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MAGAZINE

ISSUE 5

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Welcome to Issue 5

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

We certainly had a turbulent few weeks since the last issue, with the triggering of Article 50 and a hung parliament likely to impact on future legislation in this sector. The Queen's speech in June announced the new Civil Liability Bill and Patient Safety Bill, which survived the Conservative's manifesto cull (see our 'News' article for further information and links).

In this issue we present topical articles, including the options for healthcare messaging, once the new European data regulations (GDPR) come into force next spring; the perceived risks of DNA technology in healthcare for medical insurers; and the work of the Centre for Health and Public Interest (CHPI) in raising concerns over the safety of patients in private hospitals.

We hear about the work of the Parliamentary and Health Service Ombudsman (PHSO), including advice on how healthcare professionals should deal with patient complaints; and a personal injury lawyer offers suggestions for experts on how best to conduct claimant interviews.

We are also pleased to include articles on the most common medico-legal issues in the Gynaecology and Maxillofacial Surgery specialties.

Once again the magazine will be circulated to more than 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 90,000 UK consultants and GPs, including approximately 8,800 consultants and 2,700 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

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 types of ML courses that we are holding during 2017 are listed opposite with links to our booking page.

New courses for 2018 – details to be confirmed soon!

Standard (Personal Injury) Medico-Legal Course
(General Overview for anyone starting a medico-legal practice):

- *13th September 2017* – **London** *(Limited places left)*
- *22nd November 2017* – **Manchester**

£330 (plus VAT)

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

Advanced Medico-Legal Course
(for those who want to update their knowledge):

- *6th December 2017* – **London**

£355 (plus VAT)

For further information about the Advanced 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):

- *4th-8th September 2017* – **Leeds**
- *18th-22nd September 2017* – **Manchester**
- *2nd-6th October 2017* – **London**
- *6th-10th November 2017* – **London**
- *11th-15th December 2017* – **London**

£1,700-£2,100 (plus VAT)
(or £420 plus VAT per day if split into Modules)

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

Clinical Negligence Medico-Legal Course
(we recommend moving onto this course only after some basic training has been completed):

- *14th September 2017* – **London**
- *23rd November 2017* – **Manchester**

£355 (plus VAT)

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

Court Room Skills Medico-Legal Course
(mock court sessions with realistic cross examination):

- *15th September 2017* – **London**

£440 (plus VAT)

For further information about the Court Room Skills course, please visit: www.specialistinfo.com/a_ml_courtroom.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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FACILITATE EXPERT SOLUTIONS TAKES THE STRESS OUT OF RUNNING YOUR BUSINESS

By Claire Labio, Practice Director, Facilitate Expert Solutions Limited

Running a business is hard, not least having to learn a whole new skill set to stay on top of the paperwork and ensure the smooth running of a medico-legal practice.

In an ideal world, you would have have admin staff and an accounts team to look after such matters for you but the reality is not everyone can afford it nor do some practices warrant those additional costs. Many of the experts we look after have a full time NHS practice which they supplement with weekend drafting of reports to build their medico-legal client base. This means that every bit of their time is taken up with working and trying to build work for the future. We understand that pressure and know how best to assist. After 21 years' experience in the Medico-Legal field we offer a range of services to leave you free to concentrate on running the business and attracting new clients and servicing the important current ones.

We can help you with all aspects, including invoicing and chasing payment, providing monthly reports to you so you can easily see where your finances are up to, together with producing reports to assist with your annual accounts/VAT and liaising with your accountant.

We exhibited recently at the British Medical Institute. During a breakout session an expert approached the stand and asked if we provided typing support as that was what he really needed. The company he had been using could only return typing to him in 7 days and he did not think that was good enough. We completely agreed! We offer diary assistance and typing support which is carried out by experienced legal secretaries, such typing is returned within 24hrs.

Facilitate Expert offers three different service packages, to suit businesses of all sizes and needs.

The Bronze package is our Basic Fee Collection Service – where we will chase your clients for outstanding fees and you pay us (between 2% and 5% depending on practice size) of the fees received.

Our Silver package includes the Basic Fee Collection Service as above plus management of your accounts. If you do not currently have an accounts package the fee of 7% of fees received would also include the purchase of one.

Finally, the Gold package is everything from the Bronze and Silver package as well as our Practice Management service and the smooth running of your diary, for just 12% of fees received – giving you back the time to do the parts of the job that you love.

Many experts have said they see advertisements all the time for companies to assist with their practice management or chasing of outstanding debt but they would rather go on personal recommendation than choose someone from an advert or email offer.

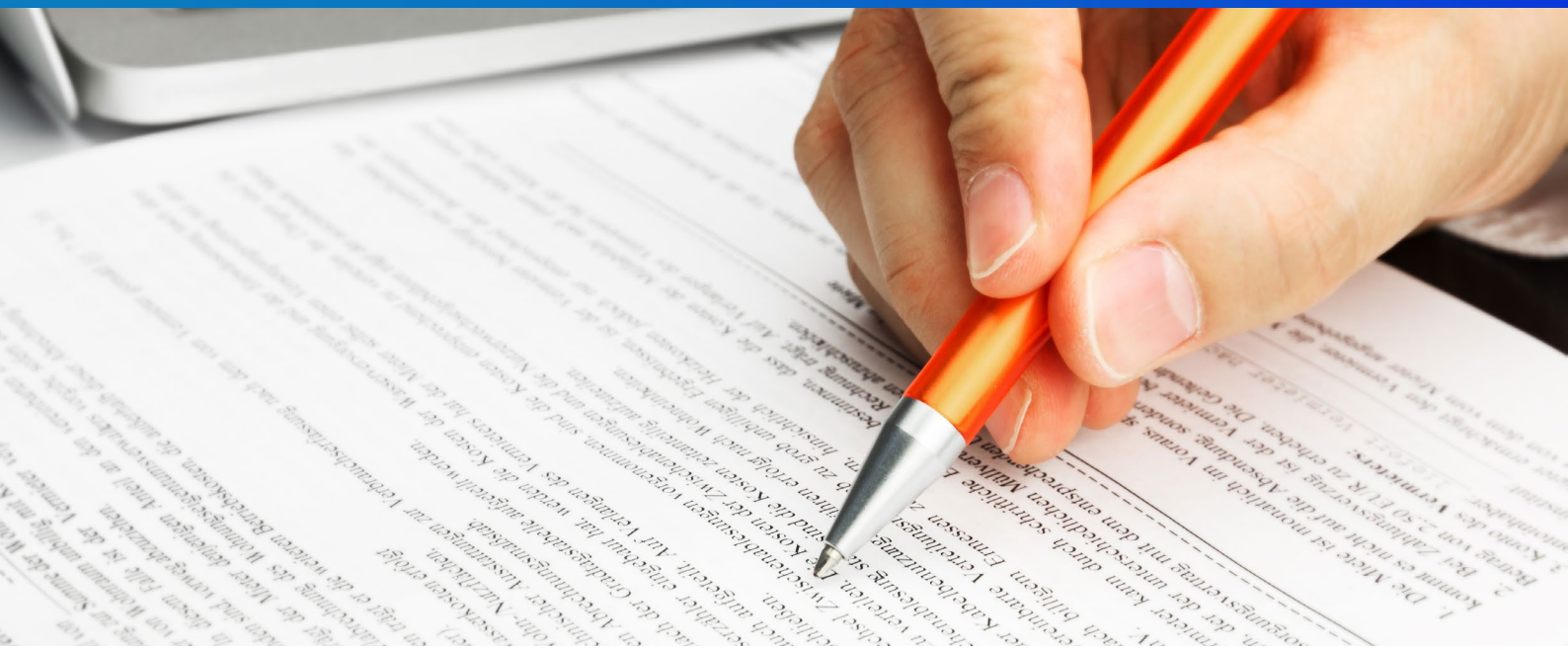
Professor Gus A. Baker, Clinical Neuropsychologist, is one of the experts we look after. He, amongst others have provided us with testimonials to help breakdown this barrier.

Gus tells a story of a visit from a VAT inspector which shocked him enough to employ our services and that of a full time practice manager to run his diary. 'I have now had 18 months of working with Facilitate and the impact has been significant. I no longer worry about the VAT returns, ***they do that***. I no longer chase unpaid invoices, ***they do that***. I no longer have to worry about preparing data for the accountants for my business tax return, ***they do that***. I still retain a practice manager for the management of my business on a day-to-day basis. However, she has a good relationship with Facilitate.

In addition to the services I receive, every month I get a printout of the invoices raised and the deposits into the bank. In respect of the bank conciliation – ***they do that.***

So why would I recommend them? Simply peace of mind and the freedom to do what I am good at. Oh incidentally, I had a VAT inspection recently – passed with flying colours.'

Full testimonials can be found on our website www.facilitateexpertsolutions.co.uk



MEDICO LEGAL AGENCIES:
THE GOOD, THE BAD AND THE UGLY. HOW TO CHOOSE?

By Ben Elsom, Medical Reports Ltd

When choosing and negotiating with medico-legal agencies, you need to consider a number of different factors. How you weigh up the importance of these different factors will depend on your business priorities and strategy.

There are a number of key characteristics that you should look for when identifying and short listing possible agencies as suppliers.

Quality and reliability

The quality of your reports needs to be consistent – your customers associate poor quality with you, not your agencies. Equally, if your agency lets you down with a late delivery or sub-standard report, you may let your customer down.

Number of experts and specialisms covered

Get the agency to identify the specialisms they cover and the number of experts they are contracted with. Also ask if they can supply redacted reports from any expert prior to you instructing them.

Speed and flexibility

Flexible agencies help you respond quickly to changing customer demands and sudden emergencies.

Value for money

The lowest price is not always the best value for money. If you want reliability and quality from your agencies, you'll have to decide how much you're willing to pay for your reports and the balance you want to strike between cost, reliability, quality and service.

Strong service and clear communication

You need your agencies to deliver on time, or to be honest and give you plenty of warning if they can't. The best agencies will want to talk with you regularly to find out what needs you have now and how they can serve you better in the future.

Financial security

It's always worth making sure your supplier has sufficiently strong cashflow to deliver what you want, when you need it. A simple check on the companies house website will help reassure you that they won't go out of business when you need them most.

Certifications

Does the agency hold any certifications such as ISO 9001, ISO 27001, ISO 14001? If they do this would indicate an agency that has detailed processes and

procedures in place and are regularly audited on the services they provide.

Drawing up a shortlist of agencies

Remember biggest does not always mean best!

Once you have got a clear idea of what you need and you have identified some potential agencies, you can build a shortlist of agencies that meet your needs. Ask yourself:

- Can these agencies deliver what you want, when you want it?
- Do they have an extensive database of cross discipline medico-legal experts?
- Can they add experts that are not on their panel that you have used before?
- Are they financially secure? Are there any CCJ'S registered against them, have they posted accounts, what are the capital reserves?
- How long have they been established?
- Can they provide contact details of anyone who has used and can recommend them?

Once you have a manageable shortlist, approach the potential agencies.

Provide a clear brief, summarising what your requirements are and giving an idea of the level of business you hope to place. When you have got the responses, compare the agencies in terms of what matters most to you.

Wherever possible, meet potential agencies face-to-face at their offices and see how their businesses operate.

Before signing a contract with any agency, you should carry out due diligence to check it can fulfil the agreement. You should credit check potential agencies to ensure they have the cashflow to deliver what you want, when you need it.

Drawing up service level agreements with agencies

Draw up a service level agreement that defines the services they must provide and the level of services to be delivered, and which also sets out responsibilities and priorities.

SLAs themselves are contractual obligations and are often built into a contract in the form of one or more clauses or as an entire section. Typical SLAs should set out:

- the service being provided
- the standards of service
- the timetable for delivery
- respective responsibilities of supplier and customer
- provisions for legal and regulatory compliance
- service monitoring and reporting mechanisms
- payment terms
- how disputes will be resolved
- confidentiality and non-disclosure provisions
- termination conditions

Building good relationships with agencies

It pays to invest time in building good relationships with your key agencies. Consider doing the following:

- Meet your contacts face-to-face and see how their business operates. Understanding how your agency works gives you a better sense of how it can benefit your business.
- Keep in regular contact and update them on strategic changes or new products early on. This helps them adapt to meet those changes.
- Ask about their plans for development or expansion. Will this affect the goods or services they're providing to you?
- Help your agencies by placing orders in good time, being clear about deadlines and paying on time.
- Make sure you have efficient purchasing, report control and payment systems.
- Keep an eye open for any opportunities you can pass their way – in a good customer-agency relationship they'll do the same for you.
- Make your business important to your agencies and they will work harder for you. Some agencies may offer better deals if you promise to use them exclusively.

ABOUT THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

By Dr Paul Gray, GP and Clinical Adviser for PHSO

The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on unresolved complaints about the NHS in England, UK government departments and other UK public organisations. We do this independently and impartially. We are not part of government or the NHS in England, nor are we a consumer champion.

We look into complaints where an individual believes there has been injustice or hardship because an organisation has not acted properly, or has given a poor service and not put things right.

We normally expect people to complain to the organisation in question first so that it has a chance to put things right. If, after an organisation has responded, an individual believes there is still a dispute about their complaint, they can ask us to look into it.

We share findings from our casework to help Parliament scrutinise public service providers and more widely to help public services improve. Examples of our reports and publications that have supported policy change and service improvements nationally include our Time to Act report on sepsis, our Midwifery Supervision and Regulation report, and more recently a report on how complaints are handled in Primary Care.

How the Ombudsman investigates complaints

There are a number of issues that we consider when deciding whether we are able to investigate a complaint. These include:

- whether there are signs that the organisation potentially got things wrong that have had a negative effect on the complainant and that haven't been put right;
- whether the complainant has the option of taking legal action instead and would prefer this;
- whether they complained to us within a year of knowing about the issue – there are some exceptions to this.

Once we have decided to investigate the case, it will be passed to a caseworker. If it is a health service complaint, they may seek clinical advice appropriate to the case. For example, if the complaint is about GP care they approach a GP Adviser such as myself and if it is a nursing issue the caseworker will go to the nursing advisers.

What is the role of clinical advisers?

The Ombudsman's clinical advisers all work in the NHS and provide advice for their area of expertise. We provide clear, impartial and timely advice, based on professional standards and clinical guidelines which applied at the time of the events complained about. We have a robust Quality Assurance programme in place which uses a peer-based approach to ensure the accuracy of the clinical advice we give to our caseworkers.

When assessing the standard of care, we do not use the Bolam/Bolitho principle which refers to the 'reasonable body of clinical opinion'. This is because these are tests used in the courts in relation to medical negligence and we make determinations about maladministration and service failure. Where there is an absence of recognisable guidance or standards, the benchmark used is one of 'established good clinical practice'.

Clinical advice is just one part of the evidence reviewed in the investigation of a case and the final decision about whether or not to uphold a complaint lies with the caseworker/investigator.

Good complaint handling in the NHS

The cornerstone of good complaint handling is to accept that there is always room for improvement. Encouraging patients to speak up when things have gone wrong could prevent problems from escalating, save money by avoiding formal complaints and identify areas in need of improvement quicker.

One Senior Clinician we know encourages his staff to actively seek out feedback from patients, carers and

visitors on a daily basis and leads the way by very visibly doing this himself. His team meetings include a standing agenda item on 'how are we doing' to review the feedback they collect, discuss any action needed and review the implementation of changes made.

When they receive a formal complaint, a senior team member calls or meets with the complainant within a couple of days to demonstrate that they take the concerns seriously. This early conversation also helps in understanding the issues and what the complainant wants to achieve. It is also a good chance to explain how the matter will be investigated, how the complainant will be involved and kept updated, and how long it is likely to take.

Clinician also feels it is essential for staff to feel supported and involved in the process, by making it clear that it is a matter for the team and they were not alone. It is not about blame and 'pointing the finger' but rather learning and accountability.

Research around procedural justice shows that the more a person feels that the process has been fair, the more likely they are to accept a decision that goes against them. What people want in complaint decision-making includes:

- a real opportunity to be heard and have input into the process before a decision is made;
- to see how decisions are made via clear, understandable and transparent rules; and
- complaint handlers showing they are acting neutrally by basing decisions on objective information and appropriate criteria.

Top tips for handling patient complaints

- Making a complaint takes courage. Patients often fear that speaking up could affect their care, so be clear that complaints and feedback are welcome as a means of improving services.
- Show patients that complaining will make a difference and promote any changes already made in response to complaints and feedback. People are more likely to speak up if they feel they will be listened to.
- Always look beyond the complaint in front of you to understand what may have led to it. This will help you identify wider concerns, issues or themes.

UPDATE IN SELECTED GYNAECOLOGY MEDICO-LEGAL ASPECTS

By Mr Ellis Downes FRCOG, Consultant Obstetrician and Gynaecologist

Ellis Downes FRCOG is a Consultant Obstetrician and Gynaecologist based in London. He has an active clinical practice, specialising in endoscopic surgery and urogynaecology. He receives over thirty instructions annually and is a member of The Faculty of Expert Witnesses (FEW).

Endometrial Ablation & Bowel Injury

Endometrial ablation has now firmly established itself as an excellent surgical option to treat heavy periods. There are a number of different automated devices available of which Novasure, using bi-polar radio-frequency energy, is the market leader. All these ablation techniques use different energy modalities to essentially destroy the endometrium, the lining of the uterus. This reduces menstrual blood loss and has been shown in clinical studies to be a safe, effective day case/outpatient treatment.

Like all surgical procedures complications, potentially serious can occur. However in studies, endometrial ablation has a much lower complication rate than hysterectomy. The most serious complication occurs if the uterus is perforated, during initial dilation of the cervix or during the placement of the device, bowel injury can occur and the patient may present with life-threatening peritonitis.

Without prompt treatment usually involving a laparotomy and sometimes a stoma the patients life may be threatened. Patients typically have a stormy post-operative course on ITU but thankfully generally recover. A claim generally follows alleging breach of duty.

Having participated in ablation studies, and in the past consulted with manufacturers, during the regulatory process to allow these devices to be used in routine clinical practice, the manufacturers devise a very clear and concise protocol – Instructions For Use (IFU) which is robustly tested in clinical trials. The IFU lists which patients are suitable, and not suitable for each specific ablation procedure and gives a clear step-wise guide as to how the procedure should be performed.

If a complication occurs during endometrial ablation, and it can be shown the surgeon has deviated from the IFU and introduced their own procedures 'that's how I do it', then the case is impossible to defend and prompt settlement is recommended.

Montgomery Principle and Gynaecology

All readers will be intimately familiar with the Montgomery Principle, initially developed following a sad obstetric complication. This firmly established that doctors have a duty to discuss all treatment options with patient, including their risks and benefits, to allow the patient to decide which treatment modality they prefer.

When instructed by a legal colleague following a surgical mishap, one of the first parts of the records I turn to are the outpatient notes where the patient is initially assessed following a GP referral, examined, and a treatment plan formulated. All too often I see poor documentation by the doctor of management options, this makes defending a subsequent problem much more challenging.

A recent instruction was of a case of haemorrhage after a vaginal hysterectomy performed for heavy periods. The patient needed repeat surgery to stop the bleeding, had a six unit blood transfusion and a prolonged stay in hospital. The claimant, assisted by her legal team and expert, argued that alternative treatment options were not discussed with her, and had they been so, she would not have chosen a hysterectomy. The poor documentation made this point difficult to defend and a settlement was negotiated.

Laparoscopic Surgery Complications

Over the last few years there has been a significant rise in laparoscopic surgery in gynaecological practice. Open procedures (laparotomies) are now performed much less commonly.

At laparoscopy, instruments are used with the assistance of a video camera to allow surgical procedures to be performed. To enter the abdomen involves placing a special needle through the umbilicus, inflating with carbon dioxide to distend the abdomen and then inserting surgical trochars into the abdomen, this method (known as the 'Veress needle technique') is the commonest in UK gynaecological practice. It will be understood therefore that the initial insertion of the veress needle to distend the abdomen and umbilical trochar to allow the laparoscope to be put into the abdominal cavity is essentially a blind technique.

While inserting the instruments into the abdominal cavity initially, bowel, bladder or even major blood vessels may be damaged. This may cause life-threatening injuries which need rapid corrective treatment. For a straightforward diagnostic laparoscopy the risk of bowel injury is in the order of 1-2 per thousand patients, for more advanced operative laparoscopies 5-8 per thousand.

Evidence based guidelines have been developed by the Royal College of Obstetricians & Gynaecologists (RCOG) and the British Society of Gynaecological Endosccopy (BSGE) detailing the techniques for entering the abdomen which have been shown to be the safest with the lowest risk of complications.

Generally speaking if the surgeon has used a recognised technique and has a complication on initial entry, this is defendable. Once a pneumo-peritoneum has been established and the initial umbilical port has been safely inserted, if there were any complications during insertion of additional (accessory) ports, this is indefensible.

Mesh in Gynaecology

The story of mesh in gynaecology is a tragic one which has affected many women. In trying to develop new ideas to help treat vaginal prolapse, a growing clinical problem which can be challenging to treat, medical

device manufacturers five to ten years ago introduced a range of meshes to be used surgically to help reinforce weak vaginal tissues during the prolapse repair. These meshes were often introduced with minimal research studies and 'similarity' regulatory approval.

Sadly they had a high complication rate of erosion, vaginal discharge, painful sexual intercourse or damage to bladder and or bowel. Most of these meshes have now been withdrawn from the market. I have been instructed on a number of cases of mesh related complications, the vast majority of which were settled in favour of the claimant.

In UK practice currently, I believe there is virtually no role in their use for first time (primary) prolapse surgery. For patients who develop a subsequent prolapse after surgery, needing repeat surgery, some meshes may have a limited role to improve long-term outcomes.

The prolapse mesh controversy should not be confused with the mesh used to treat bladder incontinence via the sub-urethral approach. The tension free vaginal tape (TVT) is one of the commonest procedures performed to treat urinary stress incontinence. This mesh is much smaller and narrower than prolapse meshes and has a much lower complication rate, although erosion may still occur.

G(E)NOMES AND TROLLS

– DNA SEQUENCING AND FUTURE RISK

By Greg McEwen, Healthcare Expert and Partner, BLM

Typically, when we talk about futuristic technologies in healthcare, it's often hard to anticipate how quickly society will make the bridge between science fiction and mainstream medical practice. That was almost certainly the case in the early noughties when scientists were at work developing the publication of the first complete genome in an effort to provide a DNA bible by which future medicine would abide. However, just 14 years on from the big breakthrough in 2003, DNA sequencing is making itself uncompromisingly known in the daily lives of health practitioners in some of the most important fields of treatment.

2017 itself was intended to be a landmark year for the development of 'genomic services' – a term coined by the Department for Health when it launched the 100,000 Genomes project in 2012, with the intention of sequencing 100,000 genomes from NHS patients within the space of five years.

While that initial deadline may have been moved back a year, all signs are pointing to DNA sequencing becoming this century's defining revolution in mainstream treatment as it creates a sprawling mass of new data with which to develop treatments for previously untouchable diseases. The economics and scale are also becoming a lot more attractive; with big businesses like Philips and IBM engaged in research, the production of a complete DNA sequence can now be achieved in less than a day at a rapidly dropping cost, projected to soon reach just $100.

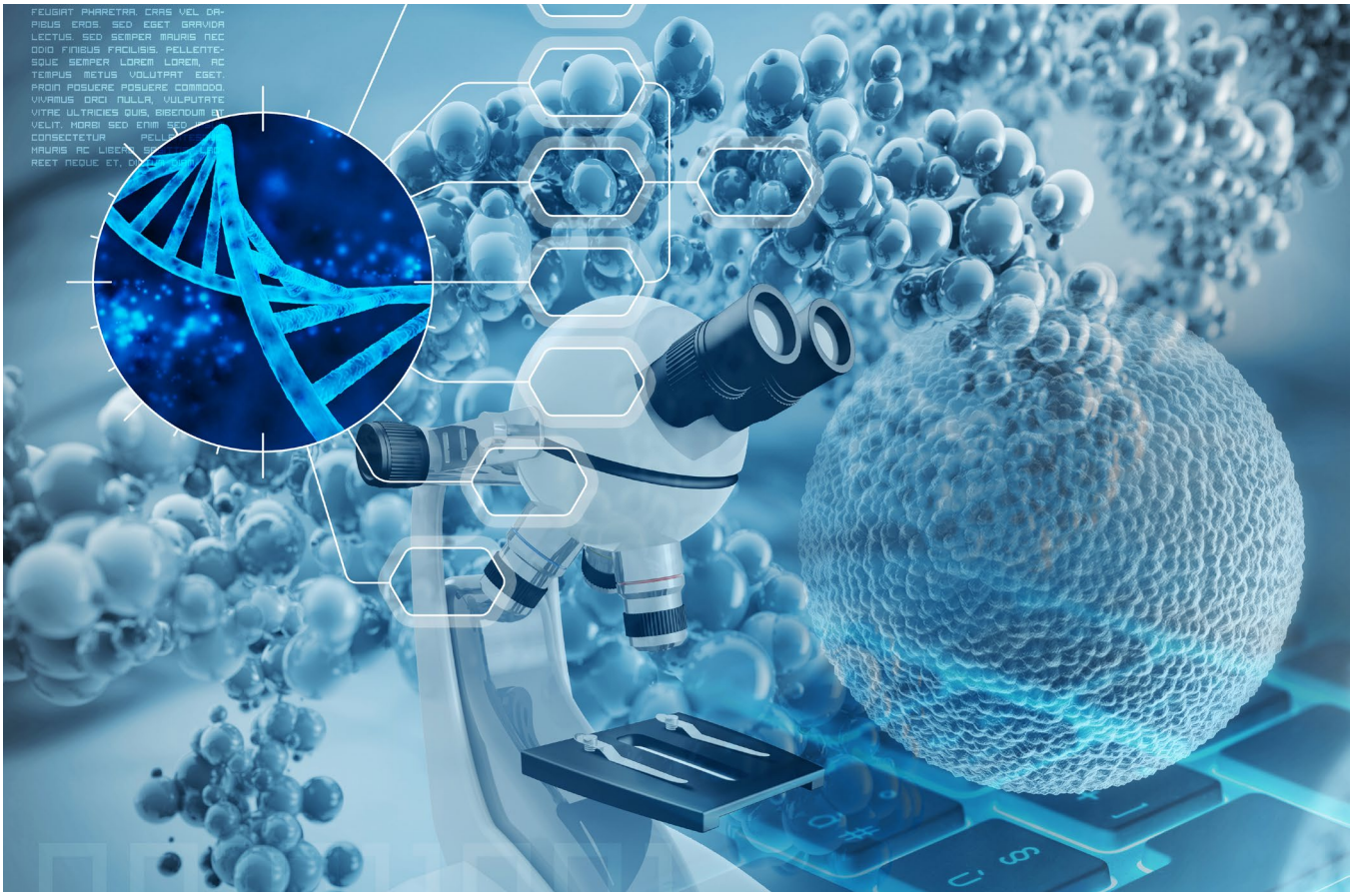
The future looks bright but, as with any new development, there is a level of risk that needs to be assessed, and medical insurers are rightly doing their due diligence for current and future policy. Interestingly, while insurers might have once been predominantly concerned with issues of negligence and malpractice in treatment, the threat profile is following general insurance practice and moving in the direction of the IT department.

Biological data is becoming increasingly important as technology provides us with greater access to what makes us human.

However, what begins with the issue of access can often lead to questions of ownership. Is our genetic information 'property'? If so, who owns it and what rights does the owner have over it? One of the co-discoverers of the BRCA1 and BRCA2 genes (that signal an increased risk of developing breast cancer) sought to patent its discovery in the US. A US court held that the genetic information already existed in nature and that naturally occurring compositions are (at least in the US) incapable of being patented. Elsewhere in the world though, companies have been able to patent naturally occurring genetic information. Since the usual aim of obtaining a patent is to allow an invention to be exploited commercially, this raises the spectre of the testing and treatment for certain genetic conditions being available only to those with deep enough pockets.

In the UK, our genetic data satisfies the definition of sensitive personal data within the Data Protection Act 1998, consisting of information regarding our 'physical or mental health'. Such data must be held and processed within the strict provisions of the Act, in recognition of its value and sensitivity and the potential for it to be exploited. For example, how would we feel about the idea of an employer, or an insurer, having access to our genetic data? This gives rise to the potential for decision making (potentially discriminatory decision making) on genetic grounds – not necessarily for what is, but for what might be. Insurance premiums could be raised for those with certain genetic markers, jobs offered to those with more 'favourable' genetic profiles.

The uses to which our genetic data might be put are many and varied. There is huge potential for medical



advancement, such as bespoke cancer treatments. There is also the risk of significant harm. In 2013, the US Food and Drug Administration determined that a particular genotyping test was intended for the 'diagnosis of disease…or in the cure, mitigation, treatment or prevention of disease' and warned of the potential consequences of false positive or false negative results.

Worse still is the prospect of our genetic data falling into the hands of other, shadier, third parties. A biological data breach, for example, is much more invasive than someone stealing your bank details – your biological passport can't be restored with a new pin number or password. Once it's out there, your entire genetic make up is available to the highest bidder.

All of this points to something of a Big Data headache. The raw data from one genome alone amounts to around 200GB, with every genome offering millions of variants from a reference model. The data generated by the NHS's 100,000 Genomes project alone is therefore significant in itself, and all of it needs to be protected from those wanting to exploit it for the wrong reasons. As technology makes the data easier and cheaper to obtain, obvious questions arise – how is my genetic data held? How securely, by whom and to what end?

The direction of travel for analysing data also points towards future risk. Filtering down millions of DNA combinations to isolate just a few harmful ones inevitably requires the input of artificial intelligence. Again, this opens the door to potential cyber threats and creates a product liability chain that extends beyond doctors and pharmaceutical manufacturers.

The potential for DNA Sequencing, both the positive and negative, is clearly huge and it's a door we're unlikely to close again. When you consider that the cost of discovering your genetic make up costs less than a new iPhone, it's not hard to believe this could very quickly become an industry in itself. And as with any industry, insurers will need to be ready to pick up the pieces.

Medicolegal Expert Services

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Dr Bryan Beattie MD FRCOG

- full time NHS Consultant in Obstetrics and Fetal Medicine for over 20 years
- founder and owner of Innermost Healthcare (a women's healthcare private medical clinic in Cardiff)
- provider of expert medico-legal services for over 15 years including provision of reports, court medical expert witness and advice for medical protection societies

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

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.

The treatment of facial injuries has evolved considerably over the last 30 or so years and many injuries can now be reliably repaired to a reasonable level of precision. However, patients' expectations have also evolved in parallel. Together with the portrayal of the cosmetic industry by some elements of the media, this has resulted in a culture of high expectation and a demand for perfect results. Yet, the reality is that surgery is never free of risk and despite these advances, many patients will often be left with some stigmata of either their injury or its treatment. Some aspects of normal recovery (such as prolonged bruising or swelling) may also be perceived as complications if patients are not warned beforehand. Failure to meet such expectations can therefore result in disappointment and sometimes litigation.

Furthermore, not all treatments are freely available in the NHS. Some dental treatments, rhinoplasties and scar revisions for example, are not always available and can be quite expensive privately. Understandably therefore, some patients may feel aggrieved when they are suddenly faced with the prospect of a sizeable fee (and the inconvenience of multiple visits) to repair or replace damaged teeth, or undergo treatment for a deformity. This may be compounded if (in the patient's opinion) the injury was through no fault of their own, such as following an assault or accident. Consequently, they may seek retribution or compensation to ease their financial burden by any means possible, which may include clinicians or Trusts.

For many patients, the treatment of their facial injuries can be a long and complicated process. For us, as clinicians, this process has the potential to be a medico-legal minefield. As an observation, the more common claims centre around:

1. The precise determination of the presence of injuries.

The medicolegal implications of whether a fracture is actually present or not, are self evident when its comes to personal injury claims or following assault. However fine 'cracks' in the facial bones (which are technically fractures) can not always be proven (or disproven) with absolute certainty, based on clinical examination, or even following 'X-Rays'. There will always be an element of clinical judgement required in making such a diagnosis. X-Rays themselves are limited in their ability to visualise fine fractures. If the presence of a fracture is uncertain, clinicians are trained to err on the side of caution and will manage patients as though they do have a fracture. This is to minimise the likelihood of complications developing. However, such caution may then become misrepresented as 'proof' that a fracture is present.

Furthermore, not all facial injuries require X-rays. The over-riding reason for taking these is if they will alter the management of the patient. As such, suspected 'cracks' and most isolated fractures of the nose do not require imaging. The days of x-raying purely for medico-legal reasons have long past. Aside from the unnecessary expense to the NHS, GMC and GDC guidance is clear on this and we must resist requests to take an X-Ray if they do not alter the care of our patients. Clinicians may be put under pressure from patients (and relatives) to 'get a scan'. Refusal to do so can often be misconstrued as incompetence, inexperience, or not taking the patient seriously. Not surprisingly, some patients may feel aggrieved by this apparent lack of thoroughness. Nevertheless, unnecessary imaging is regarded as a major 'sin' within our regulating bodies and as such carries the risk of disciplinary action if guidance is ignored.

2. Missing treatable injuries.

Not all injuries are obvious and, despite our best efforts, there will unfortunately be occasions when treatable injuries are overlooked. Whilst these are seldom life-threatening, some can result in disfigurement and troublesome symptoms. Some may require expensive treatment, for example the eventual loss or discolouration of a tooth. One particularly difficult group of patients to assess are those that are unconscious, for example following a head injury. In this group it is not possible to assess whether the patient has sustained any significant visual impairment. Examination of the eyes and face is at best relatively crude. In children, certain fractures of the eye socket may present with an irritable, vomiting child – signs more often associated with head injuries. Significant delay in diagnosis because of this 'misdirection' can result in permanent double vision (diplopia).

3. Pre-existing problems

Whilst the impact of missing such injuries may be difficult to defend, this may not always be the case. Pre-existing dental neglect and dental disease (notably decay and periodontal [gum] disease) will predispose teeth to injury and loss (including damage during anaesthesia). Any new injury may simply be the 'straw that broke the camels back' in a tooth that was already destined to be lost in the near future. Therefore, when determining 'blame' such considerations need to be balanced against the likelihood that the tooth in question did indeed have a good prognosis before the injury occurred. This may be difficult to prove, especially in patients who rarely see a dentist.

4. Interpreting injuries.

In most cases, it is not possible to say with certainty the manner in which a particular injury occurred. Unfortunately, the likes of 'CSI' and other similar TV programmes tend to suggest otherwise. Police reports often ask clinicians to state whether a fracture occurred as a result of an assault, fall or some other mechanism. However, such information falls under the remit of forensics rather than medicine, particularly when it is required as part of the prosecution's evidence. Whilst the 'balance of probabilities' test eases this pressure, as clinicians our expertise is in establishing the presence of an injury and treating it, not in establishing how it occurred. Police and medical reports can therefore be a slippery slope to the court.

Interestingly, it could even be argued that our entire experiences are in fact flawed. In my experience (of over 20 years) only 2 patients have ever admitted they actually 'started the fight'. This could lead to one of two conclusions – i) either attack really is the best form of defence, or ii) perhaps (more likely) we are never given the entire story. If this is indeed the case, then

our experiences in the understanding of facial trauma mechanisms are to some extent flawed and could be challenged. As a matter of course, I do take patients' stories with a small pinch of salt and I have wondered if other specialists have the same experience.

Nevertheless, in some cases some conclusions can be drawn. Some types of laceration may give an indication as to the cause of the injury, for example whether the skin was cut or split. Similarly, the shape of a bruise, or split in the skin may indicate the type of blunt weapon used. Some wounds may also give an indication about the site of impact and direction of the force. But again, this is really forensics, not medicine.

5. Delays in diagnosis.

Excessive delays in diagnosis and treatment may adversely impact on outcomes, for example treatments aimed at either salvaging teeth (such as replantation, or root canal therapy), or maintaining their cosmetic appearances. Similarly, significant delays in repairing facial wounds and fixing fractures can result in suboptimal outcomes. Over time, simple fractures become more difficult to treat. Understandably therefore, patients may not be too happy with the prospect of an extra surgical scar on their face, because a simple fracture was initially 'missed' and now requires more complex surgery. Similarly, If a tooth is ultimately lost the patient may feel there has been a shortfall in care by not diagnosing the problem sooner.

That said, some patients need to take ownership of their injuries and act accordingly. Failing to attend follow up appointments is a common problem which immediately adds to any delay in management. Many hospitals have policies in place to discharge patients that fail to attend follow up appointments and this can result in significant delays, if patients then need to be re-referred. 'Choice' and 'partnership' are words commonly used by politicians and managers to empower patients. So, if a patient 'chooses' not to attend a pre-arranged (and agreed) follow up appointment, who is at fault if subsequent treatment then becomes more complicated?

However, it is also important to remember that co-existing concussion, fatigue, alcohol and drugs (both analgesic and recreational) can impair anyone's ability

to retain information. Telling a very drunk patient to attend a follow up appointment may therefore result in non-attendance. Written instructions should therefore be given. Detained prisoners comprise another small but important group. Normally, with non-prisoners' review appointments are often given at the end of the consultation, but this practice may be deterred by the accompanying officers, so that the prisoner does not know. In my experience this (plus the lack of staff) can result in missed appointments and delays in follow up and treatment.

In the second part of this article, to be published in the next issue, 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.

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CLAIMANT INTERVIEW TIPS FOR EXPERTS

By Andrew Gray, Owner, Truth Legal Solicitors

Five years ago, when I set up my own boutique personal injury firm, I wrote a blog entitled *'What to expect at a personal injury medical appointment'*. Thank goodness that I wrote that blog, because it has been the webpage which has directed the most traffic to my firm's website. The reason for the article's online success is because so many personal injury law firms inadequately explain to their clients what is going to happen to them when they are examined by a medico-legal expert and, crucially, what is the function of the expert in the claim process.

When I am explaining to my clients what is going to happen at this make-or-break appointment, I tell my clients not to expect a Rolls Royce service from the expert. I advise my clients that the expert is providing a critical function, ultimately for the courts, and that, as a result, the expert's bedside manner is unlikely to be to their tastes. In most cases, sadly, my advice proves sage, but it shouldn't be like this.

Naturally, all personal injury solicitors appreciate that their client is attending the appointment to be examined as a specimen, but, in my view, if an expert is somewhat standoffish, then the client is more likely to challenge every aspect of the expert's report, sometimes with justification. In my experience, when my client and an expert get on well, my client is more accepting of the expert's report, irrespective of what it may say. And if clients are routinely complaining about a particular expert's bedside manner, then instructions to that expert will inevitably decrease.

As one of SpecialistInfo's newest trainers of medico-legal experts, I have put together my top five tips. To the proficient medico-legal expert, of course, you will

regard these tips as somewhat obvious, but as an experienced personal injury practitioner, some experts really ought to follow these tips.

Here are my tips.

1. Ensure that the Claimant fully explains the impact of the accident.

For a Claimant, being examined by a medico-legal expert is simply a bizarre experience. Most lay people are in awe of the medical profession, and so when the medical expert is acting as an expert, many Claimants fail to explain themselves properly – how the accident happened and how the injury has impacted upon them. As a result, the reports are often accurate reflections of the appointment, but not a fair reflection of the injuries. When we solicitors challenge a medical report, arguing that the impact of the accident was greater, the usual refrain from the expert is that the Claimant did not volunteer the information during the appointment. I therefore encourage experts to ensure that the Claimant has felt able to volunteer all the information; that they have got everything off their chests. Assume that the Claimant hasn't explained everything to you, not because of deceit on their part, rather because they are anxious about appearing stupid.

2. Physically examine the Claimant.

Not always relevant, of course, but this is the Number One complaint from Claimants – a complaint which is hard for the solicitor to defend. It sounds obvious, but I can assure you that a physical examination of a Claimant in respect of a physical injury doesn't always occur. Even if it takes longer, have a good examination of the Claimant, even if you are of the view that it is somewhat unnecessary. This will ward-off any likely complaints, as well as giving the Claimant confidence in your opinion.

3. Assume that the appointment could be crucial to the Claimant's future care.

Clearly the NHS is under intense pressure. No doubt we have all seen many a case in which a patient has fallen off the NHS's radar, and that the patient has been reluctant to bother their GP with their long-term niggle. I tell my clients that the medico-legal appointment – all paid for by their solicitors – is a reason in itself to pursue a personal injury claim. This is because there are no other times in a Claimant's life when they get to see a top expert – at no cost – who has all their medical records from birth, and who will provide a detailed report on their injuries. Clients love to read your reports!

Frequently, medical experts have highlighted problems which my client's own doctors haven't spotted, saving my clients from years of misery and inevitably saving the NHS a great cost. My tip, therefore, is to remember that the Claimant may not have received appropriate care and to therefore remedy this by telling them in the report what care you think they need. I often tell my clients to give a copy of their medico-legal reports to their GPs, so that there is a permanent record of what has occurred. I thank all experts who have helped my clients to get the appropriate care.

4. Write the report at the time of the appointment or shortly thereafter.

Fact: Claimants are more likely to challenge a report which was written some time after the appointment. Fact: Claimants are impressed by experts who write the report during the consultation. Whilst I appreciate that this isn't always possible, there is a greater degree of accuracy in contemporaneously-written reports. Many Claimants seize upon a minor factual inaccuracy as evidence that the expert's opinion is flawed. Accurate reports make for happy Claimants and happy lawyers.

5. In most cases, particularly non-MedCo cases, only examine the Claimant when you have enough medical records in your possession.

It is a personal injury solicitor's greatest bugbear that some experts provide their report before they have received all the correct medical records (though there are often difficulties in obtaining all the medical records and confusion with agencies). This often leads to addendum reports which might deviate from the first position. And if you have the full medical records for the appointment, you can in person test a Claimant's response to tricky points in the medical records.

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SHORT TERM PAIN FROM NEW EUROPEAN DATA REGULATIONS WILL LEAD TO LONG TERM GAIN IN DIGITAL HEALTH

By James Flint & Neville Dastur, Co-founders, Hospify

Neville Dastur is a consultant vascular surgeon and IT developer with his own medical software company; James Flint is a former technology journalist turned tech entrepreneur. They are co-founders of Hospify, a secure, GDPR-compliant healthcare messaging platform for currently undergoing extensive trials in the UK.

Damaging as it was, the WannaCrypt ransomware attack earlier this year made one thing very clear to everyone who heard about it: the UK's health comms are broken.

Doctors, nurses and support staff at hospitals and surgeries throughout Britain and indeed Europe rely on a crazy network of landlines, pagers, paper records and out-of-date computers to stay in touch with one another, and this system – or lack of it – is dysfunctional to the point of being actively dangerous.

It's not unusual for medical staff in the same hospital to have to make up to ten switchboard-mediated calls before they can talk to one another, a situation which wastes valuable time as well as increasing patient and professional frustration.

So when WannaCrypt made many of the ancient Windows machines underpinning this network inoperable, it also made many hospitals up and down the country inoperable, with catastrophic results for patient care.

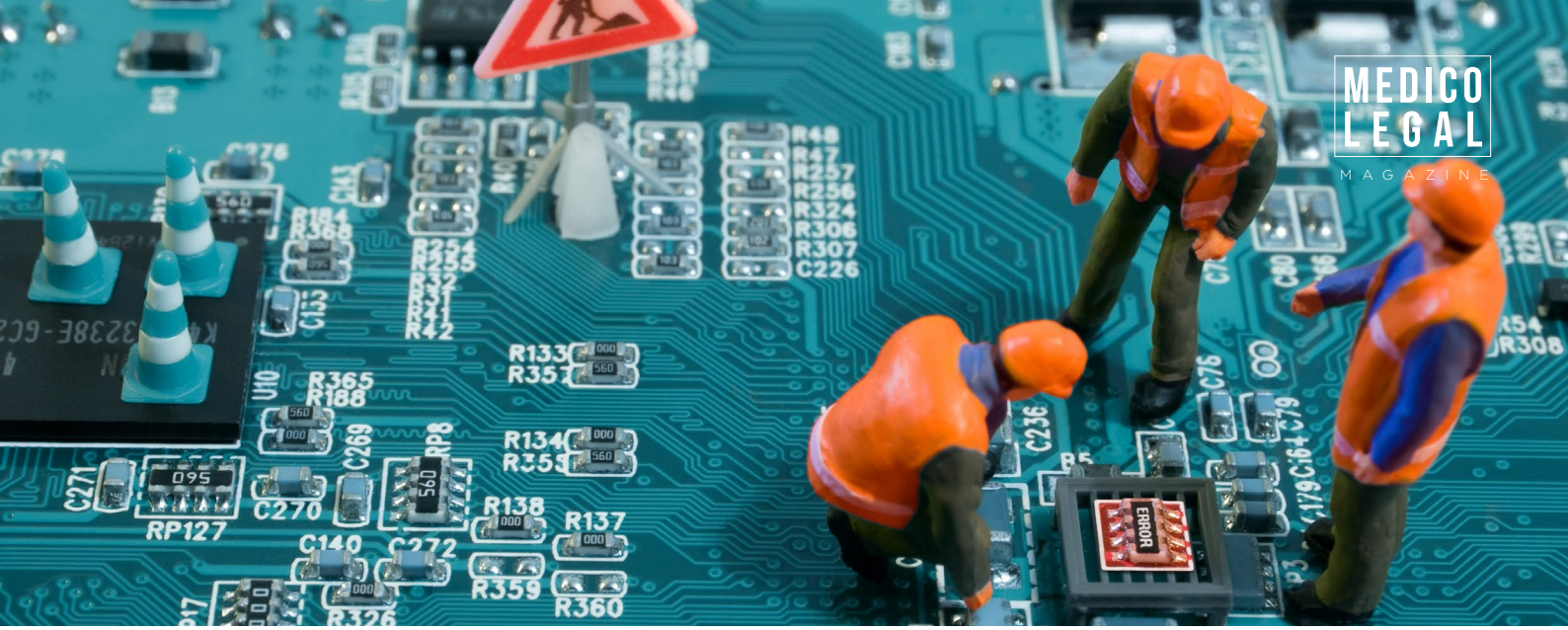
What is also worryingly clear, however, is that despite these shortcomings there is no money available to improve the situation. NHS IT procurement has been a financial black hole for decades (www.theguardian.com/society/2013/sep/18/nhs-records-system-10bn) and many of the data standards that health care professionals have been expected to abide by – such as the need to both encrypt sensitive data and at the same time make it available for access in the event of patient data requests – often seem – and often are – confusing and contradictory.

And yet in the world beyond the confines of the ward and the surgery, encrypted secure communications are today taken for granted. In the UK 72% of people now own a smartphone and as a result have access to a multitude of apps that allow them, for no additional charge, to communicate via text, email, pictures, video and social media with any of the billions of other people on the planet who now also carry similar devices with them wherever they go. And that's before they've even made a phone call!

These days most doctors (98%) and nurses (95%) own smartphones, and it will come as no surprise to anyone that they're routing around the problems of legacy systems by turning to consumer messaging apps. According to a recent study published by the BMJ [http://innovations.bmj.com/content/1/4/174], in the course of their work 65% of doctors have used SMS, 33% have used app-based messaging, and 46% have used their smartphone camera and picture messaging to send a photograph – for example of a wound or X-ray – to a colleague for an opinion. Around 94% of doctors and 29% of nurses said they used their smartphone to communicate while at work, and more than 50% of doctors reported that they were now using their smartphone to replace the traditional bleep.

So where's the issue? Institutional health comms are failing, but everyone's got a smartphone and they're all using that? Problem solved, right?

Not quite. Because riding into this situation on its great white charger is the small matter of the General Data Protection Regulation (GDPR). From May of next year this new set of European rules – already enshrined in UK



law and with us regardless of what happens with Brexit – will classify the transmission of patient identifiable data via servers that are not geographically based solely in the European Economic Area (EEA) as a data breach.

On top of that, the rules demand that all data breaches be reported, and that fines of up to 4% of the offending Trust's, surgery's or medical business's annual turnover be levied on those who do not comply.

Since WhatsApp, iMessage, Slack, Telegram, Snapchat and all the other commonly used messaging apps will just as likely pass your data via North America as via Europe, using these apps to send any data relating to a patient is pretty much guaranteed to put you – or the institution you work for – in breach of the GDPR, regardless of whether or not the data has ended up in the wrong hands, and regardless of whether or not the data has been encrypted,

There are other issues too – the need to provide for patient access requests is one example that counts these tools out for use in the health industry. As NHS England points out in its Information Governance bulletin [http://webarchive.nationalarchives.gov.uk/20160603154026/https://www.england.nhs.uk/wp-content/uploads/2015/01/ig-bull-21.pdf], "Whatever the other merits of WhatsApp, it should never be used for the sending of information in the professional healthcare environment. WhatsApp, which is owned by Facebook, is a consumer service, which does not have a service level agreement with users and has no relevant data security certification. There is no valid reason for its use within the NHS."

The NHS is already the worst performing public-sector body when it comes to data breaches and has been fined £1.3m by the ICO for data transgressions over the past few years. Once GDPR outlaws WhatsApp, the fines are likely to get worse, and it's only a matter of time before a medical negligence or personal injury claim based on either unauthorised use of messaging or a failure of the existing communications infrastructure is brought against a Trust.

The upshot is that the one industry in which fast and efficient communication is quite literally a life-or-death issue is the one industry which cannot take advantage of the plethora of virtually free communication tools that the vast majority of us keep in our pockets, take entirely for granted, and use every day.

It's not all bad news however. Because the GDPR – the same set of rules that's about to scare the pants off everyone – may also prove to be the set of rules that allows the situation to improve, and improve rapidly. Its arrival has allowed the Information Commissioner's Office (ICO) to reformulate UK legislation into a coherent rubric that is relatively free of many of the paradoxes of the past.

Since similar clarity in the form of the HiPAA guidelines was introduced to the US in 1996, a marketplace of digital health apps has been able to thrive secure in the knowledge that there are best data practice standards to which they can conform.

So while in the short term GDPR compliance may bring some pain for those slow to stop using consumer grade tools inappropriately, it will also allow increasing innovation to take place in the market place, innovation that will unlock a wave of digital solutions for healthcare that inadequate, out-of-date and contradictory regulatory standards have managed to stifle for so long.

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COMMON AREAS OF LITIGATION IN GYNAECOLOGY

By Mr Joseph Aquilina, Consultant Obstetrician and Gynaecologist, Barts NHS Trust and Honorary Senior Lecturer, Queen Mary University of London

Mr Aquilina provides a specialist service in Fetal Medicine and Gynaecological Ultrasound. He is recognised as a preceptor for training in gynaecological scanning by the Royal College of Obstetricians and Gynaecologists and is the Editor for the Women's Health Section of Current Opinion in Obstetrics and Gynaecology. He is a GMC accredited expert witness and has been a member of the Federation of Expert Witnesses since 2012. He has extensive clinical governance experience with management of gynaecology SUI's in his role as chairperson of the Gynaecology Governance Board at St John and St Elizabeth Hospital where he sits as participating member of the Hospital Governance Board. He can be contacted via his secretary lynmedisec@aol.com

Complications are part of and parcel of gynaecological surgery, but litigation often arises when there is inadequate counselling prior to the procedure or complications are not promptly recognised and treated, which result in subsequent long-term and unexpected morbidity. This short article looks at the most common areas where these pitfalls arise and steps that should be undertaken to minimise litigation.

Consent

A signature on a consent form does not equate to valid consent. Before seeking a woman's consent for a test or intervention, it is important to ensure that she understands the nature of the condition for which it is being proposed, benefits and risks inherent to the procedure, likely consequences and the risks of receiving no treatment, what can realistically be expected following surgery, as well as any reasonable alternative treatments. A discussion of the commonest risks, as well as rare but significant risks, are essential to ensure informed consent. Litigation related to consent may also arise from the performance of procedures that were not discussed with the patient, such as removal of both ovaries when she consented to removal of one or none.

Laparoscopy

Delay in recognition of bowel injury is the most common cause of litigation. Possible damage to the bowels can result from:

- initial laparoscopic entry into the peritoneal cavity;
- extensive use of diathermy in close proximity to the bowel.

Delayed recognition of such injury is one of the major factors in assessing liability. The other litigious issue involves cases performed laparoscopically resulting in recognised injury, which would have been done by a more experience body of gynaecologists as open surgery. When significant intrabdominal adhesions are anticipated, due diligence would be to undertake bowel preparation and involvement of a bowel surgeon at a very early stage of any suspected bowel injury. In fact, it is common practice these days that some of these cases are done jointly with laparoscopic general surgeons in attendance to reduce risk of litigation. Post-operatively with any suspected or confirmed injury, the level of monitoring is important and if close monitoring (which has been clearly documented) is not undertaken negligence is more likely to be proven.

A less common but recognised type of injury is bleeding due to blood vessel injury during entry using a lateral port. This arises most commonly due to injury to the inferior epigastric artery. Litigation arises from delay in identifying this bleeding once the ports are removed, which can result to a return to theatre and/or significant abdominal wall hematoma, which will have a significant detrimental impact in the recovery process. This is a very rare complication and specific counselling is probably not called for but can be covered under the clause of 'bleeding' which should always be included in any consent form which involves surgery.

Hysteroscopy

The failure to recognise uterine perforation and subsequent internal organ injury is the commonest cause of litigation. When there has been internal organ damage, such as bowel, patients may remain asymptomatic for 2–10 days before the nature of the injury, often thermal, becomes apparent. Factors

that increase the risk of perforation include cervical stenosis, acute anteversion or retroversion, lower-segment fibroids or intrauterine synechiae and operator inexperience. Uterine injury without the use of an electrical source can usually be managed by observation of signs of vaginal or intraperitoneal bleeding, but if an electrical source has been used, laparoscopy is advised to rule out bowel injury.

Sterilisation

The most common reason for litigation is conception post-sterilisation. This could be for one of the following reasons:

- A luteal phase pregnancy which was not identified at the time of surgery.
- An actual failure because the procedure was inappropriately or inadequately performed.
- Recanalisation of the fallopian tubes post-procedure.

If pregnancy occurs within 12 months of sterilisation it is likely to be a failure of the technique whereas after 12 months it is more likely to be recanalisation. There are also recorded cases of litigation because of failure to perform procedures concurrently for which the patient has consented, such as removal of an IUCD. More serious is non-consented tubal sterilisation performed at caesarean section (CS), or regret related to sterilisation done at the time of CS when the patient was consented immediately before the procedure. Medico-legal law relating to maintenance of the child born after sterilisation is controversial. In the *McFarlane*[1] ruling it was held that parents of healthy children born after sterilisation were not entitled to the costs of bringing up the child. However, a valid claim can be made following the birth of a child with disabilities, based on the additional cost of raising a child with those disabilities (*Parkinson*[2]).

Hysterectomy

Failure to detect ureteric injury is the most common cause of litigation related to this procedure. Damage to the bladder and bowel are probably more common but are not generally considered to be negligent, especially if the procedure is difficult due to scarring from a previous surgery. A successful claim for compensation is unlikely when the injury is recognised and has been appropriately repaired. A missed bladder injury may lead to a vesico-vaginal fistula and a missed bowel injury could result in sepsis or peritonitis. These will frequently be classed as negligent. It may be argued that some occur because of ischaemic necrosis in the bladder base, and these may be defensible. Therefore, timing of onset of the leakage is important. Early leak is probably a result of direct injury whereas later leak is a sequel of ischaemia. Litigation may also be related to unnecessary hysterectomy or an oophorectomy. Questions relating to the indication for surgery can arise particularly when a hysterectomy is associated with complications and less invasive options such as an intrauterine contraceptive device or endometrial ablation have not been offered or discussed.

Urogynaecology

Litigation related to urogynaecology cases are centered on the use of meshes and related complications. Clinicians undertaking synthetic meshes for the treatment of pelvic organ prolapse should familiarise themselves with NICE guidance on the use of meshes interventional procedure guidelines https://www.nice.org.uk/guidance/ipg581.

General gynaecologists must also be aware that without a sufficient workload, continuing to perform complicated urogynaecology procedures is fraught with the risk of litigation.

Time bar

Claims should be brought within 3 years of the injury or the date of knowledge of the alleged negligence. Where the injured person is a child, the 3-year period will only begin when they have reached their 18th birthday. In practice that means that a child has until their 21st birthday to bring a claim. In cases of claimants who lack capacity there is no time limit, as is often the case in birth injury cases. If an adult dies as a result of their medical treatment, their personal representatives or dependants may bring a claim within 3 years of the date of their demise.

References

1. McFarlane v Tayside HB [1999] 3 WLR 1301.
2. Parkinson v St James' [2001] 3 All ER 97.

MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

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

Fixed Costs in Clinical Negligence

An open letter from AvMA (action against medical accidents) and 8 other patients' charities calling on the Secretary of State for Health to reconsider proposals on imposing fixed costs in clinical negligence was published in the Daily Telegraph in early May, coinciding with the close of the consultation on 2 May 2017.

The letter describes the proposals as 'premature; ill informed; and a threat both to access to justice and patient safety'.

For full details see the link below:
www.avma.org.uk/news/opposition-to-fixed-costs-in-clinical-negligence-growing/

Whistleblowing Doctor Wins Legal Battle in the Court of Appeal

Dr Kevin Beatt, consultant cardiologist, has successfully won his case against Croydon Health Services NHS Trust after he was sacked for raising safety concerns.

In his Court of Appeal judgment, Lord Justice Underhill said the NHS trust had classed Dr Beatt as 'a troublemaker' for raising genuine concerns.

He added: "It is all too easy for an employer to allow its view of a whistleblower as a difficult colleague or an awkward personality to cloud its judgement about whether the disclosures in question do in fact have a reasonable basis."

Dr Beatt was unfairly dismissed in September 2012 and subjected to detriments by the Trust after he blew the whistle about patient safety after the death of a patient, following the suspension of a cardiology nurse in the middle of an operation. The Trust alleged that Dr Beatt's concerns about patient safety were made in bad faith and with an ulterior motive.

NHS Resolution are currently updating their whistleblowing policy:
www.nhsla.com/AboutUs/Documents/Master%20Board%20Papers%20May%202017%20-%20Part%201.pdf

Alternative Business Structure for National Accident Helpline (NAHL)

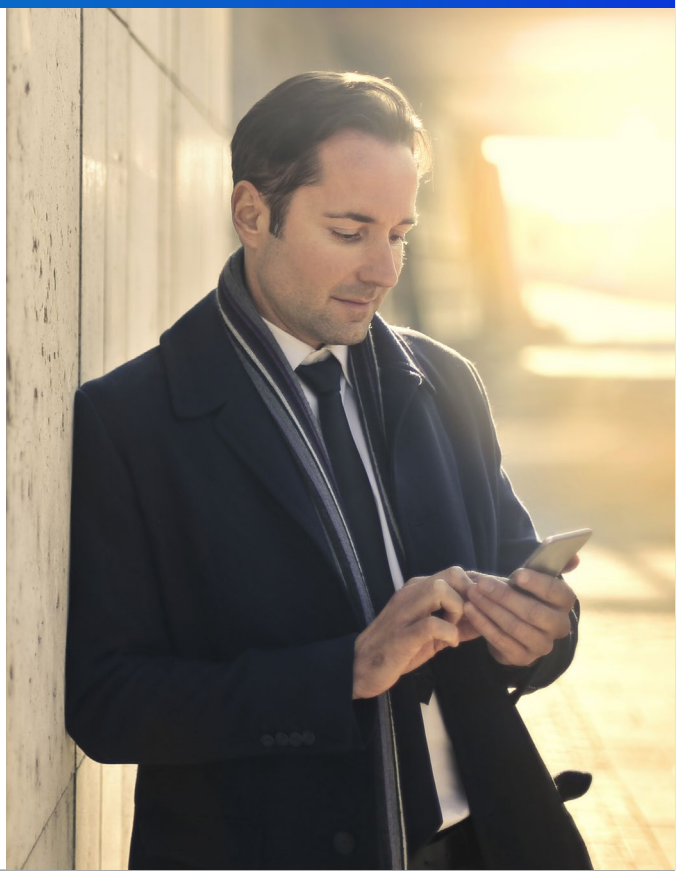
NAHL is to launch its own law firm on 1 July 2017 after being awarded an alternative business structure (ABS) licence and signing a deal with Cardiff-based NewLaw Solicitors.

This is in response to the recent personal injury reforms, and will put it in competition with its own panel law firms.

Russell Atkinson, CEO of NAHL, said: "The setting up of this ABS is a positive development in executing the group's strategic plans to advance its business model and prepare the division for the PI market changes announced by the government in February 2017."

The ABS will trade under the name Your Law LLP and is expected to start business on 1 July 2017.

Read more at markets.ft.com/data/announce/detail?dockey=1323-13239248-RU8JQ3TB90UJU7B81CMDNI2TB



Reducing Fraudulent Holiday Sickness Claims

The Solicitors Regulation Authority is investigating several firms in the claimant personal injury sector that are suspected of taking on fraudulent or exaggerated holiday sickness claims. There has been an unprecedented rise in these types of personal injury claims, due to touts targeting tourist hotspots and encouraging people to seek compensation. The Foreign Office is warning people travelling to Spain not to be tempted into making a false holiday sickness claim or they risk prosecution.

Andrew Twambley, spokesperson for A2J, the campaign group for the claimant PI sector said: "We need to help the SRA help the sector. The public has made clear they want an end to cold calling and claims touting, and all of us, law firms, insurers, travel operators and regulators, are responsible for making that happen and shoring up public trust in the system. We also need insurers, travel operators and law enforcement agencies to take a much more aggressive approach to prosecutions."

Read more at www.lawgazette.co.uk/news/report-firms-making-fraudulent-holiday-claims-claimant-group/5061446.article

MedCo news:

Expert Hacking Warning

At the end of June, MedCo discovered a potential scam involving false invoices raised against genuine Medical Expert appointments. The scam does not involve the MedCo system itself. It seems that fraudsters are attempting to hack the electronic diaries of Experts and steal appointment details, which they can use to send false invoices to authorised users.

More details on their site:
www.medco.org.uk

How will Brexit Affect Personal Injury Law?

Brett Dixon, President of the Association of Personal Injury Lawyers (APIL), has told the Law Society Gazette that he is worried that, "The Great Repeal Bill will convert EU laws (as they apply in the UK) into domestic law but the government has the power to pick out what is needed and dispense with what is not. Proper parliamentary scrutiny of this process is essential. Many of the relevant legislative provisions applied to personal injury have their roots, and the basis for their continued development, in Europe, particularly those relating to workplace health and safety requirements. Health and safety regulations and subsequent case law have been an important factor in a decline in workplace deaths. We need to ensure this decline continues and is not reversed."

Read more at www.lawgazette.co.uk/comment-and-opinion/what-we-want-from-the-new-government/5061591.article

Survivors of the Conservative Manifesto from the Queen's Speech

The Queen's speech in June revealed that the Civil Liability Bill will keep elements of the last parliament's Prisons and Courts Bill aimed at reducing whiplash claims. In briefing notes, the government said the bill would 'tackle the rampant compensation culture'. It will ban offers to settle claims without the support of medical evidence and introduce a new fixed tariff of compensation for whiplash injuries lasting up to two years. The new legislation is predicted to cut motor insurance premiums by £35 a year.

The new Patient Safety Bill will be published to improve how the NHS investigates mistakes and encourage staff to share information freely. It will 'embed a culture of learning and safety improvement across the NHS' and ensure serious incidents can be investigated by an independent and impartial body 'without the need for expensive, lawyer-led inquiries where that is unnecessary'.

Read more at www.gov.uk/government/publications/queens-speech-2017-background-briefing-notes

LIABILITY AND ACCOUNTABILITY IN PRIVATE HOSPITALS – A PRECONDITION FOR PATIENT SAFETY

By Colin Leys, an Emeritus Professor, Queen's University

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The recent conviction of the consultant surgeon Ian Paterson for unlawfully wounding ten patients in two private hospitals seems bound to force a final resolution of the longstanding issue of the safety of patients in the private hospital sector, and of the respective liabilities of surgeons and the hospitals in which they operate.

Background

In 2014 the Centre for Health and the Public Interest carried out a major study of the operation of the private hospital model and the associated patient safety risks. We identified a number of weaknesses with the hospitals' operating model and the governance and assurance regimes which are supposed to keep patients safe.

The first concern we identified was that very few of the current private hospitals have intensive care beds to deal with situations where things go wrong during surgery. In theory, there should be a limited risk of operative and post-operative complications in private hospitals because these hospitals should only admit patients deemed to be low risk.[1] But despite this there are around 2,500 emergency transfers of patients from private hospitals to NHS hospitals every year.[2] As Sir Bruce Keogh has pointed out, the NHS operates as a free safety net for private hospitals for when things go wrong – without it, it is unlikely that any private hospital carrying out surgery without intensive care beds would be deemed to be safe for patients.

The second concern was that most private hospitals rely heavily on a single junior doctor (a Resident Medical Officer, or RMO) for post-operative care. Following an operation the surgical team (including the anaesthetist) hand over responsibility to the hospital whose RMO monitors the patient and deals with any complications. Unlike NHS hospitals there is no specialist team on the site to provide back-up and the RMO – who is usually contracted from an outside agency – has responsibility for a large number of patients, with most of whom he or she will have no previous acquaintance.

In terms of governance and oversight, the private hospital model is also very different from the NHS model. Unlike the NHS, where surgeons are directly employed by their hospital trust, in a private hospital the consultant is granted 'practising privileges' by the hospital to treat patients in the hospital's facilities. These privileges are granted by the hospital on the advice of a Medical Advisory Committee, a non-statutory body drawn from among the consultants practising at the hospital.

Private patients in private hospitals have separate contracts with the consultant to undertake the surgery and the hospital as the provider of facilities. As the victims of Ian Paterson are currently discovering, whereas the NHS has already paid out £9.5m in compensation to patients he injured in the NHS hospital where he worked, the private hospital provider has refused to pay any compensation, except in a small number of cases, because they argue that Paterson was not technically their employee and so they are not responsible for his actions.[3]

Perverse incentives

Because the hospitals rely on consultants to bring in business and because their liability for the actions of their surgeons is limited there is a potential financial incentive to be more lax in their clinical governance than the NHS. There is also a practical problem: a 40-bed private hospital may have several hundred consultants with practising privileges so that seriously vetting, monitoring and auditing their work will always be difficult, time-consuming and costly.[4]

As the independent report into the Paterson case revealed, this lack of oversight can be fatal. Concerns about Paterson's work that were raised to one Medical Advisory Committee were dismissed on the basis of his assurances, and he was even allowed to continue working at the private hospitals for several weeks after evidence of his malfeasance had come to light and he had been suspended by his NHS trust.[5]

An issue of public policy

How should policy makers respond to this challenge? The NHS now relies heavily on private hospitals to provide elective surgery for its patients, to the tune of half a million a year. Conversely the private hospital sector is now heavily dependent on the taxpayer for its income – in 2012 around a quarter of all of its income came from the NHS, a revenue stream which has shielded the sector from the worst aspects of the financial downturn.[6] As a result patient safety in private hospitals is now even more an issue of public policy, as opposed to a purely civil matter between private individuals and businesses.

In our view the starting point for addressing these concerns is accountability. It is unclear to us how an effective patient safety regime can be expected to operate in a hospital which denies liability for surgery carried out in it. Without liability there is no incentive to prevent errors or malfeasance; without liability there is no mechanism for holding private hospitals to account for their actions. All of these gaps leave patients vulnerable.

Will regulation address the liability gap?

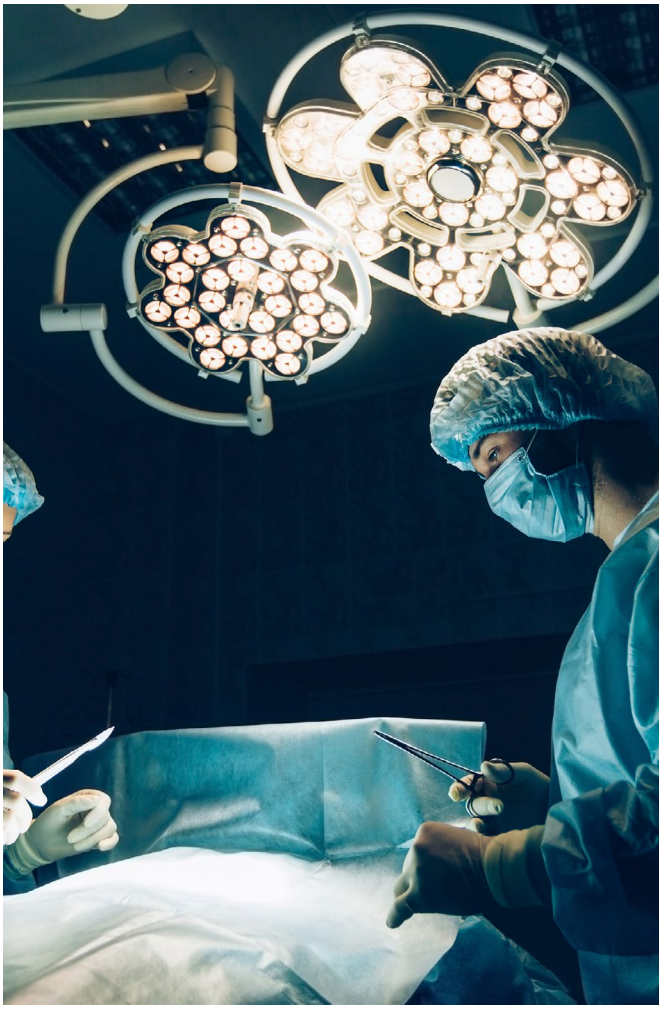
The current regulatory framework which governs private hospital care does recognise that hospitals have responsibility for the activities which are conducted within them. In fact, contrary to the arguments put forward by the hospital sector this does not appear to support the argument that private hospitals are not liable for the work of their surgeons because they are not direct employees. The 2008 Health and Social Care Act Regulated Activity Regulations clearly state that a medical professional who has been granted 'practising privileges' is an 'employee' of the hospital for the purposes of carrying out regulated activity.[7]

Regulation 19 of these regulations which relate to 'fit and proper persons employed' and which have been in force since 2009 requires hospitals to employ people with 'the necessary qualifications, skills and experience to carry out the regulated activity'; and the Care Quality Commission (CQC), which regulates the hospitals, consequently requires them to 'operate robust recruitment procedures, including undertaking

any relevant checks. They must have a procedure for ongoing monitoring of staff to make sure they remain able to meet the requirements, and they must have appropriate arrangements in place to deal with staff who are no longer fit to carry out the duties required of them.'[8]

On a prima facie reading these regulations clearly apply to private hospitals which grant practising privileges to consultants to perform surgery on their premises and hence make the hospitals responsible for overseeing and monitoring their work. However it is unclear whether these regulations have been enforced: the CQC carried out inspections of the two private hospitals where Paterson worked 18 months after he had been suspended by the NHS, but the inspection reports make no mention of any attempts by the inspectors to discover whether the hospitals had in place procedures for monitoring the work of the consultants who practised in them. Instead the CQC's focus at that time was solely on those other healthcare staff who were directly employed by the hospital such as ward nurses and theatre staff.[9]

Despite the content of these regulations, the current difficulty experienced by patients in seeking redress for the harm caused by Ian Paterson shows that liability for what goes on within private hospitals remains a contested matter. Unless it is resolved to the satisfaction of the victims, a change in the law will be necessary to make private hospitals fully accountable for all surgery which takes place on their premises. Without this there is no guarantee that patients receiving care in private hospitals will be safe or that a similar tragedy will not be repeated.



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[1] Patients rated ASA 3 (having a severe systemic illness) or less.

[2] Centre for Health and the Public Interest – Patient Safety in Private Hospitals – the known and the unknown risks, Table 3 2014 https://chpi.org.uk/wp-content/uploads/2014/08/CHPI-PatientSafety-Aug2014.pdf

[3] Patients rated ASA 3 (having a severe systemic illness) or less.

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[5] Verita Independent review of the governance arrangements at Spire Parkway and Little Aston hospitals in light of concerns raised about the surgical practice of Mr Ian Paterson http://www.verita.net/wp-content/uploads/2016/04/Independent-review-of-the-governance-arrangements-at-Spire-Parkway-and-Little-Aston-hospitals-Spire-Healthcare-March-2014.pdf

[6] Centre for Health and the Public Interest – Patient Safety in Private Hospitals – the known and the unknown risks. 2014 https://chpi.org.uk/wp-content/uploads/2014/08/CHPI-PatientSafety-Aug2014.pdf

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