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Welcome to the Medico-Legal Magazine

Welcome to Issue 25 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This first issue of 2024 contains more of our featured experts, in our Expert Witness Directory, who are available for instruction now.

The following articles are included:

John Walker, Expert Liaison Department Manager, Premex Services, gives an interesting insight into the workings of one of the leading medico-legal agencies and details of how experts can join their panel; and

Sarah Prager KC, Deka Chambers, discusses how the Health and Care Act has given the Secretary of State for Health and Social Care the power to introduce a licensing regime for non-surgical cosmetic procedures; and

Professor Cam Wareham, Geurnica37 Chambers, summarises the recent decision of the Court of Appeal in Churchill v Merthyr Tydfill County Borough Council, which confirmed the court's support of Alternative Dispute Resolution in civil and commercial disputes; and

James Gould, Pupil Barrister, Normanton Chambers, describes key changes the introduction of the intermediate track has brought about in civil litigation and how this might affect experts.

Finally, Rebecca Pelling, UK & International eHealth Product Manager, CFC, discusses cyber insurance in future healthcare.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It has a dedicated website www.medicolegalmagazine.co.uk and a page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed. Printed copies can be ordered from Iconic Media.

Specialistinfo maintains a database of contact details for up to 90,000 UK consultants and GPs, including approximately 11,000 consultants and GPs who undertake medico-legal work. We also provide Medico-Legal courses for expert witnesses and promote the members of the Faculty of Expert Witnesses (the FEW).

We welcome feedback from our readers, so please contact us with any suggestions for areas you would like to see covered in future issues or share your news and experiences with us.

Lisa Cheyne

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THE LEADING PROVIDER OF INDEPENDENT MEDICAL REPORTS

By John Walker

Premex Services Is No One-Trick Pony

In 1996, three notable events occurred: NASA launched the Mars Global Surveyor, Walt Disney World celebrated its 25th anniversary and Premex Services Limited was established. We may not be pioneering space travel or be a leading kids' entertainer, but since our inception, we've become the UK's largest provider of medico-legal reports used to assist in the resolution of personal injury claims.

It's been nearly 30 years since we were established, and in this time, the industry has taken notice of the unrivalled service we deliver to our clients and the care we show to our employees. That's why we have a full suite of accolades, including Medico-Legal Provider of the Year and Investors In People Gold, and we have Disability Confident Leader status.

So, What Else Can Premex Do?

On the way to becoming a leading medico-legal provider, we've also developed a diverse range of products and services for the insurance and legal sectors, forming Premex Group. Sitting under the group's umbrella is Premex+ which seamlessly

delivers reports for serious injury, clinical negligence, industrial disease and other complex cases, dealing with over 19,000 cases per year.

Alongside this, we also offer pagination on all medical records. Pagin8, our company situated in picturesque Durham, delivers a secure, easy to instruct pagination service, all whilst maintaining the highest levels of data security that's certified with ISO27001.

But of course, we haven't stopped there. With this much time and experience in the industry, we understand that no two cases are ever the same and our clients need a rehabilitation partner they can trust. That's why 3d Rehabilitation joined the group, becoming one of the UK's largest providers of rehabilitation and specialising in both physiotherapy and psychological treatments. 3d Rehabilitation offers a range of services that can be combined to best assist with the recovery of an injured party. With every case we work on, we ensure that all rehabilitation programs are tailored to the individual to allow for the most efficient recovery possible and offer services such as physiotherapy, Cognitive Behavioural Therapy (CBT), acupuncture, osteopathy and chiropractic sessions.

Premex's Expert Panel Reaches Far and Wide

We may be headquartered in the north of England but are proud to offer the largest panel of experts in the industry, stretching to all corners of the country. As a MedCo Tier 1 agency, our customer-focused solutions are always delivered with convenience, speed, innovation and quality. But we wouldn't be able to do this without our incredible panel of medical experts. These experts sit at the heart of everything we do, and we pride ourselves on the calibre and quality of medical professionals we have on our panel.

As we know flexibility is key to ensuring our medical experts can deliver the best quality service, our panel has the freedom to choose how they interact with us and our customers. This means our experts always have control over their workload, giving them the power to manage their existing clinical commitments.

The Premex Team

Each member of our experienced team goes through extensive training on specific areas/specialisms. This training puts each member of the team in a position to offer the highest standard of care and service to every solicitor, injured party and/or family member that we work with. Alongside our process training, we also offer support and counselling to each member of staff, including emotional resilience training which prepares them for the often difficult and emotional cases they will work on.

Our Expert Panel is supervised by our Chief Medical Officer (CMO), who is essential to ensuring the highest level of service from our panel members. As well as overseeing the development of our internal processes, our CMO ensures the wellbeing and privacy of all our claimants while also maintaining our clinical governance across every aspect of Premex Group.

MEDICO LEGAL MAGAZINE

Meet John Walker, Expert Liaison Extraordinaire

John has been part of the Premex family since 2001, undertaking a variety of operational management roles. In 2007, he became the Expert Liaison Department Manager and is responsible for the recruitment and management of the Premex Services Expert Panel while also ensuring we always deliver the high-quality reports we're known for. Recently, John progressed to Head of Expert Liaison. Here's what he had to say about working with Premex.

"It's part of the Expert Liaison team's role to oversee the recruitment of experts to our panel. But that's not all we do. We also provide ongoing support to our experts and monitor overall performance across the panel. As we understand medical reporting isn't our experts' primary job roles, we monitor instruction levels, appointment availability and report timescales to suit their availability and individual requirements. Plus, we also bring industry experts together at the annual CPD-accredited conference we host, which gives us the opportunity to build lasting relationships with our experts."

Leading By Example

Every year, we hold our Leading By Example conference. This is our annual CPD-accredited event, where our experts gain the opportunity to network with other medical professionals and solicitors working in the industry while also enjoying topical presentations and panel discussions. The aim is to inform, advise and assist experts in all aspects of medico-legal work, as well as aiding in professional development.

Last year, we covered a wide variety of topics, including presentations on pitfalls from a barrister's point of view, whiplash injury in adolescents and report writing software, to name just a few. We've been running this event for 15 years now, which just goes to show how valuable our attendees find this conference.

Need More Reasons To Work With Premex?

We know there are so many providers out there you could choose to work with, but by choosing Premex, you're also choosing favourable fees and payment terms, a flexible workload, an annual CPD-accredited conference and opportunities to work with industry-leading personal injury and clinical negligence firms.

If you're interested in working on the panel at Premex, we'd love to hear from you.

Email: ExpertRecruitment@premex.com
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www.premexservices.co.uk

NON-SURGICAL COSMETIC PROCEDURES: IS TIME RUNNING OUT FOR UNLICENSED PRACTITIONERS?

By Sarah Prager KC, Deka Chambers, London
email: clerks@dekachambers.com

Called to the Bar in 1997, appointed a KC in March 2023, Sarah Prager has been listed in the legal directories as a Band 1 practitioner in travel and cross border work for many years. Together with her colleagues at Deka Chambers, she co-writes the leading legal textbook in the area, and has been involved in most of the leading cases in the field in the last decade. She undertakes purely domestic high value personal injury work as well as cross border work and has a wealth of experience of difficult and sensitive cases.

Recent years have witnessed a growing prevalence and normalisation of non-surgical cosmetic procedures. This has been associated with the rise of social media, the increasing accessibility and affordability of high street providers and aesthetic clinics and the advancement of technologies and products applied in this field. Procedures such as botulinum toxin (commonly known as Botox) anti-wrinkle injections, cosmetic fillers (commonly known as dermal fillers), chemical peels and energy-based treatments are growing in popularity, with new unlicensed procedures rapidly emerging onto the market. Evidence suggests that most non-surgical cosmetic procedures are carried out by private providers[1] and therefore subject to both tortious and contractual liability.

In April 2022, the Health and Care Act[2] gave the Secretary of State for Health and Social Care the power to introduce a licensing regime for non-surgical cosmetic procedures in England. The purpose of the scheme is to ensure that consumers who choose to undergo a non-surgical cosmetic procedure can be confident that the treatment they receive is safe and of a high standard.

The current regulatory framework places few restrictions on who can perform non-surgical procedures. The aesthetics industry comprises both regulated healthcare professionals (including nurses, designated allied health professionals, dentists, doctors and pharmacists) and aesthetic practitioners such as beauty therapists.

There are existing training standards for practitioners, such as the National Occupational Standards (NOS)

in beauty aesthetics, in addition to competency frameworks developed and held by professional bodies, but (perhaps surprisingly) there is no legislative framework to mandate that all practitioners are required to meet both training and infection control standards in order to carry out procedures.

The current regulatory framework comprises a patchwork of legislation, giving rise to significant inconsistencies between areas of practice and even geographical areas within England. The following legislation is relevant in this context:

- the Local Government (Miscellaneous Provisions) Act 1982 allows (but does not require) local authorities to put in place arrangements for the registration of certain cosmetic treatments, including cosmetic piercing, electrolysis, tattooing and semi-permanent make up, in addition to acupuncture. Some local authorities have also created byelaws relating to staff hygiene and the safety and cleanliness of the premises, furniture, and equipment;
- a small number of local authorities in England have also introduced local licensing schemes which vary in the number and type of treatments they cover. These include:
  - Nottingham (under the Nottinghamshire County Council Act 1985);
  - Essex (under the Essex Act 1987);
  - Birmingham (under the Birmingham City Council Act 1990);
  - London (under the London Local Authorities Act 1991).

Some local authorities are also using a range of other legislation to regulate elements of businesses providing these treatments, including the Health and Safety at Work etc Act 1974 and Health Protection Regulations 2010.

In addition, in 2021, the Botulinum Toxin and Cosmetic Fillers (Children) Act was introduced. The Act made it a criminal offence to administer injectable toxins or a filler by way of injection for a cosmetic purpose to a person under the age of 18 in England, even if they have the permission of someone over 18.

The September 2020 report The ugly side of beauty: improving the safety of cosmetic treatments in England[3], published by the Chartered Institute of Environmental Health (CIEH), found 90% of respondents to its consultation on the regulation of cosmetic interventions supported the introduction of a specialised national licensing scheme to improve the safety of cosmetic procedures.

The proposed licensing scheme will ensure that those who offer specified procedures:

- are suitably knowledgeable, trained and qualified;
- hold appropriate indemnity cover;
- operate from premises which meet the necessary standards of hygiene, infection control and cleanliness.

Under the proposed scheme, which will be operated by local authorities in England, practitioners will need to be licensed to perform specific non-surgical cosmetic procedures and the premises from which they operate will also need to be licensed.

The government has just concluded a consultation seeking views on whether to implement the proposed scheme and, in addition, to restrict the treatments to be captured through the licensing scheme to persons over the age of 18. This will be in line with existing age restrictions on botulinum toxin injections, cosmetic fillers, tattoos, teeth whitening and sunbed use.

In essence, the government sought views on:

- the procedures in scope;
- restrictions on which practitioners should be permitted to perform procedures;
- age restrictions for those undergoing such procedures.

The consultation made it clear that the proposed scheme will:

- identify the procedures that present a risk to the public;
- consist of two interlinked components: a practitioner licence and a premises licence;
- be administered and enforced by local authorities, who will work with a range of partners such as environmental health officers, trading standards officers and the Health and Safety Executive;
- make it a criminal offence for an individual to carry out non-surgical cosmetic procedures without a licence;
- require those people who offer procedures to:
  - be suitably trained and qualified;
  - hold appropriate indemnity cover;
  - operate from premises which meet the scheme's standards of hygiene, infection control and cleanliness;
- introduce a minimum age of 18 for those people seeking to receive the procedures licensed under the scheme.

In addition, the government considers that there are certain non-surgical cosmetic procedures that are of sufficient complexity and invasiveness that they should only be performed by suitably qualified and regulated healthcare professionals and that the lack of current restrictions to determine who is entitled to legally perform the more invasive procedures creates a significant risk to members of the public.

Examples of the types of treatment that it is considering restricting are:

- procedures aimed at augmenting the genitals, typically using autologous fat or dermal fillers;
- any injectable procedures - such as dermal fillers - undertaken to intimate areas of the body, such as the rectum, genitalia or breasts;
- the combination of ultrasound and large bore cannula for the purposes of liposuction.

Such procedures would not be included within the local authority licensing scheme, but would be restricted via a two stage process:

- the government would set out in regulations that specified high-risk procedures should be restricted to qualified and regulated healthcare professionals only. This would mean non-healthcare professionals would not be able to carry out these procedures; and,
- they would amend CQC regulations so that restricted high-risk procedures are classed as regulated activities by CQC.

The government consultation closed on 28th October 2023, and there will now follow a period of analysis and consideration of the responses to it.

Comment

Anyone working in this field must surely welcome the proposal that this part of the cosmetic surgery industry should be regulated more consistently and transparently. But could the government have gone further? After all, the Package Travel and Linked Travel Arrangement Regulations 2018 provide protection based on the sale or offering for sale of holidays within this jurisdiction, not merely holidays taking place here; could the licensing scheme work in a similar way? Or, as with the consumer contract jurisdictional provisions set out in the Civil Jurisdiction and Judgments Act 1982, could practitioners worldwide be required to have a licence when directing their business operations to this jurisdiction? If domestic practitioners are required to train, licence and insure, will this process render their prices less competitive, making foreign providers still more attractive to consumers? And if so, might the licensing system proposed actually do more harm than good?

In the view of the author, the proposals are to be welcomed, albeit perhaps with some concern that they might, and perhaps should, have gone further to encompass practitioners based outside the jurisdiction, or at least to strengthen consumers' protection in respect of such practitioners in the event of a problem with treatment. After all, the Foreign and Commonwealth Development Office has recently had cause to issue a travel warning to those considering travelling to Turkey for cosmetic surgery and other less invasive procedures, and this market seems to be expanding greatly. Still, any consumer protection in the area must be welcomed as being a step in the right direction in an industry that has been allowed to operate almost wholly unregulated for far too long.

References:

[1] https://www.nuffieldbioethics.org/publications/cosmetic-procedures/cosmetic-procedures-guide

[2] https://www.legislation.gov.uk/ukpga/2022/31/section/180/enacted

[3] https://www.cieh.org/policy/campaigns/improving-the-safety-of-cosmetic-treatments/

THE NEW INTERMEDIATE TRACK – PRACTICAL POINTS TO CONSIDER FOR EXPERTS

By James Gould, Pupil Barrister, Normanton Chambers, London
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Many readers will no doubt be familiar with the court tracks in civil litigation. Previously these were the small claims track, fast track and multi-track. The track system has been extended with the introduction of the intermediate track on 1st October 2023[1]. The aim of this article is to highlight the key changes which the introduction of the intermediate track has brought about. This article will look at when the intermediate track will apply, how it will apply, the introduction of complexity bands and how charges are incurred.

The purpose

The intermediate track is designed to cover lower value cases which, under the previous rules, would have been allocated to the multi-track (i.e., for cases over £25,000 but lower than £100,000.) The aim of the legislation behind the intermediate track – the Civil Procedure (Amendment No.2) Rules 2023[2] – is to ensure that there is more certainty in the amount of costs to be incurred and in turn to make sure that costs are proportionate across civil law claims.

When will the intermediate track apply

The intermediate track will apply where, for instance, a trial is not expected to last longer than 3 days or where oral expert evidence is likely to be limited to a maximum of 2 experts per party. The intermediate track will also apply where the claim is brought by 1 claimant against up to 2 defendants, or the claim is brought by up to 2 claimants against 1 defendant.

When will the intermediate track not apply

If a claim is brought for a remedy other than money, it is unlikely to be allocated to the intermediate track unless it is considered by the court to be in the interests of justice. Despite the changes for lower-value cases, the multi-track remains unchanged for claims with a likely value of over £100,000. The court has the power to allocate more complex cases to the multi-track if it does not consider the intermediate track appropriate.

Application key points – how does it apply to experts?

The intermediate track continues fixed fees for reports in road traffic accidents ('RTAs'), where there are soft tissue injury claims and whiplash injuries. Where these claims arise, the cost of obtaining the first report from an accredited expert selected from the MedCo Portal is £180. The cost for a further report is as follows:

1. Consultant Orthopaedic Surgeon - £420
2. Consultant in A&E medicine - £360
3. GP registered with the GMC - £180

The intermediate track also explicitly states that it applies to claims where there are no additional factors which make the claim inappropriate for the intermediate track. Unhelpfully these factors are not defined yet and it is likely that these 'additional factors' will be fleshed out by case law!

Some cases are excluded from the intermediate track, these include:

- Mesothelioma/asbestos claims.
- Clinical negligence claims, unless both breach of duty and causation have been admitted.
- Harm, abuse or neglect claims of or by children or vulnerable adults.
- Various claims against the police.

It may seem that a breach of the duty of care and causation will be rarely admitted by those defending claims, however, dental negligence claims may be a good exception to this. Breach of duty and causation may be admitted in full, yet the patient may have been likely to lose their teeth in any event. It could well be the case that a similar approach is taken in other clinical negligence claims.

Fixed recoverable costs

Following consultations by the Ministry of Justice, fixed recoverable costs apply to the intermediate track, where proceedings are issued on or after 1st October 2023. Personal injury and disease claims are the exception here. Fixed recoverable costs will instead apply, first, to personal injury claims where the claim arises on or after 1st October 2023 and second, to disease cases where the letter of claim was sent after 1st October 2023.

The Civil Procedural Rules ('CPR') for civil litigation allow courts to consider a claim greater than fixed recoverable costs in exceptional circumstances. These include where a party or witness is vulnerable and that vulnerability requires more work to be done. For this additional work, the claim can be for an amount at least 20% greater than fixed recoverable costs.

Tips for claiming disbursements

The use of the expert and the cost must be justified. Where medical expert report fees are not set out in the intermediate track, they are to be decided by what is reasonable and proportionate as disbursements. The courts will only allow disbursements which have been reasonably incurred so readers should be mindful about what is proportionate, given the severity and size of the claim. Two points may be helpful here. First, the fixed fees in RTAs give an indication: Orthopaedic Consultant - £420, A&E Consultant - £360. Second, fees received for previous reports provide a suggestion when quoting for fees or considering an instruction - if the fee proposed is wildly lower or higher than this it should be checked. This is because there is a risk that judges may not consider these sums reasonable. The following factors are considered by the court to decide whether the cost will be reasonable and proportionate and so recovered in full:

1. Do the costs bear a reasonable relationship to factors such as the sum in issue?

2. How complex is the litigation?
3. Has additional work been generated by the conduct of the paying party?
4. Is there extra work or expense incurred due to the vulnerability of a party or witness?

Complexity bands

The disbursements will also be checked alongside the complexity band for the litigation. The intermediate track has four complexity bands, with complexity band 1 for the simplest cases and complexity band 4 for the most complex. More complex cases will recover higher fixed recoverable costs. The parties may agree on a complexity band but the court retains discretion to assign whatever band it sees as appropriate.

The simplicity of complexity band 1 means it is unlikely that costs here will be questioned. With complexity band 4 being the most complex this also means that high costs are expected. The real battleground will likely be complexity bands 2 and 3. Here there may be challenges and the expert and the cost must be justified.

Under the intermediate track, each of the four complexity bands has fixed recoverable costs for each of the specified stages. These range from Stage 1 to Stage 15. Costs can be awarded in addition to disbursements, depending upon the complexity band given. The risk of fixed recoverable costs applying to cases allocated to the intermediate track may encourage parties to settle. Using the name 'complexity band' is very appropriate here. The proposed new system does not come across as 'simple'!

Relevant factors for experts

Importantly, medical expert reports are to be limited to no more than 20 pages. This excludes any necessary photographs, plans or technical articles which are attached to the report. Although this limits the size of the reports, the page limit for attachments is unlimited. This may encourage more annexed documents and images to be included in reports. A good index will be helpful here. The total length of witness statements should also not exceed 30 pages in the intermediate track. The courts are keen to reduce reading material length – this is nothing new – experts should assist the court and conciseness supports this process.

Although the limit for reports is 20 pages, the CPR introduces the limit with the words "unless the court orders otherwise". This caveat should not be relied upon – it is unlikely courts will allow a greater limit very often. Three strategies for the page limit could be adopted: first, when being instructed, a term could be inserted into the terms and conditions, requesting to be informed promptly if allocated to the intermediate track. Secondly, as a safeguard, when writing reports, experts should ask their instructing party whether they are subject to the 20-page limitation. This will help dictate the level of the quote to be made for fees. Third, if the limit applies, consider whether you can help the court on matters within your expertise in the 20-page limit. It is helpful for solicitors to know as soon as possible.

Reaction

The intermediate track is an important development. It is one of the larger changes to litigation in recent years and it will be important to keep an eye on this development. The 20-page limit for reports is likely to be strictly followed and fixed costs will become the new norm on the intermediate track. The intermediate track is an exercise attempting to standardise and create a degree of certainty about process and costs for those involved. It remains to be seen whether this will be the case. Like all recently introduced laws, there may be changes made through case law as the new legislation matures.

Checklist to consider:

1. The track
2. Experts
3. Other expertise needed
4. Impact of fixed costs on your fees
5. Impact of the track on report/witness statement length

References:

[1] https://www.legislation.gov.uk/uksi/2023/572/contents/made

[2] https://www.legislation.gov.uk/uksi/2023/572/pdfs/uksi_20230572_en.pdf

CYBER INSURANCE: ENABLING THE FUTURE OF HEALTHCARE

By Rebecca Pelling, UK & International eHealth Product Manager, CFC
Will Hodson, Cyber Analyst, CFC - email: healthcare-uk-intl-team@cfcunderwriting.com

Over the last 30 years, healthcare has undergone nothing short of a technological revolution. Almost all medical professionals now rely on computer systems to some extent, whether that's simply accessing health records in an electronic format or using sophisticated AI-diagnostic tools, remote patient monitoring (RPM) tools and surgical robots.

There's no doubt that technology is bringing about significant improvements in the quality of healthcare provision, driving greater productivity and cost savings for healthcare providers on the one hand and better patient outcomes on the other. Nevertheless, the growing use of digital tools brings new exposures: most notably the burgeoning threat of cybercrime and bodily injury that arises from these cyber events .

New risks to face

The transformative impact of technology is no clearer than in RPM, a technology that gives patients the freedom to be more easily treated outside of a hospital or clinic.

RPM is significant in reducing both patient stress levels and costs for the healthcare provider. But what if the software behind the service is targeted in a cyber attack? It's easy to think that cybercrime doesn't impact healthcare, but the headlines say differently. Recently, the US healthcare provider Ardent Health Services[1] fell victim to a cyber attack which closed many of its emergency rooms for five days. While earlier this year, data for over one million NHS patients[2] was compromised in a ransomware attack. And, with cyber attacks becoming more frequent and sophisticated, these examples are just the tip of the iceberg.

How about a different type of technology failure or cyber event, like the RPM platform not completing a software update or a ransomware attack leaving the platform inoperable? The tool could produce incorrect readings or not produce readings at all, with the medical professional none the wiser and patient conditions potentially worsening as they haven't been picked up.

In this scenario, it's likely that, on top of the risk of bodily injury, the healthcare provider will experience additional financial and business interruption costs. This type of system failure can force patients to travel to the hospital for their care and clinicians to spend unplanned hours and money delivering that care, taking resources away from other parts of the service.

That's not all. Faced with a cyber incident, most healthcare providers will need to hire external support to effectively remediate the incident itself, restore digital systems and recover lost data. They may also incur unexpected legal fees if they need to defend a claim following an incident. And in cases where data is stolen, they may be subjected to regulatory fines. If it's a ransomware attack, there will usually be the cost of a ransom payment to take into account, if you choose to pay it. Altogether these form a huge financial burden for any provider to bear on its own.

Types of emerging healthcare technologies

AI

Today, there are a wide range of AI-led healthcare tools, including triaging patients, chat bots and assistive diagnosis. While these tools bring many benefits, AI is only as good as its human input. Whether it's the size and quality of the data set, the medical expertise of the individuals inputting data, or ongoing monitoring for errors in the AI code, it's possible for things to go wrong. If they do, who is to blame, the technology tool or a human?

It's important to cover bodily injury risk, to avoid confusion if a claim occurs from an ambiguous cause.

Telehealth

Accelerated by the pandemic, telehealth is only becoming more accessible and diverse in the specialities it delivers via real-time video consultations. By offering services online, telehealth entities can face risks not experienced by traditional clinics, such as a technology failure or a ransomware attack that could take video consultations offline. With most telehealth entities enabled by a separate technology provider, who takes the blame?

To make things clear, taking out blanket coverage for services provided on behalf of the main policyholder is vital, ensuring protection if a sub-contractor, such as an individual doctor, does not have adequate cover in place.

RPM

We've already touched on how RPM can make a difference. Digging deeper, RPM often includes wearable devices such as watches to monitor electrocardiogram data, and glucose monitors and pacemakers which constantly feed data back to the practitioner. But since RPM is heavily reliant on devices, what if a device produces an incorrect reading? This is in addition to the risk of a cyber attack, as mentioned earlier.

By getting cover for technology services and the products they use, you'll have protection if a device fails to perform or if a cyber event hits.

Thinking outside the box

If you're using technology to improve healthcare provision, then you're operating in a new and emerging field with new risks and exposures. That means you need to think outside the box when it comes to insurance.

In the past, it's usually been sufficient to focus solely on insurance cover which provides protection for traditional clinical negligence matters (medical malpractice) or traditional financial losses (professional indemnity). But to address new risks and ensure support is in place when it's needed, it's time to broaden the scope. Today, you also need to consider bodily injury that results from technology failure and cyber events, as well as other financial losses that can be associated with these events. That's where cyber insurance comes in.

How cyber insurance works

The more the healthcare industry comes to rely on digital assets, the more exposed it is to the theft, loss or destruction of those digital assets as a result of cyber attacks. Fortunately, there's a simple way providers can get the support they need.

Cyber insurance is designed to help healthcare providers take full advantage of digital capabilities, by enabling them to effectively share their cyber risk with the insurer. We've already touched on the various costs caused by a cyber incident. Cyber insurance provides cover for those financial losses, enabling the provider to focus on delivering quality care to those who need it most.

But the best cyber insurance policies go further than providing cover for financial loss. Today, cyber insurance is defined by the innovative services that come with the policy, including advanced proactive protection and incident response, designed to stop cyber attacks from happening and minimise impact when they do occur.

Reactive and proactive services

So, how do these services make a difference?

Incident response is like your digital fire service. In the event of a fire, speed is of the essence, with every moment the fire blazes causing more disruption and destruction. It's the same when a cyber event hits. The cybercriminal will be working quickly to complete the attack, perhaps exfiltrating data or deploying malware. Defending an attack quickly and decisively can make a significant difference in minimising system downtime, preventing data theft and getting the provider, such as a hospital or clinic, back up and running.

But if there's one thing better than responding to a cyber attack effectively, it's stopping it from happening in the first place. At a time when budgets are tight, hiring an expert team that offers proactive prevention services like threat hunting and vulnerability scanning can cost tens of thousands. But they come free as part of any good cyber insurance policy. Some cyber insurers have the ability to actively monitor their policyholders and alert them to cyber threats targeting their business, so they can avoid cyber incidents altogether.

When doing your research, always consider the services that come with a policy, and go with an insurer that offers the expertise to prevent and remediate cyber incidents quickly and effectively. This way, you're free to focus on patient care, safe in the knowledge you have a team of experts on side when an incident occurs.

Cyber insurance in action

Operational disruption

In the US, a mid-sized hospital providing a variety of surgical procedures was hit by a malware attack, disrupting all devices and services and making patient data inaccessible. The hospital had no choice but to bring in teams of additional nurses and issue a Red Alert, diverting patients to other hospitals in the area.

Since the hospital had taken out a cyber policy with CFC, we covered the financial loss caused by system damage—including the replacement of hardware, something many cyber policies exclude—and further losses incurred due to business interruption, such as the cost of hiring additional nursing staff.

Click here for the full case study[3].

Social engineering

After a CEO's email account was hacked, a care home faced financial loss from a social engineering attack. The fraudster sent emails impersonating the CEO to the care home's finance team, requesting the urgent payment of some £87,315 to accounts controlled by the fraudster.

Fortunately, the care home had purchased cybercrime cover on their cyber policy with CFC, and were reimbursed for the losses. This claim illustrates not only how CEOs and senior executives are prime targets for cybercriminals, but it also shows that IT security doesn't remove the need for cyber insurance, with many cyber incidents resulting from human error.

Click here for the full case study[4].

Getting started with insurance

Modern technology innovations are key in bringing improved healthcare outcomes to people across the world. But to truly maximise the opportunity that technology presents, it is essential that the healthcare industry also mitigates their emerging risks and exposures, in the form of cyber risks and bodily injury arising from technology failure or cyber events.

CFC is a specialist insurer in emerging risks, backed by more than 25 years' experience in cyber. With us, healthcare professionals don't need to source multiple covers for their unique needs. We offer best-in-class healthcare and cyber cover under one roof, making it easy for providers to get the protection they need to build a healthier future for everyone.

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MEDICO LEGAL MAGAZINE

CHURCHILL V MERTHYR TYDFILL: INTEGRATING DISPUTE RESOLUTION INTO THE MANAGEMENT OF CLINICAL CLAIMS

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Holding dual citizenship in New Zealand and Britain, Cam's influence extends globally, with a track record of being regularly engaged as an Expert Opinion in support of Litigation throughout England & Wales, Scotland, ROI, Australia, and New Zealand.

The recent decision of the Court of Appeal in *Churchill v Merthyr Tydfill County Borough Council [2023] EWCA Civ 1416*[1], confirmed the court's support of ADR (Alternative Dispute Resolution), answering a number of issues as to it's place in the litigation process. With it, we enter a new era whereby dispute resolution becomes further integrated into civil and commercial disputes.

Out of court dispute resolution in the personal injury and clinical negligence space is not new. In many respects, it is common practice for disputes to be resolved well before parties attend Court hearings. The National Health Service reports that of the 13,511 claims in 2022-2023, 80% were resolved outside of court via a range of means. Claims of a clinical and non-clinical nature were resolved with damages paid in 57%[2]. The emergence of round-table meetings, negotiated settlement meetings or discussions between experts all contribute to the process designed to circumvent judicial intervention and use of court resources. The decision in Churchill, arguably takes us a step further.

What is significant about the case?

The decision in Churchill clarified the judgement in the earlier case of *Halsey v Milton Keynes General NHS Trust [2004] EWCA Civ 576, [2004] 1 WLR 3002*[3] in which Dyson LJ suggested that obliging parties to engage in mediation and other forms of (A)DR would obstruct their right of access to a fair hearing before a court and infringe their human rights.

The Court of Appeal in Churchill, clarified whether the court can lawfully stay proceedings, or order parties to engage in 'out of court' (Alternative) dispute resolution before proceeding further?

Yes, said Sir Geoffrey Vos, Master of the Rolls with whom Lady Chief Justice Carr and Birss LJ agreed. In doing so, the court ushered in the expectation that parties in dispute do everything reasonably expected of them to settle a dispute before recourse to litigation. With caveats in place to ensure that rights are not breached and that the process is reasonable and proportional in its aim to resolving issues, the court indicated its support for avoiding litigation where possible. Crucially, its decision openly supported the use of (A)DR as a method of using less formal means to resolution of disputes.

The Background

The decision followed the earlier proceedings issued by the Respondent, Mr Churchill. His property was adjoined by land owned by the Appellant (The Council). The Respondent claimed that Japanese Knotweed (a known noxious and invasive weed) had encroached from the Council owned land and into his. He claimed that he lost enjoyment of his property, damage and a reduction in its value.

Mr Churchill issued the initial proceedings. The Council (Appellant) applied for a stay, citing that its own complaint procedures had not been followed. The initial application was dismissed. The court applied the decision of *Dyson LJ in Halsey v Milton Keynes General NHS Trust [2004]* at [9] in that

> "to oblige truly unwilling parties to refer their disputes to mediation would be to impose an unacceptable obstruction on the right of access to the court."

In its subsequent appeal, the Council raised a number of points, from which three central issues arose. The first was whether Halsey was binding, the second concerned the Court's ability to stay proceedings or order Alternative Dispute Resolution, the third considered what relevant principles must be considered.

Halsey

The Court of Appeal was asked to consider whether the decision in Halsey was binding. Rather than being considered to be a mere (*obiter*) 'comment' made by Dyson LJ, it considered whether it may be considered ratio decidendi, a central themed justification for the decision thereby binding all courts below it. The Court of Appeal held that it was not.

Staying the proceedings or ordering parties to attend ADR.

The Court of Appeal was asked to consider Mr Churchill's submissions.

Churchill argued that his right to bring proceedings could not be circumvented by a requirement to pursue an internal complaints process which would not likely address his concerns.

He argued that no 'secure statutory footing' existed to allow such an impediment.

Following, he argued that any statutory impediment could only authorise intrusion to a minimal level sufficient to reasonably fulfil its objective.

The Council (with Intervenors) submitted that the Court may order a stay subject to three criteria.

1. It did not impair the right to a fair trial
2. that it was in pursuit of a legitimate aim
3. that its actions were proportional to that aim

In its consideration the Court of Appeal concluded that its authorities derived from within the jurisdiction, the European Court of Human Rights and the EU Court of Justice. It concluded that the court could stay proceedings in lieu of ordering Dispute Resolution, and that the impediment did not require any specific secure, statutory footing.

The relevant principles.

The Court of Appeal held that any Order or facilitation of a particular form of ADR must be at the Court's discretion. Broad principles for the courts consideration were the merits and demerits of differing ADR methods, the process must not impair the right to a judicial hearing and it must be proportionate to achieving resolution of the dispute in a fair, swift and cost effective manner.

Although a fourth point was raised it subsequently failed. The Appeal (in part) was allowed, its decision heralding a clear sign of the courts position on the place of mediation (and other forms of dispute resolution) in the claims process.

The Importance of the decision to ADR

Whilst some may have been disappointed that the decision of Vos MR in Churchill fell short of specifying mediation (or any other form) as the preferred method of dispute resolution, others agree that the decision allows flexibility and avoids a 'one size fits all' model[4,5]. In doing so, Vos MR empowered courts to maintain some control in tailoring the form of resolution to meet the needs and wishes of the parties in dispute.

The decision escapes further criticism of 'the introduction of mandatory mediation'. Whilst seen as an attempt to keep parties out of court in smaller actions such as those falling under the Small claims protocols, mandatory mediation has been criticised as bringing together unwilling parties in a 'watered down' attempt to resolve issues both damaging the reputation of mediation and the confidence of parties[6].

The more strategic 'open' approach of the court of appeal, avoids this concern allowing for Dispute Resolution to become rather less 'alternative' and more integrated or inclusive as a mechanism in the overall resolution of claims, whether through the court or other means.

What impact does the decision have on clinical negligence and practice and the requirement to mediate (or undertake other forms of Dispute Resolution)?

Proponents of mediation cite it as being helpful in allowing parties to take control and ownership of their dispute, allowing novel methods of resolution to be tabled, allowing the possibility of apology or explanation to be given and issues to be agreed or put aside for further discussion. Many mediations settle on the day or soon after. The use of court time is significantly reduced[7].

As the courts move forward in its support of Mediation, others have taken a different view. Detractors often point to the lack of power of the Mediator to offer a binding decision, the inability to compel parties to present themselves, or witness/evidence in support of their case and the potential to add an unfruitful or unnecessary step in the process[8].

In part, some of the concerns will be ameliorated by the Court's open support of ADR and its power to stay proceedings or order parties to mediation. However, it remains as to whether court ordered mediation will meet its objectives. What will be interesting, is whether Courts accept the new decision as being a tool in their armamentarium to dispose of cases, putting the onus back on to parties. Or whether they will be reticent to impose mediation or ADR for all and every case going forward.

What does it mean for the Expert Witness?

It is unlikely that Experts will be called to a mediation session (unless they are needed to explain a particularly technical or complex piece of evidence). It is likely that mediation will continue without the Expert and be focused on the positions put forward by the parties counsel (as remains the case currently). It is uncommon for Experts to attend anything other than meetings with their own party or where they are called before court. Counsel prefer to negotiate with other Counsel, to a point where some remain uncomfortable with the claimant in the room.

What about other forms of ADR?

Courts within the Civil Procedure rules have always been able to order that parties narrow the issues by either round table meetings or by Experts meetings. The new ruling takes matters a step further.

Currently, facilitated negotiation or mediation relates to a structured meeting in which a mediator attempts to move parties from 'zero sum'[9] positions to meeting the needs (or interests) of parties. Counsel play a crucial role in these negotiations, often buffering the emotion, the expectations and practicalities of parties individual positions. It is often helpful when voices need to be heard, emotions and the 'impact' of the event needs to be 'realised'. It is helpful where parties wish to see the other sides response to their concerns. The power in mediation is that almost any dispute can be mediated and for the most part, the profession of the mediator is irrelevant when compared with their skills in facilitation of discussion. The NHS Resolution scheme provides this opportunity for parties in dispute, using a small number of mediators who contract their services. The challenge for non-lawyer mediators however, remains that (despite the very technical nature of clinical complaint) lawyers tend to trust lawyers, even where a technical expert may have the requisite skills in both medicine and law. A criticism of the NHS scheme therefore, is inclusion of very small numbers of mediators who come with a healthcare background.

Evaluative mediation, provides a more nuanced approach. Whilst not able to compel parties to mediation, or provide a binding decision, the Evaluative mediator provides parties with a greater understanding of the merits of their claim. This may serve to provide parties with a more realistic understanding of their position, whether clinical negligence has occurred or whether quantum may be realistic. Whilst still a form of 'mediation', evaluative mediation provides a flexible and informal forum for parties to discuss matters with a skilled professional, who is in a position (often through qualification) to make a reasoned and close approximation to the value of the claim. It does however require a mediator to possess a number of skills, including facilitation, mediation, evaluation, clinical and legal skills. With smaller numbers of individuals having such an array of skills, evaluative mediation might be best reserved for very technical cases or recalcitrant parties who would benefit from the insight into the merits of their claim other than solely from their own advocates.

Early Neutral Evaluation (ENE), whilst useful in early claims or highly technical claims, is unlikely to feature heavily in the armamentarium of the Courts. Often conducted solely as a 'paper exercise' the evaluator is able to provide answers to discrete matters. Parties do not attend meetings and do not have an opportunity to air their grievance. Expert Witnesses who hold training in 'evaluation' and an understanding of the fundamental legal aspects of a claim may find their skills called upon more frequently at the pre-action stage, especially where ENE can be useful. Where the success or failure of dispute resolution turns on a technical aspect, ENE provides an opportunity for parties to provide evidence and an 'opinion' at an early stage in support of their claim with the purpose of heading off lengthy disputes over discrete but important issues. Whilst non-binding, the opinion of the Evaluator is persuasive and as such may carry significant weight in the eventual decision.

Arbitration of clinical disputes remains a final option although it is less common in England and Wales, Scotland, and Northern Ireland, than it is in the United States. As a very formal, binding decision process, it is more likely to be applicable to disputes

relating to contracts, Healthcare and Life Sciences. Provided parties agree, Arbitration before a skilled legal and technical panel can be used with great success. Arbitration, having closely related judicial methods follows a similar procedure to Court. A panel or sole Arbitrator sits, hearing the case following procedural orders, evidence presented as written or oral testimony, examination and cross examination culminating in a 'judgement' known as an Award. Enforceability is possible through the application of legislation (Arbitration Act 1996) . One might reasonably question the use of Arbitration given its proximity in style to a Court hearing. Arbitration does however carry a number of benefits over traditional court hearings. Procedures may be scoped by the parties, rules of evidence can be applied in a bespoke manner and the panel is frequently chosen by the parties for their expertise in both legal and technical skills. In the clinical negligence or quantum arbitration, the panel may consist of a medical professional, a legal practitioner and/or a patient representative . Despite its usefulness, Arbitration is likely to apply only in cases of a very technical matter, a large multi-national dispute (where international suppliers of drugs or products are party to the action), or an issue of quantum.

The decision in Churchill, has recognised the usefulness of (A)DR as an integrated tool in the management of civil claims through the judicial system. Its proponents cite high rates of satisfaction and success. Whilst less likely that Expert Witnesses will take an active part in mediation, their evidence may form an important part of the resolution process. Alternatively, their opinions may be expanded to ENE, proving useful in contributing to the early resolution of claims.

For Experts interested in Mediation training, SpecialistInfo offer accredited Mediation Foundation training over 5 days with the Society of Mediators. See link below for upcoming courses and more information:

www.specialistinfo.com/mediation-course

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MEDICO LEGAL MAGAZINE

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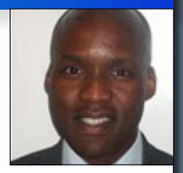

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Mr Chukwuemeka was the Royal College of Surgeons' Regional Specialty Advisor and served on the Medical Technologies Committee at NICE. He serves on the NHSE - Clinical Reference Group for Cardiac Services, NHSE - London Clinical Senate Council and the Medicines and Healthcare products Regulatory Agency (MHRA).

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He specialises in the analysis of gait related musculo-skeletal problems relating to foot and leg malfunction, dividing his time between his private practice and expert witness work. He focuses on Personal Injury cases where approximately 75% of his work is for the claimant, and 25% for the defendant.

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- Primary and Revision Shoulder replacement surgery
- Management of post traumatic, degenerative and sports-related
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With his modern tertiary referral practice and extensive research portfolio, Mr McCann is able to provide comprehensive medicolegal reports (full reports and desktop screening reports) for both personal injury and clinical negligence cases.

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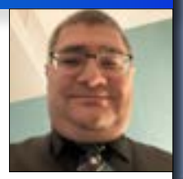

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Her medico-legal practice includes medical negligence, second opinions, decisions on escalation and resuscitation, ethical situations, inappropriate/harmful testing and treatments, and breeches in communication. She is able to provide comprehensive case reviews and expert opinion on the quality of the care provided at the different stages of care.

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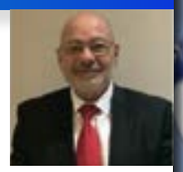

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- Facial & neck trauma
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- Musculoskeletal injuries
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- Reports vetted by solicitors
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EXPERT WITNESS DIRECTORY

MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

A round-up of news in the industry of the First quarter of 2024

NEWS

GMC to Regulate Medical Associate Professions (MAPs)

In July 2019, the Department of Health and Social Care (DHSC), asked the GMC to regulate two groups of medical associate professions (MAPs), the physician associates (PAs) and anaesthesia associates (AAs). These changes are dependent on new legislation, the AA and PA Order 2024, which was approved by the House of Commons this January. The statutory instrument (SI) will establish the GMC as the statutory regulator for PAs, meaning they set out the standards for their practice, education and training and operate fitness-to-practice procedures.

The GMC is currently designing the processes and policies needed to make regulation possible and will consult on these this year, expecting regulation to begin before the end of 2024.

The BMA and the RCP (Edinburgh), among other bodies, have both expressed concern over the ways in which Medical Associate Professions (MAPs) are being integrated into healthcare services.

A BMA survey of members highlighted widespread professional concerns with 87% of the 18,182 doctors who took part in the survey reporting that the way AAs and PAs currently work in the NHS was always or sometimes a risk to patient safety and the same proportion felt patients were not aware of the difference between MAPs and doctors.

Read more:
https://www.legislation.gov.uk/ukdsi/2024/9780348255195/contents
https://www.bma.org.uk/news-and-opinion/bma-statement-responding-to-the-royal-college-of-physicians-of-edinburgh-stance-on-maps

Award-Winning Patient Charity Launches New Aortic Dissection Website

Aortic Dissection Awareness UK & Ireland, named the UK's Best Specialist Patient Support Charity 2023 in the international Non-Profit Organisation Awards, has launched a brand-new website designed by a team of patients, relatives and healthcare professionals, all active members of the charity.

The charity's impact report was published in December, highlighting how the charity aims to continue to:

Support Patients – Save Lives – Improve Care – Enable Research

Read more: https://aorticdissectionawareness.org/

Football Brain Injuries Case at High Court

Brain injury claims brought by former footballers, including the family of England World Cup winner Nobby Stiles, reached The High Court this January. The claimants allege they were harmed by heading the ball repeatedly during their professional careers.

Mr Stiles died in October 2020, aged 78, after suffered from dementia and was found to have chronic traumatic encephalopathy, a progressive brain condition caused by repeated blows to the head.

The case could include up to 70 claims against the International Football Association Board, the Football Association, the Football League Limited, and the Football Association of Wales, and follows similar group litigation against World Rugby Limited and others.

Read more: https://www.lawgazette.co.uk/news/first-high-court-hearing-in-nobby-stiles-brain-injury-claim/5118431.article

Secondary Victims in Medical Negligence Claims: Paul (and others) v Royal Wolverhampton NHS Trust (and others) [2024] UKSC 1

In this landmark group action, the claimants sought compensation for psychiatric injuries after witnessing the death of close family members following the negligent failure of the defendants to treat or diagnose life-threatening conditions.

The claims failed, the decisions were appealed and reached to the Supreme Court, where the appeals were all dismissed. The court held that a negligent failure to treat or diagnose an illness did not constitute an "accident".

An accident being defined as "an unexpected and unintended event which caused injury (or a risk of injury) by violent external means to one or more primary victims."

The court observed that:

"In medical negligence cases the event (or its aftermath) witnessed by the secondary victim is generally not an accident; it is the suffering or death of their relative from illness. As a shorthand and without intending it to be a term of art, we will refer to such an event as a medical crisis."

The majority decision means that in virtually all circumstances of medical negligence it will not be possible for loved ones to bring a secondary victim claim for psychiatric injury.

Read more: https://www.supremecourt.uk/cases/docs/uksc-2022-0038-0044-0049-judgment.pdf

Should Patient Deaths be Excluded from new Fixed Costs Regime?

The Association of Personal Injury Lawyers (APIL) has urged the Government to remove all fatal cases from the forthcoming fixed costs scheme for lower-value clinical negligence claims.

"Any case in which a patient has died at the hands of the NHS needs more time and greater sensitivity than is afforded by the new regime," said Guy Forster, executive committee member of the Association of Personal Injury Lawyers (APIL).

Stillbirths and newborn deaths are already excluded from the new scheme of fixed recoverable costs for claims valued at up to £25,000, which comes into effect on 1 April.

"It makes no sense to us, for example, why the death of a toddler with meningitis might fall within the scope of fixed costs when a neonatal death is excluded. All bereavements must be treated with the same sensitivity and compassion," said Guy Forster, executive committee member of APIL.

"It is within the Government's power to act now, delay the reforms, and amend the rules."

Read more: https://www.apil.org.uk/press-release/Patient-deaths-must-be-excluded-from-fixed-costs-regime

New GMC Guidance: Using Social Media as a Medical Professional

The GMC published new guidance for doctors using social media in December 2023, which will come into effect on 30 January 2024. The full guidance can be accessed below but the following extract is a good summary of its intentions.

"Communicating as a medical professional

All professional communication

88 You must be honest and trustworthy, and maintain patient confidentiality in all your professional written, verbal and digital communications.

89 You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means:

a. you must take reasonable steps to check the information is accurate
b. you must not deliberately leave out relevant information
c. you must not minimise or trivialise risks of harm
d. you must not present opinion as established fact"

The GMC suggests that "the new guidance should be read alongside Good medical practice, and the more detailed guidance that supports it".

Read more: https://www.gmc-uk.org/-/media/gmc-site/ethical-guidance/mdg-2023/using-social-media-as-a-medical-professional-english.pdf

https://www.gmc-uk.org/professional-standards/good-medical-practice-2024/get-to-know-good-medical-practice-2024

GMC Workforce Report 2023

The GMC published its Workforce Report in November summarising "The state of medical education and practice in the UK 2023".

The report highlights that numbers of practising medical professionals in the UK will not improve in the foreseeable future, stating in the opening point of the Executive Summary, "Even with the expansion of medical school places, continuing to attract skilled and experienced international medical graduates will be crucial".

And, from the *Doctors leaving the UK workforce section*,

"We are also aware from The state of medical education and practice in the UK: workplace experiences 2023 report that an increasing proportion of doctors reported taking hard steps towards leaving the profession and there could be higher leaving rates observed in the coming months and years. We may have a limited time to ramp up initiatives to improve retention before dissatisfaction translates into higher proportions of doctors leaving the UK's healthcare systems altogether".

Read more: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

Annual Medico-Legal Conference, London, 20th June 2024 - Speakers Announced

With just over 5 months to go before the Annual Medico-Legal Conference in London this June, SpecialistInfo is excited to announce the current speaker line up:

- **Mr Justice Ritchie**, High Court Judge - King's Bench Division, Judiciary of England & Wales – KEYNOTE SPEAKER
- **Professor Dominic Regan**, City Law School, London. Legal Speaker, Writer and Broadcaster
- **Mr Amar Alwitry**, Consultant Ophthalmologist, Alwitry Medicolegal Services
- **Simon Hammond**, Director of Claims Management, NHS Resolution
- **Jennifer Harris**, Legal Director, Capsticks LLP
- **Dominic Woodhouse**, National Training Manager and Advocate, Partners In Costs
- Clare Stapleton, Medicolegal Consultant, Medical Protection Society
- **Hugh Johnson,** Partner, Stewarts
- **Dr Michael Spencer**, Consultant Psychiatrist, Cambridgeshire and Peterborough NHS Foundation Trust
- **Dr Nikhil Shah**, Consultant Trauma and Orthopaedic Surgeon, Wrightington, Wigan & Leigh NHS Foundation Trust, Nikhil Shah Limited
- **Dr Stephen Falk**, Consultant Oncologist, University Hospitals Bristol and Weston NHS Foundation Trust
- **Richard Williams-Lees**, CEO McCollum Consultants
- **Kim Morris**, Clinical Operations Director, Tessa Gough Associates

Read more and book your place:
www.medicolegalconference.com/speakers

Prescription Drugs sold by Online Pharmacies without Robust Checks

Highlighting the death of young woman who accidentally overdosed on medication she bought online in 2020, a BBC investigation into safety checks online pharmacies carry out when selling prescription-only medicines, has found many of them still fall short.

BBC researchers posing as online customers found evidence of high-risk and potentially addictive medicines, including benzodiazepines and antidepressants, being sold on the basis of online questionnaires, without further checks such as proof of previous prescription by a doctor, or permission to contact the customer's GP.

Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet, is provided by the General Pharmaceutical Council (GPhC), and was updated in 2022, but it has been described as too vague, and not stating clearly enough which checks online pharmacies should be conducting.

Read more:

https://www.pharmacyregulation.org/news/bbc-news-investigation-safety-checks-online-pharmacies-carry-out-when-selling-prescription-only

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