Providing Expert Reports: Knowing the Limits of your Competence

Michael A Foy

A recent brief article in the BMJ provides food for thought for Orthopaedic surgeons who carry out expert witness work (Dyer, 2014)[1]. It concerns the case of a Consultant Psychiatrist who was felt, by the Medical Practitioners Tribunal, to have acted beyond his competence in preparing an expert report on a paramedics' fitness to work.

Briefly, the Psychiatrist in question was instructed by solicitors in October 2011 to provide a report for the Health Professions Council on the fitness of a person to work as a paramedic. The paramedic had a personality disorder and PTSD. The doctor worked as a psychiatrist in a prison and specialised in learning disability. His standing as an expert was challenged by the expert for the paramedic. It transpired that the only time he had worked in the field of general adult psychiatry was as an SHO. The tribunal concluded that he did not have sufficient experience to act as an expert in this case and had misled those instructing him. It was agreed that he was more than competent in his day to day practice at the prison. However, the Medical Practitioners Tribunal suspended his licence to practice for three months. They concluded that his behaviour amounted to,"misconduct which required a message to be sent to you and to the public that undertaking the duties of an expert witness is not a matter to be taken lightly".

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A number of references were made to the GMC guidelines on the duties of an expert witness (2013)[2] and in particular paragraph 12 "You must only give expert testimony and opinions that are within your professional competence or about which you have relevant knowledge. If a particular question or issue falls outside your area of expertise you should either refuse to answer or answer to the best of your ability but make it clear that you consider the matter to be outside your competence".

I recently attended Court in a "whiplash" claim where there were significant ongoing neck/shoulder girdle symptoms and more general pain issues. I was acting as an expert witness for the defence and there was a Pain expert on each side. The "Orthopaedic/Spinal" expert for the claimant was a Spinal Injuries Consultant. It became clear during the trial that the Spinal Injuries Consultant didn't have a great deal of day to day experience of managing patients with neck and shoulder girdle problems and was not a sensible choice of expert to act for the claimant. The Judge dismissed his evidence. As far as I am aware the matter was not taken any further. However it appears to me with the precedent set by the case discussed above it is only a matter of time before experts from other specialist areas find themselves before the Medical Practitioners Tribunal if they stray outside their areas of expertise.

The message to take from these cases is that it behoves all of us to ensure that we really are experts in the area that we are providing opinions on. If seriously challenged in Court it may not be sufficient to put forward an argument that we treated patients with back pain, shoulder problems, foot/ankle problems or whatever as an SHO but have not been actively involved in their management for a number of years.

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References:

1. Dyer C (2014) Tribunal suspends doctor for acting as expert witness beyond his competence BMJ ; 348 : g4126

2. *www.gmc-uk.org/static/documents/content/Acting_as_an_expert_witness.pdf*

Indemnity for treating NHS patients in the independent sector

Dan Howcroft

In years gone by, before Foundation trusts ISTC's and "Any Qualified Provider", the opportunity to undertake NHS waiting list initiative work was seen by many as an opportunity to supplement their NHS income without incurring the further costs of indemnity required in private practice. Patient choice has been seen as vitally important by successive governments for a number of years. There have been many reforms over the years to facilitate this, the latest being that of AQP.

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Since April 2012 any provider can now provide NHS services if they meet the required standards and they will be paid a fixed fee (tariff). This was started in a few specific initial priority areas, but the areas included are growing year on year. In theory providers supplying excellent quality care will be more popular and therefore lower quality providers will improve in order for them to be able to compete. Of course whether this desired effect will be realised is yet to be determined[1].

Historically it was straightforward to identify the "NHS patient" bringing with them the benefit of NHS indemnity provided by the Clinical Negligence Scheme for Trusts (CNST) on behalf of the NHS Litigation Authority (NHS LA).

The purpose of this article is to highlight how these new ways in which NHS patients can receive care both in NHS hospitals and the private sector can impact on this previously seemingly straightforward arrangement.

The BMA have provided some helpful "clarification" on this issue[2]. Although the NHS LA has confirmed that nationally procured NHS contracts attract the benefit of CNST indemnity, locally arranged initiatives are not specifically covered. It is imperative to check the individual contract for each agreement prior to commencing any clinical work. Most indemnifiers base their subscription rates on the amount of money that is earned on "non-indemnified" patients. This means that if you are operating on "NHS patients" outside of your formal NHS employment contract which do not bring with them CNST indemnity and this represents a significant proportion of your additional income, then you may be operating without appropriate cover. This may leave you personally liable for any potential litigation should it follow. The risk is not merely financial. The GMC imposes an obligation on all registered medical practitioners to have appropriate indemnity cover as highlighted in "Good Medical Practice" [3], paragraph 63:

"You must make sure you have adequate insurance or indemnity cover so that your patients will not be disadvantaged if they make a claim about the clinical care you have provided in the UK."

Given that Medical Defence Organisation's base subscriptions on earnings (as a proxy for the number of patient interactions and therefore risk), surgeons need to ensure that they make accurate declarations of their earnings in respect of procedures and consultations that are not covered by the CNST. This can cut both ways – some surgeons may have declared income that was, in fact, derived from NHS-indemnified procedures, and may be able to claim a refund of subscriptions. Others might have assumed that all consultations and procedures were covered by NHS indemnity when in fact some were not, in which case additional subscriptions may be payable. For this reason, we would encourage all surgeons to double check their contracts and

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ensure that they are clear about the indemnity arrangements for each patient seen.

What should you do?

It is clear that the ways in which patients are able to receive NHS funded care are changing. It is much more difficult for surgeons to know where they stand regarding indemnity for these patients. The GMC, however, are less changeable. It is therefore important to be very clear at the outset what the indemnity arrangements are for any NHS patient for whom you are providing care. The suggestion would be:

- Ask for a contract before starting any work;
- Make sure you understand the contract. This is often more difficult than it sounds. If in doubt clarify indemnity arrangements with the contracting body or with your own indemnifier;
- Make sure your own MDO is kept up to speed on your working pattern.

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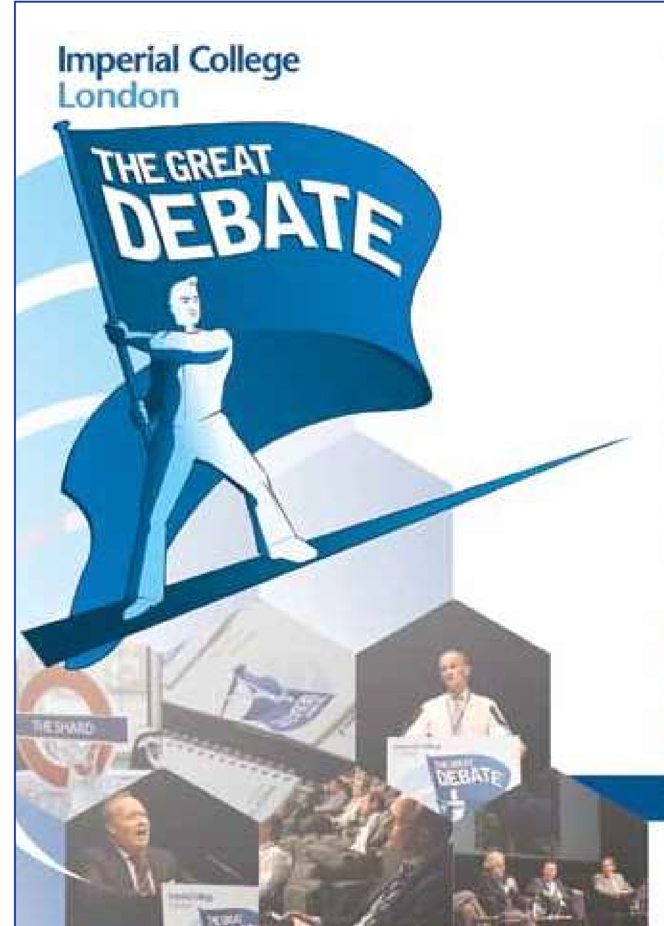
References:

1. Understanding the reforms… Choice and any qualified provider. BMA (April 2013)

2. Private Practice – Medical indemnity for NHS-funded treatment in the independent sector. BMA *http://bma.org.uk/practical-support-at-work/private-practice/medical-indemnity-in-the-independent-sector*

3. Good Medical Practice (2013). GMC



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