Clinical Negligence: Powers and Barton, fifth edition (2015)

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I am pleased to have been asked to provide the Foreword for this edition.

Negligence is largely a creature of the common law. The underlying legal principle is simple – the test of liability is reasonableness. Clinical negligence applies it to infinitely variable, often novel, and usually complex medical facts. It deals with the different aspects of medical management: advice, diagnosis, and treatment. The approach of the courts reflects simplicity and clarity, but avoids the simplistic. The reasoning and decisions are generally pragmatic, flexible and robust - they accord with common sense. It is well suited to consider liability in medical innovation.

Parliamentary attempts to change the basis and process of compensation for clinical negligence have generally not been happy or, arguably, useful.

In the early 1990s two Bills (Rosie Barnes and Harriet Harman) sought to introduce no-fault compensation for medical accidents. Both failed, and rightly so too. Even where proof of fault is not required, the question of causation cannot be avoided.

More recently, I was a shadow Health Minister when the NHS Redress Act 2006 was passed. The scheme of the Act was that redress for clinical negligence could be provided without resort to court; we opposed it because the proposed scheme was fundamentally flawed. My central concern was that the Redress process involved the health service acting as judge and jury in the investigation of its own fault-based liability but then attempting to resolve the matter by engaging in a consensual process with injured patient who had neither medical advisers nor legal representation. It proposes an ambitious one stop shop Redress package – explanation, compensation, apology and treatment. Little has been enabled of this enabling legislation in England. It is as well that the legislation remains merely useless in England rather than worse than useless. The same cannot be said of the situation in Wales where the Redress scheme has been implemented.

In a similar vein, many of us in Parliament had concerns with Lord Saatchi's Medical Innovation Bill. No-one doubts the good intention of promoting medical innovation, but we had concerns the Bill sought to create an anomalous statutory exception in the general common law of negligence for innovative medical treatment.

Parliamentary scrutiny demands evidence. The Bill was based on the false premise that doctors are deterred from innovating by the threat of being sued in negligence. If such evidence exists, I am not aware of it. Doctors can and do innovate without this proposed law - the innovative response to the Ebola crisis is an excellent example. Every day one learns of new treatments.

The Access to Medical Treatments (Innovation) Bill is another private member's bill which seeks to promote medical innovation, and which will be debated shortly in the House of Commons. Again, many believe it is fundamentally flawed because it addresses a non-existent problem of seeking to create an anomalous statutory exemption in the general common law of negligence for medical innovation.

Often, the hardest thing to do is nothing. The best thing legislators can do is by and large to leave the common law of clinical negligence alone. If it is not necessary to legislate, it is necessary not to legislate. Moreover, there is a duty not to pass bad law.