‘MEDICAL MISHAPS’

Time For A New Approach?

A review of current practice for the settlement of clinical claims for medical errors

Author: Mohammed MEMON

MPhil (Law)  University of Bolton

June 2016
## Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preface</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Declaration</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Abstract</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td><strong>Chapter 1</strong></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Chapter 2</strong></td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Literature Review</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Chapter 3</strong></td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Methodology</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Chapter 4</strong></td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Comparative Studies</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Chapter 5</strong></td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Conclusions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bibliography</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Appendices</td>
<td>80</td>
</tr>
</tbody>
</table>
List of Appendices

1. Interviews with barristers and solicitors
2. Correspondence with Chief Medical Officer Dept. of Health England
3. Correspondence with Chief Medical Officer Dept. of Health Scotland
4. Correspondence with embassies of the Nordic countries
5. Correspondence with the United States embassy.
6. List of North West legal firms specialising in medical negligence
7. Useful contacts and addresses
Preface

I am most grateful to the many individuals who have helped me with my research, especially the barristers and solicitors who found the time to be interviewed and provided insights into the medical claims process. They kindly shared their experiences and made valuable contributions with their frank comments in relation to this research project.

I wish to thank:

Professor Stephen Hardy for his guidance, patience and support; Dr Iain Goldrein QC for his time, valuable critique and contribution to ideas; and Professor Rob Campbell for his support and encouragement.

I wish to thank my family for their understanding during this journey.

Mohammed Memon
April 2016
**Declaration**

I solemnly declare that this piece of work and the related research contained in this thesis document were carried out by me.

It is unique to me and has not been submitted before by anyone, to Bolton University or any other institution for the purpose of receiving a degree or any other qualification.
ABSTRACT

Within the context of clinical negligence, often described as ‘medical mishaps’ or ‘medical error(s)’, the latest estimate of the cost to the NHS is about £22.7 billion (NHS Litigation Authority, July 2013). It is expected that this cost will rise to 28.6 billion (Gibb, F, August 2015). The MPS, expressed concerns of escalating costs (Medical Protection Society, 2011).

Study Reviews current practice by analysing randomly selected court cases, time frame to resolve / reach a settlement and quantifying legal costs.

Furthermore, review, how medical mishaps are redressed in Denmark, Norway and New Zealand., where a no-fault scheme operates, eligibility criteria, differ, between various existing no-fault schemes (Brahams, D., 1988a), and (Erichsen, M., 2001).

The Scottish Government Review Group (2011), recommended a no-fault compensation scheme, emphasising “removal of a fault-based approach offers the opportunity to collect valuable data on medical error, as well as to engage in systems learning to facilitate error prevention and therefore enhance patient safety” (Frank Stephen, Angela Melville and Tammy Krause, 2012).

In Florida and Virginia USA, a no-fault scheme has been operated since 1980s onwards for birth related neurological injury.

A ‘no-fault’ compensation approach for medical mishaps used in other countries may help develop an alternative model for England and Wales. Further, such an approach may save considerable resources for the NHS.

Overall, in terms of contribution to knowledge, this study seeks to contribute to the current corpus of knowledge:
Chapter 1 - INTRODUCTION

As a retired medical practitioner, I have come across difficult situations where families have tried to seek redress from NHS practitioners for clinical negligence. Such experiences have inspired this study.

Within the context of clinical negligence, often described as ‘medical mishaps’, the latest estimate of the cost to the NHS is about £22.7 billion (NHS Litigation Authority, 2015). Furthermore, in 2012-13, over 16,000 claims have been lodged against the NHS for clinical negligence claims. Consequently, there appears to be an increasing rise in medical negligence claims by some 18% compared to the previous year. The starkest statistical indicator is that approximately a quarter of this is accounted for by legal fees (Donnelly, L., 2013)

In a recent article in The Times’ Law Section, it is outlined that: “At the end of March 2015 the NHSLA (NHS Litigation Authority) had £12.5 billion of claims on its books”. The estimated costs of reported and not yet reported claims from negligent claims are said to be £28.6 billion (Gibb, F., 2015). Against this general statistical context, litigants and legal practitioners, as well as medical practitioners’ report that it takes several years and a lot of hardship for all concerned to seek a resolution of their ‘medical mishap’ (and/or clinical complaint or claim). Herein lays the motivation for this study.

Accordingly, this research seeks to examine, current practice of reaching a settlement or an award of compensation by:

- Reviewing and analysing randomly selected court cases of medical errors/negligence and also establishing the timeframe it takes to resolve or reach a settlement and establishing the attributed legal cost compared to the amount of compensation awarded, and

- Secondly, legal practitioners who assist litigants are being approached for an interview about the current practice of reaching a resolution and whether there are alternate methods in their opinion for bringing about settlements to
minimise anguish and grief which individuals and families have to suffer due to considerable delay, to bring about a closure and/or resolution.

Defining ‘Medical Mishaps/Errors/Mistakes/Negligence’

Central to this study is the term “medical mishaps” or errors or mistakes which can be defined as an adverse outcome of health care treatment, whether it is evident or harmful to the recipient. This occurrence can be due to misdiagnosis, treatment and injury or due to an act of clinical practice, treatment procedure or investigative process.

A review undertaken by John Bonifield and Elizabeth Cohen (2012), disclosed:

Ten shocking medical mistakes which included:

1) Treating the wrong patient.
2) Surgical souvenirs (equipment left inside the body post-surgery).
3) Lost patients (patients mostly with conditions such as dementia).
4) Fake doctors (instead of getting better, patients get sicker, check physician is licensed).
5) Long waiting times in ER (emergency rooms).
6) Air bubbles in the blood.
7) Operating on the wrong body part.
8) Infection infestation.
9) Look-alike tubes.
10) Patients waking up during surgery (under dose of anaesthesia).

Furthermore, a recent update (CNN, September 15, 2015) added the following additional causes for medical mistakes:

11) Dispatching ambulances to the wrong address (delayed treatment).
12) Baby switches.
13) Dumb discharges (patients sent home without appropriate arrangements).
14) Mistakes during fertility treatment (embryos implanted in wrong women).
15) Misdiagnosis.
16) Botched plastic surgery.
17) Baby security breaches.
18) Dosage disaster (wrong dosage prescribed).
19) Biopsy blunder.
20) Pharmacy mistake.
21) Blood transfusion mistakes.
22) Too much radiation mistake (CT scan radiation or treatment mistake).
23) Burns – during treatment due to lasers.
24) Injury due to metal in MRI room – patient injury.
25) Treating the wrong patient.
Reasons for Medical Negligence

To that end, in order to understand how and why clinical errors occur which may have serious repercussions for individuals and/or their family carers, as well as the medical practitioners involved in providing care, one needs to understand the reasons for occurrence of these errors, these can often, according to Right Diagnosis (rightdiagnosis.com., 22nd April 2014)) be due to:

- lack of training
- carelessness
- overwork
- excessive consumption of alcohol or drug misuse by the medical practitioner
- erroneous medicine prescribing
- human error
- investigation failures
- procedural/surgical error(s)
- inadequate care

For any of the above reasons, medical errors are bound to occur in certain circumstances. The challenge for managers and practitioners is how to minimise the risks, which lead to errors causing harm, pain and suffering. Therefore, once a medical error has occurred, the purpose of resolution is to return the sufferer to recovery without any sequelae, or addressing the mistake(s) by apology and/or appropriate compensation.

Currently cases are settled are through the courts or by an out of court settlement offer. Another avenue for resolution is through a multidisciplinary body - the Clinical Disputes Forum. This forum has been established as a result of Lord Woolf’s ‘Access to Justice Inquiry’ in 1996 (Woolf, the Right Honourable Lord, 1996). The aim of resolution through this process is deemed to be “a less adversarial and more cost effective way of resolving disputes about healthcare and medical treatment” (No Fault Compensation Schemes).

Consequently, the purpose of this research is to ascertain whether there can be other avenues which need to be considered for resolving/compensating individuals and families who have had the misfortune of suffering and experiencing medical errors during the course of care and treatment provided by health care professionals.
Patients’ Views on Medical Errors

In general terms, it is accepted that most of the individuals receiving healthcare look up to professionals and are grateful for the medical input which they receive during the course of treatment. To that extent, medical errors remain a rarity. However, “medical error and those resulting in severe adverse consequences of treatment occurring in less than 1% of cases (medical mishap)” (Frank Stephen, Angela Melville and Tammy Krause, 2012), supports the assertion. Even so, against a background of mass NHS re-organisations with organisational memory being lost and new systems requiring time to embed with the consequential staff shortages and use of agency staff, clinical errors, so-called ‘medical mishaps’, do occur.

The most pertinent point is that when they do, the patient will often turn from friend, into a hostile foe. For the majority of patients this is so, since whilst in hospital they fear lack of staff input, no consistency of care and they cannot relate to the same staff members. Such is regarded as the ‘revolving door situation of the NHS’. Consequently, patients perceive that health staff are over-worked and therefore, medical negligence can occur. Furthermore, for as long as patients continue to become aware of over spent hospital budgets, the lack of cleanliness in some hospitals and the over-use of external agency staff, the more rife the healthcare arena becomes for legal action and /or the threat of the legal claims.

Medical Practitioners’ Views

The on-going re-organisation of the National Health Service, alongside the mergers of hospitals has been met by much opposition from medical practitioners. Often in the ‘new NHS’, these medical professionals have to travel between several sites in order to provide care, which adds additional burden to their daily lives and on their professional commitments. Increased tiredness due to additional work and the lack of trained staff, in addition to unfilled staff vacancies keeps them under persistent pressure. Moreover, apart from the personal demands placed upon them, a poor hospital record retrieval system and the lack of availability of medical notes, due to healthcare multi-site locations does not help to recall important health care facts about individuals and
claimants. To that end, the medical practitioners feel ‘under fire’ from the overwhelming threat of litigation.

In response to new demands and pressures, the NHS has invested resources to make all the healthcare information available to professionals online but it is still subject to failure and unreliability. In any event, many hospitals are using different informatics systems compared to primary care practitioners and these complexities can often lead to confusion and errors, as medical records not being to hand when required. Furthermore, the EU Working Time Directive has sought to govern and limit the hours of work for healthcare workers and whilst welcome, it also increases the risk of medical errors, due to widespread usage of agency staff. Accordingly, the NHS Budget spends £9m on agency staff as 1,500 jobs go unfilled (The Herald Scotland, 12 June, 2014).

Are Errors Increasing?

It is unclear whether ‘medical mishaps’, i.e. medical claims are on the increase or whether individuals are becoming more aware of the setbacks due to the availability of information in public domain. Equally, individuals feel more empowered at challenging the healthcare teams than previously due to new legal funding arrangements, such as contingency fee arrangements. Yet the UK Press has certainly highlighted an increase in such claims. This is evidenced from the statistics by the NHS Litigation Authority that shows an increase of 22% in only one year (NHS LA, 2015).

As previously outlined, in 2012-13, over 16,000 claims have been lodged against the National Health Service for clinical negligence claims. Consequently, there appears to be an increasing rise in medical negligence claims by some 18% compared to the previous year. As a result, it is estimated that more than £1 billion is spent on settlements of which approximately, more starkly, a quarter is accounted for by legal fees.

Can Medical Errors Be Prevented and/or Reduced?

Medical ‘mishaps’ (errors/mistakes) can occur anywhere within the healthcare system by any person involved in providing care. The modern healthcare system has become
complex and errors can be attributed to many factors, as discussed above. However, in order to prevent medical errors and promote enhanced well-being, it has been advocated by various patients groups and medical professionals that:

- the provision of more detailed information is achieved (learning from mistakes)
- that central prescriptions records are kept, and
- in-patient health records are improved, including information about medicines, procedures and infection control practices.

Medical Protection Society research (2011), records that, “According to the US organisation, the Institute of Medicine, the first and most fundamental step in preventing medication errors is to work in partnership with patients”. Asghari, F, Fotouhi A., Jafarian A., (2010), report that the most acceptable approach to dealing with a peer’s medical error is to report it to the responsible doctor and encourage them to discuss, disclose that a clinical mistake / error has occurred by the practitioner to the patient and what are the likely consequences of this mistake and how this will affect the individual concerned.

Exploring Options for the Resolution of Medical Errors

With the implementation of the proposed measures suggested by the patients and medical professionals, medical errors may be reduced but can never be eliminated altogether. A combination of oversight, human error and system failure will result in medical errors. Plainly some of these errors will result in morbidity and may lead to mortality. For instance, in England, currently, compensation is awarded for medical negligence, either through the courts or in the form of settlements. In contrast, some countries, for example in Denmark, Norway and New Zealand, a no-fault scheme operates. No-fault schemes provide an alternative route to financial compensation for harm allegedly caused through medical treatment. Although there is still a need to establish causation, an important feature of no-fault schemes that have been established to date is that there is no need to prove negligence in order to be eligible for payment of financial compensation. This is in addition to the need on the part of injured patients to meet particular eligibility criteria, which may differ, as between, existing no-fault schemes (Royal Commission of Inquiry, 1967).

Most notably, on 1 June 2009, the Scottish Cabinet Secretary for Health and Well-being announced that a working group would be established to examine the issues
involved in establishing a no-fault compensation scheme in Scotland. The No-Fault Compensation Review Group (Review Group) began its work in August 2009 “asserted that one of the advantages of no-fault schemes is that the removal of a fault-based approach offers the opportunity to collect valuable data on medical error, as well as to engage in both systems learning to facilitate error prevention and therefore enhance patient safety” (Frank Stephen, Angela Melville and Tammy Ktause, 2012). More recently, the Medical Protection Society discussions on claims experience in South Africa highlighted concerns of escalating costs associated with payments that are not sustainable, MPS holds roundtable discussions to address sharp rise in clinical negligence claims (Medical Protection Society, 21 October 2011).

Evidently, given the current views and practices, the current legal avenues available to resolve and/or compensate victims of medical mishaps, are through litigation in the courts with the hope of settlement. Accordingly, this study will gather evidence through case studies, focused interviews with key stakeholders and comparative studies in order to assess the current effectiveness of the English management of medical (clinical) negligence claims, as well as to assess alternate methods of dispute resolution of medical claims.

Consequently, the researcher has chosen to pursue this study in view of his personal insight of working within the NHS, he has witnessed a number of medical errors over his working lifetime within the NHS and has come across clinical practitioners as well as patients who have to deal with the consequences of medical mishaps. Further, the researcher intends to review current practice prevailing within the English and Welsh health system(s) to deal with the process of compensation award(s) and time this takes to resolve the difficulties encountered by individuals and families, as well as practitioners.

The study will review a random sample of cases, which progressed through the courts to seek compensation resolution for medical mishaps and to get an insight from the legal practitioners who specialise in medical negligence matters and to explore an alternative way of seeking solution, which may be more expeditious and timely.

In Chapter 2, this study reviews literature to look at systems in other countries for dealing with resolution for medical mishaps. That is countries where funding for
compensation is through taxpayer funds, and compare their process of compensation with the current system in place in England and Wales.

**Aims of this Study**

Above all, the aims of this MPhil thesis are to:

- To evaluate the effectiveness of the present English and Welsh system for handling clinical negligence claims;
- To compare the English and Welsh systems of managing clinical negligence claims with the existing systems in New Zealand, USA, Nordic countries and Scotland;
- To suggest a way forward for resolving medical mishaps claims in England and Wales.

The benefits of such a study will be to look at current practice in an informed way and review whether there are alternate ways of resolution which will benefit the sufferer and their families in a timely manner and fairly and minimise such events in future as well. This may also be a more cost effective way of using taxpayer funds.

By reviewing the current practice prevailing in England and Wales and making a comparative analysis of the ones prevailing in other countries, one can identify a better and more cost effective way of resolving medical mishaps compensation outcomes and resolutions and minimising the impact of medical mistakes in future through a process of on-going training and education?

This study will also scrutinise the most cost effective ways to pay compensation as well as the process for achieving this outcome so public funds are used effectively and savings are directed towards funding education and training to prevent future similar medical mishaps - if this can be achieved.

Mistakes will continue to be made. The aim is to learn from mistakes and put systems in place to avoid these happening in future or at least to aim to reduce such re-occurrences.
Chapter 2 – LITERATURE REVIEW

This Chapter reviews no fault compensation schemes in the UK and other countries.

Current practice for resolution of medical mishaps in England and Wales is by legal recourse, resolution by out of court settlement or through the court’s decision. In England and Wales, the tort-based systems for clinical negligence claims have risen considerably in recent times. In order to seek redress or compensation for medical mishaps in England and Wales, the researcher’s own observations about colleagues facing this dilemma confirms that the existing system is torturous and time consuming and is adversarial for individuals and their families. The cost of legal input is costly, this further burdens the taxpayer as the costs are added on for recovery from the Health Service or the recipients of the compensation award have to pay personally costs for legal input, in some cases this may be up to 50% of the awarded claims.

This research has identified a number of countries where no fault compensation schemes operate and compensation award is by public purse or insurance based. Embassies of various countries were approached, where a no fault compensation scheme operates, to make inquiries and seek information to learn about the processes and the outcome experiences so a comparison could be made to the prevailing system in England and Wales.

Medical errors will continue to happen and compensation for harm allegedly caused through medical treatment will co-exist. Estimated costs of reported, and not yet reported, claims from negligent claims may be £28.6 billion (Gibb, F., 27th August 2015).

Consequently, there appears to be a rise of claims for negligence by 18% compared to previous year. More than £1 billion was spent on settlements in 2011/12 of which approximately are one quarter were costs, which were spent on legal fees. The views generally held by individuals and practitioners alike are that it takes several years and a lot of hardship for all concerned (families and equally for the professionals) to seek a resolution.

In contrast, in some countries (i.e. Denmark, Norway, other Nordic countries and New Zealand) a no-fault scheme operates to resolve and reach a settlement. These “no-
fault" schemes provide an alternative route to financial compensation for harm allegedly caused through medical treatment. Although there is still a need to establish causation, an important feature of no-fault schemes that have been established to date is that there is no need to prove negligence in order to be eligible for payment of financial compensation. This is in addition to the need on the part of injured patients to meet particular eligibility criteria, which may differ as between existing no-fault schemes (New Zealand Royal Commission, 1967).

No fault systems encourage and identify system malfunctions and learning to prevent recurrence. When an individual has suffered harm, the no fault system compensates individuals. The health care systems are upgraded and fixed to prevent error happening again. Such a deficit can be a health care practitioner who may require further training and rehabilitation (Seubert, D.E. MD; April 2007).

**New Zealand - No Fault Compensation Scheme**

A Royal Commission, chaired by Sir Owen Woodhouse in 1966, reviewed the law relating to compensation claims for damages, incapacity and death. The Report was published the following year (Woodhouse Report), this recommended a no fault compensation scheme for personal injury based on the following principles: community responsibility, comprehensive entitlement, complete rehabilitation, real compensation, and administrative efficiency (Royal Commission of Inquiry, 1967), (McKenzie, P., 2003). The Accident Compensation Act (1972), was subsequently passed with the scheme coming into effect in 1974.

The main aspect of this legislation is based on “*Injury Prevention, Rehabilitation, and Compensation Act 2001 (IPRCA 2001) which came into effect on 1 April 2002, although it has been subject to amendment over time*”.

The key goals of New Zealand Legislation are ‘The injury prevention, complete and timely rehabilitation, fair compensation and Code of ACC (Accident Compensation Corporation) claimants’ rights’. As part of realizing these goals, the scheme operates on the basis that individuals forgo the right to sue for personal injury in the courts, with the exception that the right to sue for exemplary/punitive damages remains.
For instance, public trust and confidence is reported to be 62% and overall satisfaction is 83% (Accident Compensation Corporation Annual Report, 2009).

Funding comes from variety of sources, and the ACC retains a number of different accounts for managing compensation paid in respect of various types of injuries.

In summary, the emphasis of the New Zealand Model is based on fairness, rehabilitation and injury prevention (minimise injury impact). This no fault approach limits compensation and lessons to be learnt from mishaps to educate professionals thus reducing similar events. Individuals forgo the Right to Sue except the Right to Sue for Exemplary or Punitive damages. Compensation is made from general taxation. There are clear-cut deadlines for claim submission and processing of the claim. Awards are generally based on the severity of the injury, the overall client satisfaction is very high 83%. The running costs of this scheme are 12% of the total awards made, which is cost effective and a good use of public funds. In fact, $122 billion is spent per year in medical malpractice in the United States, whereas only $29 million per year is spent on the no-fault compensation in New Zealand. In the USA legal costs amount to 55% of the compensation awards, compared to 10% in New Zealand.

The Nordic No fault Compensation Scheme (collectively the Nordic Schemes)

In the Nordic region, the adoption of no-fault schemes for medical injury has been the preferred approach. Sweden took the lead in adopting a no-fault scheme in 1975, although the parameters of this scheme have been amended over time. The Swedish model provided the inspiration for the adoption of no-fault schemes in Finland in 1987, Norway in 1988 and Denmark in 1992. The extent to which schemes vary reflect differences in national preferences on particular issues (Kachalia et al., 2008).

All have similar legal and social goals, which may be summarized as

Follows:

- The patient’s right to compensation where they have suffered harm as a result of medical treatment
- Easy and broad access by injured patients to compensation
- The fostering of good relations between health practitioners and patients
- The promotion of safety and quality in care through learning from medical error
An emphasis away from attaching blame to individual health practitioners with a view to promoting learning from medical error and enhancing patient safety

Administrative schemes providing compensation for medical injury are more efficient in terms of costs and time to resolution

Claims are resolved quickly and provide easy and broader access to justice for those who have suffered medical injury (Danzon, P.M., 1994), Fallberg, L.H. et al, 1997).

The schemes aim to promote good relations between health practitioners and injured patients. Although patients are not required to obtain the support of their physicians, patients often seek their advice in deciding whether or not to make a claim. In Sweden, for example, it is estimated that health practitioners facilitate 60-80% of all claims made under its no-fault scheme (Injury Prevention Rehabilitation & Compensation Act, 2001)

These schemes erect a “Chinese wall” between compensation and professional accountability and disciplinary activities. This has resulted in the separation of all information collected and used under the no-fault scheme from fault-finding or disciplinary activities in relation to health practitioners. There are limitations on compensation awards with maximum caps and threshold requirements regarding the level of disability a claimant must have before being eligible for compensation (Kachalia, et al., 2008)

Swedish compensation is based on sub-sets of medical injuries, as all injury compensation models will be prohibitive. Principles adhered to by the Nordic model is based on patients’ right to compensation, away from the blame culture and fostering good relations between the health care practitioners and patients even after the event of a medical mishap.

Such an approach helps with rehabilitation to minimise the injury sustained and re-enforces the belief that the practitioner was not intending to cause the harm and anguish and is not responsible for the injury or harm thus sustained. Such an understanding approach will assist in rehabilitation as well as limiting the harm caused and minimise the limitation of harm.
United States

In Virginia and Florida, no-fault schemes have been introduced which are limited to coverage of birth-related neurological injury. The political impetus for the adoption of such schemes in both jurisdictions in the late 1980s had its origins in political and professional concerns about the growing cost of compensation in such cases, as well as difficulties experienced by obstetricians in relation to the growing cost of insurance premiums and in obtaining liability insurance.

For instance, in Virginia, the compensation claim for birth related neurological injuries were capped at $750,000 injuries related to medical malpractice. As of December 2008 (80%) were claims-related and 20% related to general administration expenses (Oliver Wyman Actuarial Consulting, Inc., 2009). The definition of ‘birth-related neurological injury’ under the governing legislation (Section 38.2-5001 Code of Virginia) is as follows:

‘Injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation necessitated by the deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital which renders the infant permanently disabled, and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled... such disability shall cause the infant to be permanently in need of assistance in all activities of daily living’.

The two initiatives achieved their objectives of maintaining affordable obstetric insurance coverage for physicians with obstetrical liability premiums declining much more rapidly after the introduction of the schemes. This was achieved through removing the most expensive obstetrical medical malpractice claims from the existing tort system (Bovbjerg, R.R., Sloan, F.A., 1998). The existence of the scheme leads to fewer claims and lower malpractice premiums (Kessler, D.P., McClellan, M.B., 1997).
In terms of summarizing the comparative ‘No Fault Compensation’ schemes:

**MODEL 1**

**New Zealand  ‘No Fault’ Compensation**

<table>
<thead>
<tr>
<th><strong>Background</strong></th>
<th>Royal Commission Established</th>
<th>1966</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Woodhouse Report Published</td>
<td>1967</td>
</tr>
<tr>
<td></td>
<td>No Fault Compensation Scheme Recommended</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accident Compensation (NZ) Passed</td>
<td>1972</td>
</tr>
<tr>
<td></td>
<td>Implemented</td>
<td>1974</td>
</tr>
<tr>
<td></td>
<td>Current Legislation Effective from</td>
<td>2002</td>
</tr>
<tr>
<td></td>
<td>Governs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injury Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and Compensation (IPRCA 2001)</td>
<td></td>
</tr>
<tr>
<td><strong>Principles:</strong></td>
<td>Fair and Sustainable Scheme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimising Injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and Impact of Injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete and timely Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individuals Forgo the Right to Sue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Except the Right to Sue for Exemplary / Punitive Damages</td>
<td></td>
</tr>
<tr>
<td><strong>Administered</strong></td>
<td>Crown Entity (ACC)</td>
<td></td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>General Taxation</td>
<td></td>
</tr>
<tr>
<td><strong>Operating Cost of the Claim Paid</strong></td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

**Time Period for Filing Claims**

<table>
<thead>
<tr>
<th><strong>Filing Claims</strong></th>
<th>within 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Assessment</strong></td>
<td>majority 21 days</td>
</tr>
<tr>
<td><strong>Claim Processing</strong></td>
<td>Max time 4 months</td>
</tr>
<tr>
<td><strong>Assessment at Treatment Centre</strong></td>
<td>absolute 9 months</td>
</tr>
</tbody>
</table>

**Awarding Bands for Claims**

<table>
<thead>
<tr>
<th><strong>Public Acceptance</strong></th>
<th>Accident Compensation Corporation (2009)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Trust</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>Client Satisfaction</td>
<td>83%</td>
<td></td>
</tr>
</tbody>
</table>
MODEL 2

Nordic ‘No Fault' for Medical Injury

Background
- Sweden 1975
- Finland 1987
- Norway 1988
- Denmark 1992

Principles:
- Patients Right to compensation when they suffered harm as a result of medical injury
- Easy and broad access by injured patients to compensation
- Fostering good relations between patients and practitioners
- Away from blame
- Efficient System for providing compensation

Administered
- A Public Company

Funding
- County Councils
- Pharmaceutical Co contribute to scheme

Operating Cost of the Claim Paid ??

Time Period for Filing Claims
- Filing Claims on becoming aware: Within 3 years
- Time of Injury: within 10 years

Assessors from Clinical and Legal background

Claim Rejection 50%

Claim Assessment ??

Claim Processing ??

Awards
- Pecuniary damage: loss of income and medical expense
- No Pecuniary damage: for pain and suffering
disability and disfigurement and inconvenience
- family entitled funeral expenses and loss of earning

Public Acceptance
- Public Trust ??
- Client Satisfaction ??
The core principles adhered to in the Nordic model are based on the patient’s right to compensation, away from the blame culture and fostering good relations between the health care practitioners and patients even after the event of a medical mishap. Such an approach helps with rehabilitation to minimise the injury sustained and re-enforces the belief that the practitioner was not intending to cause the harm and anguish and is not responsible for the injury or harm thus sustained. Such an understanding approach will assist in rehabilitation and limiting the harm caused and minimise the limitation of harm.

There is clear guidance and a time-defined approach for seeking compensation and award of compensation.

Such an approach currently does not exist within the framework of the NHS even with the ADR approach recently introduced, the time guidance and defined settlements payments are not as yet set out clearly. Still the use of the legal approach is open-ended which may in itself cause difficulty in reaching an early or timely resolution for medical mistakes. This adds additional costs for settlement of legal input and if the matter does not get resolved then additional court costs and time delays add to the burden for seeking resolution for medical mishaps

There is a high rejection rate of claims through the system set up in Nordic countries but this seem to work well and overall is a cost effective way of dealing with the compensation for mistakes which were unintended as well as continue to build better relationships with practitioners who are available to assist with minimising the impact of injury through additional input and rehabilitation.
USA

‘No Fault’ Compensation
Virginia and Florida

Background
1960
Medical Malpractice Reform
on-going political, policy and academic debate
No Fault Compensation Scheme Recommended

Insurance Crisis, difficulty for health practitioners to obtain liability cover
Also accessing justice by individuals who have been harmed
also frivolous or vexatious claims by disgruntled Patients
In Virginia and Florida - no fault scheme which to coverage of birth related neurological Injury

1980
Virginia imposed cap of $750,000 on injury Minimising Injury related to medical practice
Virginia Birth related Neurological Compensation Act 1987
Goals
a) Children receive the required care
b) reduction of financial burden on parents and
c) medical insurance become readily available

Administered
Independent Organisation (input by Virginia Assembly)
Governor of Virginia appoints 9 Directors

Funding
Insurance paid by health practitioners and hospitals

Operating Cost
(Oliver Wyman 2009:53) 20%

Time Period for Filing Claims
Filing Claims within 5 years of birth (Florida)
Claim Assessment Meet the Criteria
Live Births (excludes disability, death and congenital malformation)
Claim Processing not well advertised or targeted
at potential claimants
Compensation limited by Cap

Uptake

Compensation

Public Acceptance Public Trust ??

Client Satisfaction
On 1 June 2009, the then Cabinet Secretary for Health and Well-Being announced that a working group would be established to examine the issues involved in establishing a no-fault compensation scheme in Scotland.

The No-Fault Compensation Review Group (Review Group), Chaired by Professor Sheila McLean, Glasgow University began its work in August 2009 to consider potential benefits for patients in Scotland of a no-fault scheme, whether this can be introduced alongside existing clinical negligence arrangements. As a result, the Department of Health (Scotland) observed that:

“….. it is asserted that one of the advantages of no-fault schemes is that the removal of a fault-based approach offers the opportunity to collect valuable data on medical error, as well as to engage in both systems learning to facilitate error prevention and therefore enhance patient safety”.

The Review Group’s report (Volume 1), was published, in February 2011 (No Fault Compensation Review Group Report), giving consideration of a no fault scheme for clinical injury, along the lines of the “no blame” system currently operated in Sweden. The Review Group agreed:

“a compensation system was not just about financial compensation, rather the objective should be to restore the person who had been harmed to the position they had been in prior to the injury, as far as this is possible”

The Scottish Government Review Group’s recommendations for a no-fault compensation scheme in Scotland were published in April 2014, summary of the recommendations are below:
Recent Scottish Review Group Recommendations for No Fault Compensation

The following Recommendations were made:

Recommendation 1
We recommend that consideration be given to the establishment of a no fault scheme for medical injury, along the lines of the Swedish model, bearing in mind that no fault schemes work best in tandem with adequate social welfare provision.

Recommendation 2
We recommend that eligibility for compensation should not be based on the ‘avoidability’ test as used in Sweden, but rather on a clear description of which injuries are not eligible for compensation under the no fault scheme.

Recommendation 3
We recommend that the no fault scheme should cover all medical treatment injuries that occur in Scotland; (injuries can be caused, for example, by the treatment itself or by a failure to treat, as well as by faulty equipment, in which case there may be third party liability).

Recommendation 4
We recommend that the scheme should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHS Scotland.

Recommendation 5
We recommend that any compensation awarded should be based on need rather than on a tariff based system.

Recommendation 6
We recommend that claimants who fail under the no fault scheme should retain the right to litigate, based on an improved litigation system.

Recommendation 7
We recommend that a claimant who fails in litigation should have a residual right to claim under the no fault scheme.

Recommendation 8
We recommend that, should a claimant be successful under the no fault scheme, any financial award made should be deducted from any award subsequently made as a result of litigation.

Recommendation 9
We recommend that appeal from the adjudication of the no fault scheme should be available to a court of law on a point of law or fact.

Recommendation 10
We recommend that consideration should be given to our analysis of the problems in the current system, so that those who decide to litigate can benefit from them.

The Scottish ‘no fault’ review recommendations for clinical negligence outline eligible faults for award, as well as for injuries, which are not considered eligible for compensation. This scheme will cover professionals working within the NHS as well.
as in private sector health care. This is in contrast, to similar schemes in countries (i.e. Denmark, Norway, other Nordic countries and New Zealand), where a no-fault scheme covers all areas of care and cases are considered on merit, and the overall direction is to resolve and reach a settlement. These "no-fault" schemes provide an alternative route to financial compensation for harm allegedly caused through medical treatment. An important feature of no-fault scheme proposed for Scotland, is the need:

- to establish a clear description of which injuries are eligible for compensation and others which are excluded and
- to distinguish injuries due to treatment/procedures and identify the ones attributed to faulty equipment

The above provisos are to assist learning lessons and put systems in place to avoid and minimize recurrences in future as well as to use these mishaps and lessons to develop educational tools.

A No-fault system encourages, identifies system malfunctions and learning to prevent recurrence. When an individual has suffered harm, the no-fault system compensates individuals as well as to upgrade health care systems to prevent errors happening again. Such a deficit can be a health care practitioner who may require further training and rehabilitation (New Zealand Royal Commission of Inquiry: 1967) and or system failure or equipment failure.

The Scottish Review Group have "asserted that one of the advantages of no-fault schemes is that the removal of a fault-based approach offers the opportunity to collect valuable data on medical error, as well as to engage in systems learning to facilitate error prevention and therefore enhance patient safety" (Stephen F et al (2012)). The Scottish no fault recommendation retains the right for individuals to litigate negligence in order to be eligible for payment of financial compensation. This is in addition to the need on the part of injured patients to meet particular eligibility criteria, in contrast to existing no-fault schemes in other countries (Seubert D.E. MD, April 2007)
Additional safeguards have been built in for individuals who are eligible for compensation through court and adjudication to safeguards rights, this is different to the no fault compensation scheme operated in New Zealand, where individuals have to forgo the right to sue, except for exemplary or for punitive damages.

Scottish no fault compensation extends to all the staff employed in Scotland and not only those working for NHS Scotland. This is reassuring as private and non-NHS establishments are now providing a number of procedures being carried out for the NHS.

Unlike in other countries where there is a clear time frame for submitting claims and also for processing these claims for compensation, the Scottish review recommendations have not been specific about time frames.

A current disquiet is the time lag from occurrence of clinical mishaps and resolution through the legal route. This may be an area, which will require addressing if a no fault compensation scheme is implemented in Scotland.

**Alternative Dispute Resolution**

This form of resolution involves reaching a resolution outside the legal framework. Such an approach can be expeditious and cost effective. Also, this type of approach is widely acceptable and used to resolve commercial disputes relating to transactions, property matters, shipping disputes and airline disputes. For example, in Australia, such an approach is known as “external dispute resolution” (Australian Securities and Investments Commission - Complaints resolution schemes. Generally, ADR (Alternative Dispute Resolution) is used widely alongside formal legal options to resolve or achieve settlements for parties concerned, as this offers following benefits:

- Suitability for multi-party disputes
- Flexibility of procedure - the process is determined and controlled by the parties to the dispute
- Lower costs
- Less complexity ("less is more")
- Parties choice of neutral third party (and therefore expertise in area of dispute to direct negotiations/adjudicate
- Likelihood and speed of settlements
- Practical solutions tailored to parties’ interests and needs (not rights and wants, as they may perceive them)
• Durability of agreements
• Confidentiality
• The preservation of relationships and the preservation of reputations

Mediation or arbitration. This can be a facilitative process or collaborative approach. The goals and objectives are a win-win situation for all concerned and to preserve the respect and identifying mutual benefits of 50 – 67% success in avoiding litigation benefits for the parties involved in reaching an outcome which is perceived to be of benefit/resolution without having to go through a formal process which can be time consuming and costly. (Sohn, D.H. MD and Bal,S. MD, 2012) identified in his article on medical malpractice that “an early apology” and “disclosure” would lead to widespread acceptance of ADR among physicians.

Various models used for alternative dispute resolution in resolving medical errors, negligence or malpractice situations are due to ever increasing legal costs and unpredictable awards, these models are as follows:

**Rush Model**

In 1995 the Rush Model was developed in Chicago, the main principles of this model are:

i) Mediation Agreement (includes early exchange of pre-mediation submissions, brief presentation by each party and process outline.

ii) All parties share expenses equally.

iii) Describes confidentiality and defines finality (Blatt, R., Brown, M., Lerner, J., 2001), (Guadagnino,C., 2004)

iv) The plaintiff selects mediators from a list of trained medical malpractice trial lawyers.

As a result, 80% of the cases were successfully resolved within one year of the lawsuit being filed within 3 – 4 hours of mediation (Cooley, J.W.,2002)

The Rush Model led to a win-win situation for both plaintiff and defence counsel and reduced the ever-increasing costs and time of traditional route to reach a resolution.
The VA (Veteran Affairs) Model

This model was piloted in Kentucky in 1987 after an increase in the number of lawsuits and size of the awards (Kraman, S. S., Hamm, G, 1999).

This model is based on:

i) Proactive or full disclosure (even if the patients have no idea), complete disclosure surrounding the error or adverse event, alongside any corrective action that was taken to prevent similar events happening in future. The disclosure included an apology from the chief of staff with full acceptance of responsibility.

ii) An external party or mediator was used to determine any restitution or settlement.

iii) The patient, next of kin and their attorney, which the VA (Veteran Affairs), are satisfied with the compensation offered and believe” it is fair” (Joint Commission on Accreditation of Healthcare Organisation, 2007).

University of Michigan Model

The University of Michigan Health System implemented a new policy for handling medical malpractice claims in 2001, based on the following principles:

i) quick and fair compensation for unreasonable medical care causing patient injury

ii) defence of staff and medical center when care was reasonable or no injury was caused

iii) learning from mistakes and patients experiences (Weber, D.O., 2006)

This has reduced the overall average cost of the claims from $48,000 to $21,000 and the overall length of time to resolve claims from 1,000 to 300 days.
Pew Mediation and ADR Model

This method was implemented in four Pennsylvania hospitals and healthcare systems in 2002. This focuses on improving communication between physicians and patients following a medical error or event. Learning from mistakes, fair and cost-effective resolution of claims (Liebman, C.B., 2004)

Under this scheme, the mediator facilitates discussions and allows individuals to gain greater understanding of the situation. In cases, which are mediated, apologies and exchange of information, resulting in change of policies or practice were part of the settlement.

Internal Neutral Mediator Model

Other healthcare providers have adopted an Ombudsman or internal neutral mediator program to resolve healthcare issues. The Ombudsman may be responsible for investigating errors and adverse events and develop plans to prevent future mishaps, which will include education and training provisions.

Eighty-two cases were handled in the first 18 months, all were settled within 10 hours, and no claims were filed on those cases. Effective communication has helped avoid litigation.

The overall lessons learnt from ADR approaches are that this promotes disclosure, meet the needs of the patients, reduces cost and improves patient safety. Medical malpractice or errors may have an impact on healthcare professionals and their families. The professional may lose productivity, may suffer with anxiety, may have difficulty finding future employment, there may be financial implications of legal costs, hence a way forward to seek early resolution serves both the professionals, patients and providers of healthcare.

UK – NHS ‘New’ Model

In November 2014, UK Government issued the Alternative Dispute Resolution Directive. The ADR Directive means certain requirements have to be fulfilled, including ensuring that ADR is widely available for consumer disputes, and the ADR
providers meet certain quality standards. This Directive gives the opportunity to examine the UK ADR landscape and to ensure that they have a system, which works for both consumers and business.

The EU ADR (Alternative Dispute Resolution) Directive was published in May 2013 and which needs to be enacted into UK law through Regulation under the European Communities Act 1972 from 19th July 2015 (Legal Eye Optimising Best Practice and performance, 2015). In fact the NHS Litigation Authority handles medical errors and malpractice claims for England and Wales. In 2014/15, the NHS LA received 11,497 claims (including potential claims) under its clinical negligence schemes the figures for 2013/14 were 11,945. The NHS LA (2015), had 30,049 “live” claims as at 31 March 2015, and CNST claims are now settled in an average of 1.31 years, counting from the date of notification to the NHS LA to the date when compensation is agreed or the claimant discontinues their claim (NHS LA, August 2015).

As from July 2014 onwards, the NHS has a new mediation service designed to support patients, families and NHS staff in working together towards a solution, and avoids the need to go to court. The service will provide access to an independent and accredited mediator, selected from a panel drawn from a wide range of backgrounds. The NHS LA’s partner for its mediation service is the Centre for Effective Dispute Resolution (CEDR, 2015).

CEDR are invited by the NHS Litigation Authority to provide independent Mediation input to resolve disagreements and disputes rather than through the formal legal input or through the courts (http://www.cedr.com/solve/services/?p=33). Through CEDR mediation input, the parties can have confidence in an independent, non-biased resolution. This can reduce time spent in formal proceedings, sets a clear focus on the problem, which requires resolving and parties, feel they are in control. The overall expectation is to enable and bring about a resolution, to the problem and avoid positions of entrenchment.
This chapter outlines the research methods used for this study.

Given the nature of this study and to inquire into the process and relevance of the current system of resolution of medical negligence compensation, it was deemed necessary to apply two distinct methodological approaches i.e.:

1) Qualitative – this applies to how individuals feel (Qualitative and Quantitative research for small business), how they make choices (make a decision), it is about the soft options which cannot be explained by just number crunching. This method has been used for this research along with a quantitative approach

For the purpose of this study, this approach was adopted by use of semi-structured interviews with practising legal professionals (barristers and solicitors).

2) Quantitative approach - this approach utilises structured data, statistical and numerical analysis. For this study the data was collated and reviewed or analysed by collecting random data sets from the court cases of medical negligence (reported Case Law sample).

The qualitative survey will assist in obtaining answers of this complex research area which involves various stakeholders i.e. individuals, carers, various professionals (health and legal practitioners), public bodies (NHS) and other stakeholders i.e.: management, providers of various services, manufacturers of products (medicines, surgical instruments, medications, healthcare aids etc.).

Quantitative research data is collected to produce information on a particular subject to reach general conclusions by analysing specific information. In this study data is reviewed from court cases. A Quantitative research approach method is applied to review an historical perspective of the court cases, the causes and outcomes of the variant situations, time-frames to reach a resolution and the cost implications for the public service for awards to recompense for medical faults as well as the cost borne by individuals / carers as well as the cost of the process, which
includes the legal costs to achieve resolution. A Qualitative study can generate useful results / material even with a small sample size, unlike the one for a quantitative approach.

In this study quantitative research was carried out by:

i) A random review of court cases over a period of time – to assess the outcome of claim success or otherwise;
ii) The value of compensation awarded; and,
iii) The time it took for individuals or families to seek an outcome.

The purpose of this approach was to identify the funding implications for both the cost of healthcare and compensation for medical mishaps as in England and Wales this is paid through public funding An additional aim was to compare practices prevailing in other countries, where healthcare and compensation is funded through public funds i.e. Scandinavian Countries, New Zealand.

The current system in England was examined retrospectively as it takes considerable time to achieve the outcome justified in seeking compensation. This approach was preferred for this study, as a prospective study design to seek the above answers would take too long and this may have built in expectations or biases from the sufferer and /or their families’ perspectives. This might put the professionals under focus, who then may behave differently, compared to existing practices.

The prospective study can be conducted in countries where currently, a no-fault compensation system is in place and this can be used to monitor current practice and the outcome this achieves and whether this has any impact on professional practice by monitoring the reduction of medical mishaps.

No system can be made perfect but the researcher’s belief is that if there are alternatives than these should be examined and an alternative way forward to help with resolution and minimise the anguish faced by sufferers and families should be considered for a better use of resources to fund healthcare in England and Wales, as well as to educate professionals to minimise and prevent similar events in future.
Research Design

As a medical practitioner, I have come across difficult situations where families have tried to seek redress from the NHS Practitioners for clinical negligence. The latest, forecast estimate is for negligence claims to reach £28.6 billion (Gibb, F., 2015). In 2012-13, over 16,000 claims were lodged against the health service (NHS Litigation Authority - 2013). There appears to be a rise of claims for negligence by 18% compared the previous year. More than 1 billion pounds was spent on settlements in 2011/12 of which approximately a quarter of costs were spent on legal fees. Therefore, in order to test these hypotheses, the research design adopted seeks to establish current practice and the facts of dealing with medical mishaps (compensation and process) in England. This was undertaken by a mixed method of quantitative methods, by way of a random, reported Case Law sample and, a qualitative approach focussed on interviews and comparative studies.

Such methods enabled the:

- reviewing of medical negligence court cases (historical perspective)
- and
- by interviewing legal practitioners on their view of current practice experiences and any alternative suggestions in addressing issues of medical mishaps.

The latter was tested by a semi-structured questionnaire with legal practitioners, in order to gather relevant information, which may inform the current practice of dealing with medical negligence matters and seek views of addressing any shortcomings in dealing with such matters.

Finally, in terms of research design, in order to make an informed judgment of current prevailing practice in England, the researcher will review alternative approaches of resolving medical negligence cases by the “No-Fault Compensation Approach”, in some countries, such as the Nordic countries, New Zealand and practice in Florida and the State of Virginia in the USA.

Random Review of Medical Negligence UK Case Law

As noted above, this research adopts two distinct methodological approaches to the research questions: a quantitative approach, by way of a random, reported
case law sample and, qualitative studies concerning focused interviews and comparative studies.

In order to establish current practice in England, a random sample of medical negligence court cases were selected for review:

i) to establish the time frame to bring about a resolution

ii) compensation awarded

iii) costs (court costs and legal fees)

iv) Additional costs incurred by families during the period to bring about a resolution and/or settlement is difficult to ascertain retrospectively. The researcher proposes time duration it took for each case to conclude, can be used as an indicator of the period of suffering for individuals and families.

The random sample was selected from 10 cases from a period of 15 years, from 1988 onwards.

Below, is the summary of the cases, reason for claim (negligence – causation? outcome, causing health and social difficulty), cost attributed to legal costs and the damages awarded.
Random case law sample findings*

<table>
<thead>
<tr>
<th>Case No</th>
<th>Citation</th>
<th>Claim</th>
<th>Case Outcome</th>
<th>Litigation Duration</th>
<th>Costs</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>B3/2000/0213</td>
<td>Burke v Leeds HA [2001]</td>
<td>Encephalopathy - Negligence/ delay in treatment</td>
<td>Drs not negligent</td>
<td>12 years</td>
<td>£85k</td>
<td></td>
</tr>
<tr>
<td>HQ11X00895</td>
<td>Ecclestone v Medway NHS [2013]</td>
<td>Post-operation</td>
<td>£6.5k (and £2k pa until age of 12)</td>
<td>7 years</td>
<td>£60k</td>
<td></td>
</tr>
<tr>
<td>OMA 90123</td>
<td>Spencer v NW NHS [2012]</td>
<td>Cerebral palsy failed diagnosis</td>
<td>Claim dismissed</td>
<td>18 years</td>
<td>£35k</td>
<td></td>
</tr>
<tr>
<td>U20040156</td>
<td>Mellor v Sheffield Teaching Hospitals [2004]</td>
<td>Negligence</td>
<td>£103k Awarded</td>
<td>6 years</td>
<td>£50k</td>
<td></td>
</tr>
<tr>
<td>B3/2003/1458 and B3/2003/1582</td>
<td>Halsey v Milton Keynes NHS Trust [2004]</td>
<td>ADR and costs of medical litigation</td>
<td>£198k awarded</td>
<td>6 years</td>
<td>£20k</td>
<td>court impose costs sanction against a successful litigant on the grounds that he refused to take part in ADR</td>
</tr>
<tr>
<td>HQ06X00522</td>
<td>Oliver v Whipps Cross NHS Trust [2009]</td>
<td>Negligence (MRSA)</td>
<td>Succeeded</td>
<td>3 years</td>
<td>£20k</td>
<td>(£40k with success fee @ 100%)</td>
</tr>
<tr>
<td></td>
<td>Reynolds v UK [2012]</td>
<td>Premature death</td>
<td>8,000 Euros awarded</td>
<td>7 years</td>
<td>£420k</td>
<td>Test case under s. 7 HRA 1998 ECHrts, Strasbourg</td>
</tr>
</tbody>
</table>
By way of summary, these empirical findings highlight:

- A random selection of 10 court cases of ‘medical negligence claims’ through legal websites
- Period range: 1998-2013
- Average legal costs per case: ££££ (unable to establish exact cost, as these were not made public in all cases, as a proxy, costs will reflect the time duration for litigation / resolution / judgement, which is on an average 9 years;
- The litigation period varies from 16 years to 6 years; and,
- Litigation costs (where disclosed) vary from £900,000 to £35,000.

In one case the cost was £20,000 – “court impose costs sanction against a successful litigant on the grounds that the applicant refused to take part in ADR”.

This was a random sample of cases. It reflects the length of time an individual or family has to wait to seek resolution through the legal system currently prevailing in England and Wales for medical mishaps.

This only outlines the litigation period and does not include the time the individual and/or family members suffer i.e. from the event of medical mishap, this may be months or years before there is a recognition or understanding that the adverse outcome may have been the result of health care mishaps (negligence) and individuals or families try to seek answers or approach the health care practitioners and management to seek an honest answer. Individuals may than have to seek legal input. All this may take considerable time, if a resolution is not achieved and the matter may finally reach the court. The legal processes in court may also take a considerable time to conclude. Hence the overall time span is considerable but this...
may look like an eternity for those trying to achieve an outcome and redress for medical mishap.

When the legal process starts, the deliberations that take place and the time it takes for disclosures and attempting to find a resolution through the health care system is a tiring and a long journey for individuals and families. This does not only effect the claimants but also the professionals involved with this mishaps, as they also have to wait without any certainty to find out what the outcome will be. This entire wait can only add to a hardening of attitudes towards the health care providers and the professionals.

Similarly, the legal costs keep mounting up for individuals who end up signing agreements, which may ultimately have to be paid through the compensation, awarded or through the state system. In our sample the litigation costs varied from £900,000 to £350,000 (figures identified through the quantitative research conducted for this study)

All the misery and suffering and the un-quantified costs incurred by families during the course of seeking resolution is very hard to quantify.

Mistakes will continue to happen, no professional will want to harm the patients intentionally (with the exception of certain individuals such as Dr Shipman), overwhelmingly, it is believed that professionals have the best interest of their patients at heart. These should be kept at the forefront so as not to cause animosity between the care providers and the receivers of care. Trust between professionals and patients is the key.

Any system that continues to support such nobility should be supported and professionals need to be open and transparent. Such systems need to ensure that the medical practitioners are permitted to admit their failings. In return, early remedial rehabilitation or additional health care can be recommended so sustained harm can be minimised and such events do not recur if this can be aimed for. For instance, where harm has occurred, appropriate redress through supportive health care input and financial payment will achieve a win-win situation for all.
Such models have been in place in number of countries where the health care system is funded through the taxpayer.

**Qualitative Interviews**

Given the quantitative results, the need to learn more and get a better understanding, a qualitative approach was adopted by conducting semi-structured interviews of legal practitioners (barristers and solicitors), involved in assisting individuals and families with compensation for medical negligence claims.

This approach was undertaken in order to seek first-hand information from practitioners about the time period it takes to reach a settlement in such matters, and their view of costs and if an alternative route(s) for early resolution can evolve, including any suggestions from practitioners.

A questionnaire was sent out to legal practices (both solicitors and barristers), identified as specialising in medical negligence matters. Details of names and addresses of legal practitioners were obtained through:

- personal contacts,
- searches on the Internet to identify legal practices specialising in medical negligence matters,

An approach was also made to:

- the Bar Council (BSB) and
- the Law Society
for assistance with the details of legal practices/practitioners specialising in medical negligence matters.

A draft questionnaire was sent out to legal practitioners by email or by post with a request for an interview with the researcher or by returning a self-completed questionnaire through the post or by email.
A number of legal practices in the North West, (who employ a total of around 1600 solicitors), were contacted by email, additionally ten barristers, were approached individually by the researcher.

Despite repeated requests by email, a limited response was received. (For details of the firms approached see – appendix vi)

A total of three interviews were conducted (two barristers, one solicitor) and only one response of a self-completed questionnaire was received by email from a solicitor even though respondents were assured of their anonymity. The researcher is mindful of commercial sensitivities and peer competition.

**The Pilot Questionnaire**

The script adopted was as follows:

Thank you for giving me the time to speak to you regarding medical errors.

Introduce myself:

I am a medical practitioner of over 30 yrs standing recently retired from NHS, currently doing an MPhil/PhD on medical errors at the University of Bolton, supervised by Prof Hardy.

Forecast for medical negligence errors will reach £19 billion, there has been an increase of 18% in new cases compared to the previous year.

May I please ask you a few questions? Your responses will be anonymised.

1) Is there any in-house expertise to deal with medical negligence/clinical litigation? How many members of your team are involved and have you any non-legal experts or do you seek outside expert non-legal input?

2) Approx. how many cases has your firm dealt with in the past five years?

3) Are you able to advise about the outcome of these cases and the number still pending?

4) How long on average does it take to resolve/settle medical/clinical cases: less than one year, between two to three years or more than five years?

5) How are most of the cases funded (i.e. self-funded, insurance based, or CFA - no win no fee basis)?

6) How many of the cases are you aware of that have been settled out of court in comparison to through the courts? (i.e. percentage of settlement rate than litigation)

7) Have you been involved in ADR forms of resolution? If so, what are your views on their application to medical / clinical cases?
8) Are you aware of no fault compensation schemes in place in Nordic countries? In your opinion, could such schemes be applied in England?

9) Have you any other suggestions or do you wish to share any other aspects of medical /clinical cases.

Thank you very much for your help.

This script was used to seek personal views about one’s own practice experiences, as to the time frame to achieve resolution, cost implications and if these experiences have enabled them to consider an alternate approach to seek redress for their customers.

**Summary findings of the collated interviews from legal practitioners**

These findings may support or refute the findings identified through quantitative research conducted by the review of court cases. Overall findings confirmed a lengthy process to seek redress for medical mishaps through the courts, high legal cost and long struggles for individuals / families seeking answers and compensation.

Below is the summary of the survey of legal practitioners:

- The average period to resolve and settle medical negligence varies from one year to three years;

- Case funding by practitioners, agreed on CFA (Conditional Fee Agreement) basis with individuals / families;

- Case settlement is almost 100% (this may reflect the choice of cases selected by practitioners based on CFA arrangement) and,

- Practitioners interviewed, employ nurses and experts in house or work closely to obtain medical input.
Feedback from practitioners on ADR approach to seek resolution

Their views were:
- “not productive”
- “views become entrenched”
- “this is complete waste of time”
- “flexible solution”

Other comments:

Other views expressed were:
- “compensation to be capped”
- “after care to be provided established health care providers within the locality of residence”.

Furthermore, the researcher approached the Chief Medical Officer of the Department of Health in England with a view to obtain a few minutes of her time to discuss alternative(s) for the resolution of medical harm. After reminders, the researcher was advised that current resolution time scale is between one to two years hence no other options were being pursued (Appendix ii).

The reluctance of legal practitioners to participate in this survey may be a reflection of protective business practice.

The researcher’s view is that the current system is onerous and has burdened legal practitioners with work and may in turn deter many others who have suffered harm to come forward to seek redress through the current system. Equally, this may have made practitioners defensive in their medical practice, which may not be a cost effective way of using scares resources or this may in turn be harming patients with additional tests and medication. This may be very difficult to quantify.

Openness and admitting mistakes can be more productive provided this is used for education and on-going training, rather than having to face hostility and uncertainty of continuing to practice their chosen career.
Reflections on the empirical work

This was a very small sample size and the results require careful consideration as to their applicability and making an overall judgement of the current state of affairs.

The perception of the time-frame, it takes to resolve medical negligence claims from healthcare practitioners and families reflects high legal costs for bringing a resolution to cases pursued through the legal route.

The overall increase of estimated costs for medical negligence cases and a fair portion of the settlement claim value for legal fees, is in keeping with the research findings. Notwithstanding the repeated efforts by the researcher to interview legal practitioners to share their experiences of time frames to resolve medical negligence cases and the costs to achieve a resolution for these cases has met with silence, as only four practitioners were available to be interviewed. This could be due to increased work load or to protect commercial sensitivities surrounding this area of legal practice.

In view of the ever-increasing burden of claims and costs currently estimated to be well over £20 billion, the NHS Litigation Authority has recently established a mediation route to bring about a cost effective way of compensating medical mishaps. This practice has just come into being from August 2014 onwards.

The following tabulated results highlight the key themes, as follows on following page:
The findings are consistent with the survey undertaken by reviewing random court cases:

- Lengthy time frames to seek resolution for individuals or families as well as health care practitioners
- Considerable legal cost implications
- Implications for public funding for health service as well as compensation claims
- Alternative methods are used in other countries to seek resolution or redress to better use public funds for service enhancement and reduce escalating legal costs
- The NHS Litigation Authority has already taken a step forward by introducing a Mediation route to resolve medical mishaps matters speedily and this may save considerable cost (in time this can be ascertained)
- The Scottish Review Group has already recommended a no-fault approach in line with other countries where health care and medical mishaps compensation are from the “public purse.”
Chapter 4 – **COMPARATIVE STUDIES**

The purpose of this comparative study is to review and compare the current systems and processes for clinical disputes resolution in England and Wales with the systems and/or processes in other countries where funding both for healthcare and compensation for medical mishaps is made from public funding.

The currently estimated compensation bill for medical negligence and mishaps is running into billions and as on-going funding for health care is perceived as not keeping up with the level of services expected by the population, urgent examination to review ways of dealing with medical mishaps is considered an urgent priority to ensure the viability of public funding for existing health care is not put at risk.

Other countries have similar healthcare funding systems and medical mistakes require a resolution to be compensated. This requires a fairer system to evolve to continue to meet the healthcare needs of the population at large.

Education and training are at the forefront to minimise the impact of medical mishaps and for the prevention of such events.

**The Comparative Studies**

The researcher/author of this thesis approached the Nordic embassies to seek their insight into current no fault compensation scheme practice in Sweden, Denmark and Norway. Similarly, approaches were made to the New Zealand and to the United States embassies. Responses from all the above countries was prompt and helpful in corroborating findings already identified through the literature review about current practices to resolve and compensate medical negligence matters, outlined in the previous chapter.

In some countries (ie Denmark, Norway, otherr Nordic countries and New Zealand) a no-fault scheme operates to resolve or reach a settlement. Such “No-fault schemes provide an alternative route to financial compensation for harm allegedly caused through medical treatment. Although there is still a need to establish causation, an important
feature of no-fault schemes that have been established to date is that there is no need to prove negligence in order to be eligible for the payment of financial compensation.

The Advantages of the Nordic no fault compensation scheme are summarized in *No-Fault Compensation Schemes for Medical Injury: A Review* (Dr Anne-Maree Farrell et al., 2010) as follows:

“Claims are resolved quickly and provide easy and broader access to justice for those who have suffered medical injury (Danzon, P.M., 1994), (Fallberg, L.H. and Borgenhammer, E., 1997).
In general terms, the schemes operate eligibility criteria structured around the notion of avoidability, where patients are eligible for compensation if they have suffered injury that could have been avoided. This enables a more broad ranging approach to be taken to the circumstances in which medical injury occurs. In order to facilitate greater access to justice in relation to medical injury, patients are able to submit claims under no-fault schemes free of charge”.

Equally, there are disadvantages to the Nordic scheme, summarised below:

The Nordic schemes have erected a “Chinese wall” between compensation and professional accountability and disciplinary activities. This has resulted in the separation of all information collected and used under the no-fault scheme from faultfinding or disciplinary activities in relation to health practitioners (Kachalia,A., Mello, M.M., Brennan, T.A. et al., 2008).

There are also limitations on compensation awards with maximum caps and threshold requirements regarding the level of disability a claimant must have before being eligible for compensation (Kachalia,A., Mello, M.M., Brennan, T.A. et al., 2008). Levels of compensation remain relatively low by comparison with what claimants would receive for successful clinical negligence claims under delict or tort-based systems. This needs to be set against the fact that Nordic no-fault schemes operate in the context of what would be considered well-funded and comprehensive social security systems.
In the USA there is an on-going political, policy and academic debate since 1960 onwards to find a solution for medical injury compensation.

In Florida and Virginia, for examples, due to insurance crisis and difficulty for health practitioners to obtain liability cover, a no fault scheme has been operated since 1980s onwards for birth related neurological injury.

In contrast, the emphasis of the New Zealand Model is based on *Fairness, Injury Prevention Rehabilitation and Injury Prevention* (minimise injury impact). This no fault approach limits compensation and the lessons to be learnt from mishaps to educate professionals thus reducing similar events.

- Individuals forgo the right to sue except the right to sue for exemplary or punitive damages
- Compensation is made from general taxation and there are clear cut deadlines for claim submission and processing of the claim
- Awards are based on the severity of the injury - the overall client satisfaction is very high at 83%.
- The running cost of this scheme is 12% of the total awards made, which is a cost effective and good use of the public funds.

Research for this project identified great variations in time frames to settle compensation for medical mishaps through the legal system and in many cases it took years to obtain compensation and services to minimise injury already suffered by the individual. The legal costs vary from case to case it can be as high as 25 to 50% of the awarded compensation received by the individuals or survivors.

As the funding is coming from the “public purse”, this can lead to better use of resources and is timely. Settlement of such claims is the right approach as practised in New Zealand. It is contended that in some cases (I suggest very few) that the level of compensation may be relatively less than expected but overall satisfaction results are a testimony of the users of the service and are paid for by the tax-payer.
Principles adhered to by the Nordic model are based on a patient’s right to compensation, away from the blame culture and fostering good relations between the health care practitioners and patients even in the event of a medical mishap. Such an approach helps with rehabilitation to minimise the injury sustained and re-enforces the belief that the practitioner was not intending to cause the harm and anguish and is not responsible for the injury or harm thus sustained. Such an understanding approach will assist in rehabilitation and limit the harm caused.

There is clear guidance and a time defined approach for seeking compensation and an award of compensation. Such an approach currently does not exist within the framework of the NHS even with the ADR approach recently introduced, the time guidance and defined settlements payments are not as yet set out clearly. Still the use of the legal approach is open-ended which may in itself cause difficulty in reaching an early and/or timely resolution for medical mistakes. This adds additional cost for settlement for legal input and if the matter does not get resolved those additional court costs and time delay add to the burden for seeking resolution for medical mishaps.

There is a high rejection rate of claims through the system set up in Nordic countries but this seems to work well and overall is a cost effective way of dealing with the compensation for mistakes which were unintended and also continue to build better relationships with practitioners who are available to assist with minimising the impact of injury through additional input and rehabilitation. In order to continue to provide the service to the public and the threat of legal action for mishaps on practitioners, the public services developed this model to attract practitioners who could not be recruited for fear of law suits for medical mistakes. This approach has limited total pay-outs for medical mistakes but overall the service to the public has improved by recruiting practitioners who were unwilling to practice in these states for fear of litigation. Children receive the required care for the injuries sustained and the parental financial burden is reduced and medical insurance becomes readily available. There is a maximum cap for injuries of $750,000. An independent body runs the compensation scheme with non-executive directors appointed by the Mayor of the State. The practitioners and the hospitals pay insurance.

The advantages of the above legislation in Virginia (Dr Anne-Maree Farrell· Ms Sarah Devaney and Ms Amber Dar, 2010):
“A total cap (increasing annually) on damages available in medical malpractice litigation was introduced in 1992, almost US$2 million in 2008 (Siegal, G., Mello, M.M., and Stddert, D.M., 2008); this meant that similar awards of damages would be available either through court action or through the Program.”

The eligibility criteria are expansive making it easier to obtain cover or compensation under the Program than to be successful in a tort-based action.

A shortened time frame for making decisions on cover under the Program.”

Overhead costs, in particular legal fees, are lower than would be the case in relation to tort-based claims (Sloan, F.A., Whetten-Goldstein,K., Entman, S.S., et al., 1997)

The number of high cost claims in the tort system has been reduced”

Prior to completing the writing up for this study, details of the symposium on medical negligence malpractice and compensation in Global Perspective by Ken Oliphant and Richard W Wright (2011), was brought to the author’s attention. It is plain from this set of papers that since 2010 medical malpractice and compensation was becoming visible and the controversy surrounding the issue was building. Most notably, the symposium, which was held in Vienna in December 2010, brought together experts from the countries of Austria, Brazil, Canada, China, France, Germany, Italy, Japan, New Zealand, Poland, Scandinavia, South Africa, USA and the United Kingdom. This brought to bear a good mix of common law and civil law systems’ lawyers, academics and practitioners. Overall, the aim was to provide a broader foundation for consideration of such difficulties and analyse as well as disseminate the pros and cons of various alternative schemes available. This will assist in better understanding to develop future policy and a legal framework for this crucial medico-legal area. The focus of this comparative study was intended to find a rationale way forward for the current burden of compensation facing the “public purse” in England and Wales.

At present, in England, compensation is paid from the “public purse”, there is no cap on the payouts and the on-going additional costs of legal input continue to rise.
Consequently, the UK NHS faces an overall £22 billion pounds of claims. If a rational approach is not adopted then this is likely to have a serious impact on providing the services under the NHS, funded from public funds, most notably, birth injuries pay-outs are high, due to lifetime support being required and the specialist long term care burden. An approach such as the one adopted in Virginia and in Florida (USA), is worth considering to limit the awards and reduce the added legal cost burden for the overall pay-outs made. If the compensation is paid promptly along with the service provision required for the life time duration. Such an approach, will serve the overall objective of providing this service to the population, otherwise there is a serious risk that the “public purse” will not be able to sustain the service cost and the cost of compensation award for medical mishaps currently facing the country. This may also impact on recruiting health care practitioners, as was the case in some states of the United States.
Chapter 5 - CONCLUSIONS

Medical Negligence claims have continued to rise. In this context, the latest estimate of the cost of clinical negligence claims is £22.7 billion pounds (NHS Litigation Authority Fact sheet 2; July 2013).

This study’s findings clearly add weight to the current burden of legal cost in bringing about resolution to medical mishaps and the length of time it takes to bring about closure to such situations. Numbers of studies confirm that claims of this nature take too long and the legal costs are considered excessive (National Audit Office (2001), (Fenn, P et al., 2004)). Furthermore, it has been “recommended that the current system be abolished and replaced by an ‘alternative administrative system’ which did not foster a ‘culture of blame’”


Despite calls for the adoption of alternative tests for eligibility (e.g., avoidability), the Government has retained the established tort law principles as the basis for determining eligibility. The CMO’s recommendation regarding the establishment of a no-fault scheme for birth-related neurological injury was not taken on board.

In the wake of the report by Lord Woolf (1996), the management of medical negligence claims is now centrally managed by the NHS Litigation Authority. The current clinical negligence litigation system in England has undergone significant reform in the last ten years. Yet, as from August 2014, the NHS Litigation Authority has initiated mediation to settle claims in the NHS, to support patients, families and NHS to resolve disputes fairly. The purpose of this initiative is to protect NHS resources, encourage safer care, learn from mistakes and resolve disputes fairly.
It is reported that:

i)  The time taken to process claims is much reduced. Claims under the largest scheme are taking on average 1.56 years to resolve.

ii)  Only 4% of claims go to court, and this includes settlements requiring court approval.

iii) The number of claims made on an annual basis has been largely static, although there was a small increase in the last year.

iv)  Forty one % of claims do not proceed beyond the notification/investigation stages.

Overall legal costs are considered high, with claimant legal costs a particular source of concern (NHS Redress Act, 2006). Elsewhere concerns are being expressed about the “claims environment threatening service provision”, (NHSLA, 2009).

At a seminar on organized by the Royal College of Surgeons in Ireland, it was highlighted that the culture of litigation and rising indemnity costs were causing anxiety amongst practitioners and, in turn, were having an adverse effect from the patient’s perspective. Further, it was observed that some “42% of physicians in the US have reduced levels of activity in the past three years. In Ireland, ten surgeons close to retirement will stop entirely rather than ‘wind down” (Royal College of Surgeons Ireland, 2004)

Similar debates are being aired all over the developed world, both by governments, professionals and insurance risk companies.

Still, in the UK, current estimates of the liability for clinical claims lies at a potential of over £22 billion. Such medical mistakes and/or errors, or ‘mishaps’, will invariably occur and the practitioners, as well as the sufferers of these mistakes, have to be supported and recompensed and a system needs to be developed where a culture of openness can be created rather than the adversarial practice of seeking compensation through litigation to seek redress.
Although a balance needs to be struck between appropriate redress and timely resolution along with necessary support for professionals and on-going training input to ensure lessons are learnt and similar mistakes are minimized in future thus, reducing pain and suffering for all the parties involved.

Overall, this study advocates and recommends the following way forward, either as a stand-alone initiative or a combination of various initiatives used in other countries for a fairer way to deal with medical mishaps, to serve the interest of both sufferers and practitioners and also to minimize the viability threat for organizations providing healthcare in the UK. Such a reformed scheme would ensure:

1) Fair and Sustainable Scheme (New Zealand Model)

Reviewing the NHS Litigation Authority’s Mediation Avenue compared to other countries where such avenues have been in practice for number of years, the researcher makes the followings observations:

In New Zealand, the schemes’ principles are - “fair and sustainable scheme, minimising injury and impact of injury, complete and timely rehabilitation”

The UK’s NHS Litigation Authority, has not made any such specific principles for resolving and compensation, of the medical mishaps. The current practice of settling the medical mishaps is through an option of mediation and the Legal Avenue for resolution.

The principles enshrined in New Zealand, to minimise injury and impact of injury can only be achieved if the route to resolution of medical mishap is timely and agreed arrangements are in place from various providers of health care to provide the necessary timely package of rehabilitation.

In contrast, the UK NHS Litigation Authority may need to consider such an option to make the scheme cost effective but equally this will achieve the objectives of minimising the impact on lives and lifestyles, from medical mishaps and also to achieve the best
possible timely rehabilitation from healthcare providers, which is accessible for individuals and their families.

Furthermore, the New Zealand model limits individuals’ right to sue, except the right to sue for exemplary and punitive damages. Incorporating such a proviso within the UK NHS Litigation Authority’s new approach can only save excessive legal costs, which are currently being incurred to the value of 25% of the awarded compensation (higher in many cases), along with the additional cost (opportunity cost), incurred by individuals and their families, plus the on-going anguish which may take considerable time before a resolution is reached.

Administering the scheme in New Zealand costs the taxpayer 12% of the claim amount paid. Filing a claim for medical mishap in the New Zealand scheme has a time limit of 12 months. The majority are assessed within 21 days and it takes four months (maximum) to process the claim. Client satisfaction is 83% in respect of the scheme operated in New Zealand.

The UK NHS Litigation Authority’s new scheme should have a defined timescale for submission of claims for medical mishaps and equally a defined time scale for the assessment and settlement of such claims with built in rehabilitation package(s) from within the UK’s NHS healthcare providers rather than awarding claims and then individuals are left to find the best care and/or rehabilitation package(s).

2) Patients’ Right to Compensation (Scandinavian Model)

In Scandinavian countries (Sweden, Norway, Finland and Denmark), the principle of no fault compensation is based on “patients right to compensation when they suffered harm as a result of medical injury”.

The UK NHS Litigation Authority recognises that medical mistakes will happen and individuals and families need to be compensated either through the legal avenue or through the newly introduced Mediation Service. Experience of resolution of medical mishaps through the legal avenue only, has resulted in considerable delay and an ever-rising financial burden not only for medical mishap compensation but additional legal and other associated costs.
Adopting the Scandinavian principles of accepting patients' right for compensation and “fostering good relations between patients and practitioners and getting away from the blame culture” has proved efficient in countries that operate such a scheme. Assessors from legal and medical backgrounds undertake the assessment of medical mishap claims. The time limit imposed for making such claims is 10 years from the time of injury.

The UK NHS Litigation Authority’s new initiative, the mediation route, has no defined time scales. It also needs to consider ways to foster trust and good relations between professionals and patients. This is a relevant aspect of resolution, which both the families and healthcare practitioners will value.

3) Birth Related Neurological Injuries (Virginia and Florida [USA] Model)

In the USA, there has been a crisis in recruiting healthcare practitioners due to difficulties in obtaining insurance cover for healthcare practice. The States of Virginia and Florida now operate a no-fault scheme to cover birth related neurological injury to ensure “Children receive the required care, to reduce the financial burden on parents”. In Virginia there is an imposed cap of $750,000.

The Chief Medical Officer’s (CMO) for England’s suggestion in 2003 was rejected, primarily on cost grounds and also due to the concerns to comply with Article 6 of the European Convention on Human Rights. Recommendations were nevertheless made for an NHS redress scheme:

i) Care and compensation in the case of birth related neurological injury (inspired and adapted from the schemes operating in Virginia and Florida).

ii) A redress package (including financial compensation) for low value claims (Chief Medical Officer, 2003)

The NHS Litigation Authority, has not outlined capped limitations for compensation, this may evolve in time.

Claims made due to medical mishaps have a wide variation for similar mishaps; some cases are for high awards. Consideration be given to identify providers for
appropriate therapy or rehabilitation packages through the local NHS healthcare providers thus the need for high financial awards can be mitigated. This does not necessarily compromise the care and/or rehabilitation required, after such medical mishaps.

4) Alternative Dispute Resolution

The UK’s current system for redress of medical mishaps is costly and time consuming. Such a scheme only serves to deter individuals and their families from seeking redress due to the curtailment of the Legal Aid Scheme support.

In the interest of fairness and justice, the way put forward recently by the UK NHS Litigation Authority is welcome, but they are acting on behalf of the defendant(s) (NHS Trust or Practitioner). In order to address undue influence in the course of settlement either one of the above scheme(s) are agreed so that the claimant is clear from the onset of the expectations or alternatively a third party intervention is available to the claimants to ensure a fair way is agreed to compensate for the medical mishap. This can be by establishing an agreed framework for independent mediation.

Such approaches are in practice within various walks of life such as the building trade, family mediation, workplace mediation, boundary disputes and work colleague related issues. Mediation is also a constructive way forward in addressing international disputes.

In Queensland Australia, civil mediation tribunals have been established to assist with the resolution of compensation related matters for medical negligence cases.

An alternative approach in the UK to settle medical mishaps matters will not only save a lot of heartache to families but this can also be cost effective as the health service is funded by the tax payers as well as the outcome of compensation will be funded through collected taxes, as well.

Adopting such an approach will assist in timely resolution, prompt care input to minimise the harm and timely audit, so lessons can be learnt, which can be of great value to prevent and minimise similar errors.
Moreover, the savings made due to this initiative in turn can be channelled to on-going training of health care professionals as lessons need to be learned so similar mishaps can be minimised in future.

5) Establishing an Academic Centre of Excellence

Such an establishment will be responsible for auditing the settlement of medical mishaps and the compensation awards on an on-going basis.

To make recommendations for on-going training and evaluation of professional practice on a no-fault basis to ensure similar mishaps can be minimised, identify whether the mistakes were organisational failures or individual mistakes and how these can be remedied to minimise future events.

On-going feedback from the individual and/or family after the mishap and during the course of events is used for future learning. Such feedback will be forthcoming if an independent academic institution is undertaking a review of this evaluation.

Accordingly, this study recommends that the UK NHS Litigation Authority continues the recent initiative of: “Mediation to settle claims in the NHS, to support patients, families and NHS to resolve disputes fairly”.

The purpose of this initiative is to protect NHS resources, encourage safer care, learn from mistakes and resolve disputes fairly”.

Recommendations

This study has empirically shown that the current system to resolve and compensate medical errors takes a long time and is cumbersome and costly. The legal costs can be minimised and time to reach a resolution can be considerably reduced if models used in other countries, i.e. Scandinavia, New Zealand and certain States in the USA (outlined above), are adopted to meet the needs of the current system used in England and Wales. Such a move will help reach a fair and equitable outcome for those
who unfortunately suffer due to medical errors or negligence or system failure with adverse health outcomes

Therefore, in conclusion, this thesis recommends that the UK NHS Litigation Authority supports establishing an independent organisation (preferably an academic institution) to evaluate the current NHS Litigation Authority’s initiative. In particular, in order to evaluate:

- cost effectiveness
- time frames for settlement
- identify individual or organisational failures
- client satisfaction (recipients of compensation and practitioners)
- lessons to be learnt from the mishap(s)
- educational recommendations to minimise similar future mishaps.

In summary, the significance of this research is to compare the current prevailing practices for settlement of medical mishaps, or negligence, or system failure, primarily within the health care facilities of the NHS in England and Wales and to compare this to other publicly funded healthcare systems in other parts of the world, in respect of resolution or compensation, for individuals and families who may have suffered the consequences of medical mishaps or negligence or systemic failures whilst receiving health care.

The researcher has examined the systems in Nordic countries, New Zealand, and certain states of the USA (Virginia, Florida). In Florida and Virginia, a no-fault system had to be implemented to solve the difficulties in recruiting professionals, who were deterred by the ever increasing costs of malpractice insurance. No fault compensation or awards are used as a way of reaching a resolution after an adverse event attributed to health care services. Current practices to settle adverse outcomes due to healthcare intervention, in Nordic countries and New Zealand are well rated by individuals and families, as the compensation and care packages are put in place within an agreed time frame. Award limits are set for errors and faults and the process is not prolonged due to legalities. Individuals still do retain the right to pursue resolution through the courts, if they are not satisfied with the outcome for the compensation process. The majority of the mishaps are
resolved and compensated within a short period of time, as compared to what is being experienced by individuals and families in England and Wales with their current practices of resolution due to healthcare mishaps.

The Scottish Government commissioned a review group to recommend a no-fault compensation scheme for injuries resulting from clinical treatment in the Health Service. A number of recommendations have been put forward. (Scottish Government, Consultation Report, April 2014).

In Florida and Virginia, for examples, due to the insurance crisis and difficulty for health practitioners to obtain liability cover, a no-fault scheme has operated since the 1980s onwards for birth related neurological injury.

The experience of users of no fault systems in the Nordic countries and New Zealand is encouraging and positive. Equally, this appears to be more cost effective for funding public health care. In the current austerity climate exploring this option for England and Wales can only assist meeting public expectations and maximising the use of limited resources for healthcare provision. This can also help reduce medical mishaps / clinical failure or system failure by investing resources for training, reviewing and learning lessons from adverse events.

Limitations of the Current Research

This research was limited to a review of a small number of court cases. Given the sensitivities of professionals, only a few legal practitioners agreed to assist with semi-structured interviews.

More could have been learned if healthcare practitioners could have been identified and they were willing to share their personal experiences. Hearsay, evidence and informal conversations with practitioners confirm that their lives had been put on hold whilst the matter was getting resolved through the legal process. Their own practices became more defensive. This also impacted on their families. Additional formal views would have been helpful, hence this research is limited to informal feedback.
Similarly, feedback from individuals and families who suffered the medical mishap and adverse effects due to treatment will have helped to add to the research findings. Court review data sets confirm that the process took a very long time to achieve resolution, which cannot be easy for individuals and families and this will only add to the burden of what they have already endured.

**Future Research**

The researcher with the support of his mentors will share the findings with a wider audience to include professional practitioners (legal and health), health service users, to stimulate a debate as to the current practice for resolution and to explore the other options practised elsewhere.

The NHS Redress Act (2006), is in place for upper limit of compensation of £20,000. This provides an alternative to litigation. The redress package includes an offer of compensation, an explanation and an apology and how such an adverse event can be prevented in future.

The recent initiative by the NHS Litigation Authority to encourage mediation and arbitration to seek resolution for clinical mishaps is worthwhile in bringing early resolution, minimising delays and saving litigation costs and this should be encouraged.

Furthermore, the researcher intends to seek collaboration with the NHS Litigation Authority, the Department of Health and other stakeholders to assist with auditing and reviewing cases progressing through the new NHS Litigation Authority’s initiative for early resolution through arbitration and mediation. This review will help with better understanding and this can evaluate the cost effectiveness of the new process. The researcher considers seeking health service users’ views and input and this will be an important aspect of future work.

Healthcare professionals should be encouraged to share their experiences and an environment of learning to be encouraged so lessons can be learnt to minimise future similar events. NHS Employers should be involved in implementing on-going learning. This can be achieved by regular audit meetings of cases which come to light either through
challenges by individuals or families after medical mishaps, negligence, blame or through colleagues reviewing case files for audit or educational presentations or even by personal admittance(s) of mishaps by professionals themselves. Such learning should become part of an on-going audit for learning and may help minimise future mishaps and mistakes. Such events can be used as “lessons to be learned” for on-going education and continuous professional development (CPD).

In conclusion, this study asserts that admitting mistakes and errors should be a main element of the learning process and owning up to a “wrong” or a “mistake”, will have implications for patients. This needs to be accepted and such occurrences and events can be used to improve training to minimise similar mistakes from recurring. On-going learning needs to be incorporated as a function in professional development and as part of the CPD process, which all professionals need to embrace to avoid mistakes and mishaps in the best interests of serving their patients, who seek their professional input. This will, in turn, minimise and reduce recurrences of mistakes and mishaps, which will be worthwhile for patients and can be satisfying for professionals themselves.
Bibliography

UK


Department for Business Innovation and Skills Alternative Dispute Resolution for Consumers Government Response to the consultation on implementing the Alternative Dispute Resolution Directive and the Online Dispute Resolution Regulation November 2014.


Donnelly, F. (2nd June 2013), The Telegraph.

Dr Anne-Maree Farrell, Ms Sarah Devaney and Ms Amber Dar (Scottish Government Social Research 2010), no-fault compensation schemes for medical injury: a review, Interim Report


Gibb, F (27 August 2015) *Lawyers v doctors: Counting the cost of clinical negligence*, The Times


NHS Redress Act (2006) *Low Value Claims*

NHS Litigation Authority (July 2013) *Factsheet 2*


NHSLA (July 2014) *Mediating Claims in the NHS,: Fair Resolution Sharing Learning Improving Safety*  
http://www.cedr.com/solve/services/?p=33


Royal College of Surgeons Ireland (12/201), Surgical Affairs, Edition

Scottish Government Review Group Report (February 2011), Report & Recommendations, Volume 1


The Herald, Scotland, (Thursday 12 June, 2014) “NHS Budget spends £9m on agency staff”.


New Zealand

The Accident Compensation Act 1972 (1972 No 43)


Injury Prevention, Rehabilitation, and Compensation Act 2001 (IPRCA 2001)


**Sweden**


Finland


Denmark


Patientforsakringen (Swedish Patient Insurance Scheme) If you are injured in the health care system... (www.patientforsakring.se/international/english).


Norway


**United States**


Bonifield, J. CNN, Elizabeth Cohen, Senior Medical Correspondent CNN (10 June 2012), *10 shocking medical mistakes*; CNN


CNN (15 September 2015), “25 shocking medical mistakes”


Right Diagnosis.Com (22nd April 2014), reasons for occurrence of medical errors


Sohn, D.H. JD, MD. (November 2012), No-Fault Compensation Systems Are there benefits to not assessing blame? AAOS Now


Virginia Birth-Related Neurological Compensation Program. *Who We Are* (www.vabirthinjury.com/WhoWeAre.htm).


**Other**


APPENDICES
APPENDIX 1

Interviews with barristers and solicitors

Interviews

1. Is there any in-house expertise to deal with medical negligence/clinical litigation? 
   - In house nurses experts
   - Medics
   - Mental health
   - CP experts

2. How many members of your team are involved
   - Mental health
   - Have you any non-legal experts or do you seek outside expert non-legal input?

3. Approx how many cases has your firm dealt with in the Past five years?
   - Over 370+ staff
   - 85% fee earners
   - 5000
   - 300

4. Are you able to advise about the outcome of these cases and number still pending?
   - Majority settled
   - Majority settled out of court
   - <1% went to trial
   - 10-15% no case

5. How long on average does it take to resolve/settle medical/clinical cases: less than 1 year, between 2 to 3 years or more than 5 years?
   - 1-2 years
   - 2-3 years
   - CFA

6. How are most of the cases funded (i.e. self funded, insurance based, or CFA - no win no fee basis)?
   - CFA
   - Standard fee
   - No uplift
   - Fee 25% of the damages
   - Paid by claimant (April 2013)
6 How many of the cases you are aware have been settled out of court in comparison to through the courts? (ie. percentage of settlement rate than litigation) majority 95% majority <1% went to court

7 Have you been involved in ADR forms of resolution? If so, what are your views on its application to medical and clinical cases? not productive 25 % cases Mediation entrenched views 5 % cases medical experts treated as Gods

8 Are you aware of no fault compensation schemes in place in Nordic countries? (no fault compensation schemes)? In your opinion, could such schemes be applied in England? 2most complainant expect apology ?professional accountability 2most complainant expect apology professional accountability defence unions resist for fear of compensation

9 Have you any other suggestions or do you wish to share any other aspects of medical and clinical cases. apology / acceptance greater use of mediation/arbitration but indemnity co. at an early stage resist independent panels of experts and this leads to hardened attitudes which claimants can choose for settlement

collated 26/6/14
Interviews

Is there any in house expertise to deal with medical negligence/clinical litigation?
How many members of your team are involved and have you any non-legal experts or do you seek outside expert non-legal input?

Approx how many cases has your firm dealt with in the past 5 years?
Are you able to advise about the outcome of these cases and number still pending?

How long on average does it take to resolve/settle medical and clinical cases: less than 1 yr, between 2 to 3 years or more than 5 years?

How are most of the cases funded (i.e. self funded, insurance based, or CFA – no win no fee basis)?

How many of the cases you are aware have been settled out of court in comparison to through the courts? (ie percentage of settlement rate than litigation)

Have you been involved in ADR forms of resolution? If so, what are your views on its application to medical and clinical cases?

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>In house expertise in mediation</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>expertise in mediation flexible solutions</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>4 in house F/T nurses</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>10 Specialist Solicitors</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>3 are Law Society approved panel members</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>150 cases / yr</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>224 concluded since 2010</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>3 years (on average)</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>59% CFA</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>6% public funding (Legal Aid)</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>35% Legal Expenses Insurance</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>100% Settled without Trial</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>In past 10 yrs. case concluded at Trial</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>All parties are encouraged to consider ADR</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
<tr>
<td>&quot;this is complete waste of time&quot;</td>
<td>JT-W</td>
</tr>
<tr>
<td>04/07/2014</td>
<td>13/08/2014</td>
</tr>
</tbody>
</table>
Are you aware of no fault compensation schemes in place in Nordic countries? (no fault compensation schemes)? In your opinion, could such schemes be applied in England?

Have you any other suggestions or do you wish to share any other aspects of medical and clinical cases.

Health Trusts to offer rehabilitation and on-going care for medical mishaps (thus compensation award can be reduced)

Hospitals to encourage staff mediation training

Lawyers don't know how hospital mistakes are made, encourage visits

Written a book on Medical Negligence

"dubious about the efficacy"
"such a scheme will be appropriate for English Legal System"

collated 24/8/14
17th September 2013
Resent – 30th Sept 2013

Professor Dame Sally Davies
Chief Medical Officer
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Dear Madam

Developing a Mediation Model to Resolve Medical Negligence Claims - Please Assist

After lifetime service in the NHS, I have retired. Over the years I have come across difficult situations where families have tried to seek redress from the NHS for medical harm. This takes several years and a lot of hardship for individuals and families and equally for the professionals to seek a resolution.

In many countries a no-fault scheme operates. I wish to explore and develop a mediation model as an alternative to reach a settlement for medical harm.

Latest forecast estimate, negligence claims to reach 19 billion. I request your help and guidance in this matter - a few minutes of your time to discuss this with you? I will appreciate knowing if work has been done or is ongoing within your department to look at alternative(s) for resolution of medical harm.

I look forward to hearing from you. Many thanks for your help.

Yours faithfully

M Memon
3rd October 2013

Sir Harry Burns
Chief Medical Officer
NHS Health Scotland, Meridian Court
5 Cadogan Street
GLASGOW
G2 6QE

Dear Sir

Research – Medical Negligence Claims - Please Assist

After lifetime service in the NHS, I have retired. Over the years I have come across difficult situations where families have tried to seek redress from the NHS for medical harm. This takes several years and a lot of hardship for individuals and families and equally for the professionals to seek a resolution.

In many countries a no-fault scheme operates. I wish to explore and develop a mediation model as an alternative to reach a settlement for medical harm.

Latest forecast estimate, negligence claims to reach 19 billion. I request your help and guidance in this matter - a few minutes of your time to discuss this with you? I will appreciate knowing if work has been done or is ongoing within your department to look at alternative(s) for resolution of medical harm.

I look forward to hearing from you. Many thanks for your help.

Yours faithfully

M Memon
19 December 2013

Dear Professor Memon

RESEARCH – MEDICAL NEGLIGENCE CLAIMS

Thank you for your letter of 3 October to Sir Harry Burns, Chief Medical Officer, looking for information on the work undertaken in Scotland in relation to no-fault compensation for injuries resulting from clinical treatment. Please accept my apologies for the delay in providing a response.

You may already be aware that the No-fault Compensation Review Group, chaired by Professor Sheila McLean, Glasgow University, was established in 2009 to consider the potential benefits for patients in Scotland of a no-fault compensation scheme and whether such a scheme should be introduced alongside the existing clinical negligence arrangements.

The Review Group’s report published in February 2011 (available at: http://www.scotland.gov.uk/Topics/Health/Policy/No-Fault-Compensation/ReviewGroupVol1) set out their view on the essential criteria for a compensation scheme and recommended that consideration should be given to the establishment in Scotland of a no-fault scheme for clinical injury, along the lines of the ‘no blame’ system in operation in Sweden. The review group’s recommendations (attached for ease of reference) go much wider than NHS Scotland suggesting a scheme should cover all clinical treatment injuries that occur in Scotland.

A team of researchers from Manchester University supported the Review Group and the report of the study they conducted was published on 7 June 2012 (available at http://www.scotland.gov.uk/Publications/2012/06/2348). Part of this study explored the potential expenditure implications of a no-fault scheme based on the analysis of data on closed cases dealt with by the CLO. Cost estimates were calculated based on a range of assumptions about how a no-fault system might operate; the volume and value of claims; as well as costs of the current system in recent years.

A consultation on the Review Group’s recommendations was conducted between August and December 2012 (http://www.scotland.gov.uk/Publications/2012/08/4456) to seek wider views on the recommendations in order to help in our understanding of what the practical implications are and to assist in consideration of the scope and possible options for taking this forward. The responses to the consultation were published on 25 February 2013 and are available at: http://www.scotland.gov.uk/Publications/2013/02/4882.

This is still under consideration. I will let you know when an announcement is made on the proposed way forward. I hope this is helpful and apologise again for the delay in providing a response.

Best wishes.

Yours sincerely

SANDRA FALCONER (MRS)
3rd October 2013  
(Sent by Fax and Post)

Norwegian Embassy  
25, Belgrave Square,  
London     SW1X 8QD.  
United Kingdom  
Tel: +44- 20 7591 5500  
Fax: +44- 20 7591 5547

Dear Sir/Madam

Research - Medical Negligence Claims - Please Assist

After lifetime service in the NHS, I have retired. Over the years I have come across difficult situations where families have tried to seek redress from the NHS for medical harm. This takes several years and a lot of hardship for individuals and families and equally for the professionals to seek a resolution. I understand that in your country a no-fault scheme operates.

I will be grateful, if you can forward necessary material (policy, audit, research etc), which will assist me with my learning and research.

I look forward to hearing from you. Many thanks for your help.

Yours faithfully

M Memon
3rd October 2013
(Sent by Fax and Post)

Embassy of Finland
38 Chesham Place
London SW1X 8HW
United Kingdom

Dear Sir/Madam

Research - Medical Negligence Claims - Please Assist

After lifetime service in the NHS, I have retired. Over the years I have come across difficult situations where families have tried to seek redress from the NHS for medical harm. This takes several years and a lot of hardship for individuals and families and equally for the professionals to seek a resolution. I understand that in your country a no-fault scheme operates.

I will be grateful, if you can forward necessary material (policy, audit, research etc), which will assist me with my learning and research.

I look forward to hearing from you. Many thanks for your help.

Yours faithfully

M Memon
3rd October 2013
(Sent by Fax and Post)

Royal Danish Embassy
55 Sloane Street,
London SW1X 9SR
United Kingdom

Dear Sir/Madam

Research - Medical Negligence Claims - Please Assist

After lifetime service in the NHS, I have retired. Over the years I have come across difficult situations where families have tried to seek redress from the NHS for medical harm. This takes several years and a lot of hardship for individuals / families and equally for the professionals to seek a resolution. I understand that in your country a no-fault scheme operates.

I will be grateful, if you can forward necessary material (policy / audit / research etc), which will assist me with my learning / research.

I look forward to hearing from you. Many thanks for your help.

Yours faithfully

M Memon
3rd October 2013  
(Sent by Fax and Post)

Embassy of Sweden  
11 Montagu Place  
London W1H 2AL  
United Kingdom

Dear Sir/Madam

Research - Medical Negligence Claims - Please Assist

After lifetime service in the NHS, I have retired. Over the years I have come across difficult situations where families have tried to seek redress from the NHS for medical harm. This takes several years and a lot of hardship for individuals / families and equally for the professionals to seek a resolution. I understand that in your country a no-fault scheme operates.

I will be grateful, if you can forward necessary material (policy, audit, research etc), which will assist me with my learning / research.

I look forward to hearing from you. Many thanks for your help.

Yours faithfully

M Memon
3rd October 2013
(Sent by Post)

US Embassy
24 Grosvenor Square,
London,
W1A 1AE.
United Kingdom

Dear Sir/Madam

Research - Medical Negligence Claims - Please Assist

After lifetime service in the NHS, I have retired. Over the years I have come across difficult situations where families have tried to seek redress from the NHS for medical harm. This takes several years and a lot of hardship for individuals / families and equally for the professionals to seek a resolution. I understand that in your country a no-fault scheme operates.

I will be grateful, if you can forward necessary material (policy, audit, research etc), which will assist me with my learning / research.

I look forward to hearing from you. Many thanks for your help.

Yours faithfully

M Memon
APPENDIX 6

List of North West Legal Firms Specialising in Medical Negligence:

**Quindell Legal Services**

- Headquarters: Dempster Building
- Atlantic Way
- Brunswick Business Park
- Liverpool
- Merseyside
- L3 4UU

54 solicitors
11 offices

Phone: +44 (0) 151 236 9594

- Email: Liverpoolinfo@quindell.com

**Stephensons Solicitors LLP**

- House: Sefton
- Northgate
- Close
- Horwich
- Bolton
- Lancashire
- BL6 6PQ

101 solicitors
7 offices

Phone: 0333 344 4772

Fax: 01942 774525

Email: enquiries@stephensons.co.uk

**Connexion Partnership – M/Cr**

- Alberton House, 30 St Mary’s Parsonage, Manchester M3 2WJ

82 solicitors
2 offices

Phone: 08701 601160

Fax: 08701 975377

Email: infomanchester@cxp-law.com

**dac beachcroft claims ltd**

- 3 Hardman Street, Manchester M3 3HF

659 solicitors
16 offices

T +44 (0) 161 934 3000

F +44 (0) 161 934 3288

**Forbes Solicitors**

- 90 Deansgate, Manchester M3 2GP

101 solicitors
9 offices

Telephone 0161 918 0000
Irwin Mitchell LLP
549 solicitors
13 offices
Bauhaus, Rosetti Place Quay Street, Manchester M3 4AW
Tel 0870 1500 100
elaine.russell@irwinmitchell.com

JMW SOLICITORS
86 solicitors
1 office
1 Byrom Place Spinningfields Manchester M3 3HG
0161 828 1937
Bill Jones
Chairman
bill.jones@jmw.co.uk
APPENDIX 7

Various useful contacts and addresses (relevant for this research)

Important Websites and Contact Addresses

Commission for Racial Equality - www.cre.gov.uk
Equal Opportunities Commission - www.eoc.org.uk
Judicial Studies Board - www.jsboard.co.uk/index.htm
Judicial Studies Board- Equal Treatment Bench Book- http://www.jsboard.co.uk/etac
National Association for Mental Health (MIND)- www.mind.org.uk/
Royal National Institute for deaf and hard of hearing people http://www.rnid.org.uk/
Deaf Lawyers UK – www.deaflawyers.org.uk
Employer’s Forum on Disability- efd@employers-forum.co.uk
Centre for Accessible Environments- www.cae.org.uk

Codes of Practice

Code of Practice on sex discrimination-


The Bar Code of Conduct

http://www.barcouncil.org.uk/document.asp?documentid=173andlanguageid=1andhighlight=code%20of%20conduct

Relevant benchmark data may be found on the following websites

Bar Council Education Website- http://www.legaleducation.org.uk/Main/


DTI- “Resolving Disputes: A New Approach in the Workplace”- www.dti.gov.uk/er/resolvingdisputes.htm

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>CONTACT DETAILS</th>
</tr>
</thead>
</table>
| **The Commission for Racial Equality, (CRE).**   | Mr Trevor Phillips  
Chair,  
St. Dunstan’s House  
Borough High Street  
London  
SE1 1GZ.  
Tel- 0207 939 0000 (switchboard).  
Fax- 0207 939 0001 (general). |
| **The Equal Opportunities Commission (EOC)**     | MS Julie Mellor  
Chair  
Arndale House  
Arndale Centre  
Manchester  
M4 3EQ.  
Tel- 0161 833 9244 (switchboard)  
Email- info@eoc.org.uk (general)       |
| **The Disability Rights Commission (DRC)**       | DRC Helpline  
FREEPOST MID02164  
Stratford upon Avon  
CV37 9BR  
Telephone: 08457 622 633  
Text phone: 08457 622 644  
(You can speak to an operator at any time between 8am and 8pm, Monday to Friday) |
| **Society of Asian Lawyers (SAL)**                | Society of Asian Lawyers  
c/o Mr Aamir Khan  
Richards Butler  
Beaufort House  
15 St Botolph Street,  
London EC3A 7EE  
Tel- 020 7772 5994  
Fax-0207 539 5319 |
| Association of Women Barristers (AWB) | Angela Campbell  
c/o Association of Women Barristers  
289-293 High Holborn  
London  
WC1V 7HZ  
DX: 240 LDE |
| Association of Muslim Lawyers (AML) | Student Officer  
The Association of Muslim Lawyers  
PO Box 148  
High Wycombe  
Bucks HP13 5WJ  
Tel: 01494-526-955  
E-mail: aml@aml.org.uk |
| Bar Lesbian and Gay Group (BLAGG) | Mr Stuart Wright  
PO BOX 18459  
London,  
EC1M 3 AU. |
| South East Circuit Minorities Committee | C/O Karl King  
Hardwicke Building  
New Square,  
Lincoln’s Inn,  
London,  
WC2A 3UP. |
| The Society of Black Lawyers | C/O Peter Herbert  
Tooks Court Chambers  
Chambers of Michael Mansfield QC  
8 Warner Yard  
Warner Street  
London EC1R 5EY  
DX 68 Chancery Lane  
Telephone 020 7841 6100  
Facsimile 020 7841 6199 |
| The Department of Trade and Industry (DTI) | DTI Publications Order line  
ADMAIL 528  
London |
| Law Care for Barristers in England and Wales (for confidential help and advice call the free phone number) | Law Care  
PO Box 6  
Porthmadug  
Gwynedd  
LL49 9ZE.  
Tel- 0800 018 4299  
www.lawcare.org.uk |
|---|---|
| SW1W 8YT.  
Tel- 0870 150 2500  
Fax- 0870 150 2333. |