MEDICO LEGAL

MAGAZINE

ISSUE 12

Presented by:

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Dr Bryan Beattie MD FRCOG

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Welcome to the Medico-Legal Magazine

Welcome to Issue 12 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This summer issue follows SpecialistInfo's successful Medico-Legal Conference, held on the 16th May 2019 at the Queen Elizabeth II Centre, Westminster, London. We include articles from some of the speakers, including Sir Rupert Jackson's keynote address. You can also read a summary article of the main topics covered. The date for next year has now been confirmed as the 11th June 2020 – early bird booking is now open! Click here to book.

Also in this issue, Dominic Regan, civil litigation and liability expert, comments on the upcoming court reforms involving fixed costs and a modified claims protocol.

Healthcare expert, Greg McEwan, from BLM Law, offers advice for doctors should they become involved in a clinical negligence claim, either as a defendant, witness or expert witness.

We are also pleased to include an article on diagnosis of sepsis by intensive care medicine consultant, Dr Chris Danbury.

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 is published on the Medico-Legal Section of the Specialistinfo.com website, and printed copies can be ordered from Iconic. 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, or share your news and experiences with us.

Lisa Cheyne

Specialistinfo
Medico-Legal Magazine

Contents:

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MEDICO -LEGAL COURSES:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

Training Courses for Expert Witnesses

The dates and locations for the confirmed ML courses that we are holding during 2019 are listed below with links to our booking page.

Medico-Legal Essentials Course (a general overview for anyone starting a medico-legal practice, focussing on personal injury):

- *17th September 2019* – London
- *20th November 2019* – Birmingham
- *22nd January 2020* – London

£340 (plus VAT)

For further information about the Essentials course, please visit: www.specialistinfo.com/a_ml_standard.php

Clinical Negligence Medico-Legal Course (for higher value medical negligence cases):

- *18th September 2019* – London
- *21st November 2019* – Birmingham
- *23rd January 2020* – London

£365 (plus VAT)

For further information about the Clinical Negligence course, please visit: www.specialistinfo.com/a_ml_clinicalneg.php

Advanced Medico-Legal Course
(refresher for experts now including court-room skills):

- *19th September 2019* – London
- *12th December 2019* – London
- *5th March 2020* – London

£365 (plus VAT)

For further information about the Advanced course, please visit: www.specialistinfo.com/a_ml_advanced.php

Mediation Training Course

Foundation Training (5 days)

- *9th - 13th September 2019* – London
- *16th - 20th December 2019* – London

5 days £1,600 (No VAT)

For further information about the Mediation course please visit: www.specialistinfo.com/a_ml_mediation.php

To book your place on one of the above courses please complete the booking form on our website by clicking on one of the above links (discounts are available for multiple bookings – please call Lisa to discuss or to book over the phone).

Please contact me, Lisa Cheyne, on 01423 727 721 or email me at lisa@specialistInfo.com

Numbers are strictly limited so early booking is advised to make sure you do not miss out on these enjoyable and highly informative courses.

I look forward to hearing from you soon.

Kind regards

Lisa Cheyne
Medico-Legal Course Manager

specialist info

MEDICAL ERRORS: SANCTIONS AND COMPENSATION – IS THERE ANOTHER WAY?

KEYNOTE SPEECH BY SIR RUPERT JACKSON AT THE MEDICO-LEGAL CONFERENCE ON 16th MAY 2019

1. INTRODUCTION

1.1 My position. I no longer have any responsibility for devising or implementing reforms to the civil justice system. Nevertheless, since I have been asked to deliver the keynote speech at this medico-legal conference, I have taken the opportunity to reflect upon how our legal system deals with medical mishaps and to ponder whether the present arrangements are in a state of perfection. I offer a few suggestions for others to take up or reject, as they see fit.

1.2 This lecture. This lecture[1] addresses disciplinary proceedings against health professionals, decisions to prosecute and civil claims arising out of medical mishaps. The subject matter is not unimportant. A quarter of NHS staff say that within the preceding month they have witnessed an error that could have harmed patients or service users[2].

1.3 Abbreviations. In this lecture:
'FTT' means First-Tier Tribunal.
'GMC' means General Medical Council.
"MoJ" means Ministry of Justice.
'MPTS' means Medical Practitioners Tribunal Service.
"NHS" means National Health Service.
"NMC" means Nursing & Midwifery Council.
'Supplemental Report' means the Review of Civil Litigation Costs, Supplemental Report published on 31st July 2017.
'UT' means Upper Tribunal.

1.4 The medico-justice system. The medical world intersects with the justice system in a variety of ways: for example, disciplinary proceedings, criminal proceedings, withdrawal of life support cases and civil claims for damages.[3] But the legal system does not adopt a coherent approach to medical cases in the same way that it does to family cases or other specialist cases. It is therefore worth considering whether a more joined-up approach might be desirable.

1.5 Objectives of the medico-justice system. The first objective of the medico-justice system is to promote high quality treatment for patients. It pursues the first objective by (a) disciplining medical practitioners who fall below acceptable standards; (b) in extreme cases prosecuting them; (c) ordering health professionals or their employers to pay damages for injuries caused by their negligence; (d) delivering reasoned and publicly available decisions, which assist the health service in learning from past mistakes. The second objective is to compensate patients who have failed to recover or who have suffered injury because of clinical negligence. It pursues second objective, usually, by dipping into resources which would otherwise be available for the first objective. There is nothing intrinsically wrong with this, provided that the available resources are distributed in a just and proportionate way. It is only right that the NHS, health professionals and their insurers should pay compensation to the victims of medical accidents. All other professions do the same.

1.6 Incentivising health professionals. The possibility of being sued for professional negligence or disciplined by your professional

body are two of the factors which incentivise professional persons to perform well.[4] Health professionals rightly have these incentives, like the rest of us. But it is important not to so demoralise health professionals who make honest mistakes that they are driven out of the profession. We can ill afford to lose doctors or medical staff, who have been trained at great public expense. If reasonably competent practitioners are driven out of the profession, that defeats the first objective of the medico-justice system.

1.7 The present position. Where a medical mishap occurs, it may fall for investigation in three different fora: (i) the MPTS or the NMC's Fitness to Practise Committee or a similar professional institution's tribunal, (ii) the civil courts and (iii) (in extreme cases) the criminal courts. This involves repetition of evidence, re-examination of the same documents and waste of scarce resources. The procedures generate massive costs, lengthy delays and much stress for all involved.

2. THE SCHEME PLANNED IN 2010 AND THE LAW COMMISSION REPORT OF 2014

2.1 The scheme. I understand from Sir Robert Francis QC that in 2009/2010 plans were developed to create a single tribunal for disciplinary proceedings involving all health professionals. This would have replaced the plethora of tribunals dealing with individual health professions. This scheme was abandoned after the 2010 General Election.

2.2 Bonfire of the Quangos. The so-called 'bonfire of the Quangos' in 2010 was a bad example of slogan-driven policy. The new Coalition Government set about abolishing institutions and projects without any proper evaluation of what it was destroying. The scheme described in the preceding paragraph was one of the casualties of that exercise.

2.3 Law Commission 2014 Report. On 2nd April 2014 the Law Commission published a report on the regulation of health care professionals and social care professionals. This proposed the creation of a single unified scheme for the regulation of all health care professionals and social care professionals. Under this scheme 'fitness to practise' panels would conduct 'fitness to practise' hearings in respect of any practitioner whose fitness to practise was seriously called into question. There was a consultation about proposals along these lines in 2017, but nothing has happened since then.

3. A MODEST PROPOSAL FOR THE REFORM OF DISCIPLINARY PROCEEDINGS

3.1 Time for reconsideration. Nine years have elapsed since the famous 'bonfire' and five years have elapsed since the publication of the Law Commission report. The MPTS remains outside the general structure of the tribunal system. It also remains separate from the tribunals dealing with other health professionals. The NMC has a Fitness to Practise Committee. The General Dental Council has a Professional Conduct Committee and a Professional Performance Committee. The General Optical Council has a Fitness to Practise Committee. And so forth. These regimes are all separate.

3.2 The proposal. I propose that the MPTS and the various tribunals dealing with other health professionals be abolished. Instead disciplinary proceedings against all health professionals should be brought within the general tribunals system. There would be a Clinical Chamber of the FTT and a Clinical Chamber of the UT. These chambers could deal with all such proceedings. Upon the application of the GMC or the NMC or a similar body, they would determine whether an individual's fitness to practise was impaired by reason of clinical incompetence, misconduct or poor health. The powers of the Clinical Chamber of the FTT and UT should include powers to:

(a) recommend that a case be considered by the CPS for prosecution,
(b) recommend that a case should not be considered by the CPS for prosecution, and/or
(c) recommend performance assessment/retraining

3.3 The Clinical Chamber of the FTT could have a tribunal judge, district judge or circuit judge (as appropriate) chairing the proceedings, as well as two other members with relevant expertise. The quality of decision-making would probably be higher than that achieved by the MPTS, even though the MPTS normally employs legally qualified chairs. To be 'legally qualified' is not the same as being an experienced judge. On appeal to the UT the chair of the panel could, if necessary, be a High Court judge. But again he/she would be sitting with panel members who have relevant expertise. The appellate process would be more satisfactory, with first appeals going to the UT and (occasionally) second appeals going to the Court of Appeal.

3.4 First benefit of this proposal. With such an appellate structure in place, there would be a higher quality of decision-making at all levels. A repetition of the *Bawa-Garba* saga[5] would be less likely. Dr Bawa-Gerba appeared before the Crown Court in 2015, the criminal division of the Court of Appeal in 2016, the Medical Practitioners Tribunal in 2017, the Divisional Court in 2018 and finally the civil division of the Court of Appeal in July 2018. If there had been a dispute about civil liability, there would have been a High Court trial or a County Court trial as well. The Divisional Court, which (wrongly) reversed the decision of the Medical Practitioners Tribunal and ordered that Dr Bawa-Gerba be struck off, did not – indeed could not – include any medical practitioner.

3.5 Second benefit of this proposal. Disciplinary proceedings against all health professionals, such as doctors, dentists, nurses, opticians and physiotherapists, would be brought into the same structure, namely the now well-established tribunal system headed by the Senior President of Tribunals.[6] This would end the present confusing proliferation of individual tribunals.

3.6 Third benefit of this proposal. Any recommendation concerning prosecution or non-prosecution would not be binding. But coming from such an authoritative source, it would carry weight both with the CPS and with anyone reviewing the CPS decision. To prosecute a doctor in the Crown Court for making a mistake, whilst working under extreme pressure in an under-resourced hospital, is a serious step. Other professionals do not face a comparable risk. It is doubtful whether Dr Bawa-Garba would have faced prosecution if the above scheme were in place. I note that on the only occasion when medical practitioners sat in judgment on Dr Bawa-Garba they did not consider that her conduct merited striking off.

3.7 In those very rare cases where a doctor is prosecuted for erroneous treatment, the prior thorough investigation by the Clinical Chamber will be beneficial. It may lead to agreement of facts and narrowing of the issues.

3.8 Fourth benefit of this proposal. The tribunals, which make vital decisions concerning both public safety and the livelihood of individual professional people, would be brought into an existing court-based system. The training of tribunal members would come under the Judicial College, which has expertise in the delivery of such training.

4. A NEW FORUM FOR CLINICAL NEGLIGENCE CLAIMS?

4.1 An inevitable question. If the above proposal for reforming disciplinary proceedings finds favour, the question inevitably arises: what other functions could the new Clinical Chamber of the FTT and UT usefully take over?

4.2 My 2017 report. In my Supplemental Report published in July 2017, amongst many other recommendations, I put forward proposals for fixing the costs of (a) clinical negligence claims up to £25,000 and (b) those clinical negligence claims above £25,000 which could be accommodated in the new intermediate track. See chapters 7 and 8. That report is currently the subject of an MoJ consultation.

4.3 The reaction to that report. By and large, the reactions during 2017 to the general recommendations in my Supplemental Report were positive. There have, however, been criticisms of my proposals for clinical negligence. Claimants point to the time and costs of pursuing such cases through the civil courts and say that this makes fixing the costs difficult, even for low value cases. Many on the defence side say that my proposals do not go far enough. For example, one lawyer in the House of Lords wrote to me expressing 'disappointment' that my recommendations did not go further.

4.4 How can my fixed costs proposals be made more attractive for the parties to clinical disputes? The answer, I suggest, may be to tribunalise the process. The new Clinical Chamber of the FTT and the UT could handle clinical negligence claims, as well as disciplinary matters. The same judges who currently hear clinical negligence claims would continue to do so, but in the tribunal context. They would be sitting alongside colleagues with medical expertise. Tribunals are, historically, 'no cost' or 'low cost' fora, because they bring to bear their own expert knowledge of the field. It may be easier to introduce and – in the future – extend my proposals for fixed costs, if the forum for clinical negligence litigation becomes a specialist chamber of the FTT or the UT. In respect of cases above the fixed costs regime, the tribunal would be well able to costs manage the proceedings.

4.5 Avoid a multiplicity of hearings. In any case where there are both disciplinary proceedings and civil litigation, it would be possible to have a single fact-finding hearing at which the relevant facts are established. After that, the tribunal could deal with (a) misconduct/ impaired fitness to practise issues as between the GMC and the doctor (or the NMC and the nurse); (b) the claim for damages as between the patient and the NHS Trust/private hospital/doctor/nurse or whoever is being sued. This approach would reduce the need for the same witnesses to give evidence twice over. It would also avoid the risk of inconsistent findings.

4.6 A similar recommendation in Ireland. In August 2018 Mr Justice Meenan was asked by the Irish Government to consider how claims arising from cervical checks might be reformed. His report dated 8th October 2018[7] proposed tribunalising the claims. The advantages which he identified included greater expedition, less formal hearings and reduced costs. The reforms proposed above would have similar advantages.

4.7 Room for some joined up thinking. Tom Kark QC and Jane Russell in their recent report[8] commissioned by the Minister of State for Health have proposed setting up a tribunal, to be called the 'Health Directors' Standards Council' ("HDSC"). This would have the power to bar individuals from being directors of NHS Trusts, on the grounds that they are not fit and proper persons for the role. The Kark Report makes eminent good sense. But would it not be better for the Clinical Chamber of the FTT (if such a chamber is set up) to take over the proposed functions of the HDSC? This would avoid adding yet another tribunal to the present thicket of health tribunals.

5. HOW SHOULD THE CLINICAL CHAMBER ASSESS NEGLIGENCE CLAIMS?

5.1 Standard of care. There is a looming problem here. As the population ages and the demands on the health service increase, doctors can more and more often rely upon systemic

issues and say "I was doing my best in an impossible situation". That, of course, is no defence for the NHS Trust, which is under a duty to deploy staff in sufficient numbers and of sufficient expertise to treat the claimant properly. But the time may come, for example in an unusually long and cold winter, when an NHS Trust can demonstrate that it simply did not have the funds to deploy the requisite staff. Neither the *Bolam* test nor the *Montgomery* test requires anyone to do the impossible. There may therefore be complex arguments about liability in the post-Brexit world. The needs of patients and their legitimate claims may be drowned out.

5.2 Oh dear. What is the answer? The answer is to simplify and objectify the test for liability. Let there be a new statutory test for liability in the medical context, namely whether the patient has suffered 'reasonably avoidable injury'. If the injury was reasonably avoidable, then the fact that the doctor had been on a twelve-hour night shift and had numerous other patients to treat is neither here nor there. The relevant health trust or private hospital is liable. If this objective test is adopted, then (a) the patient is better protected and (b) the investigation of liability is depersonalised.

5.3 A further benefit of the proposed objective test. Even if the doctor or nurse involved is not joined as a party, they are often named in the proceedings. This (I am told) sometimes leads to conscientious practitioners leaving the profession. The risk of the profession losing competent doctors will be reduced if the process is depersonalised. The blunt fact is that all professional people make mistakes from time to time, especially in the early years of practice.[9] They should not be so humiliated that they give up altogether.[10]

5.4 That all sounds lovely, but can we afford it? Yes. The costs of litigating before the tribunal should be lower than the costs of litigating in court. The process of assessing damages can be simplified. The Clinical Chamber could have scales for assessing future care costs. Defendant health trusts could do more to assist the tribunal by producing care plans for individual cases, hopefully agreed by claimant representatives.

5.5 Settlement. Settlement by negotiation or by mediation should be easier if there is a simple and objective test of liability, as suggested above. Settlement will also be easier to achieve, if the processes of assessing damages are standardised, as suggested. I would add that mediation can often be effective in those cases where bilateral negotiation or a joint settlement conference has failed.

5.6 Promoting early settlement. Against the background of a simple liability test and an effective tribunal system to handle clinical claims, there should be renewed effort to promote early settlement.[11]

5.7 Establishing a redress system. The best way to promote early settlement is for each NHS Trust or hospital to establish a patient-centred complaints/redress system in which support to match the need arising from whatever has gone wrong is provided at an early stage. A redress system has been operating in Wales since 2011.[12] None has been set up in England. The NHS Redress Act 2006 has not been implemented.

5.8 Would these reforms generate a high volume of claims? Many people who suffer medical mishaps choose not to claim. Even so, if the liability test suggested above is adopted, I accept that there could be more claims. According to the *NRLS national patient safety incident reports: commentary*[13] published by NHS Improvement in September 2018, in the year to March 2018 there were 51,495 incidents causing moderate harm, 5,501 incidents causing severe harm and 4,537 incidents causing death.

5.9 Would this push up the damages bill? Not necessarily. Damages could be tariff-based. This would enable an equitable distribution

of the available compensation amongst all deserving claimants, in place of the present system in which a smaller proportion of deserving claimants recover higher damages.

5.10 Cutting the cake. The resources of the NHS, and the funds of those who insure private practitioners, are finite. They have to be divided equitably between (a) providing health care to patients, (b) compensating patients who have suffered reasonably avoidable injury and (c) paying lawyers. This fact is deeply unattractive. Nevertheless, those administering the civil justice system, those representing injured patients and those representing defendant clinicians must face up to reality.

6. LEARNING FROM PAST MISTAKES

6.1 You cannot undo mistakes, but you can try to prevent repetition. Learning from previous mistakes and preventing repetition should be a key aim of any reforms. This directly feeds into the first objective of the medico-justice system, as discussed above. Any redress system of the kind discussed in paragraph 5.7 above could operate in tandem with an objective investigation of the facts, involving both the patient and the health professional, so that learning from the mishap is used to prevent repetition. The Early Notification Scheme for birth injuries,[14] which was set up by NHS resolution in 2017, operates along those lines. I understand that this is generally effective. It should be possible to develop a similar scheme which would apply to all serious injuries sustained during medical treatment.

6.2 The benefits from a unified tribunal system. The wider reforms canvassed in this paper might make a significant contribution to the vital task of learning from past mistakes. Instead of having an array of different tribunals and courts, we would have a single tribunal structure, comprising the Clinical Chamber of the FTT and UT. They would be specialist tribunals, combining medical and judicial expertise, generating hopefully high quality publicly available decisions. It would be a straightforward task for some body, perhaps with the help of a university,[15] to monitor that output and feed it back into the health system.

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16th May 2019

References

[1] I am grateful to Sir Robert Francis QC for providing the information in section 2 of this paper and for helpful discussions about the issues. He bears no responsibility for the views which I express.

[2] See the NHS staff survey in the Health Service Journal, March 2019. In King's College NHS Foundation Trust 43% of staff said this

[3] In my work as a Court of Appeal judge, I have dealt with cases in all those four categories. When at the Bar, I acted in many cases both for and against doctors.

[4] Of course, there are carrots as well as sticks. One carrot is the satisfaction of performing well. But the carrots are not the subject of this lecture.

[5] See *Bawa-Garba v GMC* [2018] EWCA Civ 1879.

[6] Currently Sir Ernest Ryder

[7] Report on an alternative system for dealing with claims arising from cervical check: 8th October 2018

[8] *A Review of the Fit and Proper Person Test,* November 218

[9] See e.g. *FB v Princess Alexandra Hospital NHS Trust* [2017] EWCA Civ 334 at [51]-[65].

[10] *See FB* at [65].

[11] I have previously identified late settlement as being a particular problem in clinical negligence litigation: see *Review of Civil Litigation Costs, Final Report* (January 2010), chapter 23.

[12] See http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

[13] See table 4 on page 12.

[14] See https://resolution.nhs.uk/services/claims-management/clinical-claims/clinical-negligence-scheme-for-trusts/early-notification/

[15] Many university teachers are looking for socially useful research projects, from which they can publish articles and demonstrate 'impact'. I have on several occasions in the past found university lecturers who were willing to monitor pilot exercises in the courts at no cost.

DIAGNOSIS OF SEPSIS - THE HISTORY AND PITFALLS

Dr Chris Danbury, Consultant in Intensive Care Medicine,
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Sepsis is the commonest cause of death from infection. This is a statement that is often quoted, but why is this so? What is sepsis? How do we treat it, how do we monitor progress and what happens when things get worse?

Wikipaedia tells us that *'infection is the invasion of an organism's body tissues by disease-causing agents, their multiplication, and the reaction of host tissues to the infectious agents and the toxins they produce.'* Bacterial infections are most commonly considered when thinking about infection, but are not the commonest cause: viral infections are far commoner. However, there are also fungi (such as candida), parasites (such as malaria) and arthropods (such as ticks). Infection by itself is usually self-limiting, may be uncomfortable, but rarely fatal.

Sepsis on the other hand is a major problem. Sepsis is defined most recently by the Third International consensus meeting as *'life-threatening organ dysfunction caused by a dysregulated host response to infection.'*[1] So sepsis is the body's response to an infection. Different organisms are more or less likely to cause sepsis, but any infective organism can cause it. Specific infections may result in local organ dysfunction without generating a systemic host response.

Diagnosis of sepsis can be difficult. The consensus document recommends the Quick Sequential Organ Failure Assessment (q-SOFA), but this is still hotly debated. What is not in doubt is that there should be a low threshold for considering sepsis in a patient with an unexplained illness particularly one who is deteriorating.

Treatment is the appropriate antimicrobial.[2] In bacterial sepsis - an antibiotic, fungal sepsis – an antifungal and so on. Most of the time, it is not clear what type of organism has triggered the sepsis, and so a broad spectrum antibiotic is given. The choice of this agent is usually heavily influenced by the local microbiology department, who will know the prevalence of local infective agents. This varies within the country and also between countries. The antimicrobial should be given as early as possible, the 'golden-hour' used in management of trauma has been adopted in sepsis. Therefore, unless there are good reasons, the antimicrobial should be administered within an hour of sepsis being suspected. The second major limb of treatment is source control. If the infection has an identified anatomical site, then this should be debrided/aspirated or otherwise dealt with. An example is necrotising fasciitis, where it is insufficient to merely give broad spectrum antibiotics, the affected area of fascia needs to be widely debrided for the patient to have a chance of survival – this can lead to rapid limb amputation as the author has seen.

Once treatment has been initiated, then how is the patient to be monitored? How do we determine whether they are improving or deteriorating? Over the last 2 decades, early warning scores have been developed. First the 'Early Warning Score' (EWS) in 2000, then Modified Early Warning Score (MEWS) in 2005, then National Early Warning Score (NEWS) in 2012 and currently NEWS-2 from 2017. A huge amount of data has been collected on patients and these scores provide an objective way of assessing physiological condition. NEWS is a robust system. National Confidential

Enquiry on Patient Outcome and Death (NCEPOD) say 'The National Early Warning Score… should be used in all acute healthcare settings in the NHS to improve communication between clinicians regarding the level of a patient's deterioration.'[3] Serial NEWS measurements allow clinicians to track whether the patient is improving or deteriorating. Guidelines require actions to be taken when the score crosses a particular threshold and these actions are backed by a great deal of evidence. There has to be a very good reason why a patient who has suddenly hit a NEWS of 7 is not immediately referred for critical care assessment! NEWS, when used properly, saves lives and conversely, if it is ignored, costs lives and causes harm.

This leads to Intensive Care. Intensive Care Medicine (ICM) has been a specialty in the UK for 2 decades now, with its own Faculty since 2010. As a specialty, it is distinct from general medicine, anaesthesia and emergency medicine, although most UK intensivists are also trained in one of these areas. On the ICU, critical care staff can provide advanced organ support that is not available anywhere else in the hospital looking after the sickest patients. Organ support therapies require close supervision with minute to minute assessment of the patient. Patients are graded as Level 2 – one organ support, or Level 3 – multiorgan support (Level 0 & 1 cover care on a general ward). The General Provision for Intensive Care Services (GPICS) is national guidance for what constitutes an intensive care service.[4] It covers staffing, the physical structure, as well as support services. The intensivist will often be asked to support treating teams on the wards. As Prof Ken Hillman said, critical care should be without walls.[5]

Septic patients with a deteriorating NEWS will often need to be cared for in ICU. Patients in septic shock will definitely need ICU level support. Septic shock is sepsis with a low blood pressure, defined as a Mean Arterial Pressure (MAP) less than 65mmHg that is unresponsive to fluid therapy. These patients will need inotropes or vasopressor drug infusions to keep the

MAP >65mmmHg and this therapy can only be provided in ICU.

Over the last 2 decades, there has been a steady improvement in survival from sepsis. This has, in part, been related to ICM becoming a specialty in its own right and clear definitions of what is sepsis, with evidence based guidance on treatment. Early recognition and treatment is key with immediate access to the critical care team to provide the right level of care at the right time.

As well as the big drive to recognise sepsis, it is imperative to treat early with antimicrobials and escalate in a timely manner to critical care. The tools are there, and are readily available to every clinician of every grade.

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"WHAT IF MY PATIENT DECIDES TO SUE ME?"

BY **GREG MCEWEN**,
HEALTHCARE EXPERT AND PARTNER, BLM

The NHS faces just under 11,000 new hospital claims per year, and many medical practitioners will be involved in a claim – whether by providing evidence or facing an investigation directly – at some point in their career. Greg McEwen, healthcare partner at insurance risk and commercial law firm BLM, guides practitioners through the choppy waters of patient claims.

It's a sobering thought that if you follow a career in medicine, the chances are that you may find yourself involved in court proceedings at some point during your professional life.

That involvement might come about in a number of ways. For example, you may be asked to participate as an expert witness for one of the parties. This would be a matter of personal choice on your part. However, choice aside, there is also a likelihood that at some point during your career you will be involved in the defence of court proceedings, either as a factual witness or as a defendant in relation to your own acts or omissions.

How do we know this? The available data, of which there is a great deal, tells us so. NHS Resolution (NHSR, formerly the NHS Litigation Authority) publishes its annual report and accounts, containing a wealth of information regarding the incidence of clinical claims in the NHS. The latest report covers the year 2017/2018. Over the past three years, new hospital

claims have held steady at a rate of just under 11,000 per year. These figures do not include claims involving general practitioners or private treatment.

Different medical specialities present greater inherent risks and consequently generate more claims. Within the hospital setting, the greatest incidence of claims (13%) is found in the field of emergency medicine, followed by orthopaedic surgery (12%), obstetrics (10%) and general surgery (9%).

According to the NHS Confederation there were 106,430 doctors working in hospitals and community healthcare services in March 2017 and more than twice that number of nurses and health visitors. Allowing for variations across specialties, it is said that a doctor can expect to be involved in a claim roughly once every ten years on average.

As of 1 April 2019, NHS Resolution is also responsible for the new State-backed GP Indemnity Scheme, but for now the majority of claims involving general practitioners will continue to be dealt with by medical defence organisations.

The majority of claims are valued at £50,000 or less, but there remain a significant number of much higher value claims, notably those involving serious birth injuries, which may be valued at £10 million or more. The NHS spent approximately £2.2 billion on clinical claims in 2017/18. That figure is expected to rise to £3.2 billion in 2020/21.

Only around 30 percent of claims result in formal court proceedings being commenced, and of that number barely 1 percent will end up at trial before a judge. However, that still leaves a significant number of claims being pursued through the courts, over 3,000 per year based on the current figures.

Even allowing for the fact that most claims do not end up at trial, there are various stages during the course of a claim where your input might be required. These include disclosure of documents, the provision of a witness statement and discussions with both legal advisers and independent expert witnesses. Years may elapse before a claim is made, particularly if the patient was a child, or is deemed to lack capacity. That being the case, it is of vital importance that the notes made in the medical record at the time are clear and comprehensive, as these will often form the only contemporaneous record of what actually took place and memories are likely to have faded.

The litigation process is often lengthy and of those practitioners that have been through it, few would claim to have enjoyed the experience. Nevertheless, many consider it to be a real eye-opener and report that it has had a positive impact on the way in which they intend to practise in the future.

If you do find yourself embroiled in the court process, don't panic! Help, advice and support is available from your Trust, defence organisation or indemnifier and you should notify them as soon as you become aware of a possible claim. Depending on the nature of the claim and the stage it has reached, external lawyers may be appointed to investigate and lead the defence of the claim. Part of the lawyers' job is to guide you through the legal process.

Understanding the claims process

Often, the first time a practitioner is made aware of a claim is following a request for records.

The claimant's solicitors review these records in conjunction with an expert to formulate their allegations within a letter of claim. This is served on the defendant, who must then provide a letter of response within four months, or a longer period as the parties may agree. This process, known as the pre-action protocol, is an important one, which can allow a claim to be settled pre-action, where appropriate.

If a claim is not settled under the pre-action protocol, the claimant can then commence formal court proceedings. Broadly, this must be done within three years from the date of the alleged negligent treatment, or the "date of knowledge", if this is later.

Once a defendant has received the court proceedings, there is a strict 14-day deadline to

acknowledge proceedings by serving a defence or filing an "acknowledge of service" (which then allows a further 14 days in which to file a defence). The deadline for the defence may be extended, either by agreement between the parties, or following an application to the court.

After service of the defence, there will be an initial case management hearing. A procedural judge will fix a timetable of directions – a series of steps that need to be taken in order to bring a claim onwards to trial. These directions allow both parties to prove their case by the way of evidence, whether documentary, witness statement or from an independent expert. This cards on the table approach aims to narrow the issues in dispute ahead of trial, and also offers a chance to assess the evidence at each stage to see if there is any way to bring the case to conclusion before trial.

Throughout the litigation process, both parties will be constantly assessing the merits of their case. The majority of claims rarely end up going to trial, for the simple reason that either the claimant has been persuaded to discontinue the claim or the defendant has settled, generally with a formal written offer or through more informal negotiation.

However, should a claim end up going to court, the evidence gathered up to that point is brought before a judge and witness evidence may be required. At trial, a barrister will almost certainly be involved to present each party's case and may very well have previously drafted the defence and advised in conference. At the conclusion of the trial, the court will give judgment either for the claimant or the defendant, and if required, award compensation to a successful claimant.

Most practitioners will be understandably concerned at becoming involved in court proceedings. However, thorough record keeping, engagement with experienced insurers and defence organisations and a co-operative approach to their investigations you can ensure you have protection in place in the unfortunate event of a patient claim.

For more information about the legal process surrounding a claim, take a look at BLM's 'What if?' series of podcasts and accompanying materials, created by legal experts with years of experience in representing the interests of healthcare professionals before courts, inquests and professional regulators.

About BLM

BLM is the leading insurance and commercial risk law specialist in the UK and Ireland. With a turnover of over £100million, we advise insurers, Lloyd's syndicates, MGAs, brokers, corporate policyholders, professional indemnifiers and other market organisations.

For further information, please visit: www.blmlaw.com

WOMEN AND HEART DISEASE: THE CARDIOLOGY GENDER GAP

By **Laurence Vick,** Enable Law

Men and women do not always experience serious heart problems in the same way. Women's lives are being put in danger as a result.

Until only very recently the standard model of health was an adult man. The typical heart patient, said 19th century Canadian physician William Osler, was "a keen and ambitious man, the indicator of whose engine is always 'full speed ahead'," a man "from 45-55 years of age, with a military bearing, iron-gray hair, and a florid complexion.

It was only in the 1950s that heart disease was linked to diet, exercise, and other physical factors rather than emotional causes – and even then it was regarded as mostly a man's condition.

We're only beginning to recognise the scale of the gender imbalance in a host of critical areas. In 2011 it was noticed women were more likely to be seriously injured in car crashes. The reason? Safety features were optimised for adult men. In the same year the US finally introduced 'female' crash test dummies as standard.

The same blindness to gender imbalance still exists in heart care. Last year a University of Leeds study concluded over 8,200 women in England and Wales could have survived heart attacks in the last decade had they been given the same quality of treatment as men.

Twice as many women die from heart disease than breast cancer, but American research suggests only a minority of women know their risk and less than half of medics think of heart disease as a woman's top concern.

Even adjusting for age and underlying factors, women in the UK are more than twice as likely to die in the 30 days following a heart attack than men.

Conscious or not, informal cardiac terminology can be exclusive. Naming a kind of heart attack the "widowmaker" doesn't suggest a diagnosis for female patients to fear – although they can suffer it.

As I will cover in my following article, women are more likely to receive sub-optimal care during and after an acute cardiac event. And women who survive a heart attack are more likely to suffer complications.

'Normal' is 'not normal'

The classic symptom of a heart attack in men is severe chest pain, and this is often the way heart attacks are portrayed in the media – the so-called "Hollywood heart attack". But in women a heart attack can be quite different: shortness of breath, extreme tiredness, a feeling of tightening and discomfort in their arms, abdomen, neck and jaw, sweating and nausea.

Yet despite these symptoms being fairly common in women, they are still referred to as "atypical".

A University of Leeds study of 600,000 heart attack patients found women are 50% more likely to be misdiagnosed when suffering one – because they are less likely to suffer male symptoms. Warning signs are more likely to be misunderstood or missed, and often attributed to psychological factors like anxiety or depression.

There have even been reports of women having to 'sell' the idea to medical professionals that they might be suffering from a serious condition.

Women also have a different risk profile. Around a third of young women who suffer acute heart attacks have a history of pregnancy disorders such as gestational diabetes or hypertension. Scarcely male-pattern concerns.

University of Oxford analysis of the treatment of 12 million people concluded women were being undertreated for diabetes – a known heart disease risk factor. They were not given the same levels of medications as men and were less likely to receive intensive care.

Research gap

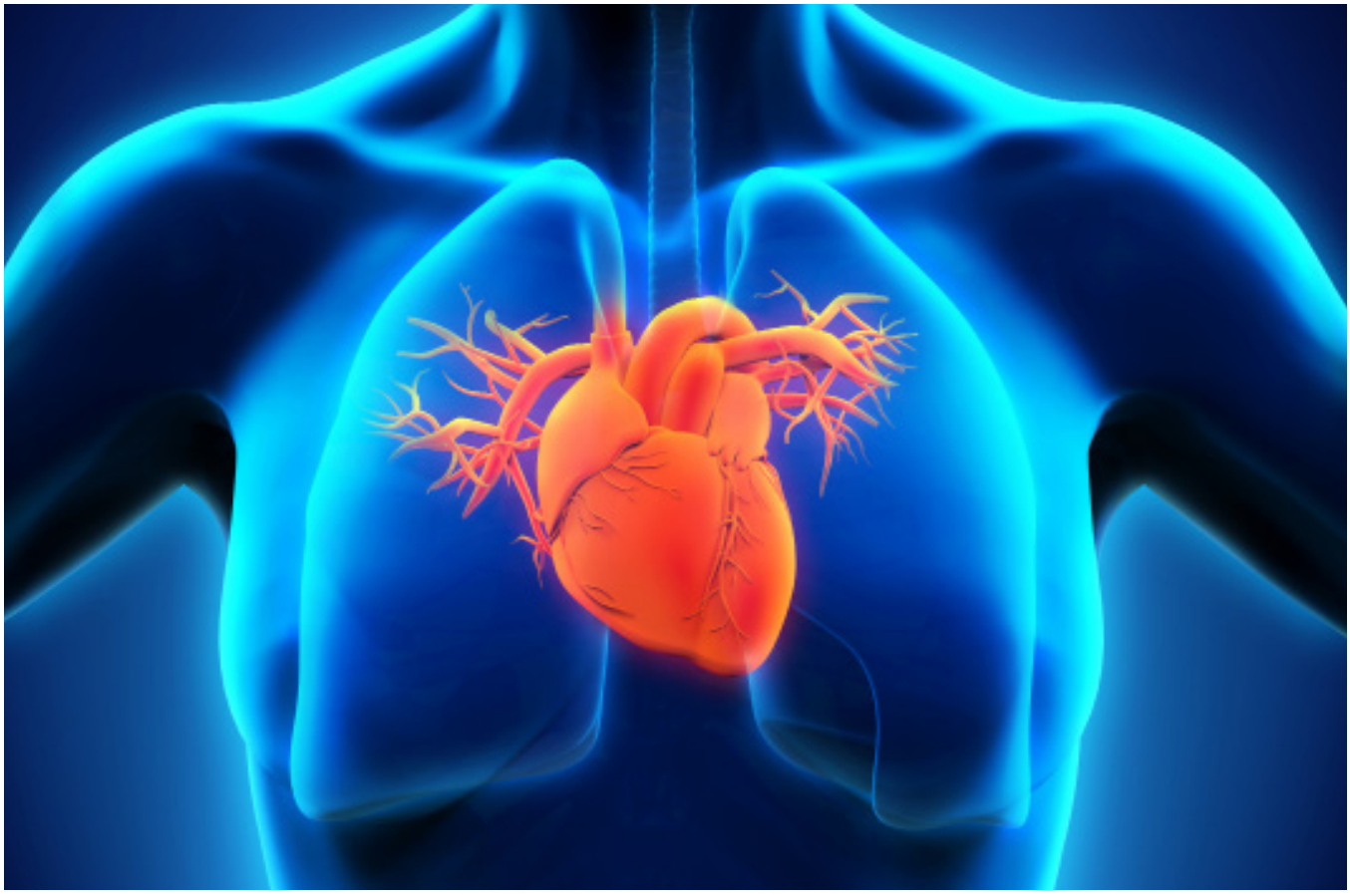
Women are still dramatically underrepresented in clinical trials for coronary heart disease and heart failure. An estimated two-thirds of heart disease and stroke research was only conducted on men.

Just like our pre-2011 crash test dummies, the assumption is that what works for men will work equally well for women when that is not always the case.

On that theme, women may be given drugs which – either in themselves or at a particular dose – are inappropriate and/or involve a risk of adverse reactions. As an example, one commonly-prescribed drug for high blood pressure which reduces heart deaths among men increases them for women.

These shortcomings in care have medical and legal implications for the NHS. Misdiagnosis and delayed diagnosis, at the cost of effective early treatment, results in additional cost for the NHS– quite Apart from the obvious human cost to the patient.

For further information and references please visit:
https://www.enablelaw.com/news/expert-opinion/women-and-heart-disease-part-1/



MEDICO-LEGAL CONFERENCE
LAUNCHES IN LONDON

Hosted by SpecialistInfo and Iconic Media Solutions, the Medico-Legal Conference 2019 took place at London's prestigious QEII Centre on May 16th. The conference brought together over two hundred of the UK's leading industry professionals, key service providers and journalists to network, do business and discuss some of the most important medico-legal issues of the day.

The energy in the room was tangible as the Master of Ceremonies Jonathan Godfrey delivered the welcome address. Lead by keynote speaker Sir Rupert Jackson, retired Justice of the Court Of Appeal of England and Wales, the quality of the programme was impressive. Sir Rupert discussed medical errors and whether sanctions and compensation are the most appropriate outcome. To find out more about the presentation please read Sir Rupert 's article on page six.

Other speakers included Mr Amar Alwitry, Peter Causton, Kerry Underwood, Professor Gus Baker, Mr Simon Jackson, Dr Chris Danbury, Shannett Thompson, Senior Associate, Kingsley Napley, David Stothard, Paul Sankey, Linda Millband, Ann Logan, Olive Lewin and Professor Dominic Regan. 86% of the delegates in attendance deemed the overall quality of content to be 'excellent'.

Some of the most impactful sessions included 'Gross Negligence Manslaughter in Healthcare – Debunking the Myths', 'A Better Way to Resolve Claims and Complaints', 'Fundamental Dishonesty', 'How to be a Better Medical Expert: 5 Top Tips', 'The Scottish Perspective on Montgomery and Informed Decisions' and 'Lack of Effort, Deliberate Underperformance or Simply Malingering: Determining Claimants' Behaviour in Neuropsychological Assessment'.

To view the full 2019 programme click here and to purchase session videos click here. Please note, video session packages are available as full day or half day purchases, individual sessions cannot be purchased.

Amongst the sponsors and exhibitors present were Parklane Plowden Chambers, Steps Rehabilitation, MAPS Medical Reporting, Pegasus Medical and Skin Camouflage Services. Feedback from participating exhibitors was very positive with over 90% stating they would recommend exhibiting or attending the conference in 2020.

The Medico-Legal Conference 2020 is confirmed to take place on June 11th at London's QEII Centre. Should you wish to discuss opportunities to exhibit please click here or email aniq@iconicmediasolutions.co.uk

Due to the success of the 2019 conference, places for 2020 are limited and available strictly on a first come first serve basis. To book your delegate pass click here or visit www.medicolegalconference.co.uk

YET MORE COURT REFORMS

By Professor Dominic Regan, Solicitor, Legal Speaker, Special Adviser, Writer and Broadcaster

Twitter @krug79

Dominic is an acknowledged authority on civil litigation and liability. He assisted Sir Rupert Jackson between 2010 and 2018 on costs controls and has advised the Government on law reform.

I am absolutely certain that we are going to see more big changes to Civil Procedure. The final part of the Jackson parcel of proposals will be in place by the end of next year or possibly early 2021. A Government Consultation closed in June 2019. The promised response by September 6th will not, a senior civil servant tells me, be delivered in time, but it will come.

Fixed costs are coming to litigation and many cases will be caught. It is true that fixed costs already apply to lower value personal injury cases. The plan is to impose fixed costs on almost all costs-bearing matters up to £25,000, regardless of subject matter. Cases worth between £25,000 and £100,000, where at present costs are at large but subject to costs management (budgeting), will have fixed costs imposed.

Clinical negligence claims throw up exotic problems. There is no avoiding the fact that they are often sensitive and emotional. The competent investigation of an oft disputed claim will demand expertise, and more than one discipline may be engaged.

For cases worth up to £25,000 there has been an ongoing Consultation to try and determine a claims protocol and a scale of fixed costs. There is no sign of progress. A target to produce detailed proposals by December 2018 has sailed by. I recently attended a talk by the Senior Costs Judge who sounded pessimistic about anything changing soon.

For cases worth over £25,000, complex cases will be excluded. Sir Rupert Jackson in his July 2017 recommendations rightly said that matters involving more than 2 experts a side giving evidence would be excluded; so would an action likely to last more than 3 days. Addressing clinical negligence, he doubted that anything but the most straightforward of cases would fit within his model.

Whilst Solicitors and barristers would see their fees strictly controlled by the fixed costs regime, experts would not! That is not to say that experts can charge as they like with impunity. Accurate figures must be supplied to the Court for the purpose of budgeting. The Court will scrutinise costs carefully in pursuit of proportionate expenditure.

I see nothing on the horizon to regulate fees payable to experts. The Lawyers are envious!

Facilitate Expert

Claire Odiam Director

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MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry for the second quarter of 2019.

Government Facing Legal Action Over State Backed GP Indemnity

NEWS

The MDU is launching legal action against the government over its failure to cover GPs' existing liabilities as part of the state-backed Clinical Negligence Scheme for GPs (CNSGP) in England, that took effect from April.

Under the new indemnity scheme, only NHS clinical negligence claims relating to incidents that happened on or after 1 April 2019 are covered for most GPs.

The government has agreed terms with only one of the three main providers of GP indemnity, Medical Protection (MPS), so it only covers 'existing liabilities' before 1 April 2019 for the roughly one in three GPs who are MPS members.

The MDU and MDDUS have not disclosed the precise reasons why they have been unable to agree a deal for existing liabilities with the government.

For GPs who hold MDU policies, if they leave the MDU before the normal retirement age for their NHS pension scheme, the failure to agree a deal to cover existing liabilities could mean they need to buy 'run-off cover' following a switch to a cheaper 'transitional benefits' indemnity model introduced last year in anticipation of the state-backed deal.

Read more:
https://www.gponline.com/government-facing-legal-action-state-backed-gp-indemnity/article/1587550

The Medico-Legal Conference – 11th June 2020, at the Queen Elizabeth II Conference Centre, Westminster, London

After the success of this year's conference in May, early-bird tickets are now available for SpecialistInfo's Medico-Legal Conference in London on 11th June 2020.

Please visit the website for details and to book:

www.medicolegalconference.com

Please contact:

craig.kelly@iconicmediasolutions.co.uk. for further information if you are interested in hosting a stand at the event.

NHS Resolution's Annual Report for 2018/19 Shows Spending on Claimant Legal Costs Drops by £24m in a year

Claimant legal costs for clinical negligence cases against the NHS fell by 5% last year.

The NHSR Annual Report for 2018/19, published this July, shows that spending on claimant costs was £442.3m – a fall of more than £24m. The decrease comes as the government prepares to control legal spending with fixed costs for claims under £25,000.

Meanwhile, defence legal costs increased by 8.3% in 2018/19 to £139.6m, which the NHSR explained was partly due to more activity on early investigation.

NHSR chief executive Helen Vernon said the organisation has undergone a 'culture change' in how it handles claims, demonstrated by the number of mediations increasing by 110% to 380.

Read more:
https://resolution.nhs.uk/corporate-reports/

Problems Highlighted During MoJ Consultation on 'Lawyer-Free' System for Handling Low-Level RTA Claims

The Civil Liability Act and the new £5000 small claims limit for soft tissue injury will significantly reduce recoverability of legal costs from next April, resulting in an increase in 'litigants in person' (LiP) applications.

A new portal for whiplash claims is being developed but claimant lawyers are concerned that too many problems will need addressing before the system can go live in April 2020. The Motor Accident Solicitors Society (MASS) said it was discriminatory and unfair that claimants with and without legal representation would have different claims processes.

The draft "customer journey" for those bringing claims through the new portal has just been published. MASS are "disappointed" by the decision to run parallel portals for whiplash claims below £5,000 and one for all other claims, rather than have one integrated system.

"This has long been considered the worst option available. Having dual operating portals with no transfer of data between the two systems will increase costs and result in duplication.

"It is generally not possible to value injury claims until receipt of the medical report and inevitably there will be many claims which will need to be transferred between the two portals." There also were doubts over the integration of MedCo with the new portal.

Other concerns included LiPs understanding the various issues around medical reports and their expansion to include experts for non-soft tissue injuries.

The £180 suggested fee for experts would be inadequate for a report from a non-soft tissue injury expert, leading to a "sub-optimal service for accident victims".

Read more: https://www.legalfutures.co.uk/latest-news/lawyers-catalogue-problems-with-whiplash-portal-build

Custodial Sentence for Conman who Falsely Claimed he Suffered Multiple Injuries when a Bus Hit his Parked Car

Horwich Farrelly and bus operator First Bus have secured the conviction of a fraudster who claimed a bus severely injured him when it crashed into his parked car in Bristol in 2015. CCTV proved he was not actually in the vehicle at the time of collision.

After the minor collision, Zafar Iqbal claimed he suffered 'severe pain to his shoulder, leg, back, ankle, upper leg and right side of chest' and demanded compensation. He had initially denied all the counts against him, but just before his trial was due to begin he confessed to nine counts of contempt of court, which saw him jailed for six months. He was also ordered to pay the legal costs of First Bus, amounting to just over £30,000

Ronan McCann, Managing Partner at Horwich Farrelly, said: 'It was right and proper that the courts took a hard line against Mr Iqbal. Despite having plenty of time to admit his claim was false he persisted in pursuing First Bus. A case of this nature demonstrates the very real consequences of making a fraudulent claim.'

Read more:
https://www.insurancetimes.co.uk/news/cctv-exposes-jailed-fraudster-in-bus-crash-scam/1430672.article

New Personal Injury Discount Rate Announcement

Then Lord Chancellor, David Gauke, announced on the 15th July that the personal injury discount rate on lump sum compensation payments, known commonly as the Ogden rate, will be readjusted from -0.75 to -0.25% from 5th August 2019.

This is the adjustment that must be made to lump sum awards in higher value PI claims, so that the claimant can be confident that their compensation will last a lifetime without them having to make high-risk investments. A rise to 1% was widely anticipated, but Gauke explained that setting it any higher would have risked too many injured people being under-compensated.

Industry reactions have varied, with insurers showing anger despite the modest raise, but claimant lawyers expressing relief.

Huw Evans, director general of the Association of British Insurers, said: 'This is a bad outcome for insurance customers and taxpayers that will add costs rather than save customers money. A negative rate maintains the fiction that a claimant and their representatives will knowingly choose to invest their damages in a way that would guarantee losing them money.

Gordon Dalyell, president of the Association of Personal Injury Lawyers, said: 'The government has faced sustained pressure from the insurance industry to set a rate which would not be appropriate for injured people, who should not be forced to take any risk with their investments. We must remain vigilant that this new rate does provide them with the fair compensation they need and deserve.'

Read more:
https://www.lawgazette.co.uk/news/discount-rate-reaction-insurers-furious-claimant-lawyers-relieved/5070997.article

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