M. A. Foy
FRCS, Consultant Orthopaedic and Spinal Surgeon
foyfrcs5@gmail.com

Some final musings

Over the last five years, as chairman of the medico-legal committee (MLC) at the British Orthopaedic Association (BOA), my role has also involved some commissioning and editing of articles on medico-legal matters for both the *Journal of Trauma and Orthopaedics* (JTO) and *Bone & Joint 360*. As I have been relatively poor at organizing contributors to the two journals (but thanks, of course, to those who have obliged), I have shared my thoughts on a number of medico-legal issues with the readers. I hope that I haven't bored you too much. Professor David Warwick has now taken over as chair of the MLC and will be responsible for organizing/editing the respective journal medico-legal sections. I wish him well and hope that he may ask me to contribute occasionally!

I thought that it might be worth reflecting on 29 years in medico-legal (and clinical) practice while trying to identify some issues that either remain or have become problematic during that period. There is no doubt that we are much more likely to be sued now than was the case when I became a consultant in 1989. The National Health Service Litigation Authority (NHSLA) reported 1179 new claims in 1988/89 compared with 10 686 reported in 2017/18 by the renamed NHSR (National Health Service Resolution). I stumbled into medical negligence reporting almost by accident 16/17 years ago and have given opinions on between 400 and 500 potential claims in that period, initially predominantly for the claimant, but more recently for the defendant too. My impression is that the opinion I have given in these claims is that there was no merit in over 90% of them. Of the remainder, I believe there was an equal mix of those indefensible – "why did they do that?" – balanced against, "there but for the grace of God go I." I plan to analyze the nature and outcome of all of these claims and present a more detailed breakdown in the next few months.

In the last five to ten years, I have also been struck by the lack of interest shown by senior trainees and new consultants in starting up a medico-legal practice. In 1989, it was almost *de rigueur* that a new consultant orthopaedic surgeon nailed up his/her plate and commenced private and medico-legal practice when appointed. I can only recall being asked for advice on setting up a medico-legal practice by one senior trainee/newly appointed consultant in the last ten years. I know, from talking to solicitors, that there is a dearth of good-quality experts doing this work at the present time. What is the reason for this? Agencies? MedCo? A number of medico-legal reporting agencies have come along and some have gone bust, owing experts considerable amounts of money. Payment for reports is often poor and often delayed for a considerable period of time, which makes this an unattractive proposition to new consultants. Remuneration through the government's MedCo portal for low-value claims is poor, particularly for indirect medical experts (IME) instructed through agencies where a significant percentage of the first report fee of £180 may be taken by the agency. It is certainly more difficult to break into the medico-legal reporting market now than it was in the 20th century, but litigation for both personal injury and clinical negligence is not going to go away and therefore new consultants need to be encouraged to venture into the field. They may need to be mentored initially.

There is the vexed and controversial issue, at the other end of the career spectrum, of how long a consultant retains credibility as an expert once retired from clinical practice. There is no easy answer to this. There is a need for the courts and the profession to avoid losing the extensive experience offered by senior consultants in this type of work while ensuring that those who do continue to provide expert opinions remain abreast of current developments in their areas of expertise. It has always seemed to me simplest if experts who retire from clinical practice continue with annual appraisal on the basis of their continuing medico-legal practice (feedback from solicitors, insurers, defence unions, etc.; reflections on issues arising from reports/opinions). They can then be revalidated and remain on the medical register with a licence to practice. In these circumstances, they should be relatively immune from criticism by the courts or legal profession on the basis of their currency. If a connection can be maintained with their NHS hospital by way of an honorary contract, appraisal can continue through the NHS. If not, then all the private hospital groups have an appraisal mechanism that can be tapped into if the consultant has practising rights there. Failing that, the Independent Doctors Federation (IDF) offers an appraisal service.

At the recent BOA Congress in Birmingham, I attended the session on 'Medico-Legal Aspects of Trauma'. The central message that came across from this session, and the one that is reflected in my own medico-legal and clinical practice, was the importance of communication. Many of the problems that give rise to complaints and claims arise from poor communication. There are so many examples of this that it is difficult to know where to start. Consent is a massive issue and has been covered in numerous articles since the Montgomery ruling in 2015. With this in mind, it should and must be obvious to surgeons in 2018 that it is vitally important to inform any patient who is going to undergo an elective operation of the natural

history of the underlying condition, other options available, and the material risks and benefits of any operation that is recommended. If this is not clearly documented and recorded, then this is quickly seized upon by patients/claimants and their lawyers if there is a problem or complication postoperatively. Despite this, post-2015 clinical notes still contain comments such as, "usual risks explained", which doesn't cut much ice with the solicitors and courts when the case is being analyzed after a complication occurs that, had the claimant known about it, would have led to them not consenting to the operation.

There are communication issues between doctors. It is surprising the number of times that negligence claims arise because of this problem. In days gone by, there used to be a structure called the clinical firm comprising consultant, registrar, and senior house officer with a predictable chain of command and accountability. With the shift system that has come in following the European Work Time Directive, I have seen a number of claims arising from poor handovers, with patients being forgotten for periods of time. There are also communication issues that arise if matters are not proceeding well postoperatively and clinicians inadvertently or carelessly sow seeds of doubt in patients' minds with comments about the nature or quality of fixation or implant positioning on x-rays. We all know that fixation or implant positioning may be less than perfect or suboptimal without being substandard. However, ill-judged comments often set the patient on the road to a solicitor's door on a quest for compensation that is doomed to failure from the outset. It behoves us to choose our words carefully when seeing patients who have problems in the postoperative period, particularly if we are providing a second (or third) opinion. It is worrying that this should still have to be highlighted in the 21st century, but poor communication is still at the heart of so many complaints and clinical negligence cases.

Another area that continues to surprise and concern me in 2018 is the variable quality of expert witnesses themselves in both personal injury and clinical negligence cases. Many are excellent and give clear, well-reasoned arguments for their position after carefully examining the evidence. Although our opinions may differ, it a pleasure to discuss the cases with them in preparing joint statements. Others seem to churn out the same reports with the same causation argument irrespective of the background and nature of the claim. One assumes that they will be found out ultimately by the courts, as in the Harris v Johnston case in 2016, where the judge made the comment about one expert in her summary that his "intransigent mindset coloured his evidence throughout, and it did so in a way that was not very helpful to the court".

In clinical negligence cases there are still many experts who fall into the traps of:

1) Stepping outside their own area of expertise.
2) Setting the bar at a 'gold medal' standard of care rather than the Bolam 'reasonable and competent' standard.
3) Using hindsight bias. The psychologists define it as a tendency of someone to overestimate their ability to have predicted an outcome that could not reasonably/possibly have been predicted. The key to avoiding this, I believe, is to try to put oneself into the position of the person who was making the judgement at the time to see what the reasonable and responsible options were.

I have no doubt that, if the quality of expert evidence were better regulated and policed, many of my estimated 90% of clinical negligence cases that have no merit would never get off the ground, and those cases with a genuine claim could be resolved and settled in a more timely and cost-effective manner. Who should regulate and police the quality of expert witnesses? Is it an issue for the legal profession, the General Medical Council (GMC), the BOA (and other specialist organizations), or a separate dedicated organization that should be set up to monitor the process?

This brings me on to my final concern, the cost of it all to the country. The NHSR report published on 31 March 2018 describes a government provision of £77 billion (yes, billion) for current and future negligence claims against the NHS. It is a sobering read. The problem has been compounded by the recent change in the discount rate from 2.5% to -0.75%. The amount set aside for settling clinical negligence claims is third behind pensions and nuclear decommissioning in the government's league table of future expenditure. It is way ahead of the highest predicted cost of Brexit! Surely in the age of audit, appraisal, revalidation, World Health Organization checks, multidisciplinary teams, and 'Getting It Right First Time', this cannot be right – can it?

REFERENCES

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