Written evidence submitted by Nick Ross CBE (NLR0068)

> **Sir Humphrey Appleby**
> If you want to be really sure that the Minister doesn't accept an idea, you must say the decision is courageous.

The *status quo* is a longstanding national disgrace. It squanders precious resources while leaving many patients in the cold. It is entirely admirable that you have resolved to tackle it.

Yet I fear you will have limited success – and I say this sincerely, knowing and admiring the composition of this Committee. What conspires against you is that both the theatrical courtroom process and faith in deterrence are so ingrained in British culture (and so deeply serve the interests of the legal profession) that even if ministers found your report utterly convincing, they would scarcely need Sir Humphrey to point out that root-and-branch reform would be 'very brave'.

Everyone knows the problem: the annual bill for negligence claims has bloated from £1m in 1976 to just shy of £2.3bn today[1], enough to build 700 new primary care centres every year or meet the salaries of 20,000 more GPs. In addition, the £80bn-plus which is set aside for potential liabilities would cover the latest estimate for building HS2 or would buy 20 new Queen Elizabeth class aircraft carriers.

But plainly the fundamental issues are ethical rather than just financial.

- In a system designed and State-provided specifically to be equitable, it is morally incongruous that so much money is distributed haphazardly to a tiny fraction of people who deserve help for no better reason than that these few can find someone to blame for their predicament, whereas others (in equal distress) can't.

- If the purpose is to compensate patients, it is inefficient bordering on incompetent and improper that lawyers siphon off (most conservatively) more than 25% of the cash.

- If the purpose is to make medicine safer there is no evidence it does so, while there are reasons to believe it does the opposite.

Accordingly, permit me to address slightly different questions to those posed in your call for evidence:

[1] https://resolution.nhs.uk/wp-content/uploads/2021/07/NHS_Resolution_Annual-Report-2021.pdf

1. Is negligence litigation a fair way to use NHS resources?
2. Is there a way to reduce litigation, or at least cut costs?
3. What is the evidence that litigation improves (or harms) safety in the NHS?
4. If managers and clinicians are not in jeopardy from litigation, what alternatives are there to improving patient safety?
5. If patients damaged by NHS mistakes can't go to court, how can they be compensated fairly?

Is negligence litigation a fair way to use NHS resources?

This is a matter of opinion, not one that can be settled by evidence. But there are competing impulses. On the one hand are the principles that underpin the NHS. These are arraigned against principles of common law.

The NHS was founded on three ideals, that it should:

- meet the needs of everyone
- be free at the point of delivery
- be based on clinical need, not ability to pay.

The first two values have been sorely tested, with rationing through waiting lists, and with (relatively minor) incursions into the principle of free NHS delivery. But nothing has emerged since these ideas were adopted by Beveridge and applied by Bevan in the 1940s to undermine the principle of equity. On the contrary, mounting evidence that ill-health can be *caused* by inequality has placed an ever-greater emphasis on fairness.

This ideal of ethics has come into conflict with another: the moral case for a law (more accurately a tort, or civil rule) of negligence as a way to compensate victims for the fault of others. The principle is ancient: allowing for damages should one party default from a contract or pre-existing duty. But claims against medical practitioners were almost unheard of until the 20th century. The opportunity to sue for negligence was greatly expanded by a court case in the 1930s, while the prospect of going to court was transformed between mid-1980s and 2000 when lawyers were allowed to tout for business and to offer clients no-win-no-fee guarantees.[2]

It was this that unleashed the clash of values that the Committee now seeks to address. And the collision of these values is perhaps best illustrated by analogy offered by the senior judge in the appeal that widened the scope of the law in 1932.

[2] The Law Society of England & Wales permitted advertising in 1986, conditional fee agreements were made legal by the Courts and Legal Services Act of 1990, and from 2000 success fees could be recovered from the losing side.

The case came about literally by accident: because a snail fell into a bottle of pop. When the purchaser fell ill she sued the manufacturer even though she had no contract with them (her ginger ale had been bought in a café). As a result, the Law Lords invented, though only by majority, a novel legal principle: you are liable for damages for negligence even if you do not have a contract with the injured party.

Lord Atkin explained the judgment by invoking Christ's story of the Good Samaritan.

You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to inure your neighbour.[3]

But even Lord Atkin could not have imagined that reasonable care by a fizzy drinks company would be extended to tragic mistakes made by Good Samaritans themselves. Since the central purpose of the NHS is to share risks among the population as a whole, it would normally be considered immoral to divert resources to a privileged minority, or to let a favoured few elbow others aside, for any reason other than clinical need. After all, every penny paid to one person in damages deprives others with equally deserving - or even greater clinical – requirements and financial needs.

So this is the perhaps the central dilemma for the Committee: the clash of social purpose. Which moral case is the stronger?

The effects of *any* civil actions can have unintended consequences – workers can lose their jobs if a company has to make a big pay-out. But in private enterprise there is almost always an alternative supplier who will gladly fill the void. On the whole *customers* don't lose out.

But when NHS money is involved, customers do. Even litigation lawyers sometimes acknowledge that the NHS stands apart from other potential defendants.

Note that parliament has never enacted legislation which governs this area effectively[4]. Like Topsy, it just 'growed'. I am not complaining about judge-made law; it is fundamental to the English separation of powers. But after centuries of case law, your deliberations are to be welcome simply for the fact that they are happening. It is time parliament took time to consider these competing moral pressures in the round: the duty to compensate victims of medical error and the victim to share equitably all the resources available to safeguard the nation's health.

[3] Donoghue vs Stephenson, 1932, AC 562

[4] The NHS Redress Act, 2006 did attempt to curb the worst excesses of negligence litigation against the NHS but without success.

Is there a way to reduce litigation, or at least cut costs?

Three-quarters of cases brought against the NHS are overtly motivated by profit – no-win-no fee, which means the solicitors and barristers involved must be red in tooth and claw – and many lawyers advertising for business make no secret of the fact. Indeed, few claims against the NHS now qualify for legal aid.

This leads to asymmetric warfare. The 'let's-give-it-a-go' culture means around half of all claims are settled without damages[5], but not without cost to NHS Resolution. For the rest, in the confrontational process beloved of English law, the idea is that the best argument wins[6]. In negligence cases it is a judge and not a jury who decides the case, but nonetheless the resources available to one side or the other can be decisive. One set of lawyers is usually much better endowed (and personally more motivated) than the other. Naturally those representing victims like to portray themselves as champions of the underdog against an overweening Goliath, but the practical reality is often the reverse. The litigants have a motive to challenge, obfuscate and generally make things difficult, pushing the burden of risk to those at NHS Resolution who are generally paid less and whose role is to protect the public purse. Unsurprisingly there is huge pressure on NHS Litigation to pay out regardless of merit rather than risk expensive and drawn-out battles in court. Accordingly the overwhelming majority of cases is settled without going to trial.

Sadly, some medics themselves encourage the process, since they too have found it agreeably lucrative. This too came about through another specific ruling without parliament considering the wider implications. In 1957 a patient sued a hospital for negligence after electroconvulsive therapy caused him to fall off a couch and break his hip. The case resulted in the so-called Bolam rule: that doctors were the best judge of whether other doctors had acted reasonably. [7] Thereafter an industry developed of litigation lawyers hiring medical experts and jointly making money from the NHS. After a series of highly publicised miscarriages of justice involving expert witnesses, efforts have been made to tighten up the rules but nonetheless (a) expert witnesses who give the 'wrong' answers are unlikely to be hired; (as I can testify myself); (b) much expert testimony is subjective or at least subject to unconscious bias; and (c) even when it isn't, judges are not qualified to distinguish the wheat from the chaff. Moreover, genuine experts, by virtue of their specialist expertise, may have much more experience (as well as time to consider at leisure) than those accused of medical negligence. Even if we assume, as we should, that most clinicians who give evidence against fellow clinicians are doing their best, the profit motive, to say the least, can never be discounted. And given that healthcare is a very risky business (despite the best efforts of health professionals some 600,000 people die every year in England and Wales) there is always tragedy to exploit.

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[5] https://resolution.nhs.uk/2019/07/11/clinical-negligence-numbers-steady-but-rising-costs-remain-a-concern/

[6] Derived from Greek rhetoric, although not for nothing does the word debate come from *debatre* in Old French, meaning to fight or to beat down.

[7] Bolam v Friern Hospital Management Committee, 1957, 1 WLR 583

In response to this obvious problem, parliament has sought to curb the worst excesses[8], but without success.

This is not merely a clash of social purpose and the profit motive. It is a clash of moralities: the needs of a lawyer's client against the needs of others treated by the NHS. After all, every penny paid to one person in damages deprives other people with equally deserving - or even greater clinical – requirements and financial needs.

There are no doubt ways in which the costs of the claims process could be curbed, perhaps in part by rebalancing the risk of litigation so unsuccessful claimants have to pay their costs just as NHS Resolution does; but such reforms are no more than tinkering with a system which, on balance, is intrinsically against the public interest.

This is an issue which has not made much impact on the national public agenda, but if it did it could play either way depending on the spin: harmed patients getting their just rewards, or parasitical lawyers preying on the NHS. On balance I suspect the latter is more likely.

It is time parliament took time to consider these competing moral pressures in the round: the duty to compensate victims of medical error and the victim to share equitably all the resources available to safeguard the nation's health.

[8] The NHS Redress Act, 2006

What is the evidence that litigation improves (or harms) safety in the NHS?

Some hold it to be self-evident that legal jeopardy causes people to make fewer mistakes. It a beguiling idea, one that has guided humanity through almost every culture and every period in history.

But it is substantially wrong.

The grim reality is that the evidence for the effectiveness of punitive sanctions is poor *even for premeditated criminal offences*.[9]

The evidence is even stronger against punishing mistakes. Generally carrot is better than stick[10]. This is not to say that punishment doesn't work. We can learn from pain and shame, and neuroscientists have located parts of the brain that help to explain how[11]. Touch a hot stove, and you try not to do so again. But deterrence works well only under limited conditions.

A simple thought experiment might help. Imagine a behaviour that would likely cause your death. Surely you would be discouraged. Some argue this is why ballistic nuclear weapons have prevented wars between the superpowers: if you drop the bomb so will I. But what if the sanctions are not so swift, so decisive or so inevitable? This turns out to be quite different – and this is why, despite an effective risk of capital punishment, almost 7 million Britons smoke and 28% of adults are clinically obese. Humans are really not that responsive to penalties far removed from the moment.

So now imagine you are in a busy hospital dealing with dozens of sick patients, administering to some, trying to diagnose what is wrong with others, and calling for batteries of tests to check on your intuitions. Do you even, for a second, when examining a patient, consider NHS Resolution? As you take a pulse or insert a canula does a financial threat to the hospital trust feature in your calculations? [12]

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[9] I am happy to provide the Committee with evidence for this statement, including meta-analyses and randomised trials; but coming as it does from someone who spent more than two decades trying to lock people up, along with countless years on government crime-fighting agencies and police review bodies, and who set up a crime science department at UCL to improve the scientific rigour of evidence about the effectiveness of crime prevention, you may safely assume my perspective is not entirely liberal biased. A simple illustration is that there is no consistent correlation between penal tariffs and crime – other than that high crime tends to invoke a more punitive response as crime rates peak. Thus most Americans believe that *prison works* and accordingly have the world's highest rate of imprisonment (of 724 per 100,000 population), whereas crime rates in punishment-averse Nordic countries like Sweden (with 73 per 100,000 population) follow almost precisely the same trends – but with lower recidivism rates.

[10] For a large-scale review of laboratory experiments on leaning from error, see 'Learning from Errors,' Metcalf, *Annual Review of Psychology*, 68, 2017 Metcalfe, pp 465-489.

[11] eg 'Punishing an Error Improves Learning: The Influence of Punishment Magnitude on Error-Related Neural Activity and Subsequent Learning', Hester et al, *Journal of Neuroscience*, 17 November 2010, 30 (46) 15600-15607; DOI: https://doi.org/10.1523/JNEUROSCI.2565-10.2010.

[12] Committee members may be familiar with the case of Jack Adcock, a 6-year-old boy who died as a result of misdiagnosis by a hospital registrar, Hadiza Bawa-Garba. She was convicted of gross negligence manslaughter for making a mistake while trying to help Jack. Only because of an outcry was she restored to the medical register.

The idea that a potential claim for negligence will make doctors or nurses behave better is not just unevidenced; it is also insulting to the thousands of clinicians who work in the NHS with the specific intention of helping not harming. Indeed, if they do cause serious harm, through misdiagnosis or other medical error, the emotional consequences are often severe – with or without any formal external intervention.[13] Many published studies document extreme and troubling emotional harm to doctors.[14]

Perhaps the real-world acid test of whether litigation improves safety is whether the need for such litigation has diminished over time. If negligence litigation worked (for safety, that is, not for lawyers and claimants) there would be less and less need for it.

On the contrary, the very *raison d'etre* of this Committee's call for evidence is the long-term rise in claims[15]. The idea that the law on negligence drives up clinical safety is self-evidently self-defeating.

In fact it may make matters worse.

It has long been known that the biggest enemy of medical safety is cover-up. Back in the mid-2000s Jane Moore, the director of healthcare quality at the Department of Health lamented that, 'We still blame individuals rather than look at what the causes of patient safety incidents are. This means people still find it difficult to report.[16]' And the problem is bad enough without external threats. Clinicians themselves are far too ready to resort to negativity. A randomised analysis of NHS GPs in 2017 revealed 'a health care culture that leads to blame and retribution, rather than to identifying areas for learning and improvement'.[17]

These lessons should not need much rehearsal here, especially after the series of inquiries into scandals including the Francis Inquiry into Mid Staffordshire NHS Foundation Trust. The clearest lesson from these reviews was spelled out in the title of the report signed off six years ago by the Chair of this Committee when he was SoS: '*Learning not blaming*'[18]. In response to so much dismaying evidence of cover-ups, the NHS was to invert the blame and litigation cultures and to

[13] **'**Medical error: the second victim,' Wu, Albert, *BMJ*, 2000, 320:726–27

[14] eg **'**Guilty, afraid, and alone—struggling with medical error,' Delbanco Tom and Bell Sigall, *New England Journal of Medicine*, 2007, 357:1682–83; 'Psychological impact and recovery after involvement in a patient safety incident: a repeated measures analysis,' Gerven, Eva, https://bmjopen.bmj.com/content/6/8/e011403

[15] NHS Resolution reported 12,629 clinical negligence claims in 2020/21, compared to 11,678 in 2019/20, continuing a long-term trend.

[16] 'Blame culture is still a problem in tackling patient safety,' Hitchen, Lisa, *BMJ*, 2007 Dec 8; 335(7631): 1172. doi: 10.1136/bmj.39415.492164.DB

[17] 'Nature of Blame in Patient Safety Incident Reports: Mixed Methods Analysis of a National Database,' Cooper, Jennifer et al, Annals of Family Medicine, 2017 Sep; 15(5): 455–461. doi: 10.1370/afm.2123

[18] 'Learning not blaming: The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation,' CM 9113, 2015.

replace them ‘from top to bottom’ by a culture of learning from errors. The key drivers were to be campaigns for openness and honesty, a duty of candour towards patients, a commitment to listening to patients as well as families and staff, an obligation to finding and facing the truth, and an encouragement to whistleblow through a network of ‘freedom to speak up’ guardians.

But there is a long way to go. A consistent message from a recent survey of clinicians was that ‘fear is too prevalent across NHS staff, particularly in relation to involvement in patient safety incidents.’[19]

Perhaps the most compelling authority on this is Prof Sir Ian Kennedy, the UCL lawyer who chaired the Bristol Royal Infirmary inquiry, and whose views in general I commend to the Committee. He has championed radical reform throughout his career but made his approach to medical safety most unambiguously clear by quoting Henry VI in his 1980 Reith Lecture: ‘First… let’s kill all the lawyers.’ He has pointed out repeatedly that true patient safety requires dispassionate ‘analysis of what went wrong… conducted without the threat of blame and consequent tendency to cover up.’

But he also concedes that, ‘As a lawyer myself I have seen from the inside the stranglehold that lawyers exert over a system.’ [20]

My own view, and I suspect Prof Kennedy would agree, is that it is not just financial self-interest that makes so many lawyers cling to the adversarial approach (although it is naturally a factor). Indeed such cynicism is unfair to many in the legal profession who care as strongly as you or I do for the safety of NHS patients. Instead the more powerful motive is even harder to contest: it is a matter of faith. To become a lawyer is to be inducted into a priesthood, one steeped in precedent, tradition, and where the ability of cut-and-thrust of argument to winkle out the facts is itself essentially unchallenged - just as their assertion that litigation is the best way to improve safety is essentially unevidenced.

[19] The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, July 2019 (https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf)

[20] Ian Kennedy, ‘Clinical negligence reform is an ethical and financial necessity,’ *Prospect*, 9 August 2021. https://www.prospectmagazine.co.uk/politics/clinical-negligence-reform-is-an-ethical-and-financial-necessity-law-hospitals-medicine

If managers and clinicians are not in jeopardy from litigation, what alternatives are there to improving patient safety?

Without any compelling evidence that litigation drives up standards in the NHS, the negligence industry should be considered a distraction so far as patient safety is concerned, and it is reasonable to suppose that the adversarial model must inevitably promote defensiveness and so do more harm than good.

But if law suits aren't the answer, what is?

The first answer is that there is already an independent quality assurance framework in the GMC and NMC. The General Medical Council licences doctors and the Nursing and Midwifery Council (itself overseen by the Professional Standards Authority) does the same for nursing and midwifery professionals. These are far from soft touches. The GMC's sole purpose is to protect the public, and doctors have to be revalidated yearly. As standards rise the number of doctors struck off each year has trebled in the past two decades, many for lying during an investigation. Thousands more were sanctioned. However, the GMC suffers from some of the same adversarial burdens as litigation, and most doctors regard the Council as hostile rather than an ally. Until it is reformed (which will take primary legislation) it cannot be expected to do more to improve patient safety.

On the other hand the NHS has already adopted the lessons from effective safety programmes elsewhere, and not least from the remarkable record in civil aviation[21] where lawyers are effectively excluded from the investigatory phase. The search for responsibility is aimed solely at preventing a repetition of the accident. The concept of culpability has no moral connotations, as in 'metal fatigue was to blame', and organisations like the AAIB in the UK have no interest in assigning legal liability.[22] Only once safety has been prioritised do lawyers bicker about who can be sued for what.

The airline analogy of civil aviation is far from perfect. For one thing the sheer scale of the safety challenge is much greater. Each day some 800,000 patients see their GP, 66,000 seek emergency care in hospital, 10,000 are admitted, 35,000 are treated as day cases and about 2m diagnostic tests are performed.[23] Each episode is freighted with opportunities for something to go wrong. And unlike civil aviation, where if a risk is identified flights can be cancelled, the NHS can't stop work.

Nonetheless the comparison is instructive, and strikingly similar approaches have been adopted to the extent that the model of the Air Accident Investigation Branch has been borrowed for the NHS and, Keith Conradi, a former head of the AAIB has been recruited to take charge.

I will return to Mr Conradi later, since the Committee may feel he and his colleagues should have a larger role to play than he does at present.

Given the extent to which risk is intrinsic to the NHS it is important that the public should be aware of just how much is already done to make things safer. At national level there is an ever-growing

[21] Fatal accidents per million flights fell from 12 in the 1960s to virtually nil by 2015.
[22] The only exceptions are where criminality is involved, such as forged aircraft components or sabotage.
[23] NHS Key Statistics: England, October 2021, Carl Baker, House of Commons Library

emphasis on metrics and on safety learning, a Patient Safety Incident Response Framework has been introduced to help raise improve investigations, and there is a new National Patient Safety Strategy to coordinate initiatives[24]. At local level even errors which cause no harm are logged and investigated (so-called 'never events' are given high priority simply because they should never have happened), recommendations are better disseminated than in the past, training has been improved and, where possible, changes are made to procedures or equipment to make a recurrence impossible (for example, redesigning fittings on epidural lines so they can't be confused with intravenous ones).

Nonetheless, there is much more that can be done.

It starts at the top. The big pressures on NHS managers (and therefore on clinicians) are more about cutting costs and waiting times than about improving outcomes. Ministers, NHSE/I and the CQC need to be more aligned about risk and the importance, at least as much as financial targets, of measurably improving outcomes. Where cost and quality is incompatible – and let's face it, any public health provider has limited resources and almost unlimited demand – it is unethical and undemocratic to disguise or obfuscate what is to be rationed and what its effects will be on patient safety and general outcomes. The DH needs to walk the talk: quality is as important as quantity, and should be conspicuously so in priorities for providers.

The Patient Safety Incident Response Framework must ensure that lessons learned are lessons shared. Even relatively trivial failures at local level need to be logged and date shared centrally so that dots can be joined. The Healthcare Safety Investigation Branch should have oversight.

Equally, the royal colleges and others with leadership roles among doctors and nurses (and to a much lesser extent allied health professionals) need to act on what they say. If learning, not culpability, is the surest path to safety then they must dismantle the old-fashioned hierarchies which intimidate juniors and make the professions much more collegiate; and academic deans must develop ways to improve the behaviour of consultants, some of whom make little effort to train their juniors and some of whom are frankly unsupportive. Doctors in training provide the backbone of the NHS and training and quality control is every consultant's responsibility.

Clinicians who claim to endorse the learning-not-blame approach to safety should be less eager to earn money from the blame game, acting as expert witnesses where error, as opposed to malfeasance, is on trial. If there is too much blame then physician, heal thyself. Conversely, all clinicians must be transparently candid outside court where errors have taken place. The only proper culpability for medical error is where it has been wilfully concealed (see next section).

[24] The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, July 2019

Lawyers maintain that nonetheless they must also have a role in patient safety. I disagree. Even inquisitorial inquiries by lawyers tend to be long-winded and phenomenally expensive.[25] Nor is there much to support the claim that the adversarial system is reliable at finding facts. I have already cited the example of the Air Accident Investigations Branch; in fact *no* other important areas of fact-finding – safety, science, engineering, audit, or indeed medical research itself - relies on adversarial combat.

As with air safety, where the experts are aviators and avionic or aeronautical engineers, so the best investigators of clinical mishaps will be clinicians. On the other hand, the NHS cannot be held to investigate its failings on its own. If the public is to have confidence, there must be independent scrutiny. Some lawyers might share in this role, bringing their literally forensic intelligence to bear in a team made up largely of clinical experts. However, they should be independent not biased. Objectivity is important even where it is thought appropriate for a patient to be represented in an investigation (and where serious harm has been caused there is a powerful case for patient representation). But evidence should be tested dispassionately; cognitive bias is something to be guarded against, not encouraged.

Once again there is a case for the Healthcare Safety Investigation Branch should have oversight. No doubt Keith Conradi will have his own views for the Committee.

[25] Sir Martin Moore Bick's Grenfell inquiry has cost £117m so far, the Bloody Sunday Inquiry cost £210m, the Chilcot Inquiry £13 million and the Leveson Inquiry was a bargain at £5m.

If patients damaged by NHS mistakes can't go to court, how can they be compensated fairly?

It is a long-established principle that anyone injured through negligence should be entitled to redress. But like many long-established principles, it needs to be challenged. Does redress mean justice, and does justice entail financial compensation or retribution, or both? Does it mean the satisfaction that lessons have been learned so that the same mistakes are much less likely to recur?

The answer is that different people want different things. The assumption behind negligence litigation is that the main things is compensation; indeed, in cases where harm results in serious disability and long-term needs this is clearly an important factor.

Nonetheless, the overriding need appears to be for candour. As a US research programme discovered, 'Patients wanted disclosure of all harmful errors and sought information about what happened, why the error happened, how the error's consequences will be mitigated, and how recurrences will be prevented.'[26] Another team interviewed patients who had each experienced serious harm (but had no live malpractice claims) and found that patient satisfaction was 'highest after disclosure and reconciliation efforts made by hospitals,' and when communications were not adversarial. While reparation played an important part in many of these cases, here again disclosure and reconciliation played a pivotal role. While a majority felt satisfied with their compensation, 'Those who found it to be inadequate also described dissatisfaction with the overall communication process.' [27]

In short, patients understand things can go wrong. But, when they do, they and their families want to be treated as part of the team – which of course they are. Importantly, many patients also want to know about mistakes even if no harm results.[28]

So, the first priority is candour.

That still leaves the thorny problem of compensation.

There is a powerful argument that, within the NHS, provision is accorded solely on the basis of need. Just as you should not be able to elbow your way to the front because you are rich, so you should not be able to do so because you caught your infection or suffered your accident inside the NHS rather than outside. In my view this so-called 'no fault' approach has more merit than any other, and I urge the Commission to recommend that as part of the bargain for being treated in the NHS citizens should forgo the right to sue for negligence. We have already rehearsed the evidence that litigation does not improve safety, and we have acknowledged that in an inevitably rationed system a privilege for one patient is act the expense of another.

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[26] 'Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors, Gallagher, Thomas et al, *JAMA*, 2003, 289(8):1001-1007. doi:10.1001/jama.289.8.1001.

[27] Patients' Experiences with Communication-and-Resolution programs after medical injury, Moore, Jennifer et al, *JAMA Intern Med*, 2017, 177(11):1595-1603. doi:10.1001/jamainternmed.2017.4002.

[28] 'Disclosure of "Nonharmful" medical errors and other events duty to disclose,' Chamberlain, Catherine et al, *Archives of Surgery*, 2012, 147(3):282-286. doi:10.1001/archsurg.2011.1005.

This would have the added advantage that the NHS would save on professional indemnity as well as on premiums to NHS Resolution.

Since the private sector is commercial rather than mutual, it should have to make its own case for any legal immunities.

There remains a compelling case to do more for *anyone* injured however their injury occurred, and there have long been calls for the UK to follow New Zealand's example of so-called no-fault compensation[29]. As the Committee will be aware, the Accident Compensation Corporation contributes to the cost of treatment and rehabilitation for all personal injuries, including medical error and regardless of fault, and prohibits litigation in order to seek damages.

The name 'no-fault scheme' is something of a misnomer because tracing accountability remains critically important in medical mishaps – at least in the sense of precluding recurrence. Nonetheless the virtue of the system is that it helps resolve the consequences of accidents in an equitable way. So far as medical mishaps go the New Zealand scheme is also self-funding. The costs are met by indemnity fees paid by doctors and are relatively modest – usually less than £1,000 pa – although pay-outs are accordingly modest too.

Nonetheless, it remains an anomaly that accidents but not illnesses are covered. I see no ethical reason to offer more help to one class of people suffering than to others. Nor do I think it is political feasible in the UK at present. It is better that patients simply forgo the right to sue the NHS in exchange for the right to transparency when things go wrong, and the right to share – like anyone else – in the resources of the welfare state.

Of course Sir Humphrey Appleby would warn that even thinking about such things is daring, let alone proposing them as policy. It is more than audacious enough to consider confronting the legal establishment – one of the most powerful lobby groups in the country – with ideas about cutting them out of lucrative work. But I hope you will be brave and propose just that.

Nick Ross has served on two ministerial advisory committees on the NHS, the Nuffield Council on Bioethics and the RCP ethics committee and is an independent director of Imperial College Healthcare NHS Trust, president of Healthwatch (which promotes evidence-based medicine), chairs the Wales Cancer Bank Advisory Board, and is an adviser to the UK Biobank and trustee of several charities including the UK Stem Cell Foundation and Sense About Science.

[29] Although New Zealand is usually cited as the model for no fault compensation, Germany was the first to introduce universal compensation (limited to vaccine injuries) in 1961. According to the WHO some 25 countries now have no fault systems of varying scope.