Expert Witness Institute (EWI) Annual Conference 24th September 2015

Michael A Foy

The EWI was founded in November 1996 to improve the quality and standards of the provision of expert evidence in the both civil and criminal cases. It is a multidisciplinary organisation with representation from the legal profession and a variety of disciplines from which expert opinion might be requested.

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The medical profession is well represented among the membership with 45-50% of the 992 members belonging to it. However, there are also members from diverse disciplines ranging from building/surveying to DNA, fingerprinting and phonetics. In addition to the Annual Conference the EWI runs training courses for experts, has meeting rooms for rent at its London offices and offers a mediation service.

Professor Colin Howie, was asked to form part of a panel for a discussion on the subject of, "Experts and the Rule of Law: Was Runnymede 1215 the first hot tub?". Colin asked me as Chairman of the Medico-Legal Committee to represent him and the Association and I thought it might be useful to provide some feedback on the day's activities for members through the columns of the JTO. There were 190 people present at the conference and looking at the delegate list I noted that there were nine orthopaedic surgeons in attendance.

The conference was chaired by Amanda Stevens, ex NHS manager, latterly solicitor and now a partner at Irwin Mitchell solicitors and a Governor of the EWI. The panel for the Runnymede discussion was chaired by solicitor Michael Napier with myself and two barristers, Theodore Huckel QC (Counsel General for Wales) and Graham Aldous QC. The Runnymede theme was topical as we are now in the 800th year since the sealing/signing of the Magna Carta by King John.

The hot tubbing issue was dealt with fairly speedily. As you will be aware, this is an innovation arising from the Jackson CPR reforms introduced in April 2013. Essentially it involves witness conferencing with judge and counsel able to cross examine expert witnesses less formally outside the Court room in order to resolve differences that have proved irresolvable following joint discussions and preparation of Joint Statements. It was introduced following experience in the Australian legal system. It soon became evident after a show of hands among the delegates that there was very little experience of hot tubbing amongst the attendees with only a handful of the 190 present having any experience of it. The majority of these appeared to be non-medical. It may be that the type of cases that we are involved in do not lend themselves to this process. If any of the JTO readership has experience of hot tubbing or can relate any experiences that we can usefully learn from, I would be interested to hear from them. While the legal profession speak enthusiastically on the subject it seems to be something of a damp squib for orthopaedic and medical experts at the present time.

During this session there was also debate about the role of the medical expert in relation to the Court and to the claimant/patient. The point was made that from time to time one still sees cases where the expert is recommending treatment as part of his/her opinion and then carrying it out. The prevailing view was that this represented a conflict of interest and potentially subjected the expert to criticism and should be discouraged.
In my own practice I have come across this most commonly with Pain Management experts. There was also discussion about how we might try to better educate patients/claimants and GPs about the nature of the legal process

given that in some cases the legal process overtakes the investigation and treatment of the underlying condition. There sometimes appears to be a misunderstanding by the claimant and his/her GP that various investigations (MRI in particular) and specialist appointments for the legal process are not a direct part of the clinical investigation and treatment of the underlying problem. However, common sense would dictate that any investigations carried out for the purposes of the claim could/ should be made available to the treating consultant rather than be duplicated. There were also discussions on when experts should hang up their boots with the issues of appraisal and revalidation raising their heads again.

There were presentations from John Sorabji, legal adviser to the Ministry of Justice (MoJ) and David Marshall from the Law Society. Both focused on the effect that governmental cuts in funding would have on the legal process as we experience it. The latest round of savings cuts £249 million from the MoJ budget. Much of the savings are planned to come from closure of Courts and tribunals on the basis that they are underused and there should be greater use of modern IT methods, such as video links in the process. There has been a suggestion that for claims under £25,000 (the current fast track limit) a system should be established for Online Dispute Resolution (ODR). However, with Medco (see later) this will probably not have a great effect on us as orthopaedic surgeons. The legal experts expressed concerns that the adversarial system that exists at present may be replaced by an inquisitorial system. It was felt that advocates of the adversarial system must engage with austerity, IT and proportionality rather than fighting for the status quo.

Judge Allen Gore spoke on, "Current Expert Evidence Issues: A view from the bench". Much of what Judge Gore said went over my head but he made some interesting points. He reminded me that part 35 questions are merely for the purpose of clarification. It is worth remembering that the Chancery guide indicates that, "If questions are oppressive in number or content" and are not agreed with the other side the Court will disallow them. This was timely as far as I was concerned having very recently received part 35 questions running to 56 pages from a claimant solicitor effectively exploring every avenue possible to get me to change my opinion as it was not particularly supportive of the claimants case. Judge Gore also made the point that in high value/complex cases the expert should be involved in drafting the agenda for the joint discussion with his/ her opposite number as laid down in the 2014 Guidance. I found this interesting as I would estimate that 90% of the joint statements that I am involved in preparing have no agenda! I am probably asked for advice/input into the agenda in 20/25% of the 10% where there is an agenda. Judge Gore indicated that there were three common reasons why an experts' opinion would be rejected:

1. Descent into advocacy i.e. taking sides or lacking impartiality
2. Expression of opinion outside expertise
3. Demonstration that factual assumptions on which the opinion is based are incorrect.

(L-R) Mike Napier, Mike Foy, Theodore Huckle QC & Graham Aldous QC

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JTO Medico-Legal Features

The point was also made that it is reasonable and acceptable for an expert to change his/her opinion as long as there is a clear reason for the change, for example receipt of additional information.

We were then, I thought, about to be entertained by Stephen Webber, Chairman of the Society of Clinical Injury Lawyers (an organisation that I had never heard of) speaking on the provocative subject of, "What Solicitors really think about Experts". In fact this was more of a practical and pragmatic offering on how to be a good expert and keep the instructing solicitor happy with advice including:

1. Check carefully that the matter falls within your area of expertise (clinical practice)
2. Check for conflict of interest
3. Read the letter of instruction carefully and ensure that any specific questions within that letter are answered. Don't just produce a generic report
4. If there is more than one factual scenario provide your opinion on the alternatives. Don't argue the case for which is correct, that is for the Court to decide
5. The judge is not a doctor. Make the report understandable to a lay person, even a professional lay person
6. Have a proper administrative set up and point of contact. Respond to letters and emails, don't ignore them
7. Prepare thoroughly for conferences and joint discussions
8. Solicitors have to provide a budget for all costs including expert fees therefore experts have to be prepared to provide a budget if requested
9. Adhere to agreed timetables and particularly timetables set out in Court directions.

EWI Chairman, The Rt. Hon. Sir Anthony Hooper

It seems that the Society of Clinical Injury Lawyers has been formed this year by leading clinical negligence lawyers, who are concerned that recent legal changes will make it more difficult for victims of medical accidents to obtain full compensation for their injuries and financial losses. Moreover the Society's members believe that the bigger picture is that medical accidents in England and Wales will increase if medical negligence claims decrease since there will be less financial incentives for medical professionals to commit enough resources to ensure such accidents are avoided. Perhaps it is time to revisit the question of a no fault compensation scheme for medical accidents, as exists in New Zealand, Sweden, Finland and Denmark. The Scottish Government have been investigating such a scheme for the last five years and as I understand it now intends to proceed with caution and further explore how the system may work.

There was then a joint presentation from Senior Costs Judge Peter Hurst and Nicholas Bacon QC on costs with more focus on the state of play with austerity and reduced MoJ funding. The matter of proportionality raised its head again. This is something highlighted recently by the MPS in their briefing paper where they discussed two recent negligence cases:

∞FROM TIME TO TIME ONE STILL SEES CASES WHERE THE EXPERT IS RECOMMENDING TREATMENT AS PART OF HIS/HER OPINION AND THEN CARRYING IT OUT. THE PREVAILING VIEW WAS THAT THIS REPRESENTED A CONFLICT OF INTEREST AND POTENTIALLY SUBJECTED THE EXPERT TO CRITICISM AND SHOULD BE DISCOURAGED.∞

1. A cosmetic surgery case where damages of £17,500 were agreed within five months of notification of the claim by which time legal costs in excess of £50,000 were being claimed
2. In a second case relating to delayed diagnosis of skin cancer damages of £30,000 were again agreed within five months of claim notification by which time legal costs had risen to £60,000.

Obviously as experts instructed by solicitors for the claimant we don't usually have a clear idea of the bigger costs picture. In over 25 years of providing expert reports in PI cases and 14/15 years in negligence, I haven't had my fees reduced during or after the case. Perhaps I'm not charging enough or perhaps the expert fees are more protected than other areas of expenditure.

The fixed cost medical report through MedCo was discussed. The first report, whoever provides it, will carry a fee of £180. This will presumably be considerably reduced if the expert is instructed by a Medical Reporting Organisation (MRO). A further report, where justified, will carry a fee of £420 (consultant orthopaedic surgeon), £360 (A&E consultant) or £180 (GP or physiotherapist). Finally, in this session there was a discussion on conditional and contingency fees. These are strongly discouraged. The impartiality of the expert is called into question if the nature of the expert opinion might be influenced by payment dependent on the outcome of the case.

The final session directly relevant to JTO readership was titled "Whiplash Reforms: MedCo-Improving the quality and independence of medical reporting". Again there was a double act presenting with Patrick Allen (Managing partner Hodge Jones and Allen solicitors) and Donald Fowler (CEO, Premex). Those of you who attended the Medico-Legal session at the BOA Congress in Liverpool the previous week will know that we ran a MedCo session with a representative from APIL, an orthopaedic surgeon and the MedCo Chairman to try to and establish some balance and perspective. Therefore, I was interested to see where we got to with two senior figures in the provision of reports in whiplash cases and no balance from MoJ or MedCo.

Predictably, MedCo, set up on 6th April this year was castigated by Messrs Allen and Fowler. They believed that following the MoJ consultation last year MedCo was rushed without proper thought or consultation because of the impending general election. The principal complaints/criticisms were:

1. There is no longer any freedom of choice for solicitors in choice of experts. It is now a random allocation process based on post code
2. Accreditation of experts will be necessary by 1st January 2016, although there is no agreed means of accreditation at the present time. However, since the meeting MedCo have announced two means of accreditation and this has been passed on to the membership via the e-newsletter and elsewhere in this edition of JTO
3. MoJ aim was to improve quality of medical reporting – there is no evidence that this has been achieved
4. "A complete mess and a retrograde step all round".

I believe that we had a more proactive discussion session at the BOA Congress, although the orthopaedic audience were critical of the set up and the fact that there was a lack of clarity on whether second reports were to be commissioned through the MedCo site. Obviously it will be interesting to see whether MedCo stays the course or is consigned to the scrap heap. At the time of writing it has still not been up and running for six months so we will have to see how the situation evolves.

All in all this was an interesting day at the EWI Annual Conference with some useful issues aired. Consent and Montgomery were not really discussed. However, it seems that with Montgomery and the Society of Clinical Injury Lawyers, Bolam is coming under increasing attack from the legal profession. They really don't like us having much say in our own regulation. Interesting and perhaps worrying times for trainees and newly appointed consultants. ■

Michael Foy is a Consultant Orthopaedic and Spinal Surgeon, is Chairman of the BOA's Medico-legal Committee, Co-Author of Medico-Legal Reporting in Orthopaedic Trauma and author of various papers on medico-legal and spinal/orthopaedic issues.