

THURSDAY 6 NOVEMBER 2008

Present

Gale, B
Howarth of Breckland, B (Chairman)
Kirkwood of Kirkhope, L
Lea of Crondall, L
Morgan of Huyton, B
Neuberger, B
Trefgarne, L
Wade of Chorlton, L
Young of Hornsey, B

Memorandum submitted by Medical Defence Union

Examination of Witnesses

Witnesses: **Dr Christine Tomkins**, Deputy Chief Executive and **Dr Hugh Stewart**, Head of Case Decisions, Medical Defence Union, examined.

Q99 Chairman: Good morning and welcome. We are really grateful to you for coming this morning. We do see this as a very important inquiry into the Directive and your part of it is something we need to be clear on because I think there is currently a lack of clarity in this area. We had a short debate in the House on health where it became clear that there is lack of clarity at government level at the moment. We are going to conduct the session in two halves, as you realise. We thought it would be better to ask you both the questions; your colleagues then have the benefit of hearing your answers so may be able to elaborate, but we want to leave you time at the end for any other remarks you may want to make. You can give us supplementary evidence if you think we have not amplified the questions that you would have liked us to ask. I am going to ask the Medical Defence Union to start. Could you begin by giving your name and your position for the record and then we will proceed with any statement you wish to make.

Dr Tomkins: My Lord Chairman, thank you for inviting the Medical Defence Union here today. I am Dr Christine Tomkins; I am the Deputy Chief Executive of the Medical Defence Union.

Dr Stewart: I am Hugh Stewart, Head of Case Decisions at the Medical Defence Union.

Dr Tomkins: If I may make an opening statement, the Medical Defence Union is the UK's leading provider of medico-legal services. Our members are over half of the UK's doctors in hospital and general practice and over a third of the UK's dentists. We were established in 1885 and we concentrate on doctor and dentist members in the UK and Ireland although until the 1990s we used to provide the benefits of membership in a great number of countries worldwide. Since 2000 we have provided members as part of their benefits of membership with indemnity insurance for professional negligence claims arising out of their treatment of patients in the primary care and independent sectors. It is important to remember that patients who may need to rely upon compensation if they are harmed by negligence are not in a position to make the decision about the types of indemnity that are available for the practitioner treating them, in their state. They are reliant on the state to protect their interests and to ensure that there are adequate provisions for indemnity, be it state indemnity or individual indemnity held by healthcare professionals. We believe, therefore, that it is in the interests of protecting patients that there should be an EU-wide requirement for mandatory regulated insurance or state systems providing equal certainty in respect of liability for clinical negligence claims. We do not believe there is room for any type of unregulated indemnity and all patients who are negligently harmed as a result of healthcare must be confident that they will receive compensation no matter in which state their treatment has been provided.

Q100 Chairman: We are really quite exercised about indemnity. You explain in your evidence that most doctors who are not NHS indemnified arrange their indemnity through one

of the three medical defence organisations like yours, and unlike the other two MDOs the Medical Defence Union provides an insurance scheme in respect of claims for clinical negligence. Could you explain to us – we really do need to understand this and we do not – how the MDU model of indemnity functions, and what you consider to be its advantages and disadvantages compared with other models? Could you expand on your comment in paragraph ten of your written evidence which highlighted that the terms of the policy can hinder the right to assistance?

Dr Tomkins: I am a little confused by the reference to paragraph ten of our comments because in fact we have not made a comment that the terms of the policy can hinder the right to assistance¹. I think that may be a comment which comes from somewhere else. To explain our model of indemnity, MDU medical and dental members working in primary care and in the independent sector in the UK are provided with an insurance policy co-underwritten by SCOR Insurance (UK) Limited and International Insurance Company of Hannover Limited. The policy provides indemnity for negligence claims arising from our members' provision of professional services in the UK. The policy has a limit of £10 million for each individual case and in the aggregate per policy year and the policy provides indemnity on a claims made basis. What that means is that our members are entitled to assistance under the terms of the policy for claims notified to the MDU while they hold the policy no matter when they arose providing that the member was a member of the MDU at the time of the incident. So if a member holds a policy today and reports to us an incident from ten years ago when he was a member of the MDU it will fall to the policy. Members are also covered for Good Samaritan acts they perform worldwide. In addition to the policy MDU members are entitled to seek indemnity on a discretionary basis for matters that fall outside the policy. Retired members or those who have left the MDU and no longer hold a policy are also entitled to seek assistance

¹ The comment the MDU made was "subject only to the terms of the policy", which is addressed later in Dr Tomkins's evidence to the Committee.

on a discretionary basis in respect of claims arising from any incident that took place when they were members of the MDU. Dental members do not need to rely on discretionary indemnity when they retire because they can extend their policy to provide cover for ten years after retirement or if they cease practising because of death or disability. We believe that doctors should also have similar cover if they move provider or cease to practise for whatever reason and we would aim to provide this if mandatory insurance became a requirement in the UK. It is important because clinical negligence claims can be brought some years after the event which gives rise to the claim. Turning now to the advantages and disadvantages of insurance, the advantages of insurance are that they provide a contractual guarantee to pay, subject to clearly stated terms of the policy, whereas with discretionary indemnity there is no contract and there is no guarantee. Secondly, insurance is provided by companies which are regulated by the FSA for that type of business in the UK; MDU Services² itself is regulated as an insurance intermediary. That brings with it protection for the policy holder and so for the patient as a recipient of the compensation award. Protection comes through the Financial Ombudsman Service which, if there is a complaint or dispute about cover, can make a decision which the insurer has to adhere to. There is also the Financial Services Compensation Scheme that applies if an insurer is unable to meet its obligations so that the insured is not disadvantaged. None of those protections is available with discretionary indemnity. One of the key roles of the FSA is also to secure the right degree of protection for consumers and that includes vetting at entry, which aims to allow only firms and individuals satisfying necessary criteria to engage in these regulated activities. Once authorised it expects firms and individuals to maintain the standards it sets and it monitors firms and individuals to ensure that these standards are met and to enforce their requirements if that is necessary. It oversees the financial management of insurance companies in order to protect solvency

² MDU Services Limited is the MDU's subsidiary which is its operating vehicle

margins and reduce the risks of things like, for example, capital flight³. Another advantage is that if a doctor or a dentist is insured patients can benefit from the Third Parties (Rights Against Insurers) Act 1930 which provides them with a direct means of recovering compensation even if a doctor goes missing or fails to respond to the claim and that is not available with discretionary indemnity as a protection⁴. The disadvantage of insurance is that it is more expensive than discretionary indemnity. The subscriptions our members pay need to reflect the insurance premium tax and the cost of complying with the FSA's regulatory requirements, but regulation is, in our view, vital because it provides safeguards for our members and equally important, to any of their patients who claim compensation. It has been suggested there is a disadvantage by organisations providing only discretionary indemnity that an insurance policy might be restrictive but that is not the case. With discretion doctors or dentists can never know if they will be assisted and to what extent until they seek that assistance, and even while they are being assisted it is open to the defence organisation to limit or withdraw that assistance at any time and that is at the defence organisation's absolute discretion with no regulatory challenge and no regulatory oversight. No matter what comments may have been made about discretionary assistance provided to members in the past, the discretionary provider may not give any guarantee that assistance will be forthcoming and can only make the decision if it will assist and to what extent when the doctor or dentist asks for that assistance. There is nothing written down. Doctors and dentists do not know what they are entitled to receive nor whether they will receive it. Their absolute and only right is to seek assistance and to have that request considered. Those are the advantages and disadvantages of insurance.

³ In respect of an unregulated indemnifier this could mean, for example, that funds subscribed by UK members are used to pay claims in another country.

⁴ The Act responds if the insured becomes insolvent or is made bankrupt and allows the claimant to claim direct from the insurer under the insurance policy.

Chairman: Thank you very much indeed, that is helpful. We look forward to your colleagues' view of that. Lord Lea is going to ask you about EU countries and the comparisons, but before he does that can I just say that we may have misunderstood your comment in paragraph ten where you say, "In the UK, insurance is regulated and provides a contractual right to assistance, subject only to the terms of the policy".

Lord Kirkwood of Kirkhope: Can I come back to that in a moment?

Chairman: Do go ahead now.

Q101 Lord Kirkwood of Kirkhope: Have you ever refused a claim?

Dr Tomkins: Under the policy of insurance?

Q102 Lord Kirkwood of Kirkhope: Yes.

Dr Tomkins: We have and we have been to the Financial Ombudsman Service and the Financial Ombudsman Service determined in that case that we should pay the claim and we did⁵.

Q103 Lord Kirkwood of Kirkhope: So the terms of the contract are discretionary.

Dr Tomkins: No, the terms of the contract are not discretionary.

Q104 Lord Kirkwood of Kirkhope: Could you give me more information about what the terms of the contract actually are. Give me some examples of the omissions on which you could found to deny the claim.

Dr Tomkins: I have brought a copy of the policy of insurance if that would be helpful. The aim of the policy is to provide insurance for the members for clinical negligence claims. There are certain circumstances in the policy where indemnity for a claim is not included and

⁵ The case in question was ultimately the subject of an arbitrator's decision in the insured's favour and the claim was paid.

they might be things like a claim against a doctor by one of his employees which would generally fall to employers' liability so that the contract specifies that an exclusion is a claim against a doctor by one of his employees, that is assuming, of course, that the employee is not also a patient (if the employee was putting a claim as a patient it would be covered by the policy); a claim which has something to do with the doctor's premises; a claim which has something to do with pollution although, of course, that would not include patients who have suffered as a result of pollution who are being treated by the doctor. The exclusions in the policy are really exclusions which make it clear that this is a policy which meets clinical negligence claims.

Q105 Lord Kirkwood of Kirkhope: Could we take up the offer of the copy of the contract? You rely rather heavily on regulation of insurance companies. In the recent past there have been one or two failures of regulation. Are you confident that the regulation is available to insurance companies and gives the guarantee that you seem to be professing in the course of your suggestion that your system is better than anything else on offer?

Dr Tomkins: Yes I am confident that this provides the security for doctors which is better than anything else on offer. Does that mean that it is one hundred per cent safe in every circumstance? Clearly not because nothing is one hundred per cent safe in every circumstance, but that is why we have the Financial Ombudsman Service and that is why we have legal mechanisms in place to compensate the insured if an insurer is unable to meet its obligations and we have the third party rights against insurers. All of those are designed to protect the consumer. So the regulatory environment in as far as it is possible to do so protects the consumer whereas with discretion there is absolutely no oversight.

Q106 Lord Trefgarne: You referred to the Financial Ombudsman; there is an Insurance Ombudsman as well I think. Which one is it in this case? I once took a case to the Insurance Ombudsman and lost, needless to say.

Dr Tomkins: The case I referred to earlier was not a clinical negligence claim, as it happened, which shows that the Financial Ombudsman Service will always err on the side of protection of the consumer where there is an argument to do so. The redress of the insured who has a complaint against the insurer is through the Financial Ombudsman Service⁶.

Q107 Lord Trefgarne: Not the Insurance Ombudsman.

Dr Tomkins: No⁷.

Q108 Lord Lea of Crondall: It is often difficult to pin down exactly what we are asking in relation to the European Directive and perhaps you could indicate a general reaction to the draft Directive, to what extent the MDU model is similar to that deployed in other countries and what problems might be caused to the cross-border provision of healthcare by differing indemnity models across the EU. In that connection, in paragraph 14 of the notes signed by Mary-Lou Nesbitt, could you just enlarge on the last sentence which says “The UK (and Ireland) are the only Member States where discretionary indemnity is still available and we believe this is neither adequate nor appropriate”. That could be read perhaps in two different ways.

Dr Tomkins: There is a mix of indemnity provision throughout the EU depending on whether healthcare is provided by the state or the independent sector or both. The insurance provided to MDU members is similar to insurance that is mandatory in the majority of EU states where there is either a requirement for the healthcare institution or the doctors they employ to be

⁶ If the insured is dissatisfied by the decision of the Ombudsman, he or she may pursue the complaint through the courts or, if the policy so provides, through arbitration.

⁷ The Insurance Ombudsman was brought within the Financial Ombudsman Service.

insured or both. In Austria, Germany, Latvia, France and Slovakia it is, as we understand it, mandatory for doctors to have insurance. In the Czech Republic, Finland, Hungary, Poland and Spain there is a requirement for healthcare institutions and individual doctors to be insured. In Lithuania and Portugal there is a requirement for institutions to be insured and it is advised that doctors be insured because the institution can claim back from them any compensation payments it makes on their behalf. In Italy and Estonia insurance is voluntary. That is how we understand the situation to be. In a few states we have not found a requirement for insurance for doctors and those are Greece, Luxembourg and Slovenia. In Denmark and the Netherlands there is a state indemnity scheme and, as we understand it, individual doctors do not need to be insured but in Sweden, where there is also state indemnity, there is an additional requirement that doctors practising in the private sector are insured either personally or through the service companies in which they work. A minority of states allow discretionary indemnity; they are the UK, Ireland and Malta. If discretionary indemnity was considered acceptable for cross-border healthcare it would not meet the expectations of the majority of EU patients who expect certainty of compensation either because there is a state indemnity or the clinical institutions or individual healthcare providers are insured or a combination of any of these. That could give rise to difficulties so, for example, a German patient who was treated in the UK and negligently harmed by a doctor who was reliant only on discretionary indemnity might not be compensated if the indemnifier decided not to assist the doctor with the claim. Of course a German patient who had been treated and harmed in Germany by an insured doctor would have received insured compensation. There is a real risk with discretionary indemnity that doctors and dentists may not be assisted and the patient will go uncompensated. In the United Kingdom while discretionary indemnity is currently provided to some doctors and dentists – including those who are members of the MDU – many other healthcare professionals actually have to be

insured, their registration body requires them to be so. We have new regulations which came into force on 3 November⁸ which set out a requirement for all healthcare professionals, including doctors, who undertake assessments of mental capacity to be insured in respect of any liabilities that might arise in making those assessments. They have to provide evidence to the supervisory body that they have such insurance. Physiotherapists, chiropractors, osteopaths and optometrists in the UK have to be insured; their registration bodies require them to be. That leads to a further potential anomaly with cross-border healthcare. For example, if you had a German patient who sought treatment in the UK from an insured healthcare professional, like a physiotherapist or an optometrist, that patient could be sure of compensation if he or she was negligently harmed because these and other healthcare professionals are required to be insured. So it is inconsistent that patients would be subject to different levels of certainty in respect of compensation depending on which healthcare professional treats them or, if it is a doctor or a dentist, depending on which medical defence organisation they belong to. We believe that any indemnity requirement should make it clear that the indemnity must provide consistent cover for patients so they have the same guarantee that they will receive compensation no matter which healthcare professional they consult in another Member State.

Chairman: I think you have just very helpfully answered the next question. Lord Trefgarne, you may want to follow something up after Lord Lea.

Q109 Lord Lea of Crondall: I am not clear whether you suggested, arising from this paragraph 14 of your note, an amendment in any prior consultation on the Directive and now is your opportunity if you did not. Where would you want to amend the draft Directive to deal with the point?

⁸ The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008

Dr Tomkins: I think it would be helpful to have something explicit in the Directive specifying that the applicable law and court jurisdiction concerning compensation for harm arising from cross-border healthcare is that of the Member State where the care is provided and that indemnity must be on an insured basis so that there is clarity and certainty for patients.

Q110 Lord Lea of Crondall: Was that thought fed into the consultation before the Directive?

Dr Tomkins: We have fed that into the EU officials who are dealing with it.

Q111 Lord Trefgarne: Much of my question was covered by your response to the earlier question, but we are concerned that the legal framework under which all this will in due course be provided (following, as we assume, the implementation of the Directive) will mean that the legal basis in all Member States is more or less the same. Are you content that that is what will indeed emerge from this process?

Dr Tomkins: I think that there is a difficulty with the wording because Article 5(1)(e) allows indemnity to be provided by state schemes' insurance which are the only means in most of the Member States, but as it stands at the moment it could be interpreted as allowing discretionary indemnity to be used for clinical negligence claims because the phrase that concerns us is "systems of professional liability insurance or a guarantee or similar arrangement, which are equivalent or essentially comparable as regards their purpose". We understand that the draft Directive is phrased in this way because of the need to encompass state indemnity schemes so it did not have discretionary schemes in mind, it had state indemnity schemes in mind with this wording. We do not believe discretionary arrangements are similar or essentially comparable because they do not provide a guarantee of indemnity and are not subject to regulation. The courts in the UK and Ireland confirm that discretionary indemnity is not insurance and that discretionary indemnifiers are not subject to the law relating to insurance

regulation. We do think that the draft Directive should be amended in the interests of patients and healthcare professionals so it is clear that the treating states are required to ensure compensation for claims in respect of treatment in their territory through state indemnity or indemnity insurance underwritten by regulated insurance companies.

Chairman: What is clear for everyone is that we do need absolute clarity.

Lord Trefgarne: It does not follow that it all has to be the same, does it?

Chairman: No, not the same; it has to be clear, I would have thought.

Q112 Lord Trefgarne: Clear but not necessarily the same. I am much in favour of the policy of subsidiarity. Maybe a one size fits all is not the best way.

Dr Tomkins: I think that is right but, on the other hand, we have, for example, in the Non-Life Directive on insurance a move towards harmonisation of insurance arrangements throughout the EU and the only way to achieve certainty and clarity for the patient is to have a clear contract which the patient understands.

Q113 Lord Trefgarne: Harmonisation is one thing, but identical policies is another.

Dr Tomkins: I do not think identical policies are viable because the risks and the judicial systems and the compensations systems in the different territories are different and the policy applying in any particular state needs to take that into account.

Chairman: I would advise the witness that Lord Trefgarne is a great defender of subsidiarity.

Q114 Baroness Young of Hornsey: I wonder if you could give some indication of the current numbers of patients who have made claims as a result of having treatment across different borders. Is there any kind of sense of what that currently stands at. I am trying to get the grip of what is currently happening and what then might change as a result of any Directive?

Dr Tomkins: No, I do not have any numbers of claims in relation to patients who have had medical treatment outside their home state but I understand that the number of patients actually receiving treatment is relatively small, fewer than one per cent of the number of patients being treated. I do not imagine that the number of claims arising from those would currently be large but, of course, for various reasons we can expect the number of patients being treated abroad to increase in the future and therefore I think the problem needs to be addressed before that happens.

Chairman: Of course; I am just trying to get a benchmark.

Q115 Baroness Neuberger: You were very clear that basically patients ought to be able to get compensation in the host country wherever they have the treatment and you have obviously fed that in to the officials and there has not been thus far, as far as we can see, a lot of response. Are you concerned that this is going to be a major obstacle in allowing patients to be more mobile in Europe? Do you think it is going to stop people travelling? Do you think the EU should take it seriously from that point of view?

Dr Tomkins: I think it might stop people travelling, perhaps not initially but if circumstances arise in which there is an uncompensated patient then the problem will come to the fore and may well be a deterrent to free movement of patients across boundaries.

Lord Trefgarne: We are talking about microscopic numbers, are we not?

Baroness Neuberger: We are at the moment but it may change.

Q116 Baroness Morgan of Huyton: Obviously the situation is complicated already and, picking up on that last point, I suspect most people now do not know what the position is. Moving forward, if this Directive were to come into operation, what sort of information do you think should be given and who should be responsible for making sure that patients are informed properly?

Dr Tomkins: We believe the Member States should be responsible for provision of information about redress and compensation within that state.

Q117 Baroness Morgan of Huyton: Is that the governments or the health practitioners in different states?

Dr Tomkins: I think there may be an argument for having a body whose function it is to provide this information and having such a body in each of the EU states who are charged with providing information about the delivery of healthcare, the quality, the safety and the methods of complaint and redress within that state so that patients who are going to go across borders for healthcare have a reference point; they have one in their country and they know that each EU state has that equivalent body in their country.

Q118 Baroness Morgan of Huyton: I do not really quite follow that. Surely you are not suggesting that in Britain we set up an additional body that only does that.

Dr Tomkins: That is one way of looking at the problem, or the responsibility might devolve, for example, to the Department of Health. I think that is a matter for those who decide how the information should be disseminated. What is key is that patients should know where to go and that the Member States should be providing that information which is clear, accurate and up-to-date for the patients so that they can make an informed decision.

Q119 Chairman: What is absolutely clear again is that patients will fall between a variety of different organisations. I know this is not your area, but do you have a preference? Do you think independence is important in giving information?

Dr Tomkins: Yes, I do think independence is important in giving information. If I were a patient and I knew that there was a body in my territory that I could go to and that every other

EU state had such a body too, then I think that might help me to find out what I needed to know.

Chairman: We are very grateful to you for getting through this. We are going to have to change over right now because of the timing. Thank you, and thank you to Dr Stewart for supporting you. You will come back at the end if you so wish. We will now move on to the MPS.

Memorandum submitted by Medical Protection Society

Examination of Witnesses

Witnesses: **Mr Tony Mason**, Chief Executive and **Dr Stephanie Bown**, Director of Policy, Medical Protection Society, examined.

Q120 Chairman: Could I ask you to state your names and titles for the record and then say if you want to make a short opening statement.

Mr Mason: My Lord Chairman and members of the Committee, my name is Tony Mason and I am the Chief Executive of the Medical Protection Society.

Dr Bown: I am Dr Stephanie Bown; I am Director of Policy and Communications in the Medical Protection Society.

Mr Mason: I would like to make a short opening statement. First of all, thank you for inviting us to give evidence this morning. I would like to start by saying that MPS welcomes the development of a community framework that provides high quality healthcare services and which lends greater clarity about patient and community law to cross-border healthcare issues. We also fully support the requirement that patients have access to compensation should they suffer negligent harm arising from cross-border treatment. We are particularly pleased that article 5(1)(e) of the proposed Directive supports the view of the UK Parliament that various forms of indemnity, not just insurance, are acceptable. During 2005 and 2006 both Houses of Parliament in the UK debated the issue of insurance and discretionary indemnity and after extensive consultation legislation was enacted that requires all medical and dental practitioners to have adequate and appropriate indemnity in this country. The legislation provides for a policy of insurance or discretionary indemnity or a combination of the two and currently the General Medical and Dental Councils are drawing up rules to put all this into place. The wording of article 5(1)(e) is therefore very important in recognising the core principles of subsidiarity and proportionality that are enshrined in the original European

treaty. The members of this Committee will have seen from my CV that before joining MPS as their Chief Executive I was a consulting actuary and for nearly 25 years I specialised in the field of clinical negligence. My clients have involved doctors' mutuals, governments and insurance companies, and I have advised on all the different types and ways and methods of actually providing medical negligence indemnity. Although I fully support the principle of giving individuals the freedom of choice - a choice between insurance and discretionary indemnity - I am personally convinced that discretionary indemnity is the best form of cover. In my view the fair and appropriate compensation of victims of medical negligence is far too important for governments to leave in the hands of insurance companies. I believe that the best approach is for governments to work closely together with the medical and dental professions to ensure that it will be a long term and sustainable solution. The insurance industry actually has a very poor record when it comes to medical negligence and in my career I have seen more than a dozen examples of insurance companies that have entered a market when conditions look good only to withdraw when they see claims rise and profits fall. Perhaps the most infamous case was that of St Paul which was an American insurer and the largest in the world (the largest indemnifier of medical negligence cover in the world) which in 2001 announced that with immediate effect it was withdrawing from the market and it left 750 hospitals and 115,000 healthcare professionals in America without on-going cover. It also operated in other countries around the world and its withdrawal was quite devastating at the time to some of the healthcare professionals involved. The Medical Protection Society was formed by doctors and dentists in 1892 as a mutual company and over the last 116 years it has grown to having more than a quarter of a million members around the world with half the practising doctors in the UK and two-thirds of the dentists who remain owners of the company. Its initial ideals today are the same as when it was established, that is to protect the financial interests and reputations of the medical and dental professions, to improve patient

safety through education and risk management and, equally importantly, to ensure that patients who have suffered as a result of clinical negligence receive fair and appropriate compensation. In all the history of MPS there is no example of MPS exercising its discretion so as to allow a patient to go uncompensated where that patient has been found to have suffered from the medical negligence of one of its members who was entitled to assistance. That is the true strength of discretionary indemnity. It is a system that works with a proven track record.

Q121 Chairman: You have explained in great detail how your model works. Can I do what I did to your other colleagues, you have told us its advantages but what are its disadvantages? You say there has been no instance of a patient going uncompensated where that patient has been found to have suffered from the medical negligence of an MPS member who is entitled to assistance. Can you tell us if there are any instances where indemnity might be withheld?

Mr Mason: A member, a doctor say, who has a claim brought against him by one of his patients applies to MPS for assistance in the same way that a member of a trade union would apply for assistance. The first thing we do is to check that the individual was a member of MPS at the time the incident took place because it is a very important part of our cover that we are occurrence based. This means that we will indemnify a doctor if he was a member at the time the incident took place even though he may have retired, left or even died in the meantime. If the individual was not a member at that time then we obviously would not give cover. The problems that are sometimes encountered – not that often – are when a doctor has, say, said that they operated in one area of medicine when, in fact, they were giving treatment to a patient in a different area of medicine where they should have paid a significantly higher subscription to us. In those circumstances we will normally require that member to pay us the back subscriptions. What we do not like to have happen is to allow patients to go uncompensated. When it comes to claims we have looked and there are no examples of

where we have allowed patients of a member entitled to assistance to go uncompensated. Where MPS tends to exercise its discretion sometimes against the doctor is not related to claims of negligence and patients, it may be to do with disciplinary hearings or other matters⁹ occasionally where we feel that the doctor wants to pursue something way beyond any chance of success. But that in itself is rare. All our decisions are subject to appeal at MPS's Council which is an elected body of doctors, dentists and other professionals – lawyers, accountants, actuaries, insurance specialists – and they always have the right to appeal there. Basically all our members have a right to ensure that any exercise of discretion has been done fairly and properly. At the end of the day there really are no drawbacks to the system: only the perception that we may not cover.

Q122 Chairman: The previous witnesses gave us the impression that it felt unclear and insecure. What would be your response to that?

Mr Mason: There has to be a level of trust with discretion and really it is the track record that is really important. I do not actually believe that knowing a doctor has a contract of insurance gives any particular guarantee or comfort; it does depend on the wording of that contract and the exclusions. Every insurance contract will be different in the different countries. In various countries in Europe there will be maybe seven, eight, ten, twelve different insurance companies offering contracts of insurance, all of those will be different, there will be different exclusions. One of the common reasons why insurance companies will turn things down is the non-disclosure or inaccurate disclosure. I am sure everybody in this room either themselves or will know somebody who has had an insurance claim which has been turned down. They considered it to be a valid claim but it was turned down because insurance companies stick to the letter of the policy. That is correct; regulators insist that insurance

⁹ Other matters might involve criminal charges such as indecent assault outside a clinical setting; civil claims such as defamation claims; personal misconduct; and employment issues such as discrimination.

companies stick to the letter of the policy because otherwise they would potentially have liabilities that the regulators do not know about. So it is a fundamental part of insurance.

Q123 Lord Kirkwood of Kirkhope: You will have to look at this from our point of view; this is not a beauty contest. You are both very helpful at helping the Committee understand; all we are trying to work out is how we get the best protection in this European Directive. I think we are all on the same side in that. For the sake of completeness, you must have some sort of agreement, could we ask similarly that we see what it is that you offer as a template example that could be made available.

Mr Mason: We are very happy to let you see our memorandum and articles for the MPS and give you all the details. The key thing is that we cannot guarantee to pay. The real strength of discretion is that when you get odd circumstances – something unusual, something which falls outside an insurance contract – we can still help and assist. Our main aim is not just the individual doctor, it is the reputation of the medical profession and it is not good for the medical and dental professions to leave any patient uncompensated.

Q124 Lord Kirkwood of Kirkhope: You referred to St Paul in 2001 in America, but the MDU tell us there was an example of a failure in Australia in 2000, a discretionary indemnifier. What do you say to that?

Mr Mason: That is actually my specialist area because I had five clients in Australia at the time. There were seven medical defence organisations in Australia, six of them provided discretionary cover, one of them provided a contract of insurance on a claims made basis with discretionary additions. That is exactly the same model as the MDU. It is that company that got into difficulty and it was the insurance company that actually had the problem, it was not with the discretionary indemnifier. The directors of that insurance company went to the courts and asked for provisional liquidation and in fact it was turned down. They did not

actually need it but they went back again because the directors could not get directors and officers insurance. It is quite a complex matter.

Q125 Lord Kirkwood of Kirkhope: I am beginning to wish I had never asked the question

Mr Mason: The actual discretionary organisations in Australia were all sound and continue to be sound. Australia is a prime example of what is wrong with insurance actually.

Q126 Lord Kirkwood of Kirkhope: You say you have a council of the good and the great to look at all this stuff but you have no right of legal appeal if all that fails.

Dr Bown: We have a legal obligation to exercise discretion fairly and not capriciously and there is a remedy for a member to challenge a decision to withhold discretion. They have a contractual entitlement to have the exercise of discretion exercised fairly.

Lord Trefgarne: I was going to come to exactly that point which Lord Kirkwood has made. The liability of a negligent practitioner is not confined to the insurance cover or other cover that he has secured; it is a question of fact decided by law. If I feel that a practitioner has been negligent and I get a judgment against him for X thousands of pounds, if his insurance cover provides payment for that then that is fine but if not he is personally liable and that is that.

Chairman: I think the answer is yes and Lord Trefgarne has answered his own question. Can we move onto Lord Lea and Europe now?

Q127 Lord Lea of Crondall: You heard the interchange a few moments ago with the MDU on this broad area. You seem to be reasonably happy about the draft Directive as far as I understand it. Could you comment on the problems that may be caused by different indemnity models and, in that connection, could I ask how you do your representations in

Brussels? Do you get together or is it under the umbrella of the BMA or something? Is there a European body that does the negotiations or input or whatever you like to call it.

Mr Mason: The problems that I see are that the insurance policies are all different; there are some very good insurance policies out there. In some countries you can actually buy an occurrence based insurance but most insurance contracts are claims made in Europe which means that if a doctor ceases to pay his premium and then moves overseas or returns to another continent, if they have not taken out what is called run-off cover, patients are potentially going to be exposed because there is no doctor there to actually sue. The main issue is really exclusions or conditions in the contract of insurance. Just putting one thing into perspective, the chances of a patient going uncompensated as a result of the indemnity arrangements of a doctor are very small, miniscule. There will, however, every year be thousands of patients who go uncompensated because they either did not know they were subject to harm or they knew, but decided not to take it forward, or they cannot find lawyers who will represent them, or the Legal Aid system is not good enough, or the causation is a bit dubious and they cannot prove what is actually a valid case, or through the inexperience of their solicitors. There are a lot of reasons why patients go uncompensated and we are actually talking here about the possibility that over a very long period something might happen that has not happened in the past. Compared with all the other problems of trying to ensure proper healthcare we are talking about a really, really minor point. The real issues are that in a lot of the European countries it is actually very difficult to bring a claim against a doctor. My major concern for you really is that there will be patients going from the UK to other countries who will find it very difficult to bring a claim. It has nothing to do with the indemnity arrangements for the doctors concerned, it is just that the legal system does not make it easy to bring claims and I think that is one of the important issues.

Q128 Lord Lea of Crondall: I asked you about the structure of your representational body in Brussels, can you say a bit about that?

Dr Bown: MPS undertakes its own representation and we make arrangements to meet with and speak with MEPs. We started on this with the Services Directive which initially included healthcare and then the healthcare component was dropped. So we do have links with MEPs but we lobby and we do our relationship building as an independent, stand alone organisation.

Q129 Lord Lea of Crondall: Are there sister bodies around France and Germany that you get together with?

Dr Bown: No.

Chairman: We are going to have to move on in view of the time if that is all right with you. Lady Young, you are going to pursue any other remaining bits about this legal framework.

Q130 Baroness Young of Hornsey: Uncovering all these complexities is very interesting particularly as we understand that a relatively small – miniscule is the word that keeps being used – number of people might be affected, nonetheless for those individuals it is quite high stakes so it is quite important that we clarify it. In terms of your interpretation of the proposed legal framework, how do you interpret it? What obligations do you feel it is placing on each Member State? We have had this debate about harmonisation or is it making things similar or is it making things the same, how workable is it and how might the provisions be clarified to your satisfaction?

Dr Bown: Our interpretation is that the legal framework is setting out the responsibilities on Member States for ensuring that these patients' rights are accessible. There is also the emphasis that it is for individual Member States to decide how they will achieve the purpose of protecting patients. In our written submission we based our suggestion on the system in the UK whereby the commissioner of healthcare is responsible for ensuring that there is

insurance indemnity in place. Having really reflected on this at length, and looking at the potential complexity of the bringing together 27 different Member States providing treatment to patients from 27 countries, we do not think that is workable and we do not completely accept the proposal in the Directive that it should be the obligation on the Member State of treatment to ensure that those providing the treatment hold professional liability insurance or indemnity. We see that it is the obligation on Member State of treatment not only to ensure that there is appropriate indemnity in place but also to ensure that there are mechanisms for redress and compensation. Moving on to your question about how workable this is, we do have grave concerns about how workable it is going to be. If you look at the situation in the UK we have a position, as has been explained, whereby doctors and dentists have an obligation to have professional indemnity in place and we do not know whether that applies across different European states. It is terribly important if you think about our UK patients that when they travel to other Member States they must have confidence that they are going to have access to redress and compensation. Similarly in the UK we have a well-developed complaints system and a well-developed system for access to redress. Although sometimes it catches its critics it is well developed. We are not confident that such similar mechanisms of redress are necessarily currently available within other Member States. There is a whole thorny area of what happens with split care where you have your original treatment in France and then you come back and have follow up treatment perhaps in the UK and there may be deficiencies in both sites, and that again is a potential for complexity. In terms of clarification of the provisions certainly we would be looking for absolute clarity and unambiguous wording about who is responsible for the delivery and funding of aftercare and for where the indemnity should lie. We know that there are interpretive guidelines to be developed and they will have a crucial role. Then we have a very grave concern about the definition of harm in Article 4 which defines harm as “adverse outcomes or injuries stemming from the provision

of healthcare". We believe that essentially this introduces a no fault compensation which would be a fundamental departure for the UK. If I could illustrate what that might mean, for instance a patient with diabetes we know is at greater risk of potential post-operative wound infection. They are warned about that, they accept the risk, surgery is performed with all due care but the patient is unfortunate enough to get a known, recognised complication of a wound infection, the wound might break open, they are in hospital for much longer, they have suffered harm as a result of treatment. Under the current clinical negligence that would not be compensatable and we do believe that the terminology of harm should refer to negligence.

Q131 Baroness Young of Hornsey: Is that under clinical negligence in the UK?

Dr Bown: Under our system yes; it would have to be avoidable harm as a consequence of sub-standard care. So you would need to have deficiency in care which causes or materially contributes to the patient's harm.

Chairman: It is a question of clarity of wording, that is absolutely crucial. We need to move on because of the time. Lord Wade, are there other things you want to ask about the differing legal system?

Q132 Lord Wade of Chorlton: You have dealt with a lot of the questions that I was going to ask on the question of differing legal systems within that answer but I would just like to follow on one or two things. Could I just say that I have suffered from exactly the point that you made, that being diabetic I have had some very serious problems and there was nothing I could do about it, I just had to solve it myself. Mr Mason mentioned the fact that the legal system could be so different than legal systems in other areas, and that is an interesting point which he might be able to talk about a bit more because that depends on different legal systems not so much on the question of redress and compensation but on the actual way of dealing with the matter from the beginning. The other point I would also like to make is that

you referred to the fact that most people treated elsewhere other than their home country will make the decision to move there. You may well be ill but did not intend to be treated in the other country but you happen to be taken ill there. Clearly in those circumstances it is much more difficult to actually find out the legal process, is it not? Is that not an issue that we will need to be looking at as well?

Dr Bown: I think the circumstances of what happens when you fall ill on holiday are outwith this particular Directive and would come under the E111 mutual recognition of treatment. We do see the potential for a great confusion when you have 27 different states with potentially multiple different systems and, in addition to that, we have to consider for our patients language barriers, different meanings and interpretations. There are challenges with regard to accessing evidence if you go back to your state of domicile, accessing the medical records, getting witness statements and even access to professional advice and representation. We see Article 12, which provides for a national contact point in the Member State of affiliation, as being the potential way of ensuring that there is comprehensive, accessible and consistent information available for patients in their state of domicile but, similarly, there must be an equal obligation on the treating Member State to provide information about what treatments are available and what mechanisms for redress there are.

Q133 Baroness Gale: It seems to me that the big thing is information. The information you say should cover access, redress and compensation. How do you think this information can be provided and who should be responsible for its provision? You talked earlier about a national contact point, could you say more on that?

Dr Bown: Certainly I think that patients will want information that is accessible and consistent in terms of quality, scope and being understandable. Therefore we would suggest that having it provided at a national level so there is consistency is probably the right way. However, we do not underestimate the size of the task and the potential cost for doing this,

but we owe it to patients to make sure that the choices they make are informed choices. There was one other point that I thought might be useful to mention which is that in January 2009 an EC regulation called Rome II is coming into effect. It is our view that it is better for patients that there should be clarity about the country in which they should pursue their redress. We think it is better that that should be the provider country. Rome II, which comes into effect in January next year, will apply the basic rule that where the parties are domiciled in their relevant jurisdiction - so the claimant, patient and respondent doctor or organisation - the governing law will be the law of the country where the damage occurs. In the vast majority of cases that would be the Member State in which the treatment is being given and that, to us, would reinforce the value of having a consistent mechanism whereby the claim is brought in the country of treatment.

Q134 Chairman: I absolutely see the logic of that but if you are a patient and you have gone home how do you think that that patient can then pursue the difficulties in another jurisdiction?

Dr Bown: That comes back to the role of this national contact point which is going to be hugely important.

Mr Mason: There are some real issues in countries that have no-fault compensation - the doctors will not have any indemnity cover. You can only really deliver the proper compensation in the country where the treatment took place. This is what we have actually concluded.

Dr Bown: That must therefore be a critical component to the decision that the patient makes about where they go for their treatment.

Q135 Baroness Gale: They would need really to have all that information before they have their treatment.

Dr Bown: Absolutely.

Q136 Baroness Gale: That is the important thing, that they know at that point what is going to happen if they are unfortunate enough that something goes wrong.

Dr Bown: Indeed, and whilst we very much welcome the role of general practitioners as being gatekeepers for access to cross-border healthcare we think it is of absolute crucial importance that they should not be held liable for the quality of the information that should be available at a national level.

Lord Wade of Chorlton: If a patient decided to travel to another country for a particular operation and he was aware of the difficulties, could he then take out an insurance in this country against any eventuality of going wrong?

Chairman: You can take out a general insurance for anything.

Q137 Lord Wade of Chorlton: Is there an insurance company that deals with that sort of thing?

Mr Mason: I suspect you could certainly take out personal accident insurance. There will be insurances out there and I suspect it may be an area that could be developed. I am not sure that there are any that are specific to that risk but you could take out insurances which would cover you for actually being off work or incurring some serious harm.

Lord Wade of Chorlton: It could be a lot more expensive in one country than another. That might be a good thing to find out.

Chairman: I think we might want to pursue that aspect, Lord Wade. Could I ask the other witnesses if they would like to join us again. Time is moving on but we have two or three minutes in which to pursue any remaining matters.

Witnesses: **Dr Christine Tomkins**, Deputy Chief Executive, **Dr Hugh Stewart**, Head of Case Decisions, Medical Defence Union, **Mr Tony Mason**, Chief Executive and **Dr Stephanie Bown**, Director of Policy, Medical Protection Society, recalled.

Chairman: We only have a very few minutes left and we are very grateful for all the work you have given us so far. It is an area where you can see we have a lot of interest and there is a lot of clarity to be sought if this is going to work in any way.

Q138 Lord Lea of Crondall: In most walks of life in the analogous situation there would spring up links between the French and the German set up or the Spanish and the British set up and you would have colleagues who would have regular contact with each other and there would be the emergence of some sort of forum where you get to know your colleagues in Poland or wherever may be. Take Poland as an example, do you never meet anybody or have I misunderstood?

Dr Bown: What I omitted to make reference to is the Physicians Insurance Association of America which is a group of a number of healthcare indemnifiers and insurers which do indeed come together and share experience.

Dr Tomkins: If I could add to that perhaps more relevantly there is an organisation called Europa Medica which does exactly that. It is an organisation of insurers of doctors and hospitals in Europe. The MDU is a member of that.

Q139 Lord Kirkwood of Kirkhope: You have been very helpful this morning. Is this worth doing? In your evidence you have both shown enthusiasm for establishing this right, it is a right for people to exercise if they wish to do so, but the more you look at this the more complex it becomes. Is it worth the candle?

Dr Tomkins: Yes, I believe it is worth the candle because, as we have an increase in tertiary centres of excellence, there is going to be an argument for people crossing borders to go to tertiary referral centres; for people who have rare conditions there will be specialist centres across borders; for people who live near borders there will be hospitals that are across the border to which they need to go. Then there is the question of people who find themselves in another EU state from their home state and who fall ill there. They need to know what the arrangements are. Yes, there should be free movement of patients across borders. I anticipate that there will be more of it as time goes on and if there is then patients need to be clear of what they are going to get.

Q140 Chairman: So what you are saying is that choice and availability is worth working hard at getting clarity in these other areas. I think Lord Kirkwood is wondering how easy is it going to be to get clarity in your particular area. I think we feel even more doubtful; this is not your fault, we have found it very helpful having heard your evidence.

Dr Stewart: I think it is worth emphasising that the preamble to the draft Directive makes clear that there are European Court judgments which say that you can move in this way and that is why the draft Directive is there. It is not a question really for us as to whether a patient should be able to move across borders; they are able to move across borders and that is now a matter of European law. This is clarifying the means in which they can and the protections for them and the main part of our evidence today was that one of those protections is the issue of the nature of any indemnity provisions for them. I wonder if I might make one brief comment following our colleagues' comments. Stephanie Bown pointed out that there are risks for UK patients who may go abroad in terms of them getting indemnity. Lord Trefgarne suggested the principle of subsidiarity was important and that not all countries require the same insurance requirements but what the European Union can do more effectively than individual Member States is to ensure that as a minimum there is some guarantee of a right

for patients who are harmed by clinical negligence in a European Union country to obtain compensation. Mr Mason said that with discretion there is no guarantee and the point I wanted to make is that this is not about the MDU and the MPS, it is about discretionary indemnity as opposed to contractual indemnity by insurance. I do not think it is enough to say “trust us” or “look at our past record” because it is not about one individual supplier, it is about whether UK patients may go to other European Union countries, be harmed and be reliant only on discretionary indemnity where the doctors only have a right to request assistance but there is no guarantee that any indemnity will be forthcoming. Although, as Lord Trefgarne said, you can take action against individual doctors, but if your claim is for £5 million because you are brain damaged as a result of negligence the doctor is unlikely to have sufficient funds.

Mr Mason: I think it is important considering that the patients do have the right to go between countries. It is not going to be a simple matter. It really is, I believe, up to each country to decide what is adequate and appropriate indemnity. The General Medical Council and the General Dental Council have, over the last year, been considering the issues; there are some very, very complex issues. It is not just indemnity; some doctors are covered by their employer; some by government, some by universities, some by schools. Some of the hospitals do not insure, they carry self-insurance. There are a lot of very, very complex issues which the General Medical Council is wrestling with at the moment and I think they are the body to define what is adequate and appropriate indemnity. Whatever else, this Directive is not going to be able to answer everything. It cannot. It can only, at a high level, give an indication of what is required and until you actually have harmonisation of the law in every different country it will be impossible to have equal redress for compensation.

Q141 Lord Wade of Chorlton: What I would like to get your view on is whether the market place is likely to try to solve the problem? In other words, if you have a specialist centre that

wants to attract people they are going to have to provide all these insurance services in order to get the people. So if the Directive is passed is the market place going to find solutions to these sorts of problems?

Mr Mason: I think it will. There will be different solutions in each country because of the different legal systems.

Dr Tomkins: Certainly there are different legal systems in different countries and there will be different policies of insurance in different countries to accommodate that, however the point is that patients need to rely upon compensation if they are harmed by negligence but they are not making and are not in an informed position to make a decision about the type of indemnity that is available to the practitioner treating them. They may be referred to the tertiary referral centre but they are not in a position to decide for themselves what the indemnity arrangements will be. Insured indemnity is already a requirement in many EU states and regulated insurance is recognised across the EU and it has been established through, for example, the Non-Life Directive that there should be harmonisation of the laws, regulations and administrative provisions relating to insurance not to the delivery of healthcare.

Chairman: So really what we are saying is that we do not think the market place in the first instance will actually be able to influence and therefore we have to have proper procedures and clarity in place. I think the point you were making – with reference the *Watts* case for example – is that we have to move forward otherwise we will have the lawyers in the European courts making the decisions for us. We are immensely grateful to you for helping us with this which, as you can see, is complex for you and it is even more complex for we who have to deal with the issues around the whole of the Directive. Do let us know if there is anything else you want to tell us. We may well come back if we find there is an issue that we still need to clarify, but meanwhile thank you very much indeed for spending the time with us.