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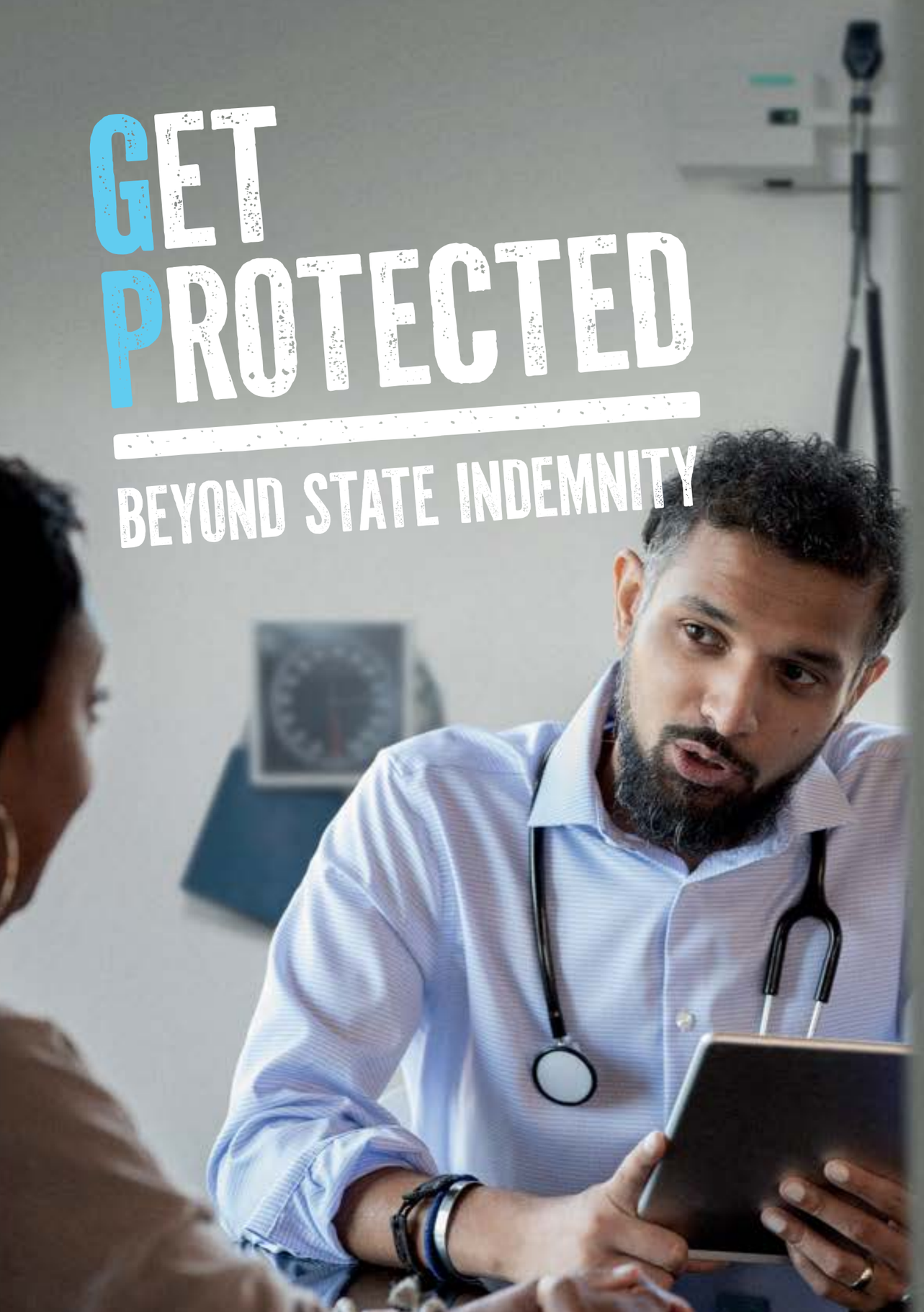

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MEDICO-LEGAL SECRETARY ONLINE COURSE
Monday 17th November
£195 + vat virtual classroom

Welcome to the Medico-Legal Magazine

Welcome to Issue 29 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This Conference issue of 2025 contains the following articles: Dr Jeremy Platt, GP Partner and Expert Witness, discusses the General Practitioners' Duty of Care; and

Francesca O'Neill, Barrister, Deka Chambers, describes the liability risks of AI in medicine; and

Dr Allan Perry, Consultant Clinical Neuropsychologist and Director of Clinical Services at PJ Care, discusses how new guidelines could improve care for patients with functional neurological disorders (FND); and

Dr Heidi Mounsey, Medical Protection, Medicolegal Consultant, advises medical professionals how their indemnity provider can help in Coronial inquests; and finally

Dr Claire Harrison, Medicolegal Consultant at Medical Protection, presents a Coronial case report.

In our Expert Witness Directory we showcase more featured experts, who are available for instruction now.

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
Specialistinfo
Medico-Legal Magazine

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SpecialistInfo
t: +44 (0)1423 727 721
e: magazine@specialistinfo.com
www.specialistinfo.com

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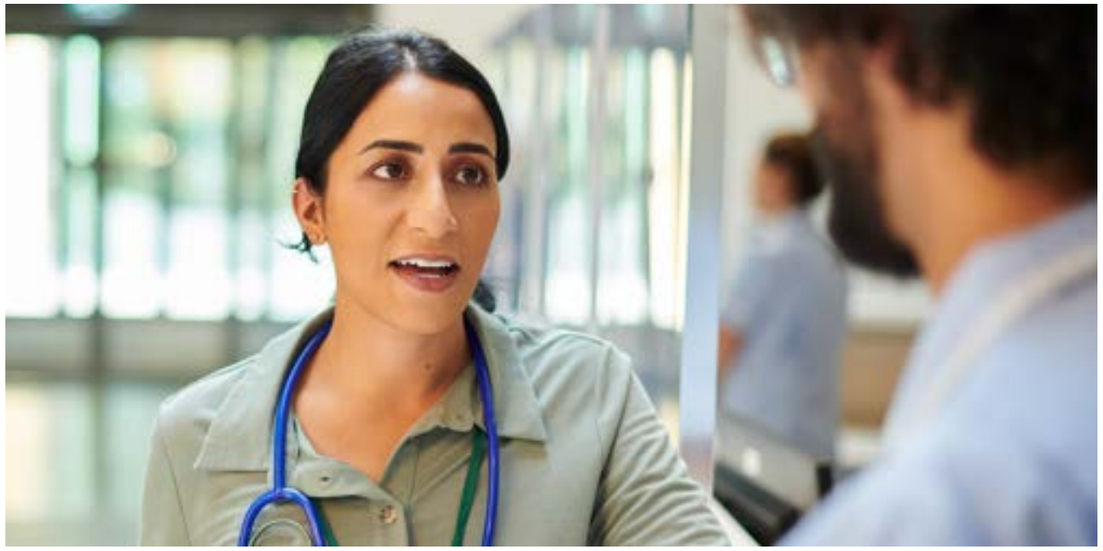
t: +44 (0) 20 3693 1940
e: info@iconicmediasolutions.co.uk
www.iconicmediasolutions.co.uk



CORONER'S INQUESTS – WHO'S IN YOUR CORNER?

By Dr Heidi Mounsey, Medical Protection, Medicolegal Consultant

Inquest proceedings can be unpredictable and stressful, and support with managing requests from the Coroner are not included in the England and Wales state indemnity schemes.

Medical Protection has a wealth of experience in coronial law and can assist and advise members with inquest proceedings from the outset, by advising on your draft statement to the Coroner.

The Coroner presides over the inquest hearing. They are responsible for seeking evidence to answer four questions: who died; when they died; where they died; and how they came about their death. If you are asked for a statement by the Coroner, it is highly likely to be in relation to that final question.

Many Coroners set out what they want the doctor to cover in the statement - for example, consultations relating to mental health or prescriptions of controlled drugs - and many doctors write statements without the input of a medical defence organisation and without consideration of possible consequences, believing this to be a straightforward request.

Medical Protection advice

Why our advice is important:

We can assist in identifying those aspects the Coroner may consider to be particularly relevant. In writing a statement the Coroner usually wants a chronology of the relevant appointments, but it is also common for the Coroner to delve into matters further by asking pertinent questions, for example, what was the policy for giving repeat prescriptions and conducting medication reviews for a patient who overdosed and died?

We can guide you in writing your statement so that it comprehensively addresses issues which we think the Coroner will be particularly interested in. Based on our extensive experience, we can read between the lines and see how the nuances might play out at a hearing.

We can assess whether there is a need for a Significant Event Analysis to address any learning points. This might sound counter-intuitive, but it is advisable to get ahead of potential criticisms which might come out at the inquest hearing. The reason to do this early is to be in a position to say to the Coroner, "We have talked about this case and identified what we did well, what we could have done better and what we will do in future." Reflection and remedial action is key.

If the first time any learning points are identified is from the witness box, there is a risk the Coroner could issue a Regulation 28 report for the Prevention of Future Deaths. This is a matter of public record and there is an obligation to respond within a timeframe prescribed by the Coroner. It is preferable that if there are learning points arising from the care, the family and the Coroner are able to read about this in advance, thus potentially avoiding a difficult line of questioning.

Should there be criticism by the Coroner of the care provided, we also advise doctors following inquests on their self-referral obligations pursuant to the General Medical Council's Good Medical Practice guidance. This sets out the circumstances under which a doctor must self-refer to the GMC, and includes being criticised by an official inquiry, which would include inquests.

Coroners will sometimes ask you to speculate on what may have happened had the sequence of events been different – for example, would the deceased have survived if they had been referred to hospital earlier? Or they may ask you to speculate on the actions of others, which can lead to incredibly difficult questions at the time of the inquest. This is straying into the territory of a medicolegal expert witness and should be avoided. We are alert to such requests and where a clinician may have inadvertently overstepped their remit when replying.

Medical Protection is able to request that the Coroner places less weight on certain aspects of a statement, if it has been injudiciously submitted before our involvement, but ensuring the first statement provided to the Coroner is the definitive document, is our priority.

In addition, there have been cases where Coroners have called the clinician as a witness simply because their statement was not detailed enough – again, a situation that could be avoided if a doctor is able to request support early. Of course, a doctor may still be called to give evidence even in the face of a detailed statement, but a well-written, comprehensive statement will put you in the best starting position possible.

Finally, but of no less importance, we can help you set the tone of the statement. It is important to bear in mind it will be read by a grieving family (who will be able to ask questions of you about it), and sensitivity over particularly difficult matters is key.

If you receive a letter from the Coroner asking you for a statement and/or summonsing you to give oral evidence at the inquest, it is important to be able to request appropriate support early. The sooner you can seek help, the better. We can assist with your statement, write to the Coroner where necessary, liaise with other parties and gather in relevant documents.

You must not ignore any correspondence you receive from the Coroner – a failure to cooperate may lead to a fine, imprisonment, or both.

We can ease the burden for you, and help to put you in an optimal position, so our advice is to ensure you have professional protection in place which enables you to request support with inquest proceedings.

Not yet a member?
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Medical Protection

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GENERAL PRACTITIONERS' DUTY OF CARE

By Dr Jeremy Platt, GP Partner, Bracknell, Berkshire
jeremyp@doctors.org.uk

Jeremy read Physiological Sciences at Magdalen College, Oxford, and qualified in medicine from the University of Edinburgh. He trained in hospital medicine and haematology, before training to be a General Practitioner. He has worked full time as a GP partner at Binfield Surgery, Bracknell, Berkshire for 25 years.

Jeremy has been supplying evidence to Claimant and Defendant solicitors about allegations of General Practitioner Breach of Duty for 10 years and in that time has written around 500 reports. He has attended many conferences with lawyers, and expert witness meetings. He has given advice to the GMC to assist in their investigation of over 80 allegations of poor practice. He has a special interest in prescribing, and he has sat on various committees charged with delivering policies for the local NHS bodies in this field.

I still have the slides of one of the first presentations that I attended when I started training to be an expert witness. It described the first part of the test for negligence, namely the Duty of Care, and brooked little discussion. The headline was "Duty of care is not often disputed".

This remains true – after all if a GP is consulting with a patient who he or she has admitted to his list, or if a surgeon has his or her laparoscope in someone's abdomen, it is clear that the clinicians involved have assumed a duty of care. There are nonetheless some situations where duty of care cannot be taken for granted.

Modern General Practice has many challenges, but one is that there is a torrent of work that still – despite the best efforts of representatives and the GPs themselves – would come from secondary care providers if they were allowed. How much of this is actually the clinical responsibility of the GP, and how much can or should be resisted, whether for contractual or medico-legal reasons?

"Instructions" to GPs

Claimant solicitors do contend that GPs should follow "instructions" from their hospital colleagues. I quote from Letters of Claim that I was asked to give an opinion on:

"The GP failed to refer the Claimant for an ultrasound scan … when the Consultant wrote a letter to the GP asking the Claimant to be referred"

It is important to understand that there is no hierarchy or "chain of command" between hospital and primary care doctors. They are both senior doctors in their own specialities. It is surprising to this expert, from the perspective of a practising GP, that a consultant would not just request such an investigation him or herself. There is no Duty of Care to accede to such requests, and a GP can take his or her own decisions about the need for them to be carried out, if they are to make the request.

In another case, it was alleged that:

"*The GP was negligent in that she failed to manage the titration of rivastigmine* [a drug used in Parkinson's disease] *after receiving instructions from* [the Consultant] *to do so*."

The use of the word "instructions" is misleading in that it implies that there is indeed a hierarchy in the medical world where hospital doctors can "instruct" GPs. This is not the case.

To take responsibility for supervision of a prescription for a drug that a GP may not be familiar with is not mandatory. No clinician should be expected to prescribe, or otherwise act, outside their competence. I can do no better than quote the comments of the Defendant GP in this case, which I quoted verbatim in my report:

"*It would be considered that it would be the normal practice for a consultant commencing a new medication (especially one not usually prescribed in primary care), to review that medication him or herself, which is what my colleagues would have concluded.*"

And

"I would comment that this remains a medication of which we have little experience in titrating. We currently only have two patients on this medication and the doses have been adjusted by secondary care."

The situation of taking over prescribing after secondary care is clarified in some areas with the publication of "shared care agreements", which specify the respective responsibilities, and give guidance to the GP when a medication that is usually or historically prescribed in secondary care is prescribed in primary care. It is important to understand that these agreements are permissive, and GPs cannot be compelled either contractually or medico-legally to engage in them. This point is not always fully understood by secondary care doctors.

When patients are on waiting lists

There have been instances of hospital doctors asking GPs to monitor or otherwise treat patients who are on a waiting list. This expert has been asked to monitor the calcium level of a patient with primary hyperparathyroidism who was waiting for an appointment. This issue was dealt with by a short e-mail! It is the duty of care of the hospital service to see patients in a timely manner. This position is held by this expert and by GP representatives.

When a patient is under the care of a hospital service, GPs are not completely immune to allegations of negligence on the basis of their duty of care, if by their actions they assume such a duty. This can take different forms, and I will give two illustrative examples.

I was asked to comment upon this allegation:

"*Following the Claimant's diagnosis of Graves' disease* [the commonest cause of overactive thyroid] *and commencement on carbimazole* [for its treatment] *the GPs failed to undertake further blood tests and review his thyroid function prior to the endocrinology appointment*"

The difference between this case and the one that happened to this expert in his own practice cited above is that the GPs assumed a duty of care by prescribing. The GPs felt that they were competent and experienced enough to initiate treatment which was therefore appropriate, but by doing so they assumed a duty of care that they did not have in the first instance and were in breach of said duty by their failure to appropriately follow up the Claimant. The duty of care came about because they initiated treatment of their own volition, and this was not because of the hospital's perceived or actual lack of ability, or lack of will, to see the Claimant in a timely manner. They had the option to insist that the hospital service saw the patient at a time that was clinically appropriate.

Assuming a Duty of Care

Another situation where a GP can become vulnerable to allegations of Breach of Duty when they may not have had a duty of care in the first place, is when they attempt to be "helpful" by assuming the role of communicator and interpreter of other clinicians' investigations, most often the hospital service.

I was asked to give an opinion on an allegation against a GP who had given inappropriate advice after interpretation of a hospital-initiated investigation. The Claimant was pregnant and had requested a screening test for Group B streptococcal carriage. This is a bacteria which can, rarely, lead to devastating neonatal infection. Screening is not offered by the NHS.

The GP agreed to carry this test out, but before it could be done the Claimant was seen in a midwife led clinic with an episode of bleeding in her third trimester. As part of the investigation, the clinic performed a swab to exclude infection.

The Claimant asked her GP to chase up the results which did not seem to be forthcoming from the hospital. The GP did so and conveyed the negative report to the Claimant. The GP confirmed to the Claimant that she was, therefore, negative for Group B streptococcus carriage.

This was not a valid conclusion. Firstly, the result would have been invalid because (as it happened) it was taken too early in pregnancy, and secondly it is necessary to request of the bacteriology laboratory to set up the test in an "enhanced culture medium", which had not been done because it was not a test designed to detect Group B streptococcus. The outcome was tragic because the Claimant was, in fact, a carrier of the bacteria, and her newborn baby developed meningitis and deafness.

This is a cautionary tale that I tell GP colleagues when I am asked to address them about medico-legal issues. It was wholly unnecessary, clinically, contractually and medico-legally, for the GP to get involved at all, and the error was compounded by the fact that the GP did not have the specialist knowledge required to safely and appropriately interpret the result. It would have been entirely acceptable in every respect to refer the Claimant back to the hospital service.

When one clinician carries out an investigation, the responsibility for its communication to the patient and any action that is required rests squarely with that clinician unless – and this is the kernel of my argument – another clinician assumes a duty of care.

What responsibility does the patient have?

Emergency departments especially are in the habit of requesting "GP to follow up - 2 weeks" for example. I have argued that GPs do not necessarily have a duty of care in this situation, and it is particularly galling for practising GPs to feel that they are put in a position whereby work is transferred to them by secondary care that should properly be their responsibility.

It could be argued that there is a duty of care on the part of a GP in receipt of such a request. However there has to be some acknowledgement that a competent patient has a responsibility here too. It is not reasonable to expect a GP to notice a single sentence such as the one above in a discharge note that may be a few hundred words long, and to a considerable degree a competent patient should be expected to approach their GP with a request for an appointment. This expert can attest that they frequently do, often on the day after their attendance even before the important information is in the possession of the GP! In this situation I would argue that, although a GP cannot do nothing when approached, the duty of care rests with the hospital service to inform the patient of their recommendations, and of the patient to follow it through.

Dr Allan Perry

NEW GUIDELINES FOR LONG-TERM CONDITIONS COULD TRANSFORM PATHWAYS AND FUNDING FOR FND CARE

By Consultant Clinical Neuropsychologist and Director of Clinical Services at PJ Care, Dr Allan Perry

In May the Government committed to (subject to Spending Review decision) improving health outcomes for people with long-term conditions, and for the first time, this will include functional neurological disorders (FND). This will be welcomed by medical and legal professionals alike as it signals the possibility of developing clinical pathways for FND and its inclusion in the National Service Framework (NSF) for Long-Term Conditions – paving the way to access to much-needed specialist care and funding across the country.

Despite the number of people diagnosed with FND, a condition that causes symptoms including seizures, movement disorders and sensory disturbances, rising year on year, only 21 of the 215 Integrated Care Boards (ICB) currently fund treatment and have a clear treatment FND pathway.

Often triggered by trauma with no identifiable structural cause in the brain or nervous system, FND is frequently misdiagnosed and stigmatised as not as 'genuine' as other neurological disorders such as stroke or measurable brain injury.

Greater recognition of FND could also help legal professionals looking for future NHS funded care packages. While there are no guarantees that FND will be included in an NSF and ensure specialist FND funding within every ICB, it's likely provision will increase, and more NHS funded packages will become available.

And funding is always a key thing. Throughout my 22-year career as a Neuropsychologist and now Director of Clinical Services, medico-legal professionals always want to know what funding is available and how long treatment will take.

Funding

In reality, funding associated with an FND NSF won't be without its challenges. Not least in the fact that suggested guidelines by NICE to standardise rehabilitation treatments, expected this September, will focus on holistic levels of care including psychological support.

The suggestion that multidisciplinary teams should be created incorporating psychology, physiotherapy, occupational, speech and cognitive therapies within regions will prove difficult due to workforce challenges and organisational costs. Multidisciplinary teams are essential to pathway development yet in short supply, especially the Neuropsychologists needed for disorders such as FND.

But there are other current funding routes. The NHS's Continuing Healthcare (CHC) care package can be used to meet the needs of patients with FND. In order to receive funding, individuals have to be assessed by a legally prescribed decision-making process to determine if they have a primary health need.

Covering everything from mobility and cognition to breathing and nutrition, understanding and applying the weighting to each category can be complicated, especially with FND patients facing varying degrees of symptoms. Those who are discharged from hospital into inpatient services are often more likely to receive CHC funding because their symptoms are more severe and they score highly in many of the assessment categories.

The greater challenge is for those wanting out-patient support where they might only have 'high' needs in 2 of the 11 categories. An outpatient service can have a lower long term cost implications, so this is where we can support legal professionals in interpreting the decision-making process to ensure the best funding route for their client.

Timeframes

Timeframes are trickier but we all share the same aim of supporting patients to return to better health as quickly as possible, thus returning independence and self-determination for the individual as the core tenets of rehabilitation in shortest time possible. Whether inpatient or outpatient, the benefits of bringing together practitioners from across the disciplines is the key to success. Reduced waiting times for referrals and appointments, reduced treatment costs and most importantly better and quicker outcomes for patients as teams talk, amend and tailor treatment accordingly.

The expansion of provision

In response to the lack of provision for the 50-100k people affected by FND in the UK we've recently expanded our inpatient service to outpatients, opening the door to greater numbers of referrals, particularly those living with long-term symptoms not severe enough to be funded as an inpatient and paying privately.

But for me and the rest of my team our aim is to be a torchbearer for FND, raising its profile and importance. Our knowledge, experience and best practice of multi-disciplinary care has never been more relevant, and we'll continue to support the health sector to understand and implement future frameworks and guidelines.

To arrange a visit or referral please contact Robert Jones, PJ Care's FND, Referrals and Placements Manager, at pjcare.referrals@nhs.net or call 07796713172.

PJ Care
specialised neurological care

www. pjcare.co.uk

TRANSFORMATIVE REFLECTION FOR PRACTISING PHYSICIANS AND SURGEONS. RECLAIMING PROFESSIONALISM, WISDOM AND MORAL AGENCY

Book written by Linda De Cossart and Della Fish (2020)

Review by Dr G Spoto FRCPsych MA FAcadMEd MEWI, Consultant, IDF, London
giuseppe.spoto@ntlworld.com

BOOK REVIEW

Linda De Cossart and Della Fish (2020)
"Transformative Reflection for Practising Physicians and Surgeons. Reclaiming professionalism, wisdom and moral agency "
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Although Reflective Practice is now accepted to be part of Medical Education, its implementation is variable and guidance as to how this should be carried out in practice is virtually absent. This latest book by De Cossart and Fish therefore is timely.

Unlike other publications in the field of Medical Education which are mostly examination oriented and in the main concerned with what is known as *"behavioural objectives"*, this volume makes the case for an entirely different approach based on Reflection.

The book is aimed directly at practising clinicians, and although the content mostly seems to have the surgeon in mind, it is of immediate practical application regardless of any particular medical Specialty.

De Cossart and Fish are leading authorities in the field of Medical Education and need no introduction. Readers will be familiar with their previous titles (*De Cossart and Fish 2005; Fish and De Cossart 2007*).

The book looks at the theory and practice of Medical Education today and the Authors advance a view of education which is not at all didactic or formal but essentially constructivist[1].

The book is divided into four parts subdivided into chapters. The chapters are thoroughly referenced and there are useful tables and check lists. Each chapter has Summaries and diagrams.

There is a demonstration of what they call the Transformative Reflective Process (TRP) based on a real case, which is provided as an Appendix. Case material used in this way is rarely found elsewhere.

As in their work previously, the book draws attention, with examples, to the many opportunities for teaching and learning that are available in the clinical settings also further advancing the distinction between Education, an essentially moral occupation[2] and Training which is aimed at learning skills. At the same time, and contrary to the prevailing view, they place Education squarely in the clinical settings[3].

The distinction is of fundamental importance philosophically and of course the idea of education as a moral occupation sits opposite to the concept of *"learning styles"*.

It is also clear from this book that the Authors believe that the practice of reflection needs to be systematic in order to be effective or to borrow their own language, truly "transformative". It cannot be incidental or casual.

The book addresses matters organically always starting with First Principles and then looking at existing practice to finally provide a critique. Opinions are based on research findings, which are always credited and often original. This scholarly approach will be familiar to devotees and is instantly recognizable. The Authors speak with conviction and in a style which is characteristically forthright though never moralistic or prescriptive.

In the exam orientated literature of today Reflective Practitioners have been criticised for being ineffective and it is certainly the case that in the not-too-distant past "*real*" teaching was deemed to be able to only take place in the classroom, the clinical settings being thought to be only of secondary importance[4].

It is not surprising therefore that in this book possibly their most philosophical to date. The Authors should take issue with the Academy of the Medical Royal Colleges and the GMC for failing to be fully committed to practice-based learning in their guidelines and being still far too theoretical.

I have personally found, speaking as a Psychiatrist and an Educator, that in the Curricula and in many rotational training schemes, Reflective Practice is regarded as an adjunct and proposed simply as an "add on" that is to say added to old fashioned didactic teaching, which it does not seek to replace, which I find very artificial. I suspect this to be a hangover from the traditional Teaching Hospital (Heaman, 2022) and true both of the clinical settings and of the Regional Courses.

It is also very clear from this book, that for De Cossart and Fish the practice of education always starts at the level of the Learner and never the other way round, a point of fundamental importance generally but especially important when working in the clinical settings, for example when working with underachievers.

Although very academic, the book always engages the reader very readily and concepts that for many are still esoteric such as "*Reflection* in *Action*" and "*Reflection on Action*" (Schon, 1983) readily come to life and are easily accessible.

I also personally enjoyed their critique of the widespread use of technology, and especially online training, which in this book is stated to be excessive and "*de-humanising*", a point which is critical in a post COVID environment.

The intention of this book as they also say in the introduction, is to assist professionals and the professions, to reclaim their own practice and the reader is never left in any doubt that for the Authors Reflective Practice is the only practice which is of any value in a clinical setting.

The book has much to offer to those who work in a mediocolegal setting, possibly the clinical setting "*par excellence*", where despite the many excellent courses available the practice of education is to this day still very classroom based[5]. The book therefore provides significant added value.

One only has to remember that teaching in the clinical settings, including reflection, was only accepted relatively recently and only because of the introduction of the European Working Time Directive (EWTD) into UK law, thereby limiting the time spent by trainees on the wards, but was otherwise met with scepticism if not downright hostility (*KSS Deanery. Liberating Learning, 2007*).

This is of course a far cry from the Vygotskyan imperative requiring a teacher always to abstain from doing anything even remotely didactic but instead "scaffold" the learner (Vygotsky, 1978).

My only criticism of this book is that the case material rather than being included in the book as an individual chapter is instead featured as an Appendix, thereby significantly reducing its impact if not entirely undermining the scope of the book. This however is a criticism of form and not of substance.

Although difficult in places for the uninitiated, this book will readily appeal to anyone seeking to update themselves with regard to the practice of Medical Education. The book is highly recommended.

Footnotes:

[1]The constructivist view of Education believes knowledge to be something that cannot be transmitted but is always constructed by the learner

[2] The definition of education as an essentially moral practice, has a long history which can be traced back to the ancient Greeks. It holds that Education is the natural extension of "phronesis", the moral virtue.

[3] The safe place where knowledge is constructed through experience is known as the "practicum" (De Cossart and Fish 2005).

[4] Didactic teaching in Medical Education was until recently still highly prevalent, the clinical settings being regarded as merely a place suitable for the application of knowledge gained in the classroom.

[5] In the medicolegal setting resistance to practice-based teaching and learning, including Supervision, continues to this day to be almost intractable, the only clinical teaching available to aspiring Experts being limited to what is available in the Judges' comments on their reports, often not very favourable.

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[5] Schon D (1983)" *The Reflective Practitioner. How Professionals think in Action* " Hachette Books Group

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MEDICO LEGAL MAGAZINE

AI AND MEDICAL NEGLIGENCE: A FINE LINE?

By Francesca O'Neill, Barrister, Deka Chambers, London
FONeill@dekachambers.com

Francesca's practice is chiefly focussed on the negligence liability of professionals and public authorities. These include the most complex clinical negligence cases, multi-million pound claims in respect of lawyers, architects and surveyors, social services claims and high-profile cases examining the extent of public authorities' duties.

She is the author of Thomson Reuter's Practice Note on lawyers' scope of duty and has a particular interest in the nature and extent of the duty of care.

In 2020, Francesca was appointed to the Attorney-General's Panel of Counsel, and in 2023, she was appointed a part-time Judge of the First-tier Tribunal, sitting in the Health and Social Care Chamber.

Sir Geoffrey Vos MR is one of our most senior judges. Recently, he has given a series of excellent speeches on professional negligence and AI. He describes a clear tension in how professionals approach the use of AI and the liability risks that this causes – mainly focussing on the issue of how the courts

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will approach a negligence claim where AI has been used. His maxi is "damned if you do, damned if you don't" – adopt AI technology without care and caveat, and you will come to grief. A hesitancy to embrace it all though, is just as dangerous.

This applies to medicine as it does to all professionals, including lawyers and accountants. By now, we all know that AI is a powerful tool in the medical arsenal. Yes, it has the potential to hallucinate, or get things wrong. But where AI can help diagnose whether a skin defect is cancerous with 99% accuracy, doctors may be as much liable for using an available AI tool wrongly, as they might be liable for not using it at all.

A failure to use a tool that can be vastly more accurate than even the most experienced and skilled doctor is likely to fall below the standard required by the courts. If DERM (Deep Ensemble for Recognition of Malignancy), developed by Skin Analytics, analyses images to assess and triage skin lesions, potentially redirecting benign cases to non-urgent pathways and flagging suspicious lesions, it can and should be used widely. We are all familiar with the Bolam test: whether a doctor acted in accordance with a responsible body of professional opinion. If their actions were supported by that body of opinion, they are not considered negligent. If a body of opinion includes the use of AI tools, that becomes part of the required standard of care.

This is appreciated by those in management at the NHS. In 2024, the NHS Humber Health Partnership said its Flow initiative includes measures designed to streamline every stage of a patient's progress from emergency department to discharge. AI software will be used to prepare X-ray reports and read blood test results, while bosses have pledged rapid assessments in emergency departments, more home-based treatments and virtual wards.

Many experts talk about the potential of artificial intelligence (AI) and machine learning to fundamentally improve disease research and overall health outcomes, but few people know that these technologies are already employed in more mundane, administrative parts of the health care system. In America, many hospitals, for example, employ AI-assisted predictive models to help them perform a range of tasks, including automating billing procedures and appointment scheduling. Anyone who had tried to re-arrange an appointment at an NHS hospital recently can only dream of the improvement that AI might bring!

In a world where medical negligence claims often arise from delayed diagnosis, or because a GP's 10-minute appointment was insufficient to properly understand a patient's problems, it is worth dwelling on how important and useful AI will be in speeding up these routine administrative elements of healthcare. Properly adoption and training on these types of AI tools is not just time-saving, it could be life-saving. I would be surprised if medical indemnifiers did not start seriously considering whether the use of these tools should be mandatory.

A recent study by the University of Minnesota School of Public Health (SPH) shows how hospitals in the U.S. are using AI-assisted predictive models. Approximately 65% of U.S. hospitals reported using AI-assisted predictive models. These models were most commonly deployed to predict inpatient health trajectories (92%), identify high-risk outpatients (79%), and facilitate scheduling (51%). While 61% of hospitals evaluated their predictive models for accuracy, only 44% conducted similar evaluations for bias.[1]

Bias matters. AI models are built on analysing huge data sets, which enable it to accurately diagnose or predict the course of disease or treatment. When those data sets are derived from clinical trials where sex difference has not been properly analysed, the AI that become less effective. It becomes less effective in the treatment of women, who are often unrepresented or under-represented in medical trials.

An example: experts said an algorithm developed using AI had enormous potential to improve patient care after a trial found it was more effective than current testing in ruling out heart attacks. Heart attacks are diagnosed based on the levels of troponin, a type of protein, in the blood. The new approach combines a patient's troponin test results with other information and was able to rule out a heart attack in more than double the number of patients compared with the current approach, with 99.6 per cent accuracy. In *Invisible Women*, Caroline Criado-Perez complains that troponin levels differ by sex, and that if a dataset turns out to have been trained on male dominated data and its performance has not been sex-analysed, it is of much reduced value.

There are two important lessons from this observation.

The first is that where AI is to be deployed for diagnostic or predictive purposes, doctors need to be aware of its limitations. This means that AI should be used alongside more traditional methods in treatment, unless there is sufficient certainty about the reliability of the source material used to train the AI.

The second important point is the accurate recording of sex data. Although it is very important that patients are free to express their gender identity without fear of discrimination, it is imperative that accurate sex data is recorded by health professionals.[2] A triage form that asks for gender is not of no use whatever. A review led by Alice Sullivan, a professor of sociology and research specialist at University College London, said the use of "gender" as catch-all term had begun being used in the 1990s and had become increasingly common, leading to what she termed "a widespread loss of data on sex".[3]

My view is that inaccurate reporting and recording of sex data will create additional liability risks for medical professionals, especially as the use of AI becomes more widespread. It is trite to say that women's pain and conditions which overwhelmingly affect women have been under-studied and remain a critical problem in healthcare. The vaginal mesh scandal is just one example where many millions of pounds have been paid out in compensation.[4] All doctors should be concerned by the obfuscation created by inaccurate data recording, and even more so by the BMA's Resident Doctors Committee for condemning the recent UK Supreme Court ruling that the legal definition of a woman in law is based on biological sex. That is backwards step when technology should be moving treatment forward.

It is not just sex which matters. Sara Khalid, Associate Professor of Health Informatics and Biomedical Data Science at NDORMS, explained: *'Health inequity was highlighted during the COVID19 pandemic, where individuals from ethnically diverse backgrounds were disproportionately affected, but the issue is long-standing and multi-faceted.*

'Because AI-based healthcare technology depends on the data that is fed into it, a lack of representative data can lead to biased models that ultimately produce incorrect health assessments. Better data from real-world settings, such as the data we have collected, can lead to better technology and ultimately better health for all.'[5]

For doctors who are keen to avoid additional liability risks, the outlook is clear: AI is going to continue to improve and become an essential tool. Ignoring it or failing to use it in obvious cases such as in skin lesion diagnosis, may well become a negligent failing. Refusing to embrace AI as a way of managing administrative tasks and scheduling of appointments will lead to delay which may indirectly contribute to heighten liability risks. Doctors should be aware of bias and use AI with care and in a proper context and can themselves contribute towards better outcomes by accurately recording sex and ethnicity data.

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[4] https://www.theguardian.com/society/article/2024/aug/19/140-women-in-england-receive-compensation-for-vaginal-mesh-implant-complications

[5] https://www.ox.ac.uk/news/2024-02-22-removing-bias-healthcare-ai-tools

CASE REPORT FROM THE MEDICAL PROTECTION FILES: HOW A STANDARD KNEE REPLACEMENT RESULTED IN A CONSULTANT SURGEON BEING CALLED TO GIVE EVIDENCE AT A CORONER'S INQUEST

By Dr Claire Harrison, Medicolegal Consultant at Medical Protection

A consultant member contacted Medical Protection after receiving a complaint from the wife of a deceased patient. Ms T, a consultant orthopaedic surgeon, had undertaken a total knee replacement, but two weeks later the patient died as a result of developing bilateral DVTs and a pulmonary embolism.

As the treatment had taken place during the junior doctor strikes, Ms T had been the clinician writing the patients discharge letter. It was later found that she had accidentally discharged the patient without providing low molecular weight heparin, while the ward pharmacist checking the discharge letter, had also not spotted the error before discharge.

Furthermore, the patient had struggled to wear compression stockings while on the ward. His wife reported that the patient found them very uncomfortable and chose not to wear them at home. She alleged that they must not have been fitted properly in the first place.

Realising that the coroner would open an inquest into the death of the patient, Ms T called the Medical Protection advice line.

The member was required to respond to the patient's wife's complaint which Medical Protection could assist with, so Ms T sent in her draft complaint response which was reviewed and finalised by medicolegal experts. Ms T was also required to provide a statement for a Serious Incident (SI) investigation. Her dedicated case manager advised her to draft a single factual statement which could be used for both the SI investigation and for the coroner's inquest.

When the statement had been finalised, some time passed before we next heard from Ms T. The Trust's SI report had been published and it was critical of the mistake made by Ms T but, made no mention of the role of the ward pharmacist, nor the ill-fitting stockings that the patient refused to wear.

Ms T's attempts to ensure that the SI report was more balanced were rebuffed. Simultaneously the coroner listed the inquest hearing. During a meeting with the Trust's solicitors, it became apparent to Ms T that the Trust were not going to be able to represent her interests along with their own, so she returned to Medical Protection for help.

After reviewing the documents, her medicolegal advisors determined that there was a risk of criticism at the inquest and applied to the coroner to request that Ms T was made an 'Interested Person' in her own right, thus entitling her to legal representation. Medical Protection's in-house solicitors were instructed to assist with her preparation for the inquest and to represent her.

At the inquest, Ms T gave cogent evidence and advised the coroner of the changes to her practice, and those of the department, since this incident. The coroner's conclusion was balanced, referencing the mistake by Ms T, but also describing the system errors and circumstances of that day. Ms T was content that it was a fair conclusion given the circumstances.

As a result of the conclusion, which identified the failing in the care provided, Ms T was obliged to self-refer to the GMC.

The GMC decided to open an investigation, based in part on the self-referral and in part from a complaint received from the patient's wife. In addition to the concerns raised about the discharge medication, the GMC complaint alleged substandard surgery and raised probity questions regarding Ms T's evidence at the inquest.

The GMC obtained an expert report. The GMC's expert was critical of the member and referred to several aspects of the surgery which they felt fell below the standard expected.

In response to Ms T's concerns regarding the expert report, Medical Protection instructed its own expert. Using the expert evidence and Ms T's evidence and reflections, a 'Rule 7 response' was submitted to the GMC.

After consideration by the GMC's case examiners, the case was closed with no further action, citing the member's reflections and the demonstrable changes to her practice. Note was also made of the numerous testimonials that were provided and the excellent patient feedback that had been included as part of the robust defence of the member.

MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry of the first quarter of 2025

NEWS

Health and Care Overseas Worker Visa Restrictions

In May the Government announced that the Health and Care Worker visa route will be closed to new overseas applicants for adult social care roles.

The adult social care sector currently faces more than 130,000 vacancies, but the Government has cited future reforms, including the Fair Pay Agreement and the Employment Rights Bill, as long-term solutions.
Professor Martin Green OBE, Chief Executive of Care England, commented:

"Cutting off international recruitment before a domestic solution is in place puts the cart well before the horse. The Fair Pay Agreement and the Employment Rights Bill, as outlined by Government, are years away from implementation and remain underfunded and undefined. They cannot replace what is being taken away now."

Care England concluded that "Preventing overseas recruitment places even greater strain on a fragile system and jeopardises care for thousands."

Read more: https://www.careengland.org.uk/from-crisis-to-collapse-care-england-express-concern-over-sudden-end-to-overseas-recruitment/

Patient Safety Watch Survey Closing Soon

Campaign group, Patient Safety Watch, aims to reduce avoidable harm in healthcare and advocates for change to build safer healthcare systems. Patient Safety Watch is currently running a survey until 2nd July, inviting healthcare professionals to:

"Tell us about your interventions to improve patient safety. We're gathering NHS insights on what really works."

Read more and take part: https://www.thiscovery.org/project/interventions-to-improve-patient-safety

Personal Injury Costs Challenge Judgement - *Richardson & Ors v Slater & Gordon UK Limited*

Law firm Slater and Gordon won a group-action case in May brought by hundreds of former clients, 10 of whom were selected as test claimants, and who argued that they did not give informed consent to deductions from personal injury damages.

In *Richardson & Ors v Slater & Gordon UK Limited* each claimant approached the firm to pursue a personal injury claim on a conditional fee agreement. The agreements required the claimant to pay the firm's basic charges, disbursements and success fee which was capped at 25% of damages plus payment of the after the event insurance premium.

A spokesperson for the firm said: 'We have repeatedly stated in response to these challenges that we reject any suggestion that former clients had been pressured to sign up to retainers or that the retainers were defective in some way. We are pleased that the costs judge found, expressly, that there was no pressure to complete the process and that the retainers were found to be fully enforceable.

Judge Rowley said the law firm had used a "perfectly appropriate method" for explaining what the clients had signed up for.

Read more: https://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Costs/2025/1220.html&query=(Richardson)+AND+(Ors)

MedCo Examination Guidelines for Medical Experts

MedCo, medical report providers in low-value claims, has issued new guidelines for personal injury lawyers and expert witnesses on how client examinations must be administered.

The rules remove any reference to the use of remote examinations put in place during Covid and add the instruction that clients must always be assessed in an appropriate setting.

"Examinations must take place in locations that are confidential, private, safe, secure and regarded as a professional environment," advised MedCo. "The examination location must be neutral and examinations should never take place at the offices of the instructing party or any other premises belonging to the instructing party."

Hotel bedrooms, commercial premises and homes without medical facilities are considered not suitable by MedCo. Best practice for consultations is regarded as a clinic, GP practice or medical centre.

The updated guidelines also state that medical experts cannot carry out any more than 35 examinations in a day, with a minimum of 15 minutes spent face-to-face with a claimant.

Since 2021 The Civil Liability Act requires that all claims must be accompanied by a medical assessment.

Read more: https://medco.org.uk/examination-guidelines-update-and-reminder-cloned/

Seshni Moodliar v GMC Judgement

The judgment in *Moodliar v General Medical Council [2025] EWHC 913 (Admin)* is a reminder to medical experts that giving expert evidence is a significant undertaking. In this case, failures in the process led to eventual erasure from the medical register, after a failed attempt to appeal from the defendant, who was representing herself.

Dr Moodliar graduated in medicine from the University of the Orange Free State in South Africa in 2000 and gained full registration with the GMC in 2002. She then worked in various mental health roles in the fields of general and forensic psychiatry, until she qualified as a member of the Royal College of Psychiatry and, from 2015, she worked as a Consultant Psychiatrist in Learning Disability. She started undertaking medicolegal work in 2005.

Below is the background to the case and selected extracts from the High Court Decision:

"In 2020, a colleague reported concerns to the GMC in respect of Dr Moodliar's work as an expert witness in two criminal cases. The matter was referred to the MPTS and a hearing was held by a tribunal in May 2022. The tribunal found that Dr Moodliar had dishonestly copied sections of another expert's report when acting as an expert witness for the prosecution in the case of Patient A at a hearing in 2017. Further, the tribunal found that, when acting as a defence expert in respect of Patient B between September and December 2019, she had failed to assess the patient adequately in that she failed to obtain a detailed history, perform a detailed mental state examination or take steps to check the veracity of the patient's account; she had failed to explore the possibility of insanity, schizophrenia or psychosis; she had failed to prepare a report that was factually accurate; she had acted beyond her training and expertise in that she acted as an expert witness in a murder case without sufficient knowledge of the law of diminished responsibility; and she had failed to make or keep accurate records. The tribunal concluded that Dr Moodliar's fitness to practise was impaired by her misconduct and imposed conditions upon her registration for a period of 18 months.

"Subsequently further allegations of misconduct in respect of Dr Moodliar's medicolegal practice came to light. The new allegations concerned her work as a defence expert witness in the criminal trial of Patient D in March 2019. The allegations therefore arose from her conduct in another case between that of Patients A and B, and before the 2022 tribunal proceedings.

"Erasure is the most serious sanction available to a tribunal. A doctor who is erased from the medical register cannot apply to be restored to the register for five years and will only be restored if a tribunal is satisfied that they are then fit to practise: s.41(2)(a) of the Act.

"The Sanctions Guidance issued by the General Medical Council provides that the tribunal may erase a doctor from the medical register where this is the only means of protecting the public, and that erasure may be appropriate even where the doctor does not present a risk to patient safety but where such sanction is necessary to maintain public confidence in the profession. At paragraph 109 of the guidance, the list of non-exhaustive factors that may indicate that erasure is appropriate include "dishonesty, especially where persistent and/or covered up" and "persistent lack of insight into the seriousness of their actions or the consequences".

"The tribunal heard submissions as to the appropriate sanction and on 15 December 2023 it handed down its written decision directing the erasure of Dr Moodliar's name from the medical register."

Read more: https://www.bailii.org/ew/cases/EWHC/Admin/2025/913.html

New Legislation to Protect 'Nurse' as a Title

In May new measures were announced through the government's NHS Plan for Change to protect the title 'nurse' in law. Anyone misleading the public and describing themselves as a nurse without the relevant qualifications and registration will face a fine.

Those struck off by the Nursing and Midwifery Council (NMC) for serious misconduct or criminal convictions can still currently call themselves a nurse.

There will be exemptions for relevant professions like veterinary nurse, dental nurse and nursery nurse, where the title 'nurse' is legitimately used.

Health and Social Care Secretary Wes Streeting said: "Nurses carry out lifesaving work every day, and I am determined we do everything we can to support them and safeguard trust in the profession.

"I've been appalled to read reports of so-called nurses spreading dangerous misinformation and harming the public.

"This new legislation will help crack down on bogus beauticians and conspiracy theorists masquerading as nurses, and those attempting to mislead patients."

Only the title 'registered nurse' is currently protected in law, so the new legislation will ensure that only those individuals registered with the NMC can legally use the title. Anyone violating this will be committing a criminal offence.

Rachel Power, Chief Executive of The Patients Association, said:

"We welcome this commitment to ensuring patients know who is treating them and offering healthcare advice, and that those professionals are properly qualified. With health misinformation increasingly common, it's more important than ever that patients can trust the expertise of those caring for them."

These changes, which require legislative change, will be implemented within this Parliament as part of the government's commitment to reform the regulation of health and care professionals in the UK.

Read more: https://www.gov.uk/government/news/fake-nurse-crackdown-to-boost-public-safety

Pre-action Protocols and ADR after Churchill

Churchill v Merthyr Tydfil [2023] EWCA Civ 1416 was the landmark case concerning Judges having the power to compel parties to engage in alternative dispute resolution (ADR) during court proceedings, but more recent caselaw has indicated that parties should consider ADR even if they already have had a failed attempt during the pre-action stage of disputes.

In *Francis v Pearson [2024] EWHC 605 (KB)* HHJ Matthews, sitting as a judge of the High Court, advised that the parties engage with a second mediation. HHJ Matthews explained: "Experience shows that it is often in entrenched cases such as this that ADR can make a real difference, often requiring honest conversations with parties as to the merits of their respective cases, and the potential downsides, as well as looking at pragmatic ways forward.

"I would strongly recommend that the parties reconsider some form of alternative dispute resolution process – which might include further mediation, or some other way of facilitating agreement – before matters in this case move forward and further costs are incurred."

Read more: https://www.casemine.com/judgement/uk/65f9da68f2fa06429dd5d663

If you are interested in training to be a civil mediator, then please see the training courses run by the Society of Mediators here: https://www.specialistinfo.com/mediation-course

BMA Back Fight to Challenge GMC over regulation of PAs and AAs

The BMA has announced it is appealing its case against the GMC over the regulator's use of the term "medical professionals" to describe Physician and Anaesthesia Associates (PAs and AAs), *British Medical Association, R (on the application of) v General Medical Council [2025] EWHC 960 (Admin)*.

Meanwhile another legal case supported by the BMA and brought by Anaesthetists United (AU) and the parents of Emily Chesterton over the GMC's failure to properly regulate PAs and AAs was heard at the Royal Courts of Justice in May.

Emily died aged 30 after two appointments with a PA whom she believed was a GP. A judicial review against the GMC alleges it has failed in its statutory duty to set standards by ensuring a clear scope of practice that would prevent such dangerous blurring of lines between the roles of PAs and doctors in the future.

BMA chair of council Professor Philip Banfield said:

"What Brendan and Marion Chesterton went through, losing their daughter Emily in such tragically avoidable circumstances, is something no parent should ever have to experience. It is a testament to their courage and determination to see that the chances of this happening again are drastically minimised that they have joined this case against the GMC. As we begin this court case today, we are saying simply that there must be no more stories like Emily's. When our patients need to see a doctor, they must know that they are seeing a doctor.

"At its heart the case is simple: the GMC is our medical regulator. It should have a duty to protect patients. Yet it persistently declines to set out what PAs can and can't do. There is no scope of practice, no clear guidance, and thus no way the GMC can claim it has 'set standards' in any manner that patients or other staff would regard as necessary to ensure patient safety. The GMC has washed its hands of these duties and, along with the NHS, has perpetuated a postcode lottery with frightening inconsistencies.

"We know from bitter experience that without a clear scope of practice in place, PAs will be permitted to do medical work and procedures that far exceed their capabilities, often with terrible consequences.

"We are grateful for the work of grassroots campaigners like AU who have raised so much money from public donations, including from doctors who are rightly concerned about this issue. Along with AU we hope to bring the GMC back to its most crucial purpose: protecting patients. This should not have taken legal action - but it's not too late to correct."

Read more: https://caselaw.nationalarchives.gov.uk/ewhc/admin/2025/960

https://www.bma.org.uk/bma-media-centre/bma-backed-high-court-case-brought-by-parents-of-emily-chesterton-and-anaesthetists-united-against-gmc-over-regulation-of-pas-begins

MEDICO LEGAL MAGAZINE

Mr Tim Burge MB ChB FRCS DMCC(Plas)

Consultant Plastic Surgeon (GMC: 2702249)

t: (+44) 07515 094 348
e: info@clifton-plastic-surgery.co.uk
w: clifton-plastic-surgery.co.uk

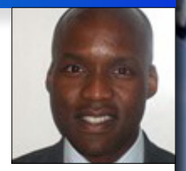
- Consultant Plastic Surgeon since 1996 and has a broad experience having worked in the Army, the NHS and the Private Sector.
- Over 20 years of experience writing reports and receives about 300 instructions per year.
- Instructed by Claimants, Defendants, and as a Joint Expert.
- Aware of the Part 35 requirements of an Expert Witness and has obtained Part 1 of the Certificate of Medical Reporting (Bond Solon).
- Has experience appearing in court as an expert witness.
- Appointments are available in Bristol, London, Cardiff, Birmingham and Salisbury.
- All reports are produced within agreed timescales, usually 6 weeks, which can be expedited.

EMAIL ME

Andrew Chukwuemeka

MB BS MD FRCS (Eng) FRCS (CTH) LLB (Hons)

Consultant Cardiothoracic Surgeon



t: +44 (0)208 383 2026
e: andrew.chukwuemeka@nhs.net

Acting for Claimants, Defendants and as a single joint expert, a Consultant Cardiothoracic Surgeon with Imperial College Healthcare NHS Trust, he is Medical Director at Hammersmith Hospital and was previously Clinical Director for Cardiac Sciences (Cardiology, Cardiothoracic and Vascular Surgery). His clinical interests include Chest Trauma, Aortic Surgery including Transcatheter Aortic Valve Implantation (TAVI), Heart Valve and Coronary Artery Bypass Surgery.

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).

EMAIL ME

David Simon Costain

Gait & Posture Centre

Podiatric Consultant and Gait Specialist

t: +44 (0)207 636 4465
e: clinic@gaitandposture.com
w: www.gaitandposture.com

David Simon Costain is a Podiatric Consultant and Gait Specialist, based in Harley Street, London. He has over 45 years of experience in Podiatry and is the CEO of the Gait & Posture Centre.

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.

THE GAIT AND POSTURE CENTRE

EMAIL ME

Dr Suprio Ganguly

BSc MBBS MD FRCR

t: (+44) 7733 156 406
e: suprio.ganguly@nhs.net

Dr Suprio Ganguly has over 37 years' experience of radiology practice earned in five countries spanning three continents, traversing both military and civilian sectors. Dr Ganguly is on the GMC's Expert Witness and Associate Medical Performance Assessor panels. Dr Ganguly undertakes expert witness instructions, including the preparation of medico-legal reports and giving evidence in court in clinical negligence cases relating to Neuro, Chest, abdomen and pelvis, Gynaecology and obstetrics, Paediatric, Cancers, Trauma, and Emergency radiology. Dr Ganguly can act on behalf of either claimant or defendant or as a Single Joint Expert. He has provided expert witness evidence in the coroner's, judicial, and military courts.

EMAIL ME

Atul Khanna

Consultant Plastic, Reconstructive and Hand Surgeon

t: +44 (0)7360 750011
e: mrkplastics2021@gmail.com
w: www.atulkhanna.co.uk/expert-witness

Mr Khanna is a substantive NHS Consultant in Plastic, Reconstructive and Hand Surgery at The Sandwell and West Birmingham NHS Trust and has been involved in medical legal work since 1998. In this period he has provided over 4000 medical reports. He has prepared a chapter for the Encyclopedia of Forensic & Legal Medicine entitled "Medical malpractice in Cosmetic and Plastic Surgery".

Areas of expertise:

- Hand surgery: Sequelae of hand injuries and surgery
- Soft tissue injury:
- Burns management: Sequelae of disability following burns injury, scarring and surgery
- Medical negligence in Cosmetic Surgery

EMAIL ME

Mr Shyam Kumar

Consultant Orthopaedic Surgeon

t: +44 (0)7596852737
w: www.medicolegalorthopaedics.com

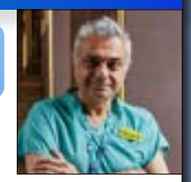
Mr Kumar, is a Consultant Orthopaedic Surgeon, specialising in trauma and upper limb conditions, with a focus on medicolegal practice since 2011. He serves on the trauma rota at the Royal Lancaster Infirmary. He holds an LLM in Medical Law & Ethics and is on the Medicolegal Committee of the British Orthopaedic Association. He performs assessment of doctors for the General Medical Council and examines for the Royal College of Surgeons. With regulatory experience, he has advised the CQC. He provides concise medical reports for clinical negligence and personal injury cases, with clinics in Manchester, Lytham, Bolton and Lancaster.

EMAIL ME

Kulvinder Lall

Consultant Cardiothoracic Surgeon

KULVINDER LALL CONSULTANT CARDIOTHORACIC SURGEON



Consultant Orthopaedic and Trauma Surgeon

e: cardiothoraciclegal@icloud.com
w: www.cardiothoracic-surgeon.co.uk

Kulvinder Lall is one of the top cardiothoracic surgeon's in the UK, with particular expertise in aortic valve replacement, mitral valve repair, coronary artery bypass graft, and thoracic aortic aneurysm. Mr Lall is listed on the General Medical Council Specialist Register as a specialist in cardiothoracic surgery. Qualifying in 1989 from the University of London, he has trained in cardiothoracic surgery in London, Glasgow & Sydney. He was appointed to St Bartholomew's Hospital as one of the youngest cardiac surgeons in the UK aged 36. As an NHS Surgeon he has performed in excess of 5,000 heart operations with outstanding results as measured by The Care Quality Commission & Department of Health.

As a leading cardiothoracic surgeon, he has published in over 15 peer reviewed worldwide journals and is actively involved in NHS research. He teaches extensively in China, Europe, Hong Kong and Israel, and was the first implanter of a stentless heart valve in Asia (Beijing 2010).

VISIT WEBSITE

Philip McCann

Philip McCann

Consultant Orthopaedic and Trauma Surgeon

t: +44 (0)117 933 9985
e: philmccann.secretary@soc-bristol.co.uk
w: www.shouldersurgeonbristol.co.uk

Mr McCann is a full time Trauma and Orthopaedic surgeon at University Hospitals Bristol and Southmead Hospital Bristol. He has a Specialist interest in:

- Fractures of the clavicle, shoulder, humerus and elbow
- Arthroscopic (keyhole) surgery for shoulder problems including tendon tears, impingement, stiffness, instability and arthritis
- Primary and Revision Shoulder replacement surgery
- Management of post traumatic, degenerative and sports-related
- conditions of the upper limb

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.

VISIT WEBSITE

EXPERT WITNESS DIRECTORY

MEDICO LEGAL MAGAZINE

Dr Neil Mo

BSc (Hons), MSc, MBBCh, FRCP

Consultant Rheumatologist

t: +44 (0)800 433 2380
e: enquiries@drneilmo.com
w: www.drneilmo.com

Dr Neil Mo is a consultant rheumatologist and clinical lead in Swansea Bay University Health Board. He was previously a consultant in Charing Cross and Hammersmith Hospitals. He has received training in report writing and courtroom skills, and has produced over 300 medicolegal reports. He provides comprehensive, authoritative and well balanced reports with a quick turnaround time.

He has expertise in all areas of adult rheumatology, and maintains his clinical and medicolegal knowledge to deliver an up to date expert opinion. He is experienced with risk management within the NHS and has undergone training with NHS resolution.

EMAIL ME

P N Plowman

MA MD FRCP FRCR

Senior Clinical Oncologist

t: +44 (0)20 7631 1632
e: nplowman@doctorplowman.com
w: www.drnickplowman.com

Dr P N Plowman is senior clinical oncologist to St Bartholomew's Hospital, London and has a paediatric interest and on the staff of Great Ormond Street Hospital. He has a long history of medicolegal work with around 50 new instructions each year. He has been an expert in the Tobacco Litigation and the class action of 22,000 USA women claiming breast cancer caused by HRT. Most of his instructions are to do with delay to diagnosis of cancer or causation aspects of cancer treatments' complications.

EMAIL ME

Dr David Newby

BSc MBChB FRCA LLM

ANAESTHESIA EXPERT WITNESS

Consultant Paediatric and Adult Anaesthetist

t: +44 (0)7428467803
e: ddp.medicolegal@gmail.com
w: www.anaesthesiamedicalexpert.co.uk

Dr David Newby is a substantive anaesthetic consultant at Ipswich Hospital. He is the lead anaesthestist for paediatric services and established and runs the consultant-led paediatric preoperative assessment clinic. His adult work includes orthopaedic trauma and vascular surgery.

Areas of particular expertise:

- anaesthesia for children in the district general hospital
- paediatric preoperative assessment
- TIVA in children

In addition to:

- all aspects of adult perioperative care, including preoperative assessment
- high-risk surgery
- awareness under anaesthesia
- anaphylaxis
- shared-decision making

EMAIL ME

Mr Sarwat Sadek

MBBCh FRCSI FRCS (ORL-HNS) FRCS

Consultant Otolaryngologist and Head & Nech Surgeon

t: +44 (0)7802 974000
e: sarwatsadek@doctors.org.uk

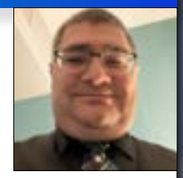
Mr Sarwat Sadek has been practising as an ENT Consultant for nearly 40 years and is currently Consultant Otolaryngologist and Head & Neck Surgeon at the Nuffield Hospital, Taunton.

Areas of interest:

- Military noise induced hearing loss
- Noise induced hearing loss
- Occupational rhinitis
- Facial & neck trauma
- Traumatic loss of sense of smell and taste
- Deafness, tinnitus and vertigo as a result of road traffic accidents

EMAIL ME

Professor Panayiotis (Panos) Kyzas



Consultant OMFS H&N Surgeon

t: +44 (0)750 5402 640
e: kyzasp@icloud.com

My name is Professor Panayiotis (Panos) Kyzas. I am a consultant in OMFS/Head and Neck Surgery with a clinical specialty interest in ablation and reconstruction of head and neck cancer and facial skin cancer. I am the Editor-In-Chief of the main UK scientific journal for my specialty, a pst that commenced in 2024 for 5 years. I held the post of the chair for the OMFS Specialty Training Committee and the regional research advisor. I have acted as the national OMFS representative on the TIG H&N fellowship committee and the Quality Assurance Lead from 2019 to 2023. I have recently graduated my law degree with honours. I currently hold a Bronze National Clinical Excellence Award for my services to the NHS. I am the Chief Investigator of the MANTRA trial, a with multimillion pounds NIHR funding. In August 2023 I have been appointed as a visiting Professor in OMFS H&N Surgery at Edge Hill University.

EMAIL ME

Mr Aruni Sen

MS, FRCS, FRCEM, DipMedEd.

Lead Consultant in Emergency Medicine, Princess Elizabeth Hospital, Guernsey

t: +44 (0) 7839 755001
e: thesens@msn.com

Medico Legal Expert since 1996
Experience as independent expert for claimant, defence & SJE.

Areas of interest:

- Clinical Negligence
- Personal Injury
- Hand Injury
- Resuscitation
- Trauma, Burns, Sedation & Acute Pain
- Musculoskeletal injuries
- CPR Part35 trained
- MEDCO accredited
- Up to date medico-legal CPD portfolio
- Reports vetted by solicitors
- Consultation Venues at: Chester (Cheshire, Northwest & North Wales), Guernsey & Jersey
- Happy to provide pro-bono opinion

Member of EWI, APIL, Law Society.

EMAIL ME

Dr Ana Phelps

MD, PhD, FRCP, RCPathME

Substantive Consultant Geriatrician

t: +44 (0)79706 27996
e: ana.phelps@nhs.net

Dr Phelps is a substantive Consultant Geriatrician at Buckinghamshire Healthcare NHS Trust. She is an experienced Medical Examiner, regularly reviewing hospital mortality cases and advising doctors on medical certification of cause of death and when to refer to a Coroner. Her expertise includes Orthogeriatrics, Frailty, Dementia, Peri-operative Medicine and complex cases in patients >65y.

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

EMAIL ME

Mr Nikhil Shah

FRCS(Tr & Orth) FRCS MCh(Orth) MS(Orth) DNB(Orth) MBBS

Consultant Trauma & Orthopaedic Surgeon

t: +44 (0)161 393 3059
e: nikhil.shah@consultantcare.com

Mr Nikhil Shah can act as an expert witness in personal injury and clinical negligence cases, taking instructions from either claimant or defendant or as a Single Joint Expert. He can provide medico legal reports for personal injury claims involving:

- Trips and slips
- Pelvic and acetabular fractures
- Low velocity impact cases
- Whiplash
- Long bone and articular fractures
- Ankle, knee and hip fractures, lower limb injuries
- Soft tissue injuries

Mr Shah can provide clinical negligence related reports in his specialist areas of expertise concerning:

- Primary and revision hip and knee replacements
- Pelvic and acetabular fractures
- Long bone and periarticular trauma

EMAIL ME

EXPERT WITNESS DIRECTORY

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Professor David Warwick

DM MD BM FRCS FRCS(Orth) Diploma of Immediate Medical Care
European Diploma of Hand Surgery

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t: +44 (0)345 4505007
e: davidwarwick@handsurgery.co.uk
w: www.handsurgery.co.uk

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VISIT WEBSITE

Past Chair: British Orthopaedic Association Medicolegal Committee
Informal advice by telephone and email
Deferred fees on request
Southampton, Winchester, Jersey

Paul Whittingham-Jones FRCS

(Trauma and Orthopaedics)

Paul Whittingham-Jones HIP AND KNEE

t: (+44) 07506 504351
e: mrpaulwj@gmail.com
w: www.paulwj.com

Mr Whittingham-Jones is a consultant Hip and Knee surgeon with an NHS and private practice. He has produced over 1000 reports since 2013. Reports are accurate, concise and well reasoned. He is always happy to talk through any issues with reports. Having a particular interest in breach of duty cases, he will provide full reports or desktop screening reports as required.

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