

The 'Jackson Reforms' in Civil Litigation and the Impact on the Expert Witness (Part 2)

Giles Eyre

Continued from JTO Volume 2 / Issue 1

The so-called 'Jackson reforms' – the changes in the civil procedure process introduced with effect from 1st April and 31st July 2013 – have recently been described as creating 'the most chaotic period in legal costs and funding since the concept of legal costs was codified in the Statute of Westminster 1275'.

The lives and business practices of lawyers, and particularly those dealing with injury claims (personal injury, disease and clinical negligence), have been and will be fundamentally changed by the reforms, and the access of an injured person to professional support in bringing a claim will in some areas be substantially restricted.

The impact of the reforms on the medical expert providing reports in civil litigation is both direct and indirect. Some reforms directly

refer to the use of medical experts in litigation, while others will affect the approach to the use of medical expert evidence in litigation.

Costs estimates and identification of issues

Part 35 of the Civil Procedure Rules 1998 is concerned with the use of expert evidence. Rule 35.4 has always required the court's permission to rely on expert evidence. However an amendment to Rule 35.4(2) now requires (from 1st April 2013) that an application for such permission be accompanied by an estimate of the cost of the proposed expert evidence as well as identification of the issues which the expert evidence will address. The order granting permission may specify the issues which the expert evidence should address.

Therefore in future the expert must provide the solicitor with sufficient information for the solicitor to provide the court with an estimate of costs, that is the potential fees of all the stages of the litigation

down to trial, and the solicitor may require assistance in identifying the issues which the expert will address. The estimate will, in many cases, therefore be provided prior to formal instructions being received and without knowledge of the potential dispute on expert evidence to which the claim might give rise. Unless permission is granted the cost of the expert will not be recoverable by the successful party at the end of the case, even if a report has already been provided. This is of course only an 'estimate' of costs but, as will be seen below, estimates may well get turned into, or reduced to, straightjackets within which the litigation will thereafter be conducted.

As the court is effectively required to have consideration of the potential cost of employing an expert in a claim, it is likely that there will be greater pressure to restrict the number of experts permitted and to increase the use of single joint experts.

Concurrent evidence

The Practice Direction to Part 35 has been amended with effect from 1st April 2013 to add a new paragraph 11 to provide for the giving of concurrent evidence (or 'hot-tubbing' as it is sometimes referred to).

11.1 At any stage in the proceedings the court may direct that some or all of the experts from like disciplines shall give their evidence concurrently. The following procedure shall then apply.

11.2 The court may direct that the parties agree an agenda

for the taking of concurrent evidence, based upon the areas of disagreement identified in the experts' joint statements made pursuant to rule 35.12.

11.3 At the appropriate time the relevant experts will each take the oath or affirm. Unless the court orders otherwise, the experts will then address the items on the agenda in the manner set out in paragraph 11.4.

11.4 In relation to each issue on the agenda, and subject to the judge's discretion to modify the procedure –

- (1) the judge may initiate the discussion by asking the experts, in turn, for their views. Once an expert has expressed a view the judge may ask questions about it. At one or more appropriate stages when questioning a particular expert, the judge may invite the other expert to comment or to ask that expert's own questions of the first expert;
- (2) after the process set out in (1) has been completed for all the experts, the parties' representatives may ask questions of them. While such questioning may be designed to test the correctness of an expert's view, or seek clarification of it, it should not cover ground which has been fully explored already. In general a full cross-examination or re-examination is neither necessary nor appropriate; and
- (3) after the process set out in (2) has been completed, the judge may summarise the experts' different positions on the issue and ask them to confirm or correct that summary.



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∞ THE PROCESS IS INTENDED TO ENABLE THE JUDGE PERSONALLY TO INVESTIGATE AREA OR AREAS OF DISPUTE BETWEEN THE EXPERTS AND TO TRY TO CLARIFY THE NATURE, EXTENT AND REASONS FOR THE DISPUTE. ∞

It is unlikely that an expert will turn up at court expecting traditional cross-examination, and instead be subjected to concurrent evidence. The direction for an agenda will normally mean that the concurrent evidence needs to be directed in advance of the hearing. However the judge has the power to decide at the trial to conduct the giving of evidence by experts in this manner. Particularly if the joint statement has effectively provided an agenda for

such concurrent evidence then there is no reason why the judge should not so direct on the day. Given that the judge hearing the trial may only be identified very shortly before trial, and that some judges will be far more comfortable and pro-active than others in their approach to concurrent evidence, a direction could be made at trial.

The process is intended to enable the judge personally to investigate the area or areas of dispute between

the experts and to try to clarify the nature, extent and reasons for the dispute. The process is therefore dependant on the judge having a good understanding of the issues. That will have been obtained, not (as with counsel) by meeting with and having a discussion with one or more of the experts prior to the hearing, but largely (if not entirely) from the written evidence of the experts submitted in their reports and their joint statement. Given

the non-specialist judiciary usually assigned to cases, it cannot be assumed that the judge will have any background or experience prior to the case relevant to the issues involved. Therefore the importance of the expert addressing the salient issues clearly in a medical report in language which can be readily understood by a professional with no medical knowledge is again emphasised.

The experts do not have to be of the same or identical disciplines, >>



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∞ *ALTHOUGH THE ADVERSARIAL APPROACH OF CROSS-EXAMINATION MAY BE FOREIGN TO THE EXPERT'S NORMAL PRACTICE IN DISCUSSING DIFFERENCES OF OPINION WITH COLLEAGUES, THE APPROACH OF THE JUDGE IN DISCUSSING THE ISSUES WITH THE EXPERTS MAY BE EQUALLY, ALTHOUGH DIFFERENTLY, FOREIGN, IN PARTICULAR IF THE JUDGE'S UNDERSTANDING OF THE ISSUES... IS LIMITED.* ∞

and that can, as it does in joint discussions, lead to some difficulty for the experts who may have a different approach from one another to the issues in the case. It is also likely that the experts will be of different personalities and therefore there may well be an imbalance in the way they present their evidence in the course of this process.

The court is likely to direct that an agenda for concurrent evidence be prepared, and this will be based on the areas of disagreement in the joint

statement. The agenda is concerned only with the areas of disagreement. In an effective joint statement following a joint discussion, the agenda should already be apparent, listing the areas of disagreement and the reasons for such disagreement. Although the 'parties' are ordered to prepare the agenda, the lawyers will most probably provide the final agenda based on the input of the experts, which should have been largely provided in the joint discussion. The agenda will be

crucial in guiding the process of the concurrent evidence and in assisting the judge to investigate the disagreement with the experts.

The Judge is in charge of the process of concurrent evidence and has discretion as to how this is done, but the Practice Direction above suggests a format in paragraph 11.4.

Although the adversarial approach of cross-examination may be foreign to the expert's normal practice in

discussing differences of opinion with colleagues, the approach of the judge in discussing the issues with the experts may be equally, although differently, foreign, in particular if the judge's understanding of the issues, in the absence of any medical training, is limited.

The process of the judge summarising the experts' positions at the end of the evidence will be extremely important and is likely subsequently to form an important aspect of the judge's judgment. It

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will therefore be a very important task for the expert to ensure that the summary, while for example trying to simplify the area of dispute into non-expert language, is also accurate and does justice to the areas of disagreement and the matters which have to be resolved by the judge.

How extensively 'hot-tubbing' will be used is difficult to predict, and will depend to some extent on judicial training, the confidence of the judge to deal with the issues in the case in this manner and the nature of the

dispute. Judges with more specialist knowledge are likely to find an advantage in this procedure and to see a way in which to shorten trials, while some interventionist-minded judges will believe that ought to be an advantage. ■


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Giles Eyre is co-author of a manual for medico-legal experts and those instructing them, 'Writing Medico-Legal Reports in Civil Claims - an essential guide' (2011) and co-presenter of the e-learning programme 'Medico-Legal Report Writing (Core Skills)' (www.prosols.uk.com). He frequently gives seminars and workshops for medical experts in medico-legal report writing, giving evidence and other medico-legal issues.

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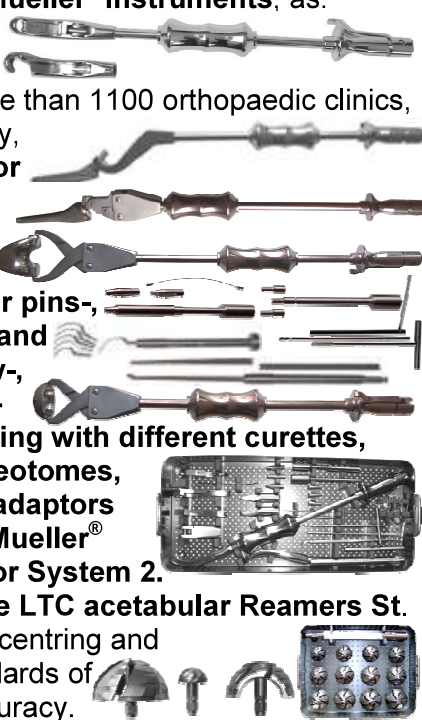
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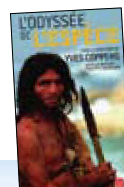
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Medico-legal aspects of adult tibial shaft fractures

Leela C Biant

Fracture of the tibial shaft is a common injury. There is a bimodal distribution of incidence¹. The mechanism of injury is usually high-energy trauma or sports injury in the young, and fall from a standing height in the elderly². The long term outcome from such injuries is of great importance when preparing medico-legal reports. Recently results after 12-22 (mean 17) years, including functional outcomes, have been reported.

Fractures are graded by multiple different systems in the literature. Gaston et al³ reviewed AO fracture classification, Winquist-Hansen grade, open and closed injuries, fracture displacement, Tscherne Score, location of fracture and associated fibula fracture in an attempt to find a prognostic correlation with outcome. These factors may be significant in predicting closed plaster or bracing treatment outcomes, but fragmentation and initial displacement of fractures are not reliable indicators of outcome when fractures are treated with intramedullary nailing³.

Open fractures are usually graded after Gustilo and Anderson. Approximately 20% of open fractures are Grade 1; 25% are grade 2 and 55% are grade 3. Of the grade 3 open fractures, approximately 45% are grade IIIA, 50% are grade IIIB and 5% are grade IIIC^{2,4}. The majority of open fractures unite. The literature reports a range of non-union from 0-17%, the majority reporting around 4%.⁵ There is no clear breakdown of non-union rates between Gustilo grades.



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Tibial Shaft Fracture

Fracture Union

Time to fracture union can be influenced by the severity of the injury and the treatment method. In a meta-analysis of 2372 trials⁶, the time to union varied slightly with fixation device, but there was no difference in the number of fractures united at 20 weeks, or the incidence of non-union between treatment devices. However, caution should be exercised when interpreting such data as the more severe injuries may have been nailed. Primary union occurs without further intervention in over 90% of tibial shaft fractures². Some require further interventions such as bone grafting, exchange nailing, removal of locking screws and alternative fixation methods.

Compartment syndrome

Compartment syndrome is a potentially devastating complication of tibial shaft fracture. The intra-compartment pressures are related to the extent of the associated soft tissue injury⁷. Even in open fractures the associated soft tissue injury can cause a compartment syndrome. The incidence of compartment syndrome is reported from 1.6 - 9%^{8,9}. However, true comparisons between case series are difficult due to lack of criteria for diagnosis and severity. There is a huge clinical difference between early decompression of oedematous muscle that responds and recovers fully, and excision of necrosed dead muscle as a lifesaving measure or the later formation of ischaemic

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Treatment

Treatment of tibial shaft fractures may be through plaster immobilisation, functional bracing, intramedullary nailing, plating, or primary amputation in the unsalvageable limb. Undisplaced transverse fractures may be treated non-operatively, however, the majority of displaced fractures in the UK are treated operatively in 2014.

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∞ KNEE AND ANKLE DISCOMFORT ARE COMMON LONG TERM COMPLAINTS. AT A MEAN OF 17 YEARS, 47% PATIENTS WERE FREE OF DISCOMFORT. ∞

contractures. However, all can be labelled compartment syndrome. We found an 11.5% fasciotomy rate, but no functional difference between those who underwent fasciotomies and those who did not at mean 17 years follow-up. The majority of the patients in this series had compartment pressure monitoring, so it was likely that timely intervention was undertaken before irreversible muscle necrosis occurred.

Knee and Ankle Symptoms

Stiffness of the knee or ankle may occur after tibial shaft fracture. This was a more prominent immediate feature when the knee, ankle and subtalar joint were immobilised for protracted periods by plasters and splints¹⁰. Joint stiffness may occur in the long term, but this has not been specifically studied in patients treated by modern operative techniques. It is possible that articular cartilage injury within the knee or ankle can occur at the time of tibial shaft fracture that may contribute to degenerative joint pathology and late stiffness.

Knee and ankle discomfort are common long term complaints¹¹. At a mean of 17 years; 47% patients were free of discomfort, 17% had both knee and ankle discomfort, 26% had knee discomfort alone and 10% had only ankle discomfort². The level of discomfort in the

majority did not affect their ability to work. The presence of long-term discomfort in the ankle was related to the severity of the initial injury, suggesting a degenerative process. Women were more likely to have ankle pain in this series, and this may be due to the women being much older than the men at the time of fracture, with the higher likelihood of pre-existing degenerative change in the joint. Vallier et al¹² found that joint pain did not affect function in the majority of patients with a tibial shaft fracture. Tibial nails inserted through the patella tendon are associated with higher rates of anterior knee pain than nails inserted without disruption to the tendon¹¹. Removal of metalwork does not always resolve knee discomfort¹¹.

Post-phlebotic syndrome

Post-phlebotic syndrome of the lower limb and venous ulceration can occur, particularly in older patients, after tibial shaft fracture. This phenomenon may not present clinically for up to 10 years following injury and therefore Aitken et al¹³ highlighted the potential medico-legal implications of early settlement of cases with regard to the onset of these symptoms.

Return to work

In a series of 1502 patients, of the patients alive for review; 74.6% were able to return to their pre-injury employment. Of the remaining 25.4%; 17.3% were unemployed at the time of injury, 2.3% changed to a less physically demanding job, 0.5% took early retirement and

7% reported they were unable to return to work due to continuing disability. Younger patients had a higher likelihood of return to work, and earlier return to work. Increased age and presence of a grade II open fracture was associated with a reduced likelihood of returning to work at all.

Mortality

Crude mortality at 17 years following a tibial shaft fracture is 37.5%. Mortality in the 12 months following fracture is high in the elderly. The one-year mortality in patients aged 65-69 is 6.5%, this rises to 21.6% in those aged 70-74 and 31.6% in those aged over 85 years at the

time of injury². This mortality rate is similar to patients who sustain a hip fracture. ■

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References can be found online at www.boa.ac.uk/JTO or by scanning the QR Code

