the joy and benefits received…(3) that no damages may be recovered……..An orthodox application of familiar and conventional principles of the law of tort would I think, have pointed towards acceptance of the first of these solutions. The five members of the House who gave judgment in McFarlane adopted different approaches and gave different reasons for adopting the third solution. But it seems to me clear all of them were moved to adopt it for reasons of policy (legal, not public policy). …..It seems to me that it is a question of policy which we, as judges, have to decide. The time has come when in cases of new import we should decide them according to the reason of the thing.
In previous times, when faced with a new problem, the judges have not openly asked themselves the question: was is the best policy for the law to adopt? But the question has always been there in the background. It has been concealed behind such questions as: Was the defendant under any duty to the plaintiff? Was the relationship between them sufficiently proximate? Was the injury direct or indirect? Was it foreseeable or not? Was it too remote and so forth? Nowadays we direct ourselves to considerations of policy.

Lord Steyn in *Rees v Darlington Memorial Hospital NHS Trust*
"…the House [in McFarlane] did not rest its decision on public policy in a conventional sense….instead the Law Lords relied on legal policy. In considering this question the House was bound in the circumstances of the case to consider what in their view the ordinary citizen would regard as morally acceptable. Invoking the moral theory of distributive justice and the requirements of being just fair and reasonable, culled from case law, are in context simply routes to establishing the legal policy."

5 Level of Loss

Here are several issues. One is the level of care. Another is the deduction of the benefits receive from the state.

In *Freeman and Lockett* [2006] EWHC 102 (QB) Mr Justice Tomlinson would not deduct financial benefit from the local authority funding the provision of practical assistance in the home.