A FRAMEWORK FOR SURGICAL MEDICO-LEGAL PRACTICE

PART 1: THE PREPARATION OF REPORTS AND THE DANGERS OF DABBLING

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Medico-legal reporting is an influential yet often overlooked factor in the conduct of surgical practice. Many surgeons provide reports for the purposes of civil litigation. Medico-legal practice can be a stimulating and intellectually challenging area of professional work. Some surgeons provide medico-legal reports as a regular part of their practices, whilst others accept invitations from the legal profession to assist on an occasional basis. Whichever category clinicians come into, understanding:

The standard of care required in producing medico-legal reports, and

The role and duties of the medico-legal expert when reporting are essential to the evidential process. This is especially so since the protections previously enjoyed by expert witnesses in the production of their evidence have been removed by the Supreme Court.

The freedom of dissatisfied clients and opponents to seek disciplinary redress through the GMC, and/or financial redress through the Civil Courts, for perceived or actual harm as a result of sub-standard medico-legal reporting may lead to substantial professional sanction and awards of damages. Even in the absence of such sanction, this freedom imposes substantial costs on healthcare providers, their insurers and professional indemnity bodies, as well as the NHS Litigation Authority (NHS LA) [1]. These professional and financial pressures now affect the ways in which clinical practitioners approach their professional duties, whether these are purely medical or medico-legal in nature.

Medical and surgical expert evidence in England and Wales is presented primarily in the form of medico-legal reports. Such medical opinion has a profound influence on the conduct and outcome of cases, both for claimants and defendants. Solicitors, barristers and judges generally have a limited understanding of medicine, anatomy and the functioning of the human body, and of the nuances of individual cases and clinical circumstances. The lawyers on both sides of a case will study the medical expert evidence before making decisions on whether and how to proceed with a claim, and on what terms to attempt to settle it.

Surgeons may be instructed by lawyers to review the work of other surgeons in cases where outcomes have fallen short of that which the patient perceives to be desirable, whether or not there have been any shortcomings in the treatment of the patient. The lawyers' decision whether or not to recommend suing the operating surgeon (or the NHS Trust or other healthcare provider) will be made on the basis of the advising surgeon's report. Medical experts, therefore, have a pivotal role in the litigation process.

Medico-legal casework usually deals with claims for compensation and falls within the remit of the Civil Courts, where the only redress for a claimant is financial recompense. The system is designed (not always successfully) to contain costs and to encourage settlement within reasonable time scales and within fair and appropriate limits. The responsibilities of medical and surgical experts within this process are considerable. These responsibilities include working with the lawyers on both sides, who themselves will be operating under a court directed timetable to progress the case.

Should they come to give evidence in court, medical experts can expect to be subjected to rigorous cross-examination. Their opinions and the manner in which these are expressed will be closely considered. Written evidence in the form of a medico-legal report - and supported by meetings between the instructing lawyers and the experts in more complex cases - is the usual means by which lawyers assess the medical basis of cases; some 98% of claims involving medical experts are settled out of court.

Litigation involving medical experts may variously involve insurance companies, the NHS LA and the Professional Indemnity Societies. Whereas charges in Criminal Courts must be proved to a standard of being 'sure' of a defendant's guilt, in Civil cases the standard of proof is 'on the balance of probabilities'. This could, in theory, come down to a 51:49 decision, although such quantification of the standard of proof would be misleading and never happens in reality. Nevertheless, reaching an opinion on the basis of it being 'more likely than not', the bread and butter of the civil lawyer's diet is unfamiliar territory for a surgeon. Many problems with medical evidence arise from a misapprehension about what this basic test means and how it is applied.

Lawyers' Dissatisfaction with Medical Evidence

Lawyers often comment that the medico-legal reports that they receive demonstrate a fundamental lack of understanding of the role of the surgical medico-legal expert. For that reason, they are inadequate for their purpose. This may surprise many, as surgeons are considered to be intelligent and responsible practitioners. To understand how it is that surgeons may be falling short of the required standard, it is useful to consider how many surgeons come to develop a medico-legal practice in the first instance. A surgeon may, for example, receive an unsolicited call from a lawyer who is seeking a suitable medical expert to instruct, or may perhaps receive an approach from a medico-legal agency. The subject matter of the request may range from the reporting of the consequences of injury in a road collision, a workplace accident, or an accident in a public place, to considering complex clinical episodes and outcomes.

With the best of intentions, many surgeons write their first report without having explored the complex issues and requirements in providing medical evidence and the sometimes difficult legal tests that have to be applied to the facts of a case. James Badenoch, QC, Chairman of the Expert Witness Institute [2], advises experts to be cautious about accepting instructions without an appropriate level of training for the role: "*There is little doubt that medical experts are often faced with very difficult medico-legal issues to address. It is essential that, before accepting instructions, experts understand the basic legal principles and legal tests that they will need to apply when expressing their opinions in evidence.*"

Medico-legal practice is essentially unregulated. The qualification to be appointed an expert witness focuses on the clinical expertise of the practitioner rather than on his or her knowledge of expert witness work. The advantage of the system as it stands is that any qualified professional can bring his or her expertise to the court and can give opinion evidence. The courts are thus able to hear from the widest possible range of professional opinions when considering cases. There is always a ready supply of experts who can fulfil the role. However, practitioners who do not have sufficient skill or training in medico-legal work may be undermining the proper outcome of cases as well as exposing themselves unwittingly to possible claims for damages.

Rules of Court

The current system of duties and responsibilities for medical experts was codified in the reforms to the Civil Justice procedural framework introduced by Lord Woolf (the Master of the Rolls) in April 1999. His Civil Procedure Rules (CPR) removed the control of litigation from litigants and their lawyers and placed it firmly in the hands of the Court [3].

The 'overriding objective' of the CPR is that the court will deal with all cases 'justly'. This objective is the basis for the discipline imposed on the parties in bringing cases to court expeditiously; in limiting the scope and duration of cases; in establishing a greater degree of equality and fairness between claimants and defendants; and in reaffirming that the overriding duty of all expert witnesses is to the Court (i.e. to the presiding judge) rather than to the party that instructed the expert. Part 35 of the CPR and its associated Practice Direction set out clearly the duties and responsibilities of (medical) experts when providing reports, and their broader responsibilities within the litigation process [3].

Removal of Experts' Immunity from Suit

The removal last year in *Jones v Kaney* [4] by the Supreme Court of the immunity from suit (in negligence or breach of contract) enjoyed by expert witnesses in the production of expert evidence has brought renewed focus on the duties, responsibilities and required quality in the provision of expert evidence. Lord Collins stated that enabling a dissatisfied litigant to seek redress against his or her expert witness '…would tend to ensure a greater degree of care in the preparation of the initial (medico-legal) report'.

Although the judgment is couched with the necessary legal understatement, expert witnesses should be in no doubt about the serious implications of this decision. In the light of this decision, all who practise as experts should pause for thought and be stimulated to improve their knowledge and skills in producing expert evidence, while ensuring their professional indemnity insurance covers this form of work.

The Acquisition of Medico-Legal Reporting Skills

Medical and surgical experts are engaged to help the Court (i.e. the judge) to decide on technical matters that are beyond its expertise. Experts need to understand the legal context and principles that guide the writing of reports and the profound differences between the medical and the legal approach to problem solving [5].

There are seven areas where a medical report written for other clinicians necessarily differs from a medico-legal report written for lawyers, vis:

1. The medico-legal report is written about a claimant and not a patient;
2. It is written for (usually) a non-medically qualified readership;
3. It is used for litigation and not for treatment;
4. It deals with medico-legal rather than clinical issues;
5. It is an independent assessment of a claimant rather than supportive of a patient;
6. It must assess all contributory factors and likely outcomes objectively;
7. It must take an independent and objective view of the actions of other clinicians [5].

There are difficulties for medical experts in developing their specialist skills 'on the fly'. Solicitors rarely provide feedback on individual reports and the outcome of cases, and an expert will rarely be told what impact his or her report has had on a case or a settlement, or even

whether the report achieved an acceptable standard. Clinicians who develop a good working relationship with individual solicitors and legal practices may secure better feedback than those who deal through medical-reporting agencies such as **Mobile Doctors**, **Premex** and **Premier Medical**.

Clearly, it is essential to attend appropriate initial training and then to remain current by attending specialist courses, combined with private study of texts and of the various web resources available. It is also essential to keep abreast of developments in the Civil Procedural Rules on the Ministry of Justice website.

The Range of Surgical Medico-Legal Reports
A surgeon in medico-legal practice may be asked to report on a wide range of different factual scenarios and in a range of circumstances. Reports are usually commissioned by solicitors, acting on behalf of claimants or defendants. Parties may be individuals, companies or other institutions. Requests may be channelled through medico-legal reporting agencies, which deal, for a fee from the instructing solicitor, with the administration of the report phase of the case, including finding an appropriate expert to report on the case.

Personal Injury Reports
Probably the commonest form of report is the Personal Injury Report, in which the surgeon is asked to provide a report on the likely causation and prognosis of injury following an accident. Such reports are particularly common in orthopaedic practice, as with alleged whiplash injuries, but also crop up in general surgical practice, as with the alleged workplace causation of hernias.

Clinical Negligence Reports
Liability and Causation (also known as Breach of Duty and Causation) Reports, and often referred to as Clinical Negligence Reports, require the expert to give supported opinions on what was the duty of care owed by the defendant clinician or health care provider to the claimant; whether there has been a breach in the duty of care; and whether the adverse outcome was consequent upon that breach of duty. The last question addresses the legal issue of causation, i.e. the causal link between the alleged breach of duty and the alleged damage or injury sustained and which the claimant must prove.

Advisory Reports
Solicitors will sometimes commission an Advisory Report at an early stage in the consideration of proceedings. This is a more informal report that is not produced for the court (and is not, therefore, bound by the CPR) but is intended to offer advice to the solicitor and client on the medical issues in the case; to consider whether there has been a breach of duty that has caused damage and hence, to allow the solicitor to weigh up the chances of a successful outcome in running the case. An instruction for a more detailed report for the court may follow this initial request.

Single Joint Expert Reports
A Single Joint Expert Report may be commissioned jointly by the parties, or be required by the court, to help resolve a relatively non-contentious or low-value aspect of a claim, especially so where there is no alleged breach of duty. As this, in effect, involves the Court in surrendering an aspect of decision making to the expert, a single joint expert will not be instructed to report on breach of duty or on aspects of the claim likely to have a high financial value.

Concepts governing the preparation of reports
In preparing reports, the expert must be aware of the legal principles that underlie the claim. The expert is required to apply the appropriate legal tests in the course of the medical report, and is generally expected to understand the requirements of such tests without guidance from the instructing solicitor. If an expert is ever unsure as to what legal test to apply, or how to apply it, on the facts of the particular case (whether considering breach of duty, contributory negligence, causation, consequential loss, life expectancy or prognosis), the best course of action is to seek advice from the instructing solicitor or to attend training that covers these points or refer to an appropriate text on the subject.

Medico-legal reports must be written with clarity, conciseness and simplicity. All necessary technical terms should be defined and the expert's opinions should be expressed with reference both to the relevant facts in the case and the medical reasoning that supports the conclusions reached. Reports must be 'internally consistent' with a logical and ordered structure that addresses all relevant facts and the range of professional opinion on all relevant matters. Reports must also be 'externally consistent', by accurately reporting all relevant facts, whether or not these support the client's case, and by clearly explaining the medical context of the issues in the dispute.

Establishing a Medico-Legal Practice
Newcomers to surgical medico-legal practice may wonder how to get established and how to promote themselves. The first step is preparation and education, following which an individual is free to advertise on a variety of databases that are distributed to lawyers. These include ***Legal Hub***, the ***Expert Witness Directory***, and the ***UK Register of Expert Witnesses*** (JS Publications). The financial resources and professional commitment to expert witness work will determine whether the surgeon runs his/her practice on an ad-hoc basis or as a formal business. The putative expert will generally be asked by solicitors to provide a CV and terms and conditions of service, including a scale of fees, which may be raised on an hourly rate or on a fee-per-case basis.

Concluding Comments
There is considerable professional danger in treating medico-legal reporting as simply an extension of clinical practice. The surgeon undertaking a successful and effective medico-legal practice must understand his or her duties and obligations as an expert witness and must follow the court rules and requirements. Not to do so runs the risk of creating problems for the expert or the instructing party, or both. The position is the same whether the surgeon is an established expert witness or only occasionally receives instructions.

To provide a competent medical expert report the surgeon must:

- Prepare adequately for medico-legal practice by way of education, courses and reading
- Adhere absolutely to the golden rule of objectivity and independence of mind, regardless of the source of instruction and who is paying the bills
- Demonstrate a clear understanding of the legal and procedural processes and terminologies involved
- Understand the contents of Part 35 of the Civil Procedure Rules (the Rules, Practice Direction and Protocol).

The skills of medico-legal reporting can be acquired, but they are founded upon a clear understanding of the legal tests to be applied to the evidence and a good command of the English language. Words and grammar facilitate precise interpretation and the quality of the written word can have a significant bearing on the outcome of cases and upon the reputation of the report writer. Excellence in report writing often keeps cases out of court and facilitates early settlement, which should usually be the primary aim. Poorly written reports can land the writer in deep water and create profound discomfort under cross-examination if the case proceeds to court.

References

[1] NHS Litigation Authority website and reports: www.nhsla.com/publications

[2] The Expert Witness Institute is a not-for-profit membership organisation for expert witnesses: www.ewi.org.uk

[3] Civil Procedure Rules and Ministry of Justice website: www.justice.gov.uk/courts/procedure-rules/civil/rules/part35

[4] [2011] UKSC 13. A copy of the full judgment can be found on the Supreme Court website: www.supremecourt.gov.uk/decided-cases/index.html

[5] **Eyre G, Alexander L**
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REVALIDATION OF SURGEONS IN THE UNITED STATES OF AMERICA - NOTHING NEW

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To coin a phrase, there is nothing new in this world. For generations, the surgical profession has wrestled with the concept of demonstrating to the public that they were safe in the hands of their doctors. However, for the best part of two centuries, this reassurance has been largely based on trust alone. For their part, the various Royal Colleges played critical roles in the development of training programmes and, of course, the establishment of a process whereby an adequately trained surgeon would sit an exam to be awarded the Fellowship of an individual College. For many decades, holding such a fellowship was represented by the profession as proof of quality and, for the most part, accepted as such by patients and the rest of the medical profession. Naturally, there was some legitimacy to this process.

However, one obvious flaw was the lack of any re-appraisal of competency for the duration of a surgeon's career. In common with many professions, surgery worked on the basis of "once competent, always competent". Times change of course, and such a concept is no longer accepted by society in almost any walk of life. The challenge facing surgery around the world is actually quite simple: the patient wants and needs to know that their surgeon is safe, skilled and competent, while for their part, the surgeon needs to be able to demonstrate to their patients that these qualities exist. Perfectly reasonable expectations and desires one might suggest. However, it is somewhat easier said than done to satisfy both parties and, to be fair, efforts in this regard have existed for many years.

Board certification of American surgeons first came into being with the establishment of the American Board of Surgery (ABS) in 1937. This board was established as a direct result of Dr Edward Archibald's Presidential address to the American Surgical Association two years prior, and represented the eleventh accrediting medical professional board in the United States. Over the ensuing decades, the numbers of medical and surgical specialties grew somewhat organically and by 1970, the American Board of Medical Specialties (ABMS) was formed to oversee the ABS and 23 other specialty boards.

Board Certification requires the completion of at least five years of training in a residency programme (allopathic or osteopathic) that is approved by the Accreditation Council for Graduate Medical Education (ACGME). Following review of their operative log and attestation by their programme director as to