Royal College of Surgeons
ADVANCING SURGICAL CARE

THE SURGEON AS
AN EXPERT WITNESS

Royal College of Surgeons
ADVANCING SURGICAL CARE

The Royal College of Surgeons

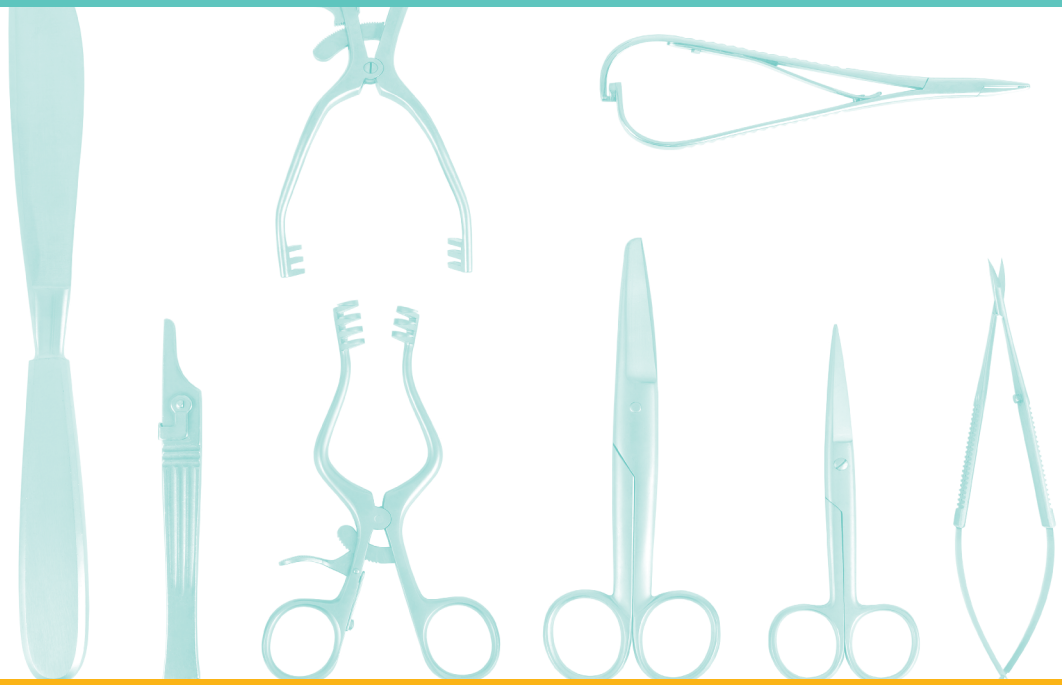
The RCS produces a wide range of standards and guidance to support the surgical profession within the areas of team working and leadership, legal and ethical concerns, personal development and service improvement. To find out more about our work, visit: **www.rcseng.ac.uk/standardsandguidance.**

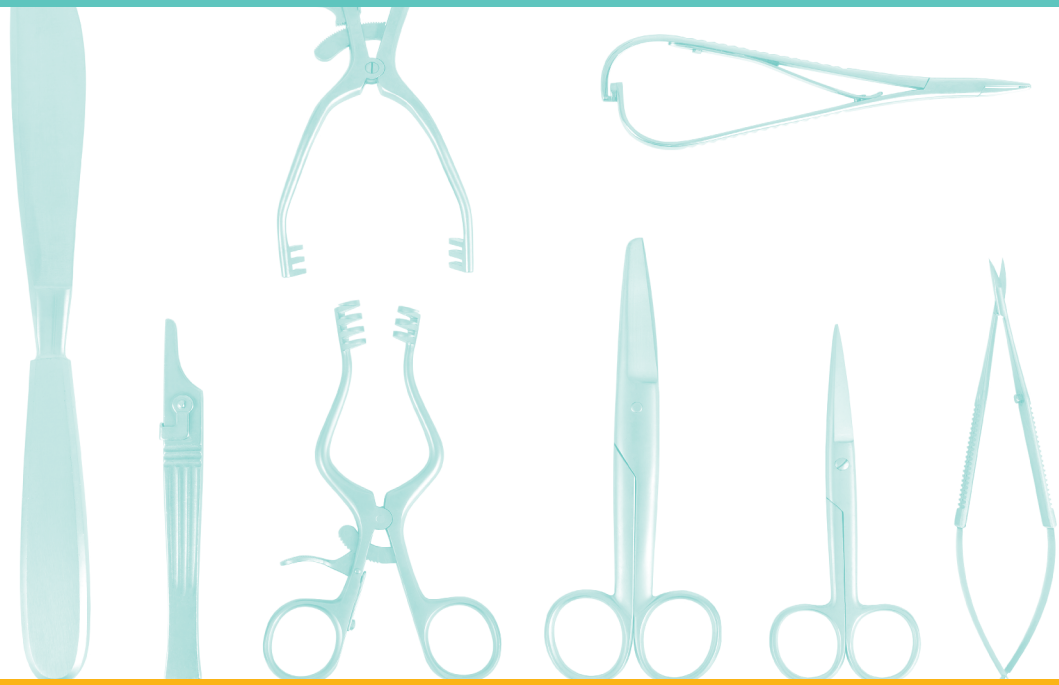
The Royal College of Surgeons
35–43 Lincoln's Inn Fields
London WC2A 3PE

The Royal College of Surgeons
The Royal College of Surgeons of England
@RCSnews

THE SURGEON AS AN EXPERT WITNESS

A Guide to Good Practice





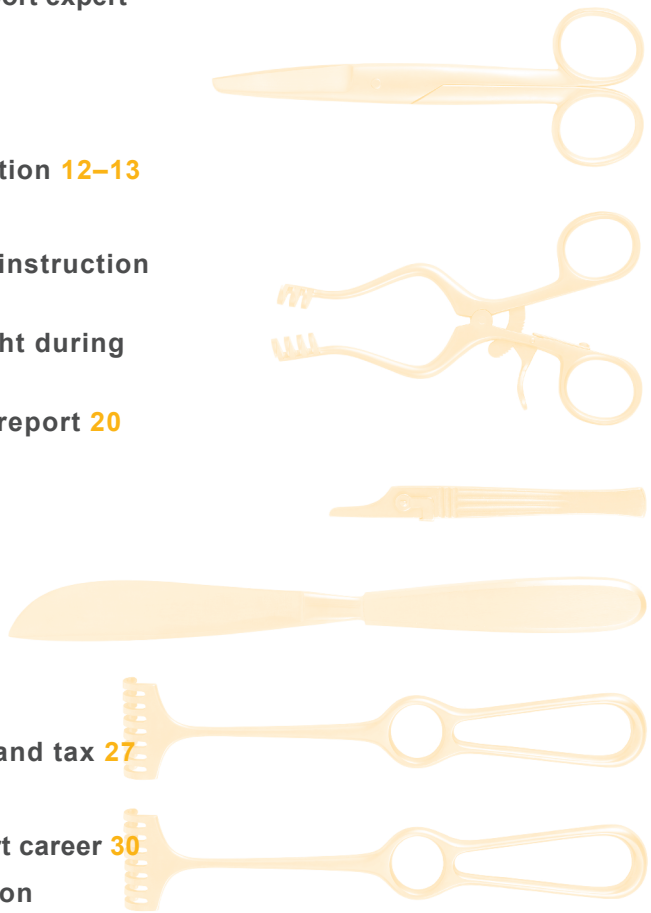
www.rcseng.ac.uk/standardsandguidance

Professional and Clinical Standards

September 2019

The College would like to thank Mr Robert Wheeler, Consultant Neonatal and Paediatric Surgeon, Associate Medical Director, Department of Clinical Law, NHS University Hospital Southampton, who prepared the draft of this document.

Contents



1. The role

WHY EXPERTS ARE REQUIRED

During routine daily business in criminal and civil courts, judges decide cases based on the cases that are pleaded by solicitors and barristers. These lawyers require no third party to translate or explain the law for them. In the crown court, the judge will explain the law to the jury. Equally, dealing with commonplace human vicissitudes and transgressions of law, the lawyers are fully equipped to articulate the circumstances of criminal or civil wrongdoing.

On occasion, the context of the case will involve surgical practice or an intimate knowledge of anatomy, or the requirement to predict the natural course of events following serious injury and disease. In these matters, unless lawyers are also doctors, the absence of both elementary and advanced knowledge of science and surgery will render them incapable of deciphering either the surgical vocabulary or the concepts these words explain. Furthermore, when the standard of surgical care is in question, only a surgeon steeped in the relevant specialty will be in the position to assert whether the patient's management fell within the reasonable standard that he or she was entitled to expect. For this reason alone, 'expert witnesses' in surgery are sought by the parties to civil, criminal and coronial legal actions.

TO WHOM EXPERT EVIDENCE IS ADDRESSED

Surgeons are expected to be honest and objective when providing evidence to courts and tribunals (The Royal College of Surgeons of England, 2014). While it is intuitive to believe that the party who pays the expert 'owns' the expert, it can now be seen why that is untrue. The decision maker in legal actions is the court (usually a judge, sitting alone) and thus the expert serves the court. The duty of the expert witness to the court overrides any obligation to those who are instructing or paying the expert (General Medical Council, 2013).

The surgeon writing an expert report addresses it to the court, and when he or she gives oral evidence, will look at the judge and direct the answers to questions posed straight to the judge, notwithstanding that the questions emerge from barristerial mouths. The principle of being a servant of the court ensures that the expert is not misled into believing that they are partial nor acting as a persuader on behalf of the party who is paying for the evidence. On the contrary, the expert must be independent, providing opinions based upon their experience, founded upon any available and justifiable evidence. Plainly, each party enters litigation aiming to win. It is a matter for the barrister and supporting solicitor on each side to formulate questions which draw from their own experts' answers supportive of their client's case, and at the same time eliciting answers from the opposing experts that will undermine their position. The barrister ('counsel') will be devoted to the task of creating the impression, for the benefit of the court, that the opposing expert evidence is unreliable. The barristerial process is rightly described as 'adversarial',[1] but opposing experts must resist becoming adversaries at all costs, since that is contrary to their role. Acting as an adversary hints at having a conflict of interest between serving the court and serving the paymaster.

CONFLICTS OF INTEREST

The legal system requires that expert witnesses are scrupulously careful not to take sides in any sense. For this reason, an early question prior to instruction is whether the expert knows either the defendant or the claimant. The risk of partiality is obvious in this context. If your subspecialty is a small one, it may be impossible to find an expert within the UK who has no knowledge of the surgeon involved in the claim. Instructing solicitors will then seek to ensure that there are at least no close connections that may be identified by the other side to support a complaint of conflict. Reports must include a statement by the expert to this effect.

Less obvious conflicts may be more corrosive than personal connections, if an expert sees their report as an opportunity to air a favoured hypothesis, while failing to beware of the danger of following pet ideas beyond their logical foundations. The conflict in this case may arise if the determination to propound a personal opinion shifts the expert's concentration away from serving the court to his or her best ability.

[1] L, *adversarius* (noun), opponent, antagonist, enemy

2. Witnesses: factual, professional and expert

Factual witnesses give evidence, usually in writing, as to what they did or saw, often in the context of an adverse event. Professional witnesses, such as clinicians and pathologists, give evidence as to what decision or diagnosis they arrived at and why.

Expert witnesses are by definition distant from and entirely uninvolved in the claimant patient's clinical care. They cannot testify to the validity of facts or assert the reasons that underpinned decisions made during the course of a clinical event. It will be for the court alone to decide the facts as to what happened, when and why, after the evidence has been submitted. The expert must not attempt to usurp the court's role in the finding of facts, even if tempted to do so by counsel of either side.

The expert is likely to be giving an opinion on the standard of care that the patient received; as to whether *on the balance of probabilities* the surgical management fell within the spectrum of reasonable care that the patient was entitled to expect. Furthermore, whether (using the same standard of proof, ie 51%), *but for* demonstrable substandard care, the harm that the patient suffered would have been avoided. The latter is the concept of causation.

3. Jurisdiction

CIVIL

Surgical expert witnesses are usually instructed in the civil courts in relation to the tort (a civil wrong) of clinical negligence. They will either be instructed by solicitors' firms, who in turn represent the claimant patient, or NHS Resolution, on behalf of the defending hospital trust and/or general practice. The question for the expert witness may be related to the alleged poor standard of care, the causative link between that and harm caused or the condition and prognosis of the patient.

In very narrow spheres of practice, surgical expert witnesses may be instructed in 'personal injury', where a citizen has been harmed by a non-clinical event. Cervical spine 'whiplash' injury is a memorable example, ultimately having a profound detrimental effect on the motor insurance industry. The results of citizens' slips, trips and falls is another example; in these cases of injury, the question for the expert will be restricted to causation, condition and prognosis.

After often prolonged litigation, civil cases will usually be either discontinued or settled; neither of these outcomes requires the expert witness to attend court. In the rare circumstances that a trial is required, this will occur in front of a single judge at either county- or high court level, largely depending upon the estimated financial value of the case. Experts for claimant and then defendant will give their evidence, both 'in chief' when led with encouragement by counsel from their own side; and then under cross-examination in response to (usually pointed) questions from the opposing counsel. The judge acts as both an umpire during the opposing legal arguments and as the final decision maker. The decision is invariably written and read out in court often many weeks after the experts' appearance at the trial.

CRIMINAL

Surgical experts are rarely instructed in relation to crime (a criminal wrong, prejudicial to the community). If only because involvement is unusual, caution is advised. The request for involvement usually stems from an injury inflicted due to alleged violence. An example may be of an 18-month infant who presented with a ruptured liver and a transverse bruise in the skin overlying it. It is alleged that the estranged father struck the child a karate blow to her abdomen. The father counters with the assertion that, in reality, his daughter, momentarily unattended on a sofa overbalanced, suffering a glancing blow on the abdomen from an adjacent table edge as she fell. The police, initially alerted by the child safeguarding authorities, will take statements from radiologists and clinicians as witnesses of fact. But for various reasons, the Crown Prosecution Service (CPS) may seek independent surgical expert evidence as to whether the table edge could have caused such an injury. The expert should bear in mind that the CPS will be trying to obtain conviction and may encourage them to take

a view as to whether an alleged karate blow was a more likely cause of rupture than the table's edge, given all the clinical facts.

It is easy to see how this may lead surgical experts outside their area of expertise. It should also be borne in mind that guilt is decided upon by a jury in the crown court (where the serious criminal matters are heard). The judge will set out a summary of the prosecution and defence cases, but leaves the decision over guilt to the jury. For this reason, it is vital that expert witnesses do not give opinions to the jury on questions that they are not entitled to answer. For example, a surgical expert would be entitled, if asked, to assert whether or not a surgeon's conduct (related to a criminal case) equated to substandard care, but whether or not that care was 'exceptionally bad', which can lead to manslaughter charges, would be for the jury to decide. While the CPS might pose such a question (hoping for an affirmative reply), the expert should not answer it, since their role is restricted to the binary question: substandard care or not. Although these distinctions seem trivial, they are of the utmost importance to the orderly conduct of a criminal trial. It is for this reason that caution is advised.

CORONIAL

Surgical experts will sometimes be instructed by a coroner to give evidence in relation to why a patient has died, even though this patient was not in their care. The surgical expert's role will be exclusively in relation to cause of death, rather than avoidability or related substandard care. Coronial proceedings are generally conducted in a less formal atmosphere than civil or criminal matters, often in municipal buildings. Coroners usually arrange the running order of their inquests at the last minute, immediately before the start of the hearing on the first day. For this reason, it is perfectly possible that having been required to attend on the Monday, the 'surgical' evidence will be deferred to the Tuesday or Wednesday, so foresight may assist planning. Inquests are rarely overtly confrontational, but it should be borne in mind that they represent an opportunity for a potential claimant to garner evidence that may support a future claim on behalf of their deceased relative. Expert witness evidence given on oath at an inquest can in some circumstances be referred to in subsequent civil litigation or criminal procedure. For this reason, it is important to keep a record of what you said and wrote in relation to the inquest.

4. Surgical expertise

Surgical expert witnesses are only useful to lawyers for their surgical expertise. For this reason, it is unlikely that surgeons can claim 'expert' status in the first five years of consultant life. It is vital that the expert only takes on cases that he or she encounters as part of their routine practice. If you are a vascular surgeon, tempting as it may be to give your view on the standard of diabetic care, or the quality of the associated retinal surgery, this is not acceptable to the courts. The same applies to subspecialisation; if the case turns on an issue lying within your surgical specialty, but outside your own field of work, be wary of accepting instructions. Hypospadias falls within the paediatric surgery curriculum, but if as a paediatric surgeon you have not dealt with one for 20 years, do not start now. Furthermore, inexperienced instructing lawyers may not appreciate where the inter-specialty or subspecialist boundaries lie, and may be taken in by your eloquent opinions, oblivious to the fact that they are based upon no recent experience whatsoever. The same will not be true of your opposing expert, who will point out your error to their legal team, who in turn will point it out to the court.

5. Prior experience to support expert practice

Plainly, the central skill on which to found an 'expert' practice is technical and academic mastery of a surgical specialty. Instructing solicitors invariably request curriculum vitae prior to engaging an expert, and its contents need to substantiate clinical experience relevant to the litigation. Most of us work within an immediate specialty group, whether in secondary or tertiary care, and thus belong to a much wider regional or national group of our own specialty, ultimately within one of the ten disciplines. These connections are of great importance when forming an expert opinion, since a surgeon steeped in their specialty will have every opportunity to view the spectrum of what is normal and reasonable practice. Put at its simplest, if you ask four surgeons the best way to close a wound, you'll get five answers… and all of them are likely to be reasonable. This teaches us all that our own preferred approach to surgery is matched by other different but equally reasonable variants. It is this knowledge that is particularly prized by the courts, since in setting the standard of care with which to compare that employed by the defendant the question for the expert will be whether the defendant fell within the reasonable range. If you have insufficient experience to articulate this normal range, you will be unable to decide whether the defendant's management fell within that range of reasonable practice.

Many experts will also be able to rely on their publication record to substantiate their assertion of expertise, so in this competitive market, you will need to be able to match this. The skills developed by consultants in the course of hospital or College life may also transfer naturally into expert work. Any roles in the investigation or resolution of serious clinical incidents in any specialty within or outside your NHS trust are relevant. These may be seen by solicitors as a proxy measure of the forensic skills vital to analyse the context of the clinical misadventure that has resulted in the litigation they are conducting.

6. Training

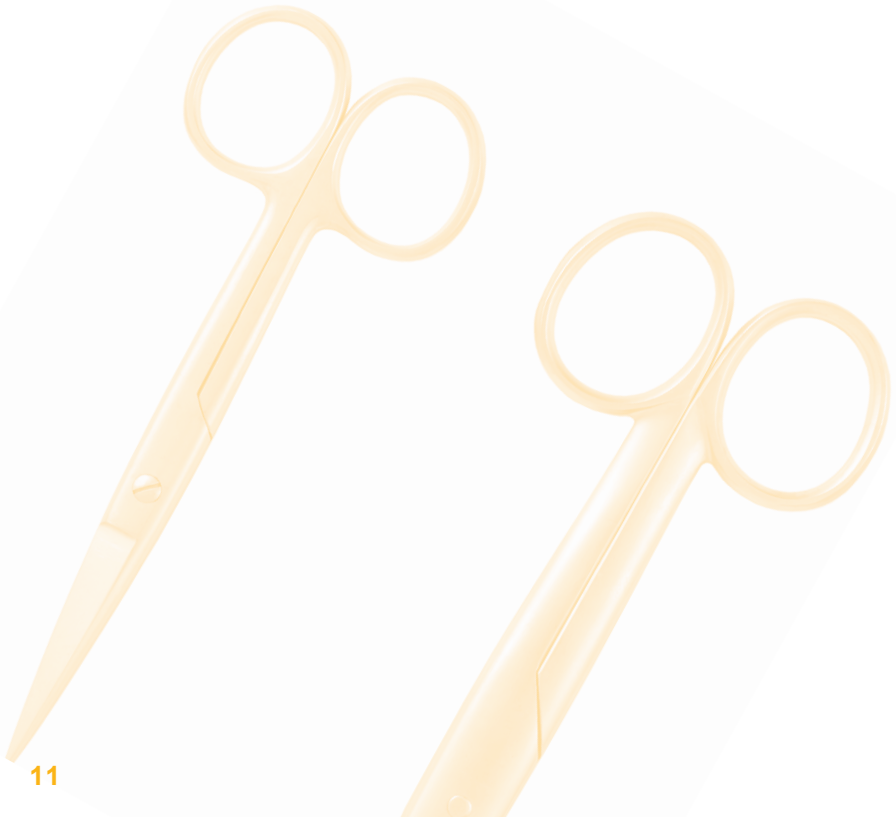
The College strongly recommends that a medical expert in a criminal case should have undergone appropriate medicolegal training. Training courses abound for expert witnesses and some elements are essential. The Civil Procedure Rules Part 35 (the definitive and obligatory guidance on the subject) prescribe, among many other things, certain aspects of the content of expert reports destined for disclosure to the court. Various organisations provide training in report writing, and it would be foolhardy to submit a report untutored. Equally, the fact that the expert is unlikely often to give oral evidence in court makes training for that eventuality essential. The witness box is a lonely and intimidating place; it is hard to overestimate the value of prior training in the required etiquette, formalities and survival techniques when faced with counsel.

Courses are also available (either separately or as part of training 'bundles', the latter embarked upon with a view to a certificated qualification) on other aspects of expert work. These include dealing with expert meetings in the course of litigation, conference with counsel, marketing, data protection and refresher courses reflecting changes in the law. It seems likely that the more training in preparation for expert practice one does, the better. But a sense of proportion must also prevail; these courses are expensive in time and treasure. To distinguish the essential from the optional, it may be helpful to decide whether expert practice is going to be a central or tangential component of one's professional portfolio.

Some surgeons undertake a master's course in medical ethics, sometimes touching on medical law. On occasion, they do so in the belief that it will enhance their practice as an expert witness. Doubtless academic ethic and law is a rewarding subject that will enhance the candidate's clinical practice, since it improves knowledge of consent, confidentiality and tissue 'ownership', among other things. It is nevertheless important to realise that surgical expert witnesses are valued for their knowledge in surgery, a field where lawyers are very unlikely to have personal experience. Experts are not valued for their knowledge of the law outside the exceedingly narrow sphere of the provision of expert evidence. For this reason, while any surgeon is encouraged to pursue legal studies as a matter of general education, it would be a mistake to believe that a law degree will make them more attractive as an expert. On the contrary, 'legal' Latin emerging from expert reports (*res ipsa loquitur* is a favourite) is more likely to generate ironic smiles than further legal instructions. The smile is indicative of a fundamental truth, worth repeating; despite the misleading but ubiquitous badge of 'medicolegal', there is effectively no legal authority or learning vested in the concept of an expert witness. Surgeons, during their expert training will be given sufficient vocabulary and understanding of litigation procedural rules to be able to engage with lawyers, but expert witnesses are visitors to, not participants in, the law. They are simply giving their opinion, and provide information on which legal decisions are made.

7. Expert organisations

There are many expert organisations, and it is helpful early to differentiate between those whose purpose is merely to facilitate advertising your expert practice, those who act as conduits between instructing solicitors and experts with the relevant specialties, those purporting to have a regulatory function, and those who exist primarily to sell their training schemes. Many organisations provide more than one of these elements. The only invariable common ground is that they charge fees, often for entry and always on an annual basis. As far as it is possible to ascertain, few of these bodies can provide reassurance as to whether the individual expert's data is ever viewed by potential instructing solicitors, in justification of their claim of 'advertising widely'. Nevertheless, registration with any institution that can fairly claim to 'set standards' for expert witnesses is desirable. It is impossible to know to what extent instructing solicitors take note of institutional membership, but intuitively, such affiliations are likely to encourage instruction. And if the expert wishes his or her practice to flourish, some form of advertising will be necessary.



8. The sources of instruction

Most instructions to a surgical expert are derived from clinical negligence litigation. This usually results from an unexpected clinical outcome, where the patient or their family are seeking a remedy from an NHS trust. While the alleged substandard management was instituted by clinical staff, the patient will sue their employer, since any financial remedy will be paid by the NHS, a guaranteed fund.

If instructed by the claimant, the expert will be contacted by a firm of solicitors or an agency employed by the solicitors to make that approach. In these latter circumstances, the agency will expect all reports and invoicing to be routed through them. Some agencies have become bankrupt and experts have been left with unpaid invoices, so it is worth confirming that the solicitor employing the agency will be responsible for the payment in these circumstances.

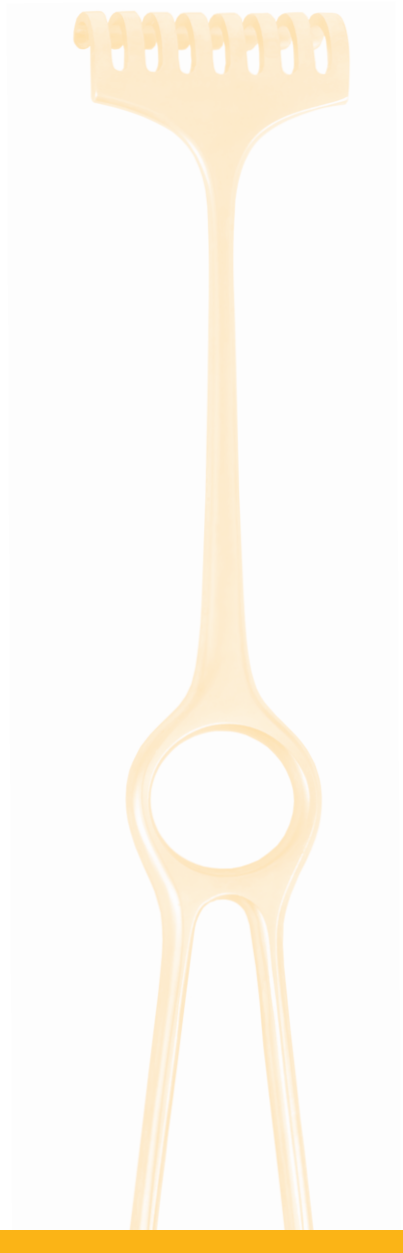
The quality of claimant instructions vary wildly; if the claim is being handled by a firm experienced in clinical negligence, that will be obvious from the outset, since the tone of the proposed claim will be measured and carefully phrased. On the other hand, there are still solicitors who are only involved very occasionally in clinical litigation; in these cases, the original approach may need to be discussed in some detail, to ensure that the solicitor is aware of the fundamental clinical principles and realities underlying the allegation being proposed.

If the expert is instructed by the NHS, the responsible arm is (currently) known as 'NHS Resolution'. It is now usual, particularly for low-value claims, to be approached by one of the ten or so NHS-designated defendant solicitors' firms. They will initially seek a 23-page 'opinion', which falls outside the Civil Procedure Rules, allowing them to take a view on likely defensibility. These short opinions are commissioned on behalf of fee-earning solicitors by clerical staff who are not lawyers. Their task is to cut and paste the letter of claim and present it to the expert, reproducing the assertions of the claimant solicitor without at the same time applying critical thinking. This may mean that the questions asked of the expert are nonsensical, so it is worth having a discussion on the phone before starting work. The so-called fixed fee for this work is £500, but the designated defence firms vary from £400 to £600, perhaps more, so again it is worth setting out your own suggestion for fees. If your opinion concludes that no substandard management occurred, the instructing solicitors will make a financial decision as to whether the case should be defended. That defence may then involve the expert being asked to prepare a full scale report, compliant with the Civil Procedure Rules. At this stage, unchained from the fixed-fee scheme, the expert's normal charging terms are applied.

Other clinical negligence litigation arises from surgical events in private practice. In these cases, the claim will be identical, but the defence instruction will come from the medical defence organisations. In some

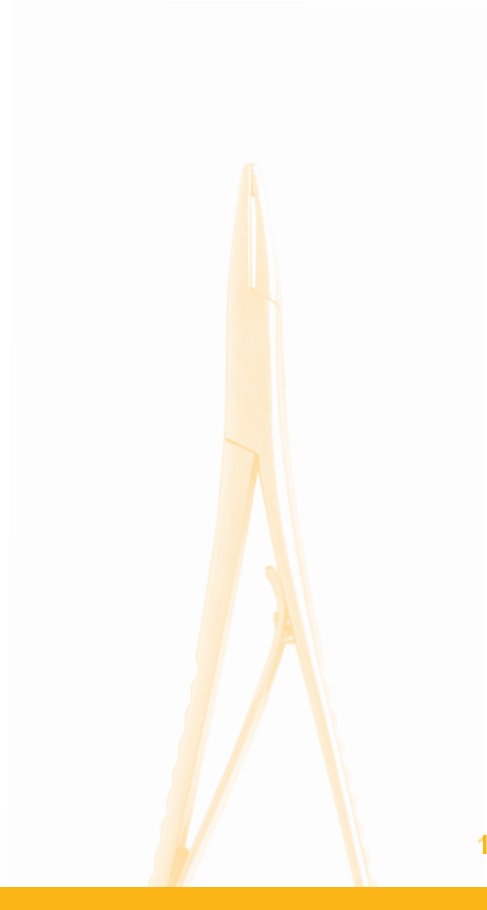
contrast to the fixed-fee scheme, these defence cases are run from the outset by experienced and insightful claims handlers, who ensure that only relevant questions arising from the original letter of claim are presented for expert review.

Less frequently, expert surgeons are instructed by the coroner, sometimes to comment on whether a death could have been avoided by different management. It would be unusual to be instructed by parties anticipating litigation prior to a coronial hearing. Finally, instructions may emerge from criminal or family cases, usually seeking an opinion on causation or timing of a victim's injuries; and from personal injury companies seeking recompense for their client's injuries that may have resulted from contravention of health and safety, workplace, or transportation rules, among others.



9. Patient charities

Some charitable organisations exist to assist patients who may have been harmed by the healthcare services, both individuals and cohorts. Part of this assistance involves identifying experts of the appropriate specialty to provide either free (pro bono) or paid advice in relation to a potential claim. These organisations maintain a register of experts and work closely with lawyers specialising in clinical negligence. This is (at least in part) an altruistic aspect of expert practice that many expert witnesses value and support. In many respects, even if a brief expert examination of the evidence reveals no substantial cause of action, the patient and their family derive consolation that they have taken reasonable steps to ensure (without having to pay disproportionate fees) that the harm incurred could not have been avoided.



10. Preliminaries, and the instruction

A claimant solicitor initially approaches an expert with only the claimant's complaint, perhaps founded on a hospital investigation relating to a clinical incident that the claimant asserts has caused them harm. Depending on the experience of this solicitor and the arrangement for funding the potential claim, several experts in the relevant field will be contacted simultaneously and asked to indicate their experience in the relevant field of surgery, their timescale for a report and an estimate of cost. It is also possible that this preliminary legal approach will suggest the possibility of deferring payment for the report until a variety of future events, such as final settlement of the claim, have occurred. Depending on the replies, the solicitor will choose the expert most likely to provide a timely report of good quality for an economical price.

The preliminaries from defendant solicitors are not very different, but in this case a request for a brief screening report for a fixed fee is more likely to advise on whether the accusation of substandard care or causative linkage is likely to be plausible. Generally, the defendant solicitor will contribute very little or no refinement to the initial letter of claim, and will leave it to the expert to make of this what they will.

Following this selection process, if you are the chosen expert, a letter of instruction will arrive, setting out the agreement between expert and solicitor relating to both the report and the specific questions of standard of care, harm and causation that must be answered; together with a reminder of the importance of compliance with the Civil Procedure Rules and data protection.

The 'instructions' refers to the letter of instruction and accompanying copies of the patients clinical notes. In addition, there may be copies of imaging, statements of fact, internal investigations, claimant statements and expert reports, among other sources.

The report written by the claimant's expert witness, if supportive, will form the basis of an initial letter of claim, which will be sent to the trust. If this does not result in immediate settlement and the claimant wishes to persevere, the defendants will reply in writing, and litigation commences.

The expert report(s) for the claimant (there may be more than one, depending on the clinical specialties involved) will then be scrutinised by counsel, usually involving a 'conference with counsel' that experts and claimant will attend. The quality of the claimant case is assessed and measured against the defendant trust's initial response. A decision will then be taken by counsel as to whether the case is worth continuing. If the claim does continue, much legal wrangling will usually result in a settlement, both sides making careful calculations as to whether continuing litigation is likely to be eventually worth the money it will cost.

If the case does continue, a meeting of opposing claimant and defence experts will be arranged, primarily to identify areas of agreement (which will no longer require legal argument), while narrowing down areas of disagreement that the opposing advocates will need to test in court. This process reduces the time a trial will take, reducing costs on both sides. It is unusual for clinical negligence cases to get to the point where a trial commences; perhaps fewer than 5% of claims started by letter.

11. What evidence is sought during litigation?

If the claimant's case is to succeed, he or she will need to prove that a tort (civil wrong) of negligence has occurred; comprising among other elements substandard care, avoidable harm and a causative connection between the two. The burden of proof is on the claimant; he or she must provide evidence to satisfy the court that the tort has been made out.

STANDARD OF CARE (LIABILITY)

At the heart of most clinical negligence cases is the notion that the patient was harmed due to care that fell below the reasonable standard that he or she was entitled to expect. It is the role of an expert in the relevant field of surgery to set that standard and to give an opinion as to whether the care fell below that level (a breach of duty). It should be noted that doctors are obliged to exercise reasonable care and skill in diagnosing, advising, and treating the patient.[2] The duty is the same irrespective of the experience of the doctor; rather, it is tailored to the doctor's specialty and the task undertaken. Equally, the standard of care is not set at the level of the most expert of practitioners; it remains based on the 'reasonable' surgeon, as judged by the standards of his or her peers (the so-called the Bolam test).[3] Accordingly, there may be one or more perfectly proper standards, reflecting the diversity of management strategies to surgical disease.[4]

A further consideration is that, since 1998,[5] judges must be satisfied that experts providing medical evidence can demonstrate that the opinion they offer is able to withstand logical analysis. In rare cases where this cannot be demonstrated, the court is entitled to reject the expert evidence. Judges have made clear that it will be very unusual for a court to dismiss expert evidence on the basis of illogicality, but *Bolitho*[3] provides a warning that no expert can assume their evidence will be accepted on face value.

Although the Bolam test still applies in most cases of negligence, when it comes to cases of negligence regarding consent to treatment, it has been replaced by a different principle introduced by the UK Supreme Court in 2015,[6] which held that there is a duty for a doctor to warn a patient of a material risk inherent in the treatment and that there was a duty for the doctor to discuss this with the patient. The test for materiality is not the 'reasonable surgeon', but rather whether a reasonable person in the position of this particular patient would think the risk significant (objective test for materiality) and whether that particular person would consider the risk significant (subjective test for materiality). A key issue is setting out reasonable alternative options for the patient.

In preparing an opinion, the expert will need to carefully consider the actions of the surgeon under scrutiny, and ask themselves not only what the reasonable surgical approaches to the patient in these circumstances would have been, but also whether the actions of the surgeon in question were consistent with these reasonable approaches. The era of the alleged substandard care is also relevant. The instructing solicitor should ensure that the expert he or she instructs was in practice as a consultant surgeon at the time of the surgical event under scrutiny, thus able to consider the events in the light of what the reasonable surgeon would have done at that time. There is statutory limitation controlling the length of time after a putative personal injury emerges beyond which a claim cannot be mounted. This limitation period is in principle three years in the case of adults,[7] although enmeshed in common law qualifications.

If a solicitor has instructed you to report on a case that occurred prior to your consultant career, discuss with them the possibility that you are not in an ideal position to comment.

An exception to the ability of a surgical expert to set standards is in the field of consent. Courts have made it very clear since 1999 that they feel entirely comfortable when deciding for themselves what disclosure the reasonable patient will require prior to choosing clinical options.[8] They need no assistance from an expert during this exercise. This is understandable; all judges are potential or future patients and they see no reason why they need an expert to guide them as to which accepted risks and complications will influence their decisions as they consider the question from the position of a 'reasonable' patient. The expert's role in identifying which risks and complications are foreseeable or reported and what benefits may accrue from the treatment, or the alternatives to the proposed procedure are open to the patient, remains.

HARM

The expert is often asked to articulate the harm that flowed from the alleged breach of duty. It is obviously important to distinguish harm that would not have occurred in the absence of the substandard care from that which was an inevitable consequence of either the illness with which the patient presented, or from the reasonable surgical management that would have been necessary to deal with this pathology.

CAUSATION

The claimant will have to prove, among other things, that the harm he or she sustained

[2] *Sidaway v Bethlem Royal Hospital Governors [1985] 1 All ER 643 @ 657*
[3] *Bolam v Friern Hospital Management Committee [1957] 1 WLR 582*
[4] *Maynard v West Midlands RHA [1984] 1 WLR 634*
[5] *Bolitho v Hackney Health Authority [1998] AC 232*
[6] *Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015] UKSC 11*
[7] Limitation Act 1980 s.11(1)
[8] *Pearce v United Bristol Healthcare NHST (1999) PIQR P 58*

was caused by the substandard care they allege. One role of the surgical expert is to identify evidence of this causative link, if that exists. A simple example would be an allegation that but for a delay in the diagnosis of acute appendicitis, the appendix would not have perforated, peritonitis would not have occurred and adhesions would not have formed. Consider the 20-year-old claimant who presented to her general practitioner (GP) with a history of 24 hours of abdominal pain, and was discharged with no follow-up. Nine days later, she presented with peritonitis due to appendiceal perforation. She hopes that she can prove on the balance of probabilities that but for the failure of her GP to make the correct diagnosis; (i) her preoperative suffering during those 10 days would have been truncated to 36 hours; and (ii) her putative risk of adhesion obstruction and infertility in the future would have been significantly lower than eventually transpired. The second question poses daunting questions of causation, when one considers the risk of adhesion formation in relation to the appendicitis itself; the treatment required to cure her; and to what extent the perforation and ensuing peritonitis will have contributed to the final risk of adhesion formation. Then, furthermore, how likely it will be that the adhesions cause a subsequent illness, and what that might be? It is possible for a breach of duty to contribute to, while not being the sole or major cause of, harm. A 'material contribution to the injury' may be sufficient to make out causation.[9]

[9] *Bonnington Castings v Warlow [1956] AC 613*

CONDITION, PROGNOSIS AND QUANTUM

If a claim is succeeding, the claimant solicitor will need to know the current extent of the injury their client sustained (condition) and to what extent this will impinge (if at all) on the patient's future health, mobility, accommodation and education. Depending upon the nature of the injury, the claimant's needs for long-term care, employability and ability to enjoy their lives in the broadest sense will need to be ascertained. This information will allow the lawyers to provide an estimate on the monetary value of the claim, 'quantum'. Those defending the claim will make lower counter proposals based on the expert evidence from their side. It is for this reason that clinical negligence cases involving severe neurological injury may be worth tens of millions of pounds, while damages for death seem derisory.

PERSONAL INJURY

Many surgeons' expert practice is founded on injury caused by non-medical accidents; whiplash injury after collision deceleration is an example. The surgical expert will be asked to give an opinion on causation, condition and prognosis. High volumes of sometimes questionable litigation has shone a light on some aspects of the personal injury claim industry, resulting in central curtailment, relieving the burden on insurers.

12. Reading and writing a report

Training organisations provide advice in abundance as to how to set out a report and how to accumulate evidence from the sources of information provided in the instructions. Most reports revolve around a chronology relevant to the incident or period of care that the claimant complains about. Drafting a chronology will be familiar to any investigator of adverse events. But, at the same time, the expert needs to be ruthless at discarding interesting material that is irrelevant to the claim. With apposite evidence laid out, an opinion as to breach of duty and causation should emerge and needs to be set out separate from the evidence. Each conclusion must be stated on the basis of the civil standard of proof: the balance of probabilities.

If you do not believe that this threshold can be reached, make that crystal clear within your opinion and reflect this precisely in your conclusions. It may still assist counsel better to understand the case if you point out the matters that do not reach this threshold, so they are not necessarily irrelevant. The civil standard of proof is all that is required or desired by lawyers. They do not wish to know whether you are certain or convinced or sure; simply whether on the balance of probability, the issue in question is made out. If you do not comply with this formula, you will be asked to redraft your report, or modify your answer in oral evidence.

It is helpful to come to a firm and settled view before writing your opinion, since consistency of opinion is vital. Repetitive or near-identical questions within the letter of instruction may tempt answers which can become inconsistent unless carefully phrased.

The independent review of gross negligence manslaughter and culpable homicide which was commissioned by the GMC in 2018, recommended that those providing expert witness reports and evidence should be required to:

- state the basis on which they are competent to provide an expert opinion on the matters contained within the report or evidence
- state where their views fit on the spectrum of possible expert opinion within their specialty
- calibrate their reports to indicate whether an individual's conduct was, in all the circumstances, within or below the standards that could reasonably have been expected, and also give their reasons for the views reached.

13. Confidentiality

The constraints of confidentiality on an expert witness are severe, since the duty to maintain the confidentiality of the patient involved is matched by an equal duty to reveal nothing about the behaviours or performance of clinicians looking after them. Beware revealing the facts of the case to your local group, since if the case is memorable and subsequent publicity links those facts with a specified hospital, your colleagues may be able to deduce the identity of the accused surgeon. This inadvertent disclosure reflects upon your integrity. It is not unheard of for experts to be sanctioned for breaches of trust, which could be seen by a court as contempt.

14. Privilege

The doctrine of 'legal privilege' exists against a background presumption that any information relevant to a legal case that a court wishes to see will be accessible to it and, if necessary, demanded by an order of the court. This means that all clinical, managerial and administrative communications of any form relating to hospital or general practice are within reach of the court.

It is self-evident that if this transparency also included the preliminary discussions between client and lawyer as to how claimant or defendant cases should be pleaded, both criminal and civil litigation would be rendered impossible. Claimants, prosecutors and defendants must be able to shield crucial information from the eyes of the court. This is necessary to allow decisions as to whether actions should be brought in the first place; as to what claims might feasibly succeed, or be defended and the likely financial and personal consequences measured and balanced before decisions are made. For example, a man charged with assault will need to consult his lawyer as to whether he is likely to be able to avoid conviction. If he was unable, for fear of the court having sight of them, to disclose facts to his lawyer that might hint at guilt, he would not be able to determine whether he should plead guilty on the hope of a reduced sentence or defend in the hope of acquittal.

It is for this reason that 'legal privilege' exists, shielding the discourse between the client and his lawyer during legal actions.

Although seemingly straightforward, the reality is different and an expert witness needs to pay careful heed to advice on privilege when dealing with the instructing solicitor. In general terms, it is better to assume that you enjoy no privilege whatsoever; assume that whatever you disclosed orally or in writing (printed or email or personal notes) in the course of a case could be seen by the court if it so wished.

15. Retired surgeons

Expert work is a tempting prospect as one contemplates retiring from surgery, and many surgeons take this step. By the time of retirement, many surgeons are replete with knowledge and experience, and some will have the forensic skills to deploy these assets effectively. What can be lost on retirement is the continuous exposure to the 'normal range' of management for any particular condition and, on occasion, claims have failed when an expert's lack of appreciation of the breadth of reasonable practice is exposed during cross-examination. In these circumstances, a beleaguered expert is made to look isolated, out of touch with everyday practice. This danger can be reduced by attending professional meetings, but the daily chatter in handover or the other myriad regular meetings within a surgical unit is surprisingly hard to properly reproduce in retirement. Another inherent weakness of the retired surgeon acting as an expert is exposed by an unfavourable comparison made in court with his or her surgical opponent; the fact that the expert on the 'other side' was in theatre last week, performing the relevant operation…while you explain to the judge that you have not seen the inside of a chest for five years can be demoralising, and may subtly disadvantage your position.

Although there is no legal requirement for surgeons to hold a licence to provide expert advice, it may be part of a contractual requirement and even if there is no contractual requirement, insurers, organisations and patients may still want doctors to have a licence to show that they are up to date. The College recommends that surgeons should not provide medicolegal services after three years from retirement.

16. Setting fees

Some instructions are agreed on the basis that the expert will adhere to the rate of pay prescribed by the Legal Aid Agency, which is set at a modest hourly level. Equally the fixed-fee scheme prescribes a notional £500 limit (although see the section on Sources of Instruction, pages 12–13). But outside this stricture, the expert will set an hourly rate that he or she regards as a realistic reflection of how much their time is worth to them… and then sit back to see whether the solicitor agrees that their opinion is worth the quoted figure. Bear in mind that it is almost certain that the solicitor will have sent out three or four identical approaches to rival experts, of whom you are only one. Your competitors may have provided lower estimates, so excessively high estimates are unlikely to secure work. There is no opportunity to modify and lower your first bid.

Hourly rates range from £150 to £500 and folklore hints that some surgeons value their time even more than this. The law of supply and demand is intriguing. Plainly, if you set your hourly rate too high, you will get no work. On the other hand, you may find there is rather too much work coming in when you charge, say, £250, and raise the stakes to £350. Your express intent has been to reduce the number of cases while maintaining the income, but it transpires that the solicitors take your more expensive terms as a proxy mark of your 'success rate' and clamour for your services. This 'gaming' has such uncertain outcomes that it is probably simplest to decide how much your time is worth to you and stick to it.

Solicitors will usually ask you to quote not only for the rate of pay for report writing, but also the projected number of hours this will involve. It is prudent to ask how many pages the notes run to and, by this or another method, formulate a system of estimation. Quote separately for expert meetings, days in court, travel time, and late cancellation fees.

If, once the projected fee is agreed the volume of notes cannot be dealt with under the original estimate, do not start work until the revised estimate has been agreed by the solicitor.

17. Indemnity

Ironically, those who bear witness are at risk of litigation in relation to this role, so indemnity is essential. Some expert organisations, such as the Academy of Experts, provide indemnity in conjunction with membership. Alternatively, the medical defence organisations underwrite expert witnesses. It is important to ensure that the cover of your medical defence organisation includes your expert witness work. This often requires a supplement to standard cover arrangements. If you are carrying out this work abroad, you should also ensure that your cover includes work outside the UK.

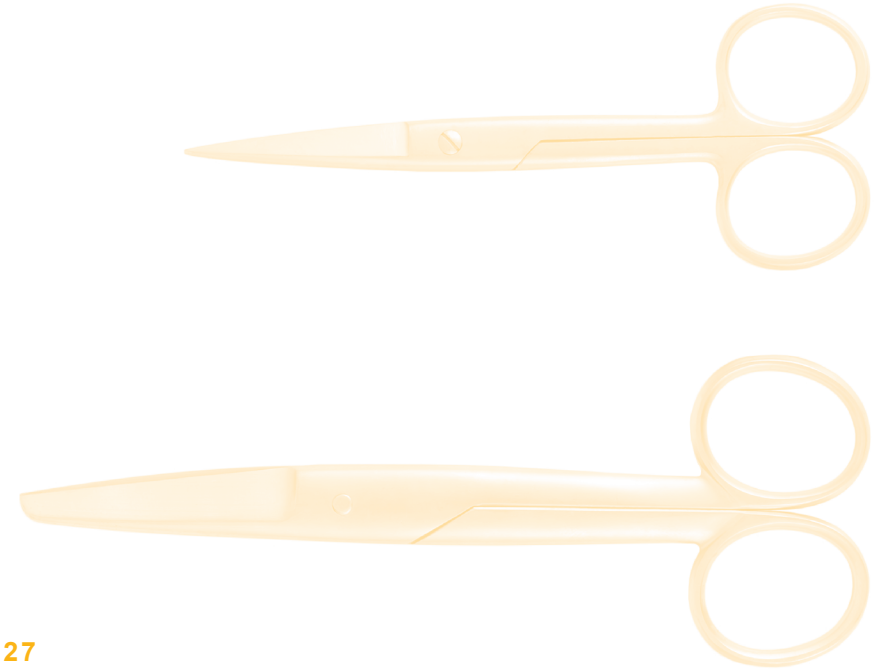
18. Conduct

Surgeons acting as expert witnesses should not resort to personal or unprofessional attacks on the behaviour of doctors involved in the cases that they are advising upon. Although this may seem elementary, self-evident, it is not unusual to read a report or hear live evidence in which a surgeon in the role of an expert refers to a defendant's clinical actions or decisions as 'something no first year medical student would do'. All that is required is to note that, on the balance of probabilities, no reasonable surgeon in the defendant doctor's circumstances would have provided such care. The sweeping unkindly rhetoric hints at pomposity. It will attract the unwelcome, possibly lacerating, attention of the opposing counsel, and is simply ill mannered. Poor conduct will not make further instructions more likely. It is worth remembering that every surgeon makes mistakes that cause harm.

19. Terms and conditions and tax

Expert work represents a business venture, notably marked by terms and conditions. In summary, this document sets out what you expect of the instructing solicitor and what, in turn, they can expect of you. Increasingly, solicitors' own terms and conditions point out that where yours conflict with theirs, experts are overridden. Quite where this leaves the expert is beyond this guidance, but clear messages can be deduced. First, it is prudent to have terms and conditions for a variety of reasons, not least to give your expert business some form of structure and status. Specimen terms and conditions are available from the various training organisations; it makes little sense to build these from scratch while the specimen may be easily modified to conform to your needs.

Second, if you are going to dedicate substantial time and treasure to this enterprise, seek legal and accountancy advice and recognise that you will need to retain some form of advice while the business endures. Third, tax is inevitable and it pays to calculate your hourly rate on the basis of what you will then lose to the Inland Revenue. Early guidance from accountants will assist in identifying what aspects of business set up and maintenance may be set off against tax. In some cases, experts set up limited companies, again beyond the purlieu of this document.



20. Common errors

As in all surgical practice, it is simple to make errors in expert work. The most common mistake is internal inconsistency. Beware setting out subtly different statements in the opinion and conclusion sections of your report.

It is surprisingly simple when answering separate but similar questions to contradict oneself. Lawyers often ask experts the same question from different perspectives as an internal test of consistency, anticipating unfriendly opposing counsel. However, the law reports are replete with instances of experts who need no assistance in making mistakes. It is easy to provide oral evidence conflicting with one's original report. Opposing counsel uses this anomaly to cast doubt on the experts' certainty that they know what they are talking about, seeking to discredit his evidence. As in surgical life, experts are sometimes ill prepared in court, having not refreshed their memory of what they originally wrote. On occasion, it becomes clear for the first time in the witness box that the expert has not read the clinical notes or has misunderstood the anatomy or surgical findings in an operation crucial to the claim.

Another common error, too late to mitigate in the witness box, is to take on a case which falls outside your experience or expertise. This puts the expert in an impossible position and will (perhaps irreparably) damage the interests of the instructing party.

Worse, the expert who demonstrates a dogged determination that their view of reasonable practice is the only acceptable view; failing to heed hints from any quarter that the opposing expert may be making fair-minded points. In many respects, this doggedness reflects a lack of insight that is more generally feared by all surgeons, since it robs us of intellectual flexibility and makes us less able to adapt to rapidly changing situations. In the witness box, lack of insight rarely survives a confrontation with the opposing counsel or the scrutiny of a high court judge. The problem is that changing your mind midway through a case is very likely to dismay those who instruct you, unless new information emerges that gives you an excuse to do so. Even so, an honest and explicable change of heart is probably less dangerous than a dogged lack of insight.

In the criminal and coronial courts the expert has authority to comment on the standard of care; either it was reasonable or it was not. But do not be tempted to propose any adjectives further to define the gravity (as you see it) of substandard care, such as 'truly exceptionally bad'. To do so exceeds the competence of the expert witness and risks usurping the role of the judge in finding facts. Further usurpation may be committed if experts use the word 'negligence'. To a lawyer, the word describes a civil wrong, established only after all the elements of this tort (duty, breach, harm, causation) are made out. For experts to pronounce 'negligence' is presumptuous, unhelpful, beyond their remit.

A more general error is to argue with counsel (in particular the advocate for your own side). Barristers live to argue and, unlike surgeons, almost never take adversarial contests personally. In the unlikely event of laying a glove on counsel, they will still have the final say. Because long after you have left the court, a few days later, 'closing speeches' will give barristers from each side a chance to say what they thought of the experts, and it will be based upon those submissions that the final judgement will be written. If a point of law emerges, the judgement will appear in the law reports and the judge will set out for public consumption whether one or other expert was preferred and why. That is why it is never worth arguing with counsel.

Finally, the surgical expert should avoid being drawn to practices resembling 'expert shopping', whereby the police or the CPS might seek a surgical opinion but then reject it when it is not in agreement with the views they have formed on the case and go on to request further opinions until they get one that is favourable. For all these reasons and more, experts require training in report writing and how to handle oral evidence.

21. The benefits of an expert career

The main benefit of an expert career is that it is fascinating. All surgeons encounter unexpected or unwished for outcomes, and we all make mistakes. Expert practice allows insight into how some of these events transpire and act as a solemn reminder to all experts that surgery and tragedy go hand in hand. By experiencing these misadventures by proxy, the expert can then relate, albeit in unrecognisable terms, the core safety point to their own department, in the hope that lessons learnt elsewhere can improve local practice.

The experience gained in producing evidence prepares an expert for many forensic positions, within or without hospital trusts and potentially in legal firms. The newly established medical examiner service will doubtless require the forensic skills to determine clinical shortcomings resulting in deaths, and both commissioning groups and the Care Quality Commission (or its future incarnations) will value these skills. It will also provide ample material for research, providing the data can be anonymised.

Many expert witnesses diversify into mediation; this form of alternative dispute resolution can become a career in itself, rather well suited to surgeons contemplating a change of career in their seventh decade.

Appendix 1: Common law on standards of care

Webster v Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62

This case concerned the events leading up to Sebastian Webster's birth on 7 January 2003 at the Queen's Hospital, Burton. During the course of his birth Sebastian sustained a hypoxic ischaemic brain injury as a result of a short period of umbilical cord compression. He was left with cerebral palsy, involving profound physical and cognitive impairments. The claim was brought by Sebastian's mother, Ms Butler, on his behalf.

At first instance, and applying the well-known Bolam test for breach of duty, the high court judge found that there was a reasonable and responsible body of obstetric opinion who would have acted in the same way as the consultant would have done (ie they would also not have altered their management plan). The case was therefore dismissed on this basis.

On appeal by Ms Butler, the court of appeal reaffirmed the 2015 decision of the Supreme Court in the case of *Montgomery v Lanarkshire Health Board* [2015] AC 1430 that the Bolam test no longer applies to issues of consent in clinical negligence claims, and applied it retrospectively (see summary of the *Montgomery v Lanarkshire Health Board* case in the next column).

Jones v Royal Devon and Exeter NHS Foundation Trust [2015] EWHC 2154

This was a successful claim based on lack of consent, in which a patient was told, only on the day of the operation, that her spinal decompression surgery was not to be performed by the expected clinician. Following the operation, the patient was left with serious and permanent spinal injuries. The patient claimed that the operation had been performed negligently and that the replacement, more junior, surgeon ought to have been (more closely) supervised. The court dismissed this claim but found that there had been a breach of the trust's duty to provide sufficient information regarding the operating surgeon to ensure that full and informed consent had been given.

The case reaffirmed the principles in *Chester v Afshar* [2004] (see summary of case on page 32) which establish the ongoing duty to provide sufficient information so that the patient can 'make an informed choice as to whether, and if so when, and by whom to be operated on'.

Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015] UKSC 11 on appeal from [2013] CSIH 3 Since Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] A.C 871

The case of Montgomery clarifies the correct test to material risk in the consent process and repositions the focus of legal requirements regarding what information should be provided to patients prior to their making of a decision regarding healthcare.

The case was brought as the claimant, Mrs Montgomery, a type 1 diabetic, was not told of her increased risk of shoulder dystocia during vaginal delivery because, in the doctor's opinion, the possibility of it causing a serious problem for the baby was very small and advising of the risk would lead to most women electing for a caesarean section. During delivery the umbilical cord was occluded, depriving the baby of oxygen and resulting in a subsequent diagnosis of dyskinetic cerebral palsy. The claimant argued that had she been told of the risk of shoulder dystocia she would have elected for a caesarean section.

The Supreme Court held that there was a duty for a doctor to warn a patient of a material risk inherent in the treatment and that there was a duty for the doctor to discuss this with the patient. The test for materiality was whether a reasonable person in the position of this particular patient would think the risk significant. In the claimant's case it was found that the risk of shoulder dystocia was substantial and should have been disclosed, as had the risk been discussed the claimant would have elected to have a caesarean.

Mr Leslie Burke v GMC [2005] EWCA Civ 1003 – requests for treatment

For the purposes of this guidance, the key point of this case is that doctors are under no legal or ethical obligation to agree to a patient's request for treatment if they consider the treatment is not in the patient's best interests.

Chester v Afshar [2004] UKHL 41 – the duty to warn patients about risk

Ms Carole Chester was left partially paralysed after surgery for lumbar disc protrusion. The court held that Mr Afshar had failed to warn Ms Chester that this was a foreseeable (1–2%) but unavoidable risk of the surgery. The House of Lords concluded that, although the failure to warn was not a direct cause of injury, it did result in negligence.

Patients should be told of any possible significant adverse outcomes of a proposed treatment.

In this case, a small but well-established risk of a serious adverse outcome was considered by the House of Lords to be 'significant'.

Re B (Adult, refusal of medical treatment) [2002] 2 All ER 449 – right of a patient who has capacity to refuse life-prolonging treatment

B was a 43-year-old woman who had become tetraplegic and who no longer wished to be kept alive by means of artificial ventilation. She asked for ventilation to be withdrawn but the doctors caring for her were unwilling to agree to this. B, whose mental capacity was unimpaired by her illness, sought and obtained a declaration from the court that the hospital was acting unlawfully.

This case asserts the principle that a competent patient has the right to refuse treatment and their refusal must be respected, even if it will result in their death.

Bolitho v Hackney Health Authority [1998] AC 232

Patrick Bolitho, a two-year-old child, was admitted to hospital suffering from breathing difficulties and was placed under the care of a senior registrar. Following two respiratory episodes, the senior registrar was notified but never received the notification due to a low battery on her pager. The child died. The child's mother brought an action claiming that the doctor should have attended and intubated the child, which would have saved his life. The doctor gave evidence that, had she attended, she would not have intubated. Another doctor gave evidence that they would not have intubated. The trial judge applied the Bolam test and held that there was no breach of duty.

The claimant appealed to the House of Lords, but the original judgement was held. However, the appellant court held that 'a defendant cannot escape liability by saying that the damage would have occurred in any event because he would have committed some other breach of duty thereafter'. So there was a need to decide whether the hypothetical decision not to intubate Patrick would have been a breach of duty. The Bolam test says that an action cannot be a breach of duty if it conforms with a reasonable body of professional opinion. The professional opinion relied upon cannot be unreasonable or illogical. If the opinion were illogical, then the action would still be a breach of duty. Only in 'a rare case' would the courts find that the body of opinion is unreasonable. Therefore, in applying the Bolam test where evidence is given that other practitioners would have adopted the method employed by the defendant, it must be demonstrated that the method was based on logic and was defensible.

The House of Lords' decision in *Bolitho* seems to be a departure from the old Bolam test established by the Queen's Bench Division in a 1957 case *Bolam v Friern Hospital Management Committee*. According to that test, a doctor would not have acted negligently if his actions conformed to a practice supported by a body of professional opinion. However, the court in *Bolitho* did not specify in what circumstances it would be prepared to hold that the doctor has breached his duty of care by following a practice supported by a body of professional opinion, other than stating that such a case will be 'rare'.

Re MB (Adult, medical treatment) [1997] 38 BMLR 175 CA – capacity to refuse treatment

MB needed a caesarean section, but panicked and withdrew consent at the last moment because of her needle phobia. The hospital obtained a judicial declaration that it would be lawful to carry out the procedure, which was a decision that MB appealed. However, she subsequently agreed to induction of anaesthesia and her baby was born by caesarean section.

The court of appeal upheld the judge's view that MB had not, at the time, been competent to refuse treatment, taking the view that her fear and panic had impaired her capacity to take in the information she was given about her condition and the proposed treatment. In assessing the case, the judges reaffirmed the test of capacity set out in the *Re C* judgement.

An individual's capacity to make particular decisions may fluctuate or be temporarily affected by factors such as pain, fear, confusion or the effects of medication; therefore, assessment of capacity must be time and decision specific.

Re C (Adult, refusal of treatment) [1994] 1 All ER 819 – refusal of treatment by a competent adult

This case asserts the principle that mental illness does not automatically call a patient's capacity into question.

C had paranoid schizophrenia and was detained in Broadmoor secure hospital. He developed gangrene in his leg but refused to agree to an amputation, which doctors considered was necessary to save his life. The court upheld C's decision.

The fact that a person has a mental illness does not automatically mean he or she lacks the capacity to make a decision about medical treatment for a physical condition. Patients who have capacity (that is, who can understand, believe, retain and weigh the necessary information) can make their own decisions to refuse treatment, even if those decisions appear irrational to the doctor or may place the patient's health or their life at risk.

Rogers v Whitaker (1992) 175 CLR 479 HC (Aus)

This was an Australian ophthalmology case in which the patient developed sympathetic ophthalmitis (after the other eye was removed). The risk was estimated at one in 14,000. The patient was not informed. The court held that 'a risk is material if: a reasonable person… if warned of the risk would be likely to attach significance to it'.

Re T (Adult) [1992] 4 All ER 649 – the effect of coercion/pressure on patient consent

A 20-year-old pregnant woman was injured and developed complications that required blood transfusions. She did not indicate on admission that she was opposed to receiving transfusions but after spending some time with her mother, who was a practising Jehovah's Witness, she decided to refuse the treatment.

The court of appeal considered that she had been pressurised by her mother and that her ability to decide about the transfusions was further impaired by her treatment. The court allowed the blood transfusions to proceed.

This case asserts the principle that a patient's consent to a particular treatment may not be valid if it is given under pressure or duress exerted by another person.

Gillick v West Norfolk and Wisbech AHA [1986] AC 112 – children and young people's competence to consent to treatment

Mrs Gillick challenged the lawfulness of Department of Health guidance that doctors could provide contraceptive advice and treatment to girls under the age of 16 years of age without parental consent or knowledge in some circumstances. The House of Lords held that a doctor could give contraceptive advice and treatment to a young person under the age of 16 if:

- she had sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
- she could not be persuaded to tell her parents or to allow her doctor to tell them
- she was very likely to begin or continue having sexual intercourse with or without contraceptive treatment
- her physical or mental health were likely to suffer unless she received the advice or treatment
- the advice or treatment was in the young person's best interests.

This case was specifically about contraceptive advice and treatment, but the subsequent case of *Axon, R (on the application of) v Secretary of State for Health [2006] EWHC 37 (Admin)* makes clear that the principles apply to decisions about treatment and care for sexually transmitted infections and termination of pregnancy, too. As a result of this decision, a young person under 16 with capacity to make any relevant decision is often referred to as being 'Gillick competent'.

Sidaway v Bethlem Royal Hospital Governors [1985] 1 All ER 643 @ 657

This case concerns the duty of a surgeon to inform a patient of the risks before undergoing an operation. The claimant, Ms Sidaway, suffered from pain in her neck, right shoulder and arms. Her neurosurgeon took her consent for cervical cord decompression but did not include in his explanation the fact that, in less than 1% of the cases, the said decompression caused paraplegia. She developed paraplegia after the spinal operation.

The claimant alleged negligence in the failure by her neurosurgeon to disclose or explain to her the risks inherent in the operation which he had advised. The court rejected her claim for damages and she appealed to the Appellate Committee of the House of Lords.

The appellate court rejected Ms Sidaway's claim for damages. It held that consent did not require an elaborate explanation of remote side effects. Lord Diplock stated:

We are concerned here with volunteering unsought information about risks of the proposed treatment failing to achieve the result sought or making the patient's physical or mental condition worse rather than better. The only effect that mention of risks can have on the patient's mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo. To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgement as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The Bolam test should be applied, and a doctor's duty of care, whether he be general practitioner or consulting surgeon or physician is owed to that patient and none other, idiosyncrasies and all.

Maynard v West Midlands RHA [1984] 1 WLR 634

In this case, the patient in this case presented with symptoms of tuberculosis but both the consultant physician and the consultant surgeon took the view that Hodgkin's disease, carcinoma and sarcoidosis were also possibilities, the first of which, if present, would have required remedial steps to be taken in its early stages. Instead of waiting for the results of the sputum tests, the consultants carried out a mediastinoscopy to get a biopsy. The inherent risk of damage was to the left laryngeal recurrent nerve, even if the operation was properly done. In the event, only tuberculosis was confirmed. The risk materialised and the patient suffered a paralysis of the left vocal cord.

The court rejected Mr Maynard's claim for damages, as the decision of the physician and the surgeon to proceed was deemed by expert peers to be reasonable in all the circumstances.

The appellate court upheld the original decision. It held that it is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.

The test of professional negligence is the standard of the ordinary skilled man exercising and professing to have that special skill. Lord Scarman said:

A doctor who professes to exercise a special skill must exercise the ordinary skill of his specialty. Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgement. A court may prefer one body of opinion to another: but that is no basis for conclusion of negligence.

As to evidence of what constitutes evidence of professional standards:

A judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished, is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose

opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate specialty, if he be a specialist) is necessary.

A case that is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances.

St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S [1998] 3 All ER 673 – the right of a competent pregnant woman to refuse treatment even if that refusal may result in harm to her or her unborn child

S was diagnosed with pre-eclampsia requiring admission to hospital and induction of labour, but refused treatment. Although competent, S was detained for assessment under the Mental Health Act. A judge made a declaration overriding the need for her consent to treatment, and her baby was delivered by caesarean section.

The court of appeal held that S's right to autonomy had been violated, her detention had been unlawful and that the judicial authority for the caesarean had been based on false and incomplete information. A competent pregnant woman can refuse treatment even if that refusal may result in harm to her or her unborn child. Patients cannot lawfully be detained and treated for a physical condition without their will, under the terms of the Mental Health Act (Application of the Mental Health Act 1983).

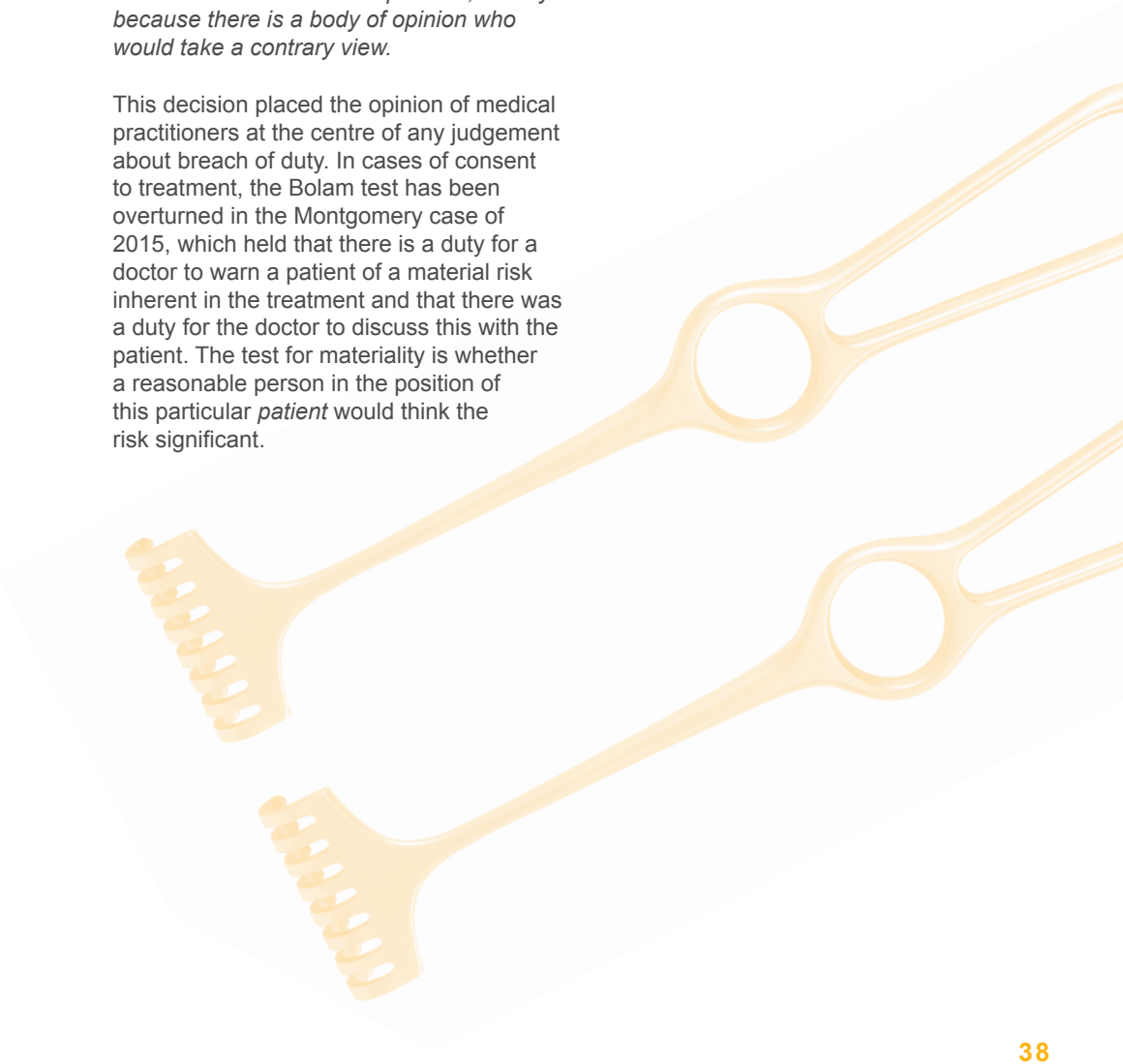
Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

The claimant was undergoing electroconvulsive therapy as treatment for his mental illness. The doctor did not give any relaxant drugs and the claimant suffered a serious fracture. There was divided opinion professionals as to whether relaxant drugs should be given. If they are given there is a very small risk of death, but if they are not given there is a small risk of fractures. The claimant argued that the doctor was in breach of duty by not using the relaxant drug.

The court held that the doctor was not in breach of duty. The House of Lords upheld the original court's ruling and formulated the Bolam test:

A medical professional is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.

This decision placed the opinion of medical practitioners at the centre of any judgement about breach of duty. In cases of consent to treatment, the Bolam test has been overturned in the Montgomery case of 2015, which held that there is a duty for a doctor to warn a patient of a material risk inherent in the treatment and that there was a duty for the doctor to discuss this with the patient. The test for materiality is whether a reasonable person in the position of this particular *patient* would think the risk significant.



Appendix 2: Further resources

GUIDANCE

Royal College of Surgeons of England. *Good Surgical Practice: A Guide to Good Practice.* London: RCS; 2014.

General Medical Council. *Acting as a Witness in Legal Proceedings.* London: GMC; 2013.

British Medical Association. *Working as an expert witness*. www.bma.org.uk/advice/career/progress-your-career/being-an-expert-witness/working-as-an-expert-witness (cited October 2019).

British Medical Association Expert witness guidance. *J Patient Saf Risk Man* 2007; **13**: 143–146.

General Medical Council. *Independent Review of Gross Negligence Manslaughter and Culpable Homicide*, 2018, chaired by Mr Leslie Hamilton, former RCS Council member and former consultant cardiac surgeon. www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/supporting-a-profession-under-pressure/independent-review-of-medical-manslaughter-and-culpable-homicide (cited October 2019).

LEGISLATION

England and Wales

Civil Evidence Act 1995: www.legislation.gov.uk/ukpga/1995/38/contents.

Civil Procedure Rules, Part 35 Experts and Assessors: www.justice.gov.uk/courts/procedure-rules/civil/rules/part35.

Criminal Justice Act 2003: www.legislation.gov.uk/ukpga/2003/44/contents.

Criminal Procedure Rules, Part 19 Expert Evidence: www.justice.gov.uk/courts/procedure-rules/criminal/docs/2015/crim-proc-rules-2015-part-19.pdf.

Scotland

The Criminal Procedure Rules and Court Rules: www.scotcourts.gov.uk/rules-and-practice/rules-of-court/criminal-procedure-rules.

Northern Ireland

Criminal Justice (Evidence) (Northern Ireland) Order 2004: www.legislation.gov.uk/nisi/2004/1501/contents.

USEFUL INFORMATION

Academy of Experts: www.academyofexperts.org.

AvMA Action against Medical Accidents: www.avma.org.uk/resources-for-professionals/lawyers-resources/information-for-medical-experts.

Bond Solon. Expert Witness Courses: www.bondsolon.com/expert-witness/courses.