

MEDICAL ERRORS: SANCTIONS AND COMPENSATION – IS THERE ANOTHER WAY?

KEYNOTE SPEECH BY SIR RUPERT JACKSON AT THE MEDICO-LEGAL CONFERENCE ON 16th MAY 2019

1. INTRODUCTION

1.1 My position. I no longer have any responsibility for devising or implementing reforms to the civil justice system. Nevertheless, since I have been asked to deliver the keynote speech at this medico-legal conference, I have taken the opportunity to reflect upon how our legal system deals with medical mishaps and to ponder whether the present arrangements are in a state of perfection. I offer a few suggestions for others to take up or reject, as they see fit.

1.2 This lecture. This lecture¹ addresses disciplinary proceedings against health professionals, decisions to prosecute and civil claims arising out of medical mishaps. The subject matter is not unimportant. A quarter of NHS staff say that within the preceding month they have witnessed an error that could have harmed patients or service users.²

1.3 Abbreviations. In this lecture:

‘FTT’ means First-Tier Tribunal.

‘GMC’ means General Medical Council.

“MoJ” means Ministry of Justice.

‘MPTS’ means Medical Practitioners Tribunal Service.

“NHS” means National Health Service.

“NMC” means Nursing & Midwifery Council.

‘Supplemental Report’ means the Review of Civil Litigation Costs, Supplemental Report published on 31st July 2017.

‘UT’ means Upper Tribunal.

1.4 The medico-justice system. The medical world intersects with the justice system in a variety of ways: for example, disciplinary proceedings, criminal proceedings, withdrawal of life support cases and civil claims for damages.³ But the legal system does not adopt a coherent approach to medical cases in the same way that it does to family cases or other specialist cases. It is therefore worth considering whether a more joined-up approach might be desirable.

1.5 Objectives of the medico-justice system. The first objective of the medico-justice system is to promote high quality treatment for patients. It pursues the first objective by (a) disciplining medical practitioners who fall below acceptable standards; (b) in extreme cases prosecuting them; (c) ordering health professionals or their employers to pay damages for injuries caused by their negligence; (d) delivering reasoned and publicly available decisions, which assist the health service in learning from past mistakes. The second objective is to

¹ I am grateful to Sir Robert Francis QC for providing the information in section 2 of this paper and for helpful discussions about the issues. He bears no responsibility for the views which I express.

² See the NHS staff survey in the Health Service Journal, March 2019. In King’s College NHS Foundation Trust 43% of staff said this.

³ In my work as a Court of Appeal judge, I have dealt with cases in all those four categories. When at the Bar, I acted in many cases both for and against doctors.

compensate patients who have failed to recover or who have suffered injury because of clinical negligence. It pursues second objective, usually, by dipping into resources which would otherwise be available for the first objective. There is nothing intrinsically wrong with this, provided that the available resources are distributed in a just and proportionate way. It is only right that the NHS, health professionals and their insurers should pay compensation to the victims of medical accidents. All other professions do the same.

1.6 Incentivising health professionals. The possibility of being sued for professional negligence or disciplined by your professional body are two of the factors which incentivise professional persons to perform well.⁴ Health professionals rightly have these incentives, like the rest of us. But it is important not to so demoralise health professionals who make honest mistakes that they are driven out of the profession. We can ill afford to lose doctors or medical staff, who have been trained at great public expense. If reasonably competent practitioners are driven out of the profession, that defeats the first objective of the medico-justice system.

1.7 The present position. Where a medical mishap occurs, it may fall for investigation in three different fora: (i) the MPTS or the NMC's Fitness to Practise Committee or a similar professional institution's tribunal, (ii) the civil courts and (iii) (in extreme cases) the criminal courts. This involves repetition of evidence, re-examination of the same documents and waste of scarce resources. The procedures generate massive costs, lengthy delays and much stress for all involved.

2. THE SCHEME PLANNED IN 2010 AND THE LAW COMMISSION REPORT OF 2014

2.1 The scheme. I understand from Sir Robert Francis QC that in 2009/2010 plans were developed to create a single tribunal for disciplinary proceedings involving all health professionals. This would have replaced the plethora of tribunals dealing with individual health professions. This scheme was abandoned after the 2010 General Election.

2.2 Bonfire of the Quangos. The so-called 'bonfire of the Quangos' in 2010 was a bad example of slogan-driven policy. The new Coalition Government set about abolishing institutions and projects without any proper evaluation of what it was destroying. The scheme described in the preceding paragraph was one of the casualties of that exercise.

2.3 Law Commission 2014 Report. On 2nd April 2014 the Law Commission published a report on the regulation of health care professionals and social care professionals. This proposed the creation of a single unified scheme for the regulation of all health care professionals and social care professionals. Under this scheme 'fitness to practise' panels would conduct 'fitness to practise' hearings in respect of any practitioner whose fitness to practise was seriously called into question. There was a consultation about proposals along these lines in 2017, but nothing has happened since then.

⁴ Of course, there are carrots as well as sticks. One carrot is the satisfaction of performing well. But the carrots are not the subject of this lecture.

3. A MODEST PROPOSAL FOR THE REFORM OF DISCIPLINARY PROCEEDINGS

- 3.1 Time for reconsideration. Nine years have elapsed since the famous ‘bonfire’ and five years have elapsed since the publication of the Law Commission report. The MPTS remains outside the general structure of the tribunal system. It also remains separate from the tribunals dealing with other health professionals. The NMC has a Fitness to Practise Committee. The General Dental Council has a Professional Conduct Committee and a Professional Performance Committee. The General Optical Council has a Fitness to Practise Committee. And so forth. These regimes are all separate.
- 3.2 The proposal. I propose that the MPTS and the various tribunals dealing with other health professionals be abolished. Instead disciplinary proceedings against all health professionals should be brought within the general tribunals system. There would be a Clinical Chamber of the FTT and a Clinical Chamber of the UT. These chambers could deal with all such proceedings. Upon the application of the GMC or the NMC or a similar body, they would determine whether an individual’s fitness to practise was impaired by reason of clinical incompetence, misconduct or poor health. The powers of the Clinical Chamber of the FTT and UT should include powers to:
- (a) recommend that a case be considered by the CPS for prosecution,
 - (b) recommend that a case should not be considered by the CPS for prosecution, and/or
 - (c) recommend performance assessment/retraining
- 3.3 The Clinical Chamber of the FTT could have a tribunal judge, district judge or circuit judge (as appropriate) chairing the proceedings, as well as two other members with relevant expertise. The quality of decision-making would probably be higher than that achieved by the MPTS, even though the MPTS normally employs legally qualified chairs. To be ‘legally qualified’ is not the same as being an experienced judge. On appeal to the UT the chair of the panel could, if necessary, be a High Court judge. But again he/she would be sitting with panel members who have relevant expertise. The appellate process would be more satisfactory, with first appeals going to the UT and (occasionally) second appeals going to the Court of Appeal.
- 3.4 First benefit of this proposal. With such an appellate structure in place, there would be a higher quality of decision-making at all levels. A repetition of the *Bawa-Garba* saga⁵ would be less likely. Dr Bawa-Gerba appeared before the Crown Court in 2015, the criminal division of the Court of Appeal in 2016, the Medical Practitioners Tribunal in 2017, the Divisional Court in 2018 and finally the civil division of the Court of Appeal in July 2018. If there had been a dispute about civil liability, there would have been a High Court trial or a County Court trial as well. The Divisional Court, which (wrongly) reversed the decision of the Medical Practitioners Tribunal and ordered that Dr Bawa-Gerba be struck off, did not – indeed could not – include any medical practitioner.
- 3.5 Second benefit of this proposal. Disciplinary proceedings against all health professionals, such as doctors, dentists, nurses, opticians and physiotherapists, would be brought into the same structure, namely the now well-established tribunal system headed by the Senior

⁵ See *Bawa-Garba v GMC* [2018] EWCA Civ 1879.

President of Tribunals.⁶ This would end the present confusing proliferation of individual tribunals.

3.6 Third benefit of this proposal. Any recommendation concerning prosecution or non-prosecution would not be binding. But coming from such an authoritative source, it would carry weight both with the CPS and with anyone reviewing the CPS decision. To prosecute a doctor in the Crown Court for making a mistake, whilst working under extreme pressure in an under-resourced hospital, is a serious step. Other professionals do not face a comparable risk. It is doubtful whether Dr Bawa-Garba would have faced prosecution if the above scheme were in place. I note that on the only occasion when medical practitioners sat in judgment on Dr Bawa-Garba they did not consider that her conduct merited striking off.

3.7 In those very rare cases where a doctor is prosecuted for erroneous treatment, the prior thorough investigation by the Clinical Chamber will be beneficial. It may lead to agreement of facts and narrowing of the issues.

3.8 Fourth benefit of this proposal. The tribunals, which make vital decisions concerning both public safety and the livelihood of individual professional people, would be brought into an existing court-based system. The training of tribunal members would come under the Judicial College, which has expertise in the delivery of such training.

4. A NEW FORUM FOR CLINICAL NEGLIGENCE CLAIMS?

4.1 An inevitable question. If the above proposal for reforming disciplinary proceedings finds favour, the question inevitably arises: what other functions could the new Clinical Chamber of the FTT and UT usefully take over?

4.2 My 2017 report. In my Supplemental Report published in July 2017, amongst many other recommendations, I put forward proposals for fixing the costs of (a) clinical negligence claims up to £25,000 and (b) those clinical negligence claims above £25,000 which could be accommodated in the new intermediate track. See chapters 7 and 8. That report is currently the subject of an MoJ consultation.

4.3 The reaction to that report. By and large, the reactions during 2017 to the general recommendations in my Supplemental Report were positive. There have, however, been criticisms of my proposals for clinical negligence. Claimants point to the time and costs of pursuing such cases through the civil courts and say that this makes fixing the costs difficult, even for low value cases. Many on the defence side say that my proposals do not go far enough. For example, one lawyer in the House of Lords wrote to me expressing 'disappointment' that my recommendations did not go further.

4.4 How can my fixed costs proposals be made more attractive for the parties to clinical disputes? The answer, I suggest, may be to tribunalise the process. The new Clinical Chamber of the FTT and the UT could handle clinical negligence claims, as well as disciplinary matters. The same judges who currently hear clinical negligence claims would continue to

⁶ Currently Sir Ernest Ryder

do so, but in the tribunal context. They would be sitting alongside colleagues with medical expertise. Tribunals are, historically, ‘no cost’ or ‘low cost’ fora, because they bring to bear their own expert knowledge of the field. It may be easier to introduce and – in the future – extend my proposals for fixed costs, if the forum for clinical negligence litigation becomes a specialist chamber of the FTT or the UT. In respect of cases above the fixed costs regime, the tribunal would be well able to costs manage the proceedings.

4.5 Avoid a multiplicity of hearings. In any case where there are both disciplinary proceedings and civil litigation, it would be possible to have a single fact-finding hearing at which the relevant facts are established. After that, the tribunal could deal with (a) misconduct/ impaired fitness to practise issues as between the GMC and the doctor (or the NMC and the nurse); (b) the claim for damages as between the patient and the NHS Trust/private hospital/doctor/nurse or whoever is being sued. This approach would reduce the need for the same witnesses to give evidence twice over. It would also avoid the risk of inconsistent findings.

4.6 A similar recommendation in Ireland. In August 2018 Mr Justice Meenan was asked by the Irish Government to consider how claims arising from cervical checks might be reformed. His report dated 8th October 2018⁷ proposed tribunalising the claims. The advantages which he identified included greater expedition, less formal hearings and reduced costs. The reforms proposed above would have similar advantages.

4.7 Room for some joined up thinking. Tom Kark QC and Jane Russell in their recent report⁸ commissioned by the Minister of State for Health have proposed setting up a tribunal, to be called the ‘Health Directors’ Standards Council’ (“HDSC”). This would have the power to bar individuals from being directors of NHS Trusts, on the grounds that they are not fit and proper persons for the role. The Kark Report makes eminent good sense. But would it not be better for the Clinical Chamber of the FTT (if such a chamber is set up) to take over the proposed functions of the HDSC? This would avoid adding yet another tribunal to the present thicket of health tribunals.

5. HOW SHOULD THE CLINICAL CHAMBER ASSESS NEGLIGENCE CLAIMS?

5.1 Standard of care. There is a looming problem here. As the population ages and the demands on the health service increase, doctors can more and more often rely upon systemic issues and say “I was doing my best in an impossible situation”. That, of course, is no defence for the NHS Trust, which is under a duty to deploy staff in sufficient numbers and of sufficient expertise to treat the claimant properly. But the time may come, for example in an unusually long and cold winter, when an NHS Trust can demonstrate that it simply did not have the funds to deploy the requisite staff. Neither the *Bolam* test nor the *Montgomery* test requires anyone to do the impossible. There may therefore be complex arguments about liability in the post-Brexit world. The needs of patients and their legitimate claims may be drowned out.

⁷ Report on an alternative system for dealing with claims arising from cervical check: 8th October 2018

⁸ *A Review of the Fit and Proper Person Test*, November 218

- 5.2 Oh dear. What is the answer? The answer is to simplify and objectify the test for liability. Let there be a new statutory test for liability in the medical context, namely whether the patient has suffered 'reasonably avoidable injury'. If the injury was reasonably avoidable, then the fact that the doctor had been on a twelve-hour night shift and had numerous other patients to treat is neither here nor there. The relevant health trust or private hospital is liable. If this objective test is adopted, then (a) the patient is better protected and (b) the investigation of liability is depersonalised.
- 5.3 A further benefit of the proposed objective test. Even if the doctor or nurse involved is not joined as a party, they are often named in the proceedings. This (I am told) sometimes leads to conscientious practitioners leaving the profession. The risk of the profession losing competent doctors will be reduced if the process is depersonalised. The blunt fact is that all professional people make mistakes from time to time, especially in the early years of practice.⁹ They should not be so humiliated that they give up altogether.¹⁰
- 5.4 That all sounds lovely, but can we afford it? Yes. The costs of litigating before the tribunal should be lower than the costs of litigating in court. The process of assessing damages can be simplified. The Clinical Chamber could have scales for assessing future care costs. Defendant health trusts could do more to assist the tribunal by producing care plans for individual cases, hopefully agreed by claimant representatives.
- 5.5 Settlement. Settlement by negotiation or by mediation should be easier if there is a simple and objective test of liability, as suggested above. Settlement will also be easier to achieve, if the processes of assessing damages are standardised, as suggested. I would add that mediation can often be effective in those cases where bilateral negotiation or a joint settlement conference has failed.
- 5.6 Promoting early settlement. Against the background of a simple liability test and an effective tribunal system to handle clinical claims, there should be renewed effort to promote early settlement.¹¹
- 5.7 Establishing a redress system. The best way to promote early settlement is for each NHS Trust or hospital to establish a patient-centred complaints/redress system in which support to match the need arising from whatever has gone wrong is provided at an early stage. A redress system has been operating in Wales since 2011.¹² None has been set up in England. The NHS Redress Act 2006 has not been implemented.
- 5.8 Would these reforms generate a high volume of claims? Many people who suffer medical mishaps choose not to claim. Even so, if the liability test suggested above is adopted, I accept that there could be more claims. According to the *NRLS national patient safety*

⁹ See e.g. *FB v Princess Alexandra Hospital NHS Trust* [2017] EWCA Civ 334 at [51]-[65].

¹⁰ See *FB* at [65].

¹¹ I have previously identified late settlement as being a particular problem in clinical negligence litigation: see *Review of Civil Litigation Costs, Final Report* (January 2010), chapter 23.

¹² See <http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20-%2020140122.pdf>

*incident reports: commentary*¹³ published by NHS Improvement in September 2018, in the year to March 2018 there were 51,495 incidents causing moderate harm, 5,501 incidents causing severe harm and 4,537 incidents causing death.

5.9 Would this push up the damages bill? Not necessarily. Damages could be tariff-based. This would enable an equitable distribution of the available compensation amongst all deserving claimants, in place of the present system in which a smaller proportion of deserving claimants recover higher damages.

5.10 Cutting the cake. The resources of the NHS, and the funds of those who insure private practitioners, are finite. They have to be divided equitably between (a) providing health care to patients, (b) compensating patients who have suffered reasonably avoidable injury and (c) paying lawyers. This fact is deeply unattractive. Nevertheless, those administering the civil justice system, those representing injured patients and those representing defendant clinicians must face up to reality.

6. LEARNING FROM PAST MISTAKES

6.1 You cannot undo mistakes, but you can try to prevent repetition. Learning from previous mistakes and preventing repetition should be a key aim of any reforms. This directly feeds into the first objective of the medico-justice system, as discussed above. Any redress system of the kind discussed in paragraph 5.7 above could operate in tandem with an objective investigation of the facts, involving both the patient and the health professional, so that learning from the mishap is used to prevent repetition. The Early Notification Scheme for birth injuries,¹⁴ which was set up by NHS resolution in 2017, operates along those lines. I understand that this is generally effective. It should be possible to develop a similar scheme which would apply to all serious injuries sustained during medical treatment.

6.2 The benefits from a unified tribunal system. The wider reforms canvassed in this paper might make a significant contribution to the vital task of learning from past mistakes. Instead of having an array of different tribunals and courts, we would have a single tribunal structure, comprising the Clinical Chamber of the FTT and UT. They would be specialist tribunals, combining medical and judicial expertise, generating hopefully high quality publicly available decisions. It would be a straightforward task for some body, perhaps with the help of a university,¹⁵ to monitor that output and feed it back into the health system.

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16th May 2019

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¹³ See table 4 on page 12.

¹⁴ See <https://resolution.nhs.uk/services/claims-management/clinical-claims/clinical-negligence-scheme-for-trusts/early-notification/>

¹⁵ Many university teachers are looking for socially useful research projects, from which they can publish articles and demonstrate 'impact'. I have on several occasions in the past found university lecturers who were willing to monitor pilot exercises in the courts at no cost.