MEDICO LEGAL

MAGAZINE

ISSUE 22

Presented by:

specialist info

Welcome to the Medico-Legal Magazine

Welcome to Issue 22 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This first issue of 2023 includes articles from:

Dr Rebecca Whiticar, Medicolegal Consultant, MPS, and Medical Expert Witness, shares her insight into the world of the expert witness; and

Caroline Bennett, Medicolegal Risk Management and Education Consultant, asks clinicians if they should consider arming themselves with a Risk-Management Toolkit.

Also in this issue, a special ENT focus:

Mr Maurice Hawthorne, Consultant In Otorhinolaryngology, James Cook University Hospital, summarises common clinical negligence cases in otorhinolaryngology; and

Mr Andrew Parker, Consultant ENT Surgeon, Peak Medical Practice Ltd, Hope Valley, brings us up-to-date on noise induced hearing loss.

Finally, Jonathan Dingle, Barrister and Mediator, Normanton Chambers, London, and Training Faculty Leader, SpecialistInfo, celebrates 10 years of the Faculty of Expert Witnesses.

Once again, the magazine will be circulated to up to 30,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It has a dedicated website www.medicolegalmagazine.co.uk and a page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed. Printed copies can be ordered from Iconic Media.

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 CPD Training for expert witnesses and promote the members of the Faculty of Expert Witnesses (the FEW) to subscribers.

We welcome feedback from our readers, so please contact us with any suggestions for areas you would like to see covered in future issues or share your news and experiences with us.

Lisa Cheyne

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SpecialistInfo has been providing highly acclaimed CPD accredited Medico-Legal Courses for doctors since 2007. In 15 years we have trained over 2,500 doctors.

Our tutors are leading practising Barristers, Mediators & Personal Injury Solicitors. We work closely with them to develop our course programme and to build our panel of experts (The Faculty of Expert Witnesses – The FEW)

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- **Andrea Barnes** - Specialist Personal Injury & Clinical Negligence Mediator (Normanton Chambers)
- **Professor Derek Auchie** – Academic, Tribunal Judge, Arbitrator and Mediator
- **Caroline Bennett** – Risk Management Consultant and Trainer

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Please be aware: *Rules for expert evidence have changed since 2020 and it is recommended that all experts book an updating session to ensure they are compliant.*

BOOK YOUR PLACE TODAY

To book your place please use the QR code or visit **www.specialistinfo.com/course-calendar** or you can email **lisa@specialistinfo.com** or call us on **01423 787 984**

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A RISK MANAGEMENT TOOLKIT – SHOULD I HAVE ONE AND HOW CAN I GET IT?

Caroline Bennett, Medicolegal Risk Management and Education Consultant

Caroline has 30-years' experience (1989-2019) in the medical and dental indemnity industry in the UK and internationally, both as litigation solicitor and in claims management.

Let's think about that.

You are a clinician with perhaps few or many years of experience, or you may be just starting out in your career.

Whatever the case may be, you are totally committed to your patients and just want to get on with being a good doctor without having to think about medico legal risk, professional indemnity and court cases.

However, there is that niggling worry in the background about complaints and negligence claims. It is pushed aside until it is forced to the forefront of your mind either because you are in the firing line or someone you know is and then vulnerability and stress sets in.

Even before any problem actually emerges, you are likely to have experienced challenging moments and conversations with patients. You may have had sleepless nights worrying about whether a complaint or claim may ensue when something has not gone as well as you hoped, your advice has been questioned, or there is tension around a decision you have made.

As a doctor, you have your medical tools such as your stethoscope, your identity badge conveying your expertise and status, your PPE, your scalpel or diagnostic machinery, but what about the tools to protect yourself against the emotional and professional fallout which I would argue is an occupational hazard of being a doctor? Where is your toolkit for that?

It may never happen and in most medical careers doesn't… but it may. I have taken newly qualified and retired doctors who had never previously been the subject of a claim along the litigation journey and seen where the errors and pitfalls occur both medically and in purely practical terms.

Unfortunately, we live in a much more litigious environment than before, with the internet and social media widening the scope for complaint and challenge. The current cost-of-living crisis is also arguably a catalyst for dissatisfaction and the seeking of compensation and accountability.

In the New England Medical Journal in 2006, Martin E Gordon MD referred to:

"The toxic cauldron of actionable causes – the delay or failure in the diagnosis of a disease and its subsequent treatment, a mishap in surgery or anaesthesia…failure to obtain informed consent… can bring on months or years of agonising, tenacious discomfort and chronic dyspepsia for the physician…"

Other professions have, for example, stab vests and riot shields if you're a police officer, hard hats and ear defenders if you work on a construction site, to protect themselves against injury. They have risk-management equipment.

I suggest that if you understand the medico-legal risk landscape you will have yours in your risk-management toolkit and be able to navigate it for the wellbeing of yourself and indeed your patients.

Claims brought following an adverse event are not necessarily due to negligence, and a variety of factors come into play when they are investigated and handled through to their conclusion, whether this be a successful defence or a settlement.

With that in mind, one of your tools is to understand where and how the pattern of behaviour and approach starts which ultimately leads either to a claim, whether or not there has been negligence.

This involves examining the way in which you communicate with colleagues and work as an effective team, how you communicate with your patients, putting yourself in their place, seeing their perspective, and recognising that a patient's memory of a conversation or consultation with you may well be very different to yours. There are numerous examples of this.

Another tool is to fully appreciate the central importance of the quality of your records, and the far-reaching ramifications of not doing so in various scenarios so you are aware of the pitfalls that exist.

Thirdly, understanding the law and what is expected of you as a doctor is crucial and is an indispensable tool. What is the legal standard, how does it work and how does it link to the bringing or outcome of a claim?

Also consider how you take care of your own wellbeing so as not to burn out. Unwell doctors make mistakes, so another tool is to understand how to protect yourself in this respect.

Once a claim has been brought, you need more tools by understanding the claim process, how to work with your indemnity organisation and legal team, how to listen to and appreciate the focus and input of any independent expert instructed on your behalf and how to conduct yourself and demonstrate credibility. Managing yourself well through a claim supports your ability to continue caring for your other patients, care for yourself and certainly assists the handling of the claim on your behalf.

These factors are vital in determining whether any claim brought can be successfully refuted either at an early stage or at any point through to trial.

There is a synergy between the facts, the law and the evidence when it comes to litigation. With your risk management toolkit, you will appreciate this, and how your understanding and approach factors into prevention and outcome. You will be equipped to avert and face challenge to your clinical judgement and management with more equanimity.

Forewarned is forearmed!

I would welcome the opportunity to talk to you in much more detail about all of this. Having defended doctors, managed claims, claims teams and clinical negligence lawyers in different countries in the world in different cultures and jurisdictions during many years in this field, I have a very real insight into the effect the breakdown of the patient/doctor relationship has on both patient and doctor. I also recognise how both a single act or pattern of behaviour can have serious and sometimes devastating consequences.

Having more recently turned exclusively to risk management and education, I would like to pass on the benefit of my experience to provide you with your risk management toolkit which I hope will assist you in your future career.

If you would like to hear more, I will be running an interactive 1-day course on 5th July 2023 in London or online where I will provide you with the tools for you to use. We will dig into case examples and scenarios. Could they have gone differently? Do they chime with your own experience? What questions do they prompt? What nuggets and objectives for your future practice can you take away in your toolkit?

Ensure a better experience for yourself and others so you can concentrate on providing the best care to your patients knowing you have the tools to navigate the medico legal landscape.

If you would like more information about Caroline's training course in July please click here, where you can also book a place:
https://www.specialistinfo.com/ml-risk-management-toolkit

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The Faculty of Expert Witnesses FEW

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- training Doctors since 2007 -

THE FACULTY OF EXPERT WITNESSES PANEL

The Faculty of Expert Witnesses Panel (the 'FEW') promotes high quality Medico-Legal expertise to law firms and insurance companies.
Membership of the FEW has two grades:

Fellows

Consultants and GPs who:

- Have undertaken appropriate Medico-Legal training and agreed to undertake refresher training every 3 years so that they are consistently up to date with all the latest rules and procedures.
- Have confirmed their agreement to adhere to specified standards of good practice covering compliance, availability and service by signing a **Code of Good Practice .**
- Have satisfied SpecialistInfo's Lawyers as to the quality of his or her reports by submitting an anonymised sample report for review*, including presentation and compliance with Civil Procedure Rules
- Have their Medico-Legal CV listed on SpecialistInfo

Unlike other panels, membership is FREE for Doctors.

Members

Consultants and GPs who:

- Have undertaken appropriate Medico-Legal training and agreed to undertake refresher training every 3 years so that they are consistently up to date with all the latest rules and procedures.
- Have their Medico-Legal CV listed on SpecialistInfo

Both grades are expected to adhere to specified standards of good practice covering compliance, availability and service by conforming to a Code of Good Practice.

Non-Members appearing on the SpecialistInfo directory are Consultants and GPs who have indicated their willingness to undertake Medico-Legal work but have not yet qualified for FEW membership.

If you are a medical expert interested in joining our panel or you are a company looking for a quality expert, please contact Lisa Cheyne lisa@specialistinfo.com 01423 787 984

MANY ARE CALLED – FEW ARE CHOSEN

Celebrating 10 years of The Faculty of Expert Witnesses

Jonathan Dingle FRSA, Barrister and Mediator, Normanton Chambers, London, Training Faculty Leader, SpecialistInfo

It was the summer of 2012. The Olympic Games and for me, more importantly, as a barrister dealing with complex personal injury, particularly those with a military element, the Paralympic Games were in full swing. Her (late) Majesty had seemingly descended from a helicopter with James Bond and all was well in the world. No one had heard of COVID 19 and almost as little (except perhaps my companion) the idea of Brexit. Little did we know...

We, in this case, meant my friend the late Hugh Whiteside – who with his family and the team in Harrogate had conceived, set up and run SpecialistInfo, making it the successful and effective enterprise it had become. My friend and colleague at the Bar, Andrea Barnes and I had been offering courses in medico-legal reporting with SI for around five years by then and Hugh was a big fan. Right up to his sudden lamented death in January 2020, he always wanted to innovate.

"How..." he asked, that lovely day on a bench munching fine buns outside Weetons, "...how can we add value to the whole process of reporting? We have experts you are training, and we have the database that provides information. I think we are missing something."

What Hugh did not want to do was to create another medico-legal agency. There were plenty of those, from the huge to the small, the aggressively commercial to the charmingly intimate. Many have gone to wall and others prosper, but Hugh saw the need for doctors, whom he cherished as a special breed, to have something more to support their work as expert witnesses.

"I have a few ideas" I ventured, the taste of exquisite pork pie stimulating the little grey cells. "Doctors tell us they never get feedback – except if their evidence is assaulted in Court. They feel isolated and unappreciated. After they have trained, they feel on their own.

The late Hugh and Ruth Whiteside (bottom left) with the SpecialistInfo team in 2017

"Why don't you provide a service that might vet redacted reports, to check that they are of a reasonable standard, and provide access to advanced and refresher training? And keep them engaged through news and information. Updates and where to find contacts."

Hugh was seized at once. "Yes, quite so – I see it. We have a club or group for experts, which supports and builds them, and helps with their career. We can do that. But we need a name. A name is everything."

I have to say at this point plainly not when you are pondering the desserts menu of Weetons on summer's day. Prosecco and Raspberry possets or the cheese board? I was brought back to reality by Hugh's always delicate interjection.

"I have it!" he said "We will call it the FED – the Faculty of Expert Doctors. How is that for a name?" Fed sounded great but not as good as the Amaretto Trifle we settled on, so we scoffed and pondered. "Do you really want to limit it to doctors?" I asked.

"Ahhh" – it came to us both "The Faculty of Expert Witnesses" "Yes, yes – the FEW". And so it was born. A friendly grouping of those who wished to be truly expert, and able to demonstrate their standards, by providing a redacted report for assessment and approval, and a commitment to reporting excellence thereafter. The FEW was quite an idea.

Ten years on, so it has proven. There would be members and fellows, and a Code of Good Practice. The Code states:

When undertaking Medico-Legal work, all grades of the FEW membership are expected to:

1. Keep up to date with the Civil Procedure Rules and to ensure best practice as an expert by undertaking medico-legal training courses at least every three years.
2. Review and update as necessary their Medico-Legal CV annually and include in it a statement of typical waiting times for appointments and report completion.
3. Reply to communications from law firms or insurers normally within one working day of receipt.
4. Within seven days of receiving and accepting instruction, endeavour to schedule an appointment date for a medico-legal examination and confirm this, or otherwise, to those instructing the expert within one working day of arranging the appointment.
5. Endeavour to complete and release a report within 21 days of the appointment date: where this is not possible to record the reason on the report.
6. Comply with any Court Order provided by the instructing solicitors within the time specified: if unable to do so then promptly to notify all concerned.
7. Reply to any Part 35.6 or other questions received about a report within 21 days of receipt: or promptly to notify the questioner if this is not practicable.
8. Have an efficient administrative system including email, fax and telephone facilities for handling medico-legal work.
9. Refer in their reports to, and document, all relevant correspondence, including telephone calls, between law firms or insurers and the expert or medico-legal secretary.
10. Advise those instructing the expert of any actual or potential conflict of interest before arranging an appointment, should such a conflict be apparent from the instructions.
11. Decline or terminate instructions where an actual conflict of interest is detected.
12. Ensure appropriate indemnity insurance for medico-legal work is in place.

Reports would be read by a barrister and returned in 14 days for a small fee with an analysis and comment to attain Fellowship level. Members and Fellows would demonstrate commitment to the Code and to the additional expert vocation the principles enshrine.

It has been a success – and is an enduring legacy for Hugh and his team. The ten year point also makes a great time to review and re-inspire the FEW and so, to mark its decade, *SpecialistInfo* have agreed to open the doors of the FEW highest level of Fellowship to those who have completed their 2-day Foundation Course or an Advanced Course – this will not only offer refreshing of skills and a court room drama, but also the review of a redacted report and collegiate membership of something good.

Details of the courses (which cover all aspects of what is now a closely regulated profession) are on the website and offer the very best of training and companionable wisdom, learning and fellowship. Something of which we all can be proud and raise a glass, or at least a cup of tea, to Hugh for conceiving.

For more information about courses contact Lisa on 01423 787984 or email lisa@specialistinfo.com

For subscriptions contact Emma on 01423 787979 or email emma@specialistinfo.com

The Faculty of Expert Witnesses (the 'FEW') Panel promotes high quality medical expert witnesses to law firms, medico-legal agencies and insurance companies, who subscribe to the SpecialistInfo.com Medico-legal database.

The Faculty of Expert Witnesses FEW

THE WORLD OF THE EXPERT WITNESS – ARE YOU READY TO JOIN IT?

Dr Rebecca Whiticar, Medicolegal Consultant, Medical Protection Society and Expert Witness

Dr Whiticar discusses the expert witness role and the need for more doctors to take it up.

As doctors, although we may not like to admit it, many of us at different times in our career will experience self-doubt - whether it be the first time we step onto the wards as a junior doctor, stethoscope in sweaty hand or addressing our team as a new consultant. How many of us have asked ourselves how we got here, and can we do this? – a form of imposter syndrome that many of us medics may feel but very rarely share.

Is it any wonder that many of us, once we become established medics, struggle with the concept that we may be considered 'experts' in our fields and that we could undertake work as an expert medical witness?

Demand for experts

In 2020/21 the NHS spent £2.4bn on clinical negligence claims – an increase of 8.7% on the previous year[1]. In addition to the financial toll on the NHS, we must not forget the emotional toll which both the families and the doctors involved in the claim suffer.

The Health and Social Care Committee inquiry on NHS litigation concluded that "a process that is supposed to deliver justice and incentivise improvements fails to do either: lessons are rarely learned and for families accessing compensation is slow, adversarial, stressful, and often bitter."[2]

The impact of litigation on medical professionals was also described by Sir Robert Francis KC:

"*When a claim is made, they (medical professionals) can feel singled out, unsupported and worried about possible sanctions. Clinical negligence claims tend not to be discussed with colleagues and little help is offered about what to do. Consequently, concern for repercussions of any apology or admission of error can override their duties to the patient*".[3]

In this context, the role and the need for high quality expert medical witnesses is clearly vital. Lawyers will tell you a good expert can '*make or break a case*' and certainly, in my experience, good and early involvement of a medical expert witness can help reduce costs, help to align claimants with realistic expectations and lead to earlier resolution for all parties.

Expert opinion also plays a critical role in other domains, including in criminal, civil, coronial and GMC processes. Such opinion can determine, for example, whether or not the Crown Prosecution Service pursues a conviction for gross negligence manslaughter against a doctor following an incident or error that leads to the death of a patient. It can also, more broadly, dictate the standards to which doctors are held. In the Family Courts, medical opinion is relied upon in relation to decisions where the lives and wellbeing of children are at stake.

Yet there is a shortage of medical experts willing to take on this important role. Recognising this, in autumn 2018, President of the Family Division, Sir Andrew McFarlane, established a working group to identify the scale of the problem in the family courts. The barriers are varied and complex.[4]

It is not just the shortage of medical experts that is an issue, however, there are also concerns about the lack of diversity in the medical expert witness pool, an issue flagged by Medical Protection Society (MPS) in its 2022 report *Getting it right when things go wrong: the role of the medical expert*.[5] An MPS freedom of information request to the General Medical Council showed that 86% of the experts instructed in fitness to practise cases are men. MPS fears the low proportion of women on

the GMC's list of experts may be indicative of the wider medical expert witness community, and says a step change is needed to break down barriers preventing women from taking up the role.

A recent article in the Financial Times suggests a lack of gender diversity exists across experts from all backgrounds, not only medical, and this has prompted a global campaign aimed at encouraging more women to put themselves forward and more parties to appoint them[6].

Definition of an expert

An expert witness can be thought of as anyone with knowledge or experience in a particular field or discipline that is beyond that of a layman. Expert witnesses will be instructed by a party (usually a law firm) to provide their specialist knowledge by way of an opinion on a particular issue/set of issues or facts in a case to help resolve a dispute.

While opinion is sought by one party (or sometimes both parties in a dispute – otherwise known as a single joint expert), an expert's overriding duty is to assist the court with the ultimate outcome of a dispute by providing a report that is independent, objective and unbiased. The courts have stated that: "To be competent as a medical expert, a witness must have acquired by reason of study or experience or both such knowledge and skill in the medical profession as to be better qualified than the fact finder to form an opinion on the particular subject of his testimony."[7]

The life of an expert witness can be incredibly varied depending on both the speciality and area in which you work. In my speciality of emergency medicine, my expert role mostly involves providing written reports which give an objective opinion on a claimant's allegations of breach of duty at the very early stages of a claim to aid early resolution if possible.

Most of this work is done in my own time at home, but occasionally the cases will progress to joint expert conferences or conferences with the legal teams. Prior to Covid-19 these were in person, but thanks to the new remote working environment, this is now all possible through videoconferencing.

What makes a good expert

It is important to emphasise again that many doctors may not feel they are ready to be an 'expert' in their field.

So when considering whether you should undertake expert work or not, you could consider what attributes you might have as a doctor which could make you a good expert witness.

Solicitors I have worked with have always stated that the most valuable attribute in a medical expert is a clinician who has the ability to write clearly and succinctly, logically explaining their rationale for their opinion backed by relevant medial evidence. It stands to reason that an expert witness must be capable of reading large amounts of clinical information, analysing a case objectively and giving an independent viewpoint backed by up-to-date medical knowledge and evidence.

I would add that a good expert must act with honesty and integrity, have the maturity to declare any relevant conflicts of interest and to admit if the instructions from solicitors fall outside of their remit of expertise. The experienced medical expert has the ability and wisdom to only accept instructions in cases they consider relevant to their expertise.[8]

Being an expert witness is no different from being a clinician, in that we need to maintain the trust of both the legal professionals we work with and the public.

To help maintain that trust, an understanding of clinical negligence processes, the legal principles of clinical negligence and the civil procedure rules (CPR part 35) - which govern the role of the expert - are essential.[9]

This can all be learned through expert witness training, which would contribute to the clinician's own CPD and appraisals for validation. You would not endeavour to do a practical procedure such as an insertion of a traumatic chest drain without knowledge of the rationale for the procedure, the anatomy, the logistical process, and your equipment – writing an expert report is no different just with an understanding of the CPR part 35 and case law rather than chest wall anatomy.

400 years of immunity for experts was waved in the recent landmark supreme court case of Jones v Kaney [2011][10] and it is therefore important to appreciate as a medical expert that you can be held accountable in your role. It is vital to have appropriate indemnity arrangements in place, just as you would do in your clinical practice.

At the end of the day an expert witness' overriding duty is to the court and therefore an expert must be 'credible' to that court. Credibility in my opinion is linked to current knowledge of the systems in which we work and indeed the MPS report suggests that doctors should put themselves forward to provide expert opinion while being in current clinical practice.

Ongoing involvement in clinical work helps to ensure that experts are up to date and allows for a more realistic assessment of what is 'reasonable', as opposed to 'text-book' practice. Those working within a system are best placed to understand its challenges and imperfections. Systems issues often play a key role when things go wrong in medicine. They inevitably impact on the care provided by a doctor, and so deserve consideration in all situations where a doctor's practice is under scrutiny. The MPS report goes as far as suggesting it should be mandatory for medical expert reports to consider the role systems issues may have played in an adverse patient outcome.

How to become an expert witness

I created my own path to becoming an expert witness by becoming dual qualified in medicine and law while still clinically practicing in my speciality, but that is by no means the only way in, and there is no single route.

There are plenty of training options that exist for experts and some 'lists' you can join, however there is unfortunately no single central register of experts, which can mean instruction often relies on word of mouth. Work as an expert witness is often determined by 'who you know' and then in turn which solicitors learn to trust and like your reports.

There is a recognised need for more expert witnesses and with that there is a need to diversify to produce the best possible pool that instructing solicitors can choose from.

We need to look at the barriers stopping the expert pool from growing and diversifying, and what we can do to introduce our world and the benefits to others.

The majority of consultants and GPs, ideally in current clinical practice, should have the requisite knowledge to provide an expert opinion in their field of expertise after an initial period in post, and should feel confident and empowered to do so. It is diverse, challenging yet rewarding work that is vital for the profession and society.

If you are a doctor considering beginning a medico-legal practice, or feel you need an update on current rules, then please view SpecialistInfo's range of CPD courses for medical expert witnesses.
www.specialistinfo.com/course-calendar-2023

We also maintain the Faculty of Expert Witnesses, which is the largest database of approved medical experts available for subscribing law firms and medico-legal agencies to approach.
www.specialistinfo.com/specialistinfo-medico-legal-services

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CLINICAL NEGLIGENCE IN OTORHINOLARYNGOLOGY

Maurice Hawthorne FRCS(Eng) FRCS(Ed), Consultant In Otorhinolaryngology,
James Cook University Hospital

Introduction

I have been writing reports on clinical negligence and clinical performance since 1989. In those 34 years there has been several striking and, in some ways, sad things that I have observed. I accept instructions primarily from five main sources: claimant solicitors, defence solicitors, defence organisations, NHS Resolution, and the GMC. From time to time the unusual case will come from an unusual source, including solicitors and regulators in the West Indies, Australia, New Zealand and South Africa. The first thing I have noted is, whilst I get instructed about cases from all over the UK and the Republic of Ireland, how certain hospitals appear to be over-represented, with significant number of cases and other hospitals rarely appear. However, this does change with time, for example there was a hospital in the North-West that would appear at least once a year and sometimes more for about ten years, and then in the last 15 years it has only appeared twice.

The next thing that I have noted is how the same mistakes are being made now, that were being made in the nineties. It is heartening to see NHS Resolution and Royal Colleges trying to get information to clinical staff about common errors, but there is still a huge amount of work to be done in this field.

Consent in ENT surgery has changed dramatically in the last 34 years and as such I will not be discussing it in this article. I have found that even since the Montgomery case that there is a reluctance for cases to be pursued on consent issues alone.

"Dabbling"

I remember Arnold Maran, former President of the Royal College of Surgeons, in about 1993 at a conference on negligence for surgeons advising "do not dabble". This advice is still sound today, as it was then, and the surgeon that does something on a very occasional basis is more likely to make an error. Two examples come to mind, one was a case of a two-year-old with a collaural fistula, where a surgeon in attempting to excise the fistulous track cut the facial nerve – he had never done this operation before; sadly working only about 40 miles away there was a surgeon who had tackled many of these and had a national reputation for dealing with them. Perhaps if the case had been done jointly, a better outcome for the child would have occurred.

In another case of ossiculoplasty the surgeon decided that he would use histoacryl glue to attach a prosthesis to the head of the stapes bone. Sadly he glued a curved needle to the stapes and when he tried to remove the needle he pulled out the stapes, deafening the patient in that ear. Using products that are not licenced for a particular use is also fraught with problems and can lead to patient injury.

Despite the NHS issuing clear instructions on how to introduce a new procedure to a Trust or a completely new procedure to the whole of the NHS, there are still surgeons today that ignore the advice, develop an operation and try it out on patients without explaining the novel nature of what they plan. Sometimes I see an idea put into practice, without seeking any permissions, that is really a good one in principle, but when it goes wrong in a case it becomes impossible to defend.

Other examples of "dabbling" included first time injecting lateral pterygoids with botulinum toxin, leading to a paralysed palate, causing the patient to nearly drown after the surgeon told him that there was no problem swimming with a paralysed soft palate and he dived into a swimming pool. The surgeon had not considered the risks of the technique that he had chosen, and was not aware that there were safer techniques that could have been employed. In another case a surgeon chose to manage a patient with drooling by performing bilateral tympanic neurectomies. The surgery led to post-operative auditory symptoms, and there had been a consenting failure in that the option of using botulinum toxin was not discussed, though at the time it was a well-established treatment.

Cosmetic Cases

From time to time it crosses my mind "how could any surgeon in their right mind ever think it was a good idea to operate on this person." Yet in some, the ability to spot the patient that will not be satisfied no matter how good your surgery, how careful the consenting procedure and the time spent in trying to manage expectations, is lacking. Often there are clues. For example, the patient may have seen several other surgeons beforehand and none of them have taken on the case. There may have been other cosmetic procedures about which the patient is not completely satisfied. There are also personality traits. When I teach about patient selection I talk about SIMON and that every SIMON should usually be avoided. Who is SIMON, the Single, Introverted, Male with Obsessive and Neurotic tendencies.

Process

About a third of the cases I opine upon are errors of process. These are, in my experience so far, exclusively NHS cases, but the incident can occur in a private hospital. Fortunately, some progress has been made in avoiding the wrong side operation or the wrong patient operation. There was the case many years ago where twin boys aged six were placed on the same operating list – one was for a tonsillectomy and the other was for adenoidectomy and grommet insertion. On the evening after the operation there was consternation when the mother reported that the child for tonsillectomy had had the adenoidectomy with grommets and the twin for the grommets had his tonsils removed. There was a frantic check of process in the records and the theatre staff interviewed and no error could be found. It was only after the anaesthetist, a cheery jovial man that was superb with children had a chat with the boys and discovered that they had swapped their identity arm bands did it come to light how the error occurred. The Trust introduced a new policy – no twins to be operated on, on the same list. I have to say since

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that incident I have worked in many hospitals and it was the only hospital that I am aware of that has that policy.

The commonest errors of process are failures to list a patient for surgery or an investigation after telling the patient and GP that the patient was listed; failing to arrange follow-up appointments; failing to read/act upon investigation reports that report an abnormality; failing to chase a patient or even discharging a patient with an untreated serious disorder, or is under surveillance, that has failed to attend an appointment. Examples of these include ignoring a positive ANCA test with a high ESR such that the patient became profoundly deaf and required a cochlear implant; ignoring a post operative radiograph with report for two years showing that a cochlear implant electrode was not inside the inner ear; not acting on a radiograph report of a malignant tumour for six months, ignoring a radiology report of a vestibular schwannoma until the patient represented with the tumour so large that gamma knife treatment was no longer an option.

Common Errors in Surgery

Cases brought on errors of surgical technique are unusual and often unique. This article is too short to cover all, but there are some which occur again and again.

Severing the accessory nerve when undertaking a biopsy in the posterior triangle is one. There are two surgical techniques both of which can be performed under local or general anaesthetic. The best and safest technique is to undertake the biopsy under a general anaesthetic without the use of a local anaesthetic that could interfere with accessory nerve function. The nerve usually has an anatomical reliable course and so the nerve is identified first in an area of normal anatomy and then traced toward the area where the pathology lies. The pathological area, usually a node, is then excised. However, the downside to this is often the scar is quite large. If the second technique is employed which is to incise the skin over the lump and then excise the lump staying close to the lump during the dissection, the patient must be warned that using this technique carries a greater risk of injuring the nerve. The consequences of such an injury need to be explained. In most cases it is hard to defend if the first technique described above has not been employed.

In my practice, cases involving orbital injury in endoscopic sinus surgery seems to be on the wane. This might because other experts are being used, but I certainly was regularly instructed on such cases between 1990 and about 2008 several times a year. Now a I have probably only been instructed on such cases about five or six times in the last 10 years. I would like to think that this is a reflection of improvements in training. Cases where the orbit has been entered can usually be defended. It can happen to the most experienced surgeon and I would say that if it hasn't happened to a surgeon it is just that either they are lucky or they haven't done enough cases. If the surgeon recognises the orbit has been entered, then injury is unlikely to occur unless there is a bleed into the orbit. However, where it is clear that the surgeon has not recognised the complication and goes on to remove muscle or nerve then defence is not possible. Similarly, if the surgeon has entered the cranial cavity and goes on to remove brain or blood vessel then it is usually not possible to defend. Occasionally in tumour cases defence is possible.

Cases concerning injury to the recurrent laryngeal nerve are common. Often they will have multiple aspects including consent issues, surgical technique issues and post injury management issues. On surgical technique, accusations that a failure to monitor nerve function is substandard are frequent. However, many older surgeons were taught at a time when monitoring was not common. If the surgeon does not routinely monitor his patients and has a log book giving details of his complication rate and that rate is within the norm, failure to monitor can usually be defended successfully. In thyroid surgery, where the operation makes no mention of the recurrent laryngeal nerve or just states that they were identified, it is more difficult to defend compared to the case where there is detail of which anatomical variation of the recurrent laryngeal nerve was encountered or indeed details has to how the nerve was located and preserved. I had the dubious pleasure watching as a barrister destroyed a surgeon's reputation. The questioning went something like this:

"How many thyroidectomies have you done?"

"More than eight hundred"

"Presumably you are aware that there are some anatomical variations in the position of the Inferior thyroid artery and the recurrent laryngeal nerve* if you have done more than 800 cases?"

"Yes I am aware"

"What was the anatomy that you found in this case?"

"I don't remember, I didn't write it down"

"Well could you draw for his lordship say two or three of the variations that are commonly encountered?"

"Eh, Eh…. It is some time since……, I don't always see during an operation.. eh, eh"

"You can't remember, can you?"

"No not very well"

"I put it to you that if you don't know the anatomy and the common variations you can't safely perform this operation? This is why Mrs X has had a life changing injury to her voice."

In future articles I will cover delays in diagnoses, consent, prescribing errors of an ENT nature, equipment, implantable devices and errors in the management of malignancies.

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[*] Anatomical variations of the recurrent laryngeal nerve (RLN), such as extra-laryngeal branches, distorted RLN, intertwining between branches of the RLN and inferior thyroid artery, and non-recurrent laryngeal nerve, can be a potential cause of nerve injury due to visual misidentification.

NOISE INDUCED HEARING LOSS

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Without doubt the most preventable occupational health disorder is that of noise induced hearing loss (NIHL).

Exposure to excessive noise at work has long been recognised as having the potential to cause deafness and indeed with it, tinnitus.

There are essentially three ways in which noise can cause ear problems.

1. Acoustic trauma, i.e. that from an explosive type discharge or 'blast' traditionally associated with noise levels at or above 135 -140 dBC. In this situation the short duration high intensity noise causes its effect by significant structural disruption, not only of the cochlea, but also on occasions the vestibular part of the inner ear and indeed the middle ear, frequently characterised by a perforation of the tympanic membrane. This form of acoustic injury can be seen, for example, in employments which involve potentially explosive type discharges in the workplace such as the steel industry.
2. Steady-state or 'ordinary' industrial noise where the exposure is steady and constantly excessive or averagely so. This is the type of noise exposure occurs, for example, in a significant number of manufacturing processes and which will form the vast majority of compensation claims from those in allegedly noisy employment.
3. Acoustic shock. This type of acoustic injury is arises as a result of short duration sound that this is perceived as loud. There is evidence that to produce this type of disorder the noise levels need not in fact have been negligent and a significant number of claims in respect of this disorder have come from those working in the telecommunications industry, where the alleged exposure or 'acoustic incident' has been presented to the ear through a telephone earpiece or headset.

This short article concentrates on steady-state exposure to excessive noise, which will form the majority of the claims requiring medical expert reporting.

With any occupationally induced disorder, the best course of action an employer has is to prevent it occurring in the first place. Much has been written about reducing sound levels in the workplace, noting that modern manufacturing processes are simply less loud than in former times and secondly protecting the workforce from any such injurious noise levels, for example, by job rotation, enforced work breaks, acoustic refuges and most importantly effective ear protection. Although the effects of exposure to excessive noise on hearing have been recognised for probably around 200 years, it is only relatively recently that the situation has been dealt with by appropriate legislation. It has been recognised by the Health and Safety Executive that around 2 million employees are exposed to excessive noise in the workplace, each of which have a potential of having their hearing damaged (HMSO The control of noise at work regulations 2005: Statutory instrument 2005 (1643) Health and safety. Norwich, UK: HMSO.ISBN 0-11-072984-6). Furthermore, there has been stringent legal obligation for employers to address this matter, not only in respect of protection/minimisation of exposure to noise, but also appropriate health surveillance, i.e. sequential audiometry in the workplace.

It is recognised that a significant number of individuals can become noise deafened, at least in the early stages, without it being symptomatic. The role of occupational audiometric surveillance is therefore important in the early recognition of this and where matters can be addressed appropriately.

Those of us who work in the field of ENT (Ear, Nose and Throat medicine/surgery) and indeed audiology, will regularly see hearing impaired individuals, where the majority arises as a result of the deafness of ageing or presbycusis. In addition, any busy ENT Practitioner will recognise a population of patients who are hearing impaired as a result of middle ear disorder, for example the effects of otitis media/glue ear/chronic suppurative otitis media etc, none of which will be occupationally induced, and where middle ear issues lead to conductive rather than sensorineural or inner ear hearing loss.

Since the advent of pure tone audiometry from the 1950s onwards it became apparent that the predominant effect of steady-state excessive noise is to produce not only mainly high frequency hearing loss, but that particularly between 3 - 6 kHz producing the so-called noise induced 'audiometric notch'.

The diagnosis of NIHL, therefore, not only in clinical, but in medicolegal settings is first of all recognition that there has been exposure to excessive noise in the first place on a significant and substantive basis. Secondly that there is significant hearing impairment, and the main medicolegal issue here being such that it causes a material disability. Thirdly that there is an audiometric correlate from which the diagnosis can be derived (see above) and lastly that there are no confounding factors which might lead to hearing loss, but particularly that which can mimic the effects of exposure to noise, an example of which could be a significant head injury.

In days gone by it wasn't that difficult to establish significant exposure to excessive noise, because the individual under examination would have worked for many years usually in the same employment in heavy engineering, steel production or coal mining and without provision of ear protection. These kind of noise levels in heavy industrial processes and for this duration would often lead to quite striking audiometric changes, i.e. notch formation, and where the diagnosis would be obvious.

Matters became more complicated because as we have moved to more recent times, the noise

levels have frequently lessened. From the late 1980s through into the 1990s effective hearing protection generally became available and individuals tended to have more employments, not necessarily involving exposure to excessive noise, which made it more difficult to provide an informed diagnosis.

One of the mainstay diagnostic schemes to assist the clinician in advising a Court as to whether or not an individual has been noise deafened was that published by Coles et al. (Guidelines on the Diagnosis of Noise Induced Hearing Loss for Medicolegal Purposes, by Coles, Lutman & Buffin, Clinical Otolaryngology 2000:25:264-273) which has been used by most experts working in the field, although the initial acceptance did not come for 7-10 years after publication and substantively so following on from what became known as the Nottingham textile claims (Parkes v Meridian and others, Queens Bench Division, Nottingham Registry 14/02/2007), where the usage of these Guidelines was embraced by the Courts. There is no doubt that this publication, which sets out a mainly logical and schematic aid to diagnosis, has found favour with the Courts and is used extensively to the present.

In accordance with this publication, the diagnosis of NIHL is made on the balance of probability, i.e. the legal test required on satisfaction of three requirements. For a detailed explanation of these the reader is referred to the actual publication, but these are summarised below.

Requirement R1. High frequency hearing loss, i.e. when a single measurement of hearing threshold level at 3, 4 or 6 kHz is at least 10 dB greater than at 1 or 2 kHz. It will be noted that this is a non-specific requirement and can indeed be satisfied by the simple effect of ageing. It basically advises the examining practitioner that there needs to be a hearing loss as a starting point, but which needs to be developed further.

Requirement R2 is significant noise exposure. This is presented in terms of an accumulated noise dose throughout the employee's working life and is that presented to the ear. Noise dose is expressed as a Noise Imission Level or NIL and is properly a matter for acoustic advice from an engineer. This requirement is either 100 (99.5) dB NIL or 90 (89.5) dB NIL depending on the strength of the audiometric indicator (see below) and where NIL is the noise imission level, the total accumulated noise dose. This publication does not allow noise levels below 85 dBA LEPD (i.e. averaged over a working day) to be taken into account in the derivation of this requirement.

Requirement R3 is the audiometric formation, which should either be a notch, or if this is absent a so called 'bulge'. Notch formation is self-explanatory but the bulge analysis is undertaken when notching is not seen. It is essentially a mathematical construct that is derived by comparing the actual measured audiometric threshold from the individual under test with that derived from a presbycusis database to take into account the effects of ageing, but adjusted for the so-called 'misfit' at the frequencies which form 'anchor points' which are usually thresholds at 1 and 8 kHz or can be 0.5, 2 and 6 kHz depending upon the audiometric formations.

If these requirements are all satisfied, then on the balance of probability the claimant derives a diagnosis of NIHL.

Whilst this publication is in regular use, it has attracted significant discussion, especially in recent times, noting that a 'safe level' of exposure has been considered by some to be below 80 dBA LEPD and that by others some of the criteria have been considered to be too rigid, noting however that they can be altered by the use of so-called 'modifying factors'.

Nevertheless, other approaches have been advocated.

In 2015-2016 the authors of what became known as the CLB 2000 paper detailed above developed the concept further to derive noise deafness quantum, this methodology subsequently becoming known as the LCB 2015/16 approach (Guidelines for quantification of noise induced hearing loss in a medicolegal context. Lutman, Coles and Buffin. Clinical Otolaryngology (2016) August issue). Essentially noise deafness quantum was derived by these authors by taking the excess hearing loss at 1, 2 and 3 kHz (the frequencies that determine disability) over and above from a bulge type analysis, but modified from CLB 2000 where it was effectively undertaken twice and where the anchor points at 1 and 8 kHz were modified according to a hypothetically derived noise deafness component at these frequencies. This method involved a so-called 'first' and 'second' pass.

There is no doubt that CLB 2000 and indeed LCB 2015/16 clarified some muddy waters, the former informing us how to treat an audiogram where defined audiometric notching, for example, was not present and moving away from the older concept of all hearing loss in excess of that expected for age was quite simply due to noise exposure, once the diagnosis of noise deafness had been made. The concept in addition of using a more defined percentile for estimating presbyacusis, or the deafness of ageing, refined the analysis further and gave the Court a more accurate diagnosis and quantification on the balance of probability.

These publications have however attracted criticism in spite of the general acceptance both by clinicians and the Courts and most recently the work of Professor Moore et al (Guidelines for diagnosing and quantifying noise induced hearing loss, Moore BCJ, Lowe DA and Cox G, Trends in hearing 26:1-21. 2022) has tried to address any perceived shortcomings with this established methodology.

These authors have introduced some controversial concepts and their method of diagnosing NIHL is currently under scrutiny by most experts working in this field. For example, they have taken a significantly reduced noise imission level required to at least consider a diagnosis of noise deafness, and their insistence on a defined diagnostic indicator is nowhere near as rigid as in CLB 2000. Critics of this recently proposed methodology quite reasonably have commented on the fact that in order to diagnose a disorder in clinical medicine, there has to be signs of it in the first place, and simple acceptance of a diagnosis of noise deafness on the basis that there is hearing impairment and a history of noise exposure is to be depreciated. This principle was set out way back in the 1990s by Williams (The Diagnosis of Noise Induced Hearing Loss, by Williams RG (Journal of Audiological Medicine 6:45-58: 1996), and ('Advances in Noise Research: Biological Effects of Noise' (Volume 1) Edited by Prasher and Luxon, Whurr Publications, 1998).

In addition, the Moore et al. publication advises determining presbycusis from ISO 7029 (2017) which was a database that was not in fact signed off by the United Kingdom, or indeed the United States of America, and also obviating the need to correct for the well known 6 kHz artefact as a result of the use of TDH 39 headphones. Noting that the use of these devices could sometimes erroneously produce a diagnostic indicator at 6 kHz, which could have been taken as a diagnosis of noise deafness. The Moore et al. guidelines (so-called MLC 2022) no doubt will continue to attract controversy and particularly so if their usage becomes more widespread.

In terms of what constitutes a material loss, again this has attracted controversy. Hearing impairment can be translated into disability by looking at the thresholds at 1, 2 and 3 kHz (see Assessment of hearing disability by King, Coles, Lutman and Robinson, Whurr Publications 1992), although some authorities will determine this from thresholds at 1, 2 and 4 kHz. In many instances what constitutes a significant noise deafness quantum has frequently been left to the Courts to determine. A reasonable view is any hearing loss at 1, 2 and 3 kHz, which is capable of being rounded up to 5 dB or more, i.e 4.5 dB or anything in excess. Some experts will take this is as somewhat lower, but on my understanding Courts will accept a range of say 3.5 - 5 dB, depending upon the expert's advice that they receive. In my opinion a quantum of 3.5 dB should not be regarded as a material disability, but it is

reasonable to point out that there will be a range of opinion on this.

Courts are frequently required to apportion blame for noise deafness. Increasingly this is undertaken with the assistance of an acoustic engineer, who will apportion the noise exposures accordingly but in the absence of this, it is usually taken from the proportion of noise sustained on a temporal basis in each noisy employment where neglegent exposure has taken place.

There is no medical or surgical treatment for sensorineural hearing loss, however caused, and damages can sound in requirement for aiding. NHS aids are free at the point of delivery and this includes maintenance, upgrades and batteries, but frequently included in the schedule of loss are costings for private aiding. Over the course of a lifetime, given a device will last 5 - 7 years, this can mount up, and especially as some of the more modern devices can be obtained for between £2000 - £3000. Reasonable costings are obtained from Coffin and Tarrant v the Ford Motor Company, adjusted for inflation, which was set at mid-price levels obtained from Specsavers (although this is not an endorsement of this service, other outlets are available).

Tinnitus, or the hearing of noises for which there is no external correlate, is a common symptom seen in clinical ENT and audiological practice. It can be and indeed often is an accompaniment of NIHL.

Tinnitus is an entirely subjective sensation, which cannot be objectively verified, and so we have to rely on how the individual under examination describes it, but taken alongside what is written in the medical records.

Most experts in the UK will grade the severity of tinnitus as set out in the British Association publication (Guidelines for the grading of tinnitus severity: the results of a British Association Working Group commissioned by the Otolaryngologists, Head and Neck Surgeons 1999, Clinical Otolaryngology 2001 26: 388-393) and this is a necessity for the Court on which it will determine the level of compensation. A claim for NIHL will attract a significantly increased level of damages if significant tinnitus is also present, and where it is considered to be noise induced.

Most experts, including myself, uphold the principle that whatever caused the hearing loss will have caused the tinnitus, providing it didn't pre-exist the onset of noise deafness, but it isn't always the case. For example, if tinnitus occurs only in an asymmetrically deafened ear, where the asymmetric loss is not noise induced or if it arises as a result of a new event, such as a head injury/ ear infection etc. Another example is if it arises straight after a short duration loud sound, which by itself wouldn't cause hearing loss.

Some tinnitus quite simply is physiological, i.e. it falls within normal experience and therefore is insignificant. Tinnitus of this nature and severity, in my opinion, should not be regarded as noise induced, even if there is NIHL. Similarly, significant tinnitus occurring in the presence of noise deafness, which is regarded by the Court as de minimis, i.e. not material, should imply that it similarly makes no material contribution to the tinnitus the claimant experiences.

Generally if tinnitus persists for more than two years, it is frequently considered to be permanent. There is no medical or surgical treatment for it, although tinnitus retraining in the local Audiology Department with or without the use of masking devices can be tried, but frequently it will be suppressed by the simple expedient of aiding, which may be necessary anyway for any sensorineural hearing loss however caused.

This article finishes by reminding the reader that noise deafness is preventable and indeed now that the relevant personal protective equipment is easily obtained, that employers recognise their responsibilities, NIHL claims have significantly reduced in volume over recent times and no doubt will continue to do so.

MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

A round-up of news in the industry of the first quarter of 2023

NEWS

NHS England launched its “Delivery plan for recovering urgent and emergency care services” at the end of January 2023.

To support recovery, this NHS England plan sets out a number of ambitions, including:

“Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.

“Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

“NHS England has engaged with a wide range of stakeholders to develop the plan, and it draws on a diverse range of opinion and experience, as well as views of patients and users.”

Read more: www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/

NEWS
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Positive results from the Covid Clinical Negligence Claims Protocol

The collaborative approach taken by NHS Resolution, Action against Medical Accidents (AvMA) and the Society of Clinical Injury Lawyers (SCIL) in designing and operating the Covid 19 Clinical Negligence Claims Protocol appears to have significantly reduced the number of clinical negligence claims that have become litigated, creating savings benefiting the NHS and patients.

Figures from NHS Resolution Annual Report and Accounts show that since the implementation of the Covid 19 Clinical Negligence Protocol there has been a 6% reduction in the volume of settled cases that have been become litigated between financial years 2019/2020 and 2021/2222.

There are still questions to answer, for example, the size of any Covid 19 related effects on the numbers of claims received. Further data on claims trends before, during and after COVID should help isolate these effects and provide for greater certainty on the effectiveness of the Protocol itself.

If the Protocol is shown to have permanently reduced the overall volume of litigation, then this work is likely to have saved significant costs for all parties, and most importantly the NHS.

Lisa O'Dwyer, Director of Medico-Legal services at Action against Medical Accidents (AvMA), the UK charity for patient safety and justice said:

"The impressive likely cost savings are testament to what can be achieved when key, specialist clinical negligence stakeholders come together and collaborate. More generally, it is very positive to note that both claimant and defendant practitioners have derived considerable benefit from the clinical negligence protocol."

Simon Hammond, Director of Claims Management at NHS Resolution said:

"The Clinical Negligence Protocol has proven how collaboration can be of benefit to all parties. We look forward to working with SCIL and AvMA on the possibility of developing how the protocol could apply in a post-Covid environment."

Read more: www.scil.org.uk/scil-news

The NHS Complaint Standards

The Parliamentary and Health Service Ombudsman has published updated guidance for complaint handling across the NHS in 2023.

"The NHS Complaint Standards, model complaint handling procedure and guidance set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care."

Read more: https://www.ombudsman.org.uk/organisations-we-investigate/nhs-complaint-standards

Are the costs of a medical agency recoverable in the fixed costs regime?

In the judgment of District Judge Phillips in Wilkinson-Mulvaney -v- UK Insurance Ltd (19th January 2023) (reported via CivilLitigationBrief) it was held that they were.

The claimant pursued a claim for personal injury damages, following a road traffic accident, and the matter settled for just over £16,000. There was agreement in relation to costs and disbursements, except the costs of the medical reports and several court fees.

The defendant's objection was that the invoices relied upon failed to differentiate between the direct costs of the report and the medical agencies fees, and that medical agency fees are not recoverable. The only recoverable element was that of the doctor, together with fixed fees for obtaining medical records.

The judge carried out analysis of the rules and the case law on the topic, noting that there was no binding authority on the issue. He concluded that "the cost of obtaining a medical report" includes the cost of any medical agency fees incurred in the obtaining of such report.

The judge stated. "Had the drafters of the Rule and the Rule Committee wanted to limit the fees recoverable to those only paid to the doctor, they could have quite easily made this clear in the Rule, they chose not to do so."

The judge stated that it would be helpful for a breakdown to be given, since the court had to assess what sums were reasonable and proportionate.

Read more: https://bit.ly/3SsEYdg

The National Safety Standards for Invasive Procedures 2023 update

National Safety Standards for Invasive Procedures (NatSSIPs) have not been updated since they were first introduced in 2015.

NatSSIPs2 (January 2023) consists of two inter-related sets of standards:

The organisational standards are clear expectations of what Trusts and external bodies should do to support teams to deliver safe invasive care.

The sequential standards are the procedural steps that should be taken where appropriate by individuals and teams, for every patient undergoing an invasive procedure.

The NatSSIPs2 have evolved to have less emphasis on tick boxes or rare 'Never Events' and now include cautions, priorities and a clear concept of proportionate checks based on risk. NatSSIPs2 should form the basis of improvement work, inspections and curricula.

Read more: https://bit.ly/3xK9ENK

NICE recommends 3 treatments for COVID-19 in final draft guidance

Everyone with COVID-19 at highest risk of developing severe disease will have access to clinically and cost-effective treatments, under final draft guidance published by NICE on 21 February 2023.

People at highest risk of developing severe disease include those who are immunosuppressed, or who have other conditions such as heart disease, respiratory disease, diabetes, or neurological conditions.

The draft guidance means they will have access to treatments taken either at home or in hospital. It recommends 3 drugs as options for treating COVID-19 in adults:

Paxlovid (also called nirmatrelvir plus ritonavir and made by Pfizer);

Xevudy (also called sotrovimab and made by GlaxoSmithKline); and

RoActemra (also called tocilizumab and made by Roche).

Earlier in the month NICE issued draft guidance for public consultation, which does not recommend Evusheld for preventing COVID-19 in adults who are unlikely to have an adequate immune response to COVID-19 vaccination, or who can't be vaccinated, because there is not enough evidence of its effectiveness against current variants and those likely to be circulating in the next 6 months.

NICE was asked to review the clinical and cost-effectiveness of treatments for COVID-19, some of which are currently being used in the NHS under interim UK-wide pandemic-specific access arrangements.

Registered consultees now have the opportunity to appeal the final draft guidance. If no appeals are received, NICE expects to publish its final recommendations on medicines to treat COVID-19 in March.

Read more: https://www.nice.org.uk/news

Justice Committee to study 2021 whiplash claims and reform

From June 2021, the personal injury claims process changed for people who suffer from low-value injuries in road traffic accidents (RTAs), following reforms in the legal framework introduced by the government.
In February 2023, the Justice Committee announced an inquiry on the impact of the changes, and whether the reforms are on track to successfully reduce insurance premiums for motorists, while ensuring injured claimants can still access justice.

"Whiplash reform was introduced in 2021 following a realisation that insurance claims for the injury were running at over £2bn per year – adding an average of £90 to everyone's car insurance policies.

"The Whiplash Reform Programme was aimed at roughly halving the overall cost of these types of insurance claims, and then passing on savings in premiums of between £40 and £50 a year per motorist.

"As part of the reform programme, the Ministry of Justice asked the insurance industry to set up an online claiming system, or portal, known as the Official Injury Claim Service, which would deal with whiplash and claims for bruising or minor fractures.
"The reforms also required claimants to provide medical evidence of their injuries and introduced a financial limit on claims.

"The inquiry will investigate the effects of the reform programme, including any savings, and how the Claim Service portal operates."

Until 17 March 2023, the Committee invited evidence on, among other things:

To what extent have these measures met the Government's objective of reducing the cost of whiplash claims to the economy; and to what extent are any savings being passed on to motorists through lower insurance premiums?

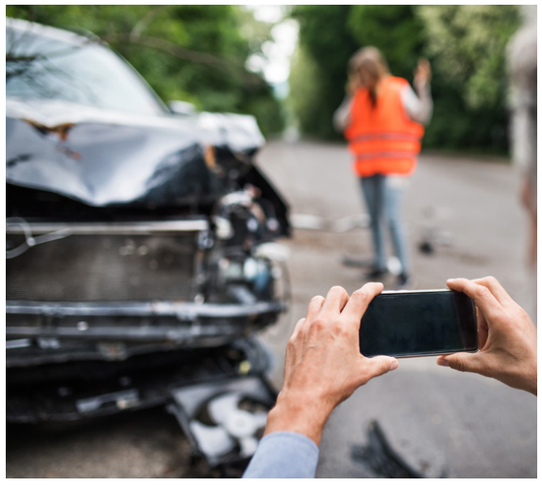
What have been the effects of raising the small claims track limit from £1,000 to £5,000; the ban on settling whiplash claims without medical evidence; and the fixed tariff of compensation for whiplash injuries that last up to two years?

Why most claimants continue to use legal representation when using the online portal (90% since its launch)?

Whether the Official Injury Claim (OIC) portal is widely known about, accessible and easy-to-use for claimants and/or their legal representatives.

How effective is the OIC portal in settling claims for mixed injury claims, which cannot be settled using the fixed tariff awards?

Read more: https://bit.ly/3XV5xZw



Personal Injury firm, medical experts and others accused of collusion after "layering" whiplash claims with inflated costs

In *Khan -v- Aviva Insurance Ltd (15/11/2022)* District Judge Lumb held that the claim by Noreen Khan after a low-speed car accident was fundamentally dishonest, saying she "took a chance on bringing an opportunistic claim for damages".

Ms Khan instructed the firm *Simply Legal*. The case did not settle in the Claims Portal and proceedings were issued with medical reports from Mr Adnan Majid, described as a medico-legal practitioner, and Dr Faisal Mir, a clinical psychologist.

Claims for injury need to exceed £5,000, and for special damages £10,000, if they are to exit the Official Injury Claim portal and move into the costs-bearing Claims Portal.

The schedule of loss claimed for 10 sessions of physiotherapy and 10 sessions of cognitive behavioural therapy (CBT) at a cost of £850 and £1,500 respectively.

A witness statement from the defendant Aviva's solicitors, detailed claims for other accidents where Simply Legal was acting and instructed Mr Majid and Dr Mir, involving Med-Room Solutions Ltd (MRSL) providing identical physiotherapy and CBT programmes.
The judge explained in his ruling that this evidence was "demonstrating a business model of deliberately layering claims for the cost of unnecessary or non-existent rehabilitation treatment for financial gain".

One of the directors of Simply Legal and the director of MRSL were brothers and both companies operated from the same building.

DJ Lumb said there was "clear evidence of the layering of this claim and others as alleged by the defendants".

The entire claim was dismissed and was found to have been fundamentally dishonest.

He said the General Medical Council might consider investigating both medical experts Mr Majid and Dr Mir, while "the Solicitors Regulation Authority may also wish to investigate the handling of claims by Simply Legal".

Miles Hepworth, from the defendant's law firm DWF, said "claims layering has been going on since the introduction of fixed recoverable costs, as higher damages means higher costs, but has become worse since the Official Injury Claim portal went live in 2021."

Read more: https://bit.ly/41fr3vb

GP suspended for nine months after promoting vitamins and iodine as Covid-19 treatments

The BMJ has reported that a GP in private practice has been suspended from the UK medical register for nine months, after an MPTS misconduct tribunal, for promoting unlicensed treatments and misleading claims about covid-19 online.

The medical practitioners tribunal in January heard that Sarah Myhill posted videos and articles on her website during 2020, describing "safe nutritional interventions" which she said were "now so well established that vaccination has been rendered irrelevant."

Dr Myhill promoted the use of high doses of vitamins C and D and the inhalation of iodine through a salt pipe for the treatment of bacterial and viral infections, including covid. She also endorsed the use of ivermectin, without discussing the risks, and sold an iodine preparation on her website. The tribunal was told that the substances had potentially serious health risks and there was no evidence that they were effective.

"These agents risked patient safety in that they exposed patients to potential serious harm, including toxicity," said tribunal chair Julia Oakford.

The tribunal found that Myhill "does not practise evidence-based medicine and may encourage false reassurance in her patients who may believe that they will not catch covid-19 or other infections if they follow her advice."

The tribunal decided that Myhill's individual breaches were not serious enough to constitute fundamental incompatibility with continued registration as a doctor. Erasure would "deprive the public of an otherwise good doctor with over 30 years' experience."

She did not attend the tribunal hearing.

Read more: https://www.mpts-uk.org/-/media/mpts-rod-files/dr-sarah-myhill-27-jan-23.pdf

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