

# MEDICAL MALPRACTICE AND COMPENSATION IN THE UK

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## 1. Introduction

It is timely to be writing a paper on medical malpractice and compensation in the UK. As we shall see, several issues are currently commanding attention in England and Wales and in Scotland. Indeed, it is fair to say that at no time in recent years has the future of clinical negligence litigation in the UK been as uncertain as it is now.

In the first part of this paper, I examine the context in which medical malpractice liability is operating in the UK. We will see that the fact that the state-run National Health Service is the major health care provider has several implications, since funding for medical malpractice compensation in the NHS comes from the taxpayer. For several years, the civil justice system has been failing to meet the needs of litigants in clinical negligence claims, and I examine the commissioned reports that have attempted to address these problems.

I go on to examine the most recent empirical evidence on the incidence and funding of claims in England and Scotland, to show a trend of expenditure on clinical negligence increasing, particularly in England. A statutory framework for the empowerment of some of the Chief Medical Officer's recommendations in his report, *Making Amends* is present in the NHS Redress Act 2006, and this is briefly assessed. In Scotland, while medical negligence remains the primary route to bringing a claim for compensation for medical injury, no-fault compensation is now the favoured way forward of the Scottish Government for the NHS in Scotland. A No Fault Compensation Review Group has just reported and I examine its recommendations, which provide a radical development in the field of compensation for medical malpractice.

The heart of the paper examines the existing basis of medical liability, with particular emphasis on the problems in establishing negligence and factual causation. Finally, I examine in the context of clinical negligence claims both the recommendations for reforming the costs of civil litigation in England and Wales and the dramatic changes being introduced to the Legal Aid system, in particular the abolition of legal aid for clinical negligence cases.

## 2. The Context of Medical Malpractice Liability

By far the majority of the healthcare provision in the United Kingdom (UK) is under the National Health Service (NHS). Since its establishment in 1948 by the then Labour Atlee Government, it has grown to become the world's largest publicly funded health service. With the exception of charges for some prescriptions and optical and dental services, the NHS

continues to remain free at the point of use for anyone resident in the UK. While funded centrally from national taxation, NHS services in England, Northern Ireland, Scotland and Wales are managed separately.<sup>1</sup> There is some private sector health care, which the Conservative part of the coalition government is keen to expand over the next few years, but the NHS continues to be the primary health care provider in Great Britain and Northern Ireland.

This has major consequences in that when compensation and legal costs are payable as a result of medical malpractice in the NHS, this money comes from the taxpayer. Indeed, in England this money comes out of the Department of Health's own budget. In an era of increasing austerity in public service provision in the UK, there is great concern as to the increasing costs to the public purse of clinical negligence claims. This concern had been present for several years before the recent world financial crisis,<sup>2</sup> but now, more than ever before, it has become the dominant issue in clinical negligence litigation.

In his review of the Civil Justice System in 1996, Lord Woolf singled out medical negligence for the most intensive examination because it was in that area that the civil justice system was failing most conspicuously to meet the needs of litigants.<sup>3</sup> Lord Woolf emphasised five major problems with the system, viz.: (a) the excessive disproportion between costs and damages in medical negligence, especially in lower value cases; (b) the often unacceptable delay in resolving claims; (c) the overly long pursuit of unmeritorious claims and the defence of clear-cut claims; (d) the lower success rate than in other personal injury litigation; and (e) the greater suspicion and lack of cooperation between the parties than in many other areas of litigation.<sup>4</sup> The resulting revision of the Civil Procedure Rules contained several measures to improve the litigation process in medical negligence cases, though whether this has resulted in a significant reduction of costs remains to be seen.<sup>5</sup> The weaknesses of the current system of providing compensation to those suffering harm arising

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<sup>1</sup> See <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx>, last accessed on 29 November 2010.

<sup>2</sup> See, generally, the Chief Medical Officer's Report, Department of Health, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence* (London: Department of Health, 2003).

<sup>3</sup> Rt. Hon. Lord Woolf, *Access to Justice: Final Report* (London, The Stationary Office, 1996), Ch 15, para 1-2.

<sup>4</sup> *Ibid*, para 2.

<sup>5</sup> Civil Procedure Rules 1998 SI No. 3132 (CPR); M. Jones, *Medical Negligence* (London, Sweet & Maxwell, 4<sup>th</sup> ed, 2008), para 1-028. See, especially, CPR Pt 35 (Experts and Assessors). Note the overriding objective of the Civil Procedure Rules, which is to deal with cases justly, having regard to, inter alia, saving expense, dealing with the case in ways that are proportionate to the amount of money involved, the importance of the case, the complexity of the issues and the financial position of each party: CPR r.1.1.

out of medical care were highlighted as needing urgent review by Sir Ian Kennedy in the Final Report of the Bristol Royal Infirmary Inquiry.<sup>6</sup> Indeed, the Report went further in recommending the abolition of the clinical negligence system, and its replacement by “an alternative system for compensating those patients who suffer harm arising out of treatment from the NHS”.<sup>7</sup>

In response to such calls for reform, the Department of Health initiated a review of the system of handling claims for compensation and complaints, which resulted in a report by the Chief Medical Officer in 2003.<sup>8</sup> While rejecting a wide-ranging no-fault scheme for all types of injury, primarily on the grounds of costs and the practicalities in framing it,<sup>9</sup> the Chief Medical Officer in his report, *Making Amends*, proposed “a composite package of reform”,<sup>10</sup> which would apply to England only, and which involved a new system of providing redress for patients harmed “as a result of seriously substandard NHS hospital care” (The NHS Redress Scheme).<sup>11</sup>

There would be four main elements to these arrangements, viz: (1) an investigation of the incident which is alleged to have caused harm and the resulting harm; (2) provision of an explanation to the patient of what happened and why, and of the action proposed to prevent repetition; (3) the development and delivery of a package of care, providing remedial treatment, therapy, or continuing care, as where necessary; and (4), payments for pain and suffering, out of pocket expenses and the costs of care or treatment, which the NHS could not provide.<sup>12</sup> The NHS Redress Scheme would also encompass a care and compensation package for seriously neurologically impaired babies, including those with cerebral palsy, where the impairment was related to or resulted from the birth.<sup>13</sup> The overall goal of these proposed reforms was that they would be “fair both to individual patients and meet their

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<sup>6</sup> Learning from Bristol: The Report of the Public Inquiry into Children’s Heart Surgery at the Bristol Royal Infirmary CM 5207 (I) (July 2001), recommendation 37.

<sup>7</sup> Ibid, recommendation 119.

<sup>8</sup> Department of Health, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (June 2003).

<sup>9</sup> Ibid, Ch 7, p. 113, para 15.

<sup>10</sup> Ibid, Ch 7, p.115, para 22.

<sup>11</sup> Ibid, Ch 8, p119, para 10, recommendation 1.

<sup>12</sup> Ibid, Ch 8, p119, para 10, recommendation 1.

<sup>13</sup> Ibid, Ch 8, pp120-121, para 10, recommendation 2.

needs as well as making care safer for all NHS patients”.<sup>14</sup> This has been subject to criticism, in that it has been pointed out that it is far from obvious that the litigation system needs to be changed “*in order* to make health care safer”.<sup>15</sup>

### **3. Recent Empirical Evidence on the Numbers and Funding of Claims.**

#### **(a) England**

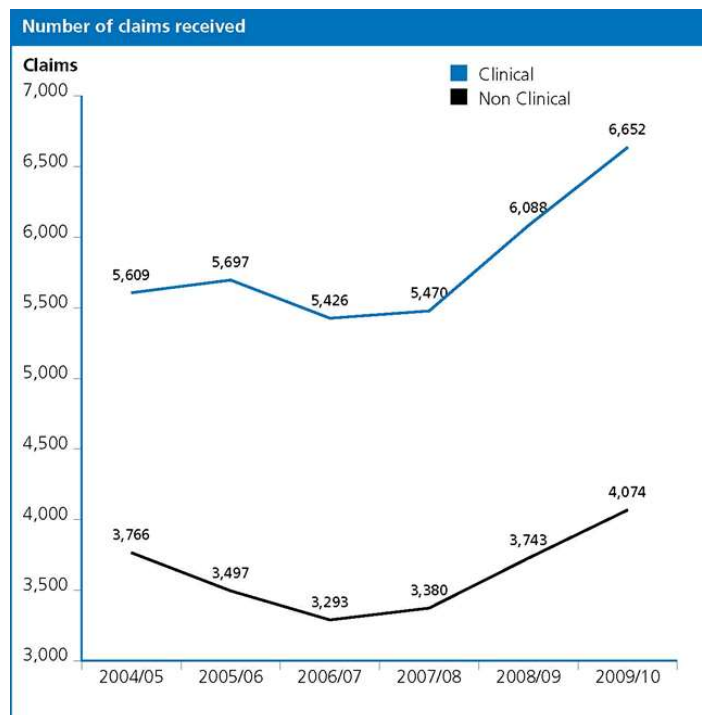
In England, the principal statistics are now published in the Annual Report and Accounts of the authority which indemnifies English NHS bodies against claims for clinical negligence, viz. the National Health Service Litigation Authority (NHSLA).<sup>16</sup> The numbers of claims made on an annual basis has been largely static, although the latest figures from the NHSLA’s Annual Report and Accounts 2010 have seen an increase in claim numbers; expenditure on clinical negligence continues to increase.

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<sup>14</sup> Ibid, Ch 8, pp117-118, para 4.

<sup>15</sup> M. Jones, *Medical Negligence* (London, Sweet & Maxwell, 4<sup>th</sup> ed, 2008), p49. While, “[t]here is no evidence that the litigation process makes health less safe there is plenty of evidence that the less safe health care is, the more litigation there will be”: *ibid*, p49.

<sup>16</sup> The NHSLA was established in November 1995 (see the National Health Service Litigation Authority (Establishment and Constitution) Order SI 1995/2800, as amended by SI’s 2002/2621, 2005/503 and 2005/1445) to indemnify English NHS bodies against clinical negligence: see NHSLA Factsheet 1: background information, <http://www.nhsla.com> .



Graph 1. Number of claims received by NHSLA.

Source: NHSLA Annual Report and Accounts, 2010, p13; © Crown Copyright 2010.

As we can see from Graph 1, the number of clinical negligence claims reported to the NHSLA in 2009/10 was 6,652, which represents a 10% increase over 2008/9 (6,088) which, in turn, recorded an 11% increase over 2007/08 (5,470).<sup>17</sup> While the NHSLA have described these figures as a matter for concern, there has been previously three years of relative stability in claim numbers.<sup>18</sup> The NHSLA have examined the reasons for the growth in volume of claims, and remain convinced that a major factor is the availability of the “ ‘so-called’ no win no fee market”,<sup>19</sup> which enables claimants to litigate without financial risk, and which proves very lucrative for claimant solicitors.<sup>20</sup> It is submitted that, when viewed in the context of the

<sup>17</sup> *The National Health Service Litigation Authority: Report and Accounts 2010* (London, The Stationary Office, 2010), Chief Executive’s report, p7; Claims received, p13. Since submission of this paper, the NHSLA Report and Accounts 2010-2011 have now been published. The number of clinical negligence claims reported to the NHSLA in 2010/11 was 8,655, which represents a 30% increase over 2009/10 (6,652). The NHSLA suggests that the significant increase in claims may be explained by the requirement for claims to now send the NHSLA a copy of the Letter of Claim at the same time as it is sent to the defendant NHS body, at which point they now record the claim. They are analysing patterns and trends to obtain a better understanding behind the increase: *The National Health Service Litigation Authority: Report and Accounts 2010-2011* (London, The Stationary Office, 2011), Claims Received, pp12-13.

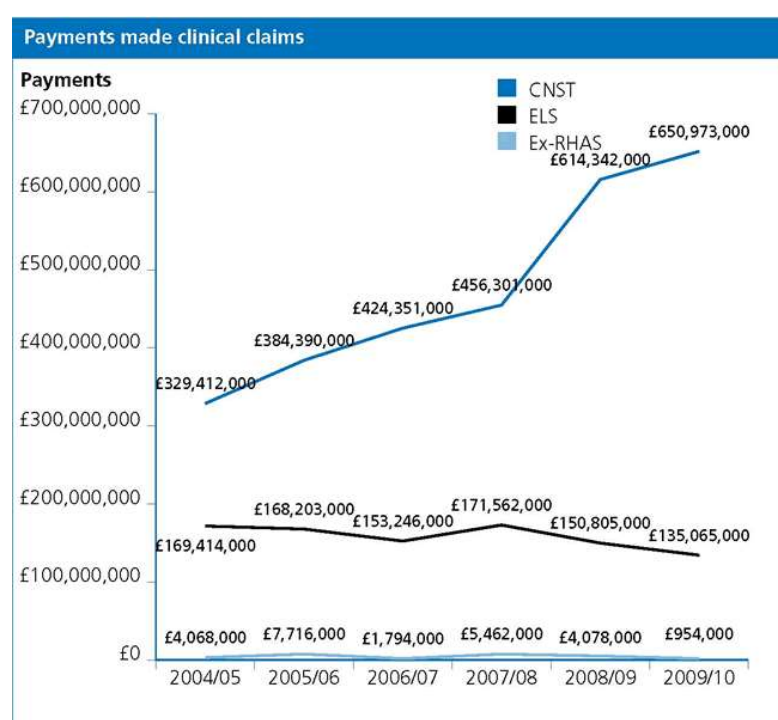
<sup>18</sup> *Ibid*, p7.

<sup>19</sup> *Ibid*.

<sup>20</sup> *Ibid*.

previous three years of relative stability, the increase in claim numbers during the last two years should not give rise to the degree of concern that appears to have emanated from the NHS LA. In this context, it should be remembered that it is difficult to identify reliable, definitive, evidence concerning the number of medical errors and claims occurring as a whole, and great care must be used when attempting to draw conclusions from the figures available.<sup>21</sup>

However, it is fair to say that the overall legal costs are rising. The authority's expenditure on clinical negligence claims has continued to rise over the last two years. Graph 2 shows that the figures have risen from £633,325,000 in 2007/08 to £769,226,000 in 2008/9, to £786,991,000 in 2009/10.<sup>22</sup>



Graph 2. Payments made in clinical claims

Source: NHS LA Annual Report and Accounts, 2010, p15; © Crown Copyright 2010.

<sup>21</sup> V. Harpwood, *Medicine, Malpractice and Misapprehensions* (Oxford: Routledge Cavendish, 2007), p46.

<sup>22</sup> *The National Health Service Litigation Authority: Report and Accounts 2010* (London, The Stationary Office, 2010), p.15. Since submission of this paper, the NHS LA Report and Accounts 2010-2011 have now been published. The legal costs figure has risen to £863,400,000 in 2010/11: *The National Health Service Litigation Authority: Report and Accounts 2010-2011* (London, The Stationary Office, 2011), p14.

As at 31 March 2010, the provisions for periodical payments (i.e. damage settlements which include payments made on a regular basis, usually throughout the claimant's life, in place of the traditional single lump sum) now total £1.88 billion.<sup>23</sup>

## **(b) Scotland**

In Scotland, the NHS Health Boards currently fund all settlements of clinical negligence claims, but receive additional protection from disproportionate losses through participation in the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS), a risk-sharing scheme whose membership is mandatory for all NHSScotland healthcare bodies.<sup>24</sup> The Central Legal Office of NHSScotland defends claims on behalf of the NHS Boards. While claims rose during the 1990s, there has been a declining trend since 1999.<sup>25</sup> In 2008/9, the number of potential clinical negligence claims notified to Health Boards was 362 (342 medical and dental and 20 nursing).<sup>26</sup> During 2008/9, 171 claims were settled with £26, 007, 747 paid out in settlements,<sup>27</sup> with adverse legal costs amounting to £2.5 million.<sup>28</sup> While the number of settled claims from 1989-2009 has only increased slightly, in respect of the total awards and costs of settled claims from 1989-2009, the average sum awarded has risen significantly over that period. In addition, for claims with awards below £20,000, during the

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<sup>23</sup> Since submission of this paper, the NHSLA Report and Accounts 2010-11 have now been published. As at 31 March 2011, the provisions for periodical payments totalled £2.41 billion: *The National Health Service Litigation Authority: Report and Accounts 2010-2011* (London, The Stationary Office, 2011), p16.

<sup>24</sup> See A-M Farrell, S. Devaney and A Dar, *No Fault Compensation Schemes for Medical Injury: A Review* (Scottish Government Social Research, 2010), para 1.2. In 2008/9, the NHS Boards contributed £27 million to CNORIS: Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Scottish Parliament Written Answers, S3W-32002, Thursday 11 March 2010, available at <http://www.scottish.parliament.uk/Apps2/Business/PQA/Default.aspx>, last accessed on 29 September 2011.

<sup>25</sup> *No Fault Compensation Review Group, Report and Recommendations: Vol. 1*, 15 February 2011, para 2.16, available at: <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport>.

<sup>26</sup> A-M Farrell, S. Devaney and A Dar, *No Fault Compensation Schemes for Medical Injury: A Review* (Scottish Government Social Research, 2010), para 1.2.

<sup>27</sup> Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Scottish Parliament Written Answers, S3W-30597, Monday 25 January 2010, available at <http://www.scottish.parliament.uk/Apps2/Business/PQA/Default.aspx>, last accessed on 29 September 2011.

<sup>28</sup> A-M Farrell, S. Devaney and A Dar, *No Fault Compensation Schemes for Medical Injury: A Review* (Scottish Government Social Research, 2010), para 1.2.

period 1998-2009, the costs have been rising and currently can be greater than the awards made. In addition, significant costs are incurred for unsettled claims: during the period of 1998-2009 the costs rose from around £300,000 to over £1million.<sup>29</sup>

### **(c) Summary**

While the numbers and expenditure in Scotland is dwarfed by England, this is unsurprising bearing in mind that Scotland has a population of 5 million, and England 50 million. It is clear, however, that in Scotland, while the number of claims is in fact declining, claim costs are increasing, especially for claims with awards below £20,000 and also costs for unsettled claims. There are therefore concerns about the increase in the cost of claims in both England and Scotland. However, the number of claims in England remains relatively static, other than the increases in the last two years, and the number of claims in Scotland is actually declining.

## **4. NHS Redress Act 2006**

A statutory framework for the empowerment of some of the Chief Medical Officer's recommendations in *Making Amends* is present in the NHS Redress Act 2006. It provides for the establishment by regulations of a scheme of NHS Redress. The Act creates a statutory framework to empower the Secretary of State to create by Regulations a scheme to enable "redress to be provided without recourse to civil proceedings".<sup>30</sup> These Regulations have still to be issued.

The NHS Redress Scheme will apply where a "qualifying liability in tort" arises in connection with the provision, as part of the health service in England, of qualifying services by: (a) the Secretary of State; (b) a Primary Care Trust; (c) a designated Strategic Health Authority; and (d) a body or other person providing services whose provision is the subject of arrangements with the Secretary of State, a Primary Care Trust or designated Strategic Health Authority. A "qualifying liability in tort" is defined as liability in tort owed:

"(a) in respect of or consequent upon personal injury or loss arising out of or in connection with breach of a duty of care owed to any person in connection with the diagnosis of illness or the care or treatment of any patient, and

(b) in consequence of any act or omission by a health care professional".<sup>31</sup>

It is clear therefore that the liability under the scheme is fault-based and is not no fault compensation.<sup>32</sup>

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<sup>29</sup> *No Fault Compensation Review Group, Report and Recommendations: Vol. 1*, 15 February 2011, paras. 2.19-2.25

<sup>30</sup> NHS Redress Act 2006, s.1(1).

<sup>31</sup> NHS Redress Act 2006, s.1(4).



The NHS Redress Scheme does not apply to liability which has been the subject of civil proceedings.<sup>33</sup> It applies to services provided in a hospital (in England or elsewhere), but the Secretary of State can extend the scheme by regulations.<sup>34</sup> However, the Scheme is inapplicable to primary dental services, primary medical services, general ophthalmic services and pharmaceutical services.<sup>35</sup> While the claimant's right to bring civil proceedings is not removed, civil proceedings and the NHS Redress Scheme will be mutually exclusive. Accordingly, the Act establishes that the Redress Scheme must provide for a settlement agreement under the scheme to include a waiver of the right to bring civil proceedings in respect of the liability to which the settlement relates.<sup>36</sup> Conversely, the Scheme must also provide for the termination of its proceedings if the liability to which they relate becomes the subject of civil proceedings.<sup>37</sup>

Since the Regulations have still to be issued, it remains to be seen how the Act will operate in practice. It has been said that since it is intended that the scheme be overseen by the NHSLA,<sup>38</sup> there may be a potential conflict of interest on the NHSLA of being a judge and jury in its own cause.<sup>39</sup> The proposed scheme has been further criticised on several grounds. It has been submitted that, while it is likely to provide nominally greater access to justice for low value claims, it is unlikely overall to result in greater access to justice for injured patients, especially given its fault-based eligibility criteria; it lacks sufficient independence from the NHS in terms of its investigation procedures; and that it fails to

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<sup>32</sup> M. Jones, *Medical Negligence* (London, Sweet & Maxwell, 4<sup>th</sup> ed, 2008), p.57. Cf, *per contra* J. K. Mason, and G. T. Laurie, *Mason and McColl Smith's Law and Medical Ethics* (8<sup>th</sup> ed) (OUP, 2010), p128 (sed quaere).

<sup>33</sup> NHS Redress Act 2006, s.2(2).

<sup>34</sup> NHS Redress Act 2006, s.1(5).

<sup>35</sup> NHS Redress Act 2006, s.1(6).

<sup>36</sup> NHS Redress Act 2006, s.6(5).

<sup>37</sup> NHS Redress Act 2006, s.6(6).

<sup>38</sup> NHS Redress Act 2006, s.11(1).

<sup>39</sup> J. K. Mason, and G. T. Laurie, *Mason and McColl Smith's Law and Medical Ethics* (8<sup>th</sup> ed) (OUP, 2010), p128.

provide for the accountability of healthcare professionals.<sup>40</sup> While the scheme has yet to be implemented in England, a Welsh version of the scheme is being introduced in 2011.<sup>41</sup>

### **5. Patients' Rights Bill in Scotland: the No Fault Compensation Review Group Report (McLean Report)**

The NHS Redress Act does not apply to Scotland. However, extensive consultation on the possible content of a Patients' Rights Bill<sup>42</sup> indicated that no-fault compensation was the favoured way forward of the Scottish Government for the NHS in Scotland.<sup>43</sup> The Consultation Paper stressed the "need for further work on the practical implications and potential costs of a change in compensation arrangements" before making any firm decision on future arrangements.<sup>44</sup> The Scottish Government announced in August 2009 the creation of a short-life working group, the No Fault Compensation Review Group, chaired by Professor Sheila McLean,<sup>45</sup> in order to progress this work.

The Group's remit was to consider the potential benefits for patients in Scotland of no-fault compensation and whether such a scheme could be introduced alongside the existing clinical negligence arrangements, taking account of (i) the cost implications; (ii) the consequences for healthcare staff, and the quality and safety of care; (iii) the wider implications for the system of justice and personal injury liability; and (iv) the evidence on how no fault compensation has operated in other countries. The Group was also charged with making recommendations on the key principals and design criteria that could be adopted for a no fault compensation scheme.<sup>46</sup>

The Group reported in February 2011,<sup>47</sup> concluding that the current system for dealing with claims in relation to injuries sustained during NHS treatment is not meeting the needs of patients, and potentially creates an atmosphere of tension between patients and their

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<sup>40</sup> A.-M. Farrell and S. Devaney, 'Making Amends or making things worse? Clinical Negligence Reform and Patient Redress in England' (2007) 27 *Legal Studies* 630-648; *No Fault Compensation Review Group, Report and Recommendations: Vol. 1*, 15 February 2011, para 2.32.

<sup>41</sup> *No Fault Compensation Review Group, Report and Recommendations: Vol. 1*, 15 February 2011, paras 2.32, 2.37-2.41.

<sup>42</sup> See *Patients' Rights: A Public Consultation on a Patients' Rights Bill for Users of the NHS in Scotland* (Healthcare Policy and Strategy Directorate, Scottish Government, September 2008).

<sup>43</sup> *Ibid*, para 69.

<sup>44</sup> *Ibid*, para 69

<sup>45</sup> International Bar Association Professor of Law and Ethics in Medicine in the University of Glasgow.

<sup>46</sup> No-fault Compensation Review, MRG, Paper 1.

<sup>47</sup> *No Fault Compensation Review Group, Report and Recommendations: Vol. 1*, 15 February 2011, available at: <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCGReport>.

health care providers. In addition, the widely accepted view that patients are more interested in a meaningful apology, an explanation and assurances about future practices was reinforced by the empirical research undertaken and part of the review.<sup>48</sup> The group explored several well-established no fault schemes in other jurisdictions, in particular the New Zealand and Swedish models.<sup>49</sup> The report recommended that consideration should be given to the establishment of a no fault compensation scheme for medical injury, along the lines of the Swedish model.<sup>50</sup> While the proposed new system would remove the need to prove negligence, it would still require proof that harm was caused by treatment. The thorny issue of causation is therefore not eliminated by the proposed system. Although the Swedish model provided the basis for the no fault system, the Group's view on eligibility for compensation was that it should not be based on the so-called 'avoidability' test as used in Sweden (i.e. that patients are eligible to receive compensation if they have suffered injury that could have been avoided), but rather a clear description of which injuries are not eligible for compensation.<sup>51</sup>

The McLean report recommended that the no fault scheme should cover all medical treatment injuries that occur in Scotland. Such injuries could be caused by, for instance, the treatment itself, failure to treat, as well as faulty equipment, in which case there would be third party liability.<sup>52</sup> It was considered that the scheme should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHSScotland.<sup>53</sup> Claimants who fail under the no fault scheme should retain the right to litigate, based on an improved litigation system.<sup>54</sup> Should a claimant be successful under the no fault scheme, any financial award made should be deducted from any subsequent award made as a result of litigation.<sup>55</sup> Appeal from the adjudication of the no fault scheme should be available to a court of law on point of law or fact.<sup>56</sup>

The group has suggested that more patients could have claims resolved under such a system than currently achieve resolution through the courts, and that the proposed scheme will not lead to expenditure greatly above that which the NHS currently pays in compensation

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<sup>48</sup> Ibid, para 7.1.

<sup>49</sup> Ibid, para 7.6.

<sup>50</sup> Ibid, para 7.11, Recommendation 1.

<sup>51</sup> Ibid, Recommendation 2.

<sup>52</sup> Ibid, Recommendation 3.

<sup>53</sup> Ibid, Recommendation 4.

<sup>54</sup> Ibid, Recommendation 7.

<sup>55</sup> Ibid, Recommendation 8.

<sup>56</sup> Ibid, Recommendation 9.

and legal fees.<sup>57</sup> Its research team provided a paper which assumes a 20% increase in claims under the proposed scheme and that 40% of the claims which fall under the litigation system would receive an award under the proposed no fault scheme. It also assumes that such additional claims will be low value claims. However, the report concedes that further analysis may be required to test the availability of these assumptions.<sup>58</sup>

In welcoming the recommendations, the Scottish Government has proposed to investigate thoroughly how such a scheme would work in practice, and it will undertake a further analysis of the cost implications.<sup>59</sup>

## 6. Basis of Liability for Medical Injury

### (a) Contract, Tort and Delict<sup>60</sup>

Most claims for compensation for medical malpractice are brought in tort (England) and delict (in Scotland), the overwhelming majority of which are for the tort/delict of negligence.

A contractual relationship does not subsist between an NHS doctor and patient within the NHS.<sup>61</sup> However, in the Scottish Sheriff Court decision of *Dow v. Tayside University Hospitals NHS Trust*,<sup>62</sup> it was held that it could be possible under Scots law (without the requirement of consideration in the formation of a contract) for a doctor providing treatment under the National Health Service (Scotland) Act 1978, to enter into a contractual relationship with an NHS patient, but only where it was clear that the doctor concerned was exceptionally entering into a contract and was not relying on the statutory relationship alone.<sup>63</sup> Such an additional contract would require to be expressed in clear terms and would

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<sup>57</sup> Ibid, para 7.4

<sup>58</sup> Ibid.

<sup>59</sup> *No Fault Compensation Review Group Report-Scottish Government Response*, (Edinburgh, Scottish Government, 2011) available at: <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/NFCSGResponse>.

<sup>60</sup> See, generally, M. Jones, *Medical Negligence* (4th edn, Sweet & Maxwell, 2008), Ch 2; R. Mulheron, Ch 3, 'Duties in Contract and Tort' in A Grubb, J McHale and J Lang (eds), *Principles of Medical Law* (3<sup>rd</sup> ed) (Oxford University Press, 2010),

<sup>61</sup> *Reynolds v. The Health First Medical Group* [2000] Lloyds's Rep Med 240, Hitchin County Court (arrangement between doctor and patient in NHS based on statutory obligation rather than contract); applying *Pfizer Corp'n. v. Ministry of Health* [1965] A.C. 512, 535-6, per Lord Reid (provision of medicinal product by a pharmacist to a patient under an NHS prescription not a sale, as no contract between patient and pharmacist; pharmacist is under a statutory obligation to supply the product to the patient on the presentation of the prescription and the correct prescription charge).

<sup>62</sup> 2006 SLT (Sh Ct) 141.

<sup>63</sup> Ibid, [19].

need to demonstrate an intention to add an additional liability on the part of the doctor, corresponding with the requirements of a unilateral promise.<sup>64</sup>

However, if the patient/doctor relationship is a private one rather than one under the NHS, there will be a contractual relationship and it will be possible to bring an action for damages in contract.

#### (b) The Requirements of Negligence

In respect of negligence, a person seeking compensation for clinical negligence must establish 3 things, viz. (1) that the defendant owed the patient a duty of care; (2) that the defendant was in breach of that duty; and (3) that the breach of duty of care caused harm to the patient.

#### (c) Duty of Care<sup>65</sup>

A duty of care owed by a doctor to his patient has long existed in English and Scots law. Such a duty predates the seminal decision of *Donoghue v Stevenson*,<sup>66</sup> and Lord Atkin's celebrated 'neighbour principle' requiring the exercise of reasonable care towards all who are foreseeably likely to be injured in person or property by one's acts or omissions.<sup>67</sup> The relationship between doctor and patient also satisfies the so-called tripartite test of *Caparo v Dickman*,<sup>68</sup> that requires not only that the loss to the claimant be reasonably foreseeable, but also that there be a close degree of proximity between the parties, and that it is "fair just and reasonable" to impose a duty of care.

While establishing a duty of care in clinical negligence owed to the patient is not generally problematic, what is problematic is the establishment of the other two requirements, viz., that the doctor was in breach of his duty of care to the patient and that this breach of duty of care caused the patient harm. It is to the first of these two requirements that we now turn.

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<sup>64</sup> Ibid, [20].

<sup>65</sup> See, generally, R. Mulheron, Ch 3, 'Duties in Contract and Tort' in A Grubb, J McHale and J Lang (eds), *Principles of Medical Law* (3<sup>rd</sup> ed) (Oxford University Press, 2010).

<sup>66</sup> [1932] A.C. 562.

<sup>67</sup> Ibid, 580.

<sup>68</sup> [1990] 2 A.C. 605, at 616-618, per Lord Bridge, at 628, per Lord Roskill and at 633-634, per Lord Oliver.

#### (d) Standard of Care<sup>69</sup>

In order to establish that the defendant was negligent, the claimant must show that the defendant fell below the required standard of care. The standard of care demanded of the doctor is the standard of the reasonably skilled and experienced doctor. In *Bolam v Friern Hospital Management Committee*,<sup>70</sup> McNair J. directed the jury:

The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is a well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

In what became known as the *Bolam* test, he said:<sup>71</sup>

[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art...merely because there is a body of opinion who would take a contrary view.

So where medical opinion is divided, *Bolam* establishes that a doctor is not negligent merely because he adheres to one body of opinion rather than another. This was confirmed by the House of Lords in *Maynard v. West Midlands Area Health Authority*.<sup>72</sup> The House of Lords in *Maynard* and also in *Sidaway v. Board of Governors of the Bethlem Royal Hospital*<sup>73</sup> were subject to relentless criticism by academics in the 1980s and early 1990s, including Kennedy and Grubb, for elevating “to the status of an unquestionable proposition of law derived from *Bolam*”<sup>74</sup> that professional practice would not be reviewed by the courts.

However, over the last twenty years, we have seen an increasing inclination of the courts to question the conduct of physicians, and also to challenge the credibility of medical experts and even, on rare occasions, to override clinical judgment.<sup>75</sup> This pattern culminated

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<sup>69</sup> See, generally, M. Jones, *Medical Negligence* (4th edn, Sweet & Maxwell, 2008), Ch. 3; P. Whipple and P. Havers, Ch 4, ‘Breach of Duty’ in A Grubb, J McHale and J Lang (eds), *Principles of Medical Law* (3<sup>rd</sup> ed) (Oxford University Press, 2010).

<sup>70</sup> [1957] 1 WLR 582 at 586.

<sup>71</sup> *Ibid*, at 587.

<sup>72</sup> [1985] 1 All ER 635 at 638-639, per Lord Scarman.

<sup>73</sup> [1985] A.C. 871.

<sup>74</sup> See I. Kennedy and A. Grubb, *Medical Law: Text with Materials*, 2<sup>nd</sup> ed (London, Butterworths, 1994), p 452.

<sup>75</sup> H. Teff, ‘The Standard of Care in Medical Negligence-Moving on From Bolam’ (1998) 18 OJLS 473, at 474-5;

in the decision of the House of Lords in *Bolitho v. City and Hackney HA*,<sup>76</sup> which was heralded two years later as spawning “a velvet revolution”<sup>77</sup> in assessing reasonable care in medical negligence. In *Bolitho*, the House of Lords held that in applying the *Bolam* test, as opposed to merely accepting a body of opinion, the court had to be satisfied that exponents of the body of opinion relied upon could demonstrate that such an opinion had a “logical basis”, and that this assessment would need to be carried out on a risk-benefit basis.<sup>78</sup> However, Lord Browne-Wilkinson, delivering the opinion of the House of Lords, qualified his position in emphasising that “it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable”.<sup>79</sup> Accordingly, it has been held that if each body of medical opinion is capable of withstanding logical analysis, “there is no basis for a finding of negligence against the doctor in choosing one rather than the other”.<sup>80</sup> *Bolitho* has therefore been said to “devalue the trump card which *Bolam* presented to the medical profession, but only in limited circumstances”.<sup>81</sup>

Post- *Bolitho*, the Court of Appeal has proceeded to weigh risks and benefits to determine whether an expert’s opinion had a ‘logical basis’ in *Marriott v. West Midlands HA*,<sup>82</sup> and in *Penney, Palmer and Cannon v. East Kent HA*,<sup>83</sup> and the High Court has done so in a disclosure of information decision.<sup>84</sup> However, the Court of Appeal has sometimes failed to provide sufficient scrutiny of expert evidence in this way. A prime example is the decision of *Vadera v. Shaw*,<sup>85</sup> where it has been submitted that insufficient judicial scrutiny was made of the evidence of a GP and her experts in deciding that her administration of a contraceptive

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<sup>76</sup> [1998] AC 232.

<sup>77</sup> M. Brazier and J. Miola, ‘Bye-Bye Bolam: A Medical Litigation Revolution’ (2000) 8 Med L Rev 85, 86.

<sup>78</sup> [1998] AC 232, 241-242, per Lord Brown-Wilkinson.

<sup>79</sup> *Ibid*, 243.

<sup>80</sup> *Birch v. University College London Hospital NHS Foundation Trust* (2008) 104 BMLR 168, at para 55.

<sup>81</sup> J. K. Mason, and G. T. Laurie, *Mason and McColl Smith’s Law and Medical Ethics* (8<sup>th</sup> ed) (OUP, 2010), p139.

<sup>82</sup> [1999] Lloyds Rep Med 23, 28, per Beldam LJ.

<sup>83</sup> [2000] Lloyd’s Rep Med 41, 48, 50.

<sup>84</sup> *Birch v. University College London Hospital NHS Foundation Trust* (2008) 104 BMLR 168, paras 69-70, 73, 77, 79.

<sup>85</sup> (1999) 45 BMLR 162 (CA).

pill to a 22 year old Asian patient with a high blood pressure reading of 150/100 was not negligent.<sup>86</sup>

(e) Causation<sup>87</sup>

Merely to show that a defendant was in breach of a duty owed to the claimant and that the claimant suffered damage does not suffice to ground an action in negligence. The defendant's breach must have caused the claimant's damage and, additionally, the damage must be such that the law regards it proper to hold the defendant responsible for it. These two requirements jointly constitute causation and are often separately referred to as (i) *cause in fact* and (ii) *cause in law* and *remoteness*, although discussion will be confined in this paper to cause in fact.

(i) *Difficulties in proving causation in clinical negligence cases*

It is fair to say that causation in the context of medical law is fraught with difficulty.<sup>88</sup> Such difficulty is due both to the complexity of the factual circumstances themselves and to the (perhaps unnecessarily) complex nature of the law, when the principles come to be applied to the facts. As for the former, the complex and, to some extent, indeterminate nature of medical science means that the causal nexus between A and B, while suspected, may be hard to demonstrate. Indeed, it could be said that the more medicine is portrayed as a scientific endeavour, rather than as an art or a combination of both art and science, the harder it becomes on occasion to demonstrate to the satisfaction of the law a causative link between breach and damage.<sup>89</sup>

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<sup>86</sup> See R. Goldberg, 'The Contraceptive Pill, Negligence and Causation: Views on *Vadera v Shaw*' (2000) 8 Med LRev 316, 323 (Court of Appeal failed to ask whether the clinical practice of putting a 22-year old Asian woman on the contraceptive pill with a blood pressure reading of 150/100, and having failed to exclude the possibility of sustained hypertension before prescribing that pill, could withstand logical analysis).

<sup>87</sup> See, generally, R. Goldberg, Ch 6, 'Causation and Defences' in A Grubb, J McHale and J Lang (eds), *Principles of Medical Law* (3<sup>rd</sup> ed) (Oxford University Press, 2010); M. Jones, *Medical Negligence* (4th edn, Sweet & Maxwell, 2008), Ch. 5.

<sup>88</sup> See R. Goldberg, Ch 6, 'Causation and Defences' in A Grubb, J McHale and J Lang (eds), *Principles of Medical Law* (3<sup>rd</sup> ed) (Oxford University Press, 2010), 6.02 et seq, on which much of this section is based; and, further, R. Goldberg (ed), *Perspectives on Causation* (Oxford: Hart Publishing, 2011) (forthcoming).

<sup>89</sup> Ibid. See, eg, *Bonhron v Millan* [1985] 2 The Lancet 1137 (Lord Jauncey) (existence of cryptogenic (unknown) causes to eliminate possible causal connection between pertussis vaccine and brain damage); *Loveday v Renton* [1990] 1 Med LR 117 (whooping cough vaccine); *Kay v Ayrshire and Arran Health Board* [1987] 2 All ER 417 (penicillin overdose not capable of causing or aggravating deafness). It has recently been observed that while epidemiological evidence can be useful, it must be viewed with caution; without further non-statistical evidence there is reluctance for courts to proceed to find the existence of a causal relationship: see *Sienkiewicz v Greif* [2011] UK SC 10, [2011] 2 WLR 523, [152], [163] per Lord Rodger, [170], [172] per Baroness Hale, [190]-[192] per Lord Mance, [204]-[206] per Lord Kerr. Discussed in R.W. Wright, 'Proving Causation: Probability versus Belief' and R. Goldberg, 'Using Scientific Evidence to Resolve Causation



(ii) *The burden of proof*

In the area of clinical negligence, as in all other aspects of civil litigation, the burden of proof is on the claimant who must prove causation and it must be established on a balance of probabilities.<sup>90</sup>

(iii) *The 'but for' test*

The standard approach to causation in the law of tort or delict is represented by the 'but for' test: that the damage suffered by the claimant would not have been suffered *but for* the defendant's breach of duty. The assumption of the law is that it is possible to show (and, therefore, that the law should demand demonstration) that A would not have happened but for B. The corollary of that assumption is that if the 'but for' test cannot be satisfied, causation is not proved and the defendant, irrespective of any breach of duty, is not liable. While represented as a principle concerned with fact, it is, of course, self-evident that what is involved is a matter of policy. A limit is placed on the potential liability of the defendant by demanding that a particular form of causal nexus be shown. There are numerous circumstances, particularly in medical law, when this policy defeats the claim of the claimant. The clearest example is when the defendant's breach of duty may have been part of the background leading to the claimant's injury. If the defendant can demonstrate that the injury would have occurred in any event, regardless of any breach of duty, then the claimant's action will fail. A classic example of this is *Barnett v Chelsea and Kensington Hospital Management Committee*.<sup>91</sup> In that case, the plaintiff drank some tea, which contained arsenic and had been taken to the defendants' casualty department. Although the defendants were held negligent in failing to treat him, it was held that this refusal to treat was not a cause of the deceased's death since the nature of the arsenic introduced into his tea was such that he would have died in any event.

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Problems in Product Liability: UK, Europe and US Experiences', both in R Goldberg, (ed), *Perspectives on Causation* (Hart Publishing, 2011); see also the observations of Brooke LJ in *Wardlaw v Farrar* [2003] 4 All ER 1358, [2004] Lloyd's Rep Med 98, [2004] PIQR 19 at [35]–[36]. Even where in principle a connection can be shown between the type of harm suffered by the claimant and a specific hazard, it may be extremely difficult to demonstrate that the individual claimant's condition was caused by exposure to that hazard as opposed to another factor for which the defendant was not responsible: see, M. Jones, *Medical Negligence* (4th edn, Sweet & Maxwell, 2008), 5-020, citing *Plater v Sanotrach* [2004] EWHC 146 (QB) (claimant unable to prove on balance of probability that his HIV infection had been caused by a contaminated needle or syringe after he had been given an intravenous injection at defendant's clinic since he had been unable to exclude other possible causes of HIV infection): *ibid*, [99].

<sup>90</sup> *Pickford v Imperial Chemical Industries plc* [1998] 3 All ER 362, [1998] 1 WLR 1189 (HL).

<sup>91</sup> [1968] 1 All ER 1068.

(iv) *Cumulative causation*

Difficulties of proving causation appear to have been reduced by the ‘but-for’ test being modified so as to make it easier for the claimant to prove that the defendant’s negligence caused his injury or damage. Where the factors are cumulative, the court, following the decision of the House of Lords in *Bonnington Castings v Wardlaw*<sup>92</sup> has the option to find the defendant liable. If the factors taken together led to the claimant’s injury, then the defendant’s breach, as a contributing factor, may be held to have made a contribution which can be described as material, if it is not *de minimis*.<sup>93</sup>

(v) *Material increase in risk*

If the claimant can establish that the defendant’s negligence contributed to the *risk of damage*, he may be able to recover. In *McGhee v National Coal Board*,<sup>94</sup> the House of Lords was prepared to infer that the failure to provide showers *materially increased the risk* of contracting dermatitis from the brick dust and that *in itself* established a causal link with the defendant’s fault.<sup>95</sup> The reason for doing so was the lack of available evidence, such that the claimant could not meet the ‘but for’ test and establish that the breach had caused or made a material contribution to the injury.

(vi) *Alternative causation*

By contrast, where the injury could have been caused by any one of a number of distinct factors, the material contribution principle will not work in the claimant’s favour. This is illustrated by the House of Lords’ decision in *Wilsher v Essex AHA*.<sup>96</sup> In *Wilsher*, the baby’s RLF (retrolental fibroplasia) could have arisen from any of at least five separate and distinct factors. The defendant’s breach (excess oxygenation) was responsible for only one of these. It was impossible to assert that the breach was the sole cause of the RLF. It was equally untenable to argue that the breach materially contributed to it. It may have had no effect whatsoever. The House of Lords held that to show that the defendant’s negligence materially

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<sup>92</sup> [1956] AC 613.

<sup>93</sup> See the recent successful attempts at utilising this in the context of multiple causal factors: *Boustead v North West Strategic Health Authority* [2008] EWHC 2375, [2008] LS Law Medical 471, [70]–[71] (since on the evidence there were concurrent cumulative causes of intraventricular haemorrhage, the claimant had satisfied the burden of proving that the defendant’s breach of duty in delaying proceeding to a Caesarean section had made a material contribution to his brain damage); *Bailey v Ministry of Defence* [2008] EWCA Civ 83, [2009] 1 WLR 1052 (CA), [46] (cumulative causes (non-negligent pancreatitis and negligent lack of care), where contribution of negligent cause was more than negligible; ‘but for’ test modified and claimant would succeed); *Canning-Kishver v Sandwell and West Birmingham NHS Trust* [2008] EWHC 2384 (QB), [36]–[37] (contribution of cardiac collapse occasioned by the breach of duty constituted a contribution to the cerebral atrophy that was more than negligible; claim succeeded).

<sup>94</sup> [1972] 3 All ER 1008, 1011, [1973] 1 WLR 1.

<sup>95</sup> [1972] 3 All ER 1008, 1011, [1973] 1 WLR 1, 5 *per* Lord Reid and at 1018 and 12–13 *per* Lord Salmon; see Weinreb, E, ‘A Step Forward in Factual Causation’ (1975) 38 MLR 518, 523.

<sup>96</sup> [1988] AC 1074, [1986] 3 All ER 801.

increased the risk of the claimant's injury did nothing to exclude the other causes; therefore, it was impossible for the court to infer that the defendant was the cause of the injuries.<sup>97</sup>

(vii) *Reinstating McGhee: Fairchild*

In the landmark decision of *Fairchild v Glenhaven Funeral Services Ltd*,<sup>98</sup> their Lordships refuted the narrow construction of *McGhee* which had been placed upon it by the House of Lords in *Wilsher*.<sup>99</sup> It was, therefore, not to be seen as an application of the traditional 'but for' test, rather as a departure from it in exceptional (and specific) circumstances. The claimants were exposed to asbestos dust over a long period of time whilst working for successive employers. They developed mesothelioma, a cancer of the lung. Claims were brought against some—but not all—of the employers. The evidence was that mesothelioma was caused by exposure to asbestos dust but it was not known whether it was caused by a single fibre or whether multiple fibres were necessary or made development of the cancer more likely. On the evidence, it could not be said which employer's breach of duty in exposing the claimants to asbestos dust had caused, or materially contributed to, their injuries. There was a 'scientific deficit' in the evidence. The House of Lords unanimously held that each of the employers was liable to the claimant for their injuries.<sup>100</sup> The Law Lords held, on policy grounds, that the *McGhee* test of 'material increase in risk' applied to fix each employer with responsibility for the claimants' injuries. Where successive employers had failed to protect an employee from a disease (mesothelioma), but it could not be proved on a balance of probability which employer had caused the injury, the conduct of each employer in exposing the claimant to a material increase in risk to which the claimant should not have been exposed was to be treated as if it had made a material contribution to the disease.<sup>101</sup> It was just to depart from the 'but for' test of causation where, as in this case, the injustice of holding an employer responsible for injury that he may not have caused (or contributed to) was outweighed by the injustice of leaving the employees without compensation.<sup>102</sup>

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<sup>97</sup> [1988] AC 1074, 1090–1091.

<sup>98</sup> [2002] UKHL 22, [2003] 1 AC 32.

<sup>99</sup> With the exception of Lord Hutton who preferred to see *McGhee* as a case where it was proper to make a factual inference of causation: *ibid*, [108] and [109].

<sup>100</sup> Subject to the issue of contribution proceedings between the defendants inter se, which was not before the House.

<sup>101</sup> [2003] 1 AC 32 *ibid*, [2], [34] *per* Lord Bingham, [42] *per* Lord Nicholls, [47], [65], [67] *per* Lord Hoffmann, [116] *per* Lord Hutton, and [168] *per* Lord Rodger.

<sup>102</sup> *ibid*, [33]–[34] *per* Lord Bingham; [45] *per* Lord Nicholls; [56], [62] *per* Lord Hoffmann. The *Fairchild* exception applies to "single exposure cases" (where only one defendant exposed the victim to asbestos, and the only other exposure creating a risk of developing mesothelioma was environmental exposure to low-level asbestos dust in the atmosphere): *Sienkiewicz v Greif* [2011] UK SC 10, [2011] 2 WLR 523, [103], [113] *per* Lord Phillips, [160], *per* Lord Rodger, [173], *per* Lady Hale, [184], *per* Lord Brown, [188], *per* Lord Mance, and [203], *per* Lord Kerr.

(viii) *The scope of Fairchild and Clinical Negligence Cases*

The extent to which the *Fairchild* principle operates has been subject to judicial discussion in the Court of Appeal. While it has been observed that ‘great caution is required before any development of the *Fairchild* exception should be allowed’,<sup>103</sup> it is clear that the conditions required to be satisfied for its application were not intended to exclude its application to other conditions and circumstances, and the exception will not be limited to cases of mesothelioma.<sup>104</sup> In *Sanderson v Hull*,<sup>105</sup> Smith LJ attempted to formalise the principles from *Fairchild* by adopting<sup>106</sup> Lord Rodger’s conditions<sup>107</sup> for its application. As expressed by Smith LJ, there were five main elements to the *Fairchild* principle operating to relax the need to satisfy the ‘but for’ test of causation. First, the claimant must show the current state of scientific knowledge leaves it inherently impossible for the claimant to prove exactly how his injury was caused. Secondly, the defendant’s breach of duty must have materially increased the risk of injury to the claimant.<sup>108</sup> Thirdly, the defendant’s conduct must have been capable of causing the claimant’s injury. Fourthly, the claimant must show that the injury was caused by the eventuation of the kind of risk created by the defendant’s wrongdoing. Fifthly, the injury must be caused by the same agency as was involved in the defendant’s wrongdoing (or an agency which operates in a similar way).<sup>109</sup> It is clear that Lord Rodger’s conditions in *Fairchild* are at a higher level of generality than those of Lord Bingham and Hoffmann,<sup>110</sup> but in their principled approach they arguably provide the clearest guidance to practitioners and litigants as to *Fairchild*’s scope.

Since an essential element of the development of *Fairchild* will be the first element, namely the inherent impossibility for the claimant to prove enough to satisfy the ‘but for’ test,<sup>111</sup> the likelihood is, however, that the *Fairchild* test will have little impact in medical negligence cases. In cases where there is a ‘scientific deficit’ in the evidence, it is unlikely that the factual context will work in a claimant’s favour. Usually, the claimant will be unable to show that the injury suffered was precisely that which flowed from the doctor (or other’s) breach of duty but rather that it was the result of one of a number of possible causative events each (or some) of which lacks the same essential characteristics of the risk created by the doctor- as in *Wilsher* itself- and the Law Lords cast no doubt on the actual outcome in *Wilsher*.<sup>112</sup> Second, and perhaps more significantly, attempting to apply *McGhee* in the

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<sup>103</sup> *Sanderson v Hull* [2008] EWCA Civ 1211, [2009] PIQR P7, [34] *per* Smith LJ.

<sup>104</sup> *ibid*, [42], [45].

<sup>105</sup> [2008] EWCA Civ 1211, [2009] PIQR P7.

<sup>106</sup> *ibid*, [50], [53].

<sup>107</sup> [2002] UKHL 22, [169]–[170], and *Barker v Corus (UK) plc* [2006] UKHL 20, [2006] 2 AC 572, [97].

<sup>108</sup> The *Fairchild* threshold of material increase in risk is anything more than *de minimis*: *Rolls Royce Industrial Power (India) Ltd v Cox* [2007] EWCA Civ 1189 (CA), [21].

<sup>109</sup> [2008] EWCA Civ 1211, [2009] PIQR P7, [53].

<sup>110</sup> See [2002] UKHL 22 *per* Lord Bingham, [2] and *per* Lord Hoffmann, [61]

<sup>111</sup> *ibid*, para 43.

<sup>112</sup> *Wilsher* was approved *per* Lord Bingham, [22]; *per* Lord Hoffmann, [70]; *per* Lord Hutton, [118]; *per* Lord Rodger, [149] and [170]. For an example post-*Fairchild* of a multiple potential cause decision decided in line with *Wilsher*, see *Temple v South Manchester Health Authority* [2002] EWCA Civ 1406, where the claimant alleged that the defendant’s negligence had caused his cerebral oedema as a result of diabetic

medical context may not invoke the same policy response from the judges because of the impact that extending liability would have on the NHS and its budget.<sup>113</sup> The remarks of Lord Hoffmann in *Fairchild* suggest that the *McGhee/Fairchild* approach is unlikely to be imported.<sup>114</sup>

It is true that actions for clinical negligence notoriously give rise to difficult questions of causation. But it cannot possibly be that the duty to take care in treating patients would be virtually drained of content unless the creation of a material risk of injury were accepted as sufficient to satisfy the causal requirements of liability. And the political and economic arguments involved in the massive increase in liability of the National Health Service which would have been a consequence of the broad rule favoured by the Court of Appeal in Wilsher's case are far more complicated than the reasons given [in *McGhee*] for imposing liability upon an employer who has failed to take simple precautions.

(ix) *Loss of a chance*

Following the decision of the House of Lords in *Fairchild* to take a flexible approach towards the problems of causation on policy grounds, the question of whether a loss of a chance, in the sense of a diminution of life expectancy by reference to worsened statistical chances of survival, should be recognized as damage giving rise to a claim in negligence was addressed by the House of Lords in *Gregg v Scott*.<sup>115</sup> The claimant's GP negligently failed to diagnose that he suffered from non-Hodgkin's lymphoma. The cancer was subsequently diagnosed.

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ketoacidosis. Various theories existed as to the possible causes of cerebral oedema. One of the theories was that cerebral oedema might be produced where a patient was infused at less than normal salinity, and it was on this basis that the trial judge had found the defendants negligent. As in *Wilsher*, there were a number of different causes which were in play and which might have operated independently or cumulatively. The state of knowledge was such that it was not known whether the giving of a low saline infusion was ever the cause of cerebral oedema. The Court of Appeal upheld the trial judge's conclusion that no causal link had been established on a balance of probabilities. Note that the *Fairchild* exception has no application to cases where the claimant's injuries arise from a single incident: *Clough v First Choice Holidays and Flights Ltd* [2006] EWCA Civ 15, [2006] PIQR P22, [43].

<sup>113</sup> But *quaere* if the claimant was treated in a private hospital or clinic?

<sup>114</sup> [2002] UKHL 22, [69]. But contrast *Snell v Farrell* (1990) 72 DLR (4th) 289 (Can Sup Ct). Note the unsuccessful attempt to apply the *Fairchild* exception to a case involving a negligent dispensing of the wrong contraceptive pill. In *Wooton v J Docter Ltd and another* [2008] EWCA Civ 1361, [2009] LS Law Med 63, the claimant contended that because the current state of scientific knowledge precluded her from establishing that 'but for' the erroneous dispensing of the contraceptive Logynon for Microgynon, she would not have become pregnant, she could invoke the alternative and exceptional principles identified in *Fairchild*. Invoking Lord Rodger's principles in *Fairchild* to the facts of the case, (as explained by Smith LJ in *Sanderson v Hull* [2008] EWCA Civ 1211, [53]), counsel for the claimant contended that the current state of scientific knowledge rendered it inherently impossible for the claimant to prove exactly how her injury was caused. The negligent dispensing of Logynon was capable of causing a failure of contraception and materially increased that risk. The claimant's pregnancy was the result of the kind of risk created by the by the pharmacist's wrongdoing, and the pregnancy was caused by the same agency which the reduction in levonorgestrol permitted to occur. Counsel for the defendant stated that the 'but for' test continued to apply, and that unlike *Fairchild*, '[t]he biology was understood' (at [39]). Statistical analysis failed to establish an increase in risk due to a reduction in the intake of progesterone by 100 mcg or at most 200 mcg. The Court of Appeal held (at [40]) that the claimant had failed to establish that the erroneous intake of two Logynon pills materially increased the risk of contraceptive failure. The claimant could not invoke any principle from *Fairchild* or *Barker* to overcome the trial judge's finding that the reduction in intake of progesterone did not increase, let alone materially increase, the risk of contraceptive failure.

<sup>115</sup> [2002] EWCA Civ 1471, [2003] Lloyd's Rep Med 105.

The expert evidence was that the negligent delay in diagnosing the condition reduced the claimant's chance of survival for a five-year period from 42 per cent to 25 per cent. Could he recover damages in these circumstances? Following *Hotson v East Berkshire AHA*,<sup>116</sup> the trial judge held that the claimant had failed to prove that the delay had made any difference to the outcome for him. As a result, he had failed to prove that the negligence caused or materially contributed to any injury.

The Court of Appeal (by a majority)<sup>117</sup> rejected the claimant's action for the "lost chance" of recovery from cancer. By a majority of 3:2, the House of Lords dismissed the claimant's appeal.<sup>118</sup> Two arguments were presented by the claimant. The first, the "quantification argument", was that the delay had caused him physical injury in the form of enlargement of the tumour, because the trial judge had found that if he had been treated earlier, the cancer would not have spread as quickly as it did. He was entitled to compensation for this injury, including damages for the reduction in the chance of his survival. The second, the "loss of a chance argument", was that the reduction in his chance of survival was itself a recoverable head of damage.

A majority of their Lordships rejected the first argument of the claimant, viz, the so-called "quantification argument". Lord Hoffmann said that the issue to be addressed was whether the claimant's likely premature death would be attributable to the defendant's delay in treatment.<sup>119</sup> He concluded that the claimant was unable to show on a balance of probabilities that the delay in treatment would have caused his likely premature death, since he would probably have been in the same position of his life being shortened to less than ten years in any event.<sup>120</sup> Lord Hope dissented from this view of the facts. He considered that on a balance of probabilities, the delay in treatment had caused the spread of the tumour with consequent pain and suffering, and that this gave him a cause of action for the pain and suffering caused by that injury and for the effect of the cancer on his life expectancy.<sup>121</sup>

A majority of their Lordships also dismissed the claimant's 'loss of a chance argument' that the defendant's negligence in failing to diagnose the cancer tumour had reduced the claimant's chance of survival from 42 per cent to 25 per cent and that this was something of value and recoverable on policy grounds. However, the effect of their ruling on whether loss of a chance of a favourable outcome could ever be a recoverable head of damage in a clinical negligence case remains inconclusive. Lord Hoffmann said that the claimant was attempting to extend the *Fairchild* exception so that damages should be

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<sup>116</sup> *Hotson v East Berkshire Area Health Authority* [1987] 1 AC 750 (HL).

<sup>117</sup> [2002] EWCA Civ 1471, [2003] Lloyd's Rep Med 105, Simon Brown and Mance LJ; Latham LJ dissenting.

<sup>118</sup> [2005] UKHL 2, [2005] 2 AC 176.

<sup>119</sup> *ibid*, [68].

<sup>120</sup> *ibid*, [71]; also [57]–[58] *per* Lord Nicholls; [187], [191] *per* Lord Phillips; [202], [205] *per* Baroness Hale.

<sup>121</sup> *ibid*, [96].

awarded for the possibility that the injury had been caused by the doctor.<sup>122</sup> In his view the outcome of the claimant's disease was determinate in that the cancer would inevitably reduce his life. The outcome was not random, but was governed "by the laws of causality" and an inability to establish that the delay in diagnosis caused the reduction in expectation of life could not be remedied "by treating the outcome as having been somewhat indeterminate".<sup>123</sup> He expressly rejected the adoption of the loss of a chance approach in clinical negligence cases, concluding that adopting such a rule would be a rejection of *Wilsher*, *Hotson* and the qualifications and restrictions with which their Lordships hedged the *Fairchild* exception. No new arguments or change of circumstances could justify "such a radical departure from precedent"<sup>124</sup> which would "amount to a legislative act"<sup>125</sup> that would have "enormous consequences for insurance companies and the National Health Service".<sup>126</sup> Baroness Hale also rejected the loss of a chance approach. In her view, redefining the definition of personal injury from being in outcome terms to one being in loss of opportunity terms "would cause far more problems in the general run of personal injury claims than the policy benefits are worth".<sup>127</sup>

However, Lord Nicholls and Lord Hope were in favour of a claim succeeding on a loss of a chance basis in a clinical negligence action in a restricted set of circumstances. Lord Nicholls was willing to accept a claim for loss of a chance in cases where the patient's condition "gave rise to significant medical uncertainty" as to what the outcome would have been in the absence of negligence.<sup>128</sup> He distinguished *Hotson*, where there was no significant uncertainty as to what would have happened to Hotson's leg if treated properly, from *Gregg*, where there was "considerable medical uncertainty about what the outcome would have been had Mr Gregg received appropriate treatment nine months earlier".<sup>129</sup> In his view, Mr Gregg's prospects of recovery had he been treated promptly, expressed in percentage terms of likelihood, represented the medical reality of his position. The law, he said, "should be exceedingly slow to disregard medical reality in the context of a legal duty whose very aim is to protect medical reality".<sup>130</sup>

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<sup>122</sup> [2005] 2 AC 176, [84].

<sup>123</sup> *ibid*, [80].

<sup>124</sup> *ibid*, [85].

<sup>125</sup> *ibid*, [90].

<sup>126</sup> *ibid*.

<sup>127</sup> *ibid*, [225].

<sup>128</sup> *ibid*, [38], [44].

<sup>129</sup> *ibid*.

<sup>130</sup> *ibid*, [42].

Lord Hope also distinguished *Gregg* from *Hotson*. In *Hotson*, the “fundamental question of fact to be answered [viz, whether the boy’s fall was the cause of his avascular necrosis] related to a point in time before the negligent failure to treat began”.<sup>131</sup> Accordingly, it was to be treated “as a matter of past fact”.<sup>132</sup> By contrast, the injury which affected the claimant’s prospects of a successful recovery, namely the enlargement of the tumour, still lay in the future at the time when the claimant was seen by the doctor.<sup>133</sup> While Lord Phillips upheld the decision of the trial judge on the facts, he left open the possibility of a claim for loss of a chance. On the facts, the case’s complications persuaded him that it was “not a suitable vehicle” to award damages for the reduction of the prospects of a cure, when the long term result of treatment was still uncertain.<sup>134</sup> However, he did not rule out the possibility of a claim for loss of a chance where the medical treatment resulted in an adverse outcome and negligence increased the chance of that outcome, recovery of damages being proportionate to the increase in chance of the adverse outcome.<sup>135</sup>

It therefore seems arguable<sup>136</sup> that a claim for loss of a chance of a better medical outcome could be made where the patient’s condition gives rise to “significant medical uncertainty” as to what the outcome would have been in the absence of negligence,<sup>137</sup> and ‘where medical treatment has resulted in an adverse outcome and negligence increased the chance of that outcome’.<sup>138</sup> In *Barker v Corus UK Ltd*,<sup>139</sup> Lord Hoffmann said that the majority of their Lordships in *Gregg* rejected the claimant’s case, not on the ground that there was some conceptual objection to treating diminution in the chances of a favourable outcome as actionable damage, but on the basis that adopting such a rule in *Gregg* “would in effect have extended the *Fairchild* exception to all cases of medical negligence, if not beyond, and would have been inconsistent with *Wilsher*.”<sup>140</sup> This distinguishing of *Gregg* enabled Lord Hoffmann to characterize the gist of the damage in the *Fairchild*-type case as the creation of the risk or chance of causing the disease, without the possibility of inconsistency between the decisions.<sup>141</sup> However, it has been argued that Lord Hoffmann’s formulation in *Barker*

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<sup>131</sup> *ibid*, [108].

<sup>132</sup> *ibid*.

<sup>133</sup> *ibid*, [109].

<sup>134</sup> *ibid*, [190].

<sup>135</sup> *ibid*.

<sup>136</sup> See, especially, M. Jones, *Medical Negligence* (4th edn, Sweet & Maxwell, 2008), [5-095] –[5-100]; also *Clerk & Lindsell on Torts* (Sweet & Maxwell, 20th edn, 2010), [2-80], [2-87]–[2-90].

<sup>137</sup> [2005] UKHL 2, [2005] 2 AC 176, [38], [44] *per* Lord Nicholls.

<sup>138</sup> *ibid*, [190] *per* Lord Phillips.

<sup>139</sup> [2006] UKHL 20, [2006] 2 AC 572, [2006] 2 WLR 1027, [39].

<sup>140</sup> *ibid*.

<sup>141</sup> *ibid*, [35].



“renders precarious the authority of Hotson”.<sup>142</sup> Accordingly, the position in English law after *Hotson* and *Gregg* remains unresolved.

## **7. Reforming the Costs of Civil Litigation in England and Wales: Implications of the Jackson Report for the Costs of Clinical Negligence and the Ministry of Justice Reform of Legal Aid**

### **(a) Jackson Report**

Arguably the most comprehensive review of civil litigation costs since the Woolf Report, the Jackson Review of Civil Litigation Costs<sup>143</sup> contains several recommendations which will, when implemented, have profound implications for the costs of clinical negligence cases.

The Jackson Report notes that Conditional Fee Agreements (CFAs), of which “no win no fee” agreements are the most common, have been the “major contributor to disproportionate costs in civil litigation in England and Wales”.<sup>144</sup> As we have previously seen, in their Report and Annual Accounts of 2010, the NHSLA agree with Sir Rupert Jackson and are convinced that a major reason for the growth in volume of clinical negligence claims is the availability of this “‘so-called’ no win no fee market”.<sup>145</sup>

The two key drivers of cost under these CFAs are (i) the lawyer’s success fee and (ii) the after-the-event (ATE) insurance premium that is usually taken out when a CFA is entered into (to cover the claimant against the risk of having to pay the defendant’s costs). Both the success fee and the ATE insurance premium are currently recoverable from an unsuccessful defendant.<sup>146</sup> The Jackson Report noted that a significant part of the costs being paid by the NHSLA to claimant solicitors relates to these two drivers of cost, viz. success fees and ATE insurance premiums.<sup>147</sup>

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<sup>142</sup> See J. Stapleton, ‘Occam’s Razor Reveals an Orthodox Basis for *Chester v Afshar*’ (2006) 122 LQR 426, 448, n 77.

<sup>143</sup> Sir Rupert Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationary Office, 2010).

<sup>144</sup> Sir Rupert Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationary Office, 2010), Executive Summary, para 2.1, pxvi.

<sup>145</sup> NHSLA Report and Accounts 2010, Chief Executive’s report, p7; Claims received, p13.

<sup>146</sup> Sir Rupert Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationary Office, 2010), Executive Summary, pxvi, para 2.1; see, further, V. Harpwood, *Medicine, Malpractice and Misapprehensions* (Oxford: Routledge Cavendish, 2007), pp56-59.

<sup>147</sup> *Ibid*, Ch 23, p232, para 1.3.

Sir Rupert has made two controversial recommendations which would dramatically affect costs in clinical negligence cases. First, he has recommended that success fees and the ATE insurance premiums should cease to be recoverable from unsuccessful opponents in civil litigation. This, he believes, would lead to significant cost savings, whilst still enabling those who need access to justice to obtain it. It will be open to clients to enter into “no win, no fee” type agreements with their lawyers, but any success fee will be borne by the client, not the opponent. This is likely to mean that the success fee comes out of the damages awarded to the client.<sup>148</sup> Jackson has noted, with approval,<sup>149</sup> that success fees and ATE insurance premiums are not recoverable in Scotland, where the equivalent speculative fee agreement system works satisfactorily.<sup>150</sup> Secondly, he has recommended what he has termed “Qualified one way costs shifting”.<sup>151</sup> This means that, “the claimant will not be required to pay the defendant’s costs if the claim is unsuccessful, but the defendant will be required to pay the claimant’s costs if it is successful”.<sup>152</sup> It is “qualified” in that unreasonable (or otherwise unjustified) party behaviour may lead to a different costs order, and the financial resources available to the parties may justify two-way costs shifting in certain cases.<sup>153</sup> The justification for qualified one way costs shifting in the context of clinical negligence is that it would no longer require claimants to take out ATE insurance. It would also benefit defendants, as paying their own costs win or lose would be substantially cheaper than running the risk of paying the ATE insurance premium in those cases where they lose.<sup>154</sup>

In its consultation paper on Implementation of the Jackson Report, the Ministry of Justice have supported these reforms. They have recommended that the success fee and the ATE insurance premium should no longer be recoverable from the losing party in all categories of

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<sup>148</sup> Ibid, Executive Summary, pp xvi-xvii, paras 2.2-2.3.

<sup>149</sup> Sir Rupert Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationary Office, 2010), paras 5.15, 5.5

<sup>150</sup> See Lord Gill, *Report of the Scottish Civil Courts Review* (September 2009), Ch 14, para 96, available at: <http://www.scotcourts.gov.uk/civilcourtsreview> ; and, further, *Ministry of Justice, Proposals for Reform of Civil Litigation Funding and Costs in England and Wales* (November 2010), para 64.

<sup>151</sup> Sir Rupert Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationary Office, 2010), Executive Summary, p xvii, para 2.6, Ch 9, p 193, para 6.1.

<sup>152</sup> Ibid.

<sup>153</sup> Ibid, Executive Summary, para 2.6. For the view that the qualified aspect of one-way costs shifting creates slightly too much risk on the part of the claimant and fails to reach the optimum balance, see R. Heywood, ‘Saving Costs in Clinical Negligence: the Jackson Report’ (2010) *Professional Negligence* 124, p137.

<sup>154</sup> Ibid, Ch 9, p 87, para 4.1.

cases funded under CFAs, but that, in order to protect those who merit protection against adverse costs, qualified one way costs shifting should be introduced.<sup>155</sup>

Sir Rupert also recommended that both solicitors and barristers should be permitted to enter into contingency fee agreements with their clients (which are known as “damages-based agreements” (DBAs))<sup>156</sup> in contentious cases. These DBAs are a type of “no win no fee” arrangement like CFAs, since the legal representative is only paid if the case is successful and does not receive any payment if the case is lost. DBAs are distinguishable from CFAs in that the payment received by the legal representative is calculated by reference to the damages awarded to the client, as opposed to an uplift on the representative’s base costs. Accordingly, DBAs permit representatives to claim a proportion of their clients’ award of damages as their fee.<sup>157</sup> However, Sir Rupert recommended that costs should be recoverable against opposing parties on a conventional hourly rates basis, and not by reference to a contingency fee. He also recommended that contingency fees must be regulated and should not be valid unless the client has received independent advice.<sup>158</sup> The introduction of DBAs has been supported by the Ministry of Justice.<sup>159</sup> There is no doubt that they could be utilised in clinical negligence cases, in that it would be these cases where legal representatives would be keen to claim a proportion of their client’s award of damages as their fee. However, a legitimate concern would be that there would be no incentive to take on borderline cases in the clinical

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<sup>155</sup> *Ministry of Justice, Proposals for Reform of Civil Litigation Funding and Costs in England and Wales* (November 2010) Cm 794, paras 68, 83-84. While Jackson proposed that this would be qualified by an evaluation of the claimant’s behaviour in the litigation and the claimant’s financial resources ( Sir Rupert Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationary Office, 2010), Executive Summary, para 2.6), the Ministry of Justice has suggested that, in order to achieve the necessary certainty, there will be a presumption that the claimant would not be liable to pay the defendant’s costs. It would then be open for the defendant to apply to the court for an order that, since the claimant is “conspicuously wealthy” or the defendant is uninsured, the claimant should be liable for all or a fixed amount of defendant’s costs if the claim fails: *Ministry of Justice, Proposals for Reform of Civil Litigation Funding and Costs in England and Wales* (November 2010) Cm 794, para 143.

<sup>156</sup> “‘Damages-based agreements’ (DBAs) is the statutory term under section 58AA of the Courts and Legal Services Act 1990 [as amended by section 154 of the Coroners and Justice Act 2009 ] for agreements sometimes known as contingency fees. However, ‘contingency fee’ is a broad term which technically covers all private legal funding arrangements between representatives and claimants in which the payment of a fee to the representative is contingent on the successful outcome of the case, including CFAs”: *Ministry of Justice, Proposals for Reform of Civil Litigation Funding and Costs in England and Wales* (November 2010) Cm 794, para 220.

<sup>157</sup> *Ministry of Justice, Proposals for Reform of Civil Litigation Funding and Costs in England and Wales* (November 2010) Cm 794, para 221.

<sup>158</sup> Sir Rupert Jackson, *Review of Civil Litigation Costs: Final Report* (The Stationary Office, 2010), Executive Summary, pp xviii-xix, para. 3.3, p133, para 5.1.

<sup>159</sup> *Ministry of Justice, Proposals for Reform of Civil Litigation Funding and Costs in England and Wales* (November 2010) Cm 794, 2.9, pp 70-75, paras 220-237 .

negligence field, reducing access to justice in many complex cases where proof of negligence and/or causation may be extremely difficult to establish.

#### (b) Reform of Legal Aid in England and Wales

The UK Government has seen the CFA, shorn of the lawyer's success fee and the ATE, but with the protection of qualified one way costs shifting, as the way to fund clinical negligence cases. At present, clinical negligence cases against the NHS are funded approximately 50:50 between legal aid and CFAs (the latter in the form of no win, no fee agreements).<sup>160</sup>

However, in the face of a reduction of 23% in its overall budget, in November 2010 the Ministry of Justice proposed "fundamental reform" of the legal aid scheme.<sup>161</sup> It considered that legal aid funding was not justified for clinical negligence cases, since there was a viable form of alternative, in the form of CFAs, which were likely to be more readily available in these cases than in other claims. The government therefore proposed to exclude civil legal aid from all clinical negligence cases.<sup>162</sup> While recognising that there were likely to be cases such as obstetrics, with high disbursement costs, which were currently funded by legal aid, but for which clients might find it hard to secure funding under a CFA, they did not consider that this represented a sufficiently high proportion of cases to justify retaining clinical negligence within the scope of legal aid.<sup>163</sup> On 21 June 2011, the Secretary of State for Justice confirmed this position in his introduction of the Legal Aid, Sentencing and Punishment of Offenders Bill,<sup>164</sup> stating that with 80% of clinical negligence cases being undertaken on a no win no fee basis, and only 20% using legal aid, a no win no fee basis of funding was 'probably the better way forward'.<sup>165</sup> It is submitted that it is likely that there

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<sup>160</sup> The Parliamentary Under Secretary of State for Justice (Mr Jonathan Djanogly), HC Deb, 23 November 2010, col 160.

<sup>161</sup> Ministry of Justice, Proposals for the Reform of Legal Aid in England and Wales, CP12/10, Cm 7967 (November 2010), pp 3,5.

<sup>162</sup> Ibid, para 4.166.

<sup>163</sup> Ibid, para 4.167.

<sup>164</sup> The Lord Chancellor and Secretary of State for Justice, (Mr Kenneth Clarke), HC Deb, 21 June 2011, c 166. Clause 8(1) of the Legal Aid, Sentencing and Punishment of Offenders Bill provides that the civil legal services described in Pt 1 of Sch. 1 of the Bill are available to an individual. Part 2 of Schedule 1 lists the services that are not included in the services described in Part 1, including civil legal services provided in relation to personal injury and death and civil legal services provided in relation to negligence.

<sup>165</sup> Ibid, c. 174. But cf, the Government's own admission that clinical negligence cases against the NHS are funded approximately 50:50 between legal aid and CFAs (the latter in the form of no win, no fee agreements): see n.159 above.

will be several losers in access to justice for clinical negligence if this approach is adopted. This is particularly a concern in cases assessed as having a 50:50 chance of success.

## 8. Conclusion

This paper has examined medical liability in the UK, primarily from the perspective of clinical negligence in the NHS. We have seen that several reports have pointed to failure in the civil justice system in respect of clinical negligence claims. However, 14 years on from the Woolf report, medical negligence claims are subject to the same difficulties as they were then. A major problem, as we have seen, is that these claims are complex. It is difficult to establish a breach of duty of care in clinical negligence cases, and even if that hurdle is overcome, there is the perennial problem of establishing causation.

What is clear from the empirical data of the NHS's Annual Report and Accounts is a trend of increasing costs of funding claims. However, in respect of their concern over increase in claim numbers, it is submitted that, when viewed in the context of the previous three years of relative stability, it is premature to suggest that such an increase in claim numbers during the last two years should give rise to the degree of concern that appears to have emanated from the NHS. Indeed, it is clear that there has been a marked increase in access to justice over the last ten years in this area and this is to be welcomed. Nonetheless, there is something to be said for the view that the benefits have mostly gone to savvy claimant lawyers operating under no win no fee arrangements, especially in respect of low value claims.

The UK Government sees the CFA, shorn of the lawyer's success fee and the ATE, but with the protection of qualified one way costs shifting, as the way to fund clinical negligence cases. It considers that legal aid funding is not justified for clinical negligence cases, since there is a viable form of alternative, in the form of CFAs, which are likely to be more readily available in these cases than in other claims. It has been submitted that there will be several losers in access to justice for clinical negligence when the Legal Aid, Sentencing and Punishment of Offenders Bill is enacted, especially in cases assessed as having a 50:50 chance of success.

While the proposed changes to legal aid in England and Wales are a source of concern, these changes do not apply to Scotland.<sup>166</sup> The McLean report's recommendations that consideration should be given to the establishment of a no fault compensation scheme for medical injury along the lines of the Swedish model and that such a scheme cover all medical treatment injuries that occur in Scotland, are radical developments in the field of compensation for medical malpractice. The Scottish Government has welcomed its proposals, but the devil will remain in the detail of how such a scheme would work in practice, with its associated cost implications. Moreover, while the proposed new system would remove the

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<sup>166</sup> Legal Aid, Sentencing and Punishment of Offenders Bill, cl 117(1).

need to prove negligence, it would still require proof that harm was caused by treatment. The thorny issue of causation is therefore not eliminated by the proposed scheme.