Counting the cost of litigation against the NHS

It is not necessary to work in clinical negligence to know that the NHS is clearly upset over the amount of money it is paying out for its clinical mistakes.

Unfortunately, it would appear that rather than examining the root cause of the problem, the NHS and its advisers have apparently sought to blame claimant clinical negligence lawyers for this expenditure, as the following press headlines illustrates:

"Lawyers use NHS as £100m cash cow"
"Taking a knife to NHS leeches"
"Lawyers get more than victims in NHS compensation scandal"

It is easy to understand why, in light of such press coverage, the general public can be seduced into believing claimant clinical negligence lawyers are preying on the victims of medical accidents by prosecuting claims devoid of merit for scandalous fees, and so depriving the NHS of vital patient care funds.

The reality is very different. The first thing to consider is that by the time a claim is even put to the defendant it will have undergone a vigorous risk assessment by the claimant's solicitors and (unless the medical evidence is overwhelming, for example in the case of a retained swab) be supported by independent expert evidence. In short, the claim will be far from futile from an evidential point of view.

As a result of the ever-changing legal landscape, where claimants can no longer routinely rely on access to public funding or legal expenses insurance, an increasing number of claims are being run on a Conditional Fee Agreement (CFA) basis. It would be economic suicide for firms if solicitors were to prosecute futile claims on a CFA basis.

Further, claim prosecuted on the basis of either legal expenses insurance or public funding must at all times enjoy reasonable prospects of success (which invariably means having the support of independent medical experts) to receive continued funding.

In terms of fees charged in successful clinical negligence claims, it is true to say that as a result of the legal maxim 'he who asserts must prove', a claimant's legal costs will nearly always be higher that the defendants costs, as the burden of proof rests squarely on the claimant's shoulders. It also has to be remembered that claimant lawyers are only entitled to and will only recover legal costs which are reasonably and proportionately incurred in relation to the case. The NHS defence organisations and their lawyers have every opportunity to scrutinise and challenge a claimant's bill of costs – ultimately before a costs judge – should they be unable to agree settlement of costs.

The fact that such legal costs are paid by the NHS is in itself telling of the general reasonableness of claimant clinical negligence lawyers fees. In addition, if, as the defendant would assert, claimant solicitors prosecute futile cases, then this should not pose a threat to NHS coffers: the defendant would simply defeat those claims and then recover costs from the claimant, whose claim would most likely be insured with ATE.

In support of their criticisms of the level of claimant lawyer costs, the NHS defence organisations and their solicitors often cite a simple comparison of damages realized versus legal costs in relation to selected

cases. This argument is both simplistic and disingenuous, particularly in relation to clinical negligence claims, where the value of a claim does not equate to either its complexity or the cost of its prosecution. Many claimant clinical negligence lawyers will no doubt have had experienced of some high value claims where the issues of law and medicine have been relatively straight forward, and some low value claims which involved complex areas of medicine and law.

For defendants to cite such bare statistics portrays a wholly inaccurate and biased picture of the way that clinical negligence claims are conducted in general. There is no insight into the background of the claims or more importantly the approach which the parties (and in particular the defendant) have adopted in the litigation, it is the latter which can have a dramatic effect on the level of legal spend. All too often, claimant clinical negligence lawyers are faced with bare denials of liability which neither address the salient points of the case nor narrow the issues in dispute. In addition, by adopting this approach, the hospital or individual concerned will have demonstrated (whether unintentionally or not) both inability to admit wrong, and inability to learn lessons from what has taken place in order to mitigate the chances of a future recurrence. Once such claims are up and running, there is also an apparent desire by the NHS defence organisations to defend the indefensible, which has a clear impact on the level of both defence and claimant costs (including the acquisition of costly insurance policies). These could be significantly lessened if the defence took a more conciliatory approach early on.

Where the defendant does have scope to reduce expenditure from the NHS budget is in relation to legal costs. It seems to us that regrettably, when put on notice of claims, many defence organisations simply adopt what might be best described as a 'siege mentality'. Perhaps this is in the hope that by proffering a bare denial of liability and dragging the case out, the potential claimant will either run out of funds or a desire to continue (or both) or discontinue the action. But turning litigation into a battle of attrition is counter-productive. First, when faced with this attitude, our experience is that this simply makes many claimants more resolved to litigate. Second, this attitude serves only to increase legal costs as illustrated above. It is of then the failure of the NHS to adopt a pragmatic approach early on in cases which results in the payment of significant legal costs. Don't forget also that the defence organisation and defence solicitors get paid by the NHS win or lose: to defend a patently indefensible case not only results in the NHS paying out significant claimant legal fees when the claim later settles, it must also pay its own defense solicitors their increased costs at the conclusion of the claim.

It is only right and proper for hospitals and doctors to have access to legal advice and the opportunity to defend claims against them. It is also only equitable for hospitals and doctors to have their interests represented by experienced legal advisors. But there is an obligation on the parties' legal advisors to try to avoid formal litigation in the first place and if this cannot be done, to extricate their clients from litigation on the best terms possible as expediently as possible. It would be both professionally and morally wrong to advise and encourage a potential claimant to embark upon stressful, protracted and costly litigation when on balance, that claim would be ultimately unsuccessful. By the same token, sometimes the best advice which can be given to the NHS is that the matter is one which should be settled. To seemingly defend all claims, irrespective of circumstances, is, in our opinion, doing the NHS a disservice.