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Research Note for the Health and Community Care Committee

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THE MACFARLANE TRUST & NO-FAULT COMPENSATION

This Note sets out the particulars of the Macfarlane Trust for those infected with HIV from contaminated blood. It also sets out the particulars of no-fault systems of compensation for medical errors in New Zealand, Sweden and Finland, and considers initiatives past and present in the United Kingdom.

THE MACFARLANE TRUST

The Trust compensates those infected with HIV from blood products. In evidence given to the Health and Community Care Committee, petitioners put it forward as a model and precedent on which to base a system of compensation for those infected with Hepatitis C by a similar method. Therefore, this note is supplementary to SPICe notes RN01-47, RN00/109, RN 00/99 and RN00/85. All are on the topic of contracting Hepatitis C following Blood transfusion through the National Health Service and pursuant to Petitions PE185 and PE45 on the same topic.

The Trust was set up in 1988 following lobbying by the Haemophilia Society and a decision by the United Kingdom government in 1987 to establish a *Hardship Fund* to assist haemophiliacs who contracted HIV following treatment with blood products on the National Health Service. It is governed by ten trustees, six appointed by the Haemophilia Society and four appointed by the Secretary of State for Scotland.

The Government initially made available £10m, to be administered through the Macfarlane Trust. The Haemophilia Society was dissatisfied with this measure and continued their campaign. The Government response in 1990 was to offer all

those infected in this way an *ex gratia* payment of £20,000. While partners of infected haemophiliacs, who may have contracted HIV by means other than blood transfusion, were excluded, the families of deceased patients did receive payments. On the basis of an undertaking to exclude the government from liability, the Government made total payments to the tune of more than £24m.

In the following year, an out of court settlement was agreed between the Major Government and the Haemophilia Society, to provide further compensation to both litigants and non-litigants, on condition that claimants agreed not to pursue litigation on the basis of contaminated blood products. The scheme made one-off payments ranging from 21,500 to £60,500, depending on factors such as marital status and dependants. This is set out as follows:[1]

In respect of an infant: £1,500
In respect of a single adult: £23,500
In respect of a person married and childless: £32,500
In respect of a haemophiliac with children: £60,500
In respect of a person who is an intimate, unmarried and under 18: £21,500

To qualify for payments, the Trust had to be satisfied that a claimant has been tested positive for HIV in their first HIV test after 13th December 1990, and that on balance of probabilities the infection occurred before 13th December 1990. Almost £44m was paid out in this scheme (additional to the £24m mentioned above) through the MacFarlane Trust.

Between 1993 and March 2001, the Government made available to the MacFarlane Trust *further* sums of money totalling £15m. Including remaining assets, £94m has been made available to assist those infected with HIV by contaminated blood. Haemophiliacs with HIV receive on-going assistance from the Trust to contribute towards additional costs. Widows with children and incapacitated widows without children also receive payments. The Trust provides information on benefits and sends newsletters to those registered with the Trust for longer than three months.

On the one hand those receiving payments from the Trust waived their right to litigate. On the other hand, the Government was excluded from liability. So the workings of the MacFarlane Trust can be seen as a form of no-fault compensation, though restricted to HIV infection from blood administered by the NHS. This, by definition, operates in a different way from civil litigation, which is founded on the principle of fault, responsibility and liability.

NO-FAULT COMPENSATION

There are several arguments in favour of implementing a no-fault compensation system to replace civil court actions following alleged medical negligence. Any increase in rates of litigation is said to lead to the practice of so-called 'defensive medicine' - a term given to medical practises employed out of fear of litigation. For this reason, it is advantageous to patient care to minimise litigation rates. Other arguments advanced in favour of alternative forms of compensation include:

[1] According to the Trust Declaration of 3rd May 1991.

What are the argued disadvantages of civil litigation?

1. Civil law is ineffective as a deterrent, because vicarious liability means the employer is sued rather than the individual. This argument was put forward by the Woodhouse Commission in New Zealand, which set in place the system in that country.
2. The burden of proof is an obstacle for patients because it rests on establishing that a usual and reasonable practice exists, that it was not followed and no reasonable practitioner would have acted as the defender did.[a]
3. The role of expert evidence in examination, cross-examination and re-examination leads to time-consuming and complex cases.
4. Medical negligence actions are uniquely difficult because biological information is intrinsically variable and unpredictable. This is problematic in the context of behaviour assessed on the basis of standard practice (see 2. above) in the context of an inherently unpredictable situation. Split-second decisions are often the norm in medical practice, unlike other professional negligence fact scenarios.
5. Damages awards are generally high and the problem exists of compensating for future loss (disability worse than expected, problems with prognosis, calculating potential income, etc.), except where an award for provisional damages is made. A no-fault system can allow for periodic, adjustable payments.

By eliminating fault or blame from the system of compensation, it is argued that the chance of detection of medical error could improve. A no-fault system retains the element of proof of injury sustained while in the care of the hospital as well as the element of proof of a causal connection between treatment and injury. Because it is a stricter form of liability, claimants establish these elements by an administrative method. Their application is then assessed and compensation granted or denied on the basis of *patient eligibility* rather than *defender's fault*. There is therefore no defence as in the civil law system, as the process is non-adversarial.

In the United Kingdom, the Pearson Commission was set up in 1973 to consider ways of making up for the perceived shortcomings of the existing system of fault-based compensation for medical injury. The Commission reported in 1978. Recommendations led to the enactment of the Vaccine Payments Damage Act 1979. The *Pearson Report*[2] recommended 'that a no-fault scheme for medical accidents should not be introduced at present.' In addition, 'the progress of no-fault compensation for medical accidents in New Zealand and Sweden should be studied and assessed, so that the experience can be drawn upon if, because of changing circumstances, a decision is taken to introduce a no-fault scheme for medical accidents in this country.'

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a. This is called the '*Bolam* test' after *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, which followed *Hunter v Hanley* 1955 SLT 213 in Scotland. The test is used in professional negligence cases and holds that a doctor is not negligent if he acted in a way that the notional reasonable medical practitioner skilled in the same discipline as the defender, would have acted.

2 *Report of the Royal Commission on Civil Liability and Compensation for Personal Injury*, Cmnd 7054, Vol. 1 Paras 246-63.

NEW ZEALAND

History

The Woodhouse Commission considered alternative forms of compensation and was intended to promote safety through disincentive and levies on employers, the self-employed and owners of motor vehicles. It also sought to promote rehabilitation of victims and provide lump-sum compensation.

Following the Report of the Commission, the New Zealand legislature passed the Accident Compensation Act 1982, though the 'scheme' had been in effective operation since 1974. The Act is concerned with personal injury claims. Crucially, injuries falling within its scope are precluded from forming the basis of a judicial claim. The intention is to render impossible any personal injury claim - including assault, recklessness and surgical negligence, but excluding criminal injury and suicide.

Thereafter, the Accident Rehabilitation and Compensation Insurance Act 1992 was passed. According to that Act:

- Medical compensation is paid only for risks greater than 1:100 (and after medical treatment, if mishap occurs with less than 2% chance of occurrence, this is classified as 'sickness' and hence is excluded).
- There is no right to sue in court.
- Doctors contribute more money individually (which may be passed on to patients) so arguably not completely avoiding malpractice liability.
- Lump sum payments are no longer paid out.
- Work-related stress is no longer considered a personal injury.

Workings

The system in New Zealand provides compensation for personal injuries occasioned by accident. Compensation not confined to accidents within medical treatment scenarios. It is funded by taxation and exists as of right. Amounts are taken from a central and bespoke fund administered by the Accidents Compensation Commission, though there have been some difficulties in formulating a definition which can be applied in deciding which claimants are granted and which denied compensation. This is different from the system in Sweden and in Finland, which is based on insurance.

The New Zealand scheme depends on acceptance of community responsibility to protect the whole population against the consequences of personal injury. It replaced compulsory insurance schemes and uses funds collected from these earlier schemes. Unlike the system in Finland and Sweden, it is not an insurance scheme because benefits are granted *as of right* if the requisite elements are established. It is funded by taxation designed to compensate those injured accidentally in inherently risky activities, who are unable to find a person responsible or at fault. The injured patient persuades a board or tribunal that the injury occurred within the parameters of the relevant scheme.

What defines a successful claim?

A claimant must establish that he or she suffered a *personal injury by accident*.

Some possible problems of definition can be highlighted in a discussion of the case law in New Zealand. The court cases concern issues of definition and do not serve the function of compensating the victim. An example is the definition of 'accident'. If an injury constitutes an 'accident', it may found a claim under the Act. If not, the only recourse is to bring a civil suit.

Accident came to be judicially defined as an *unintended consequence of an intended action.*[3] The definition included medical, surgical, dental and first aid 'misadventure', actual bodily harm (including pregnancy) and nervous shock. It excluded disease, infection or the ageing process (because of the need to define the boundary between accident and disease).

A problem exists in the case of 'medical misadventure' because of iatrogenic[4] conditions, and causation. It is often difficult to establish that it was the treatment which led to the injury. This might be considered analogous to the contracting of Hepatitis C following blood transfusion, where the victim is *also* an intravenous drug user. Another example might be sepsis following an appendectomy. Some cases may be useful in explaining the importance of definition

When will a disease condition be excluded from the system?

Mrs Walbutton[b] suffered from a degeneration of the spine and had spent 13 years in physiotherapy. One morning, she bent down to pick up a milk bottle and put her back out. She was granted compensation under the scheme, for incapacity and absence from work for a period. The *Mrs W* case used the definition of 'accident' that was formulated in *G v Auckland Hospital Board*,[c] i.e. the action was intentional but resulted in unintended consequences for the victim.

What of unintentional actions caused by pre-existing conditions?

There must be an action which causes the injury for which compensation is sought. In *ACC v Mitchell*,[d] definition edged closer to exclusion of all disease, though also highlighted the fact that such systems do not necessarily dispense with the need for expert evidence. Mitchell suffered an apnoeic attack (involuntary cessation of breathing), which resulted in brain damage. The experts found no single cause, considering epilepsy, virus and 'metabolic disturbance' to be candidates. This meant that they could not prove that the attack was caused exclusively by a disease. The court held that there was no requirement of some external, identifiable, causal event and that the 'action' could be an 'internal event' such as an aneurysm.

[3] *G v Auckland Hospital Board* [1976] 1 NZLR 638, as approved in *Green v Matheson* [1989] 3 NZLR 564, 562.

[4] An adverse condition in a patient occurring as the result of medical treatment, especially to infections acquired by the patient during the course of treatment.

[b] [1983] NZACR 629.

[c] [1976] 1 NZLR 638.

[d] [1992] 2 NZLR 436. ACC stands for the Accident Compensation Commission, which administers claims and makes payments.

The *Mitchell* case shows the difficulty in drawing a useful distinction between accident and disease; between awarding a payment and denying it. The 1992 Act tried to narrow the definition of 'medical misadventure', such that standard negligence cases would always amount to misadventure, as would equipment malfunction. These would then be compensated under the scheme. Yet negligence law is concerned with unintentional harm occasioned by acts *or* omissions of a person owing a duty of care to the person injured.

What of the intentional acts or omissions of another person?

In litigation, use had been made of the so-called 'ordinary use of language' test, on which the court ruled in *Green v Matheson.*[e] This case is important when considering a *no-fault system as replacing scenarios usually covered by medical negligence* litigation. *Green* involved a negligent omission to treat. While the system might be favoured by the likes of Mrs W, *Green* demonstrates possible *dis*advantages.[f]

The medical practitioner involved would have been litigating to *get out of* a negligence suit. He would do this by proving that what happened to his patient was an accident and hence a court action is precluded by statute.

Matheson had sought treatment for cervical carcinoma. She alleged that in order to test the theory of one doctor that carcinoma *in situ* was not a pre-malignant disease, she was used as a guinea pig - without her informed consent - and subjected to 'unconventional treatment'. This is because proving that carcinoma *in situ* was not a pre-malignant disease, involves leaving the condition untreated to see whether it develops into cancer or not. The alleged result was the unnecessary advance of the condition and eventual cervical cancer (so *dis*proving the theory), as well as mental and physical suffering.

The court held this was an accident, being an unintended consequence of an intentional action, leading to injury on the part of the claimant. Accordingly, her only claim for compensation was under the scheme. This set up the 'general rule' that anything formerly known as medical negligence became 'medical misadventure', to be covered by the scheme.

Arguably, it might yet have been difficult to prove causation in a negligence suit: it would be difficult to say that Mrs Matheson would not have suffered cancer had she been treated for carcinoma *in situ*, because many such cases lead to cancer regardless of treatment. So it may have been difficult to succeed in a negligence action in court on the basis of the cancer. On the basis of an award for *solatium* (pain and suffering), she might have had a better chance. Success would have meant that her award would probably have been greater from a court than from the scheme.

In practical terms, an event is not an accident if the consequences could be predicted. A problem came in instances of injuries which are 'unfortunate side-effects' in which no wrong-doing or negligence is asserted.[5]

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e. [1989] 3 NZLR 564.

f. See Charlotte Paul, 'The New Zealand Cervical Cancer Study: Could it Happen Again?' (1988) 297 *British Medical Journal* 533.

What about known possible side-effects?

In *Auckland Hospital Board v ACC* the court held that an anticipated event as a result of surgery - albeit the materialising of a small known risk - constitutes 'medical misadventure' and therefore deserves compensation. The *Auckland Hospital* case concerned a claimant who fell pregnant following a laparoscopic sterilisation. The test applied by the court was 'can the complication which arises possibly be anticipated?' This test made no reference to either fault or to causation.

SWEDEN AND FINLAND

In 1987 the British Medical Association recommended a no-fault system based on that of Sweden.[6] The BMA urged the Government to set up a Commission on the matter. It is also worth bearing in mind that many people in Sweden carry 'litigation insurance' as part of household insurance (which covers enough for a High Court Action in that country). The systems in Sweden and Finland are broadly similar, with a few minor differences. For this reason, discussion will centre on the Swedish system, before turning to the differences shown in the Finnish system.

Sweden

While the system in New Zealand is comprehensive, the Swedish system applies only to injuries sustained in the medical care environment. It has been in place since January 1, 1975, though conditions may be revised from time to time. It came into being following discussions among politicians, medical professionals and insurers in order to indemnify so-called 'therapeutic injuries'.

Being based on employers' no-fault compensation principles, there is no dedicated legislation. Instead, the system exists by common agreement among parties. Though it was set up to provide more objective grounds of compensation than those provided by civil law, claimants retain the right to claim in the courts. In principle, civil damages will be paid only if the victim can prove negligence or intent on the part of the person causing injury.

The financial structure of the system is based on insurance, which is compulsory for health care providers. County Councils (who bear most of the cost of health care insurance) made a public pledge to accept liability for and to compensate certain injuries in connection with health or medical treatment. The scheme was not designed to compensate for general misfortune and / or accident *per se*; nor for sickness or disability benefit. These are covered by other legislation. Under the Swedish system, liability is borne by the health care providers, who will have paid premiums to a consortium of insurers. Premiums correspond to actual

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[5] For example, in the negligent omission to give information on that side effect.

[f.] [1980] 2 NZLR 748.

[6] In their 1991 study *Compensation for Adverse Consequences of Medical Accident*

indemnity and administrative costs, because awards reflect civil awards. From the literature it appears that the system is cost-effective.

Where does the money come from?

- contributions from County Councils
- a nominal surcharge for visits to GPs
- premiums paid by doctors and dentists

Compensation levels are such that earnings are compensated up to 90% and all medical care is covered, though this is usually covered by the state anyway. Compensation is also paid for pain and suffering. There are upper limits on payments, which are updated from time to time.

The procedure followed dispenses with the need for a lawyer and involves filling in a form. Claims can be brought up to three years from injury becoming apparent. It is then sent to a medical assessor at the insurance company. The claim is decided on the basis of notes and medical reports unless more information is needed on medical condition or prognosis. A report is sent to the patient. If compensation is denied, the patient is advised of their right of appeal, at which they may be legally represented. The appeal panel meets 12 times annually. Cases may go to arbitration by a judge of the Swedish Court of Appeal, whose decision is final.

Because of the way in which it is set up, insurers have a *duty* to indemnify, which gives claimants a *right* to compensation. The scope of that duty is such as to provide compensation commensurate with civil damages for injury suffered during treatment and to provide lump sums for disability or disfigurement.

In Sweden, the circumstances must be in some way related to the civil law system. The injury must be the result of a decision, act or omission on the part of someone engaged in health or medical care. As with any system of compensation, there is the need for a principle which forms the basis of a precise delineation, *and* which is not unduly narrow in its construction. If the injury was unavoidable, it is not reasonable to expect compensation. If it was preventable, on the other hand, it is reasonable to provide indemnity. However, there is a *caveat* to this rule: it does not apply in circumstances in which the risk taken was medically indicated because of the threat of death or disability.

What defines a successful claim?

The system was set up to compensate injuries *unexpected by the patient and unforeseeable or impossible for physicians to avoid*.

What limitations are applied to compensation for medical accidents?

The no-fault system applies only to injuries not already covered by other forms of insurance, either from the state or held personally. Payments are subject to the exhaustion of all other avenues, claim sources, policies or entitlements (such as third party motor insurance, workers' compensation, national health treatment, private medical insurance, etc.).

There is no absolute right to compensation as there is in New Zealand. Unlike in civil law, nothing is paid for minor injuries. Injuries worthy of compensation must result in a permanent disability or disfigurement of significance, or sick leave of a particular length of time. The underlying philosophy is to draw a clear distinction between injuries worthy of compensation and those which are not, and to do so on a basis *other* than finding the medical practitioner at fault.

What factors influence the making of payments?

Although qualitative rather than quantitative, decisions are influenced through certain questions (answered with hindsight):

1. Was a better or less risky treatment available, which should have been chosen?
2. Was injury caused by treatment later shown to have been unnecessary?
3. Would it have been hypothetically possible to avoid the injury by performing t treatment differently?

The principle of 'forseeability' inherent in the civil law has been eliminated from the Swedish system. In the same way, to argue that the equipment or technique used was State of the Art, is no defence - as it is in products liability under the Consumer Protection Act 1987 in Britain, which was used in the case of *A and Others v the National Blood Authority and Others*.[7] Viewed through the eyes of the Swedish system, for compensation to be paid, the 'fault' (failure to screen the blood) need not have been negligent, while the 'state of the art' (that the defenders used the latest available blood fractionation technology) is no defence. No importance is attached to questions of incompetence or to insufficient information, as long as the intervention was medically indicated.

This is interesting from a United Kingdom point of view in the light of the *Bristol Royal Infirmary Inquiry Report*,[8] which recommended that doctors ought to be immune from disciplinary action if they report promptly any mistakes which could have harmed patients. In general, there is evidence of action in health care provision to end a culture of blame. This is one of the aims of no-fault compensation systems.

However, the Swedish system is still not without the some of the difficulties encountered anywhere in the world, regardless of the compensation system in place. An example is iatrogenic injury in which it may be impossible to tell whether an infection was caused by the patients' own bacteria or by hospital bacteria, which even the strictest hygiene may be unable to prevent.

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[7] See RN01-47 Hepatitis C Litigation in England
http://www.scottish.parliament.uk/whats_happening/research/pdf_res_notes/rn01-47.pdf

[8] http://www.bristol-inquiry.org.uk/final_report/index.htm

For these reasons, a policy is needed to make the scheme more comprehensive and to compensate some unavoidable complications arising from medically indicated treatments, while not indemnifying *every* treatment or infection. A Schedule was therefore drawn up which set out those circumstances under which compensation is *not* to be paid. All other circumstances are covered, if they fit within the criteria already mentioned and the provisions of the scheme.

In which specific circumstances is compensation *not* paid?

- cosmetic surgery for reasons of vanity (though the right to sue remains)
- emergency or life-saving treatment, unless negligently performed: the more serious the condition the more serious the level of acceptable risk
- psychological injury which is not organically based (because, under Swedish law, this is a response to the natural condition rather than to the treatment), but neuroses and nerve damage may be compensated
- Risks assumed by the patient to prevent death or disability
- Where the treatment was reasonable in the circumstances (because medical care cannot guarantee its results)
- Pharmaceutical injuries, which are covered by other collective insurance arrangements taken out by manufacturers and importers (unless hospital staff administered them improperly).

The same principles are applied to diagnostic procedures, though other difficulties may be encountered. For example, injury sustained while performing an angiogram,[9] is often unavoidable due to the need for accurate diagnosis.

What types of injury *are* covered?

Four groups of injury are covered:

(i) Genuine treatment injuries arising in connection with interventions will be indemnified if it would have been medically possible to conduct the treatment in another, medically indicated, way.

(ii) Diagnostic Injuries: if a correct diagnosis should have been made, compensation is payable for lack of or delay in correct diagnosis. Incorrect lab results are compensated, as is (formerly) negligent interpretation of results.

(iii) Accidental Injuries are covered on the ground that a sick person is more susceptible and requires a greater degree of care. The injury must be related to the equipment and / or the premises used for health care and not due (directly) to the basic illness.

(iv) Injury arising from infection. This is effectively a 'complication insurance' where the principle is that no compensation is paid if the patient's own bacteria is causal. If it is equally likely that infection is from treatment, then compensation is payable. For example, unless the procedure is incorrectly performed, no compensation is paid for infection after operating on an abscess or a ruptured appendix, or for surgery on colon or lungs, where the probability of infection is high. At this point, the system fails to completely escape negligence principles.

[9] An x-ray of blood vessels, which can be seen because of an injection of a dye that shows up in the x-ray pictures.

Finland

The Finnish system dates from 1987. Like Sweden, Finland has a strong system of social security, in which 93% of medical care is provided by the state. As in Sweden, there is a preference for insurance schemes for personal injury.

What makes Finland different to Sweden?

1. It exists by virtue of statute: the Patient Injury Act 1987
2. There is no upper limit
3. Three categories of injury are Compensated:
   - (i) Injury that probably arose as a consequence of examination, treatment or any similar action, or neglect of the same.
   - (ii) Injury caused by infection or inflammation, probably originating in the circumstances connected with examination, treatment or similar action, or
   - (iii) Injury caused by an accident

Again, compensation is assessed in accordance with the tort damages acts. It is not paid for minor injuries (i.e. up to a set time off work). Contributions are received into a fund from health care companies relative to their market share, from the public sector and from practitioners.

Which injuries do *not* qualify for compensation?

1. those caused by a shortage of resources (though compensation will be paid for mental and psychological disturbance)
2. correct treatment which fails to achieve the desired result
3. iatrogenic injuries, or those caused by necessary risk-taking
4. cosmetic surgery for reasons of vanity.

The same 3-year limitation periods as Sweden apply, and a similar system of appeals is in place.

BRITISH PROPOSALS

Arguably, proposals which made their way to Westminster in the early nineties demonstrate some of the pitfalls of the system in New Zealand and the impracticality of directly applying the Swedish model to Britain.[10] Private Member's Bills have been brought by Harriet Harman MP and by Rosie Barnes MP. These were criticised because they failed to properly define ‘medical accident’, and hence to define eligibility for compensation. In this way they were said to be too negligence-centred for the benefits of no-fault to be properly felt.[11]

Harriet Harman’s Bill[12] considered ‘reasonable diagnostic error, having regard to the state of medical knowledge and best medical practice’ as grounds for a

[10] See Linda Blair ‘A Medical Complaints Bureau’ (1993) 143 *New Law Journal* 1377
[11] Brazier, Margaret. *Medicine, Patients and the Law (2ed).* 1992. Penguin. London. At p.226.
[12] 1990 Harriet Harman MP: *Compensation for Medical Injury Bill* & 1991.

defence. This would align her bill alongside the development risk defence in the Consumer Protection Act 1987 (products liability), which is deemed a very strong defence. Further, the use of the word 'reasonable' as a yardstick is synonymous with negligence actions and the *Bolam* test. Rosie Barnes' Bill[13] considered 'medical mishap' as including, but not restricted to any 'act or omission which gives rise to an action at common law', which was undoubtedly nothing more than writing the common law of (medical) negligence into statute.

Both Bills lacked effective procedural frameworks to ensure professional accountability. The main aim of no-fault is to separate compensation and blame and in this both bills failed. In response, the government said that it had no intention of interfering with the right of a citizen to bring an action in tort.

Another suggestion has come from Lord Woolf in his Report *Access to Justice*.[14] In it he suggested a reversal of the burden of proof in personal injury cases, as in Spain and France in workers' compensation. This would mean that the injury would be compensated, unless the compensating body can prove that they were *not* at fault. Lord Woolf might in this way be accused of bringing in no-fault by the back door.

Lord Woolf's reforms, effective since April 1999, have, according to the most recent report of the Medical Defence Union, led to an improvement in the rate at which complaints are handled. The MDU reported that negligence claims in the United Kingdom are not rising as fast as they have done in the past. However, there is still evidence of an increase in claims and in awards, which has led to the appointment of a 'health tsar' to collect information on near-misses and mistakes by health service staff. Any increase in claims arguably leads to proposals of alternative systems of compensation, including no-fault.

Professor Brazier has proposed[15] a scheme to embrace two categories of medical injury:

1. Injury or illness arising from an absence of, or delay in appropriate medical treatment provided that
   a. treatment would have prevented that injury or illness, and
   b. a reasonable request for medical care from a person or authority under an obligation to provide care has been made by the patient or some other person acting on his behalf
2. Injury or illness resulting from medical treatment provided that
   a. the injury or illness is not caused by the natural progression of disease or the ageing process, and
   b. the injury of illness is not the consequence of an unavoidable risk inherent in the treatment of which the patient has received proper warning.

Recent Developments in England

No 10 Downing Street and the Department of Health simultaneously published identical press releases on 11th July 2001.[16] The announcements said that the

[13] 1991 Rosie Barnes MP *NHS (Compensation) Bill*
[14] July 1996, available on http://www.lcd.gov.uk/civil/final/contents.htm
[15] See note 10, above.
[16] See No. 10: http://www.number-10.gov.uk/news.asp?NewsId=2272&SectionId=30,

system of compensation for negligence in the National Health Service was 'set for a major overhaul.' A new committee is to be set up, led by the Chief Medical Officer Liam Donaldson, to consider other methods of compensation with the intention of producing a White Paper in due course. Among the ideas that will be explored will be no-fault compensation as a means of saving both time and money. Other systems which lead to such savings in achieving settlements, will also be considered, as will those which seek to encourage openness, structured settlements instead of lump sum payments, fixed tariffs for certain injuries and greater use of mediation for dispute resolution. This initiative has also been reported in the medical press.

Holyrood

The review does not include Scotland. However, the Scottish Executive has given financial support to the Royal Society of Edinburgh, which is conducting a review of mediation in the health service in Scotland and is expected to report in January 2002.[17] Its remit is 'to explore the scope for using mediation as a process for resolving patient disputes involving the health services in Scotland.' It is also the case that Scottish courts are not experiencing the volume and backlogs of medical negligence cases to the same degree as they are being felt in England and Wales.

Most recently, on 29th August 2001 the Scottish Executive outlined a 'Move to settle Hepatitis C claims out of court.' Lawyers have been instructed to begin talks aimed at settling claims analogous to those which led to *A and Others v the National Blood Authority and Others*. The same announcement reported that the Executive is exploring 'ways of achieving faster, fairer resolution of disputes between patients and the NHS', and drew attention to the mediation review being conducted by the Royal Society of Edinburgh. On the recent developments in England, the press release noted that, 'The Executive will also continue to consider the most effective and sensitive way of dealing with cases of clinical negligence and will monitor carefully any parallel developments in England.'

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Department of Health: http://www.doh.gov.uk/newsdesk/latest/4-naa-10072001.html and (2001) 212 *British Medical Journal* 66: http://bmj.com/cgi/content/full/323/7304/66

[17] Royal Society of Edinburgh: http://www.ma.hw.ac.uk/RSE/index.htm