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MAGAZINE

ISSUE 14

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Welcome to the Medico-Legal Magazine

Welcome to Issue 14 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

We'd like to pass on our gratitude and thanks to all of the hard-working NHS staff and medical professionals who are selflessly guiding us through the current Covid-19 pandemic. Our thoughts and best wishes are with you all.

This first issue of 2020 includes articles from Stephen Hooper, of Hempsons Solicitors, on the importance of expert witnesses knowing their limits when accepting an instruction to write a Medico-Legal report.

Also in this issue, healthcare law expert, Laurence Vick, Consultant Solicitor, comments on the reaction to the Independent Inquiry report into the Ian Paterson, breast surgeon case, that was published on 4 February 2020 and the reforms needed in private healthcare if we are to avoid similar scandals in the future.

We are also pleased to include an article by Peter Rudd-Clarke, Legal Director and Emma Kislingbury, Associate Solicitor, from Reynolds Porter Chamberlain (RPC) LLP, looking at why clinicians and manufacturers must collaborate to mitigate Artificial Intelligence risks.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It is published on the Medico-Legal Section of the Specialistinfo.com website, and printed copies can be ordered from Iconic.

Specialistinfo maintains a database of contact details for up to 90,000 UK consultants and GPs, including approximately 11,000 consultants and GPs who undertake medico-legal work. We also provide Medico-Legal courses for expert witnesses and promote the members of the Faculty of Expert Witnesses (the FEW).

We are also taking early-bird bookings for our annual Medico-Legal Conference in London that has been postponed until 21 October 2020 due to the coronavirus (COVID-19) pandemic.

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.

Nicola Guy
Specialistinfo
Medico-Legal Magazine

Contents:

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MEDICO LEGAL CONFERENCE 2020

EARLY BIRD PASSES AVAILABLE
CLICK TO BOOK

21st October 2020
Congress Centre, London

Badge Collection & Refreshments from 8.45

Welcome and introductions from the Master of Ceremonies
Professor Dominic Regan

Keynote Address
Soon to be announced

Mediating Clinical Negligence in the NHS
Jonathan Dingle, Joint Head Of Chambers Barrister, Mediator, Arbitrator, Normanton Chambers

Controversies about consent - are we under attack
Mr Amar Alwitry, Consultant in Ophthalmology, Leicestershire Partnership NHS Trust

A lawyer's wish list for their medico-legal experts
Flora McCabe, Head of Healthcare Claims, Solicitor, Lockton LLP and Angus Piper, Barrister, 1 Chancery Lane

Reflection & Remediation: A Weapon to be Used Against Doctors
Stephen Hooper, Associate, Hempsons and Shannett Thompson, Senior Associate, Kingsley Napley

Consent for operative obstetrics – Panel Discussion
Dr David Levy, Consultant Anaesthetist, Nottingham University Hospitals NHS Trust
Mr Malcolm Griffiths, Consultant Obstetrician, Luton and Dunstable University Hospital NHS Foundation Trust

Scottish case update - some recent decisions
Ruth Kelliher, Partner Digby Brown

Supporting Clinicians
Jo Mason-Higgins, Head of Claims, Complaints and Patient Safety Investigations, Gloucestershire Hospitals NHS Foundation Trust

Top Tips for Medical Experts in Thirty Minutes
Warren Collins, Partner and Solicitor-Advocate, Penningtons Manches Cooper

Life and Death treatment of children – who decides?
Katie Gollop QC, Serjeant's Inn

Stopping Litigation going to trial
Dominic Regan, Legal speaker, writer and broadcaster, Solicitor, Dominic Regan Training Ltd

Closing Comments

Champagne Reception

Programme may be subject to change

www.medicolegalconference.com

MEDICO LEGAL MAGAZINE

MEDICO -LEGAL COURSES:

By Nicola Guy,
Medico-Legal Manager,
SpecialistInfo

Training Courses for Expert Witnesses

The dates and locations for the confirmed ML courses that we are holding during 2020 are listed below with links to our booking page.

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

- *29th April 2020* – Manchester ***postponed***
- *15th September 2020* – London
- More tbc

£375 (plus VAT)

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

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

- *30th April 2020* – Manchester ***postponed***
- *16th September 2020* – London
- More tbc

£395 (plus VAT)

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

Advanced Medico-Legal Course *New 2 day course*
(refresher and advanced techniques for experts including live court-room skills):

- *2nd & 3rd July 2020* – London ***postponed***
- More tbc

£750 (plus VAT)

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

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

- *24th April 2020* – Manchester **postponed**
- *21st May 2020* – London **postponed*
- More tbc

£450 (plus VAT)

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

Mediation Training Course (5 days)

- *20th - 24th April 2020* – London ***postponed***
- *1st - 5th June 2020* – Manchester ***postponed***
- *13th – 17th July 2020* – London ***postponed***
- More tbc

5 days from £1,400 (plus VAT)

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

Due to the current coronavirus (COVID-19) pandemic our Medico-Legal courses for April - July 2020 have been postponed until we receive confirmation that they can resume.

We are hoping to be able to offer some of our Medico-Legal courses online soon.

If you are interested in an online course and/or you would like me to keep you informed of future "live" course dates please contact me, Nicola Guy, on 01423 727723 or email me at: nicola@specialistinfo.com

I look forward to hearing from you soon.

Kind regards

Nicola Guy
Medico-Legal Course Manager

specialist info

LESSONS FROM PATERSON: THE NEED FOR PRIVATE HEALTHCARE PROVIDERS TO HAVE SKIN IN THE GAME

By Laurence Vick, Consultant Solicitor

Email: laurencevick@hotmail.com @LaurenceVick

The Paterson case highlighted multiple failures of governance, regulation and patient care at all levels in the NHS and private sector. In this article, Consultant Solicitor Laurence Vick comments on the reaction to the Independent Inquiry report published on 4 February 2020 and the reforms needed in private healthcare if we are to avoid similar scandals in the future. There were crucial lessons for responsibility and accountability of private providers, with obvious implications for outsourcing of treatment by the NHS to the private sector.

So was the report and the recommendations made by the former Bishop of Norwich, the Rt Reverend Graham James, as some have suggested, a missed opportunity to investigate to the fullest extent the many issues of concern and ensure that the necessary changes will be introduced?[1]

In their response[2], Spire's Chief Executive welcomed the report and said they supported the recommendations and will work with the government and private healthcare sector to ensure they are implemented.

Many commentators believe the conventional contractual model - by which private hospitals and clinics provide what is effectively the package of care but escape legal liability and avoid responsibility if treatment fails - to be flawed. Ultimately, I don't believe we can be sure of our safety in the private sector until operators are required to have skin in the game. In short, as the Paterson scandal highlighted, they should be accountable for the care patients receive in their hospitals.

The background

Paterson was sentenced to 20 years imprisonment in 2017 on charges of wounding with intent and unlawful wounding. He had been allowed to perform unnecessary and inappropriate breast operations and other surgical procedures for at least 14 years until 2011, at Solihull Hospital (Heart of England NHS Foundation Trust) and in the private sector at Spire's Solihull Parkway and Little Aston hospitals which had granted him practising privileges. The numbers are substantial; he had carried out 6600 operations at the Spire hospitals and 4400 in the NHS, including 'unnecessary' procedures on children.

The James Review considered a wide range of issues including responsibility for the quality of care and the appraisal and validation of staff working in the private sector, information-sharing between the private sector and the NHS, the role of insurers of private providers and the level of medical indemnity cover doctors working in the independent sector are expected to hold.

The Rt. Reverend James in his hard-hitting report said patients had been "let down over many years" by the NHS and independent providers; there had been a "culture of avoidance and denial" in a "dysfunctional healthcare system that had failed patients at almost every level" and had allowed these operations to take place in "plain sight." This was yet another scandal in which whistleblowers had been silenced or suppressed, at great cost to the patients whose terrible suffering might have been avoided or significantly reduced had colleagues in the NHS and at the Spire hospitals felt able to raise concerns without fear of retribution.

Spire and other private providers carry out a significant amount of work for the NHS. There have long been concerns over the lack of transparency in the private health sector and the culture of secrecy that seems to prevail when the NHS outsources treatment to what can often turn out to be inadequately vetted private hospitals and clinics and gaps in the supervision and monitoring of those contracts when in progress. Much of the care provided by private providers is of the highest standard, but as they are beyond the reach of a Freedom of Information request and have relied in the past on commercial confidentiality to refuse to disclose information and data how do we assess this and compare outcomes and safety standards in the two sectors? How do we check whether the private hospital has appropriate facilities and resources for the treatment we are to undergo and the ability to cope with complications that can occur with any kind of medical procedure?

These issues need to be addressed, otherwise we will lose the advances of recent years in the consent process before treatment and the duty of candour required if treatment has failed and the patient has suffered harm. Paterson's NHS and private operations pre-dated the introduction of the duty of candour, but what could patients expect from this obligation on healthcare providers if the treatment had taken place today?

A major concern has been the lack of clarity over responsibility and accountability for failed treatment in the sector. In their response to the report[3], the The Centre for Health and the Public Interest (CHPI) thinktank https://chpi.org.uk/ expressed disappointment that it had failed to address what they regard as the flawed private healthcare business model with it's potential for patient harm. Patient safety charity Action against Medical Accidents (AvMA) welcomed the report[4] but warned that it did not go far enough to protect patients receiving private treatment. AvMA wished to see a number of checks and balances: regular audits and the same level of supervision of staff as occurs in the NHS, a single robust complaints procedure for patients receiving private treatment with the right to appeal to an ombudsman or equivalent and a funded independent advice service, and a statutory requirement for private health organisations to take responsibility and provide indemnity for patients receiving negligent treatment in their hospitals.

Lack of liaison between the NHS and private sector

The emerging scandal revealed a worrying lack of liaison between the two sectors. Large numbers of both NHS and private Paterson patients had not been contacted and followed up by the Trust or Spire. The report found that the number of patients subjected to unnecessary treatment could run to more than 1000 and no less than 11,000 patients in both sectors are to be recalled and have their treatment assessed. These investigations will involve significant input from medical experts and lawyers for the NHS and together with claims brought by patients found to have been harmed by Paterson will result in enormous expense – expense which could have been avoided had steps been taken to halt Paterson and his dangerous activities. It was also announced that West Midlands Police had referred 23 fatal cases of Paterson patients who had since died of breast cancer to the Coroner in Birmingham.

Although NHS Resolution paid out £17 million to settle the claims of Paterson's known NHS victims, many obstacles were placed in the way of his private patients in their battle for compensation. Spire maintained in the separate court proceedings brought by his private surgery victims that they had relied on the NHS to vet his competence and warn them of any concerns over his abilities. Prior to the eventual settlement of the court action Spire were reported to have sued the NHS Trust for failing to warn them of his dangerous practices: a tactical move to blur lines of responsibility perhaps but surely a damaging position for a private health care provider to adopt.

Implications for outsourcing by the NHS to the private sector

Of the 211 patients who gave evidence to the Inquiry, 92 were private patients treated at the two Spire hospitals and 5 were NHS patients treated by Spire at those hospitals. Although only a small proportion of Paterson's private operations were funded by the NHS, the scandal provides a window into the private sector to which the NHS is outsourcing an increasing amount of our treatment, particularly elective procedures.

Current figures indicate that a third of all hip replacements, cataract and other ophthalmic procedures are carried out in the private sector. The NHS is now contracting out a fifth of its total healthcare budget, equivalent to more than £20 billion a year. Spire's NHS referrals nationally account for a third of its annual revenues. Nearly a quarter of their activity at the Solihull and Little Aston hospitals is funded by the NHS.

I don't personally believe that we are heading for full-scale privatisation of the NHS. There must be a doubt over the private sector's appetite for taking over and accepting the operating risk and indemnity cost of running a full-service hospital, maternity unit or A & E department after Circle's experience of running Hinchingbrooke NHS hospital. Leaving aside the long-term political considerations of this increasing trend to outsource treatment, the result is a blurring of lines of responsibility and accountability which in some places leads to concerns over gaps in safety where the two sectors overlap.

There is no national system for monitoring the care provided to NHS patients treated in the private sector. My concern, on which I've written articles published by CHPI and other journals, relates to the safety issues and the fear that private providers are not adequately vetted and NHS contracts are not adequately monitored. Local NHS management may not be in a position to intervene swiftly if problems occur and it can be difficult to establish who within the NHS has overall responsibility at the highest level for the safety of outsourced care. It is reasonable to assume this should be at least as good as that which the patient could expect in the NHS.

Whereas NHS hospitals treat patients of all ages with the full range of medical conditions, illnesses and diseases, private hospitals carrying out outsourced work for the NHS can effectively 'cherry pick' the most profitable, usually low-risk, forms of treatment that can be delivered at a predictable cost. This should present no difficulty for surgeons and their teams, but problems can and do occur. There should be few if any complications, so the 50% complication rate – attributed in a subsequent investigation to not one but to a 'constellation' of failures – only four days in to the outsourcing contract for cataract procedures carried out by Vanguard Health in 2014 for the Musgrove NHS Trust in Taunton was alarming[5]. One of my clients lost his sight. The investigation also exposed a complex chain of sub-contracting whereby three companies provided various elements of the outsourced service: Vanguard as main contractor, The Practice PLC supplying the surgeons, and Kestrel Ltd the equipment. Unless each organisation in the chain of care providers is checked there is an inevitable risk of patient harm and expense to the NHS (which they never seem to be able to recover).

The "flawed" legal structure

The contract for undertaking private treatment in the private sector (with no element of outsourcing) is between the patient and the consultant or surgeon, with a separate contract between the patient and the hospital for the use of the hospital's facilities and services. Spire refused to accept responsibility for compensating Paterson's private patients, relying on the more limited scope of a private hospital's liability in line with this traditional formulation of the private hospital/surgeon/patient relationship.

Many patients will be drawn to the private provider through on-line advertising. As the first information many patients would see, the report confirmed that Spire's website had been checked in 2019 and was found to be misleading, giving the impression consultants are employed by Spire and that Spire were therefore responsible for them and their actions. Despite advertising the fact that Spire "employ the best and brightest consultants" the patient terms and conditions stated that consultants were independent contractors and not employees.

Looking at their current on-line advertising, patients are asked to give feedback on the experience Spire has provided. The website states "we're a trusted healthcare provider delivering outstanding patient care" "Our consultants: find out about our experts and the treatments we provide at a Spire hospital near you" "You can expect outstanding care from our expert consultants and dedicated nurses", (to GPs) "Your patient will see the same consultant at every appointment".

This has been exercising the minds of leading lawyers since the scandal broke, particularly those involved in the litigation, but is it such a stretch for a court to find that private providers owe a duty of care to the patient?

Indemnity

His private patients had been unable to recover compensation from Paterson personally and his professional indemnity insurers refused to meet claims on his behalf arguing that there was no requirement to indemnify him by reason of his criminal acts.

The liability position of private hospitals would have been tested and hopefully clarified had the trial listed for hearing in 2017 gone ahead but Spire and their insurers, I believe, bowed to the inevitable and agreed to pay £27.2m into a fund to compensate 750 of Paterson's private patients, equivalent to an average of £49,600 per patient including the further £10m provided by Paterson's insurers and the NHS Trust. His NHS patients had already received an average £62,815 per patient. Neither the NHS nor Spire have admitted liability.

Concerns over transparency and governance

After it emerged that Paterson had been allowed to continue operating as a surgeon for such a lengthy period, President of the Royal College of Surgeons, Derek Alderson commented in a BBC Panorama interview on 16 October 2017 that private hospitals are not reporting enough data on patient outcomes[6]: 'We don't know exactly what's going on in the private sector... It cannot be as robust or as safe as the NHS at the moment for the simple reason that you do not have complete reporting of all patients who are treated... It's not good enough. Things have to change.' The RCS recommended that private hospitals must be required to participate in clinical audits as a condition of registration by the Care Quality Commission (CQC) and forced to report similar patient safety data including 'never events,' unexpected deaths and serious injuries as required of NHS hospitals.

Facilities and safety in the private sector

In their October 2017 report 'No safety without liability: reforming private hospitals in England after the Ian Paterson scandal'[7] the CHPI thinktank made a number of key recommendations: private providers should directly employ the surgeons and other consultants who work in their hospitals; private hospitals will not be safe unless they have adequate intensive care facilities to deal with post-operative emergencies, avoiding what can be the hazardous transfer of patients to NHS hospitals. CHPI had previously noted in their 2014 report 'Privatisation and independent sector provision of NHS healthcare'[8] that private providers without the necessary facilities rely on the NHS as a safety net – reducing expense for the private hospital but at substantial cost to the NHS.

In the interests of transparency and the need for a valid consent, patients should surely be informed of any shortcomings in the facilities available to a private hospital or clinic so they can make an informed choice between NHS or private care.

The report called on the government to address the safety and governance issues: patients should be "made aware of the risks of private hospital treatment." The problem is that with a private sector adept at marketing but not noted for its transparency or openness, obtaining meaningful information about those risks, then being in a position to understand and evaluate those risks – risks a patient faces over and above those he would encounter undergoing the same procedure in the NHS – can be extremely difficult.

The report's recommendation that individual surgeons should publish their record and experience on a website may be too simplistic. The patient needs to be warned of any shortcomings in the hospital's facilities, or the support available to the surgeon, and how this might impact on any complications he might suffer.

Whistleblowing

It was impossible to believe when the scandal was first reported that there weren't employees

MEDICO LEGAL MAGAZINE

at Spire as well as in the NHS hospital who knew of Paterson's dangerous practices and who either raised concerns which were suppressed or ignored by senior colleagues and managers or were prevented from doing so or worse, who turned a blind eye to his activities. Stephen Adams in the Daily Mail reported in June 2017 that up to ten doctors who worked with Paterson were being investigated by the GMC and that the Nursing and Midwifery Council said it was investigating 'a small number of nurses' linked to Paterson.[9]

The review found that Paterson's NHS colleagues were "genuinely fearful of the consequences" after concerns had been raised since 2003. Medical staff at Solihull Hospital had been subjected to bullying and aggression after voicing concerns. A key failing was that the NHS Trust had prioritised Paterson's right to confidentiality as an employee and had dealt with those concerns "under HR processes and not as a patient safety issue," allowing him to "hide in plain sight" for more than two decades until his suspension in 2011.

After publication of the review, five health professionals were reported to have been referred to the GMC or Nursing and Midwifery Council and one case had been referred to the police. A warning sign, hopefully, that inaction and connivance in the face of a colleague engaging in dangerous practices will be regarded as culpable. We don't have a full picture of attempts by his colleagues at the private hospitals to raise the alarm.

Continuing concerns over governance

Shortly after the release of the report, Spire announced they had launched an investigation into surgery undertaken at their hospital in Leeds between 2012 and 2018 by shoulder surgeon Michael Walsh, who was suspended and reported to the GMC by Spire in April 2018[10]. Lightning had struck twice in the same place for Spire with reports in January 2020 that they had already been forced to launch a review into the care received by 217 patients of orthopaedic consultant Habib Rahman concerning "unnecessary or inappropriate" shoulder operations performed at the Spire Parkway, Solihull hospital where Paterson had operated. Spire said they had restricted Rahman from practising at their hospital in September 2018 and suspended him in January 2019; Spire had asked the Royal College of Surgeons to review his practice and they were liaising with the CQC and the GMC over the RCS' findings[11]. Meanwhile Rahman is still employed by his NHS Trust, which says they have not been required to recall any of his patients, but they have subjected him to "interim conditions."

Spire commented in the press that the financial impact of the Rahman review on their business would be immaterial as any claims would be met by Rahman and his insurers. This reliance on the traditional private health model again demonstrates how it is too easy for the private sector to avoid responsibility. The Investors Chronicle reported on 6 March 2020[12] under the heading "Spire haunted by clinical issues" however that Spire had suffered reputational damage "which could stunt (their) ability to benefit from capacity constraints in the NHS."

Concerns were also reported in the press over a shoulder procedure carried out at the same Solihull Parkway Hospital by consultant orthopaedic surgeon Amir Salama. A letter in July 2019 from the Spire hospital director to the patient said independent specialists had found "very little clinical or radiological justification" for the operation. A Spire spokesman said: "As part of our robust oversight and governance, we continuously review consultants' practice and occasionally contact individual patients about their care if there is a concern." The company said that as "a responsible healthcare business", there would "inevitably be reviews… In this instance, following a complaint by one patient, we undertook a wider review of this consultant's practice and have been in contact with one further patient to follow-up their care." "We can confirm that we have not undertaken a recall involving this consultant's patients and that we have no reason to do so at this time"

This appears to have been dealt with appropriately by Spire, but this does beg the question: if a private provider is in a position to grant and if necessary withdraw a Consultant's practising privileges and conduct full reviews into the care a patient has received from that consultant, doesn't this assume a measure of responsibility for that treatment?[13]

Conclusion

If private providers are able to avoid legal responsibility for the actions of doctors working in their premises, alongside their staff, using their equipment, the risk is they will continue to regard themselves as untouchable and will lack the incentive to monitor the activities going on in their hospitals. As private companies often employ local NHS doctors, surely they should not be able to argue – as appears to have been Spire's reported intention – that it is the responsibility of the NHS and not the private hospital to vet those doctors. The private sector should be accountable directly to the patient for the treatment carried out in their hospitals. If a private provider has a remedy against the surgeon brought in to carry out the treatment, let them pursue it. Where treatment has been outsourced by the NHS, the NHS should not be out of pocket if patients receive negligent care in a private hospital.

Inquiries in one form or another have proliferated and have become the inevitable and entirely understandable response from the government to the many scandals that have emerged in recent years. Patients and families though, want more than catharsis. As well as the opportunity to tell their stories and be heard, they want to be reassured that issues will be fully investigated, with all relevant individuals and organisations called to give evidence and account for their actions or inactions. Above all, they want to see that positive changes will be made and that lessons really will have been learned to ensure that their experiences and suffering will not be repeated.

References

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[13] https://www.verita.net/wp-content/uploads/2018/08/aiho-practising-privileges-principles-2016-1.pdf

MEDIATING ONLINE IN THE COVID-19 ENVIRONMENT

By **Mia Forbes Pirie** and **Graham Ross**

In this time of self-isolation online mediation becomes more relevant than ever. There are, of course, advantages and disadvantages to mediating online. However, given that it may be the only option, this article focuses on tips for online mediation. Experts in workplace, tech and online dispute resolution, Mia Forbes Pirie and Graham Ross give you the low down.

We evaluate people not just through words but through the congruence of words with their body language and tone of voice. Often it is our

extremities which give us away – a foot tapping, hands moving. How, therefore, can we better evaluate and generate trust when not in the physical presence of each other? How can we make mediation work online?

Mediating online - platforms and tips

In the Covid-19 environment, we assume that mediation will take place using a dedicated online mediation platform and/or video conferencing software such as Zoom. If a combination with face to face mediation is required, most of the mediation could be conducted online with a potential face to face meeting to wrap things up once social distancing ends.

Many of these points seem obvious but make all the difference.

10 Top Tips for video mediation

1. **Tech!** Find out how comfortable participants are with the technology. Prepare with separate test runs.
2. Acknowledge the issues and signpost. Start the video call by acknowledging what may be different from a face to face meeting. E.g. time-lags, longer pauses for questions and contributions. Let people know clearly what the technical process is going to be.
3. **Use common-sense and follow social norms.** For instance, introduce yourself at the beginning of a meeting with one side. Make appropriate "chit chat" to build trust. Always be on time.
4. **Encourage a focused environment free from distraction.** Request that mobile phones be switched off and that, wherever possible, the environment be free of distractions (children, dogs, doorbells ringing, checking emails etc.)
5. **Camera angles.** Help the parties set up their camera to better display their image. Avoid angles looking up someone's nose. Each person, especially you, should be sitting upright at a desk or table at an appropriate distance from the camera. If you want to appear to be 'looking people in the eye' look directly into the camera.
6. **Neutral background.** Consider insisting on a neutral background (e.g. a white wall or a plain digital background). This is particularly helpful where there may be disparities in wealth or power between parties.
7. **Take security measures.** Ask parties to commit to not recording the session, not inadvertently sharing login details and to being alone in the room. If using Zoom, make sure you take steps to avoid "ZoomBombing" (hackers joining your meeting), including password protecting your meeting and possibly disabling "file transfer" and "screen sharing" by the parties". Have a protocol for sharing documents. Understand the security features of any platform you use.
8. **Virtual breakout rooms.** To recreate a shuttle mediation environment, Zoom allows you to have joint sessions and then move parties and their lawyers into breakout rooms which you can drop into. Participants can be reassigned to different rooms as needed, as in the real world. Get comfortable with these features. Sometimes, however, it may be better to close the joint session and schedule times to speak separately to the parties.
9. **Technical restrictions.** Consider the meeting settings carefully. For example, disable "join before host", and possibly other features to prevent Zoombombing (point 7). Consider muting participants on entry, assigning people to breakout rooms in advance.
10. **Consider hiring someone with experience in online mediation.** Mediation online requires different skills to in-person mediation.

Dedicated online mediation platforms

Platforms exist which combine video conferencing with "asynchronous" messaging (different times), and document and case management. They

provide the possibility of conducting a mediation with different parties at different times.

All of the above video conferencing tips apply here. In addition:

- Ensure you use a platform that allows you to control the times when each party can post messages.
- Since you will not be able to see hesitancy, where that may be an issue, ask the parties to scale their answers, 1-10, to 'yes/no' questions on opinion. For example - on a scale of 1-10, how important is this to you?
- To avoid delay in responses, send text alerts when posting a message.
- Carefully review your messages before posting and consider if best framed.

We hope that this will have given you some useful insights. There is only so much information we can provide in this short article. Further information, training and more tips are available from Graham Ross' distant mediation course at:

www.ODRtraining.com and
www.SeeYouOutOfCourt.com

Mia Forbes Pirie is a commercial and workplace mediator with significant experience in technology and online mediation. For more information see: https://miaforbespirie.com

The criticisms have been largely accepted by Zoom who have said it will take until July before the problems have been dealt with. So concerned were they to fix the issues that they have put all product development 'on ice' until after the security problems have been fixed. Version 5.0 was issued on the 27th April, which introduced some interim improvements,including the level of encryption' they had previously, and incorrectly, claimed to have included, and reset two settings as default to avoid users having to set them.

IN IT TOGETHER

WHY CLINICIANS AND MANUFACTURERS MUST COLLABORATE TO MITIGATE ARTIFICIAL INTELLIGENCE RISKS

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Artificial Intelligence (AI) presents clinicians with a challenge: can they harness AI to improve outcomes for patients without creating increased litigation risk? The answer coming loud and clear from the *Medical AI and Robotics Conference 2020* in February was: "Yes" – but only if doctors and hospitals work with manufacturers and computer scientists to minimise the risks.

AI risks

Litigation can arise when a patient experiences a level of medical care that does not meet their expectations. Claimant lawyers focus on the party responsible for the alleged error and sue the provider of the diagnosis, treatment or care. A manufacturer may also be a target where a product is involved.

AI complicates the picture because it brings with it some unique risks. Some of the risks debated at the conference included:

Accountability

"Automation bias" is well documented. This is where people generally (and clinicians are no exception) defer to recommendations made by AI, even in the face of their own experience and training. In a clinical setting, that creates a risk that a patient may suffer a worse outcome. It can be difficult to unpick who is responsible. The doctor, who could have used their judgement to override decisions based on AI? The manufacturer, who could have foreseen and prevented the error? The software engineer whose decisions may have led to a glitch in the programming underpinning the AI?

AI has limits

The limits of AI may not be fully understood. Too much trust can be invested in software and a blind eye turned to its flaws. The data used in machine learning or diagnosis may be low quality or incomplete, leading to poor outcomes. It is increasingly understood that AI is at risk of being programmed with hidden preferences or a demographic bias. AI may not always be the complete solution to complex problems.

Human error

Ultimately, despite the exciting potential offered by computers, the primary AI risk remains human decision making. Such decision making is present throughout the supply chain: from the design of an algorithm, through the selection of data sources and decisions over the deployment of an AI service or product, to reliance on AI in prescribing treatment. The Courts will consider the liability of doctors, hospitals or manufacturers where the level of care has been negligent, or a patient has suffered injury due to a defective medical device. Liability will turn on decisions made by people in those organisations.

Rebalancing the risks through collaboration

Early collaboration is key to mitigating the risk of litigation. Clinicians can consider the following:

Communication

The sharing of knowledge and information between developers, manufacturers, hospitals and clinicians will help to pre-empt, and potentially, avoid, some of the risks which AI creates. Manufacturers and developers should actively engage with hospitals and individuals using their products; end users who are well trained are less likely to experience issues with a product which, in turn, reduces the risk of claims.

Allocation of liability

But what about when things go wrong? How can we seek to allocate liability whilst trying to move away from a situation where all parties are fighting each other to avoid blame?

Last year the UK Government issued an updated "Code of Conduct"[1] , which sets out 10 principles for the development of "safe, ethical and effective data-driven health and care technologies". The code recommends defining the commercial strategy for a product at the outset, which should include identifying how liability is allocated between all those in the supply chain. Clear terms around who bears responsibility when things go wrong should help to avoid a situation where each component part of the chain works in isolation, concerned only with protecting its own interests. In contrast, the code endorses collaboration, transparency and accountability between all parties throughout the development process.

Guidance from regulations

Generally, defence lawyers for a healthcare provider or manufacturer will seek to rely on applicable regulations to defend their clients. In the case of a doctor, following accepted practice and protocols, supported by the appropriate regulatory body, can provide evidence of acceptable care. In the case of a manufacturer, compliance with regulations designed to ensure product safety can go a long way towards persuading a judge that a product was not defective.

Regulation which is clear and effective could also help mitigate the risk of AI litigation. Principles and guidance have been issued, and frameworks, both legal and ethical, are being discussed. But whilst some general laws will apply (including, at EU level, the General Data Protection Regulation (GDPR) and the Product Liability Directive), there is not yet a clear regulatory framework in place for the use of AI in healthcare. The pace of change in AI has been such that regulators have their work cut out in designing and enforcing a system that balances innovation with safety for the benefit of patients, healthcare providers and manufacturers alike.

In January, the CEO of NHSX, the team responsible for driving forward digital transformation in healthcare in the UK, met with the heads of 12 regulators and public bodies, including the MHRA, NICE and the Information Commissioner. The meeting focussed on the regulatory challenges posed by AI, and led to agreement by all that clear, innovation-friendly processes and regulations are necessary. The key points that emerged, and we hope will enhance collaboration between parties, were:

- The need for clearly defined roles between the different regulators;
- The importance of a joined up approach, which brings all regulatory strands together and creates a single point of contact, advice and engagement;
- Communication, with clinicians, innovators and – crucially – the public, is recognised as critical to ensure that ideas, expertise and concerns are shared.

Looking ahead

The advent of new AI techniques means that multiple parties are going to have to collaborate as never before to limit the risk that AI could lead to sub-standard treatment. If they do not, the promise of AI may not be fully realised due to a combination of poor planning and avoidable financial exposure. It is early days but guidance from the UK Government and NHSX points the way forward.

References

[1] https://www.gov.uk/government/publications/code-of-conduct-for-data-driven-health-and-care-technology/initial-code-of-conduct-for-data-driven-health-and-care-technology

DUTIES OF AN EXPERT WITNESS: THE IMPORTANCE OF KNOWING YOUR LIMITS

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The recent case of *Samantha Thimmaya v Lancashire Teaching Hospitals NHS Foundation Trust [2020]* sounded an alarm bell for all medico-legal experts, after an £89,801.68 wasted costs order was imposed on an expert whose negligent advice led to a claim being discontinued at trial. Mr Jamil, a Consultant Spinal surgeon instructed by the Claimant in a clinical negligence claim, was *"wholly unable to articulate the test to be applied in determining breach of duty in a clinical negligence case"* when cross-examined at trial. As he was the only expert the Claimant was able to rely on, she was left with no choice but to discontinue her claim in the middle of the trial. The Defendant Trust then pursued a wasted costs order against Mr Jamil, on the basis that:

1. he had not been competent to act as an expert in the case generally, as he had shown himself to be incapable of explaining the Bolam test;
2. that he had only personally carried out the operation in question twice; and
3. had he not provided his negligent advice, it is unlikely that the Claimant would have proceeded with her claim, which would have avoided costs unnecessarily being incurred on both sides.

The judge had some sympathy with Mr Jamil, who had experienced psychiatric ill-health during the course of the case – although that too ultimately counted against him, as she found that if Mr Jamil was too unwell to engage in clinical practice, he should also have withdrawn from his medico-legal duties. The judge therefore concluded that the Defendant should be awarded their costs from the point Mr Jamil ceased clinical practice. In reaching her decision, the judge made the following observations:

- Mr Jamil demonstrated that he was not aware of the test for breach of duty at the time of joint statements, when he referred in that statement to *"best practice"*, which is not the appropriate test. At trial, Mr Jamil again showed himself to be unaware of the relevant test;
- This was a significant failing which amounted to *"improper, unreasonable, or negligent conduct"* such that the jurisdiction to make a wasted costs order was engaged;
- From reading the papers, it seemed unlikely the Claimant would have succeeded with her claim. Therefore, had Mr Jamil stopped acting in the matter, it may very well have been that no other expert would have supported the claim, at which point the Claimant would have discontinued the claim and the Defendant would not have incurred costs thereafter;
- The consequences in this case were that the Claimant had lost the entitlement to have her case tried on its merits. Considerable court time was wasted, and a public body (the Defendant) had incurred significant costs;

The notion that experts can be penalised for failing in their duty to the court is not new. In 2011, the Supreme Court judgment in *Jones v Kaney* waived experts' immunity from being sued for negligent advice, and although instances of being sued are (and quite rightly should be) rare, experts are habitually warned by solicitors to remember their overriding duty to the Court. As observed by the judge in Mr Jamil's case, this does not mean that the court system will be devoid of "bad" experts. It is not unheard of for reports to be poorly written or for experts to stray beyond their expertise, and there is a role for lawyers in ensuring that any experts instructed are properly qualified for the task, that reports are properly scrutinised and that they are fit for purpose before being served. However, the consequences for those experts held to account can be severe, as Mr Jamil found to his detriment, so it is important to reinforce some key principles for those engaging in medico-legal work.

After *Jones v Kaney,* experience dictates that experts are most likely to be at risk of being penalised where they:

1. Fail to review a joint report and ensure that it reflects their views prior to signing it, so that significant concessions are inadvertently made in the litigation, as in *Jones v Kaney;* and/or
2. Fundamentally change their position.

Paragraph 2 of The Practice Direction to Part 35 of the CPR provides:

2.1 Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation:

2.2 Experts should assist the court by providing objective, unbiased opinions on matters within their expertise, and should not assume the role of an advocate.

2.3 Experts should consider all material facts, including those which might detract from their opinions.

2.4 Experts should make it clear –

(a) when a question or issue falls outside their expertise; and

(b) when they are not able to reach a definite opinion, for example because they have insufficient information.

2.5 If, after producing a report, an expert's view changes on any material matter, such change of view should be communicated to all the parties without delay, and when appropriate to the court.

It is, of course, perfectly acceptable for an expert to become aware of new material which causes them to alter their opinion. This is distinct from a 'fundamental' change indicative of them not having properly applied their minds to their initial advice or, more critically, advising on a subject which was beyond their expertise in the first place.

There are also regulatory implications for experts who stray beyond their expertise. GMC proceedings against Professor Roy Meadow established in 2006 that no expert has immunity from disciplinary proceedings before the national regulator, in relation to his or her conduct as a medico-legal expert, even where no issues arise as to their clinical competence. A few years ago, I represented a client who gave medico-legal evidence in a murder trial which was judged to be of such poor standard, a subsequent GMC investigation found him to have behaved "recklessly" – he was suspended from clinical practice for 12 months.

None of this is designed to discourage properly qualified experts from engaging in medico-legal reporting. It is a fundamentally important aspect of many areas of litigation: both lawyers and courts need good experts for the proper administration of justice. Civil and regulatory penalties are exceedingly rare, so in most instances no consequences will follow from writing a report which is not up to scratch – not to mention the lawyers' role in ensuring that their experts' reports meet the necessary requirements before they see the light of day. The message is to ensure you do not overstretch yourselves and that you remember your primary duty is to the Court, no matter how fervently the party or lawyers instructing you might want to win their case. You are there to provide independent expert advice, not to fight a party's corner. Remain objective, consider all the evidence thoroughly, and if you think there is evidence you have not seen, ask to see it. Most importantly, be prepared not to assist if you are asked to advise on a topic which is beyond your expertise. Follow these principles and you will not only avoid criticism, your services will more likely remain in demand.

MEDICO -LEGAL NEWS:

By Lisa Cheyne and Nicola Guy, SpecialistInfo

A round-up of news in the industry for the First quarter of 2020.

Defendant and claimant lawyers agree relaxed litigation rules during Covid19 restrictions

NEWS

Both sides in the personal injury sector have collaborated to create a new set of standard practices for dealing with coronavirus disruption.

The Association of Personal Injury Lawyers (APIL) and Forum of Insurance Lawyers (FOIL) often disagree about issues of policy, but have agreed the new guidance which members will be encouraged to abide by.

Measures which will impact on expert witnesses include accepting evidence by email and agreeing to use some form of video conferencing for medical examination (video diagnosis has already been allowed for soft tissue injuries by MedCo).

Many of the proposals agreed are not covered by civil procedure rules.

Gordon Dalyell, president of APIL, said: 'These are unprecedented times and both APIL and FOIL want to ensure that cases run smoothly across the UK so far as possible. Our members told us their concerns about remote working and how they might adapt to the new way in which the courts are operating. Defendants are also going to have their own difficulties. Both organisations feel it is important to do what they can to help to resolve these issues together.'

Read more:
https://www.lawgazette.co.uk/news/defendant-and-claimant-lawyers-agree-relaxed-litigation-rules/5103737.article

The Medico-Legal Conference has been postponed from 11th June 2020 and will now take place on 21st October 2020 (subject to ongoing Covid19 restrictions). The venue will still be The Congress Centre, 28 Great Russell St, Bloomsbury, London WC1B 3LS.

Please visit the website for details and to book yourself an early bird deal:
www.medicolegalconference.com

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

Footballer Rees Welsh wins landmark injury claim

The football chairman of Ossett United, based in West Yorkshire, says non-league clubs fear for their futures after a court decision on an injured opponent. They face a £135,000 court order after a Manchester court recently found in favour of a semi-professional player who suffered a broken ankle playing for Radcliffe Borough in 2015.

In a statement, Ossett said the club's insurance policy does not protect them from damages or legal fees in the case. It said not only does the potential losses put the entire club in jeopardy but also opens the floodgates for all injured sports participants to sue and win damages from the person who injured them.

Ossett chairman Phil Smith said: 'I urge all sports clubs to check their insurance policies immediately, however, that will only protect future events, not the ones in the past like the one that now threatens our club.'

The club says its only option may be to sell the ground and has started a Gofundme fundraising campaign.

Clubs or players being sued for injuries suffered on the pitch has been rare. One successful claimant was former Manchester United youth player Ben Collett who was awarded more than £4.3m in 2008 after a tackle which ended his career.

NEWS
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Lady Justice Simler has granted Dr Chris Day leave to appeal the settlement in his whistleblowing case against Lewisham and Greenwich NHS Trust and Health Education England (HEE)

In 2013 Dr Chris Day was training in Emergency Medicine and was placed by HEE in the ICU of Queen Elizabeth Hospital Woolwich, where a single junior doctor, with no intubation training, was expected to be responsible for up to 18 ICU patients on a night shift. When he raised a concern that this was unsafe, it went unheeded on the grounds that the system had worked well that way for years. In November 2013 core standards published for ICUs stated that there should be no more than 8 patients per doctor with immediate access to an anaesthetist skilled in advanced airway techniques.

Later that year 2 patients died on ICUs with non-aesthetic trained junior doctors and these were flagged as serious untoward incidents (SUIs). Safety investigations still concluded that night-time ICU staffing was acceptable. In 2018 the CQC report on the QEH was damning with the critical care and emergency departments still requiring improvement.

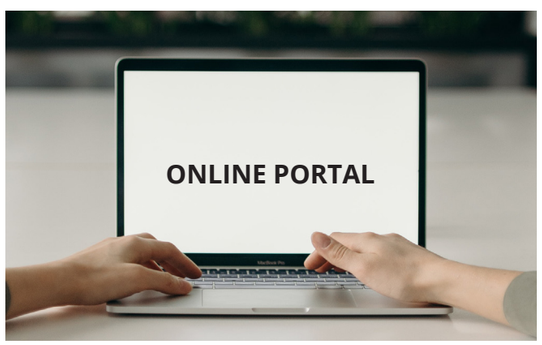
Dr Day's career path to become a consultant was disrupted by his refusal to keep his head down and his determination to fight for whistleblowing protection for fellow junior doctors. He now works as an A&E locum and recently said,

"The U.K has to fight Covid19 with half the Intensive Care beds per capita of Italy. My crime in 2014 in my whistleblowing case was trying to secure more ICU resources for South East London. Instead of spending 5 years and £700k fighting /smearing me and damaging whistleblowing law they could have fixed the problem."

Read more:
http://54000doctors.org/index.html

Online Personal Injury portal to go live

From late spring lawyers will be able to use and test the online system for claims involving one claimant and one defendant in order to submit a claim, pay the court fee, upload documents and receive notification of the issue date digitally. The case will then be transferred to a local court to continue on paper, as per the current process, but eventually most of the process will become digital.



The system dovetails with the RTA claims portal, now set to go live in August after the April deadline was recently extended, for claims worth up to £5,000. The MoJ has announced that litigants in person (LiPs) will not now be offered free mediation, where liability has been denied, in these cases. Claimants who are represented will be able to issue a court claim through the online PI service if they need to, having progressed first through the portal.

Read more:
https://www.justice.gov.uk/courts/procedure-rules/civil/pdf/low-value-personal-injury-sceheme/rta1-claim-notification-form.pdf

Civil Procedure Rule Changes for Expert Witnesses from 6 April 2020

The 113th Civil Procedure Rule Update makes changes to various Practice Directions, but the main change to note for expert witnesses is the wording of the **Statements of Truth.**

From 6 April 2020, the following words need to be added to the existing statement of truth:

"I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth".

This applies to all statements of truth except on a costs budget, therefore, it applies to an expert's report.

Additionally, the statement of truth must be in the witness's own language and it must now be dated on the day it was signed.

Because the statement of truth may well be signed several weeks after the particulars, witness statement, expert report etc have been drafted, consideration needs to be given to making the changes now.

Read more:
https://www.justice.gov.uk/courts/procedure-rules/civil/pdf/update/cpr-113th-pd-update.pdf

Court of Appeal judgment in the "holiday sickness" case of Jet2 Holidays Limited v Hughes [2019] EWCA Civ 1858.

The Court of Appeal has held that a witness statement containing false statements made before the issue of proceedings can give rise to contempt of court and can be susceptible to an application for committal for contempt, despite no claim ever being issued.

The unanimous decision of Sir Terence Etherton MR, Hamblen LJ and Flaux LJ was to allow the appeal of Jet2 against the first instance decision of HHJ Owen QC.

The decision is of interest to all personal injury practitioners as well as those who specialise in travel sickness claims, and serves as a reminder of the gravity of statements backed by signed statements of truth in line with CPR 22.1.1(c), 32.4(2) and 32.8. Rather than drawing a distinction between the Pre-Action Protocols and the Civil Procedure Rules themselves, the Court has instead considered the PAPs to be closely integrated into the litigation framework, such that alleged contempt could be committed within witness statements made without any claim ever being issued.

Read more:
https://www.casemine.com/judgement/uk/5dcce4372c94e061c29a21a3

Menstrual cup misuse can cause pelvic organ prolapse

Incorrect use of menstrual cups could be resulting in some women suffering pelvic organ prolapse.

The Chartered Society of Physiotherapy wants some manufacturers to include better safety advice.

Menstrual cups fit into the vagina and collect period blood. They are not currently regulated in the UK, and there is no safety testing.

The government said the NHS was improving pelvic health clinic access.

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