RESPONSE TO

THE CHIEF MEDICAL OFFICER'S CONSULTATION PAPER

"BEARING GOOD WITNESS - PROPOSALS FOR REFORMING THE DELIVERY OF MEDICAL EXPERT EVIDENCE IN FAMILY LAW CASES"

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Bearing Good Witness: A response from Action against Medical Accidents (AvMA)

Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK charity specializing in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

AvMA is proud of the key role it has played in making clinical negligence a specialism within legal practice. It continues to accredit solicitors for its specialist panel (without membership of AvMA's or the Law Society Panel a law firm is not entitled to a Legal Services Commission clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors.

One of AvMA's key services is the maintenance and compilation of an expert database that comprises experts willing to undertake medico-legal work, for clinical negligence claims in particular. These experts undertake expert witness work for "both sides." Clinical negligence work, like work in public law Children Act proceedings involves work of a highly complex and skilled order. As the CMO has identified in relation to family law cases experts willing to act in clinical negligence cases can be in limited supply in some disciplines. There is also the issue of quality. Therefore, although this consultation relates to the family law arena we believe that our observations born out of experience in the clinical negligence arena may well be relevant. Also we have noted the potential to

extend the model to other areas of law."[1] Therefore, what may evolve, following implementation of these proposals might serve as a paradigm for arenas outside of family. We do not believe this to be appropriate for reasons as set out in more detail below. Therefore we would urge that should these proposals be implemented in any way for family law cases that further consideration and consultation is sought before applying these principles to other contexts. This is why we are responding now. We have concerns that once these structures are set up (at considerable cost) the urge to apply them across the board will be irresistible.

It needs to be emphasized that AVMA's direct knowledge of family law is limited and therefore the focus of our response will be seen from our healthcare law perspective. We wish to concentrate on two of the overriding themes of the paper: quality and supply.

SUPPLY

AvMA is aware from its experience of the clinical negligence field of the difficulties in obtaining a suitable expert. The problem is often compounded by the fact that experts in certain disciplines are very much in demand. This invariably means that there are long waiting times in getting an expert to consider a case leading to delays. We would therefore support certain initiatives to encourage doctors to become experts subject to clinicians being of high calibre both as clinicians in their field and as expert witnesses as well. It does ***not*** follow that because a clinician is highly respected in his/her clinical field of expertise that s/he will necessarily be a good expert as well. Yet this appears to be the assumption from the proposals mooted.

[1] Bearing Good Witness: proposals for reforming the deliver of medical expert evidence in family law cases. . A report by the Chief Medical Officer, page 15

Selection of experts

AvMA strongly objects to the notion of an expert being instructed from the body commissioning the expert evidence. Letters of instruction must be undertaken by the instructing solicitor. If the process in selection of experts becomes too mechanised justice may not be done and we can foresee human rights challenges being raised. Nevertheless, we do agree that many lawyers need to do a great deal more to support experts in their work by undertaking clear and detailed letters of instruction, keeping experts abreast of developments and giving experts adequate notice of meetings, appearances and schedules. Many cases stand or fall because lawyers failed to "test" the expert appropriately on his/her position/views. Literature references and research often fails to back the expert up. A team structure might well obviate some of these problems but lawyers have played a not insignificant part in relation to some of the problems that have developed in the past.

The tenure of the paper suggests that the appointment of experts in child protection cases is a consensual one. That is certainly not the case when families are being threatened with a child being taken away from them and placed into care. Reputable lawyers ought to go to great pains to ensure that the expert appointed is based on the reputation and knowledge base of a named individual. We therefore have concerns about responsibility shifting from the individual to the team. A team may fluctuate; registrars in particular may be a mobile work force. What happens in circumstances where a department's work has been disparaged and a team member has been subject to criticism? Will their services as an expert resource be withdrawn or will the services be retained? What about accountability? We note the intention to ensure quality assurance by following ISO 9000. However, this deals with organisational structures as opposed to the quality of any named individual and whilst we note how accreditation may deal with individuals we have concerns about this that are dealt with in more detail below. If the evidence of an expert is criticized will the whole team be taken to

task? How? Will this increase the burden on the NHS as well as the court, delaying justice and increasing cost?

Notwithstanding the above, AvMA does see potential benefits deriving from experts working in teams with the support that that entails. We see benefits in particular to a National Knowledge Service with experts having access to support in relation to interpretation of statistical data and understanding of epidemiology. However, it remains the case that in a clinical negligence context, the claimant and defendant lawyers often assemble a team of multidisciplinary experts engaged to examine and/or support the case put forward in any event.

We also endorse proposals for expert witness work to form a part of training for undergraduates as well as practicing clinicians. However, we strongly object to any notion of doctors being "conscripted" to undertake this work. This is firstly, because however qualified a clinician may be as a doctor, s/he may be a poor expert. (Many doctors find it difficult to express themselves clearly in writing or orally. Clinicians - particularly at the lower level - may find they get intimidated in court or indeed in expert meetings.) Secondly, a reluctant expert is going to be of limited assistance to his/her client and/or the court.

Independence

Independence must be both real as well as perceived. Parties involved in any proceedings are entitled to a full and fair investigation and representation. There may be a temptation for a team of experts to be appointed from within the family's locality. Even outside of any locality connections between practitioners and NHS centres can be linked in other ways, particularly in areas in which the pool of expertise is limited.

QUALITY

Accreditation

AvMA has concerns about the proposals for accreditation as set out in the document. Neither the Council for the Registration of Forensic Practitioners (CRFP) or the Academy of Medical Royal Colleges are geared up for this. The CRFP is simply not geared up to dealing with a discipline, for example such as clinical negligence that is a highly specialist area requiring experts of the highest calibre. Many experts appear to concur. When AvMA conducted a survey of experts in 2005 one said:

"The Forensic Council is not an appropriate accreditation body. All of us have professional accreditation. That plus reputable legal support - such as AvMA - should be enough. Most doctors do this work in their spare time - partly as a perceived public service to deserving patients. I could earn more in private practice…"

An important pre-requisite for a clinical negligence expert is an open mind - to see both sides - and an ability and willingness to recognise a fellow professional has done wrong and not be afraid to say so. Any accreditation process will need to ensure that experts report in a fair and balanced way and that no expert is either a "defendant only" or "claimant only" one. We have other concerns as well (see below). We would resist any move that would require a claimant clinical negligence lawyer to choose a CRFP accredited expert over another selected by the claimant lawyer. AvMA maintains its own database of experts and we believe that our own system of continued monitoring of experts and rigorous assessment prior to an expert being added to the database (or, indeed removed) is the gold standard.

AvMA accepts that in some legal disciplines the quality of expert reporting can vary widely. Some experts have been known to find expert witness work so lucrative as to make a career out of it. This certainly needs to be acknowledged

and AvMA certainly would not support or encourage the avaricious expert making money out of victims of a medical accident. Such a trend is not prevalent in the field of clinical negligence. At the same time good experts who recognise their responsibilities must be appropriately rewarded. Many experts instructed in the clinical negligence field are of good quality who exhibit mastery of their specific discipline and commitment to their profession. Some experts also feel humbled when they face the reality of damaged lives following medical or clinical error. AvMA believes that it is morally, socially and ethically important for doctors to be prepared to act for patients in these cases. Most of these experts recognise that the stakes are enormously high for our clients. They do not advise recklessly or "off the cuff."

The AvMA Database

AvMA has made a very significant contribution to this state of affairs. Since its establishment, AvMA has worked with members of the medical profession in order to engage them in advising and supporting patients following an adverse incident. AvMA has maintained and compiled a database of experts willing to undertake claimant clinical negligence work. An expert is not placed on our database without rigorous checks being made first. An expert must have held a consultancy post for a minimum of five years in a respected institution. They must be well-qualified and preferably have a research background. We audit anonymised medical reports. Further, the database relies on feedback from our lawyers, reporting back on the quality of the report, satisfaction etc. No expert is removed or placed on the database without the report being audited first. We employ two medical advisors dedicated to maintain and update the database. We get approximately 100 *written* enquiries every week from lawyers requesting experts, many ask for a multiplicity of experts relating to multiple cases at the same time in one letter (we get many telephone enquiries also). We have 2,500 experts on our database covering the range of disciplines from paediatric neurologists to radiologists.

Key to the integrity of our database is that no expert gets on the database by paying us to do so. Key to the authenticity of the register is the feedback that we get from lawyers following recommendation of an expert. We also get feedback from solicitors about new experts that they have experience of. Solicitors who are experienced practitioners and panel members rarely instruct an expert on a case without giving a great deal of thought to the issue.

For some time (and prior to publication of this consultation), AvMA has been engaged internally in discussions about the recruitment of new experts to our database. In particular, the focus has been on the younger consultants, to ensure that there is adequate and additional provision of experts, particularly in the highly specialist areas of clinical practice where experts can be very thin on the ground. However, we feel that even those experts who demonstrate potential need to be mentored in some way and peer reviewed before we can “hand-on heart” recommend them. We are continually developing the service, for example, by organising specialist training days for experts. AvMA is also keen to develop an expert service that will disseminate relevant case/procedure to experts through a newsletter and expert support group meetings. AvMA is most willing to discuss any of these initiatives with the DoH.

AvMA believes that with REDRESS in the pipeline, the pressure on experts will be increased while the waiting list times in obtaining reports extended. Diminution to the reserve of experts will prejudice justice in the long run. What if the experts themselves refuse to “buy in” to accreditation, finding the system too burdensome administratively and too time consuming?

What Will Accreditation Achieve?

There is also the issue of whether there is a problem that requires fixing that accreditation would actually address. Although there may be a mechanism to

remove an expert off the “accredited list” we all know how the reality might be in practice.

Accreditation will be meaningless unless experts have to undergo some quality assurance checks that are truly measurable of their skills as an expert and their credibility as a clinician. Training will be important but the quality of the training needs to be assured. Further, accreditation ought not to mean that a certificate issued that warrants an expert’s skills is never to be revoked. A worrying feature of accreditation is whether proactive monitoring will take place. If not, then the system will be less an assurance of quality than the current one that broadly functions very well. Experts are not automatons and at the end of the day, they are providing an opinion based on their clinical experience and expertise – they are not always going to get it right. There are a lot of variables as to why an expert gets it wrong which accreditation will probably not capture. The bad ones are weeded out by AvMA and the legal practitioners, a key skill for specialist practitioners being the ability to assess experts.

The proposal also does not take into account the “one off” expert that ordinarily does not undertake public law family work but happens to be renowned in his/her field of expertise and is one of only a handful of people who understand/practice in that field of work. It is not uncommon for AvMA to get appeals from solicitors for an expert who fits an extremely esoteric bill and for us to make special enquiries based on in-house medical experience and expertise as well as contacts.

Therefore, we would be very worried if accreditation with a body like CRFP or other as a pre-requisite to instruction of an expert were to be insisted upon. Further, we do not believe that CRFP or another would run the system as well as we do; not without significant resources. Accordingly, we do not believe that accreditation will generally raise the quality of experts.

For reasons stated above we believe that key to quality is the provision of expert training and mentoring and in this we concur entirely with the CMO. Training also needs to be undertaken in relation to understanding the anatomy of a civil action, procedures and processes, the law and legal tests, relevant case law and application. AvMA is working on devising an induction pack for experts in clinical negligence clarifying the duties and responsibilities of the expert and clarification of the expert commitment as well as explanation of the legal process and the law.

Linked to quality assurance is the issue of expert accountability. AvMA wants experts to be accountable. For this reason, we believe that an agreement/protocol needs to be devised between the legal and medical professional bodies to set out the duties and responsibilities of a medico-legal expert. We suggest that it is vitally important that the GMC buys into this. The integrity and performance of a medico-legal expert reflects on the profession as a whole. The protocol might be best mediated through the Civil Justice Council. The GMC might also consider the performance of the medico-legal expert as part and parcel of the GMC revalidation process.

Summary

We have responded to this consultation because we have concerns that the scope of these proposals could potentially be extended to the civil arena, clinical negligence in particular. However, we foresee real problems in extrapolating a model designed to curtail problems in recruiting experts in public law children cases into clinical negligence. Firstly, the proposals assume an inquisitorial legal process with an expert acting to protect the interest of the child. To that extent we agree with the CMO that clinicians should see court work as part and parcel of the state's obligation to protect children. In contrast, clinical negligence is a private law matter with an individual seeking redress against a medical institution or practitioner. An individual seeks answers as to what could have gone wrong and seeks independent and impartial advice. The individual is often claiming

against the NHS and wants to be assured of an independent investigation. If the NHS is effectively managing and monitoring the quality of expertise then claimants will need assurances about the objectivity of an appointed expert and choice therefore seems a paramount consideration.

The process of clinical negligence litigation as currently constituted is not geared up to adapting from an adversarial to inquisitorial process. The proposals if transposed to clinical negligence would be tantamount to re-introduction of the appointment of the single joint expert that has not in the past been seen to work. Any consideration to extend any of the schemes proposed would thus entail a major re-think of the clinical negligence process. The government has expended a massive amount of resources to date on claims pursued against the NHS and recent experience suggests that it might be reluctant to deploy and expend further time in making changes that in the main turn out to be peripheral.

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