No-Fault Compensation for injury resulting from medical treatment: Consultation Questions

1. The research team supporting the review reported (Farrell *et al*, 2010[19]) that previous research suggests that when an error has occurred, patients expect doctors to make a meaningful apology, provide an explanation and take steps to prevent the error from recurring. The findings of their research would appear to support the contention that for many, if not most, patients this is the primary aim, rather than a financial award.

2. The Scottish Public Services Ombudsman (SPSO) has published advice in relation to apology[20]. This advice was referenced in the guidance issued to NHSScotland in March 2012 on the handling and learning from feedback, comments, concerns and complaints.

Question 1: What, if any, steps do you feel are necessary or appropriate to ensure that when an error has occurred, patients receive a meaningful apology?

This question presupposes that an "error" has occurred. The word "error" implies fault on behalf of the clinician or institution. In our experience, clinicians are generally happy to apologise if they accept that they are at fault.

The regulators of the various professions have a role to play in this. As an example the General Medical Council already provide guidance to doctors. Breach of this guidance may give rise to a complaint to the General Medical Council. Therefore, as matters currently stand, a practitioner who has made an error is expected to provide an apology and a full explanation.

There is however room for substantial differences of opinion on whether an "*error*" has occurred in any particular situation

Most complaints systems will involve meeting and discussions between the patient or patient's family and those responsible for the patients care. Involving a trained mediator in the complaints resolution process may assist in resolving the complaint and in drafting a form of words as an apology which would be acceptable to both parties.

An apology is only likely to be meaningful if it contains an acknowledgment of a mistake or wrongdoing. There is a distinction to be drawn between an apology which apologises for having done something wrong and an apology which states that an individual is sorry that a certain state of affairs has come to pass. There is little problem in providing the latter. However, generally, a patient will be looking for the former.

In the current system there is little point in a party pursuing litigation if they wish an apology. Pursuing litigation will probably make it more likely that a party will not receive an apology. Civil litigation is about money only. If a patient's motivation is to receive an apology then they should either make a complaint to the practitioner or, in more serious cases, to the regulator.

It is unusual for an apology to form part of any litigation settlement. The exception to that is in defamation cases. Under the Defamation Act 1996 it is possible for a party to offer to make amends. That offer may include an apology. However that only applies where the party making the offer accepts that they have defamed the other. It is difficult to see how a similar system in respect of clinical negligence claims could be used in cases other than those where the clinician accepts that

[19] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation/Volume-II-report
[20] http://www.spso.org.uk/files/2011_March_SPSO%20Guidance%20on%20Apology.pdf

they have made a mistake. It would be possible to explore special rules for clinical negligence cases which involved a similar option for defenders. However in order for that to be attractive there would have to be some sort of advantage to the defender in offering the apology at an early stage.

It is not clear to us how the introduction of a no fault scheme would assist patients in obtaining an apology. The threat of civil litigation would remain as would the threat of disciplinary proceedings.

3. The Review Group considered that the following were essential criteria for a compensation scheme for injuries resulting from medical treatment:

- The scheme provides an appropriate level of compensation to the patient, their family or carers
- The scheme is compatible with the European Convention on Human Rights
- The scheme is easy to access and use, without unnecessary barriers, for example created by cost or the difficulty of getting advice or support
- People are able to get the relevant specialist advice in using the scheme;
- Decisions about compensation are timely
- People who have used the scheme feel that they have been treated equitably
- The scheme is affordable
- The scheme makes proportionate use of time and resources
- The scheme has an appropriate balance between costs of administration (e.g. financial or time) and the level of compensation awarded
- Decisions about compensation are made through a robust and independent process
- The scheme has an independent appeal system
- The scheme treats staff and patients fairly/equitably
- A reasonable time limit is set for compensation claims.

Question 2. Do you agree that the principles and criteria set out above are essential in a compensation system?

Yes ✓ **No** ☐

2.1 Are there any to which you would attach particular priority or importance? Are there any others you would add?

The most important aspects are that parties receive an appropriate level of compensation and that the system is affordable and fair.

4. The Review Group identified a number of issues it believed were relevant to the likely success of any system and agreed that the following criteria were desirable, and considered and highlighted the importance of the wider issues detailed below:

Desirable

- The public in general trusts the scheme to deliver a fair outcome
- The scheme does not prevent patients from seeking other forms of non-financial redress, including through the NHS Complaints system
- The scheme encourages transparency in clinical decision-making
- The scheme contributes to rehabilitation and recovery.

Question 3: Do you agree that these criteria are desirable in a compensation system?

Yes ✓ **No** ☐

3.1 Are there any others you think are desirable and should be included?

No.

Wider issues

- The scheme contributes to:
  - organisational, local and national learning
  - patient safety
  - quality improvement
- Lessons learned can be used to influence organisational risk management in the future
- The scheme encourages and supports safe disclosure of adverse events
- The scheme does not put barriers in place for referral to regulators of any cases which raise grounds for concern about professional misconduct or fitness to practise.

Question 4: Do you have views or ideas on how a compensation scheme could more effectively contribute to the wider issues identified above?

It would presumably be possible to audit patterns of cases passing through the compensation scheme to identify trends of clinical accidents. That data could be used to improve patient information on risks involved in certain types of procedure and to assist in improving standards of treatment.

5. When considered the Review Group's suggested essential principles and criteria against other schemes and the Swedish model came out on top. Based on this the Review Group offered:

Recommendation 1 - 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.

Question 5: Based on the background information on the system in operation in Sweden given in Annex A would you support the approach suggested in Recommendation 1?

Yes ☐ No ✓

If not, why not and what alternative system would you suggest?

Why Not?

We do not consider that a no fault compensation system is affordable, workable, or desirable. We would suggest that improvements be made to the existing system in Scotland in order to allow that to function more efficiently and to increase transparency.

Funding

The paper provides no clarity on the source of funding for the proposed compensation scheme. This is a matter of significant concern, particularly as the figures presented as cost estimates are very limited in scope and analysis and do not address likely future costs in any meaningful way.

Social welfare provision in Scandinavia is entirely different to social welfare provision in Scotland. The Swedish model is founded upon a country with comparatively high levels of taxation. At the moment, in broad terms, social welfare provision in Scotland is not at the level it would require to be at in order for a no fault scheme to be supplemented by adequate social welfare provision. We would suggest that, if such a scheme is to be seriously considered, broad changes would be required to the taxation and social welfare systems in order to support it.

There does not appear to have been any consideration given to the additional strain which would be placed on the NHS as a result of returning the care of injured patients entitled to compensation into the state system. Care is currently provided by a range of private agencies on a local basis, paid for ultimately by the NHS and other compensators. This is not an insignificant burden to put back into the state system. No specific figures in relation to this are available. There would likely also be a significant economic impact upon the private agencies who are engaged to provide that care if that income were to be removed.

The figures founded upon in the consultation are contentious in our view. They are based upon a number of assumptions as to how a no fault scheme ("NFS") might operate.

1. Assumptions are made on the volume and value of claims. The estimates are not based on predictions of what an NFS would cost in the future, but estimates of what public expenditure would have been had such a scheme been in place in a typical year.

2. There is no mention of the effect that an NFS would have on volumes of cases. It is envisaged that the scheme will extend to *all* injuries resulting from medical care - presumably this will include claims for suffering side effects of drugs, failure to offer specific drug or surgical treatment and product liability. The latter would have the effect of bringing into the scheme a liability which is currently borne by individual manufacturers and their insurers.

3. Experience in this sector has been that volumes of cases have risen steeply, typically a 30 – 40% year on year increase over the last few years where there has been the removal of barriers to access to justice by the advent of CFA and public uptake of them. It can be anticipated that the removal of barriers to justice will have a similar effect in Scotland. However that has not been factored in to the assumptions of future costs.

4. In our view it is likely that, if a NFS is introduced on the basis proposed, it can be expected that the costs of claim will be significantly higher than those projected. It will often be the case in either low or high value cases that the ultimate settlement is substantially discounted to reflect litigation risk to the claimant. That risk can arise as a result of a difference of opinion between experts, a dispute on the facts, a dispute on causation or potential legal arguments. A claimant may also take a settlement less than they may ultimately expect to receive as they are reluctant to attend court to give evidence. In a NFS there is no such risk to the claimant.

5. Even on the basis suggested and the figures put forward by the researchers, on current figures, this may well lead to an increase costs to the State / compensators in the order of 50%. It is unclear how this cost is to be met. If, as seems likely, it will be accompanied by an increase in volumes the cost to the State (as the main compensator) and other compensators, is likely to be huge. From a resource standpoint, it might be suggested that those additional funds, if available, should be used to put additional resource into already stretched healthcare services and improve the quality of care at the point of delivery to reduce and hopefully avoid further such incidents occurring.

6. The Lord Chancellor's decision on discount rates is awaited following the completion of the joint consultation exercise with the Scottish parliament. The likely changes from the Taylor Review on costs and the review of the discount rate are yet to be clarified. At this stage their impact on any proposed scheme remains unclear.

<u>Proposed System</u>

One might comment that such a scheme may be contrary to public policy. The Westminster government have instructed consultations on "*compensation culture*". Most recently there has been a suggestion of moving away from strict liability for certain types of accidents in employers liability cases. The introduction of a NFS would appear to be directly contradictory to the policy from Westminster. This is likely to be difficult for the public to understand. One might legitimately ask why an employee injured at work can receive no compensation but someone injured in hospital can.

As it seems that some elements of each case are likely to be excluded under the Scheme, and it is envisaged that litigation could be pursued in addition to a NFS, this would lead to a two tier system which would be operated in tandem. Costs would then likely be incurred in pursuance, in the first instance, of compensation under the current scheme, and subsequently if that were unsuccessful under the NFS. It is likely that an NFS will be seen as an additional layer of redress, but not the primary one. In such circumstances, it is hard to see how there could be any saving in cost.

The no fault system will not mean that there is no necessity to deal with causation. The obligation to pass the test on causation will remain. Causation arguments are often at the centre of clinical negligence cases and it is hard to see how removing breach of duty in the limited sense proposed by the Paper, will produce the significant savings suggested.

In addition to causation issues having to be tackled, quantum would also have to be dealt with and again, practitioners in the area know that this often requires the majority of the work to be done in preparation of litigation cases. Again, it is hard to see where savings might be made. Legal fees will still require to be incurred.

In addition to the potential flaws in relation to costs, assumptions are also, it seems, being made that culturally the Scottish population would behave in the same or similar way to Swedish or New Zealand populations. The approach to compensation in Scotland is, it might be suggested, fundamentally different. In addition, lawyers' behaviours are very different in the UK to abroad, as are the systems within which they work.

By reason of the larger population in the UK than in Sweden and New Zealand the results in terms of overall costs are likely to be significantly different. The structures and institutions in place in the various jurisdictions are also quite different. Socio-economically and politically the various jurisdictions

are different and we would suggest that Sweden is politically placed rather more to the left than the UK is, and therefore, culturally more willing to meet the additional cost of such a scheme from taxed income.

Improvements to the Existing System

The imposition of binding pre-action protocols is something which is being investigated by the Scottish government. At the moment there is no binding pre-action protocol for clinical negligence claims in Scotland. The protocols which do exist are voluntary and are aimed at straightforward, low value personal injury and professional negligence claims. In our experience the professional negligence protocol is not widely used.

Many of the problems which are suggested with the current compensation system would be ameliorated, in our view, by the introduction of a binding pre-action protocol. That protocol would require disclosure of relevant documents at an early stage. It would require the claimant to provide a clear and candid explanation of their grounds of fault. It would provide binding timescales within which the defender would require to provide their position on liability along with an explanation, where applicable, of why liability is denied. Such a protocol already exists in England and Wales. We can see no reason why it should not be possible to introduce a similar protocol north of the border.

It is acknowledged that claimants in Scotland face difficulties with access to justice. Clinical negligence cases, generally speaking, are not straightforward. It is also generally very difficult if not impossible for a solicitor to advise on whether or not a certain act or omission amounts to negligence without obtaining an expert report. In addition it is likely also to be necessary to obtain an expert report on causation before it is possible to offer a view on whether the action has reasonable prospects of success. As a result clinical negligence actions are by their nature risky for claimant firms to take on speculatively.

Funding streams for clinical negligence claims are limited. There is an ongoing review into legal expenses in Scotland under the chairmanship of Sheriff Principal James Taylor. It may well be that review will raise funding models which will help to alleviate the difficulties claimants currently face in raising clinical negligence actions.

It is noted that it is considered that claimants in Scotland do not have access to the appropriate expertise given the shortage of accredited clinical negligence specialists in the country. We do not consider it is accurate to say that there is a significant shortage of solicitors who have the expertise to deal with medical negligence cases in Scotland. Any of the main claimants firms would be more than capable of handling a clinical negligence case. The lack of accredited specialists do not equate with lack of expertise. The test to be adopted in a clinical negligence case is well known and can be applied to cases against most professionals. We consider that the profession are more than capable of providing their clients with advice in such matters. In any event the vast majority of claimant firms will instruct counsel and follow counsel's advice in respect of the conduct of the case. There are numerous counsel at the Scottish bar who have expertise in clinical negligence on the claimants' side.

For cases that are litigated, improved case management procedures could easily be introduced. Discussions have already taken place in respect of introducing specific rules for clinical negligence cases in the Court of Session. For more complex cases we would advocate an approach similar to that adopted in Commercial actions in the Court of Session. Such procedures are extremely flexible and focus the issues in dispute much more quickly than ordinary damages actions. For example judges will issue orders requiring parties to lodge expert reports. Reformed court procedures can assist in accelerating the progress of a clinical negligence claim through the courts. The courts have demonstrated in the past (for example in respect of asbestos cases) that special provision can be made for specific types of case.

Recommendation 2 - 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.

Question 6: Would you support the approach in Recommendation 2? This would mean for example that where treatment carries a known risk and the patient has given consent to that treatment it would not be eligible.

Yes ☐ No ✓

If not, why not?

We can see no reason why a patient who is injured as a result of an operation which carries a small, known risk should be treated any differently from a patient who sustains injury in other circumstances – such as an operation where something goes wrong which is not a known risk. We cannot see that there would be any reason in principle to differentiate between the outcomes for those two categories of patient.

On the basis of the proposals one can envisage for example distinctions being made between the following:

1. An injury arising out of an operation with an unknown risk.
2. An injury arising out of an operation which carries a small, known risk – but not a risk that it is standard practice to warn patients of in advance.
3. An injury arising out of an operation with a small, known risk which it would be standard practice to warn a patient of.
4. An injury arising out of an operation where it is standard practice to warn of a well known, significant risk.

If local NHS boards are going to contribute to the funding of the scheme, differentiating between scenarios 2 & 3 may become a problem. Potentially healthcare professionals would come under pressure to warn patients of every single possible permutation and potential risk arising out of particular treatment. We can envisage that this would place an additional and potentially unworkable burden upon healthcare professionals. It would potentially reinforce the practice of defensive medicine and divert practitioner's attention away from delivery of care in compliance with standard protocols and procedures. It is noteworthy that in Sweden issues of negligent failure to provide information or treatment must proceed as a tort action in the courts.

If yes, what other injuries would you consider should not be eligible?

N/A.

6. The Review Group was of the view that any recommended changes to a no-fault system should cover all healthcare professionals including those not directly employed by the National Health Service. The group believed that fairness dictated that all patients whether treated by the NHS or privately should have access to an improved system if possible. If this proved impossible, the group nonetheless believed that there were benefits that could be obtained by a move to no-fault for NHS patients. The group's preference was that **all** patients should be covered by the no-fault scheme and offered:

Recommendation 3 - 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 - that the scheme should extend to all registered healthcare professionals in Scotland, and not simply to those employed by NHSScotland.

(As explained in the Cabinet Secretary's foreword we acknowledge that further work is needed to help in our understanding of the volume, level and cost of compensation claims handled by the Medical Defence Unions and private healthcare providers. We will seek to explore this further with the relevant stakeholders during the consultation period.)

Question 7: Do you support the view that, if introduced, a no-fault scheme should cover all clinical treatment injuries (e.g. private healthcare and independent contractors) and all registered healthcare professionals and not just those directly employed by NHSScotland?

Yes ✓ **No** ☐

If not, why not?

N/A.

7.1 What, if any, difficulties do you foresee in including independent contractors (such as GPs, dentist etc) and private practice?

We do not support a no fault scheme. If such a scheme is introduced in Scotland it will give rise to a two tier system between Scotland and the rest of the UK.

Any scheme introduced which applies only to certain types of treatment within Scotland would add further arbitrary distinctions. It is unlikely that the public would understand or favour a system which provided a better outcome for someone who suffered injury in hospital as opposed to in the doctor's surgery or dentist's chair.

We can foresee difficulties if the scheme introduced only applies to certain types of care. Often in a medical negligence action there will be several defenders – most often when they pass from primary to secondary care. That would mean that part of the patient's claim would be eligible for the scheme but part of it would not.

We consider that there would be great difficulties in including independent contractors such as general practitioners, dentists, private hospitals etc in such a scheme. There would be a requirement to consult broadly with medical defence organisations, private hospitals, insurance companies and other stakeholders. It would also be necessary to ascertain the views of other professions such as paramedics, occupational therapists etc as to whether or not they approve of such a scheme and whether or not they consider it would be beneficial to them.

Whilst the funding of claims against the NHS all comes from one central budget, indemnity arrangements in respect of non NHS claims are far more complicated. There would be a danger that insurance premiums and indemnity memberships may increase. Consideration would require to be

given to whether insurance companies would withdraw their services from the medical market in Scotland if the requirement to contribute to a no fault scheme made that market unprofitable.

Consideration would require to be given to what guarantees are in place as to the continuing solvency of other organisations who would be expected to contribute financially to any scheme to be administered. For example not all organisations are sufficiently well resourced to provide periodical payments in high value in clinical negligence cases such as those involving neurological injury to new born babies.

At the moment the potential effect on the numerous other interested parties of the proposals is not known. As stated in response to question 5 above there is a lack of clarity about how the scheme would be funded.

7.2 What are your views on how a scheme could be designed to address these issues?

A great deal more research would be required into the issues raised above before consideration could be given to such a system.

Question 8: The intention is that if introduced the no-fault system will not be retrospective. However, consideration will need to be given to when and how we could transfer to a new system and how outstanding claims could be handled if/when a no-fault system was introduced. What are your views on how outstanding claims might be handled?

Presumably if a no fault system is to be introduced a date will require to be identified when it will come into force. All the qualifying criteria will require to be tightly drafted. Presumably any treatment/omission of treatment prior to the qualifying date will require to be dealt with under the pre-existing fault system. It may be considered desirable to introduce transitional provisions which would account for claims which have been made prior to the coming into force of the no fault scheme.

7. The Review Group did not favour the use of a tariff system for compensation, as it felt that this would not address individual needs and it was unlikely that people would buy into a system where compensation was based on a tariff. The group therefore offered:

> **Recommendation 5 -** that any compensation awarded should be based on need rather than on a tariff based system;

Question 9: Do you support the approach in Recommendation 5?

Yes ✓ **No** ☐

If not, why not?

9.1 What are your views on the assumption that the level of payments will be similar to those settled under the current system?

We consider that this is highly unlikely. We consider that there has been insufficient research carried out on the costs involved. That is particularly the case if the scheme is to be expanded to all healthcare providers. As far as we understand it the only research which as been carried out has related to NHS payments.

It will be necessary for the consultation team to engage with medical defence organisations, private hospitals, insurers etc to obtain a more accurate idea of the level of compensation paid under the current system.

If it is the case that payments are going to be the same under the no fault system as they are under the existing regime then there would seem little point retaining the current negligence system.

It should also be borne in mind that, in order to provide adequate compensation, settlement levels will require to be higher than they presently are. Present settlements in clinical negligence cases will often be discounted for litigation risk. Claimants may also accept less compensation than they would necessarily be entitled to on a full liability basis due to a genuine reluctance to go to court and to avoid the stress of the litigation process.

In higher value cases a large proportion of the quantum of the claim will be made up of care costs, aids and equipment. Provision for those services is generally considered to be higher from the private sector but is more expensive. If a claimant under the NFS will be provided with care through the NHS that will likely provide a disincentive for the claimant to seek redress though NFS rather than through the existing negligence arrangements.

8. The Review Group was satisfied that a no-fault scheme established as they describe would be fully compatible with the requirements of the European Convention of Human Rights, based in particular on the need – as in Sweden and New Zealand – to build in appropriate appeals mechanisms, with an ultimate right to appeal to the courts on a point of fact or law. In addition, retention of the right to litigate will ensure that those for whom the no-fault system is felt to be inappropriate will still be able to raise claims using this route. The group recommended:

> **Recommendation 6 -** that claimants who fail under the no-fault scheme should retain the right to litigate, based on an improved litigation system
>
> **Recommendation 7 -** that a claimant who fails in litigation should have a residual right to claim under the no-fault scheme
>
> **Recommendation 8 -** 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 -** 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.

Question 10: Do you support recommendations 6 – 9 as proposed by the Review Group?

Yes ☐ No ✓

If no, why not?

Recommendation 6 - We consider that if the current litigation system is improved that addresses the majority of concerns which have been raised. Retaining the existing negligence arrangements and introducing a NFS will not, in our view, lead to significant savings. We agree that patients should retain the right to pursue negligence actions. If it were truly correct that patients could recover adequate compensation under the NFS then the utility of retaining the existing arrangements is questionable. We are not convinced by this recommendation as we consider a two tier (potentially three tier) system will potentially lead to two actions being raised instead of one – and therefore an increase in costs.

Recommendation 7 – We agree that unsuccessful negligence claimants should not be precluded from claiming under the NFS. The retention of the existing litigation arrangements would likely mean that claimants in higher value cases are likely to use the NFS if they are ultimately unsuccessful, only partially successful or do not receive full compensation in their court action.

Recommendation 8 suggests that it is envisaged that both processes would run in tandem. It is not immediately apparent how that would lead to the costs savings which are suggested as a justification for introducing the scheme. We agree that if a claimant is successful under the NFS any award should be deducted from the litigation award.

We agree with recommendation 9 that, if an NFS is introduced, there will require to be an appeal mechanism. The alternative would be a significant number of judicial review challenges to decisions made under the no fault compensation scheme.

10.1 Do you have any concerns that the Review Group's recommendations may not be fully compatible with the European Convention of Human Rights?

Yes ☐ No ✓

We are sure that the scheme could be appropriately framed so that it complies with the convention

If yes, what are your concerns?

Consideration requires to be given for whether any time limit will be imposed for claiming under the scheme.

9. The Review Group offered suggestions for improvement to the existing system and these are reproduced in Annex B. The group recommended:

Recommendation 10 - 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.

10. It is proposed that the suggested improvements will be taken forward as part of the forthcoming consultation on the Courts Reform Bill later this year by the Scottish Government Justice Directorate. In particular the Scottish Civil Courts Review[21] recommended that pre-action protocols should be made compulsory and it is considered that this would assist in resolving many of the areas identified by the Review Group In addition, Sheriff Principle Taylor's Review of Expenses and Funding of Civil Litigation in Scotland[22], which is due to report at the end the year will consider a range of issues.

Question 11: Do you agree with the Review Group's suggestions for improvements to the existing system?

Yes ✓ **No** ☐

Broadly we agree but not with every point.

11.1 Do you have any comments on the proposed action in relation to these suggestions?

We have already discussed this in the answer to question 5 above.

We agree that court procedures can be improved. However we do not consider that a timetable similar to the personal injury rules is well suited to clinical negligence actions. All clinical negligence actions must be raised as personal injury actions in the Court of Session or the Sheriff Court now in any event. If a party wishes to raise an action as an ordinary action then they require to elect to do so and obtain an interlocutor from a judge. If an action is remitted it remains open to parties to agree between themselves that the various procedures adopted in chapter 43 actions are still adhered to.

In our view, certainly in more complex clinical negligence actions, the rules of the commercial court are more conducive to robust and helpful case management. The commercial action rules have more flexibility and a greater degree of judicial control. They provide the opportunity for greater case management than is afforded under chapter 43. For example, in a cerebral palsy case arising out of alleged negligence at birth there will be discrete issues of liability, causation, life expectancy and quantum. It is helpful in these situations to have robust case management from a judge so that matters can proceed smoothly and procedurally and to avoid to delays.

The commercial type procedure, in our experience, assists in focusing the issues at an early stage. The commercial court will also order parties to lodge expert reports, within certain timescales. In the Court of Session there will often be a lengthy delay between the time when parties finalise their written cases and the proof date. Those delays, in our experience, are much shorter in the commercial court.

As per answer 5 above we agree that binding pre-action protocols are to be welcomed. This should address any concerns over the timing of disclosure and the non-disclosure of critical incident reports. In our experience the Central Legal Office, who handle all of the NHS claims in Scotland, are not keen to enter into either of the voluntary pre-action protocols on behalf of their clients.

[21] http://www.scotcourts.gov.uk/civilcourtsreview/
[22] http://scotland.gov.uk/About/taylor-review

We agree that access to justice in clinical negligence cases requires to be improved. However we do not agree that there is a lack of expertise for dealing with medical negligence claims in Scotland. The Scottish market is small. Possibly due to access to justice issues and other factors there are fewer clinical negligence claims in Scotland per capita than in England and Wales. We are not convinced that the amount of work available (even allowing for increased access to justice) would support "a comprehensive network of solicitors in private practice" dealing with these types of claim throughout the country.

We agree that in low value cases expenses can be disproportionate to the principal sum. However this can be said of all types of personal injury case. The presumed savings that a no fault scheme would bring here ignore the fact that a claimant would still require to establish causation – and it is often the causation report which is the more expensive one. In any event, legal costs in Scotland at present are, in general, much lower than in England & Wales.

11. The Review Group also considered whether or not the establishment of a scheme specific to neurologically impaired infants should be created (in the event that a general no-fault scheme is not introduced). Members considered that this group of patients arguably represents a special case and certainly accounts for the most significant sums awarded in compensation and legal costs. The Group were of the view that this was worthy of consideration.

Question 12: Would you support the establishment of a scheme specific to neurologically impaired infants if a general no-fault scheme is not introduced?

Yes ☐ No ☐

We consider that it is arguable that neurologically damaged infants constitute a special case. However various sections of the patient community might take issue with that. Individually these cases may well be the most expensive, but it is not clear from the figures supplied whether they together pose the most significant expense, or whether that is made up of the majority of the numbers of lower value cases, but which are received in higher volumes. It is likely that the vast majority of these cases will be NHS cases and if such a scheme was to be introduced across the board there would require to be careful consultation as to how it would be funded.

Periodical payments orders have been sanctioned by the Scottish courts. The claimant receives a series of payments throughout his/her lifetime. Such orders are particularly useful in the case of neurologically damaged infants.

12.1 What are your views on the Review Group's suggestion that the future care component of any compensation in such cases could be provided in the form of a guarantee of delivery of services (both medical and social care) to meet the needs of the child, instead of by way of a monetary sum?

This very much depends upon the level or standard of service which is to be provided. Claimants are unlikely to welcome being tied to NHS or state provision of care or rehabilitation, which is proposed under the Scheme. The general feeling is that state provision of care services is inferior in terms of quality and flexibility to that currently available to compensated patients who can resort to private provision.

For example, in the case of prosthetics it will very often be the case that a claimant would obtain an expert report from a specialist, private prosthetics firm such as Dorset Orthopaedics. The standard of

prosthetics provided upon the NHS are generally provided inferior to those provided on a private basis. Prosthetics provided on a private basis cannot put a party back into position where they had their legs but do improve their quality of life and are superior to those provided by the NHS. They are however significantly more expensive. Therefore, if the aim is to compensate parties who lose one or both of their legs that cannot adequately be done through the provision of such services.

Under the existing system a claimant has the right to insist upon damages which would put him back in the position which he would have been but for the accident (or as close as that is possible to do by way of monetary compensation).

General Comments

We would welcome any further general comments you may wish to offer here.

We are grateful for your response. Thank you.