The 'Jackson Reforms' in Civil Litigation and the Impact on the Expert Witness (Part 1)

Giles Eyre

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.

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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 and the 'Jackson' reforms

For lawyers, the principal impact of the reforms is on the costs which will be recoverable on successfully concluding a claim. At the heart of the reforms is an amendment to the 'overriding objective' in part 1 of the CPR, and related amendments to the rules relating to the assessment of the costs that a successful party can recover at the end of the case.

Proportionate costs

The overriding objective, which is to be considered at all stages of a claim and in relation to all decisions on case management, is amended to state that it is not only 'to deal with cases justly' but also now 'at proportionate cost'. It is expressly provided that that requires dealing with a case in ways which are proportionate to the amount of money involved, the importance of the case, the complexity of the case and the financial position of each party. How the courts will interpret that, and whether a ratio between the sum in issue and the 'proportionate' costs which may be incurred will develop, we wait to see. It is however intended to reduce the cost of litigation, and most probably to do so to a significant degree.

Costs budgeting

At the first court hearing in any claim commenced after 1st April 2013, the court is required to set a budget for the whole claim. The parties are required to provide a detailed breakdown, in accordance with a court form (in spread sheet style), of the estimated costs for each stage of the proceedings through to trial, however unlikely a trial will be. The court will, in the course of a relatively short hearing and with the minimum amount of investigation, set the budget for each stage, and for the whole claim. Subject to the court subsequently approving a variation because an assumption on which the estimate has been provided has proved incorrect through no fault of the lawyer, that will almost certainly be the basis for the costs recovered at the end of the case by the successful party. The court does not have to identify which particular items are disapproved or reduced, but can simply state the global sum approved for the particular stage. Therefore, if for the stage 'Expert Reports' the court decides to allow only half the total sum claimed on the grounds of proportionality, it will be for the solicitor, counsel and expert to resolve how, if successful, they are respectively paid from the costs eventually recovered. The expert is entitled to his contractual fee from the solicitor in any event, but the pressure on fees from this process may be considerable. >>

"THE EXPERTS CONTRACTUAL RIGHT TO HIS/ HER FEES WILL BE SATISFIED BY PAYMENTS FROM THE LAWYER OR BY THE CLIENT (FROM DAMAGES)."

Estimates of expert costs

Experts will therefore have to provide estimates of their likely fees through to trial prior to this first hearing, or rely on the lawyers to do so for them, and the likelihood is that, particularly in more modest value claims, the fees of the medical expert will not be recovered from the losing party in full. In that case, the expert's contractual right to his/her fees will be satisfied (assuming it is) by payments from the lawyer or by the client (out of damages).
Estimates of fees will need to cover provision for:

1. providing an initial report;
2. re-examining the client and preparing a supplemental report;
3. reviewing reports prepared by other experts;
4. reviewing further documentation;
5. reviewing surveillance evidence
6. replying to questions from the opposing side;
7 attending case conference(s);
8. attending joint discussions and preparing a joint statement;
9. attending trial to give (and if appropriate, listen to) evidence.

In providing an estimate, the expert should make clear the assumptions on which the estimate is made, for example the volume of medical records which will have to be read, the hours of surveillance material to be reviewed and the number of days the expert is likely to be required at court for the trial (giving evidence and hearing the evidence of others).

Funding arrangements

Funding arrangement under which claimants in most injury claims can employ a lawyer are changed so that the success fee under a conditional fee agreement (a 'no win, no fee' arrangement) will no longer be paid by the losing party, and the insurance premium on an insurance policy that was taken out to protect the claimant from a liability for the other sides' costs in the event of losing, is no longer generally necessary or recoverable. Instead a claimant may have to pay out up to 25% of the damages recovered (for the injury and past loss) to the claimant's own lawyer as a success fee (to help fund the cases the lawyer loses) and up to the whole amount of damages in satisfying a costs' claim by the opposing party, although the starting position, to which there are a number of exceptions, in an injury claim is that a losing claimant no longer pays the successful defendant's costs (so called Qualified One-Way Cost Shifting or QOCS). In the case of a fraudulent claim, or if a defendant's Part 36 offer of settlement is not bettered at trial, this protection is lost.

Fixed scale costs

The pressure on legal costs will be greatest in claims assigned to the Fast Track where damages do not exceed £25,000. Until April 2013 road traffic claims up to £10,000 were dealt with through an online portal with a scale of fixed costs recoverable by the successful claimant's lawyer, falling out of the portal (and into court) if liability was disputed. For accidents after 31st July 2013 virtually all claims up to £25,000 for road traffic accidents, employers' liability claims and public liability claims will start in the portal, and should they 'fall out' they will be caught by a scale of fixed costs. This will, in future, apply to the majority of all injury claims which are made. These costs are fixed at a level in relation to smaller value claims that are significantly less than before April and which might well make them unattractive to many lawyers who may well no longer run such claims at all.

Under the portal, the claimant submits medical expert evidence in a standard report form provided under the scheme, or in a report containing the information required in that report form, and medical evidence is generally expected to be in a single report, with the defendant not obtaining medical evidence of its own. The report must identify the relevant medical records which will be served by the solicitor with the report.

Offers to settle

The provisions in the CPR Part 36 relating to offers to settle have always been important in putting pressure on the parties to settle because of the implications in terms of costs in failing to accept an offer which is not subsequently bettered. The reliability of the expert report in assessing the risks of a claim and its likely value is crucial in assessing such offers. Additional 'teeth' have been added to offers made by claimants. From April 2013 if the defendant ends up paying no less than the sum offered as settlement by the claimant, the defendant will pay an additional sum to the claimant of 10% of the amount awarded (reducing on larger sums to 5% and capped at £75,000). On the other hand the new funding arrangements mean that a claimant who fails to do better than an offer from the defendant will pay the defendant's costs, since the offer was made, out of his/her damages.

> *THERE IS THEREFORE A SUBSTANTIAL RISK THAT A FAILURE BY AN EXPERT TO COMPLY WITH A COURT TIMETABLE WILL RESULT IN THE CLAIM BEING STRUCK OUT.*

Case management

An expert does not always (some would say, ever) see a copy of a court order relating to expert evidence. Sometimes the impression may be given to the expert that if the report or answers to questions or the joint statement is received by the solicitor a little late it does not really matter. An amendment to CPR 3.9(1) is likely to change that. From April 2013 if a party (and that includes a party's lawyers or experts) fails to comply with a court rule, practice direction or order, in deciding whether, for example, to extend time for the doing of something or for the provision of a document, the court will take into account '*the need for litigation to be conducted efficiently and at proportionate cost, and the need to enforce compliance with rules, practice directions and orders*'. There is therefore a substantial risk that a failure by an expert to comply with a court timetable will result in the claim, or the defence, being struck out, or permission to use the expert being withdrawn. The expert must therefore make sure that he/she is aware of court timetables relevant to their involvement in the litigation, and that they have appropriate insurance in place to cover such an unfortunate default.

The future for expert evidence

The pressure on costs means that lawyers will need to deal with cases more quickly and efficiently, and often with a lower grade of fee earner. The rule changes will increase the necessity for high quality, reliable and readily understood medical reports which address all of the matters relevant to the legal issues in the case, and which demonstrate the internal reasoning process, so that the reports can be used efficiently and with confidence within the litigation by lawyers. The expert who provides such evidence should develop a reputation which will assure a substantial medico-legal practice. ■

PART 2 to follow in the next edition of JTO

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Giles is a barrister specialising in personal injury, disease and clinical negligence claims. He is mediator and a member of the CEDR Solve Lead Mediators Panel. He was appointed a Recorder in 2004.

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Uneasy Bedfellows in Court?: A Psychiatrist on Orthopaedic

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Even before working as a medical expert I could personally attest that Orthopaedic surgeons would always beat you at squash, out-ski you and drink you under the table. One common factor shared by these two professions is that they are probably the most frequently instructed medical experts in personal injury litigation and by virtue of this invariably cross-paths in barrister's conferences and the courts. It is therefore tempting to rely on personal observation or well-worn stereotypes when characterising orthopaedic experts but I have looked at the medical literature, for a more authoritative and less biased view, which is revelatory in its rather bizarre detail.

Leigh Neal

It is probably no surprise that Orthopaedic surgeons are more inherently verbally aggressive and hostile than psychiatrists (Wright et al, 2012) or that psychiatrists have more open personalities and are more agreeable than Orthopaedic surgeons (Deary et al, 2007), which of course, also means that psychiatrists are more open to exploitation. Psychiatrists, who do not have to get up in the middle of the night to operate and rarely work at weekends, have less work-related stress and they report fewer clinical work demands than Orthopaedic surgeons (Deary et al, 2007).

However, this is where the questionably good news for psychiatrists comes to an abrupt end. Orthopaedic surgeons park their cars more quickly and are more attractive and taller than psychiatrists (Antoni et al, 2006; McCail et al, 2010). I also know that they have more expensive and flashier cars than psychiatrists. Admittedly, I do park my car quite slowly, but exceptions always prove the rule and I know a very tall psychiatrist and a short (though unquestionably good looking) Orthopaedic surgeon. Orthopaedic surgeons are stronger and have larger hands than psychiatrists (Barrett, 1988; Fox et al, 1990), which does not particularly concern me - inferences aside.

Orthopaedic surgeons are more extroverted and are more emotionally stable and less neurotic than psychiatrists (McGeevey et al, Deary et al, 2007). How many psychiatrists do you know that are planning their holiday steel-head fishing in Columbia?!

Slightly more worrying is that psychiatrists are less conscientiousness about their work than their Orthopaedic colleagues (Deary et al, 2007). They suffer from lower levels of job satisfaction (Baldwin *et al*, 1997; Firth-Cozens, 2000) and who honestly would not prefer to be praised for replacing a worn out hip than be beaten up by a cocaine dealer? Psychiatrists have more disciplinary actions against them at work than Orthopaedic surgeons (Dehlendorf & Wolfe, 1998) and in particular, psychiatrists have a higher proportion of disciplinary actions for substance misuse than Orthopaedic surgeons (Shore, 1982). Male psychiatrists are more often disciplined than Orthopaedic surgeons for having sexual relationships with patients (Morrison & Morrison, 2001).

Psychiatrists (who clearly should know better) are more likely to be depressed and have more burnout than Orthopaedic surgeons (Deary *et al*, 1996; Kumar et al, 2005). It seems the GMC is impotent to stop psychiatrists in training using more cocaine, LSD, and cannabis than Orthopaedic surgeons (Myers & Weiss, 1987). You may be interested to know that trained psychiatrists tend to favour benzodiazepines, amphetamines and cannabis (Hughes et al, 1992). I find it hard to believe, that psychiatrists are over-represented at Alcoholics Anonymous compared to Orthopaedic surgeons (Bissell & Skorina, 1987) but perhaps they are more "open" to admitting they are alcoholics. Psychiatrists are more like to commit suicide than Orthopaedic surgeons (Hawton et al, 2001), probably because they know the tricks of the trade.

The final *coup de grâce* is that psychiatrists show significantly raised mortality compared with Orthopaedic surgeons and are particularly more likely to contract ischaemic heart disease, injury, poisoning, and colon cancer (Carpenter et al, 2003). I am

Surgeons

fairly sure than even Orthopaedic surgeons eventually die of something.

However, much it pains me to admit it, there is no getting away from the fact that Orthopaedic surgeons are the top-guns of medicine; the Maverick's to the Mr Bean's and while I am sure this article has not revealed anything to you that you did not know already, the very least you can now do is to recommend me to your instructing solicitors.

References available on request from Dr Neal.

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Dr Leigh Neal is a Consultant Psychiatrist who has been providing personal injury reports to the legal profession for 20 years. He has prepared 100 to 150 personal injury reports a year for defendants and claimants involved in personal injury actions since 1994 He has attended training courses in the responsibilities of an expert witness and report writing. He has considerable experience as an expert witness in the High Court and County Court, giving evidence on average 5 times a year since 1994.

STOP PRESS:

Expert Witness Fees Cut Again

Civil Legal Aid (Remuneration) (Amendment) Regulations come into force on **2nd December 2013.** Expert witness fees in legally aided cases have been cut by 20% across the board. For Orthopaedic surgeons, this is a reduction from **£144** per hour to **£115.20** per hour.

The fees for different specialists are at Schedule 2 of the document.

This only applies to legally aided work but will certainly have an impact on Clinical Negligence practice where quite a number of claimants are legally aided. There are, however, caveats namely that if there is a paucity of experts in that field and the experts' opinion is crucial to the patients claim, then the instructing solicitor can apply for an uplift to the fee on a case by case basis.

www.legislation.gov.uk/uksi/2013/2877/pdfs/uksi_20132877_en.pdf