The cost of national service frameworks

Sir,

Those who derided the National Service Framework (NSF) for coronary disease as little more than 'motherhood and apple pie' written at the level of a pre-clinical student missed the point (Hampton, 2000). As Dr Boyle stated (vol 65(2), 2004, p. 68), most of us had a fairly clear idea which treatments worked in which circumstances – to save lives following cardiac arrest usually requires rapid access to a defibrillator; thrombolysis in acute infarction? Sooner rather than later. After the acute event? – secondary prevention, and so on.

Compared to our continental counterparts access to revascularization was less than adequate and patients were being subjected to prolonged and distressing waiting times. Several audits in the years preceding the NSF laid bare the perceived inadequacies of our systems of care. True, there were pockets of excellence, but the uptake of proven treatments and services was hardly uniform. This was doing patients a disservice. Colleges and societies had published guidelines at national and international level, all saying much the same thing.

What was sorely needed was action to galvanise both clinicians and their managers, by setting out as Government policy the job to be done. Also needed was an explicit statement that it was unacceptable for patients to have to depend on a 'postcode lottery' to determine whether they got timely, evidence-based and high quality care and prevention for our biggest killer, and to follow this up with money. Funny, then, how the NSF was criticized as 'undeliverable' when the professional guidelines upon which it is largely based were not…

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Hampton JR (2000) The National Service Framework for coronary heart disease: the emperor's new clothes. *J R Coll Physicians Lond* **34:** 229–30

Medical litigation: past, present and future

Sir,

The Chief Medical Officer's consultation paper Making Amends makes 19 recommendations for reform of the current system for compensating patients harmed through clinical negligence. These vary from the introduction of an NHS redress scheme, as outlined by Professor Neale (vol 65(1), 2004, p. 4), to better training for judges and a duty of candour with protection against disciplinary action for health-care professionals who declare involvement in adverse events.

But are any of the proposed changes necessary? The number of claims appears to have stabilized but average settlement values continue to rise substantially – the latest figures from the National Audit Office estimate the outstanding cost of clinical negligence claims against NHS trusts in England to be £5.2 billion as at 31 March 2002. But 80% of this sum is accounted for by obstetric claims which comprise just 20% of the total number of claims. For every child injured during birth who receives compensation, approximately 25 do not. This proposal promises more equitable treatment of these patients.

The Redress Scheme aims to deal with claims at the lower end of the scale where legal costs are often greater than the compensation awarded. The proposal is to simplify the procedure by doing away with the Bolam test by which the standard of clinical care is currently judged and replace it with a new test of substandard care. This could result in clinicians being condemned as negligent even if they have acted in accordance with accepted medical practice, which must be of great concern to the profession.

Making Amends is not a consensus document but a basis for further debate on how best to provide proper care for those who have been injured during the course of medical treatment and providing clinical services to the rest of the population.

John Hickey
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Sir,

Professor Graham Neale's narrative of the evolution of clinical negligence litigation suggests the increase in claims is a linear development.

A perceived increase in clinical negligence claims is often wrongly conflated with a compensation-driven culture. Most claimants are driven to the law because attempts to obtain a full, credible explanation, accompanied by a dose of humility on the part of the professional or institution, have failed. Compensation is often at the bottom of the wish list. Litigation can only hope to deliver on the client's least preferred option. By this time the potential claimant is no longer just perplexed and troubled by the event but resentful and probably angry too. These latter emotions propel the former patient and/or his/her family to consider litigation.

Clinical negligence litigation is not a mechanistic process. These claims are some of the most demanding of any litigation. The legal hurdles that the claimant must overcome are onerous, and determination of the clinician's competence falls to another clinician. Causation may remain contentious, even where liability is a 'given'.

Given the viscidities of clinical negligence (many cases flounder after the joint meeting of experts ordered by the court) such claims are difficult to fund. The Legal Services Commission set rigorous requirements. Conditional fee agreements have not proved the panacea hoped for. Insurers are reluctant to underwrite such claims, and purchase of a policy is costly.

The Chief Medical Officer proposes reform to clinical negligence. His stated aims are laudable. However, translating his vision into reality suggests a serious erosion of the patient's civil rights. As Neale points out the future of clinical negligence truly hangs in the balance.

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