Chapter 7
Medical Responsibility and Liability in the United Kingdom

Peter Vanezis

Abstract The first section of the chapter offers an overview of the Medical Acts which regulate medical liability in the context of the UK's common law system, along with a description of the types of enquiries carried out and the recent trends in the number of claims made in the UK. The second section of the chapter examines the diverse judicial and extra-judicial institutions and operative roles in the UK, with emphasis on the assessment of alleged medical negligence cases by doctors and others, legal procedures, no-fault compensations and the Civil Procedure rules of 1998. The third section of the chapter describes the ascertainment methodology in living persons and cadavers, while the fourth section discusses the evaluation methodology, including the standard of care, causation—the "but-for" test and the doctrine of material contribution—and the forensic use of clinical guidelines. This chapter ends by discussing the future perspectives and probable reformations that will occur in the regulations governing the assessment of medical liability in the UK.

Contents

P. Vanezis (✉)
Forensic Medical Sciences. Department of Clinical Pharmacology, Cameron Forensic Medical Sciences, William Harvey Research Institute Barts and the London, Charterhouse Square, London EC1M 6BQ, UK
e-mail: p.vanezis@qmul.ac.uk

S. D. Ferrara et al. (eds.), *Malpractice and Medical Liability*,
DOI: 10.1007/978-3-642-35831-9_7,

7.1 Overview

7.1.1 The Medical Acts and the General Medical Council

Medical professional responsibility in the United Kingdom is principally regulated by the General Medical Council, which receives its authority from the Medical Act 1983. It also falls within the judicial system in its broadest sense, which encompasses both English and Scots Law.

The General Medical Council (GMC) was first established under the Medical Act 1858 and has been updated by Parliament on many occasions since then. The purpose of this first Act was to create the body now known as the General Medical Council (previously The General Council of Medical Education and Registration of the United Kingdom) "…so that Persons requiring Medical Aid should be enabled to distinguish qualified from unqualified Practitioners".

The Act created the position of Registrar of the GMC, still in existence today, whose duty is to keep up-to-date records of those registered to practise medicine and to make them publicly available.

In 1950 a further Medical Act introduced disciplinary boards and a right of appeal to the Council. It also introduced a compulsory year of internship for doctors after their university qualification, where doctors were only allowed to practise and prescribe drugs in NHS hospitals and under the supervision of a hospital consultant. They were temporarily registered by the GMC for that year, before moving to full registration if they successfully completed their training. Currently this internship has lengthened to 2 years known as Foundation year 1 and 2.

The Medical Act of 1983, together with a number of more recent amendments, the last being in 2010, provides the current statutory basis for the General Medical Council's functions which includes governance and responsibilities in relation to medical education and registration of doctors and also ensures that medical regulation changes reflect the changing needs of the society within which physicians

work. The Council is also bound by laws that implement a European directive on mutual recognition of professional qualifications from European Economic Area countries.

In essence therefore its role involves:

- setting the standards of *Good Medical Practice* it expects of doctors throughout their working lives;
- assuring the quality of undergraduate medical education in the UK and coordinates all stages of medical education;
- administering systems for the registration and licensing of doctors to control their entry to, and continuation in, medical practice in the UK and,
- dealing firmly and fairly with doctors whose fitness to practise is questioned.

The GMC regularly publishes guidance on all the above matters which is regularly mailed to all doctors or made available on their website.

GMC regulation also takes into account Common Law, the Data Protection Act 1998, the Human Rights Act 1998 and the Health and Social Care Act 2001 (England and Wales only).

7.1.2 The Common Law System

The judicial system in the United Kingdom has, through the common law system, developed rules which encompass the essential elements of medical professional responsibility. For those not familiar with the Common Law system, it has its source in decisions on cases made by judges. The doctrine of precedent is the main difference from codified law systems. A precedent is a legal case establishing a principle or rule that a court or other judicial body may utilize when deciding subsequent cases with similar issues or facts.

Common law developed in England and was influenced by the Norman conquest of England which introduced legal concepts from Norman law. In Scotland, Common Law developed from ancient Celtic Law. Common law was later inherited by the Commonwealth of Nations, and almost every former colony of the British Empire has adopted it.

Alongside this system of Law, there is a legislature that passes new laws and statutes. The relationships between statutes and judicial decisions can be complex.

7.1.3 Type of Enquiries

Within the judicial system in both English and Scots Law, cases involving professional medical responsibility are usually subject to a number of different enquiries or hearings, depending on the nature of the case in question.

A doctor may breach professional medical responsibility in relation to confidentiality issues, performance, incompetence and so on. In such circumstances redress is usually sought by the complainant through the civil courts and also come to the attention, directly or indirectly, of the GMC.

The GMC will also examine the issues involved and so the doctor may well be subjected to its disciplinary proceedings at some stage.

If a doctor has failed in his/her professional responsibility through commission or omission to the extent that the authorities feel that he may have committed a criminal act, then it is possible that he/she may be prosecuted and tried in a criminal court.

The coroner system of death investigation is another type of judicial process which examines why a person has died although it cannot apportion blame to any particular party. Such a hearing can, nevertheless, assess issues in relation to causation and whether medical malpractice may have been involved.

7.1.4 Recent Trends in the Number of Claims Made

The figures here are sourced from the latest National Health Service Litigation Report and Accounts published in (2010).

Over the 4 years up to and including 2009, the number of clinical negligence claims has risen by 8.7 % from 5,602 in 2005 to 6,038 in 2009. However, claims rose by 12.2 % between 2007 and 2009.

Payments made by the NHSLA in 2009 for damages for clinical negligence claimant and legal costs rose to £769.2 m, a 21 % increase on the 2008 amount of £633.3 m.

The highest numbers of clinical negligence claims are made for the specialties of surgery, obstetrics and gynaecology and for medicine. Damages for obstetrics and gynaecology claims account for more than any other specialty, more than £3.3 billion since the clinical negligence scheme for trusts (CNST) began in 1995.

7.2 Judicial and Extra-Judicial Institutions and Operative Roles

A doctor' professional responsibility may come into question in a number of ways and there are different courses of action which may be taken, some of which may overlap. There may be a situation where both a judicial and extrajudicial course of action is appropriate.

A doctor is required to set an example to the rest of society as a model of a caring, compassionate individual with special skills acquired through training, which allow him/her to deliver a high standard of care to patients. However, this

altruistic view—where doctors are placed on a pedestal—is unrealistic and it is not surprising that most doctors do not meet such high expectations.

It goes without saying that both the GMC and the judicial system will take into account in their deliberations and judgements, whether the issues in question are based on real expectations of a doctor's professional responsibility rather than a standard which can only be achieved by very few in the profession if by anyone.

If there is a case of alleged malpractice where the standard of care has fallen below that which is acceptable and the expected outcome for the patient has not been achieved, the doctor may be the subject of a complaint by the patient or an interested party such as a close member of their family and may be pursued through civil litigation in the High Court (Court of Justiciary in Scotland).

Once there has been settlement of the civil case the doctor may then be subject to examination by the GMC. The doctor is reported to the GMC and after the investigation he/she may be the subject of a hearing where he/she will either be exonerated or disciplined in some way. The most extreme punishment is erasure form the medical register which therefore does not allow them to practise, although the doctor can appeal against this decision.

Before the GMC can stop or limit a doctor's right to practise medicine, it needs evidence of impaired fitness to practise. This might be, for example, because they:

- have not kept their medical knowledge and skills up to date and are not competent;
- have taken advantage of their role as a doctor or have done something wrong;
- are too ill, or have not adequately managed a health problem, to work safely.

A warning can also be issued to a doctor where the doctor's fitness to practise is not impaired but there has been a significant departure from the principles set out in the GMC's guidance for doctors, *Good Medical Practice*. A warning will be disclosed to a doctor's employer and to any other enquirer during a 5 year period. A warning will not be appropriate where the concerns relate exclusively to a doctor's physical or mental health.

After a complaint is received about a doctor and preliminary enquiries have been carried out, the GMC decides whether to refer the doctor to a *Fitness to Practise Panel*. The GMC will consider both the seriousness of the allegations and the likelihood of being able to prove the case at a hearing. If the case examiners or the Investigation Committee are satisfied that there is a realistic prospect of establishing that the doctor's fitness to practise is impaired, the doctor will appear before a *Fitness to Practise Panel*. Sometimes, if the GMC believes it is necessary, the doctor will be asked to appear before an *Interim Orders Panel*, which has the power to suspend or impose conditions on the doctor's registration while questions about the doctor's fitness to practise are resolved.

The decisions in the adjudication process are made by medical and lay panelists appointed to sit on *Interim Orders Panels* and *Fitness to Practise Panels*. The panelists are independent, but are required to take account of the Council's policy and guidance.

Interim Orders Panels consider whether a doctor's registration should be restricted, either by suspension or by imposing conditions on their registration, while questions about the doctor's fitness to practise are resolved. This ensures that action can be taken to protect patients while enquiries are carried out into the doctor's fitness to practise. This Panel meets in private, unless the doctor requests a public hearing.

Fitness to Practise Panels hear evidence and decide whether a doctor's fitness to practise is impaired. These hearings are the final stage of the GMC procedures. If the Panel concludes that a doctor's fitness to practise is impaired it may:

- take no action;
- accept undertakings offered by the doctor provided the panel is satisfied that such undertakings protect patients and the wider public interest;
- place conditions on the doctor's registration;
- suspend the doctor's registration;
- erase the doctor's name from the Medical Register, so that they can no longer practise;
- if a panel concludes that the doctor's fitness to practise is not impaired, it may issue a warning to the doctor.

Fitness to Practise Panels meet in public, except when considering evidence relating to a doctor's health.

7.2.1 Doctors and Others Undertaking Assessment of Alleged Medical Negligence Cases

Those undertaking such assessments fall into a number of categories in the United Kingdom and will depend on the nature of the medical error and in particular in which aspect of healthcare and specialism it occurs.

If the patient is living, then the assessment would normally be made by a health care professional within the relevant specialty. For example if a mistake has been made in Obstetrics and Gynaecology then a specialist from that specialty will be used. It goes without saying that the specialist must have no conflict of interest in the case i.e., not work within the same health care facility or region (depending on circumstances), not be well acquainted with the doctor in question or the patient. In small fields of practice it is sometimes difficult to be entirely unfamiliar with the doctor being assessed and occasionally where necessary, a recognised specialist from abroad is employed. The engagement of the specialists to make such an assessment will be through advocates, acting on behalf of either the plaintiff or the claimant. In the case of the plaintiff, it could well be solicitors acting for the NHS or through the medical insurance societies. For the claimant, it is through solicitors and there are many firms which specialise in medical negligence claims.

Where death has occurred, then the initial assessment will be made by the pathologist carrying out the autopsy, usually a forensic pathologist, and could also be an anatomical pathologist. There would also, depending on the complexity of the case, be further assessment as in the living patient, by healthcare specialists within the relevant area of specialism concerned. Cases will be dealt with in terms of representation as above and additionally, the case will be subject to an independent Coroner's enquiry in the form of an inquest. In such hearings no direct blame will be attached to any individual, although the evidence from such a hearing may well be used in civil proceedings at a later stage.

In the initial stages of any possible action, other health professionals are also used either directly or indirectly as advisors working in medical insurance agencies. Their role is both to act as first point of contact and discuss the concerns of the health professional and to advise on what course of action should be taken, as well as arrange representation by solicitors in civil and criminal court hearings as well as coroners courts and other hearings such as the GMC and tribunals.

The GMC, in relation to its various hearings, employs both specialist and non-specialist doctors and other health professionals and lay panelists to adjudicate. All panelists undergo regular training by the GMC to assess their suitability for such work and to ensure that they are up to date with procedures.

7.2.2 The Judicial System Procedures

One of the most commonly used definitions of *negligence* is that it is a failure to act with the prudence that a reasonable person would exercise under the same circumstances. In order to claim damages it is necessary to also show that the negligent person owed a duty of care to the injured person and that the injury was directly attributed to the lack of care. These general rules have been considerably modified in regards to claims for clinical damages where it is necessary to show that there has been a failure by the doctor to treat and care for a patient with a reasonable degree of skill and care.

The duty of care in a clinical context is usually not a difficult problem for a lawyer. Doctors almost always owe their patient or somebody that they are looking after a duty of care. If a doctor is careless or lacked necessary skills then there may a liability for them or their employer or insurer to pay compensation if someone is injured as a result of their unacceptable behaviour.

One of the most difficult questions in medical negligence law is how to judge a doctor's *competence* and whether or not it has fallen to an unacceptable level which has caused injury to a patient. The case of Bolam v Friern Hospital Management Committee (1957) attempted to resolve these issues by measuring the standard of a doctor's care against that of other doctors. If a significant number of other doctors would have acted in the same way when faced with the same circumstances then a doctor will not be found to be negligent.

The definition in Bolam v Friern Hospital Management Committee (1957) (the Bolam Test) did however, cause some consternation and was slightly modified by the case of "Bolitho-v-City and Hackney Health Authority (1997)" where it was held that even if a method of treatment was supported by a body of the medical profession that method of treatment must still stand up to logical analysis if it was to be used as part of the defence.

The final element in UK medical negligence law for a successful claim for compensation requires the claimant to *prove that he has suffered injury* as a result of the inadequate care. This can be a difficult proposition as the claimant was probably ill prior to the commencement of the treatment and expert medical advice must be produced to show that the claimant would have been in a better position had an alternative treatment been used.

The Limitation Act applies to these cases and in general terms a claim for compensation for personal injury must be settled or legal proceedings must have been issued in a court of law within 3 years of the event causing the injury. Failure to comply with this rule may mean that the opportunity to claim compensation may have been lost forever. The Limitation Act does provide certain exceptions to this rule as follows:

- the time does not start running until the age of 18 years;
- the limitation period does run until the injury was first discovered;
- mental incapacity of a potential claimant may mean that the time period never starts to run;
- judges have a rarely exercised discretion to override the time limits.

7.2.3 No-Fault Compensation

In the current tort system, liability for clinical negligence remains fault-based, despite several attempts at reform (Maclean 1988). It would be a radical change to a transition to an administrative or no-fault system for compensating medical injuries. A central tenet of such a proposal is that the system should make compensation decisions, and clinical guidelines that might bear on issues of causation or avoidability, would be likely to play a pivotal role. A no-fault system in specific defined circumstances was proposed by the consultation document *Making Amends* (Department of Health 2003) but subsequently rejected by the Chief Medical Officer Sir Liam Donaldson, because of the potential rise in claims that would be far higher than under the present system. To be affordable, compensation would need to be set at substantially lower levels.

7.2.4 Civil Procedure Rules 1998

The Civil Procedure Rules 1998 (CPR) have radically transformed the rules of court that govern clinical negligence actions and practice directions orchestrate clinical negligence claims and preaction protocols. The overriding objective of the CPR is the early, efficient and cost-effective resolution of claims (Foster 1998). The rules require the use of alternative methods to resolve disputes as a key component in keeping with the overriding objective. Experts from both sides are encouraged to confer and determine what areas can be agreed and whether there are any outstanding points at issue and how they can be resolved out of court.

7.3 Ascertainment Methodology

7.3.1 Living and Deceased Persons

The procedure for initiating claims for medical negligence is initiated by the person who feels that they have a claim, by consultation with a lawyer who specialises in medical malpractice. The advocate would initially advise the potential claimant as to whether or not in the first instance they may have a case to proceed to claim for compensation.

A substantial number of medical negligence claims that are assessed are complex and require quite extensive evaluation. A lawyer will in the first instance ascertain the nature of the complaint and then follow that up by seeking advice from an expert in the relevant clinical area. It would not be unusual where a complaint has been made against a hospital in relation to care of a patient, that there may be a several different health professionals involved and encompassing a number of different specialties. For example, a typical situation may be the case of an elderly person in a nursing home who is difficult to manage, has Alzheimer's disease, is immobile and develops pressure sores then dies of sepsis related to the sores. In such circumstances a number of healthcare workers, doctors, nurses and other staff may be accused of not caring adequately for such a patient by allowing sores to develop and not treating them appropriately.

The medical notes in the first instance will be sought and carefully examined to assess the adequacy of their documentation and the standard and type of care received, conclusions drawn from the history and clinical examination by the clinicians and other health staff. Medical records in themselves, not infrequently, present the assessor with a mass of detail, which is frequently long written in hand rather than typed with many entries being hardly legible. Furthermore, it is difficult to assess whether additions or corrections have been made to original entries without further expert examination.

Assessment reports will be requested from relevant experts employed by the claimant's lawyers and would include for example experienced consultant

physicians, radiologists and other health care specialists. The role of these specialists will be to evaluate the adequacy of the treatment the patient has had and whether or not the medical staff against which the complaint is being made, have acted reasonably and appropriately in the circumstances of the case.

A clinical examination in addition to examination of clinical records, by relevant medical experts representing both the claimant (plaintiff) and the defendant(s) may be necessary to assess the degree of harm that the plaintiff may have suffered.

When action is contemplated, the medical staff against which the complaint is made (defendant(s)) will be represented by their Hospital Authority Indemnity arrangements or by other Medical Indemnity providers such as the Medical Defence Union (or Medical Defence Union of Scotland) or the Medical Protection Society. The lawyers representing the defendants will engage their own equivalent experts to the plaintiff's.

In relation to deceased persons, such cases are reported to Her Majesty's Coroner who will then order a post-mortem examination of the body. This examination will be carried out by a pathologist who is experienced in carrying out coroner autopsies. The pathologist is obliged to be fully briefed of the circumstances surrounding the death and the concerns that the family may have. As with the living patient, all medical records should be made available, and wherever possible, relevant clinical staff, such as the physician who treated the patient should make themselves available to attend the autopsy or at least communicate with the pathologist to explain relevant aspects of the patient's treatment. On some occasions, the family of the deceased will request their own pathologist to be present at the autopsy and produce a report for them, independent to the report prepared for the coroner.

In such autopsies it is common practice to retain relevant samples from the body for further examination including for histology, microbiology and toxicology. In addition, further specialist examination may be required for example neuropathology or examination of the heart by a cardiac pathologist. Other categories of death whether or not a complaint has been made are best referred for further specialist opinion. These will include maternal and neonatal deaths.

7.4 Evaluation Methodology

7.4.1 Standard of Care, Causation and the Development of Clinical Guidelines

In evaluating a case where the adequacy of health care professionals is brought into question, the central issue will be what is the standard of care expected of the professional? In the United Kingdom, the standard of care expected of the medical profession and other health care professionals in relation to medical errors was defined by the Bolam test referred to above and restated here. The standard of care

in a negligence suit was defined in Bolam v Friern Hospital Management Committee (1957) as *the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is…sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art*, and was the standard by which medical negligence cases were judged. However, recently, the Bolitho case has resulted in a shift away from Bolam, with significant effects for all future negligence suits.

Negligence is concerned with compensating those who have suffered some kind of damage as a result of the actions or inactions of others. It is therefore part of tort law, except in exceptional circumstances where gross negligence is said to have occurred, in which case a criminal offence charge may also be available. DrAdomako was an anaesthetist in charge of a patient during an eye operation. During the operation an oxygen pipe became disconnected and the patient died. He failed to notice or respond to obvious signs of disconnection. The jury convicted him of gross negligence manslaughter. At his trial in 1990 the judge stated *you should only convict a doctor of causing death by negligence if you think he did something which no reasonably skilled doctor should have done*. In 1994 the Court of Appeal dismissed his appeal (Adomako 1994; Dyer 1994).

Three essential components need to be proven in a successful negligence claim:

- a duty of care existed between defendant and claimant;
- there was a breach in this duty of care by the defendant;
- this breach caused, or at least materially contributed to, the damages incurred to the claimant on a balance of probabilities.

7.4.2 Causation

Causation is an essential component to show of that there is a breach in the duty of care to cause negligent outcome. The test by which causation is determined is a question of law. There are traditionally two tests: the "but for" test and the doctrine of material contribution.

7.4.2.1 The "but for" Test

According to the "but for" test, but for the negligence of the defendant the claimant would not have suffered the injury. There are two limbs to the "but for" test: a question of historical fact—what actually did happen; and a question of hypothetical fact—what would have happened if the defendant had not been negligent. The negligence is a causative if there is a material difference in the two outcomes.

Consider the following example. A night watchman attended casualty one morning with a history of vomiting. The duty nurse summoned the doctor by

telephone but he refused to attend. The man left casualty but died a few hours later. It was found that the death was due to arsenical poisoning. There was no reasonable prospect of an effective antidote being delivered before death. The doctor was found to be negligent, but the man's death was inevitable and would have occurred even if he had received appropriate treatment. The claim failed because the claimant had failed to establish causation between his death and the doctor's negligence for not attending to him [see Barnet v Chelsea and Kensington Hospital Management Committee (1969) QB 428]. The question of causation in medical negligence can sometimes be difficult–one is considering the effect of a medical intervention on an underlying disease process which may be changing itself. The alleged injuries may be indistinguishable from the underlying condition. There may be several concurrent or consecutive agents contributing to the patient's condition of which only one is the defendant's alleged negligence.

7.4.2.2 The Doctrine of Material Contribution

There may be several factors responsible for an injury, including the defendant's fault; the injury may have occurred without the defendant's fault, and the defendant's fault by itself might not have been sufficient to cause injury. Where a breach of duty has caused or materially contributed to the injury complained of, the tortious factor may be considered the cause of the injury [see Bonnington Castings v Wardlaw (1956) AC 613; McGhee c National Coal Board (1972) 3 All ER 1008]. This test of causation provides some relaxation of the logical rigour imposed by the "but for" test. The doctrine of material contribution has evolved from cases involving negligent exposure to noxious agents such as industrial dusts. The courts have applied this test in situations involving discrete clinical events [see Bailey v Ministry of Defence and Portsmouth Hospitals NHS Trust (2008) EWCA Civ 883].

In the past UK courts approached the issue of medical negligence with an exaggerated level of deference to expert medical opinion. They did not want to choose between conflicting opinions, finding in the vast majority of cases for the defendant so long as he could show others in his position would have acted similarly. *Bolitho* reminded judges that the courts reserve the right to decide that even accepted medical practice may be negligent, and allowed them to scrutinize what constituted 'reasonable' in the *Bolam* test. There are significant indications that *Bolitho* is being applied, and the Human Rights Act 1998 will enforce an even higher standard than either *Bolam* or *Bolitho,* that of best or expected practice.

The development of *clinical guidelines*, by the *National Institute for Health and Clinical Excellence* (NICE) among others, will only serve to promote this higher standard being applied, as courts will rely less on expert testimony and more on these guidelines of best or expected practice to judge allegedly negligent doctors against (Samanta et al. 2003). Guidelines are consensus statements developed to assist clinicians in making decisions about treatment for specific conditions. They are systematically developed on the basis of evidence base practice (Hurwitz 2004), and aim to promote effectiveness and efficiency of healthcare delivery.

It has been argued that evidence-based practice could be used to develop a framework that ensures consistent access to services and quality of care across the country, an approach espoused by the Department of Health.

To promote the development and use of guidelines, the government created the National Institute for Health and Clinical Excellence (NICE). The Healthcare Commission (HC), The Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission ceased to exist on 31 March 2009 and their functions were taken over by the Care Quality Commission.

The Care Quality Commission, the new health and social care regulator for England was also created as part of this government agenda for quality and has a duty to monitor the implementation of clinical guidelines. Some, however, believe that guidelines might fetter clinical discretion and autonomy and define too inflexible or unrealistic standards for clinical practice (Black 1998). Discretion lies at the heart of clinical judgment and has to take into account a number of competing influences relevant to individual patient circumstances and clinical care. It has been argued, therefore, that guidelines should not constitute a legal standard that is applied rigidly in every case. The precise role of guidelines in determining the legal standard of care is uncertain and there appears to be no empirical data on their actual or perceived use in medical litigation in the UK.

The GMC and Royal Colleges have concurred that good practice should be measured against established guidelines and have stressed the importance of robust mechanisms to identify and maintain high standards in medical care. The GMC has emphasised that in order to promote the required standards of professional practice, there must be effective quality assurance and clear professional accountability. To ensure good practice, doctors must remain responsible for their own performance and conduct and should share responsibility for the quality of care provided by their team.

The findings of the Bristol Inquiry (2001), involving the management of children receiving heart surgery, shook public confidence and called into question standards within the NHS. The fifth report of the Shipman Inquiry (2004) (this inquiry investigated the activities of the general practitioner and serial killer Harold Shipman) highlighted that it is not sufficient for guidance to be implicit in the context and circumstances of clinical practice. The lack of explicit standards may result in inconsistent and widely varying decisions, as well as tragic consequences for patients and their families.

The NHS Reform and Healthcare Professions Act 2002 introduced a further layer of regulatory control over healthcare quality. This Act established the Council for the Regulation of Healthcare Professionals (now known as the Council for Healthcare Regulatory Excellence), a body that represents patients and the public in circumstances in which a professional regulatory body is perceived to have been overly lenient in the exercise of its regulatory functions. In the context of professional regulation, established guidelines might help define the expected standard of practice as well as raising the expectation of the community that good practice hinges on following established guidelines were clinically appropriate.

7.5 The Future

The NHS Redress Bill, which received royal assent in November 2006, created powers to set up a an NHS Redress Scheme to provide swift resolution to claims without the need to go to court; it would largely eradicate the need for lawyers for claims under £20,000, saving an estimated £7.6 million in legal costs in the first year (Hughes 2009). Secondary aims include establishment of a more open and fair culture in the NHS to ensure that lessons are learned from mistakes. Its origins come from the Chief Medical Officer's report, "Making Amends", released in 2003. However, the bill has been unworkable in England to date. While the Welsh and Scottish governments are speeding up plans to set up something similar to the Redress Scheme—Wales by next year and Scotland (date uncertain) probably going a step further with a no-fault compensation scheme similar to that in New Zealand—it appears that the Department of Health has not yet produced the necessary secondary legislation to make the reformation.

Many groups—including some NGOs and the august distinguished Parliamentary Health Select Committee—are concerned, disappointed even, criticising the Department of Health for dragging its heels over implementing the scheme. One charity, Action against Medical Accidents (AvMA) is especially critical of these delays. The Patient's Association, an organisation that advocates passionately on a range of issues for the public and has done successfully for many years, has consistently argued for better openness and transparency on matters of quality and safety The patient's association (2011).

References

Action against medical accidents. www.avma.org.uk. Accessed May 2011
Black D (1998) The limitations of evidence. J R Coll Phys Lond 32:23
Council for healthcare regulatory excellence. www.chre.org.uk. Accessed May 2011
Department of Health (2003) Making amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS. DoH, London
Dyer C (1994) Anaesthetist loses final appeal. BMJ 309:78
Foster C (1998) Civil procedure, trial issues and guidelines' in guidelines: law, policy and practice, vol 12. Foster and Tingle, London, pp 111–120
General medical council at www.gmc-uk.org. Accessed May 2011
Hughes G (2009) Litigation, redress and making amends. Emerg Med J 26:844
Hurwitz B (2004) How does evidence based guidance influence determinations of medical negligence? BMJ 329:1024
Maclean S (1988) No fault liability in medical responsibility. In: Freeman M (ed) Medicine, ethics and the law. Williams S Heinne & Co, Littleton, Colorado, USA
National institute for health and clinical excellence. www.nice.org.uk. Accessed May 2011
Samanta A, Samanta J, Gunn M (2003) Legal considerations of guidelines: will NICE make a difference? J R Coll Phys Lond 96(3):133–138
Smith DM (2004) The Shipman inquiry fifth report: safeguarding patients: lessons from the past–proposals for the future. In: Command paper Cm 6394, 9 Dec 2004

The Bristol Royal Infirmary Inquiry (2001) The inquiry into the management of care of children receiving complex heart surgery at the Bristol Royal Infirmary. Bristol Royal Infirmary, Crown Copyright, Bristol, UK
The care quality commission. www.cqc.org.uk. Accessed May 2011
The National Health Service Litigation Authority (2010). Report and Accounts, TSO, London
The patient's association. www.patients-association.com. Accessed May 2011

Cases Cited

Bailey v Ministry of Defence and Portsmouth Hospitals NHS Trust (2008) EWCA Civ 883
Barnet v Chelsea and Kensington Hospital Management Committee (1969) QB 428
Bolam v. Friern Hospital Management Committee (1957) 1 WLR 582
Bolitho v. City and Hackney Health Authority (1997) 4 All ER 771
Bonnington Castings v Wardlaw (1956) AC 613
McGhee c (1972) National Coal Board 3 All ER 1008
R v Adomako (1994) 3 WLR 288