MEDICO LEGAL

MAGAZINE

ISSUE 6

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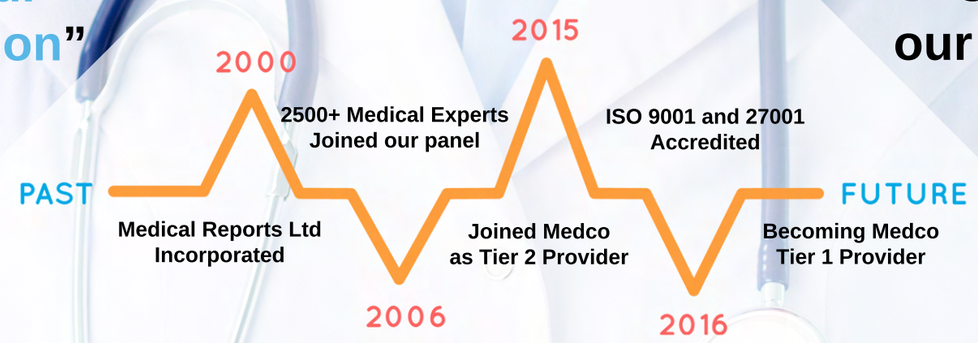

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Welcome to Issue 6

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

In this issue, our sponsor, Ben Elsom from Medical Reports Ltd, discusses how virtual reality software, CaltainVR, helps patients deal with debilitating chronic pain.

We present a history of whistleblowing in the NHS, by lawyer Laurence Vick, and how attitudes to medical professionals who need to report safety concerns within their organisation must be improved.

We are also pleased to include the second part of an article on the most common medico-legal issues in Maxillofacial Surgery, by Michael Perry.

We are pleased to announce that three new partners are joining the SpecialistInfo medico-legal training faculty for 2018: Jonathan Godfrey and David de Jehan are experienced barristers from Parklane Plowden Chambers in Leeds, specialising in clinical negligence, and Andrew Gray is Managing Partner and owner of Truth Legal in Harrogate who specialises in personal injury. Find out more about them and the training courses for next year in this issue.

Jonathan has also written a case report for us, with a warning for doctors about the importance of independence and objectivity in the provision of expert evidence. We also publish a retort to Andrew's 'tips for experts' from the last issue, which offers advice to law firms based on the experience of seasoned expert, Peter Mahaffey.

Once again, the magazine will be circulated to some 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 training 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

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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 2018 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):

- *24th January 2018* – London
- *8th May 2018* – Leeds
- *18th September 2018* – London

£330 (plus VAT)

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

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

- *25th January 2018* – London
- *9th May 2018* – Leeds
- *19th September 2018* – London

£355 (plus VAT)

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

Advanced Medico-Legal Course (now including court-room skills and an update to the law and procedures for experienced experts):

- *14th March 2018* – London
- *20th June 2018* – London
- *6th December 2018* – London

£355 (plus VAT)

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

Mediation Training Course (5 days or can be split into 3 Modules - please call for details):

- *19th-23rd February 2018* – London
- *21st-22nd Feb & 6th-8th March 2018* – Aberdeen
- *19th-23rd March 2018* – London
- *More dates tbc*

£2,100 (plus VAT)
(or £420 per day if split into Modules)

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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HOW VIRTUAL REALITY SOFTWARE COULD BEGIN TO HELP INJURED ACCIDENT VICTIMS DEAL WITH LIFE DEBILITATING CHRONIC PAIN

By Ben Elsom, Medical Reports Ltd

It is estimated that 28 million people in the UK suffer from some form of Chronic Pain. Complex regional pain syndrome (CRPS) is a poorly understood condition in which a person experiences persistent severe and debilitating pain. The impact on Claimants suffering with this condition can be devastating.

John M Snell a Barrister at Guildhall Chambers Bristol in his article C.R.P.S – all in the mind writes "Chronic pain not only arises in many guises and with different degrees of severity, but from an infinite variety of different originating causes. Many will have come across the scenario where a minor soft tissue injury to the spine has apparently produced chronic back pain. Fewer will have encountered the situation where the loss of a finger tip has left the claimant wheel-chair bound. The orthopaedic experts may have shrugged their shoulders and the psychiatrists may have diagnosed no psychiatric condition."

What is certain is that Claimant's suffering with the condition and medico legal experts who have diagnosed the condition are limited with effective treatment options.

CaltainVR Working alongside the Royal United Hospitals Bath NHS Foundation Trust Complex Regional Pain Syndrome Team, one of the World's leading treatment teams has developed groundbreaking virtual reality software to assist patients suffering from CRPS.

Evidence shows people's sensory and motor systems are adaptive mechanisms, and that in many musculoskeletal disorders such as Fibromyalgia and Rheumatoid Arthritis patients suffer from Chronic Pain. These systems can become hyper-adaptive, leading to altered body perceptions, increased pain and pain-sensitivity. Working with patients with CRPS who commonly present with these characteristics, the aim is to understand these abnormal sensory perceptions.

Currently undergoing medical trialing in the NHS it is hoped that the virtual reality solution may help sufferers of chronic pain conditions. As Virtual Reality is so immersive there is a potential to create controlled real life scenarios and environments to gain a better understanding of how our senses can manipulate how pain is perceived.

Dan Paintain one of the developers of the software, himself a sufferer of CRPS explains "Imagine if you suffered from a chronic pain condition, for example, in your right arm. You would probably perceive the world like a wounded animal. Protecting your arm from danger as any knock or bump would increase the pain. When something unexpected happens near your painful limb you are likely to react defensively and have your senses heightened maybe even enough that it gives you an adrenalin hit. This would in turn increase your pain. Chronic pain sufferers may be going through their day to day life without even realising that they are reacting this way to everyday normal unexpected incidents that normally in a healthy person would not create such a response. The pain increases throughout the day and they may have no idea why."

The Virtual Reality programs encompass a measurement and rehabilitation package. The package when finalised would involve a two week therapy program covering occupational therapy, hyrdotherapy, physiotherapy and psychology. As part of the VR program the therapist can place the patient in a virtual world that is safe with no real threat. The therapist can then recreate those unexpected events utilising a graded exposure. This will ultimately give the patient a better understanding on how their senses affect their perception of pain.

Medical Reports Ltd is investigating how this treatment when aligned to other complementary rehabilitative treatments could be utilised by Claimants and Defendants in the medico legal Sector to provide innovative treatment packages to claimants suffering from CRPS.

It is hoped that once medical trials are complete the measurement and therapy programs can be applied to all chronic pain sufferers to assist them to deal with chronic pain on a day to day basis.

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THE LONELINESS OF THE NHS WHISTLEBLOWER

Insight from Laurence Vick Legal Director at Enable Law

Laurence has 30 years' experience as a medical negligence lawyer. He is a central figure in child heart surgery litigation after representing the families affected by the Bristol scandal in the 1990s. He has appeared in the Legal 500 as the 'go-to lawyer for complex cardiac cases'. He can be contacted on laurence.vick@enablelaw.com, Twitter: @LaurenceVick

After representing the families affected by the Bristol children's heart surgery scandal at the Bristol Royal Infirmary public inquiry, which resulted in the Kennedy Report of 2001, he has taken a close interest in patient safety issues as well as the role of whistleblowers and how the NHS responds to them.

Where are we now with whistleblowing in our health services?

I attended the first Turn up the Volume conference in 2015 and the second in May this year and have now heard first hand a number of prominent whistleblowers, including Bristol whistleblower Steve Bolsin, tell their stories. These have underlined the sad fact that those working in the health services, who have the courage to raise safety concerns, continue to find themselves in a lonely place. It is difficult for the observer to understand why this bullying and victimisation still occurs when these brave employees are, by any reasonable view, acting in the public interest.

So what has changed for whistleblowers and is it any easier for health professionals to bring safety concerns to management without exposing themselves to the risk of isolation and losing their careers? What initiatives have been introduced and how have any changes in the law affected the position? In whistleblowing cases the three key questions for an employment tribunal are (i) whether the employee has made a protected disclosure, (ii) whether he or she has been treated detrimentally and (iii) whether the reason why the employee has been treated detrimentally was because he or she had made the protected disclosure. The third point is key – why has the employee been treated detrimentally as he or she alleges? I'm not an employment lawyer but the legal safeguards for whistleblowers don't appear to be the answer; the damage has already been done by the time cases reach a tribunal and the cost of pursuing a tribunal claim can be prohibitive.

The NHS does not have a good track record when it comes to the treatment of whistleblowers. As Professor Sir Ian Kennedy, in his Review of the NHS surgery undertaken by disgraced breast surgeon Ian Paterson, put it:

"Whistleblowers do not fare well in the NHS. This is one of the major indictments of management in the NHS: that it is inwards-looking, over-defensive, and prone to destroy, by a variety of means, those who suggest that the Emperor has no clothes. This is not unique to this Review. It is a blight on the NHS and is one of the principal areas where lessons must be learned."

So what factors are at play that still prevent doctors from raising concerns?

The historic cases of Steve Bolsin and Raj Mattu are well known. The acid test, to me, is how a Bolsin or a Mattu would be dealt with today if they communicated their safety concerns up the chain of command within their Trusts? I will cover some recent examples of how whistleblowers have been treated by their employers. Unfortunately these cases throw light on the way that whistleblowers continue to be suppressed rather than encouraged, both in the NHS and private sector. The use of gagging clauses when whistleblowing doctors receive financial settlements on agreeing to leave their employment is still endemic in the NHS. Even

if confidentiality terms are expressed so as not to prevent a doctor making a protected disclosure under whistleblowing laws the perception must be that if paid to leave, the mouth should remain firmly shut about whatever concerns he or she had raised.

This is hardly consistent with the new spirit of openness and transparency in our health services. With the CQC declaring that two thirds of NHS hospitals are offering unsafe care, and scandals emerging all too frequently, it seems inevitable that budget constraints and cost-cutting will lead to more failings. Against this background, it is increasingly difficult to see why whistleblowers are not listened to and protected, encouraged, or even feted as 'champions of the public interest' as one of the eminent speakers at the recent Turn up the Volume conference put it. Whistleblowing is not just about public exposure of scandals; early, internal disclosure of failings and risks gives managers an opportunity to take early preventative measures, to learn from mistakes and potentially avoid the spiral of harm and expense that characterises the scandals that continue to emerge. In extreme cases, dangerous surgeons can be weeded out and their practices addressed.

Ian Paterson

The Paterson scandal inevitably looms large over any consideration of healthcare provision, and has highlighted multiple failures of governance and patient care at all levels in both the NHS and private sector. Paterson, now serving 20 years in prison, was allowed to continue his dangerous practices in the NHS and at BUPA hospitals from 1993, then at two Spire hospitals from 2007. The NHS has paid £17.4m to around 270 of his NHS victims and Spire have now agreed to pay £27.2m into a fund to compensate his private patients. Iit is impossible to imagine that there won't have been employees at the Solihull NHS hospital or Spire who didn't attempt to raise concerns over Paterson's practices. It is extraordinary that nobody had felt able to speak out. Did doctors turn a blind eye and keep their heads down? There must have been conscientious colleagues at Paterson's NHS hospital and at the Spire hospitals who knew of the harm he was inflicting on patients but were afraid to raise concerns in the belief that they would be silenced? Were there doctors who tried to take steps to protect patients from Paterson but were prevented from doing so?

Equally, were there managers or doctors, including colleagues, who for their own reasons did not want the truth to emerge? It has now been reported that up to ten doctors who worked with Paterson are under investigation by the GMC, presumably for failing to act on concerns. Trust managers risk punishment for failing to protect patients from harm, so failing to act on a whistleblower's concerns can be a risky strategy. Bristol Medical Director Dr John Roylance was struck off for professional misconduct by the GMC in 1997 after he chose to ignore warnings from children's heart surgery whistleblower Steve Bolsin. The GMC ruled that Roylance had failed in his responsibility to intervene to ensure the safety of patients; the GMC had jurisdiction because he was a registered medical practitioner (a radiologist).

Kevin Beatt

Cardiologist Kevin Beatt's case has also been in the news. Dr Beatt had voiced concerns for 3 years over staffing and equipment shortages and workplace bullying and harassment of junior employees at Croydon's Mayday hospital and this came to a head following the death of a cardiac patient during a routine angioplasty procedure in 2011. Beatt was sacked in September 2012. The Trust maintained he had made 'vexatious' 'unsubstantiated and unproven allegations of an unsafe service' but a tribunal ruled two years later that he had been unfairly dismissed in a 'calculated attempt to damage his reputation' and subjected to unlawful detriment for 'making protected disclosures.'

Dr Beatt has now finally triumphed at the Court of Appeal after a 5 year battle. The Court of Appeal accepted the original 2014 employment tribunal decision. Lord Justice Underhill made the following statements:

"It comes through very clearly from the papers that the Trust regarded Dr Beatt as a troublemaker who had unreasonably and unfairly taken against colleagues and managers who were doing their best to do their own jobs properly."

"It is all too easy for an employer to allow its view of a whistleblower [being] a difficult colleague or an awkward personality, as whistleblowers sometimes are, to cloud its judgement."

Parliament had "quite deliberately, and for understandable policy reasons, conferred a high level of protection on whistleblowers".

"If there is a moral from this very sad story, which has turned out so badly for the Trust as well as for Dr Beatt, it is that employers should proceed to the dismissal of whistleblowers only where they are as confident as they reasonably can be that the disclosures in question are not protected."

Dr Beatt's compensation award is to be assessed at a further tribunal hearing.

Chris Day

'Junior doctor' Chris Day was successful in the Court of Appeal in May 2017. Dr Day, who qualified as a doctor in 2009, had raised concerns over staff shortages and notified managers at London's Queen Elizabeth Hospital, run by Lewisham and Greenwich Trust, that he was the only doctor covering an 18 bed intensive care unit. He claims that his career has been destroyed after false allegations were then made against him, making it impossible for him to continue with his training and achieving his ambition to become a consultant. Dr Day alleged he had suffered detriments as a result of making protected disclosures but was prevented from pursuing an employment claim because Health Education England maintained that he had a training contract with them and did not fall within the definition of a 'worker' under an employment contract. If correct, junior doctors with HEE training contracts would be excluded from the protection of whistleblower laws. After a 2 year appeal process, the Court of Appeal ruled that Dr Day was in reality an employee of the Trust where he had been working. They ordered that the case must be sent back to the employment tribunal for them to decide Dr Day's original claim that he had suffered detriment after making a protected disclosure.

Support for Chris Day has been so great that he was able to raise £140,000 for his legal fees through crowdfunding. Meanwhile the costs to the taxpayer will inevitably be in six if not seven figures by the time the case has reached a conclusion. He and his supporters are spearheading a campaign for full whistleblower protection for junior doctors.

What if Steve Bolsin and Raj Mattu had raised their concerns today?

Steve Bolsin

This story of an individual stifled by an NHS trust unwilling to acknowledge its shortcomings, has been repeated at many other hospitals since Bristol. Some of the systemic, cultural failures at Bristol in the 90s are being repeated now, a generation later; failures that I don't believe the law protecting whistleblowers or the duty of candour as currently framed are able to address. News reports of scandals in the NHS raise the inevitable question 'Have the lessons of Bristol been learned?'

In 2001, the Kennedy Inquiry into children's heart surgery at Bristol found serious, systemic failures at a unit that had clothed itself in a 'club culture' of wilful blindness to safety concerns. As early as the late 1980s, the recently-arrived consultant anaesthetist Stephen Bolsin had made his concerns over alarming surgical mortality rates clear to his superiors at the Trust; fellow clinicians and managers, occupying all levels of authority right up to the top of the NHS and the Royal Colleges, refused to heed his warnings.

Operations at Bristol continued, in the hands of surgeons whose failings were later laid bare in the GMC disciplinary inquiry. By this time, scores of children had died or suffered severe injuries. The data was incomplete but we estimated by extrapolation from the limited data available that 171 children who could have survived if they had been operated on in other hospitals had died at Bristol over the period 1982 – 1994 covered by the Public Inquiry. There was no data for the incidence of non-fatal adverse outcomes so no morbidity comparisons could be made.

Although cardiac surgery has led the field in the publication of outcomes data, to this day the only data available to assess the performance of a surgeon or unit is 30 day mortality. This lack of data and the

limited nature of the data that is available can make it difficult for a doctor to prove that his concerns over the performance of his or her colleagues are justified.

Professor Bolsin, as he became after leaving Bristol, paid the ultimate price, emigrating with his family to Australia in the face of widespread prejudice in the medical profession. Bolsin became, in his own words, 'the most hated anaesthetist in Europe.' Fortunately he has since received a number of prestigious awards and accolades in recognition of his actions. The concept of clinical governance that took root in the UK and globally arose directly out of Bolsin's actions. As with all other whistleblowers whose stories are now familiar to us, all he had done was to try and raise concerns over the safety of his unit. He had acted in accordance with his conscience and took a course of action that that he knew to be morally and ethically right. In his lecture to the latest Turn Up the Volume conference he reminded us of the simple fact that we must never lose sight of the patient.

Raj Mattu

Raj Mattu, the former cardiologist at Walsgrave Hospital in Coventry, exposed a crisis of overcrowding and patient safety at his unit in 2001. The Trust had imposed a "5 in 4" system of squeezing an extra bed into cardiac wards designed for four patients, a policy that left essential services such as oxygen, mains electricity and suction less accessible to some patients. Mattu and his colleagues believed this presented a danger to patients and would cost lives; they pleaded for the practice to end but management refused to listen.

Mattu witnessed the death of a 35 year old patient who had suffered a cardiac arrest. He and his colleagues had been unable to afford the patient the required standard of cardiopulmonary resuscitation because they could not access the patient or deploy the equipment due to his location as a fifth patient in a four bedded bay. Mattu and two senior nurses filed a serious clinical incident report and wrote details of these problems in the patient's case notes. His colleagues nominated him to put forward their concerns and in a letter to the Trust's Chief Executive David Loughton, Mattu complained that the issues he had expressed had not been acknowledged or responded to by the Trust management.

Mattu's reward was a suspension and a decade-long struggle before he was eventually exonerated. This was despite the CQC publishing a report later in 2001 describing it as the 'worst ever' patient safety report they had produced for any Trust, confirming an 'excess death rate' of 60% (compared with the subsequent excess death rate of 29% at what became the notorious Mid Staffs).

The furore over Mattu's treatment by his employers is one of many case studies in the opprobrium faced by those who break ranks and voice concerns and whose careers are blighted. Some 200 complaints about Mattu were made by the Trust to the GMC, health regulators, the former Strategic Health Authority and even the police, every single one of which was found to be without foundation. Meanwhile, the NHS, and we the public, lost the services of a skilled and conscientious doctor.

The financial cost of silencing and challenging whistleblowers

The question of how much it costs to deal with the fallout of a mismanaged whistleblowing process, let alone the human toll of patients who have suffered avoidable harm, is becoming glaringly apparent. The failure to foster a culture in which hospital staff are encouraged to come forward with their patient safety concerns is a missed opportunity to conserve public funds.

Significant legal costs are incurred by the NHS fighting claims made by whistleblowers and challenging them through endless disciplinary proceedings, tribunals and the courts. The financial cost of ignoring whistleblowers' warnings can be hugely expensive for the NHS. Where a Trust knows of a serious problem but fails to act or takes steps to cover this up, negligence cases accumulate.

I have estimated that heeding Bolsin's concerns and gripping the problem may have saved the NHS in excess of £100 million when one factors in the costs of the GMC Inquiry, Public Inquiry and the expense to the NHS of fighting some 200 claims for fatal injuries and 50 cases for significant damages where children survived but suffered serious injury. This estimate does not include the huge misery and damage done to lives, which makes for even more painful arithmetic, including the cost of all the disciplinary processes and legal proceedings Mattu's Trust built up a reported bill of £10 million. Figures of a similar amount have been suggested in the media representing the compensation paid to Mattu for his ruined career, out of which he has had to pay his own substantial legal costs to achieve that outcome.

Press reports suggest that the Trust's legal costs for their failed five year battle against the now completely vindicated Kevin Beatt already stands at £440,000.

Patient consent and the duty of candour

Information within the knowledge of a whistleblower may have implications for a patient's consent before he or she undergoes treatment and the hospital's duty of candour after treatment has taken place.

Concealing information about unsafe practices leaves hospitals vulnerable to negligence claims relating to failures of consent. It is axiomatic that, in medical procedures, a patient or his family, must give properly informed consent to treatment, understanding the risks and ramifications of what they are about to undergo. At Bristol, parents were given surgical outcome 'predictions', figures for survival rates and surgical risk, which may have reflected national averages but which a number of Trust employees clearly knew to be inaccurate for their own unit at Bristol. Where patients or families consent to surgery at a unit or hospital that is known to have a substandard record or inadequate safety record, perhaps even dangerous staffing levels, which is not disclosed to them, their consent could be tainted. The NHS may then face consent claims alleging a failure to warn, that it will find difficult to defend.

We are now in an era of self-determination and the well informed patient. The Supreme Court decision in Montgomery in 2015 ruled that it is a doctor's duty to take reasonable care to ensure that a patient is aware of material risks inherent in treatment, and of reasonable alternatives. In order fully to advise, the doctor must engage in a dialogue with the patient and must explain the risk of intervening events and complications that might occur. Placing the onus on a patient to ask questions when the patient may not know what questions he should be asking is no longer sufficient.

Quoting from the seminal passage of the Montgomery judgment:

"The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

The reported cases involve the extent of the duty owed by the doctor and the explanation of the risks and benefits of each alternative before the patient undergoes treatment. For the patient to make a truly informed choice, shouldn't he be informed of the comparative benefits of undergoing an operation at a different hospital unit with greater experience and competence, better equipment or whose surgical and medical staff have a superior safety record in that procedure? If a surgeon lacks experience in the specific operation to be performed, patients should be informed of this.

The whistleblowers whose cases have been reported have raised concerns over shortcomings at their own hospitals. The difficulty for the hospital is that if patients are informed that a doctor or nurse in that unit has raised concerns over inadequate resourcing, lack of experienced staff, or high mortality rates – or perhaps an adverse record in a particular procedure – those patients will inevitably opt for surgery at another centre. If parents had been informed of the true position at the Bristol children's heart unit in the 90s they would have chosen other hospitals which would ultimately have resulted in the loss of supra-regional status and associated additional NHS funding.

What of a Trust's obligation to inform a patient if their treatment has gone wrong?

The duty of candour introduced in 2014 for the NHS

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and in 2015 for all healthcare providers imposed a duty to provide notification of a patient safety incident – a 'notifiable event' – which has or which could (in the future) give rise to specific, defined types of harm. This duty falls on the NHS or private sector provider rather than the individual doctor. Failure to comply is a criminal offence punishable by a fine of up to £2500 and may result in the CQC revoking the provider's registration.

The duty of candour has not caught up with the law on consent and the impression from the guidance that has been issued within the NHS and private sector is that this is a box ticking exercise, with the use of template letters providing often formulaic responses. The 'apologise but don't admit liability or acknowledge fault' mantra on which much of the guidance seems to be based may comply with the wording but hardly reflects the spirit of the duty. Patients and their families expect a full explanation of what has gone wrong and why. Is the duty of candour meaningful in this context? There seems to be an ethical incongruence between candour before treatment and reticence after that treatment. There are implications of the relationship between a doctor and his employers and his conflicting duties to both patient and employer, usually an NHS Trust in this context, which represent further potential obstacles to the implementation of the duty of candour. This raises the difficult ethical issue for doctors involved in a patient's treatment; their duty to do no harm. Has a doctor fulfilled his duty to the patient if he fails to warn him before treatment or to explain after treatment has taken place that concerns have been expressed by senior colleagues?

Breaches of the duty of candour may be considered by the employer as gross misconduct on the part of the employee even if the underlying treatment failure, if attributable to the doctor's individual shortcomings, would not have led to dismissal. In addition, the employee could be exposed to the risk of fitness to practice proceedings by the GMC both for the underlying failure and the failure to comply with the duty of candour.

Doctors working in the NHS, who have concerns about safety standards in their hospital or unit can face a dilemma and conflicts may arise when it comes to complying with the duty of candour. Although doctors may wish to comply with their ethical duty to the patient, given how whistleblowers have been treated by managers in the NHS I'm not sure I would be comfortable with my employment situation as a doctor if I were to give a full explanation to a patient who has suffered an adverse outcome. What if I knew of wider systemic failings, lack of resources, dangerous practices, or incompetence of colleagues which may have played a part in the outcome?

The 'insurance factor' may also be an obstacle to the effective and genuine application of the duty of candour. A concern of mine is whether private insurers, or in the case of the NHS their indemnifiers, the NHSLA/CNST scheme, will actually allow their insured or their employees to fulfil the obligations of the statutory duty of candour in accordance with what I believe to be the intended spirit of the legislation.

Whilst being open and honest will be second nature to the vast majority of doctors, there are pressures which may have the – unintended – consequence of making doctors reluctant to admit that errors have taken place. Taking the Bristol children's heart surgery scandal of the 90s as an example, families were not given accurate explanations after their children died or suffered brain damage and other significant injury. In this situation, if a duty of candour is to have any meaning surely a patient must be informed of the part the known incompetence of a surgeon or lack of essential resources or inadequate numbers of suitably experienced staff has or may have played in the adverse outcome? On the other hand there may be a risk that the Trust loses its indemnity if it is found that there has been a failure to comply with the duty of candour.

Conclusion

I don't see that a great deal has changed for whistleblowers: a fear of whistleblowing still pervades the NHS. Sadly, the advice to the would-be whistleblower would seem to be simple and stark: only do what is right if you are very strong. Be prepared to be attacked, personally, professionally and legally. Only proceed if you have insurance to cover the legal costs and the time to spend with your lawyer going through the case in great detail. Expect little or no assistance from the regulators, your MP or anyone else, including the BMA if you read the reports into the Chris Day case. Be aware that your career may be permanently damaged; former colleagues will shun you and you will lose friends.

So how would a Bolsin or a Mattu be dealt with today? Sadly I can't help thinking the answer would be 'little differently' and they would find many obstacles placed in their way.

Giving enhanced rights to pursue a claim in an employment tribunal after alleged discrimination has taken place is only a partial solution. Suspending whistleblowers and treating them as potential litigants rather than fellow medical professionals working towards a common goal cannot be the answer.

If managers continue to take steps to crush whistleblowers when they raise concerns over dangerous practices or conditions presenting a possible safety risk, are they really going to allow a doctor to be candid when explaining an adverse outcome to a patient? If hospitals conceal wider problems and systemic failures from patients this would suggest we haven't come far.

If a breach of the duty of candour carries criminal sanctions it is difficult to see why suppressing a whistleblower, and ignoring safety concerns, is not regarded with equal seriousness. It should be a mandatory requirement for hospital management to listen to what a whistleblower has to say, investigate and act on those concerns and only dismiss them after a full investigation has found them to be groundless.

COMMON MEDICO-LEGAL ISSUES IN FACIAL TRAUMA *(PART TWO)*

By Mr Michael Perry, Consultant Oral and Maxillofacial Surgeon, Northwick Park Hospital

Michael Perry is a Consultant Oral and Maxillofacial Surgeon at Northwick Park Hospital, and the clinical lead in facial trauma for the regional maxillofacial and trauma service for the North west of London. He has over 20 years hands-on experience in facial injuries, has lectured both nationally and internationally and has published extensively in this field, including several text books. In 2011 he was listed in The Times Magazine as one of the country's 50 top surgeons.

In part 1 of this article, published in Issue 5 of Medico-Legal Magazine, I introduced common reasons for medico-legal claims in this specialty, including: the precise determination of the presence of injuries, missing treatable injuries, pre-existing problems, interpreting injuries and delays in diagnosis.

In the second part of this article, I will discuss the impact of NHS targets on treatment of facial trauma, as well as other issues such as patient consent, confidentiality and compliance, which could all arise in litigation.

6. Treatment in a timely fashion within the confines of NHS targets.

Unlike cancer treatment, there are currently no universally accepted targets within which injuries can be left safely before treatment becomes necessary. The exceptions to this are the management of the knocked out tooth and a few other rare emergency conditions. With all other injuries it is often a matter of opinion, and these differ. This may be reflected in disagreements between specialists in medical reports.

Furthermore, acceptable 'times to treatment' may conflict significantly with other NHS 'targets'. For instance, whilst the management of most facial fractures can be safely deferred several days or longer if necessary, successful management of the avulsed (knocked out) tooth is much more time dependant - there is good evidence to suggest that this should be replaced within 1 hour of injury. Yet current waiting time targets in A&E are up to 4 hours. Considering the nature of life / limb and sight-threatening injuries and medical emergencies that most A&E departments regularly contend with, it can be hard to justify or ensure any policy that dictates that the patient with an avulsed tooth should always 'jump the queue'. Similarly, urgent outpatient CT scans in facial trauma should enable treatment to be undertaken within a few days of injury, yet a two week delay (acceptable for 'cancer' patients) is often regarded as an acceptable standard for trauma.

Our ability to treat patients in a timely fashion is also greatly influenced by the pressures on the entire service and whilst all injuries should ideally be managed within relatively short deadlines the justification for relatively minor injuries to be expedited to the detriment of urgent cases, cancer patients and 'long waiters' can at times be difficult. Delays are therefore often unavoidable.

An especially difficult problem is the uncooperative patient (often a child) who requires a general anaesthetic to replace a knocked out tooth. Parents may attend with expectations of immediate treatment. However, current guidelines or a lack of fasting may result in refusal of a general anaesthetic late at night, for a non 'life or limb threatening' condition. This will inevitably lead to a significant delay and increased risk of loss of the tooth.

7. Lack of "Specialist" care

Not all fractures require surgery. The decision to operate is made jointly between the patient and surgeon, following careful assessment and weighing up the risks and benefits of treatment. However, on occasion patients attend expecting an operation, having been told they will need one. They may then be somewhat affronted when they are told that in fact, they do not and this undermines confidence. Referring practitioners should always refer for an "opinion", not for an operation.

Furthermore, not all facial injuries, notably lacerations, need to be referred to a 'specialist'. But this is increasingly becoming an expectation. However, the reality is that even if referred to a specialist service, the patient may not necessarily be treated by the most senior member of the team - facial lacerations and many simple fractures are often repaired by trainees, not consultants. That said, outcomes are dependant on an individual's competencies and not the simple fact that they are a 'specialist', or consultant. Excellent outcomes are quite achievable by 'non specialists', including nurses trained in suturing. Indeed, not all facial surgeons regularly manage or have an interest in facial trauma. Thus a referral to a specialist is no guarantee of outcomes. That said, as clinicians it beholds us to always work within our sphere of competencies and refer on if necessary.

8. Consent issues

Obtaining 'appropriate' informed consent can often be problematic. Current guidance is somewhat vague and it is left to the discretion of the consenting clinician as to what should be discussed. Terms like 'common' and 'severe' are poorly defined and are a matter of personal opinion, particularly now with the Montgomery ruling. This is open to exploitation as it is clearly not possible to discuss every conceivable complication that may occur during surgery. For example, even a simple skin incision can be complicated by pain, swelling, bruising, wound breakdown, infection, haemorrhage, unfavourable scarring, stretching, increased pigmentation, loss of pigmentation, numbness, weakness, damage to underlying structures….all of which can be a subject to the Montgomery rule - and that's just the incision!

Some complications are so rare that they may not be recalled during the consent process. Furthermore, when patients ask 'what's the risk?', the figure quoted is usually that which has been published in the literature. Of course, what they really want to know is 'what's the chance of this complication occurring in the hands of the surgeon who will be operating?' - something that is impossible to know.

Not surprisingly then, some consent forms may be considered to be lacking when it comes to litigation. For example, blindness, skull fractures and even some rare but serious brain-related complications, have all been reported following routine nasal surgery. Similarly, 'avascular necrosis', with partial loss of the jaw or its teeth has also been reported following injuries and elective surgery. Permanent discolouration of the eyelid can occur following injury or surgery. Such complications are as rare as the proverbial 'Hen's tooth', but nevertheless potentially devastating for the patient - one would think. Yet interestingly, I have encountered patients where loss of sight in one eye has not been considered serious, on the basis that they have two! On the other hand, eyelid discolouration or the loss of a tooth may be considered a major complication in other patients. Failure to restore the patient's appearances precisely is also difficult to guarantee - there will often be some residual stigmata, which they may not be happy with.

Consent is therefore a major medicolegal headache, which requires extensive, careful, full and often frank discussion with the patient and sometimes other interested parties. Just like crossing the road, we have to accept the risk of a devastating outcome - we could be hit by a car. Surgery is the same. All precautions are taken, but some risks remains. Nobody dies from an isolated broken nose, but in theory at least they could if they have an operation to straighten it.

9. Giving out information to a third party.

The devastating consequences of divulging patient information to a third party, especially over the phone, have previously been reported in the press and can be disastrous. Unfortunately people can be very deceptive. We never really know who we are talking to and a healthy degree of scepticism may save embarrassment or complaints later. Whilst we all want to help the police in their investigations, this cannot override patient confidentiality. Even acknowledging that a patient is / was seen, is a breach of confidentiality. These breaches can occur despite the best of intentions. Potential traps include

1 Police enquiries following assaults or accidents

2 High profile media cases

3 Relatives wanting to 'speak privately'.

4 Cold calls and unannounced visits.

5 Patients 'GP' or 'family friend' calling - clinicians need to be satisfied they are talking to a bona fide person - people can be devious.

6 Leaving messages on a family answer phone.

7 Care is also required when divulging the circumstances of how an injury occurred - Anecdotally the circumstances resulting in the injury may be somewhat suspicious.

Whenever possible clinicians should therefore ask the patient for their consent to speak to third parties, at the earliest opportunity. If it's an assault or road accident, the police and family may well be calling for information soon.

Aftercare

Appropriate follow up and advice should always be offered to patients. Not all patients require a specialist referral or specialist review, but if not, they do need to

be given appropriate advice, including what problems they should look out for and when it may be necessary for them to return. All patients with fractures involving one of the sinuses, even if only suspected, (i.e. most facial fractures involving the cheeks and upper jaw) should be advised 'Don't blow your nose". The concern here is that forceful blowing of air (and bacteria from the nose) through the fractures into the soft tissues will result in severe infection. Simple advise, but easily forgotten. Facial lacerations are also another source of dissatisfaction and litigation. Whilst not all need to be treated by a 'specialist', aftercare is an important part of the treatment package and has a significant impact on the final cosmetic result. All, but the most trivial of lacerations should be followed up by an 'appropriately qualified' clinician - this of course is subject to varying interpretations.

However patients themselves also need to take an active role in their aftercare, as directed by their doctor or specialist. Outcomes are often improved when a patient is highly motivated. Currently the 'invisible scar' does not exist, even in the most experienced of hands and patients should therefore never be promised this. Unpredictable factors outwith our control may adversely influence healing. All injured teeth carry an uncertain prognosis and therefore all dental injuries need to be followed up by the patient's dentist.

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THE PRIMACY OF INDEPENDENCE AND OBJECTIVITY IN EXPERT EVIDENCE – A REVIEW OF EXP V BARKER [2017] EWCA CIV 63.

By Jonathan Godfrey LLB – Barrister, Parklane Plowden Chambers, Leeds
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For those medical practitioners involved as experts in the medico-legal field, the Court of Appeal decision in EXP v Barker [2017] EWCA Civ 63 is a salutary read reinforcing the principles of independence and objectivity in the provision of expert evidence.

The Background Facts

The Defendant brought an appeal as against the decision of Kenneth Parker J of 7th May, 2015. He had decided that the Defendant was negligent in failing to identify and report the presence of a right middle cerebral artery aneurysm in the course of his review of an MRI scan of the Claimant's brain in April, 1999.

In March, 1999, the Claimant, a barrister, experienced visual disturbance. An MRI scan was organised and was subsequently reviewed by the Defendant, a then consultant neuroradiologist. By 2011, the Claimant had been appointed a district judge. On 8th September, 2011 she collapsed in her home and lost consciousness. A CT scan revealed an acute parenchymal haemorrhage centred on the right temporal lobe. The bleed had been caused by a ruptured aneurysm. Emergency surgery was performed.

At the trial at first instance the issue was relatively narrow, namely whether the MRI scan in 1999 did indicate the presence of an aneurysm which a reasonably competent neuroradiologist would have identified and reported. Each side instructed their own neuroradiologist expert. Dr Butler for the Claimant and Dr Molyneux for the Defendant. Each side instructed neurosurgical expert evidence from Mr Kirkpatrick and Mr Byrne, respectively. Mr Byrne's reports went almost exclusively towards causation. As it happened causation was conceded shortly before trial.

There had been a court direction in the case which specified that "experts will, at the time of producing their reports, incorporate details of any employment of activity which raises a possible conflict of interest". During the course of cross examination at trial it emerged that "the connection between Dr Barker and Dr Molyneux had been lengthy and extensive". In particular, Kenneth Parker J at Paragraph 52 of his judgement noted:

i. Dr Molyneux had trained Dr Barker during his 7 years of specialist radiology training and in particular had trained him for 2 ½ years as a registrar and senior registrar in neuroradiology;

ii. They had co-authored a paper for the 14th International Symposium on radiology. The paper was not shown on Dr Molyneux's list of publications on his CV. Dr Molyneux also informed the court that they may have co-operated on other papers which he could not specifically recall;

iii. Dr Molyneux had helped Dr Barker to obtain foreign placements; and

iv. Dr Molyneux and Dr Barker had been officers together on the committee of the British Society of Radiologists.

No connection had been raised by either the Defendant nor his expert.

It also emerged during the course of the trial that Dr Barker had requested that Dr Molyneux should be the defence expert. Further, Kenneth Parker J expressed himself to be "taken aback" by the fact that in an unguarded moment Dr Molyneux referred to the Defendant as "Simon", which although not his first name, is the familiar name by which he was known.

Furthermore, Dr Molyneux also knew that his neurosurgical colleague instructed in the case, Mr Byrne had relied on research ("ISUIA") which was highly criticised and yet Dr Molyneux had done nothing to bring this to the attention of anyone. He had been an executive committee member of ISUIA and could have been expected to know of the criticisms of the study. He would have known therefore that Mr Byrne's neurological evidence, which might be given, was "seriously deficient and misleading". The explanation offered that it was not within Dr Molyneux's remit to comment on any aspect of the neurosurgical evidence was one that Kenneth Parker J found "difficult to accept". He described this matter as something which "again raised doubts in my mind about Dr Molyneux's evidence in this case".

Reasoned Desicion at First Instance

Kenneth Parker J considered that the failure to disclose the connection between the Defendant and the defence expert was "a very substantial failure indeed", the more so in that there had been the specific direction provided by way of case management regarding disclosure of any conflict of interest.

Kenneth Parker J was invited by Counsel for the Claimant to totally exclude Dr Molyneux's evidence. He indicated that he had come very close to ruling that Dr Molyneux's evidence was inadmissible but declined to

do so. He recognised that Dr Molyneux was an eminent neuroradiologist but that where, as in the instant case, the core issue turned upon the court's ability to evaluate the finely balanced medical judgments of the respective experts, the court's confidence in the independence and impartiality of those experts must play an important role. Accordingly, Kenneth Parker J remarked that it was "with considerable regret, that by reason of the matters set out earlier in this judgment my confidence in Dr Molyneux's independence and objectivity has been substantially undermined". Whereas, on the other hand, he had complete confidence in the independence and objectivity of Dr Butler, and that he much preferred to accept his judgment, formed on his great experience and skill.

The Synopsis of the Court of Appeal

The Defendant appealed. The first generic ground of appeal as to whether the Bolam test had been properly formulated and applied was dismissed by the court. The other generic ground and main ground of appeal related to the approach taken by Kenneth Parker J in relation to the consideration of the expert evidence of Dr Molyneux. The Court of Appeal in the judgment of Irwin LJ determined that the trial judge had considered that the witness had so compromised his approach that the decision to admit the evidence was finely balanced, and that the weight to be accorded to his views was "considerably diminished". The Court of Appeal considered that he was "fully entitled to take that view" and proceeded one stage further in stating "indeed, had he decided to exclude Dr Molyneux's evidence entirely, it would in my view have been a proper decision".

Moreover, the Court of Appeal considered that there was good reason for doubting Dr Molyneux's approach to the "problem in hand" about the ISUIA evidence. The scrupulous expert in Dr Molyneux's position should be "pointing out the problem to the legal team well ahead of trial".

Conclusion

The precursor of any consideration of expert evidence is best referenced by CPR 35.3 which clearly sets out that the duty of the expert is to help the court with matters within their expertise and that this duty overrides any obligation to the party providing instructions or payment. Barker aptly demonstrates the importance of independence and impartiality in the provision of expert evidence. In his judgment at Paragraph 51, Irwin LJ sets out the position succinctly in stating "our adversarial system depends heavily on the independence of expert witnesses, on the primacy of their duty to the Court over any other loyalty or obligation, and on the rigour with which experts make known any associations or loyalties which might give rise to a conflict".

In practical terms, any conflict of interest should be communicated by the instructed expert upon consideration of initial instructions. In most cases, this would result in the instruction of an alternative expert, but in those rare cases where the continued instruction of the expert is a likely formality (such as a limited pool of specialist expert evidence in the area concerned), full and frank disclosure of the interest should be made to the other party as soon as possible. Echoing the views expressed by Irwin LJ in Baker and enhancing upon their direction, resonance is to be had to the dicta of Judge Davis in the South African case of Schneider NO & Others v AA & Another (5) SA 203 (WCC) (a non-clinical negligence case) in which it was stated:

"Agreed, an expert is called by a particular party, presumably because of the conclusion of the expert, using his or her expertise, is in favour of the line of argument of the particular party. But that does not absolve the expert from providing the court with an objective and unbiased opinion, based on his or her expertise, as is possible. An expert is not a hired gun who dispenses his or her expertise for the purposes of a case..."

Jonathan Godfrey came to the Bar in 1992 and now specialises almost exclusively in clinical negligence work. His expertise covers the whole breadth of clinical negligence work from orthopaedic injury to cancer misdiagnosis and cerebral palsy birth injury. Jonathan has joined the SpecialistInfo Medico-Legal Training Team and will be the lead for our Clinical Negligence Courses from January 2018.

MEDICAL EXPERTS' TIPS FOR LAWYERS

By Mr Peter Mahaffey, Consultant Plastic Surgeon, Pinehill Hospital, Hitchin, Herts

Peter Mahaffey is a plastic surgeon and expert witness, with nearly 30 years' experience, specialising in hand surgery, the sequelae of soft tissue injuries and problems after skin laser treatments. He can be contacted on pjm2cu@gmail.com

Medico-Legal Magazine's issue number 5, featured lawyer Andrew Gray of Truth Legal providing some timely advice to medical consultants in his article entitled 'Claimant Interview Tips for Medical Experts'. Doctors providing medical reports and for better or worse, often enjoying little contact with their instructing solicitors beyond in-direct correspondence, will have valued his advice. But they'll also have a number of points they would like to convey to those solicitors who ask for their opinions. If only there was a better forum in which experts and solicitors could meet occasionally on an informal basis to exchange their views. Perhaps one day that will come, but in the meantime, perhaps I can offer a few thoughts to the legal profession that crop up regularly in the course of my own many years of medico-legal practice.

1. Direct instructions or via an agency?

Once upon a time, solicitors had their favourite experts and sent instructions directly. Directories such as that created by SpecialistInfo are designed to help this process. Now, to the mystification of many experts, instructions frequently come via intermediary agencies. Some of these agencies are excellent, but some less so. When lay desk staff is interposed between solicitors and medical professionals, communication is bound to suffer, and to be prolonged through extra steps. Clearly, solicitors must see administrative advantages to seeking their experts through an agency. But from the other side, doctors see inevitable misunderstandings when, for example, a list of questions is submitted in response to a report and comes via the agency. Who do we reply to? The terms of the agencies mostly prohibit direct communication with the solicitor, and yet the act of picking up the phone to a solicitor for clarification can be invaluable.

2. Medical records

It's surprising how many times these are incomplete. For example the hospital treatment record is sent but the emergency department notes are missing. Or the records from GP, hospital and other treatment centres arrive in dribs and drabs. Or the relevant report of a former expert is missing. It would not be beyond a combined panel of doctors and lawyers to produce a simple universal checklist which could avoid these situations.

And when we do get all the records, there's another hurdle . . . . digitisation! In theory, this should help by removing the need to transfer vast bundles of paper notes. In practice the situation is not always better. Experienced doctors instinctively find their way quickly around paper treatment records. But when those records have been randomly scanned by a filing clerk, sometimes sideways to the left, to the right or even upside down, the situation becomes a nightmare to assess on-screen. Often it takes more rather than less valuable time to examine such records. Instructing solicitors need to understand that. And if we're going paperless, to ensure we receive the passwords that are frequently missing!

3. X-rays

Old x-ray records are mostly sent on disc and this is a big plus in terms of more compact information. But it is surprising how many different digital systems there are in UK hospitals alone. Each requires its own set of instructions to allow access and very commonly these are not clearly explained. That can easily involve another 15 minutes of head-scratching for the expert. And when, during or following the medico-legal consultation, we need a fresh x-ray, there is frequently a delay produced because of the necessity to obtain permission. Whilst its perfectly understandable that cost control is important, sometimes access to the solicitor by phone would result in a swift pragmatic decision. Worst of all is when an immediate decision is not forthcoming because of the need to go through an intermediary agency and the poor claimant has to be sent away, perhaps many miles, to return another day.

4. Patient ID

Because of instances of impersonation, it's understandable that solicitors and agencies are more and more asking doctors to confirm that the claimant in front of them is the one who really is the solicitor's client. But it's surprising the number of times the claimant, when asked for passport or driving licence, simply replies "I was never told to bring it!"

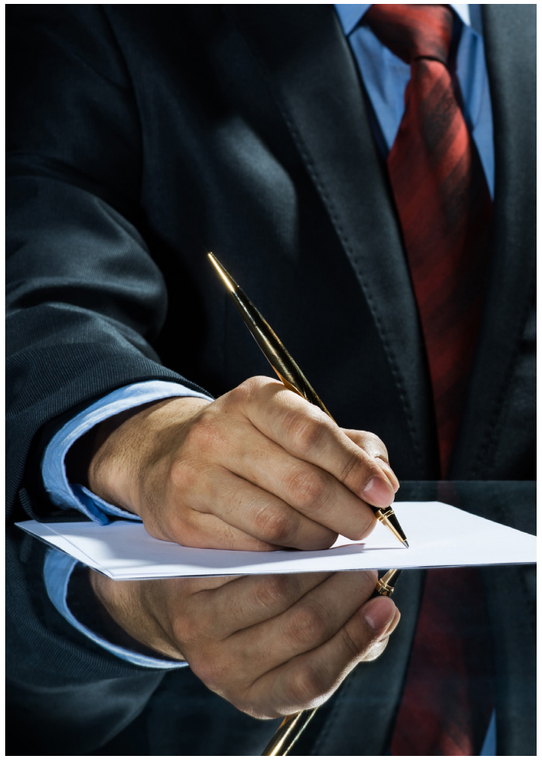
5. Requests for alteration of a report

A touchy subject amongst experts! Yes, of course, if we've missed something or expressed something poorly then most experts are only too happy to make an appropriate correction prior to service. But if a claimant goes home, and decides he/she has forgotten to tell us something despite a comprehensive interview, then it's hardly fair to ask us to review our report, make alterations, re-type, review and re-despatch at zero cost. And most contentious of all, when a claimant or solicitor reads the report and decides that an expert's opinion given in good faith doesn't do their case any good, is when the request comes for an alteration. We usually get sent copies of CPR 35 reminding us that our obligations are to the court and so it's embarrassing and frustrating to be put in this position. As I've already pointed out above, this can be the ideal time for an expert to have ease of access to pick up the phone and have a few friendly words with the solicitor. But it isn't that easy when there's an intermediary agency. And that's when heels tend to get dug in.

6. Fee payments

On the whole, not a problem, although as an expert, I do occasionally wonder if solicitors forget that doctors also need to feed their families. Or so it seems when invoices can take many months to settle. Yes, we can all set our terms and conditions, but most doctors seriously dislike chasing fellow professionals for bills for which, of course, we'll be taxed on via the invoice, irrespective of whether settlement has arrived. Even more do we dislike asking for payment for reports up front, which sometimes becomes necessary after defaults.

Over the years, I've enjoyed the happy relationships I've had with good lawyers in the course of responding to instructions for expert reports. As in all walks of life, its ease of communication which avoids almost all problems and which usually makes medico-legal work a professional pleasure. Let's talk!



MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

A round-up of news in the industry for the third quarter of 2017.

PI market continues to grow

According to a consultancy IRN Research report in September, the PI market continues to grow modestly in value terms and is worth almost £4bn a year, but it predicts the market will suffer in 2019 as government reforms begin to take effect.

Fixed fees for lower value cases, a tariff system for setting RTA claim damages and an increase in the small claims limit are likely to hit next year.

A survey of a panel of law firms confirmed the nervousness in the sector with only 35% of those surveyed expecting increases in workload in the next 12 months (compared to 48% in 2016).

All brackets of personal injury damages have been increased to reflect inflation (an increase of 4.8% compared to two years ago). For example, a whiplash injury lasting 3 months will now be awarded between £1,200 and £2,150 (up from £1,160 to £2,050).

More details on their site:
www.lawgazette.co.uk/news/pi-market-a-year-from-cliff-edge-as-damages-set-to-rise/5062978.article

Fixed Costs in Clinical Negligence

The timescale for the introduction of fixed fees for personal injury cases was delayed again this September.

While Lord Justice Jackson supported the concept of fixed recoverable costs (FRC), he also said health ministers and the Civil Justice Council should set up a working party, including claimant and defendant representatives, to develop a bespoke process for clinical negligence claims initially valued up to £25,000.

The Society of Clinical Injury Lawyers has always rejected the idea of fixed costs for its sector, and members of the group met in parliament to speak directly with MPs.

'We believe the most important issue here is patient safety – if there can be improvements and lessons learnt then the level of negligence will be reduced,' said chairman Stephen Webber. 'I do not accept the position of others who say FRC is inevitable.'

The Department of Health has yet to respond to its own separate consultation on fixed costs, a reform which the National Audit Office says will save £90m a year by 2020/21.

More details on their site:
https://www.lawgazette.co.uk/news/fixed-costs-fury-builds-as-timetable-slips-back/5062849.article

A National Audit Office Report: Managing the Costs of Clinical Negligence in Trusts

According to a report from the National Audit Office (NAO), in the last 10 years (2006/7-2016/17) the number of clinical negligence claims registered with NHS Resolution (formerly the NHS Litigation Authority) has doubled from 5,300 to 10,600, with the cost rising from £0.4 in 2007 to £1.6 billion in 2017.

The NAO report, published on 7 September 2017, lists the contributing factors and action taken to address this unsustainable rise in negligence costs.

The main contributing factors were identified as: increasing NHS activity, legal reforms, high value birth injury claims, increased life expectancy and cost of care, and low- and medium-value 'no-win-no-fee' agreements.

Proposed or ongoing actions to address rising costs include: engaging with trusts on patient safety issues, improved maternity care, repudiating claims without merit, alternative dispute resolution schemes, challenging excessive legal costs, and introduction of fixed claimant legal costs for claims up to £25,000.

Read more at: www.nao.org.uk/report/managing-the-costs-of-clinical-negligence-in-trusts/

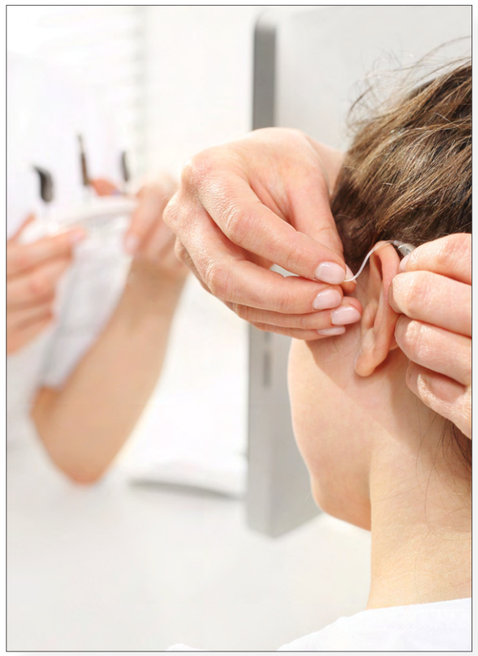
Five years of cerebral palsy claims

This thematic review of NHS Resolution data presents a detailed analysis of cerebral palsy claims, identifies the common problems and provides recommendations for improvement to reduce the incidence of avoidable cerebral palsy.

Written by: Michael Magro BSc(Hons) MBBS MRCOG, Darzi Fellow, NHS Resolution

Published this September it is available as a PDF:

Read more at www.nhsla.com/Safety/Documents/Five%20years%20of%20cerebral%20palsy%20claims%20-%20A%20thematic%20review%20of%20NHS%20Resolution%20data.pdf



Fixed costs for noise -induced hearing loss (NIHL) claims

There is one area where fixed recoverable costs now seem inevitable, after the Civil Justice Council (CJC) published a report making recommendations for FRCs and improvements to claims management for NIHL cases.

Andrew Parker, chair of the NIHL working party and CJC member, said: 'It is in both claimants' and defendants' interests that these claims are handled efficiently by both sides in the initial pre-issue stages, to avoid unnecessary costs being incurred and to ensure that all parties get the earliest possible resolution of a claim.'

More details on their site:

www.judiciary.gov.uk/wp-content/uploads/2017/09/fixed-costs-in-noise-induced-hearing-loss-claims-20170906.pdf

MDU Advice
on Protecting patient data

The MDU have emphasized that doctors must make sure that identifiable patient data is not improperly disclosed in any circumstances: an inadvertent breach of patient confidentiality could result in a trust disciplinary or GMC investigation.

Under the Data Protection Act 1998 (DPA), those responsible for patient data are legally obliged to store it securely and protect it from unauthorised or unlawful processing.

The GMC's guidance on confidentiality states that 'you must make sure any personal information about patients that you hold or control is effectively protected at all times against improper access, disclosure or loss'.

Communicating via mobile apps

NHS guidance for doctors using mobile apps which lack proper security features, such as WhatsApp, advises that they 'should never be used for the sending of information in the professional healthcare environment.' WhatsApp 'does not have a service level agreement with users and has no relevant data security certification' and, as such, should not be used to send patient information or details of clinical cases to colleagues.

Data storage on portable devices

Portable storage devices devices are vulnerable to loss or theft, so security and best practice should be prioritized. Identifiable personal data on personal mobile devices, such as memory sticks, laptops or personal mobile phones, which risk being misplaced or accessed by other people, should be avoided.

Transfer or storage of information should be in line with each trust's information security policies, and professional and personal data should not be mixed.

If any data is lost, the incident should be reported to the nominated person in the organisation immediately. Appropriate action can then be taken and patients informed, as necessary.

www.themdu.com/guidance-and-advice/guides/protecting-patient-data

NICE

NICE put its first draft guidance on Lyme disease out for consultation until November 2017

Lyme disease cases in the UK confirmed by laboratory testing rose from 346 in 2003 to about 1000 in 2015. Public Health England estimates there are around 2,000 to 3,000 new cases of Lyme disease in England and Wales each year. Lyme disease is a notifiable disease in Scotland, but not currenlty in England and Wales.

An alleged failure to diagnose the disease is the most common reason for complaints and claims about Lyme disease.

NICE draft guidance aims to raise the profile of the disease amongst general practitioners, encouraging them to consider the disease among their list of potential diagnoses, when relevant, and to be aware that there are various clinical manifestations of Lyme disease.

The guidance recommends that patients who present with a characteristic rash, erythema migrans, should be treated for Lyme disease without the need to resort to laboratory testing.

GPs should advise patients to take precautions against tick bites if they're visiting high risk areas, especially in spring and summer when ticks are most active. NHS Choices provides advice on preventing tick bites.

The consultation runs until 6 November 2017, with the final guidance expected in April 2018.

www.nice.org.uk/guidance/indevelopment/gid-ng10007/consultation/html-content-2

Personal injury discount rate reform cautiously welcome

After a consultation that closed this May, draft legislation has been published this September to change the law relating to the personal injury damages 'discount' rate. It will now be set by reference to rates of return on 'low risk' rather than 'very low risk' investments. The rate will also be reviewed at least every three years in future.

Lord Chancellor and Justice Secretary David Lidington said: 'We want to introduce a new framework based on how claimants actually invest, as well as making sure the rate is reviewed fairly and regularly. In developing our proposals, we have listened carefully to the views of others, and we will continue to engage as we move forward.'

The insurance industry, which lobbied hard for the change, claims it is fairer for claimants, customers and taxpayers. Brett Dixon, president of the Association of Personal Injury Lawyers, believes the discount rate must be set to meet the needs of catastrophically injured people.

'Someone with a life-long, life-changing injury such as brain damage or a spinal injury cannot afford to take any risks with how his compensation is invested.'

Simon Kayll, CEO of the Medical Protection Society, said:

"It is vital that Government gets this right if we are to avoid further sudden shocks to the cost of compensation, and the proposed new framework is a welcome step which could result in a more common-sense approach with the reality of how claimants invest compensation payments at its core. It is however dependent on implementation - the new framework will only apply if and when the proposed law is enacted and it will not apply retrospectively."

MEDICO LEGAL MAGAZINE

NEW MEDICO-LEGAL TRAINERS JOIN THE SPECIALISTINFO TEAM

SpecialistInfo are pleased to announce that they have recruited another three experienced partners to our training faculty from 2018. Jonathan Godfrey and David de Jehan are barristers from Parklane Plowden Chambers in Leeds, specialising in clinical negligence, and Andrew Gray is Managing Partner and owner of Truth Legal in Harrogate and specialises in personal injury.

Jonathan Godfrey – Barrister LLB (Hons)

Clinical Negligence and Personal Injury Experience

Jonathan specialises almost exclusively in clinical negligence work as his repeated recommendations in the Legal 500 attest. His expertise covers the whole breadth of clinical negligence work including orthopaedic injury, cancer misdiagnosis, cerebral palsy birth injury, surgical mishap and wrongful treatment and consent.

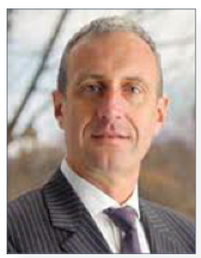
Jonathan also undertakes cases concerning negligence and/or assault in football, rugby and other sporting activities. He has been specifically recommended by the Legal 500 as being an "expert in sports related injuries".

Jonathan has considerable and invaluable experience in conducting conferences with medical experts of all disciplines and often on a multi expert basis. Jonathan regularly undertakes JSM's and in doing so has achieved very favourable and high value settlements.

Training Experience

Jonathan is an Accredited Advocacy trainer for the NE Circuit and an Inner Temple Advocacy Trainer. He regularly lectures at Avma local and regional conferences on all aspects of medico legal topics.

Jonathan is based in Leeds at Parklane Plowden Chambers.
parklaneplowden.co.uk/barristers/jonathan-godfrey/



David de Jehan – Barrister LLB (Hons), LLM (Commercial Law)

Personal Injury and Clinical Negligence Experience

David represents both claimants and defendants in a wide range of claims, including complex Clinical Negligence, most recently in the ODPL II Group action (over 1,000 Claimants).

Specialises in:

- Catastrophic injury claims - head injury, spinal injury, amputation;
- Clinical Negligence, including Dentists and Opticians;
- Human Rights in Clinical Negligence and personal injury;

• Schools and Pupil litigation;

• Sports, Travel and Adventure Activity Litigation - skiing, boarding, mountaineering, parachuting, football and rugby including failed equipment both for claimants and defendants (companies, instructors, coaches and guides);

• Nervous Shock;
• Health and Safety Law - David forms part of Chambers' specialist team of Health and Safety barristers.

• Gas escapes, poisoning and explosions.

Training Experience

David is an Accredited Advocacy Trainer (ATC) and teaches established and trainee Barristers Trial and Court-room skills; he is a founding Member of the Joint Professionals Forum Lectures, at which members of various professions are brought together to discuss pertinent legal and professional topics.

David is based in Leeds at Parklane Plowden Chambers.
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Andrew Gray – Solicitor LLP

Personal Injury Experience

Andrew is the founder and Managing Director of Truth Legal Solicitors, a rapidly growing ethical law firm of specialist personal injury claim solicitors, established in 2012, and based in Harrogate, North Yorkshire.

He is Vice-President of Harrogate and District Law Society and trustee of the Harrogate Hub charity.

Previously he was a Trade Union personal injury solicitor, specializing in accident and assault representation, for the largest and most experienced personal injury law firm in the country.

Training Experience

Andrew is the President of the Golden Triangle Group of BNI, business networking events for North Yorkshire. He has delivered numerous talks on violence in the workplace to trade union members.

Andrew can be contacted on: andrewg@truthlegal.com
For more information visit: www.truthlegal.com

All three are looking forward to interacting with our expert witness training delegates in 2018.

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