

## **Medical Negligence Seminar, Amsterdam 1 December 2006**

This seminar was organised by PEOPIIL's Medical Negligence Group in cooperation with the University of Amsterdam (UvA) and was held in the beautiful 15<sup>th</sup> century Doelenzaal of the University. It was chaired by John Beer as coordinator of the Group.

During the morning session medical negligence as a social phenomenon was explored by Professor Cees van Dam (British Institute of Comparative Law). An overview was provided of the motives for patients to start proceedings against doctors as well as the motives for doing the opposite. The four main reasons to issue proceedings are: a) the concern with the standard of care, b) the need for an explanation, c) compensation and d) accountability. On the other hand there is reluctance to issue proceedings due to lack of financial means, lack of social confidence ('the doctor is always right'), the fact that there is an ongoing relationship with the doctor or the hospital involved, and last but not least there might not be any need to start proceedings as soon as the doctor apologises. The question is whether saying sorry works. According to Van Dam this may depend on the social environment. In more 'feminine' countries saying sorry may work (e.g. in the Netherlands, with its 'polder' mentality). In typically masculine countries saying sorry will probably not work (e.g. Italy).

Professor Bas de Mol explained the cardiac surgeon's view on medical negligence and why saying sorry doesn't always work for the doctor him- or herself. The main professional problems - missed diagnosis, flawed technology, complications as well as the doctor's perception of responsibility - passed in review. By way of 'climate control' the doctor, in de Mol's opinion, should at least inform his patient, obtain adequate consent, communicate with his team and organization, educate and delegate to co-workers and last but not least, follow the guidelines.

PEOPIL President John Pickering gave a useful summary of key issues in medical negligence cases. In most European countries the claimant bears the onus of proof. The balance of proof is, in most countries, based on the balance of probabilities. Furthermore a case will stand or fall according to the quality of medical expert evidence. The art of getting the maximum benefit from an expert was explained. It was made perfectly clear that it is up to the lawyer to leave no stone unturned.

During the afternoon session AVMA Director Peter Walsh gave an overview of work done by AVMA since the 1980's. They have managed to build bridges with the medical profession and developed a pool of medical experts. Moreover, they have worked hard to raise awareness of the plight of 'victims', which also involves increasing awareness of the scale of medical errors in the UK. AVMA has been lobbying continuously for improvements to both the legal and the healthcare system. Finally, AVMA has been involved in developing Clinical Negligence as a distinct specialism for lawyers in the UK. It follows that AVMA is of great significance not only with regard to medical negligence in both the UK and other (in this regard less developed) countries in Europe.

Walsh then discussed the NHS redress scheme for a restricted number of 'small' claims which will come into force later this year. The redress scheme only covers NHS hospital services in England, with a value of below €28.000,00. According to the scheme, liability is based on tort, but assessment will be made by the NHS itself. The claimant is not entitled to legal representation. According to AVMA, the NHS Redress Scheme holds a number of missed opportunities. It has been a big mistake not to enforce independence and legal representation.

Other countries that have faced a change of law in the last few years are France and Norway. Bruno Paris (from France) discussed the introduction of ONIAM in 2002. The main objective of this new law was to remove medical negligence claims from the civil, criminal and administrative courts and encourage amicable settlements. The procedure was to be fast, free of charge and simple. Therefore a National Fund was created and funded by social security contributions.

Paris explained that although according to the rules a claim should be processed within 6 months; in fact most commissions take at least 10-12 month to review a case. As the commissions are no different from the courts comparable delays will be expected.

Free access is also a fiction. Using ONIAM requires medical consultation and involving a lawyer. However, ONIAM does not refund these costs, while in regular court proceedings these costs are recoverable.

Another reason not to choose the road through ONIAM is that the medical tables used by ONIAM are more restrictive than the ones used in Court. This implies that for a given type of injury the level of damages will differ.

In spite of the criticism against ONIAM there are some positive points to mention such as the fact that patients don't have to prove negligence anymore. Especially in cases where it was almost impossible to prove negligence this is of advantage.

Carl Jerstad elaborated on the new law in Norway introduced in 2001 as a temporary regulation (NPE). The permanent Act on Patient Injury Compensation (PIC) came into force for the public health sector on January 1, 2003. It is expected that the PIC will also come into force for the Private Health sector in 2007. The law is based on liability, regardless of blame. However, the right to compensation is related to an error or omission made by the health service. Compensation is to be assessed according to the Damages Act, which means the right of full compensation.

In order to claim compensation one is required to have sustained a financial loss of at least NOK 5,000. If one has sustained a permanent injury one may qualify for permanent injury compensation. The level of medical impairment should in that case be more than 15%.

There is no compensation for pain and suffering within the new law. Legal costs are covered although usually assessed on a general basis, which means complicated cases are usually underpaid.

Claims are assessed by medical advisors working for NPE. There is a possibility to appeal to the Patient Injury Board (Patiensskadenemnda). The claim will be reassessed by this Board. Unfortunately, this board is not an independent legal authority, such as a court. Therefore the right of access of justice (article 6 and 13 EVRM) is at stake.

During the seminar it became clear that there are big differences in medical negligence within Europe. Toine Manders, member of the European Parliament, asserted that the single market has brought huge benefits to Europe's citizens but travellers or patients treated in other countries face a range of difficulties in pursuing their claims. The differences between law systems are enormous, even ignoring the differences in culture and social environment. Therefore, harmonisation of material law at this time is not feasible. Said Manders: 'In other words: there is no 'one fits all' solution.'

The questions remains what can in fact be done? One of the proposals is a European small claims procedure for claims in cross border cases (< €2.000). In addition, there are the proposal for a mediation directive and the Rome II regulation on the law applicable to non-contractual obligations which contain a provision obliging judges to apply the principle restitution in integrum when awarding damages. Unfortunately this is only a proposal, and its acceptance is by no means guaranteed

Manders emphasised that PEOPIL has an important role sharing expertise with members of parliament and the European commission.

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