of patients with mental handicap who are cared for in their own homes are cared for by parents who are aged over 65; and, to emphasise the point again, these are usually women. Most of these women are soldiering on without adequate financial help or support from health and social services. Moreover, Mrs Val Hollinhurst pointed out, two thirds of them were themselves in poor health. It was wrong to think that they got plenty of support from friends and neighbours; in reality many were shunned, and the rosy view put forward by politicians that the community has a bottomless well of care in its breast had been proved wrong. She believed that general practitioners should do more to help carers. This included a plea to recognise that carers ran a high risk of getting ill or having social and psychological problems. The tendency to dismiss their problems and take a paternalistic "well done, you *are* coping well" approach was not helpful. In addition, general practitioners should ensure that carers knew both the diagnosis and the prognosis. On a practical level, help with claiming for benefits was needed, for many carers could not cope with the myriad of forms they had to go through to claim the benefits they were entitled to.

Allocation of resources had never matched the political commit-

ment to provide care, said Professor Alan Walker, and when it came to power struggles the hospitals and other large institutions always won. Apart from more funds, a better mechanism was needed for transferring funds from hospitals for deployment in the community. As he pointed out, "any fool can close a long stay hospital but it takes genius to transfer funds from the health service to social services." The cut in the social services budget (3% less than that required to maintain the status quo) had to be made good, and it was essential for health services, social services, and social security to collaborate with each other more effectively than they have done so far to sort out a rational approach to community care. The factors behind the extraordinarily uneven provision of care should also be looked into. Monitoring and feedback were also important, and it was reassuring to hear that most new community care projects have "audit" built into their budgets.

As a final message, it is clear that all those concerned with mental handicap must fight their corner hard to ensure that the wellbeing of people with mental handicap is not seen as less pressing than the needs of other groups—for example, the victims of child sexual abuse or the elderly, all of whom are competing for scant funds.

Medicolegal

Benoxaprofen case makes legal history

CLARE DYER

The litigation over the antiarthritic drug benoxaprofen took a dramatic turn last week with the emergence of a mystery benefactor to underwrite the claims of 500 litigants without legal aid who would otherwise have been forced to drop their actions. By the time this issue appears his (or their) identity should have been revealed, but as we went to press it was still closely under wraps. His arrival from the wings like some *deus ex machina* is just the latest extraordinary twist in a case that, with a court hearing still almost two years off, has already made legal history in several ways.

Record claim

Benoxaprofen, a non-steroidal anti-inflammatory drug marketed by Eli Lilly in the United States as Oraflex, and by its United Kingdom subsidiary, Dista Products, as Opren, was withdrawn from the United Kingdom market in 1982 after a report in the *BMJ* of the deaths of five elderly patients who had taken the drug.¹ With some 1500 plaintiffs suing seven defendants—Eli Lilly and its United Kingdom subsidiaries Dista Products, Lilly Industries Limited, and Lilly Research Centre Limited; Dr Ian Shedden (at the time in charge of Lilly's research laboratories); the Committee on Safety of Medicines, and the Department of Health and Social Security, as licensing authority under the Medicines Act—for damages that could total £10m and a potential costs bill for both

sides of £6m if the litigation goes all the way to a court judgment, this is the biggest personal injury claim ever to be mounted in the English courts. The record 30 000 documents that were disclosed in the course of the thalidomide litigation were a mere hillock compared to the mountain of 1.2m documents that will have to be inspected in this case.

A scientific coordinator

In January the Court of Appeal, unanimously overturning a judgment by Mr Justice Hirst, made an unprecedented ruling "in the exceptional circumstances of this particular litigation" allowing the documents to be inspected by Charles Medawar, a scientific and medical writer (though with no scientific or medical qualifications) retained by the plaintiffs' solicitors in the face of strenuous objections by Lilly. Medawar, the author of *The Wrong Kind of Medicine?* and a longtime campaigner for the rational and economic use of medicines, was characterised by Lilly as an "investigative journalist" who had already publicly criticised the company (his book contains a number of references to Lilly and benoxaprofen). The case is the first in which a "scientific coordinator" has been allowed to inspect documents disclosed in litigation. The Court of Appeal decided that Medawar, who was required to give undertakings that he would keep the documents confidential and would not publish or communicate anything about the drug for six years without giving Lilly the opportunity to see it and apply for an injunction restraining publication, was a careful researcher and a responsible writer rather than a fanatic engaged on a crusade against Lilly. The court thought that it would be hard to find anyone else to fill the role that he had already filled for two years: finding expert

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advisers, coordinating experts in various disciplines, analysing scientific evidence given in the United States litigation over benoxaprofen, and computerising this material. And even if a replacement could be found he would probably have to start from scratch, causing considerable disruption, expense, and delay.

Deficiencies of the system

Last month the case was back in the Court of Appeal and making front page headlines when 500 litigants—those not receiving legal aid—were left, it seemed, with no choice but to abandon their claims. The case has highlighted more starkly than any previous litigation the deficiencies of the English legal system in the face of a multiple disaster with many plaintiffs and shown a yawning gap in our system of justice that could lead to far reaching changes in the way mass tort cases are conducted and funded.

It is bound to add fuel to calls for the introduction of some form of mutual fund, already under consideration by the Law Society, to finance litigants who would otherwise be unable to sue in return for a premium. The Law Society and the official committees responsible for reviewing high court rules and procedure will no doubt soon be studying the possibility of introducing into English law the "class action": a case brought by one individual on behalf of a number of people with related claims against the same defendants, disposing of all the claims in a single action. "Clearly this is something which should be looked at by the authorities with a view to seeing whether it has anything to offer and, if so, introducing the necessary procedural rules," urged the Master of the Rolls, Sir John Donaldson.

When the legal aid scheme was set up it was designed to deal with individual cases. The idea of multiple actions arising out of a single cause was never envisaged, and the rules specifically state that the fact that a litigant is receiving legal aid "shall not affect the principles on which the discretion of any court or tribunal is normally exercised." The rule was meant to ensure that litigants receiving legal aid should not get a second class service from the legal system, but its effect in this case was to see to it that the litigants who were funding themselves were barred even from using the system.

Age a disadvantage

To save time and costs it was decided that around a dozen "lead actions" representing the different issues raised in the litigation should be chosen to go to trial to settle those issues for the benefit of the other plaintiffs. The plaintiffs' lawyers had hoped that the sample cases could all be legal aid cases with a "nil" contribution. (Depending on a litigant's means, legal aid may be granted with no contribution towards legal costs, granted subject to a contribution from the litigant's own income or capital, or both, or refused.) But Mr Justice Hirst ruled in the high court that the question of legal aid could play no part in the selection of cases and that all the plaintiffs, with or without legal aid, must share the costs equally if the case was lost. The Court of Appeal agreed.

The benoxaprofen plaintiffs are particularly unfortunate because, like most arthritis sufferers, they are middle aged or elderly. The legal aid means test discriminates against elderly people, who often have small retirement nest eggs. Savings are counted as capital even when, as for many retired people, they are really a source of income, and the income that they produce is also counted. Many of the plaintiffs, therefore, although by no means well off, either did not qualify for legal aid or could not afford to hand over a large chunk of their savings by way of contribution, depriving themselves of the income their capital produced.

Another problem stems from the way costs are awarded in court cases. As Sir John Donaldson pointed out in the Court of Appeal, "legal aid makes out and out grants to those who lose cases. It only makes loans to those who win them." Legal aid largely protects a litigant from the risk of having to pay his opponent's costs if he

loses. (Without legal aid, the normal rule is that the loser pays the bulk of the winner's costs, as well as his own.) If he wins, however, his opponent has to pay only his "taxed" costs: less than the full amount it has cost him to fight the case. The balance of the money that his own lawyer is entitled to claim from the legal aid fund will have to come out of the damages he wins. Many plaintiffs' lawyers make it a practice to forgo any costs over and above the taxed costs paid by the defendant, but in the benoxaprofen litigation there was the added hazard that a plaintiff might succeed in proving the defendants negligent over one side effect but not another, winning only a partial victory and partial costs.

This might be no great hardship if his case were worth hundreds of thousands of pounds. But here too the benoxaprofen plaintiffs' age acted against them. Disability in older people is worth less than the same disability suffered by a younger person, because the younger claimant would have to endure it for longer. The death of an elderly person with no dependants is worth much less than the death of a young man with a job and a family to support. The average benoxaprofen claim is probably worth no more than £5000, with few claims over £10 000. At this level, even with a number of plaintiffs, the danger is that the whole damages award could be wiped out by costs.

Spreading the costs

Because of the multiplicity of alleged side effects and the different issues concerned in the litigation, a number of lead cases, probably between 10 and 15, were to be chosen. But to allow those few cases to bear all the costs of such expensive litigation would mean that those plaintiffs' awards would be totally swallowed up by costs. That would be grossly unfair, said the Master of the Rolls, and in any event choosing just cases that were legally aided with a nil contribution would breach the statutory rule that the fact of legal aid should not make a difference to the way the court exercises its discretion. The effect of spreading the costs among all 1500 plaintiffs was that plaintiffs' lawyers had no choice but to advise clients not receiving legal aid that for them the risk was too great and they should drop their claims. Most had decided to do so when the fairy godparent arrived on the scene.

One of the more piquant ironies of the saga is that an attempt to sue Lilly in the American courts was thrown out because the judge decided that the English legal system would guarantee the benoxaprofen plaintiffs access to the courts and a speedy resolution of their claims. In the United States, where benoxaprofen was on the market for only three months (compared with 22 months in Britain), three cases have already come to court. In one the jury awarded the plaintiff \$6m; the other two were won by the drug company. Some of the other claims have been settled out of court. In Britain attempts to reach a settlement have foundered, although Sir John Donaldson commented "I see no grounds for thinking that these cases are an exception to the general rule that settling genuine disputes by agreement between the parties is almost always in the interests of all parties."

Need for a no fault compensation scheme

Perhaps these cases will be settled, but there will be another benoxaprofen. The new product liability law, had it been in force when the drug was marketed, would arguably have made no difference to what has happened so far in this case. Even class actions and contingency funds will not entirely redress the balance between the individual plaintiff and the mighty corporation. The case for a no fault compensation scheme for the victims of drug injury now seems overwhelming.

Reference

- 1 Taggart HMcA, Alderdice JM. Fatal cholestatic jaundice in elderly patients taking benoxaprofen. *Br Med J* 1982;284:1372.