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"The possible effect on Clinical Negligence Litigation of changes in legal practice introduced by the Civil Procedure Rules 1999."

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For some time the civil justice system within England and Wales, which fundamentally exists to enable citizens to understand and enforce their rights and other people's duties under the law, has been criticised by the Lord Chancellor's department, lawyers and the public alike, with particular attention being focused on medical / clinical negligence claims. Major criticisms were the length of time it took to resolve cases, the way in which cases were handled and perceived imbalances between parties. An overwhelming proportion (75%) of respondents in a survey said that the legal system was "out of date", "easy to twist", "slow" and "too complicated"[1]. Others (66%) disagreed that the system, then being used, was "easy to understand". Three quarters of the respondents stated that they would have preferred not to have taken the cases to Court, but instead would have preferred some form of alternative, whether it be arbitration or mediation.

The General Council of the Bar and the Law Society, amongst other leading authorities, questioned the accessibility, affordability and adaptability of the civil legal system[2]. They questioned whether the system provided justice, in the sense of social justice, over and above the strict definition. Other criticisms were that "An air of Dickensian antiquity pervades....."; "Procedures are unnecessarily technical, inflexible, rule ridden, formalistic and often incomprehensible...."; that there was an almost complete reliance on manually compiled records and information rather than using modern information technology; that some lawyers and judges were following procedures in a manner that, whilst

[1] "Seeking Civil Justice; a Survey of People's Needs and Experiences", 1995, The National Consumer Council, 5-11
2 "Civil Justice on Trial-The Case For Change", June 1993, Report by the Independent Working Party of the General Council of The Bar and the Law Society. pp.3-7.

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strictly speaking was correct, was not in the spirit of the reforms and such that any benefits of reforms already introduced were negated. The situation whereby the progress of actions rested with lawyers and parties was identified as having a severely detrimental effect in terms of unnecessary costs and delays and therefore undermining the reliability and justice of the system. The final defect identified in the Report, as in that of The National Consumer Council, was that most litigants (now claimants) did not want to take claims to Court, but simply wanted their disputes resolved in a timely, cost-effective and just manner, unfortunately in contrast to the then procedures and legal culture which were firmly organised around trials rather than dispute resolution. They summed up the problems as the ".....rigid, diffuse and sometimes archaic features of our current Court system" [3]. The concerns expressed by both organisations were despite the earlier implementation of some reforms recommended some 5 years previously by the Civil Justice Review[4].

As a result of continuing discontent and criticism, 1994 saw the appointment of Lord Woolf by the Lord Chancellor to fully review civil legal procedures and to propose changes as necessary. The final report[5] was published in 1996 with draft new rules and proposed reforms. The stated aim was to make the entire civil legal system, across both County Court and High Court jurisdictions, more stream-lined, consumer-friendly, cheaper, quicker, simpler and overall much more just, ie designed to facilitate the settlement of a dispute at the earliest possible stage. Particular emphasis was placed on seeking alternative methods for dispute resolution (ADR). Lord Woolf further particularly identified

[3] op.cit. p14, para.3.1.
[4] "The Report of the Review Body On Civil Justice (Cm394) , June 1988.
[5] Woolf, MR , "Access to Justice: Report to Lord Chancellor on the Civil Justice System in England and Wales", 1996

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clinical negligence (CN) as an area with specific problems, with parties often having considerable power over the progression, or non-progression, of cases and inevitably affecting the outcome. He expressed his concerns over the adversarial nature of the use of expert witnesses, in his words the experts were often used as "hired guns"[6]. and this is, by definition, an area that will be concentrated on within this essay.

The Civil Procedure Act 1997[7] was then passed to enable new procedural rules to be drawn up, with the subsequent Civil Procedure Rules[8] (CPR) and later amendments[9] coming into force on 26 April, 1999. The changes introduced were very wide ranging, having an impact on every aspect of civil, and in particular clinical negligence, claims. It should be clarified, however, that the Civil Procedure Rules are just that, ie procedural rules, and are not rules of substantive law. The consequences of their introduction was, and continues to be, however not without its critics:

> **They are, however well meant, based on a fundamental misconception, two in fact. The first is that lawyers cannot be trusted to process cases properly. The second is that judges can.[10]**
>
> **Judges, who have all been sent on courses to drink in the nectar of power and control and case management are flexing their muscles and raring to go...................They**

[6] op cit.
[7] Civil Procedure Act 1997 (1997 c.12.)
[8] Civil Procedure Rules 1998, (SI 1998 No.3132)
[9] Civil Procedure (Amendment) Rules 1999 (SI 1999 No.1008 (L.8))
[10] Lewis, C.J., Medical Negligence: A Practical Guide. 4th Ed., (London: Butterworths) 1998 , p.7.

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need to have regard for practical difficulties which face lawyers and parties in real - rather than virtual situations.................[11]

....the rules and their supplementing practice directions are an impenetrable mess.[12]

Whilst this essay is being written only some eight months after the implementation of the rules, it is already apparent that there are both positive and negative outcomes with regard to clinical negligence claims, together with potential trends emerging and these will be explored in further depth.

To fully understand the impact of the Civil Procedure Rules (CPR) on Clinical Negligence, it is necessary to briefly expand upon the Rules in general. The fundamental principle of CPR is that of the "Overriding Objective"[13]. This is aimed at enabling the Courts to deal with claims justly, whilst considering proportionality. In other words the case will be dealt with in a manner that considers the ratio of costs to the value of the claim; the importance and complexity of the issues involved and the relevant financial abilities of the parties, ensuring fair treatment for all parties by making it difficult for wealthier parties to gain a tactical advantage over parties by additional expenditure.

[11] Brahams, D., "The Impact of the New Civil Practice Rules on Clinical Negligence Claims" (1999) Med. Leg. J., 67(1), 7-8 at 8
[12] Prof. I.R.Scott, "New Legal Rules 'A Shambles'", 26 April , 1999, The Times, , Letters to the Editor, p.12.
[13] Civil Procedure Rules 1998, (SI 1998 No.3132) Part 1, Rule 1.1.

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In contrast to the situation prior to the 26th April 1999, the Courts are now in control of the management of cases, rather than the plaintiff, or as they are now called the claimant, and the defendant. The Courts also now have sanctions available to them, including penal costs, to apply to parties who do not abide by the strict timetables and other rules imposed[14]. Cases are now allocated at a very early stage to one of three "tracks" (small claims track, fast-track or multi-track) depending on the circumstances, complexity and value of the claim: it is unlikely that the small claims track will be used for clinical negligence. The management of the case should now be clearly visible to professionals, claimants and defendants alike, with them being aware of the timetables for various stages of the claim, unlike previously when proceedings might progress at a seemingly interminable pace with no real effective limitations on parties progressing or otherwise holding back cases.

Further changes involve the phraseology involved. The traditional legal, Latin based, language has now all but been removed, and replaced with terminology that is theoretically in more common use, thus aiding usability for members of the public and others not normally familiar with legal proceedings. For example, "ex parte" was replaced by "without notice" and "in camera" with "in private" and "writ" with "claim form"; the last "writ" being signed on 23 April, 1999[15]. One should bear in mind however that although the traditional legal language is undoubtedly out of keeping with modern practice, it has nevertheless developed over a period of many hundreds of years, and is an integral part of legal culture: to change the majority of the terms over night is possibly somewhat optimistic, but it does show a willingness and commitment to make the

[14] Civil Procedure Rules 1998, (SI 1998 No.3132) Parts 3 and 26.
[15] "Old Fashioned Writ is Written Out", The Times, 24 April, 1999. p4.

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system more accessible and understandable to the public, despite the protestations of some areas of the legal profession that the removal of Latin expressions is unnecessary and gratuitous[16].

It is also a condition of the CPR under the Court's duty to manage cases that, prior to formal legal action being started, alternative methods for resolving the dispute are considered and encouraged, and if practicable used in preference to the litigation route[17]. Although there is a general requirement of "pre-action behaviour" in all cases[18], clinical negligence is specifically covered under its own protocol in response to Lord Woolf's recommendation that

> **...patients and their advisors, and healthcare providers, should work more closely together to try to resolve disputes co-operatively, rather than proceed to litigation[19].**

This ideology is an integral part of the overriding objective of justice and fairness - the fairness being ensured by the requirement of parties to co-cooperate and be open from the outset of the dispute. The pre-action protocol should promote the early exchange of information, with the cases being stated clearly and in full, thus theoretically preventing delays and legal manoeuvring. The Courts have already shown that they are unwilling to accept delays in the presentation of papers and reports. Those, who for whatever reason, are unwilling or unable to abide by the strict timetables laid down in the Rules[20] leave themselves open to

[16] "Plaintive Cries as Law Goes Native", The Times, 27 April, 1999, p.5
[17] Civil Procedure Rules 1998, (SI 1998 No.3132) Part 1, Rule 1.4
[18] SI 1998 (No2840)
[19] Pre-action Protocol for the Resolution of Clinical Disputes (1998), Clinical Disputes Forum.
[20] op.cit.

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admonition and sanctions as in Jones and Another v Telford and Wrekin Council [21] for example.

Claimants, who should therefore have early access to written statements from the defendants, will be able to assess or be advised as to whether it is in their interests to pursue the case further. In a similar vein, defendants should be able to see exactly what the claims against them are, which under the previous system was not always clear. Thus the effect on clinical negligence claims should be advantageous to all parties, particularly those whose representatives make the most of thorough preparation at an early stage. A claimant whose case is properly prepared should therefore be able to use the Court's case management procedures to force a claim through quickly, potentially to their advantage. In contrast, defendants will be able to get claims struck out at a very early stage if the claims against them are poorly prepared or pleaded.

It should be noted that of an estimated[22] 6-8000 negligence claims brought in any year, only 20-25% result in any payment, and the cost (in the early 1990s) of each case being on average £30,000, giving an overall bill to the NHS of around £50 million, or in other words the building costs of 3 community hospitals (at current costs). Other figures related to civil litigation in total suggest that as much as £7 billion a year is spent on legal costs and payouts, with the situation possibly being exacerbated by easier access to the court system under the CPR[23]There are additional discussions surrounding funding of claims, such as the changes in legal aid eligibility, "no win no fee" conditional agreements[24] and insurance

[21] 29 July 1999, The Times Law Report.
[22] Lewis, C.J., Medical Negligence: A Practical Guide. 4th Ed., (London: Butterworths) 1998 , pp.2.
[23] "Disputes Culture Grows", The Times, 19 April 1999, p2.
[24] Courts and Legal Services Act 1990

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policies, but these are beyond the remit of this essay. There is however a substantial amount within the CPR relating to costs, under Sections 27, 44 and 46. Whilst the technicalities are somewhat complex, the basic theme is that, as previously, the unsuccessful party will be ordered to pay the costs of the successful party. Further it is important to note that in deciding what order to make about costs the court must have regard to all circumstances, including the conduct of the parties before and during proceedings; this includes whether pre-action protocols have been followed and whether the party has acted reasonably in pursuing particular issues. Given the spirit of the CPR, it would not be unreasonable to assume that the courts will take a less than favourable view of deviations from the rules and potentially deprive a successful party of some or all of their costs. Rule 44.3(6) specifically looks at flexibility, and would appear to be intended to focus claimants' and their advisors' attention on reasonable and moderate behaviour, at the risk of financial penalty.

When disputes arise in the clinical setting it is often said that patients would be, to a great extent, content with an explanation of what went wrong but, due to the quite common adversarial approach to the complaints procedures, together with the non-disclosure of medical records, the effective early resolution does not often occur. Often a major problem with obtaining records is that they cannot be traced, this being a specific area that is identified within the pre-action protocol, and that will be discussed later. It could also be argued that the expectations of patients, as a result of widely publicised, so called, "rights" under the Patient's Charter, are probably not in reality legal rights. Similarly patients often mistakenly believe that the healthcare providers have duties

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to provide certain services, which in fact are not actually legally enforceable duties[25]. Early clarification and explanation of these facts to patients who may be potential claimants could and should aid the reduction in unnecessary costly legal actions, both in terms of time and money.

The culture of denial of any wrong-doing and of "closing ranks" amongst health care professionals and organisations is also quite widespread, in the writer's experience, and even when genuine adverse outcomes, mistakes or mishaps happen that are in no way negligent on the part of any person, the fear of acknowledgement of errors and the potential detrimental impact on professional or organisational reputations is traditionally vigourously defended. This has a detrimental effect on the patient/practitioner relationship, together with directing efforts and funds away from the delivery of healthcare. Whilst it is not strictly speaking necessary, when complaints investigators acting under laid down complaints procedures are advised formally that the complaint or claim is or may be subject to litigation, the "in house" investigation of the complaint often stops immediately, this being backed up by case law[26], and is handed directly to lawyers. The situation could develop that, with the option of potentially resolving cases by arbitration or mediation, ie "out of Court" but under legal jurisdiction, any investigations already carried out could be used and developed to assist in disputes being settled earlier.

[25] see, for example, R v North West Lancashire Health Authority, Ex parte A and others, The Times, 24 August 1999

[26] See, for example, R v Canterbury and Thanet District Health Authority (1994) 5 Med. LR 132

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The pre-action protocol exists as a result of work carried out by the Clinical Disputes Forum, and is given the status of a practice direction under the CPR: it is not necessarily a prescriptive code, detailing every eventuality, but rather recommends good practice. However, it is felt that any deviation from the protocol should be treated with extreme caution as the courts, if the case proceeds, are likely to require very firm reasoning for the departures. By way of clarification, it is worth quoting parts of the Executive Summary[27] which state the objectives of the protocol:

-**Encourages a climate of openness when something "goes wrong" with a patients treatment or the patient is dissatisfied with the treatment and/or the outcome. This reflects the new and developing requirements for clinical governance in healthcare.**

-**Recommends a timed sequence of steps for patients and healthcare providers, and their advisors, to follow when a dispute arises. This should facilitate and speed up exchanging relevant information and increase the prospect that disputes can be resolved without resort to legal action.**

The changes suggested within the protocol are applicable to all areas of healthcare provision and are very broad in their effect. Many of the suggestions were already in place, in part if not in full, in a number of organisations, but the effect on a very large majority will be that of a substantial change in culture. As stated within the protocol, healthcare providers must now ensure that

- key staff are appropriately trained and have some knowledge of healthcare law and civil litigation practice and procedure;

[27] Pre-action Protocol for the Resolution of Clinical Disputes (1998), Executive Summary para.3, Clinical Disputes Forum.

- clinical governance is developed and implemented;
- adverse outcome reporting systems are in place;
- the results of complaints and adverse incidents are used positively with the aim of improving services;
- proper and efficient storage of all patient records is undertaken;
- patients are advised when a serious adverse outcome has occurred, and provide an explanation of what happened and offers of rectification, compensation, apology and changes in procedures that will benefit other patients, as appropriate.

If the above are viewed as duties on the provider or rights of the patient, then it is therefore reasonable that duties are imposed on the patient, and these are laid out within the protocol as the patients and their advisors should:

- report any concerns and dissatisfaction to the healthcare provider as soon as is reasonable;
- consider the full range of options available following an adverse outcome, not only litigation and;
- inform the healthcare provider when the matter is satisfactorily resolved.

The steps to be followed are clearly detailed in Section 3 of the protocol and do not warrant repeating here, suffice it to say that the approach is now standardised, with the aim of being specific and efficient in the gaining of information and subsequently dealing with it.

There are potentially wide ranging Alternative Dispute Resolution (ADR) routes that could be followed, although the applicability and suitability to clinical disputes of most is mainly untested at this early

stage, due to a low take up. The Lord Chancellor is currently seeking views on various methodologies and their use in practice for application across all areas of civil disputes, again particularly identifying clinical disputes, amongst others[28]. Regardless of the various guidelines and the persuasive powers of some judges, use of and participation in ADR is essentially voluntary and , by definition, must be with the agreement of all parties. It is felt however that there is the prospect of a positive effect on all parties, when the necessary frameworks are in place and people observe earlier settlements that have been dealt with in a less adversarial manner and that following this route is not a sign of weakness in legal terms, but another effective route that can be considered if appropriate. The Lord Chancellor suggests[29] that if a degree of compulsion was to be introduced then this might overcome some concerns and aid the culture change to ensure that ADR works, taking the pressure of the Court system. He does however express reservations about compulsion, taking into account Article 6 of the European Convention on Human Rights, which essentially entitles everyone to a fair and public hearing in a court of law. Some of the methodologies, amongst others, under investigation are:

- Arbitration, where both sides to a dispute agree to let a third party decide; the arbitrator's decision being legally binding and therefore enforceable through the courts.
- Expert Determination, where a third party, who is an expert in the matter under dispute is asked to decide the dispute. The decision is again binding.
-Mediation, where the third party, ie the mediator, assists both sides in dispute in coming to a mutually acceptable agreement. The outcome can

[28] "Alternative Dispute Resolution: A Discussion Paper", Lord Chancellor's Department.
[29] op.cit. paras 7.20 & 7.21

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also be legally binding, but only with agreement of both parties. Conciliation is a variation of this whereby the third party takes a more interventionist role, suggesting possible solutions.

-Early Neutral Evaluation is another process in which a professional, not directly involved in the case, gives a non-binding assessment of the merits. This can then be used for settlement or further negotiation[30]. This method has only been used to a limited extent, and then only in commercial cases. It is thought however that it may have application in other cases, where instead of a preliminary hearing to decide whether there is a legal case to answer, this could be decided elsewhere, again with the aim of minimising costs and only using courts for the cases that need to be heard.

When civil claims are now made, having exhausted the pre-action process if appropriate, under CPR the specifics must be detailed by the claimant. It is no longer acceptable for numerous and varied accusations to be made in the hope that one of them will eventually be effective. These claims have to be laid out in what were originally affidavits and are now "statements of case". As the new term indicates, the specifics of a claim must be laid out in a way that includes a concise statement of the of the facts on which the claimant is relying. The statement must be coherent and logical, using everyday language as far as possible and in the words of the person making the claims or statements. The claims included must be verified by a "statement of truth" that the party putting forward the document believes the facts stated in them are true. It will be readily apparent that if the documents are not completed by the claimant or in the claimant's words, but by their solicitor or another expert, and verbose and

[30] op.cit. Annex A

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bewildering language is used, then it is likely that the claimant will not be able to justify the statement in Court, and leave themselves open to castigation or being struck out[31]. The Courts have already shown that they are keen to uphold both the spirit and principle of the Rules as is demonstrated by Lord Justice Brooke's comments in Alex Lawrie Factors Ltd v Morgan and Others[32]:

> **Affidavits** (sic.) **were there for witnesses to say in their own words what the relevant evidence was and they were not to be used as a vehicle for complex legal argument.**

Regarding the non-disclosure of documents, it is now a requirement that any documents that will be relied upon are disclosed. However, this puts the onus on the claimant and their representatives to ensure that the correct information is referred to at the pre action-stage as, unlike previously, hospitals and Health Authorities are no longer obliged to disclose all documents held relating to the matter. They must however disclose those documents that are referred to in the statement of claim by the claimant, together with those documents that will be relied upon in their defence. It is no longer acceptable for documents to be produced at the last minute in Court in order to discredit or support a claim, as if they are not included in the list for disclosure at the pre-action stage (under the protocol) then without the Judge's permission, which will only be given reluctantly in extreme cases, they are unable to be used. As the overriding objective is one of co-operation and dialogue, then it is thought that non-disclosure or late disclosure will be viewed very dimly by Judges.

[31] Civil Procedure Rules 1998, (SI 1998 No.3132) Part 3, Rule 3.4 and Part 22.
[32] 18 August, 1999, The Times Law Report

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It is also now not possible for defendants to "hold defence" that gives nothing away ie they are not allowed to issue blanket denials or a "traverse". The major change in the area of defence is that when allegations are denied, the reason for that denial must be given and the specifics described. Also, if the defendant's version of events is different from the claimant's, then they must state their own version. It is thought that this should lead to the early identification of what the "real" issues involved in the case are. It follows that only properly constructed claims and defences will stand up under scrutiny, and if not correctly formatted they not only run the risk of being disregarded, but also of the case being struck out.

It is worth repeating at this stage that the Court must at all times aim to follow the overriding objective of dealing with cases justly when managing cases and that it is also the duty of parties to assist the Court in furthering the objective. The Court has the power to dispose of applications without hearing and / or without notice, with documentary evidence being given favour over oral evidence presented in court and thus being unable to be directly cross-examined. In other words the court can make a judgement on the basis of information provided in the statements of case, without any further involvement of either party. If cases are properly prepared, then this is the ideal situation, with interlocutory applications, and thus delays, being kept to a minimum, as hopefully the issues under dispute will have been effectively identified and dealt with under the pre-action protocol[33] and at the case management conference and pre-trial review, if the dispute proceeds that far.

[33] Pre-action Protocol for the Resolution of Clinical Disputes (1998), Clinical Disputes Forum.

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It is clear that in a number of cases, especially where there is significant variation between claimants' and defendants' versions, there will continue to be a need for expert evidence. The CPR[34] has introduced fundamental changes to this area, with the court again taking the lead, rather than the parties and there no longer being the right to call expert evidence, except with the court's permission. The court can also compel the parties to use a single joint expert and there is the power to cross examine, in writing, the other side's expert, or the single expert, before the trial. Again the importance of the case being well prepared and the proper briefing of experts are is crucial. The statement of truth that accompanies the expert's report will mean that experts will be committed to their initial report and it will be extremely difficult for them to change it without new facts coming to light. Whilst the expert has always been theoretically impartial, they have traditionally acted as part of their client's team and entered into the adversarial nature of proceedings, as in the well known "Ikarian Reefer"[35]. Now the expert's overriding responsibility and duty is to the court, with reports and any queries being addressed directly to the court. The courts additionally have powers to limit the experts fees and expenses that may be recovered ie to a cost proportional to the matters in issue; this obviously could cause potential problems until the courts become accustomed to what could be considered reasonable costs of experts.

When separate experts are appointed, they are under an obligation to have a pre-hearing conference or discussion regarding the issues in dispute and this hopefully should reduce much of the time spent in court arguing over technicalities and allow the court to focus on the real issues.

[34] Civil Procedure Rules 1998, (SI 1998 No.3132) Part 35.
[35] National Justice Compania Naviera SA v Prudential Assurance Co Ltd (1993)2 Lloyds Rep 68

Timetables, whilst focusing the attention and theoretically speeding matters along, may well prove to be problematic, as the suggested timescales are particularly short and those experts with a heavy workload may be hard pressed to fulfil their obligations. In contrast, the amount of work put in at a pre-trial stage should mean that the experts will not normally be required to attend court, as their statements should have covered all aspects in dispute.

It will be readily apparent, from the preceding, that the introduction of the Civil Procedure Rules has had a profound effect on the dynamics of clinical negligence litigation. The overriding objective of dealing with cases justly is unlikely to receive criticism in principle, however the implementation and practicality of the changes has and is likely to continue to. This is perhaps moving away from the fact that the civil legal system is founded on serving citizens and that a fundamental principle of the introduction of CPR is to increase accessibility and usability for those who need it; removing claims and cases that had no real place in court, thus clogging it up and creating unnecessary expenditure.

It would appear that the principle of proportionality in costs against claims is also a worthy one, with costs of even relatively straightforward clinical negligence cases realistically being several thousand pounds, and awards by way of compensation often matching the costs involved in achieving them. Any reduction in costs as a result of early settlements by way of ADR can only mean more funds being available for healthcare providers to do their job ie deliver healthcare. However, when a point of principle is at stake and the monetary compensation is of little real importance, this could well lead to injustices occurring if cases are not

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allowed to proceed by costs being limited; this is an area that requires further investigation by the courts.

Bearing in mind that the new rules attempt to fundamentally change overnight a system and culture that has evolved over hundreds of years, it is not surprising that there is criticism and resistance, especially considering the numerous sets of amendments introduced (ten to date, with an eleventh due at the end of January). In defence of the changes, it is apparent that any discrepancies are trying to be dealt with proactively by the Lord Chancellor's Department, although it is felt that it will require a number of cases to be appealed before clarification of various aspects starts to occur.

Whilst the practicalities remain in dispute only some eight months after the changes, the overriding principle and the efforts to modernise the civil legal system remain laudable, with the longer term effects to be awaited.