The findings of the Robert Francis inquiry into the Mid Staffordshire Trust (summarised by him in this issue) expose a horrifying catalogue of failings, both institutional and individual, of which the perpetrators and all who work in the NHS must be ashamed. That so many in the caring professions and their managers accepted, contributed to, and presided over a culture of indifference to suffering, indeed of cruelty to sufferers, seems inconceivable in our civilised society. Most would agree that those responsible should be held to account. The question is how?

I come from a large and far-flung medical dynasty on both sides of my family. As a barrister I have specialised for more than 30 years in medical negligence litigation, mainly acting for Claimants (whom we used to call Plaintiffs), and am sometimes asked how I, from such a family, can bring myself to sue doctors and surgeons? I answer that it is partly because I have seen the standards my medical relatives profess and expect that I have been willing to investigate, expose, and ultimately to condemn bad clinical practice that has avoidably caused harm. Indeed I have often found affirmation in the shocked reactions of relatives to whom I have related the (anonymised) facts of my cases. I have also been very glad often to advise, after thorough investigation, that the clinicians have no case to answer and that the proposed litigation must stop.

SHOULD DOCTORS BE IMMUNE FROM LITIGATION?

Is it right that the civil law should be invoked against the NHS, and/or against allegedly negligent practitioners when things go wrong in the practice of medicine and surgery? Should I sue doctors (I use the term generically for the whole profession)? Should they not be immune from the process, with redress for injured patients supplied instead by no-fault compensation for every bad outcome (a solution that would be expected, if universally applied, to be either inadequate in monetary terms and therefore unfair, or prohibitively expensive)?

It is true, as those who favour immunity are fond of pointing out, that civil litigation against doctors and against the NHS as an institution, is costly in the damages awards that are made by the courts, but consider in this regard three simple facts:

- Damages are not awarded for the mere fact of a mistake, but only for a mistake that has avoidably caused harm and which it is proved should not, if reasonable care had been taken, have been made at all.

- The percentage of total NHS ‘turnover’ represented by the whole annual bill for damages awards and legal costs is tiny compared to the premium an organisation of its size would have to pay for liability insurance in the commercial market place.

- Fault-based compensation means that bad practice costs money, and it follows that the right and best way to reduce the burden of damages awards in medical cases is to prevent negligent treatment in the first place by the setting and enforcing of proper standards of care.
The best way to reduce the burden of cost to the state of damages awards in medical cases is to prevent negligent treatment in the first place by the setting and enforcing of the highest possible standards.

The same expectations of due care rest on the factory owner to protect his workers from dangerous machinery, the electrician to install safe wiring, the engineer to design bridges that do not fall down, the car driver to drive safely, and so on. None of these set out to do harm, but all know that they may do harm if they are not properly careful in what they do.

And the civil law not only publicly sets, promulgates, polices and enforces appropriate standards of care in all daily activities, but it also exposes bad practice to public gaze, and it provides those accused of negligence with an opportunity to rebut the allegations and to defend their reputations. In short, it serves to deter careless conduct, to foster and promote risk analysis and avoidance, and to demonstrate society’s disapprobation of carelessness that avoidably causes harm, and its recognition of the suffering of innocent victims.

If you ask whether submission to this process is necessary for the proper governance of the NHS and the medical profession, I answer that for all the above reasons it is. And if you think the medical profession or indeed the NHS as a whole should be exempt from it, I ask what you would do about the appalling institutional failure and equally appalling individual misconduct that the Francis report has exposed? What would you do to punish it, correct it, and ensure so far as possible that such things will never happen again? Is a public inquiry alone, however critical its findings, enough without the decisive role and punitive powers that the judges have?

MEDICO-LEGAL ISSUES

MEDICAL PROFESSIONALS’ RESENTMENT

That a barrister would argue that everyone should be subject in court to the law of tort and its consequences is perhaps predictable – ‘he would say that, wouldn’t he?’ – and I recognise that the need for litigation against the medical profession is not always easy for its members to accept. It can in my experience generate extreme resentment among medical professionals, many of whom see themselves as potential prey to unfair claims by vindictive patients, rather than the beneficiaries of a sophisticated legal system with important implications for society’s good.

That resentment is borne of many considerations, chief among which are:

- that doctors do a particularly difficult job in often trying circumstances
- that the sole aim of the doctor is to alleviate suffering and to undo rather than to do harm
- that patients when they present are already damaged by illness or disability
- that the fear of litigation inhibits proper clinical practice, and may lead to so-called ‘defensive medicine’.

As to ‘defensive medicine’, I suspect that many patients would welcome an extra layer of caution in their care and treatment if it reduced the risk of harm, but the real issue is whether any of these arguments should serve to exempt doctors from the legal implications and consequences of harm avoidably caused by inexcusable mistakes, when no such exemption is ever considered appropriate for car drivers, electricians, bridge builders, etc.

Negligent clinical practice that is actionable and that results in the award of damages for injury caused is simply but strictly defined. It is not simply a decision or an action that turns out to have been wrong, nor is it the mere occurrence of a
bad outcome. As the Scottish Judge, Lord Clyde, put it:

‘In the realm of diagnosis and treatment there is ample scope for genuine differences of opinion, and one man is clearly not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test of negligence on the part of the doctor is whether he has been proved guilty of such failures that no doctor of ordinary skill would be guilty of if acting with ordinary care.’

That expresses the famous ‘Bolam’ principle, and despite the undoubted stresses of medical work, I suggest that it is a step too far to contend that such mistakes, if made with harm resulting, should be glossed over, shielded from public examination, or in some way treated as an exception to the normal rule that we are all personally accountable for our own careless actions.

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SYSTEM FAILURE

It is necessary to deal here with the issue of ‘system failure’, a description that might reasonably be applied to what happened so harmfully in Mid Staffordshire, and which is quite often invoked in defence of individual misconduct and malpractice in the context of bad NHS treatment. In my experience, such claims often have more than a grain of truth, in particular at a time when underfunding, understaffing, excessive political interference and general demoralisation appear widely to afflict the NHS and those who work in it. Again, however, it seems to me that the process of civil litigation is the best means of exposing system failure where it occurs, of highlighting the importance of avoiding and where necessary correcting it, and of holding those responsible for the system to account in a way that is both public and conducive to remedial action.

Every system, however bad, and however it defines and constrains the way individuals carry out their work within it, is the product of human minds and human actions. The rotas are devised and imposed by someone. The equipping of the units, the protocols that govern the way work shall be done, the provision of staffing, the hierarchy of direction and management, and the way authority is exercised, are all the product of individuals charged with arranging and devising the system, and for all of this those individuals ought to be held responsible. When system failures have occurred, the process of civil litigation serves both to exonerate those whose actions are ultimately caused by a bad system over which they had no control, and also (and crucially) to apportion responsibility for such failure if it can be identified – with the important advantages I have described above.

Let me give you an example of system failure from a case in which I was recently involved, the facts of which are public knowledge, as it ended up with a settlement hearing in open court (Box 1).

It was clear that, with appropriate care, this man’s life would have been saved, and that with appropriate treatment he could have been restored to mental health and able to resume normal family life and his distinguished career.

Yes this was a system failure. There was an obviously defective system for the admission and treatment of suicidal psychiatric patients, at a hospital where system failure, or quite frankly a total lack of system, could be identified in almost
every aspect of psychiatric inpatient care. And yet it is hard to deny that most of the mistakes that occurred were the direct and avoidable result of bad individual decision making of a kind that deserved public exposure and criticism, and that rightly led to the award to the widow and children of damages for the loss of their breadwinner’s support.

Yet expert witnesses enlisted by the Defendant Trust had provided reports defending every aspect of the care or lack of it from the staff. Perhaps you will agree with me that those facts, and the expert case thus made for the Defendant, cried out for trial before a judge, and for the full weight and effects of judicial findings made against the Defendant Trust, not only for the obvious system failure, but also for the obvious individual errors made by staff members for whose negligence the Trust is in law vicariously liable. The prospect of trial and its outcome did lead eventually to an acceptance of liability, and to the award of much-needed damages.

It is reasonable to suppose that it was the pursuit of this litigation, and the prospect of detailed and specific judicial findings against the Trust and individual staff members, with consequent public exposure and condemnation, and the award of damages, which led to proper compensation for the family.

I also hope and expect that the litigation and its inevitable outcome served to prompt a thorough overhaul of all systems under which similar patients will in future be managed at that hospital, not least to avoid further damages awards. Under a system of no-fault compensation, what, if anything, would ever have happened to put things right?

CONCLUSION
I end with some words from the judgment of Chief Justice Finlay in the Republic of Ireland case of Dunn v. The National Hospital in 1989, which best express the way I believe the law and the courts should approach litigation against doctors. I hope they offer some reassurance to those who argue (for understandable reasons) that such litigation should not be allowed. He said this:

‘The development of medical science and the supreme importance of that development to humanity makes it particularly undesirable and inconsistent with the common good that doctors should be obliged to carry out their professional duties under frequent threat of unsustainable legal claims. The complete dependence of patients on the skill and care of their medical attendants, and the gravity from their point of view of a failure in such care, makes it undesirable and unjustifiable to accept as a matter of law a lax or permissive standard of care for the purpose of assessing what is and what is not medical negligence. In developing the legal principles and applying them to the facts of each individual case, the courts must constantly seek to give equal regard to both these considerations.’