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## Clinical & Personal Injury newsletter

This newsletter is one in a series of publications produced by the Clinical Negligence and Personal Injury Group within the Private Individuals Division of Penningtons Solicitors LLP. If you would like further details on any of the subjects covered, please contact us at the addresses at the end of the newsletter.

### In this issue...

- 01 | A step forward in patient care?
- 02 | Element of surprise in new reforms
- 03 | Cancer and oncology claims: medico-legal issues
- 03 | Casewatch

## A step forward in patient care?

The Chief Medical Officer, Sir Liam Donaldson, has announced a shake-up in the assessment of doctors which is set to be the biggest change to the regulation of the medical profession in 150 years.

The need for further regulation has long been put forward by organisations representing the medical profession, including the General Medical Council (GMC). The issue was highlighted by the inquiry into the actions of Harold Shipman, who murdered up to 250 of his patients, often with the use of narcotic drugs that he had stockpiled. The inquiry criticised the regulation of doctors as not being focused enough on patients. But given that Harold Shipman was a criminal who may well have passed the new proposals, what will further assessment and regulation achieve? Will it result in better standards for patients, or an increased burden on doctors and the practice of 'defensive medicine' with doctors having less time for patients?

The intention of the reforms is to standardise what is currently a patchy system of monitoring and not to be a disciplinary mechanism. Doctors face no formal reassessments between entering practice as a GP or consultant and retiring. This lack of reassessment has been compared to airline pilots who are assessed approximately 100 times during their career.

The present system is carried out on the basis of an annual appraisal to consider a doctor's prescribing habits, career development and general performance. This has been described by the Chief Medical Officer as not appropriate for the renewal of licences. It is thought that some Trusts are not carrying out the appraisals each year and

there is concern over the consistency of the assessments. There is also no process for gathering feedback from patients which is a key element of the new proposals.

The new system has two strands: relicensing (confirming that doctors practice in accordance with the GMC's standards) and recertification (confirming that doctors conform to the standard appropriate for their speciality of medicine).

The relicensing component will require a uniform module of appraisal, based upon the GMC's Good Medical Practice, while there will be scope for other aspects of the appraisal to be a matter for local employers.

The recertification component will involve a clear set of standards developed by the relevant medical Royal College in conjunction with specialist associations. The basis of the assessment will be rooted in the evidence of doctors' actual practice and focused on an ongoing five year process, rather than a single 'high stakes test'.

While the introduction of revalidation is of understandable concern to some, the benefits of a more rigorous system of relicensing and recertification can only serve to justify the generally positive view that patients hold of doctors in the UK. The new initiative should provide better and safer clinical care for patients by ensuring that doctors are up to date with the ever changing field of medicine in which they practise.



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The intention is to standardise a currently patchy system.

## Element of surprise in new reforms

The Ministry of Justice has published its eagerly anticipated response to the claims process consultation. This has been received with some trepidation by those involved in personal injury claims.

It was thought that the Government would introduce proposals to radically change the claims process given concerns that it is slow and expensive, with costs often outweighing damages received.

However, on reviewing the proposals, it can be argued that the Ministry of Justice seems unlikely to implement such wide-ranging reforms as was first contemplated.

The proposals are as follows:

### **1. The small claims limit for personal injury claims to remain at £1,000**

Welcomed by claimant solicitors, this is essential to ensure that those wishing to pursue a personal injury claim have access to justice and can seek the assistance of a solicitor when bringing claims.

It is important that injured people have independent advice and representation. They should not be in a position where they do not pursue a claim because they do not understand the process, or where they risk under-settling a claim without proper advice on the relevant issues.

### **2. Fast track limit in all claims increased to £25,000**

There are serious concerns that the recommended increase to the fast track limit from £10,000 to £25,000 may result in complex claims falling into an anticipated straightforward system.

An increased limit will affect many personal injury claims resulting in cases being allocated to the fast track when they may be better served by the multi-track. Not only is value a factor in deciding allocation, but complexity should also be high on the agenda.

At present, the proposals do not suggest any procedure for the transfer of such claims from the fast track to multi-track if considered appropriate.

### **3. A new streamlined procedure for minor road traffic accident claims up to a value of £10,000**

A new claims process has been put forward for road traffic accident (RTA) claims valued between £1,000 and £10,000 where there is no dispute on liability or causation and there are no allegations of contributory negligence.

Originally thought to encompass all types of personal injury claims, the proposal is limited to RTA claims. It involves a process for quick notification of claims, early admissions of liability and attempts to reach an early negotiated settlement.

Where there is a failure to adhere to the time frames proposed, the claim exits the process and is likely to continue as claims do at present, resulting in little change to the current system.

This has to be a real possibility given the delays often experienced in obtaining a response on the issue of liability within the current protocol period.

### **4. Fixed recoverable costs in the new RTA claims process**

There is no indication of the level at which these costs will be set, but it is hoped that this recommendation will avoid the arguments over excessive and unnecessary costs. However, the experience of claimant solicitors with the current system of fixed costs demonstrates that this has not prevented insurers arguing over the level of costs, resulting in further delays.

The new proposals do leave a number of questions unanswered about how they will work in practice. The next stage is for The Civil Procedure Rule Committee to consider draft rules, practice directions and pre-action protocols which will be required to implement the new process.

It is unclear how long this will take but there are assurances that the Government will continue to work closely with contributors to ensure all opinions are taken into account before reaching a conclusion.



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The Government's proposals do leave a number of questions unanswered.

## Cancer and oncology claims: medico-legal issues

Claims arising out of delay in diagnosing and treating cancer tend to be more common than those concerning the standard of care provided once a diagnosis has been made.

A cancer diagnosis can be delayed for a number of reasons including non-negligent ones. Biomedical difficulties in detecting the disease at an early stage can make late diagnosis inevitable. Patients may not initially appreciate the severity of their symptoms, attributing them to everyday causes rather than ill health.

However, delays sadly can also result from protracted referrals, incorrect or insufficient investigations, misreporting or failure to act upon test results and failure to monitor or follow up patients.

Cancer patients receive care from a specialised, multi-disciplinary team. Therefore, choosing the correct experts to report upon the care provided is not always straightforward. They may, for example, include physicians, surgeons, radiologists, specialist nurses, histopathologists and oncologists.

Causation often proves more difficult to establish than breach of duty. At the point in time when diagnosis should have been

reached or treatment commenced, the nature, location, size and grade of the cancer need to be established. If, for example, biopsy slides are no longer available, this may be a matter of clinical judgment based upon accessibility of healthcare records, published research and what is known of the history of different cancers.

Cancers grow when mutated cells multiply and different cancers increase at different rates. A three to six month delay in diagnosing one cancer can have a devastating outcome, while a 12 month delay in another case may not materially affect the patient's prognosis. Consideration of treatment options at the date of the alleged breach is crucial. Generally speaking, early diagnosis and treatment give the greatest likelihood of a successful outcome. If the cancer remains localised, surgery can offer the best chance of a cure but may only be possible for early cases which are located in a suitable place.



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Causation often proves more difficult to establish than breach of duty.

If evidence demonstrates that the delay has not in fact worsened the patient's prognosis, it may still be possible to recover limited damages for pain, suffering and loss of amenity and for the distress caused by the manner in which the diagnosis came to light. Understandably in these situations, many claimants and their families struggle to appreciate why a claim cannot succeed in full, despite a clear finding of breach of duty. An admission and apology from the defendant can, however, go a long way towards helping them come to terms with what has happened.

## Casewatch

Examples of the work undertaken by our team:

### Delayed diagnosis of a meningioma

Our client began suffering from unilateral deterioration of her vision in the early 1990s. She attended an optometrist regularly between 1997 and 2004, during which time the vision in one eye continued to deteriorate.

Despite the lack of any formal diagnosis or clinical signs of a macular problem, and the fact that an optometrist's role is not to make a diagnosis, the defendant failed to refer our client for investigation of the cause of the deterioration, working on the basis that this was macular degeneration. It was not until 2004 that the defendant

carried out further testing and referred our client for ophthalmological investigation.

The presence of the meningioma was identified quickly and surgery was arranged urgently. Unfortunately, by this stage the tumour was quite large and was entwined with the optic structures. As a result, our client's recovery was prolonged and she has been left with some residual effects of the surgery and no vision in one eye.

We obtained expert evidence from an optometrist, ophthalmologist and neurosurgeon. Liability and causation were initially denied. After we issued



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proceedings, liability was admitted, subject to arguments of contributory negligence, and some concession on causation was made. We agreed to attempt mediation which resulted in a settlement of £130,000.



## Casewatch

...continued

### Spinal injury from a falling tree

An employee of a small country estate was topping grass in one of the paddocks when, without warning, a horse chestnut tree fell and crushed him. He sustained a serious spinal cord injury leaving him paraplegic and he spent a prolonged period of time in hospital. On returning home, he was largely dependent on his wife for care and was unable to consider any form of employment. He developed problems with his lungs and died part way through the litigation as a result of broncho pneumonia.

We pursued a claim against his employer on the basis that she owed him a duty of care for his safety. She was aware that various trees on the property were in poor condition and might be hazardous but took no steps to have an expert assess the trees and the potential hazards to her staff.

Liability was strenuously denied throughout on the basis that it was sufficient for the defendant to check the trees and that there would have been nothing to alert her to a problem with this tree.

Both sides had to investigate whether our client's lung problems were related to the spinal cord injury. Expert evidence was obtained which concluded that he had suffered an unusual but recognised side effect from one of the drugs he had been taking. This had caused the lung damage which, combined with his physical limitations from the spinal cord injury, led to his death.

The case was contested until two weeks before High Court trial. The parties had a round table meeting and negotiated a settlement on behalf of our client, his estate and his wife.

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- Clinical negligence
- Farming and landed estates
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