MEDICO LEGAL

MAGAZINE

ISSUE 13

Presented by:

specialist info

Welcome to the Medico-Legal Magazine

Welcome to Issue 13 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This final issue of 2019 includes articles from Nick Savva and Heath Taylor, Consultant Orthopaedic Surgeons, on assessing the risks of developing arthritis after lower limb trauma.

Also in this issue, healthcare law expert, Laurence Vick, from Enable Law, discusses medical risk factors in women's heart medicine that are often overlooked.

We are also pleased to include an article by Stephen Hooper, of Eastwoods Solicitors, on the difference between honesty and integrity in cases involving members of the medical profession, and what is expected by the regulators.

Finally, Dr Giuseppe Spoto, Consultant Psychiatrist, comments on the calling of the MPS for more doctors to take up expert witness work, and how this could be achieved.

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 are now taking early-bird bookings for our annual Medico-Legal Conference on 11 June 2020 in London.

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 2020 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):

- *22nd January 2020* – London
- *29th April 2020* – Manchester
- *15th September 2020* – London
- More tbc

£375 (plus VAT)

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

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

- *23rd January 2020* – London
- *30th April 2020* – Manchester
- *16th September 2020* – London
- More tbc

£395 (plus VAT)

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

Advanced Medico-Legal Course
(refresher and advanced techniques for experts including live court-room skills):

- *5th March 2020* – London
- *2nd July 2020* – London
- *1st October 2020* – London
- *10th December 2020* – London

£440 (plus VAT)

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

***NEW COURSE* Private Practice Marketing Course**
(implementable skills to increase your throughput and revenue):

- *10th January 2020* – London
- More tbc

£440 (plus VAT)

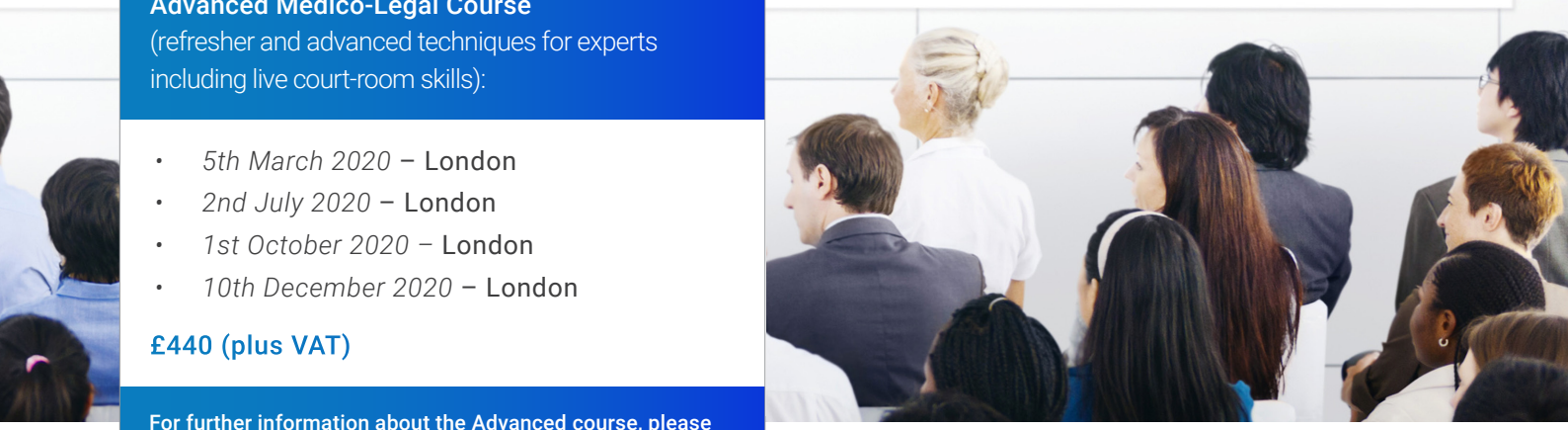
For further information about the Advanced course, please visit: www.specialistinfo.com/a_mktg_pp.php

Mediation Training Course (5 days)

- *20th - 24th January 2020* – London
- *10th - 14th February 2020* – London
- *11th - 12th and 24th-26th March* – Aberdeen
- *20th - 24th April 2020* – London
- *1st - 5th June 2020* – Manchester
- More tbc

5 days from £1,400 (plus 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

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WOMEN AND HEART DISEASE – PART 2: MEDICAL RISK FACTORS

By **Laurence Vick,** Enable Law

In the second of this series of articles, Enable Law lawyer Laurence Vick looks at medical risk factors in women's heart medicine, and how they support accusations of a gender bias.

In my last article (see Issue 12 of Medico-Legal Magazine) I showed how, compared to men, women are less likely to be believed when they're having a heart attack, less well-treated during and after a heart attack and more likely to die from one.

In this second instalment, I would like to describe specific medical conditions which place women at a higher risk of heart complications.

NSTEMI

Women who had a NSTEMI (Non-ST-elevation myocardial infarction – a form of heart attack) are 34% less likely than men to receive timely coronary angiography within 72 hours of their first symptoms.

Coronary angiography uses dye to reveal narrowing and blockages in arteries and is a crucial step in heart attack care. Research shows patients who receive early angiography for NSTEMI have better outcomes. Women were less likely to be prescribed statins and beta blockers when leaving hospital – medication which helps to lower the risk of a second heart attack.

Women who had a STEMI, a heart attack where the coronary artery is completely blocked, were less likely than men to receive emergency procedures including drugs and stents to restore blood flow to the heart.

In a 2016 study[1] "Impact of initial hospital diagnosis on mortality for acute myocardial infarction", a team at the University of Leeds, headed by Professor Chris Gale, considered the difference in survival rate that early diagnosis of STEMI or NSTEMI can make. Their research found that women who suffer a heart attack are 50% less likely than men to be correctly diagnosed.

SCAD

SCAD (Spontaneous Coronary Artery Dissection) is a rare emergency cardiac condition which predominantly affects women in late pregnancy or soon after giving birth. Although SCAD causes a small percentage of heart attacks overall, it is the most common cause of heart attack in women under 50.

It is a good example of the challenge of arriving at a correct diagnosis by traditional techniques, because a woman may suffer a SCAD heart attack without any heart arteries being blocked. Instead, an artery of the heart suddenly closes upon itself.

Women may appear healthy and have no obvious risk factors. SCAD can only be diagnosed with an angiogram demonstrating blood flow in the heart's blood supply. There is a risk that SCAD patients can be discharged from hospital in the middle of a heart attack that may remain undiscovered for days. Further, SCAD is often misdiagnosed, leading to treatment which can cause more damage to the affected artery.

BeatSCAD (www.beatscad.org.uk) is a UK charity doing an excellent job of raising awareness of the

condition and working with the BHF and the research team at Leicester University, Glenfield Hospital.

Heart Failure

A 2019 University of Oxford study[2] found GPs were 9% more likely to miss the signs of heart failure in women.

The symptoms of heart failure don't vary between the sexes, but the causes do.

In men, the most common cause is heart disease or having had a heart attack. In women, the chief cause is uncontrolled high blood pressure which, over the years, puts a strain on the heart. The extent of the underdiagnoses of heart failure was observed to be so great – especially among women – that the true figure affected could run into the millions.

AN AAA

A 2013 study[3] showed women have long been under-represented in clinical trials for treatments to a condition which has worse outcomes for them.

Abdominal aortic aneurysms (AAAs) are a bulge or swelling in the main blood vessel that runs from the heart down through the chest and abdomen. AAAs are more likely to rupture in women, and women over 65 who develop an AAA face a higher risk of death. Women's outcomes following surgical procedures for AAA are also reported to be significantly worse when compared to men.

Maternal health implications

Issues arising in pregnancy, as well as SCAD, which have heart-related risk factors include:

- gestational diabetes
- persistent high blood pressure and pre-eclampsia
- pre-term delivery
- polycystic ovarian syndrome

Maternal heart disease has emerged as a major threat to safe motherhood and women's long-term heart health. In the US, disease and dysfunction of the heart and vascular system is now the leading cause of death in pregnant women and women after childbirth – accounting for around a quarter of pregnancy-related deaths. The figure for the UK is around half of that.

Diabetes

Type 2 diabetes increases the risk of heart disease in everyone with the condition but, it is thought, more so in women[4]. Women with diabetes frequently have added risk factors such as obesity, high blood pressure and high cholesterol.

US studies show that although women tend to develop cardiovascular disease around ten years later than men, diabetes removes that advantage. In women who have already had a heart attack, diabetes can double the risk of suffering a second heart attack and increases the risk for heart failure.

Type 1 diabetes is associated with a 47% excess relative risk of heart failure in women compared to men. For women with Type 2 diabetes the excess risk is 9% higher. Around four million people in Britain are living with diabetes, with the majority (92%) suffering from Type 2. Around 44% of all cases are women.

Cancer Treatments

The chemotherapy used to treat breast cancer may increase the risk of cardiovascular disease, which remains a lasting threat for breast cancer survivors. Heart problems can appear more than five years after treatment.

In the Sports Arena

Historically female athletes have also been under-represented in the research relevant to sports cardiology, but in recent years studies have been carried out into gender differences as an important biological variable. Heart conditions including Athlete's Heart in women can present in a very different way from men. This is reflected in guidelines for the interpretation of ECGs. I will be covering cardiac testing in sport and the medico-

legal implications of gender on key issues within sports cardiology in a future article.

CONCLUSION

Progress has been made in raising awareness of heart disease and the threat it presents for women's health. Ways must be found though, and still more needs to be done, to redress the imbalance and close the gap in treatment and health outcomes for women. This should include expanding gender-focused research and the development of gender-based guidelines.

This September the British Heart Foundation has launched their Women and Heart Disease campaign, (https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/women-and-heart-disease) aiming to narrow the gender inequality in cardiac medicine, and I hope this will be a significant step towards the provision of equal heart care for all.

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[1] diagnosis on mortality for acute myocardial infarction: A national cohort study. Wu J, Gale CP, Hall M, Dondo TB, Metcalfe E, Oliver G, Batin PD, Hemingway H, Timmis A, West RM. Eur Heart J Acute Cardiovasc Care. 2018 Mar;7(2):139-148.

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[4] Diabetes as a risk factor for heart failure in women and men: a systematic review and meta-analysis of 47 cohorts including 12 million individuals. Ohkuma T, Komorita Y, Peters SAE, Woodward M. Diabetologia 2019 Sep, 62(9): 1550–1560

For further information and references please visit: https://www.enablelaw.com/news/expert-opinion/women-and-heart-disease-part-2/

MORE DOCTORS TO SERVE AS EXPERT WITNESSES SAYS MEDICAL PROTECTION SOCIETY (MPS). A SHORT COMMENTARY

By **Dr G Spoto FRCPsych MA FAcadMEd**, Consultant Psychiatrist, Independent Doctors Federation, Formerly Visiting Consultant, The Priory Hospital Roehampton - giuseppe.spoto@ntlworld.com

Introduction

Medicine and the Law have been closely intertwined since time immemorial; however, in practice, the two disciplines are separate, medico-legal work still being thought of as something which is largely outside mainstream practice.

And certainly, in the eyes of trainees, medico-legal work is something which the Consultants are doing, away from their base, sometimes in secret.

Psychiatry has never been any different, regardless of its being granted special treatment, namely a special jurisdiction and special Courts and Tribunals.

This, however, may change based on an intervention by Dr Hendry, the Medical Director of the Medical Protection Society (MPS), published this year by the BMJ (1). I provide here a summary of his ideas together with a short commentary.

Dr Hendry's Ideas

Dr Hendry said in his intervention that in tribunal hearings or criminal trials, the expert evidence of a doctor can be pivotal, for example in cases concerning incidents that have occurred in healthcare setting.

Dr Hendry went on to say that this is why there should be a wider pool of doctors with the right experience who are able to serve. Dr Hendry described this as a vital role that doctors can perform on behalf and in support of their profession.

He said that any doctor facing a tribunal or court would hope that the assessment of their practice has been carried out by someone respected by their peers and who can present balanced evidence in the context of delivering healthcare in the modern NHS.

Dr Hendry said that many doctors feel uncomfortable in this role, which he said carries a lot of different connotations, however he said that if a doctor is established in their specialty and has built up expert knowledge in a particular area, then it is likely that they have the necessary experience to act as experts.

Above all, Dr Hendry explained doctors need to be able to provide informative and balanced evidence to assist the Court to set a fair benchmark for the accused doctor.

He said we need more doctors to be freed up by their employers as well as encouraged and trained to take on this important role.

Dr Hendry proposed the following action plan:

- The role of the Expert Witness should be looked at by the GMC as part of its drive to set up new credentials for the medical register
- GP and Consultant training should include acquiring the skills to be an Expert Witness
- NHS Employers should make it easier for doctors to be relived from their clinical duties so they can act as Expert Witnesses. This may require contractual reforms to give the Expert Witness greater prominence and greater

certainty for those wishing to discharge their role and;
- More doctors should be encouraged to consider putting themselves forward to perform expert witness duties

Discussion

The provision of medical evidence by doctors for medico-legal purposes has been a problem for some time and there is no doubt that it is fast approaching crisis point, however essential this is for the safe delivery of justice.

The poor uptake of the role of Expert Witness by doctors, the "pool" in De Hendry's words, whatever the cause, is one explanation and certainly a stark reality facing instructing solicitors and the Courts.

Demand for high-quality low-cost evidence has never been greater, yet the medico-legal system strikes one as being either indifferent or unable to offer any concrete solution. Dr Hendry's radical ideas, however, do provide a glimmer of hope.

I have for some time being of the view that excellent evidence can be provided by trainees, and indeed I am wholly persuaded that doctors in training could easily take over the role of Expert Witness in certain circumstances and provided they are adequately supervised.

As a Consultant working in the NHS for over 30 years I have, in the past, introduced medico-legal experience into the Job Description of higher psychiatric trainees in a large South London Rotation. This turned out to be very successful, a great many trainees later continuing to work privately as Expert Witnesses, some even electing to join the 1st Tier Tribunal (Mental Health) as Medical Members.

Dr Hendry's call for more medico-legal training to be available to all doctors, therefore strikes one as hitting entirely the right note.

However, I would go further. In certain circumstances and provided appropriate training is available, in my opinion trainees should be the Expert Witness of choice; the instructions

of trainees by lawyers indeed requiring by statute to be the default position, in many cases and across a wide range of jurisdictions.

Conclusions

In short, doctors appearing before the GMC are thankfully still in a tiny minority, however Dr Hendry's ideas go well beyond the field of medical indemnity and have far reaching implications for all jurisdictions.

If taken to their logical conclusion, they are capable of providing a solution to the impasse and deserve much attention, not only from the medical profession but also policymakers, employers and the like.

References

[1] " More Doctors need to train as Expert Witnesses say MPS" BMJ (2019):364

Disclaimer

The opinions and views expressed in this article are only the views and opinions of the Author. They are not the views and opinions of the Independent Doctors Federation.

HONESTY & INTEGRITY: THE DIFFERENCE BETWEEN THE TWO AND WHY IT MATTERS TO THE REGULATORS

By **Stephen Hooper,** Associate, Eastwoods Solicitors Ltd

Two doctors find themselves under investigation by the GMC. The first is a young registrar who was working in A&E, presented with an 18-month-old child patient who had a non-blanching rash, high temperature, drowsiness and vomiting, but she dismissed it as a bad cold and sent the child home on Calpol. The child died the next day of meningococcal septicaemia. This was the most serious of a string of clinical errors which showed real concerns about the doctor's clinical ability and generally error-strewn practice, so the GMC duly opened an investigation. The second doctor was a consultant who had had a gleaming, unblemished career with many accolades and international recognition as a leader in his field, who wrote a reference for his wife (an aspiring junior doctor) but failed to declare their relationship when asked how he knew her, going so far as to say that he only knew her professionally – doing so because he knew his reference would carry less weight if the prospective employer knew it had come from her husband, and his wife would be less likely to get the job. The GMC investigated his conduct, accusing him of acting dishonestly. One of the two doctors ended up being suspended for six months; the other was ordered to work under supervision for 6 months, before then returning to unrestricted practice. You can probably guess, given the title of this article, that it was the second doctor who was suspended, while the first doctor continued to work throughout.

The two examples above are based (loosely) on actual cases, and illustrate the importance the GMC (like all regulators) places on honesty and integrity. Even a doctor who makes catastrophic clinical errors which lead to a tragic death can continue in practice, provided they react to their mistakes in a positive way, learn from what went wrong and implement changes to ensure it never happens again – the much-feted culture of learning, coupled with the (now statutory) duty of candour widely acknowledged as necessary to maintain standards in our healthcare system. In such cases, if the errors identified are capable of being remedied, have been remedied (through re-training, mentorship and so on), and are unlikely to happen again, the doctor will usually be able to continue to practise because it is possible to improve an under-performing doctor. By contrast, the dishonest doctor is in a far more difficult position because it is much harder to remediate dishonesty – you are either an honest person, or you are not. If the regulator concludes that you are not, it is likely they will throw the book at you and your registration will be at significant risk. Pointing out that no harm came to any patients (the 'no-one died' defence) rather misses the point.

There is an expectation that doctors, like any regulated professional, will act with honesty and integrity. This is enshrined in *Good Medical Practice,* which states: "You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession." The take-home message is that, whatever your level of technical proficiency, your patients must be able to trust you. Dishonesty is therefore treated extremely seriously by the regulators, as a breach of one of the 'fundamental tenets' of the profession. For that reason, it is commonplace for doctors found guilty of dishonesty to be suspended or erased from the medical register.

The test for what constitutes dishonesty is set out in the 2017 case of *Ivey v Genting Casinos (UK)*

Ltd [2017] UKSC 67, which overturned the long-established two-stage test in *R v Ghosh* [1982] QB 1053. The decision in *Ghosh* held that dishonesty is established if the answer to the following two questions is "yes":

1. Whether, according to the ordinary standards of reasonable and honest people, what was done was dishonest (the "objective test"); and
2. If it was dishonest by those standards, whether the defendant himself must have realised what he was doing was, by those standards, dishonest (the "subjective test").

The decision in *Ivey* changed the focus of the subjective test, deeming the *Ghosh* test to be outdated – particularly if a defendant with a warped sense of right and wrong might not appreciate that an ordinary, reasonable and honest person would consider their conduct to be dishonest (think Robin Hood complex), and therefore be found not guilty on the "subjective test". *Ivey* states that the test is now as follows:

1. What was the Defendant's state of knowledge at the time?
2. Based on that, would ordinary, honest people consider the Defendant's actions to be dishonest (objective test)?

The decision led to concerns that it would now be easier to prove dishonesty and that that would lead to more adverse outcomes, particularly in disciplinary proceedings. Whether or not the seismic change people feared has in fact eventuated is very much open for debate, as findings of dishonesty in accordance with the *Ghosh* test were far from difficult to establish before *Ivey*, and the regulators always took such findings seriously.

Honesty v Integrity

What has in the past been less clear is what to do with the individual who has not been dishonest in the sense of telling an outright lie, but who conducts himself in a manner where his behaviour or words might lead to an untruth being implied from what is said, or perhaps not said. The words used might not be untrue, but they lead to a misinterpretation of the truth. In such cases, an individual might be considered to have acted without integrity, and the decision in *Wingate v SRA* [2018] EWCA Civ 366 has offered guidance on how someone might not be dishonest, but nevertheless lack integrity, paving the way for regulators to charge lack of integrity a standalone allegation, distinct from dishonesty. In the judgment, Jackson LJ explained the distinction as follows:

"Honesty is a basic moral quality which is expected of all members of society… Telling lies about things that matter or committing fraud or stealing are generally regarded as dishonest conduct…"

"Integrity is a more nebulous concept…In professional codes of conduct, the term 'integrity' is a useful shorthand to express the higher standards which society expects from professional persons and which the professions expect from their own members…The underlying rationale is that the professions have a privileged and trusted role in society. In return they are required to live up to their own professional standards… Integrity connotes adherence to the ethical standards of one's own profession. That involves more than mere honesty."

That reference to the "higher standards which society expects from professional persons and which the professions expect from their own members" is really the nub of it: by entering into a regulated profession, we are expected to hold ourselves to higher standards than the 'ordinary' member of the public. To be in a profession which puts us in a position of trust is a privilege which carries with it responsibility; and for that reason the regulators will fall heavily on those who breach that trust. Put another way, so far as the regulator is concerned, better a negligent doctor than a dishonest one.

Stephen Hooper is an Associate at Eastwoods Solicitors Ltd and can be contacted on stephen@eastwoodslaw.co.uk

HOW TO ASSESS THE RISK OF ARTHRITIS AFTER TRAUMA

Mr Nick Savva FRCS & Mr Heath Taylor FRCS
Consultant Orthopaedic Surgeons, Specialists in Foot & Ankle Surgery

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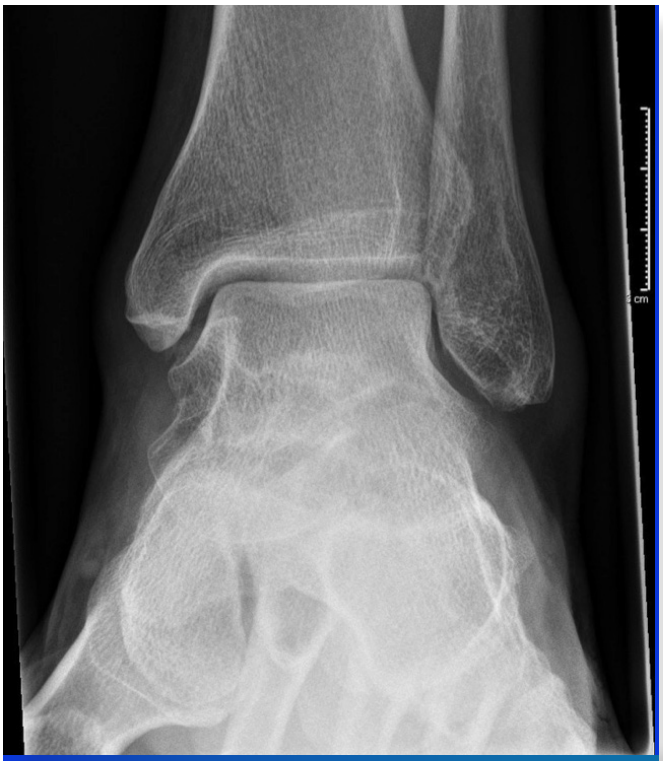
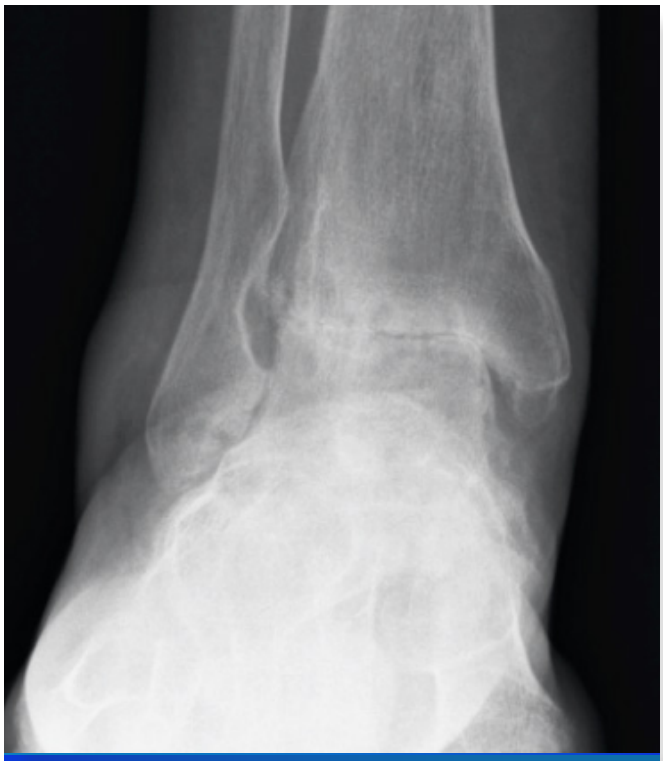
Arthritis is a degenerate joint condition that occurs commonly as part of the normal ageing process. The risk of arthritis is increased in patients that suffer injury around joints. This can occur either by direct injury to the joint surface itself, or by injury to the bones around the joint, causing mal-alignment and altering the joint mechanics.

A normal synovial joint, such as the knee or ankle, is a complex structure that allows pain free, low friction movement. It relies on the joint surfaces being a perfect fit for one another (congruence) as well as a low friction lining (cartilage).

The hyaline cartilage that lines a synovial joint is a highly specialised substance with unique properties. It has a very low coefficient of friction, allowing smooth joint movement. The body is unable to produce hyaline cartilage and repairs injury with fibrocartilage. This is

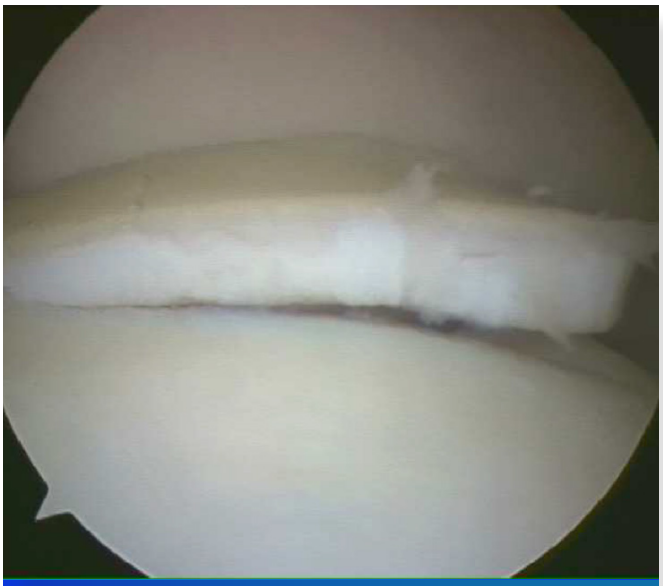


Radiograph of a normal ankle with healthy cartilage, showing a good joint space between the tibia and talus



An arthritic ankle, demonstrating loss of joint space, as a result of the articular cartilage having worn away

a less resilient, higher friction form of cartilage not usually found in synovial joints and as a result is less effective in facilitating joint glide.



Arthroscopic picture of the inside of an ankle. The layer of hyaline cartilage has been fractured away from the bone and can be seen loose in the joint

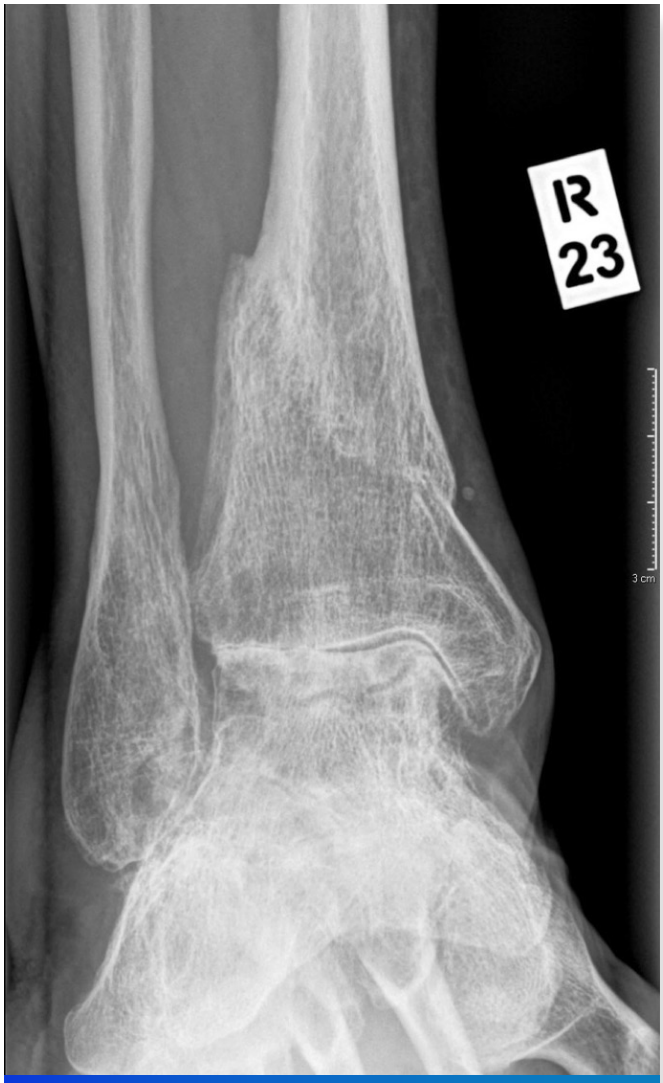
Post traumatic arthritis is a form of arthritis caused by injury. There are a number of factors to be taken into account when assessing the risk of developing arthritis.

1) Indirect Trauma to the Joint Surface.

When a long bone such as the tibia is broken in an accident, the joints at either end can also absorb a significant amount of the energy. This may not be enough to show on plain x-ray or MRI scan, but can manifest as arthritis later in life. Subtle clues, such as painful swollen joints at the time of injury are often missed or overlooked, owing to treatment being concentrated on the main injury.

2) Intra-Articular Fractures.

Intra-articular fractures occur when a large amount of force passes through a joint. Such a fracture may breach the bone and cartilage of the joint. This results in irregularities or even steps in the hyaline cartilage. These fractures can either be undisplaced and



Radiograph of an ankle, demonstrating a healed fracture of the tibia, just above the joint. The fracture has healed in a near anatomical position. Despite this, the ankle has become arthritic, with loss of joint space particularly in the outer part of the joint.

amenable to non-operative treatment or displaced, in which case surgery may be considered.

The risk of post-traumatic arthritis is particularly increased when the joint surface heals in a non-anatomical position. This can alter the biomechanics of the joint. Irregularities and steps in the cartilage predispose to arthritic change, although the height of step that is significant is difficult to estimate, and varies joint by joint. Evidence around this subject is contentious. A good

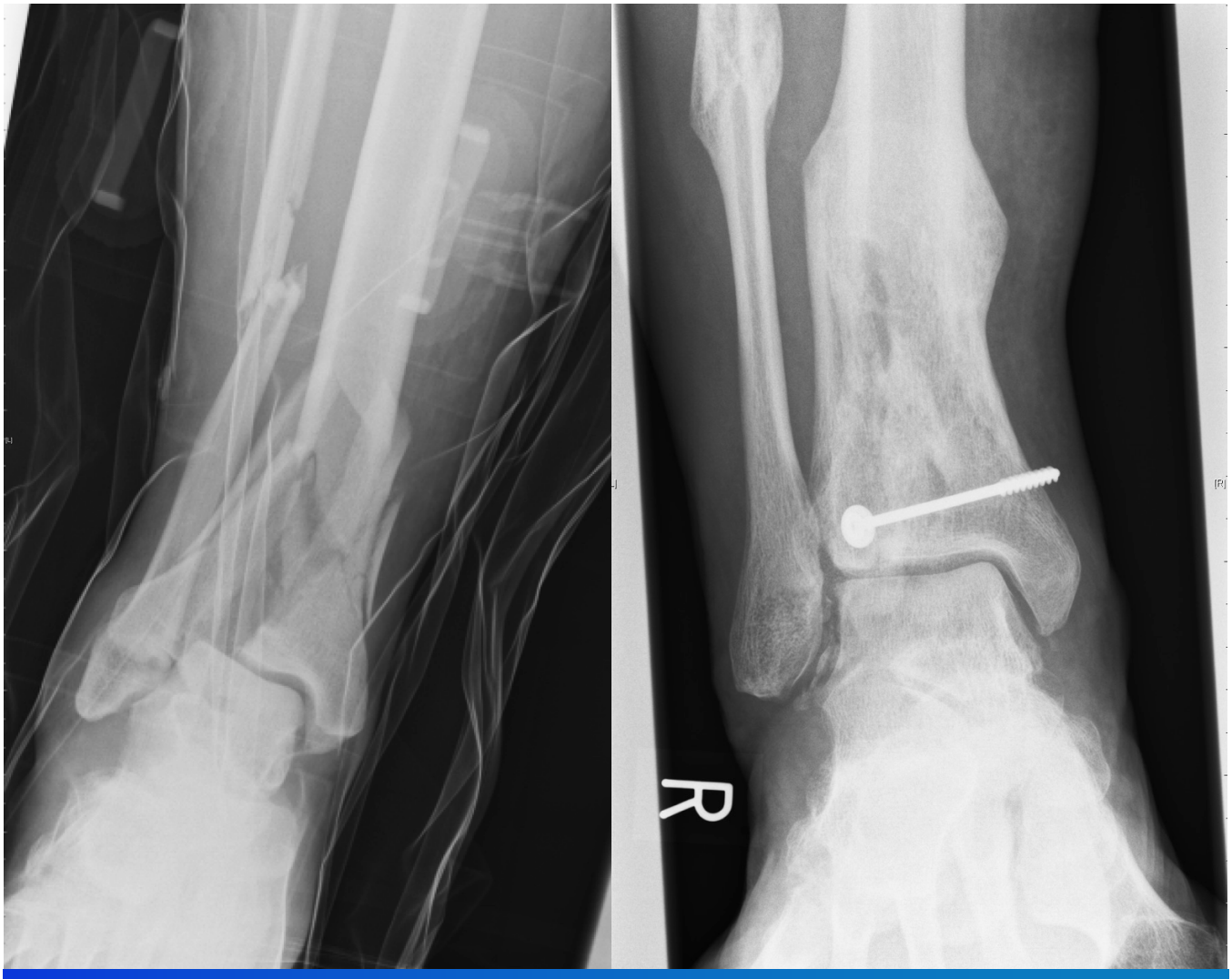
rule of thumb is that if the step is greater than the thickness of cartilage in the joint, the outcome is likely to be unfavorable.

When assessing the risks of a patient developing post-traumatic arthritis after an intra-articular fracture, particular attention is paid to the degree of comminution at the fracture site. This is the number of fracture fragments that are present - the greater the number, the higher the force applied and the greater the potential damage to the joint surface, resulting in an increased risk of the development of arthritis.

3) Open (Compound) Fractures, Resulting in Infection within the Joint - Septic Arthritis

The results of septic arthritis in uninjured joints are often poor, as the common bacteria that cause this condition release toxins that damage cartilage. The most effective treatment is prompt surgical wash out of the joint and appropriate antibiotics.

A compound intra-articular fracture is a fracture that occurs in a joint, with an overlying breach in the skin and soft tissues. These injuries have a high risk of infection, and urgent surgical debridement



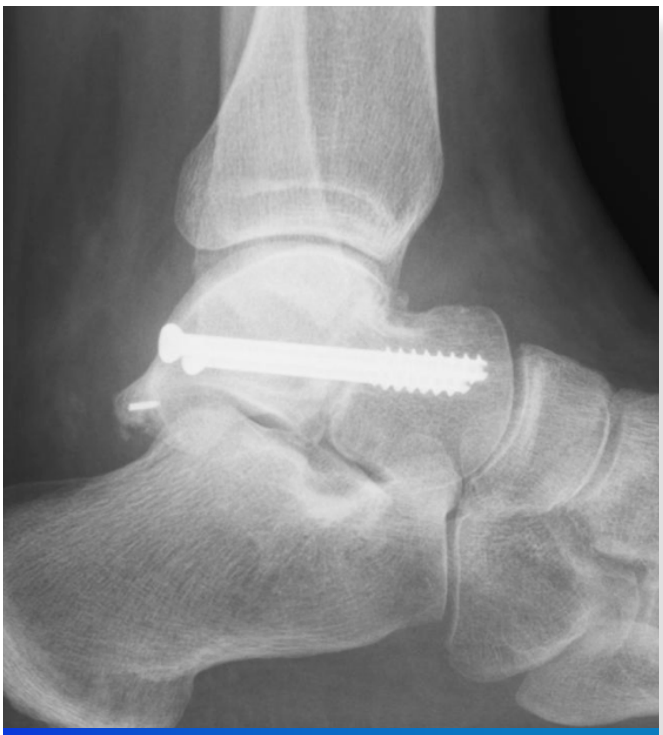
A high energy, comminuted, intra-articular fracture of the ankle. This has been treated surgically with anatomical restoration of the joint surface. Several years later, the fracture has healed and the ankle joint has a well maintained joint space.

and antibiotic treatment are required. The results of septic arthritis can be devastating, with high risks of poor outcome or arthritis. Occasionally, severe infection that cannot be eradicated may necessitate amputation. Treatment for such conditions is likely to be protracted, with poor long-term outcomes.

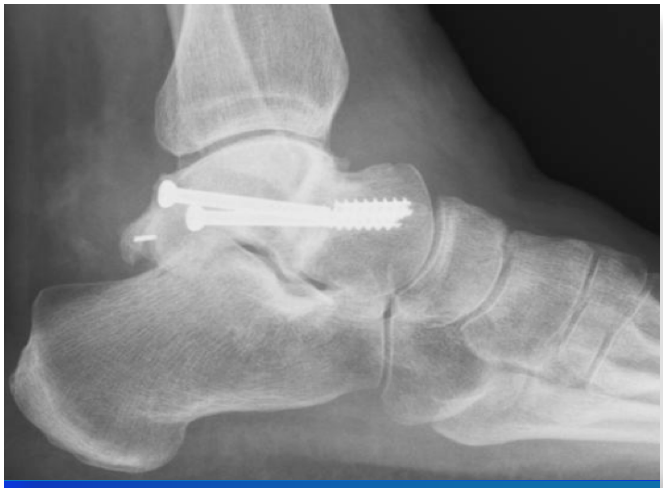
4) Damage to the Blood Supply - Avascular Necrosis

Certain fractures are renowned for damaging the blood supply of the bone. Common examples are fractures of the hip and fractures of the talus, the main bone in the ankle joint.

Talar neck fractures, if caused by a high-energy injury with significant displacement, can completely disrupt the blood supply to the body of the talus. This can cause the bone to die and collapse, resulting in arthritis and may necessitate salvage procedures such as fusions around the hindfoot.



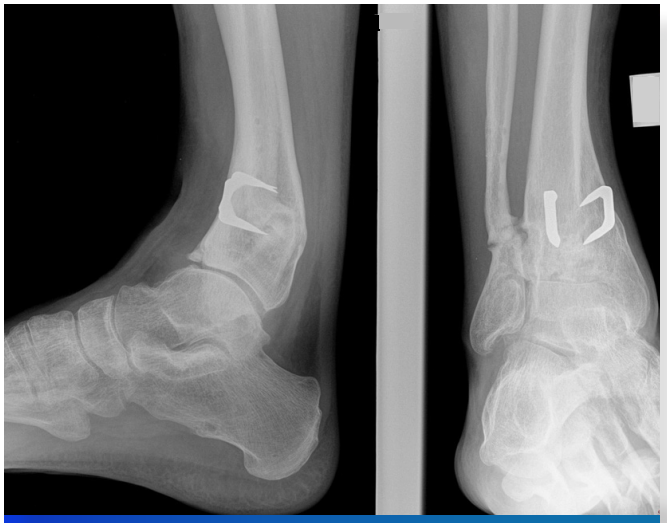
Fracture of the neck of the talus, fixed with two screws. An early sign of avascular necrosis is sclerosis (whitening) of the body of the talus as its blood supply fails, secondary to the index injury



Later signs of avascular necrosis, showing collapse of the bone. In this case resulting in breakage of one of the screws

5) Mal-Alignment of a Joint Due to Distant Fracture

The forces passing through a joint are balanced to equalise pressure on the cartilage. If a fracture heals in a non-anatomical position, this can alter the delicate balance, resulting in early arthritis of the joint. For this reason, great care is given, when stabilising long bone fractures, to ensure correct alignment is restored.



Radiographs showing a tibial fracture that has healed in a markedly non-anatomical position. Several years later, the joint has become arthritic with significant loss of joint space.

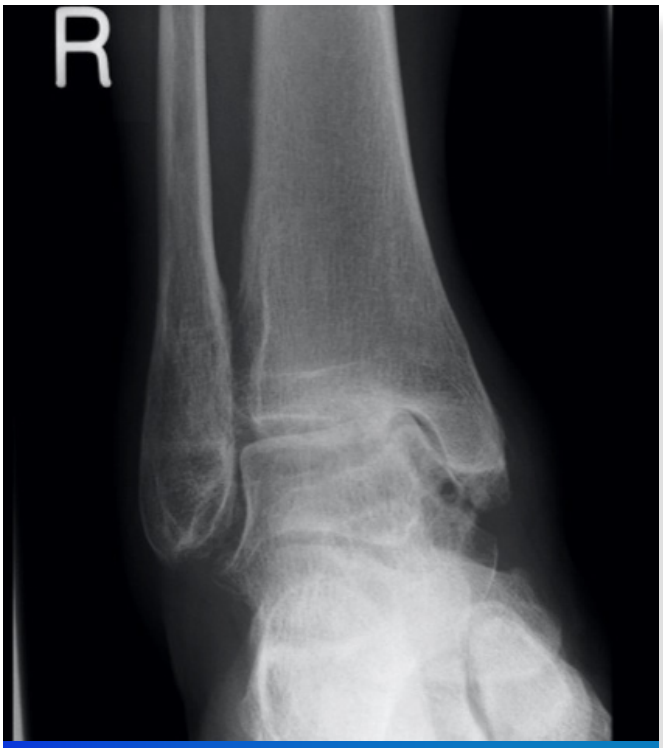
6) Chronic Instability of a Joint

Joint motion is stabilised and limited by ligaments. These ensure that the joint stays within its physiological range and avoids overload on the hyaline cartilage.

Injuries can cause rupture of the ligaments and result in joint instability. This can be a disabling problem in its own right requiring bracing, physiotherapy or reconstructive surgery.

Good examples include the lateral ligaments of the ankle and the anterior and posterior cruciate ligaments of the knee.

Chronic instability, such as can occur in patients that suffer significant ankle injury, can cause repetitive injury to the joint, resulting in eventual damage to the articular cartilage.



Radiograph of an ankle that has suffered repetitive inversion injuries due to a deficient lateral ligament complex. The talus has adopted a tilted (varus) posture beneath the tibia with signs of arthritis. There as been loss of joint space on the corner of the talus due to point loading.

7) Other Causes of Joint Injury

Injuries to other structures in a joint, such as the menisci, or shock-absorbing cartilage, in the knee, or the labrum in the hip can alter joint mechanics, resulting in the development of arthritis in the future.

Summary

In summary, the causes of arthritis after injury are multiple and all must be taken into account when calculating the risks of the development of arthritis after injury. In particular, the degree of intra-articular injury, combined with the force applied and amount of comminution are important when assessing the risk, as they all directly impact on the amount of cartilage damage sustained.

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MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

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

NEWS

No Agreement on Fixed Costs for Low Value Clinical Negligence Claims

In a report published by the Civil Justice Council (CJC) in October, claimant and defendant sides came close to agreeing fixed costs for claims valued up to £25,000.

Both sides were in reach of each other on costs with only £2,000 difference between them.

However, agreement was not reached on exclusions from the fixed costs scheme, especially fatal claims, level of expert fees or after-the-event insurance premiums.

The use of single joint experts was not supported. The CJC said it is pleased to have played a small part in facilitating discussions on issues of patient safety and learning from clinical mistakes; as an advisory body on issues of civil justice, the CJC can do little more than encourage the organisations on all sides to continue working together in the interests of patients.

Read more:
https://www.judiciary.uk/wp-content/uploads/2019/10/Fixed-recoverable-costs-in-lower-value-clinical-negligence-claims-report-141019.pdf

The Medico-Legal Conference – 11th June 2020, has moved to a larger venue at The Congress Centre, 28 Great Russell St, Bloomsbury, London WC1B 3LS, after the success of this year's conference.

Tickets are now available for SpecialistInfo's Medico-Legal Conference in London on 11th June 2020, get an early bird deal while it still runs!

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.

Expert witness 'primers' will cut costs

The Rt. Hon. Lord Neuberger, the former president of the Supreme Court, spoke at the Expert Witness Conference in September and said that the judiciary was working with the Royal Societies of London and Edinburgh to produce primers for judges on topics similar to the ones on DNA evidence and gait, available since 2017, where there is a clear consensus among experts.

Neuberger told expert witnesses: 'What [the primers] are trying to do is – I wouldn't say do you out of a job – but restrain aspects of expert evidence by telling judges that on certain topics there is a clear consensus among experts.'

While Neuberger called the primers an 'enormously valuable development' which will cut costs and increase consistency, he accepted that 'we all know that theories which were generally accepted by the world and the experts in one generation can turn out to be rejected by another generation'.

Read more:
https://royalsociety.org/news/2017/11/royal-society-launches-courtroom-science-primers/

Case Report: ZZZ v. Yeovil District Hospital NHS Foundation Trust (High Court, 26 June 2019 – Garnham J.)

A young woman was a rear seat passenger in a car which was involved in a road traffic collision. She was wearing a lap seat belt but suffered serious spinal injuries. Insurers for the negligent motorist settled her claim with a lump sum of £3 million, plus substantial ongoing periodical payments for care and case management. They started contribution proceedings against the trust, alleging that insufficient precautions were taken in the emergency department.

Shortly after arriving in hospital by ambulance, she was able to help a nurse in removing her trousers and to push her feet against the nurse's hand. However, an hour later she could no longer move her legs and four hours later a scan revealed a fracture of the lower thoracic spine and severe compromise of the spinal canal and cord. She was referred to a tertiary centre for urgent surgery, but remains seriously disabled.

Ambulance staff, on arrival at the hospital, did not suggest to trust clinicians that they had any concerns about the patient's neck or back and she was not on a spinal board.

Various expert witnesses gave evidence and the neuro-radiologists agreed that the fracture dislocation probably occurred in the collision.

Mr. Justice Garnham held that any breaches by trust staff did not cause or contribute to the patient's injury. He accepted the evidence of two neuro-surgical experts who explained that following initial damage to the spine, swelling of the cord can occur which restricts its supply of oxygen. This results in white cells and other inflammatory material appearing inside the cord. In time, those materials release chemicals which set up secondary damage.

The initial insult to the cord had been so severe that complete spinal cord injury and subsequent paralysis were inevitable, even though paralysis was not instantaneous. It was therefore wrong to view the trauma as a single event because the spine was locked in a contorted and extended position. Consequently, whilst two breaches of duty had occurred those had no causative effect. The true cause of the patient's paralysis was damage inflicted in the collision.

Read more:
https://resolution.nhs.uk/2019/10/21/case-of-note-zzz-v-yeovil-district-hospital-nhs-foundation-trust-high-court-26-june-2019-garnham-j/

Australian women win long-running class action lawsuit against Johnson & Johnson (J&J) over vaginal mesh implants

Australia's Federal Court found this November that Ethicon, a J&J subsidiary, failed to warn patients and surgeons about the risks posed by the products.

The implants were commonly used to treat pelvic organ prolapse and incontinence after childbirth, but left some patients with chronic pain, bleeding and severe discomfort during sexual intercourse.

The risks were known, not insignificant and on Ethicon's own admission, serious harm could ensue if they eventuated," the Judge said in her ruling.

The court will set damages next year.

In October, the company agreed to pay nearly $117m (£90.5m) to resolve claims over pelvic mesh in 41 US states and the District of Columbia.

It is also facing lawsuits over the product in Canada and Europe.

Senior judges attack inadequate expert witnesses

Mr Justice Martin Spencer, who chairs the Expert Witness Institute's board of governors, spoke at their conference in September to criticize expert witnesses who "were undoubtedly experts in their field but no good as expert witnesses because they have had no training and do not understand their duties to the court".

He said he had "come across just such an expert earlier this year", referring to his judgment this summer in *Arksey v Cambridge University Hospitals NHS Foundation Trust.* In his ruling, the judge described the consultant neurosurgeon as "embarrassing" and said he made "continual apologies" and used "an expletive" while giving evidence.

It became apparent during the case that the expert had not only failed to read the claimant's medical reports, but also the report of the other expert.

"Experts should be able to demonstrate not only credentials in their field but credentials as an expert.

"How is it that in 2019, in an important High Court medical negligence case, that we can have an expert witness who does not even begin to understand his duties as an expert?

"As a judge, it's not enough for me to have an expert who knows everything about neurosurgery. It's useless if he hasn't done his job as an expert."

Another senior Judge, Lady Justice Nicola Davies, also commented that she believed medical experts who left clinical practice more than five years ago should not be called as expert witnesses.

She said it was a "false point" for solicitors to instruct an expert who had not been in practice "for some time" as "ultimately it will undermine the credibility of the expert in the eyes of the court".

Read more:
https://www.bailii.org/ew/cases/EWHC/QB/2019/1276.html

RCN Reports Nurse vacancies at record high

The Royal College of Nursing published a report this October entitled *"Staffing for Safe and Effective Care in England - Standing up for Patient and Public Safety"* describing the "lack of clear roles, responsibilities and accountability for workforce planning and supply in England".

The report notes that the Secretary of State for Health and Social Care has an overall duty in law to provide a 'comprehensive' health and care system to meet the needs of the population, but there is no specific legislation detailing their responsibility to make sure there are enough nursing and other professionals to meet this need.

Dame Donna Kinnair, their Chief Executive & General Secretary, said "The significant nursing shortage in England – 12% vacancy rate in the NHS without counting social care, public health or primary care – means inadequate staffing levels across all settings. With an over-reliance on temporary staff filling gaps, we know that that the shortage is putting patients at risk and pushing nurses to leave the profession they love due to the pressures they face."

The College believes this must be resolved through legislation, alongside additional investment in the nursing workforce and a national health and care workforce strategy for England.

"The RCN is clear, it is no longer the time to be discussing whether legislation is needed, instead, we should also be focussed on how we go about securing these necessary changes in law."

Read More:
https://www.rcn.org.uk/professional-development/publications/007-743#detailTab

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