# MEDICO LEGAL

MAGAZINE

ISSUE 23

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# Welcome to the Medico-Legal Magazine

Welcome to Issue 23 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This Conference issue of 2023 includes the following articles: Professor Matthew Reed, Emergency Medicine Consultant, Royal Infirmary of Edinburgh, discusses how to reduce misdiagnosis of acute aortic disease; and

Alexander Acaster, Chief Operating Officer, TMLEP, shares his insight on how AI could transform the medico-legal sector.

Also in this issue, Dr Megan Smith, Consultant Anaesthetist and Barrister, announces the launch of the campaign group EveryDoctor's NHS whistleblowing platform; and

Stephen Hooper, Senior Associate, Clyde & Co LLP, discusses patient consent and confidentiality.

Finally, Mr Amar Alwitry, Consultant Ophthalmologist, summarises the most common reasons for ophthalmology litigation.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It has a dedicated website www.medicolegalmagazine.co.uk and a page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed. Printed copies can be ordered from Iconic Media.

Specialistinfo maintains a database of contact details for up to 90,000 UK consultants and GPs, including approximately 11,000 consultants and GPs who undertake medico-legal work. We also provide Medico-Legal courses for expert witnesses and promote the members of the Faculty of Expert Witnesses (the FEW).

We welcome feedback from our readers, so please contact us with any suggestions for areas you would like to see covered in future issues or share your news and experiences with us.

*Lisa Cheyne*

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# UNLOCKING THE POTENTIAL: HOW AI CAN TRANSFORM THE MEDICO-LEGAL SECTOR

**By Alexander Acaster,** Chief Operating Officer, TMLEP

## Introduction:

While AI has yet to make significant inroads in our field, its potential applications hold promise for streamlining processes and improving outcomes for both patients and defendants.

## Medical Records Categorisation:

One area where AI can be implemented effectively is in reading and categorising medical records. This process is manual, consuming valuable time and resources. AI algorithms can analyse and extract relevant information from medical records, automating the sorting process and significantly reducing the time required. By employing natural language processing and machine learning techniques, AI systems (such as those being developed by TMLEP's TitanEMR platform) can identify key data points, such as diagnoses, treatment plans or histories, and accurately categorise them for easy retrieval, analysis, and decision-making.

## Pre-Screening of Expert Opinions:

The quality of expert opinion is a fundamental to medico-legal cases. AI (such as that developed within TMLEP's MLM system) can play a pivotal role in helping experts proof their opinions to ensure the application of specific legal tests. By employing machine learning algorithms trained on historical case data and legal guidelines, AI systems can quickly analyse and evaluate expert opinions against predetermined criteria. This automated process not only saves time but also allows for the identification of potential inconsistencies early on. As a result, cases that require further tuning can be identified before submission, enabling faster claim resolutions.

## Trend Analysis of Case Outcomes:

AI can also be utilized to analyse trends within case outcomes by identifying common themes and extracting valuable insights for healthcare providers and legal professionals. These trends can be related to medical practices, areas of potential negligence, or even systemic issues within healthcare organisations. The feedback derived from AI-driven trend analysis can inform areas for improvement, risk mitigation strategies, and the development of best practices. By proactively addressing these concerns, healthcare organisations can reduce the likelihood of recurring incidents and improve patient safety.

## Speeding Up Report Reviews:

The review of reports on multiple cases can be an arduous and time-consuming task for medico-legal professionals. This process demands meticulous attention to detail and comprehensive analysis. AI-powered systems can assist by automating certain components of the review process. AI algorithms can be trained to identify and extract relevant information, flag inconsistencies, and even generate summary reports. This streamlines the review process, enabling legal professionals to focus their attention on critical aspects of the case. Additionally, AI can enhance the accuracy of report reviews by minimizing human errors and biases that may arise from fatigue or information overload.

## Challenges and Limitations:

The potential benefits of AI in the medico-legal sector are evident, there are challenges to consider. Many professionals in the field may be hesitant to adopt AI solutions, fearing job displacement or concerns about the human element of client care being compromised. Addressing these concerns through education and demonstrating the ways in which AI can enhance rather than replace human expertise is crucial. Additionally, ensuring compliance with legal and ethical standards, particularly regarding patient data privacy and the responsible use of AI algorithms, will be paramount.

## Case Studies and Examples:

While AI is not yet widely implemented in the medico-legal sector, there are pioneering efforts to harness its potential. One notable example is TMLEP and their development of AI-powered systems for medical records categorisation and analysis. These solutions are designed to improve efficiency, reduce costs, and enhance the overall quality of medico-legal processes. Such initiatives pave the way for further exploration and adoption of AI in the sector.

## The Future of AI in the Medico-Legal Sphere:

The future of AI in the medico-legal sphere looks promising. As technology continues to advance, AI has the potential to revolutionize the way clinical negligence claims are handled. By integrating AI systems into existing workflows, the sector can achieve faster and more accurate outcomes. However, a collaborative approach is essential for success. Legal professionals, healthcare providers, and technology experts must work together to address concerns, develop robust frameworks, and establish guidelines for the responsible implementation of AI in the medico-legal field. With proper planning and careful consideration of ethical and regulatory aspects, AI can be a powerful tool to improve efficiency, enhance patient care, and drive positive outcomes in the medico-legal sector.

## Contact Information:

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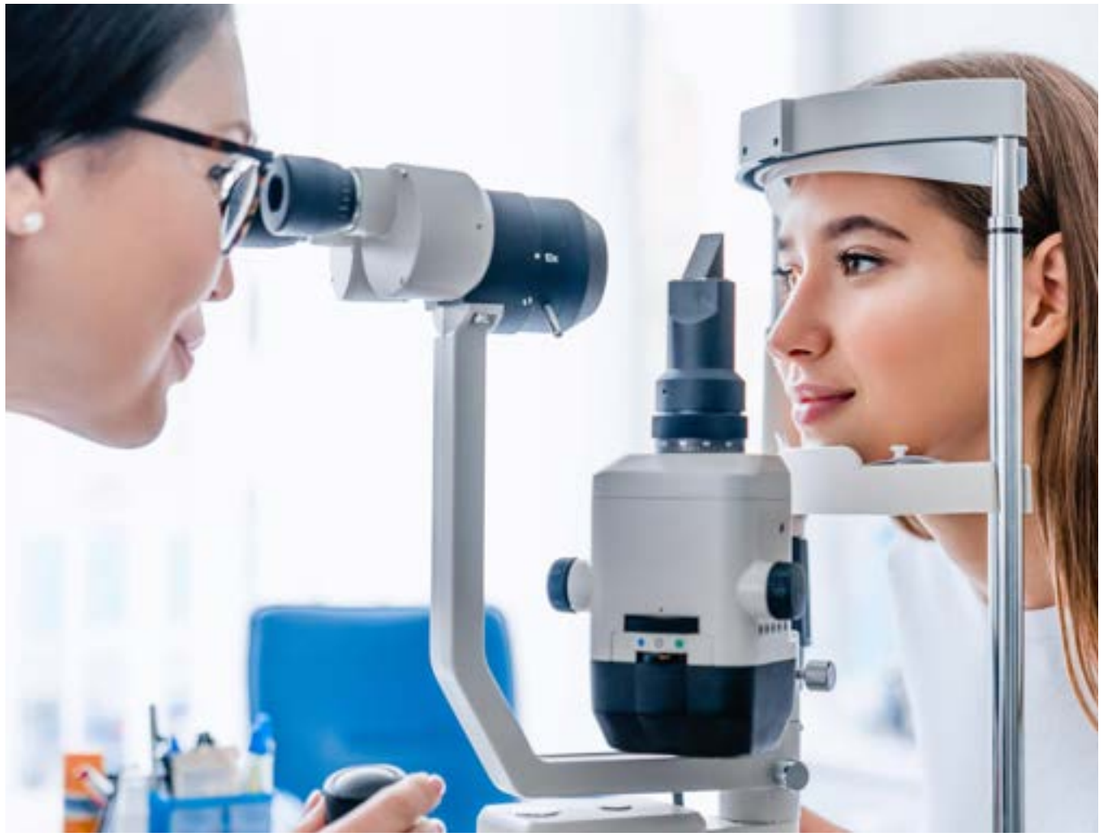

# A TASTE OF OPHTHALMOLOGY LITIGATION

**By Mr Amar Alwitry,** Consultant Ophthalmologist, East Midlands
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**Mr Alwitry is an experienced and award-winning Ophthalmologist and Eye Surgeon based in the East Midlands. He has written two text books and edited a third. He has published more than 35 research articles and has a Masters in Medical Law. He is a Speciality Advisor in Ophthalmology to the Care Quality Commission.**

The annual clinical negligence bill against the National Health Service (NHS) in England has increased considerably from £0.3 billion in 2004 and 2005 to £2.3 billion in 2019 and 2020[1]. Clinical negligence pay-outs account for more than 1.5% of the annual NHS budget in England (£148.8 billion)[2]. The rising costs have been attributed to increases in both claim volumes and legal costs[2].

Ophthalmology attracts significant litigation, which is unsurprising in that cataract surgery is the most frequently performed operation in the NHS, and Ophthalmology accounts for 8% of the 94 million hospital outpatient attendances and is the busiest outpatient attendance specialty[3].

Cataract surgery is also very successful at restoring vision, with an excellent safety profile, making it more likely a patient will seek to attribute blame if things do not go to plan and vision is lost. Ophthalmology is not a big hitter when it comes to quantum though, and therefore is not in itself a big burden on the NHS's litigation bill.

As with every speciality and, I am sure, in common with many of my expert colleagues I see the same errors happening again and again. The recurrent harm from avoidable clinical errors is heart breaking on many levels. The cause of the harm is often not high level but occurs due to well established forms of cognitive errors and bias. Historically healthcare has struggled to learn from these errors and implement effective change however there is hope on the horizon in the form of the new Patient Safety Incident Response Framework (PSIRF) which is being developed and rolled out across healthcare in the UK[4].

PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents,
2. Application of a range of system-based approached to learning from patient safety incidents,
3. Considered and proportionate responses to patient safety incidents, and
4. Supportive oversight focused on strengthening response system functioning and improvement.

Below I discuss a few conditions which are not solely ophthalmology related in view of the varied readership.

## Could it be GCA?

One of the most disheartening errors that can be potentially blinding for patients is missing a diagnosis of Giant Cell Arteritis (GCA). I personally see one or two cases of missed GCA a year with catastrophic visual outcomes. It must be remembered that GCA can cause intermittent ocular symptoms, which may not manifest as any clinical signs when the patient is examined. A history of new head pain, which may be headache, temporal pain, jaw pain or even earache, in a patient over 50 years of age with ocular symptoms should raise the concern that it could be GCA. These symptoms may be only intermittent blurring of vision, frank amaurosis fugax (in 30%), or diplopia (in 5%)[5]. Visual acuity may be normal, as may ocular motility. A GP diagnosis of sinusitis or migraine may be misleading and falsely reassure the Emergency Medicine doctor or the Ophthalmologist. Taking a C-Reactive Protein (CRP) blood test is a prudent measure and if it comes back high, referral to the rheumatology service to exclude a diagnosis of GCA could be potentially sight preserving. Untreated, I have seen numerous cases of patients being left blind in both eyes.

## Could it be hydroxychloroquine retinal toxicity?

Recent data have highlighted that hydroxychloroquine retinopathy is more common than previously reported. The prevalence following long-term use appears to be around 7.5% and depending on dose and duration of therapy can increase to 20-50% after 20 years of therapy. Risk increases for patients taking more than 5mg/kg/day for more than 5 years[6] The retinopathy is manifest as damage to the central photoreceptors and thus central visual loss. This is important, as the only intervention to prevent further damage is stopping the drug. The risk is

increased for patients taking more than 5mg/kg/day, those also taking Tamoxifen, and those with renal impairment[7].

Harm, and consequent litigation, occurs when a clinician is faced with a patient complaining of visual symptoms who has been on hydroxychloroquine for some time. Often, they are a frail elderly lady who is being overdosed according to the guidance regarding dosage per kg of body weight leaving open the allegation that the overdosage caused the toxicity. They may have started off at one weight on commencement of the drug and then lost significant weight afterwards. Failure to stop the drug and failure to refer for an Ophthalmological assessment can result in irreversible visual loss and harm.

## Could it be orbital cellulitis?

Orbital cellulitis is defined as a serious infection that involves the muscle and fat located within the orbit. It is also sometimes referred to as post-septal cellulitis. Orbital cellulitis does not involve the globe itself and the visual loss and damage to vision is usually due to an orbital compartment syndrome. Although orbital cellulitis can occur at any age, it is more common in the paediatric population. The causative organisms of orbital cellulitis are commonly bacterial originating from the sinuses.

Orbital cellulitis is potentially blinding and requires urgent treatment with antibiotics and close observation/monitoring of vision. The damage to the eye and vision is usually caused by the bacterial infiltration and inflammatory swelling in the orbit. This increases the orbital pressure. The orbit cannot decompress as it has three bony walls. The globe can move forward slightly but then it is restricted by the orbital septum. Pressure increases and the optic nerve and its blood supply become compromised. After 90 minutes of being deprived of blood supply, and thus oxygen, the retina/eye starts to die and irreversible damage ensues.

There are several common scenarios which present in litigation cases:

1. Missed diagnosis. The eyelid is red and swollen and a diagnosis of pre-septal cellulitis is made. The general practitioner or emergency doctor give antibiotics but fail to look at the eye hidden under the swollen lid. Underneath the lid the eye itself is red and inflamed. There is clear orbital cellulitis which is missed and vision is lost.
2. Missed orbital compartment syndrome. Orbital cellulitis is treated aggressively with antibiotics but the eye is not checked regularly. Vision is not assessed and when it is finally measured it is markedly reduced. The orbital pressure went dangerously high and this was missed resulting in potential blindness.
3. Failure to intervene quickly. Orbital cellulitis is diagnosed and vision reduced. There is a failure to intervene acutely/immediately with a lateral cantholysis/canthotomy (a procedure where a cut is made in the suspensory ligaments of the orbital septum allowing the globe to move forward and relatively decompress the orbit) or a failure to take urgent surgical action to drain an orbital abscess.

It is vital to differentiate pre-septal from orbital cellulitis. With pre-septal cellulitis the lid is swollen and red but the eye itself is white, vision is normal, and there is no restriction of eye movement. In orbital cellulitis the eye is red, the vision may be reduced, the eye may be proptosed (protruding) and there is pain on ocular movement. If the lid is so swollen that the eye cannot be examined orbital cellulitis needs to be excluded with imaging.

## Could there be a meningioma?

Ophthalmology clinics are unsurprisingly full of patients complaining of loss of vision and there are numerous reasons why vision could be lost. One of the diagnoses which is missed is the presence of a meningioma compressing the optic nerve. The typical growth pattern of these tumours is slow, producing insidious and chronic visual disturbances.

Often the vision goes down and there is a visual field defect detected. The patient is referred into a glaucoma clinic or a cataract clinic. Both of these conditions can co-exist and they can together cause reduced vision and a reduced field of vision. The optic nerve is usually pale which is missed. There is a delay to neuroimaging and by the time it is done vision is lost. Surgical intervention often takes place to try and remove the tumour which results in more damage to the optic nerve and the visual field resulting in permanent harm.

Usually there is an allegation that there was a delay to diagnosis which meant that a curative resection was no longer possible and that there was irreversible visual loss.

## Could it be a corneal ulcer?

The cornea is the clear window at the front of the eye responsible for the majority of the focusing power of the eye. Contact lens wearers are at risk of corneal ulcers/infections which can be potentially severe and potentially blinding. They are also at risk of acanthamoeba keratitis. Acanthamoeba keratitis is a rare but serious infection of the eye that can result in permanent visual impairment or blindness. This infection is caused by a microscopic, free-living amoeba (single-celled living organism) which is very common in nature and can be found in bodies of water (for example, lakes and oceans), soil, and air.

Red eyes are a common condition faced by numerous clinicians and the go-to diagnosis is conjunctivitis. In the vast majority of cases this is the correct diagnosis and topical antibiotics in the form of eye drops can be effectively prescribed. In contact lens wearers it is different, and the clinician needs to exclude a corneal ulcer. A corneal ulcer is usually visible as a white opaque area on the cornea. If this is seen urgent referral to the ophthalmology service is required. A breach of duty is often asserted due to failure to consider a corneal infection in a contact lens wearer. Appropriate safety netting is vital in such cases as, if no ulcer is seen, then it is important the patient is advised to return if symptoms fail to resolve or worsen.

Ophthalmologists are often in the firing line for failing to pick up/consider acanthamoeba infection until significant damage, usually manifesting as corneal scaring, is done.

A red eye in a contact lens wearer is a red flag and should prompt concern of a corneal infection.

Ophthalmology is a fascinating speciality and I spend my working day trying to improve and preserve vision. Visual loss is devastating and has a massive impact on patients.

A 2019 study[8] reported that respondents would rather have 4.6 years of life in perfect health instead of 10 years of life with total vision loss. Losing sight concerns people more than the loss of memory, speech, hearing, or chronic health conditions, such as HIV/AIDS and heart disease. It may not be a high priority in terms of the volume of payments made but avoidable visual loss is something we need to continue to tackle as well as developing pathways to effectively learn from litigation.

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# REDUCING MISDIAGNOSIS OF AORTIC DISSECTION

**By Professor Matthew Reed,** Emergency Medicine Consultant,
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**Matt is a Professor of Emergency Medicine at Edinburgh University and the Royal College of Emergency Medicine, and a Consultant and NRS Fellow at the Royal Infirmary of Edinburgh. He is Research Director of EMERGE, the Emergency Medicine Research Group Edinburgh, a multidisciplinary clinical research group delivering frontline applied health research which is the largest recruiter of EM research participants in the UK.**

**Matt's research work focuses broadly on Emergency Medicine research in challenging areas of acute care such as syncope, palpitations, and now aortic dissection, as well as the innovative use of novel technology. He has published over 120 papers and personally been awarded over £8.4 million in research grants. When not a work, Matt is a below average runner, a passable golfer, and an undistinguished cellist in The Really Terrible Orchestra.**

Mr S was a middle-aged gentleman who presented to our Emergency Department (ED) about six years ago when I was working in our Rapid Access Triage assessment area. This is essentially a triage area, common in many UK EDs, where a senior doctor is available to help identify potentially serious conditions early and rapidly fast track anyone who is unwell, or who could redirected to be better managed by another specialty or service elsewhere.

Mr S presented with a cold white left arm which had developed two hours previously. There were no other presenting symptoms and whilst I did consider acute aortic dissection (AAD), it looked very much like a straightforward case of an acute embolic event causing acute limb ischemia, a surgical emergency. Mr S went through to our ED, and I handed him over to an ED consultant colleague who also saw him and agreed that there wasn't anything else to suggest AAD. They referred to the vascular surgery team, and Mr S went to the operating theatre later that afternoon where he had a brachial artery thrombus removed. Mr S went back to the ward but tragically at 3:00 am suffered a cardiac arrest from which he was unable to be resuscitated. Mr S underwent a post-mortem examination which showed a type A AAD. It later transpired that Mr S, had presented two weeks previously to another department with chest pain, had undergone a troponin test which was normal, and he was discharged home with a diagnosis of non-specific chest pain.

Now I'm certainly not alone in having misdiagnosed a case of AAD. Data from the EDs of our two Edinburgh hospitals, showed that between 2011 and 2020, there were 26 patients whose diagnosis of AAD was delayed or missed. But it's not only us, 1 in 3 patients with AAD are misdiagnosed[1,2], 1 in 4 patients are not diagnosed until over 24 hours after presentation to the ED[3], and AAD is a common cause of fatality-related negligence claims[4]. The tragic thing is we know that prognosis is best when patients are treated early with mortality increasing 2% per hour of diagnosis delay[5]. AAD is a treatable condition with an 80% survival when diagnosed and treated on time.

Currently 4,000 patients a year in the UK suffer AAD. About half of these patients die before they reach hospital, but around 50% arrive at hospital[6]. AAD can affect people of any age, but it is more common as you get older. However, it is so important to remember that this condition also affects young people, with 25% of patients aged under 50 and half aged under 60. Although

in the older AAD patient, atherosclerosis is the predominant underlying cause, in the younger patient connective tissue disease predominates. So, take home point, never use age as a reason to not consider AAD.

Now you might say, well AAD is rare, I'm just not going to see a case. Whilst it may not be as common as some other conditions such as acute myocardial infarction, AAD is not rare. In NHS Lothian between our two EDs, we see between about 15 patients a year with AAD, the commonest type being a type A dissection. Most of our ED consultants will see at least one case of AAD a year equating to around 30-40 during a career. Another statistic to put the condition into perspective is that 2,500 patients die within a month of being diagnosed with AAD, a number that's more than the number of people who die in the UK from road traffic accidents (1,800 per year), or from pulmonary embolism (PE) (2300 per year)[6]. This large cause of mortality is put into perspective when you think of the huge infrastructure we have for managing trauma, with developed pre-hospital systems and established major Trauma Centres.

So, what does the future hold. The Oxford Vascular study[6] tells us that UK cases of AAD are set to rise over the next 10 years to over 5,500 and if the trajectory remains the same, almost 3,500 people will lose their lives every year by 2050, mainly due to the population aging and AAD being more predominant in the 40-to-70-year age group.

So, let's now move onto pathophysiology, and firstly we're going to discuss the anatomy of the aorta. The aorta starts at the aortic root where the aortic valve is sited at the outflow track of the left ventricle and from where the coronary arteries originate. The aorta then continues as the ascending thoracic aorta up to the aortic arch where three main vessels originate, the combined right subclavian and right common carotid, followed by the left common carotid and finally the left subclavian artery. This vessel is especially important when we talk about the type of AAD, whether it is a type A or a type B, as this influences the patient's management once diagnosed. An AAD that involves the aortic root or the ascending aorta up to the left subclavian artery, is classified as a type A AAD and is managed surgically with cardiothoracic surgeons replacing the arch of the aorta. Any AAD originating after this is classified as a type B AAD and is managed medically with blood pressure lowering to allow the AAD to become chronic and to settle, normally under cardiology teams in a Coronary Care Unit (CCU) environment.

If we look at a cross-sectional slice through the aorta, we see that there are three main layers. The inner intima, the media, a reasonably thick layer compared to the others made up of more than 50 alternating layers of elastin and smooth muscle cells, and the outer adventitia layer. Essentially in AAD, you get a small tear in the intimal inner lining of the aorta which allows blood into the middle media area. Because the media is weaker than the other two walls, the blood, coming straight out of the heart and therefore under pressure, tracks up and down through the media separating the layers of the intima and the adventitia. The blood in the aortic media then pushes the dissection flap into the middle of the aorta, separating the true from the false lumen.

AAD is now commonly referred to as Acute Aortic Syndrome (AAS) which is made up of 4 conditions: Type A AAD, Type B AAD, intramural aortic haematoma and penetrating aortic ulcer. In intramural haematoma, blood leaks into the aortic media at low pressure, forming a thrombus that pushes the outer wall of the aorta outward, leaving a relatively normal appearing aortic lumen. A penetrating atherosclerotic ulcer allows blood to enter the aortic media, but atherosclerotic scarring of the aorta typically confines the blood collection, often resulting in a localised dissection or pseudoaneurysm.

AAS is a dynamic process, as the calibre of the true and the false lumens is very dependent on the pressure in both these lumens, and this pressure will determine whether the dissection flap moves more towards the true lumen or towards the false lumen. When blood moves into the false lumen, a few things can happen. Pressure building up in the false lumen, can lead to rupture, re-entry tear, branch vessel occlusion or true lumen collapse. If the false lumen blood ruptures out of the aorta through the adventitia layer, the result is a bloody pericardial effusion, mediastinal haematoma or haemothorax, all normally fatal conditions. It is thought that 7% of out of hospital cardiac arrests are due to Type A aortic dissection[7].

In a re-entry tear, the blood tracks back into the true aorta through a further tear in the intima, creating a double lumen channel meaning blood can go through either lumen and arrive back into the normal distal aorta. Branch vessel occlusion is essentially where the false lumen has blood within it which surrounds branches that come off the aorta. When there is a high enough pressure in the false lumen, it collapses the true lumen and restricts perfusion to the vessels coming off the aorta. This phenomenon explains why AAS can present with bizarre symptoms like stroke as branch vessel occlusion can temporarily occlude the left carotid artery for example, or you might find that there's a STEMI (ST elevation myocardial infarction) presentation because the left coronary artery is occluded. The patient may also present with limb ischemia, as in the case of the first patient we discussed, due to left subclavian artery occlusion. With AAS being a dynamic process, pressure changes between the true and the false lumens can lead to occlusion or reperfusion of different areas at different times. The pressure in the true and false lumen, and subsequent blood flow through these stabilises over a period of minutes, hours or at the most, a few days. Finally, in true lumen collapse, the pressure in the false lumen exceeds the pressure in the true lumen impeding distal perfusion in the true lumen resulting in distal organ ischemia.

At this point it is important to discuss the difference between AAS, and an abdominal aortic aneurysm (AAA) as they are very different pathologies, presenting in very different ways, with very different treatment. It is common for these two conditions to be confused in EDs with ED staff commonly discussing the process of doing bilateral blood pressures in both arms when they are considering an AAA. In AAS, where the patient has obliterated the true lumen to one arm (commonly the left), but not to the other (commonly the right), a different blood pressure in each upper limb may be recorded, or the clinician may not be able to feel a pulse on one side. An AAA is a slow growing dilatation of the aorta that happens over years. When the AAA gets to about five or six centimetres, the risk of it rupturing becomes significant, presenting with sudden onset abdominal or back pain with haemodynamic collapse secondary to blood leaking into the abdomen or tracking into the retroperitoneal space. AAA rupture in an area of aneurysmal dilatation, is very different to AAS. Patients who suffer AAS, whilst not having a normal aorta pathologically, do not commonly have an aortic aneurysm.

So now let's talk about the symptoms of AAS, which are consistent with the three main pathophysiological processes at play here. Firstly, dissection of the aortic wall is extremely painful. It's a sudden thing that happens in seconds, with the dissection peeling away the aortic media. The pain is sudden and intense but might settle once the dissecting process has stopped. It may be described as a ripping or tearing pain but not universally. Secondly, a contained rupture leading to pericardial effusion, mediastinal haematoma or haemothorax will cause intense physiological instability and perhaps breathlessness and/or hypotension. Finally, there are the end organ symptoms associated with malperfusion, such as STEMI and stroke mimics which may be transient, may recur and which may affect different organs.

So now we have discussed the pathophysiology of AAS, we are going to address why it is so difficult to diagnose. Chest pain is the commonest AAS presenting complaint (80%)[8]. Back (40%) and abdominal pain are not uncommon[8], but there are two million chest, back or abdominal

pain presentations to English EDs a year[9], overwhelmingly due to causes other than AAS. 1 in 980 ED patients with atraumatic chest pain[10] will have AAS but 979 will have other causes. This is important when we think about how we are going to diagnose AAS, because we can't arrange a CT aorta angiogram for everybody who has chest pain. The diagnosis of AAS in the ED is a low signal to high noise ratio problem with the weak signal of AAS being overwhelmed by the background noise of all the patients that we have presenting with complaints that could, but do not have AAS.

Research into the diagnosis of AAS in the ED is also problematic. One of the reasons we miss AAS, is because we don't always think about it. It has multiple presenting complaints, not just chest pain, and the Hawthorne effect means that when we start studying AAS, clinicians' practice changes. D-dimer and CT aorta angiogram are not tests we routinely do in everybody meaning observational research is difficult, and research consent processes risk not recruiting unwell patients.

NHS Lothian recently teamed up with Frimley Health NHS Foundation Trust to perform a retrospective review of missed AAS cases between 2011 and 2020 to better understand why we miss AAS. Morbidity and Mortality records were used to identify 43 cases (including postmortem reports and complaints), as well as reviewing results of CT scans requested by downstream inpatient teams querying AAS following discharge from ED with a different diagnosis. Electronic patient records were reviewed by two independent reviewers to establish the reason the diagnosis was missed[11]. Of 43 cases, 22 were type A, 9 were type B with the rest being intramural aortic haematoma, penetrating aortic ulcer or unknown underlying AAS pathology. Chest pain was the presenting complaint in 27 patients (63%), with 28 describing symptoms being of sudden onset. The three commonest alternative diagnoses made were acute coronary syndrome (ACS), pulmonary embolism (PE) and non-specific chest pain.

So why did we miss AAS? In most of the cases, AAS was missed because it was never considered in the differential diagnosis. In some of these cases, the clinician was satisfied by an alternative clinical diagnosis or happy that ACS was excluded. In other cases, AAS was clearly considered but not pursued further with imaging due to the clinician being inappropriately reassured by the absence of certain 'textbook' clinical symptoms and signs, by resolved symptoms, or by a normal chest radiograph (CXR).

Lovatt et al[1], reviewed 12 studies, including 1663 AAS patients with a misdiagnosis rate of 33.8%. Factors leading to the diagnosis being missed included the symptoms being attributed to other conditions, the reassurance of a normal CXR, patients having walked into the ED and the absence of 'typical' AAS symptoms such as tearing or ripping pain, differential upper limb blood pressures, a pulse deficit or acute hypertension. The lack of any of these features does not reliably rule out AAS. For example, if you think a patient has a 50% pre-test (pre-CT scan) chance of having AAS, if you do a CXR and it is totally normal, you only reduce the chance of the patient having AAS to 40%, which is still significant and not sufficient to be able to rule out AAS. So, is there anything that is helpful? Well abrupt onset pain as well as worst ever pain are much more associated with AAS and are a useful start. If a patient doesn't have abrupt onset pain it halves the likelihood that the patient in front of you has AAS, but unfortunately still doesn't rule it out. If someone has abrupt onset pain, we need to be investigating further. Worst ever pain, is AAS until proven otherwise.

The NHS Resolution report released in 2022[4], looked at clinical negligence fatality claims in English EDs. Of 86 claims worth a total of £5.8 million the most common causes of deaths were related to misdiagnosis of infection/sepsis, PE, suicide, ACS and AAS. The review identified poor awareness and poor recognition of the significance of the presenting symptoms along with evidence of lost opportunities to use information from the ambulance and triage notes. It is vital we improve our use of ambulance and triage notes which always contain helpful and useful information that may be lost in handover. The patient you have in front of you, may be very different to how they were maybe several hours previously when they had their initial symptoms.

I've painted a bleak picture here of how we diagnose, or fail to diagnose AAS in the ED, so how can we do better? There have been campaigns and great educational resources such as those by The Aortic Dissection Charitable Trust (TADCT). Think Aorta have also attempted to improve awareness of AAS in the ED. However, these have not led to improvements in mortality. Awareness is extremely important, and it is vital that we have campaigns like these, but they are not the only answer. A clinician survey of practice across the UK showed that only 12 of 56 EDs have a formal pathway for working up patients with potential AAS and no particular guideline predominated, probably due to none being particularly simple to use in the ED, and there being no robust evidence-based method of ruling out AAS[12].

The diagnostic challenge is that Aorta CT Angiogram (CTA) has high sensitivity and specificity to diagnose AAS. Locally in NHS Lothian we scan around 300 patients per year looking for AAS, and about 5-6% of these scans are positive for AAS. However, over testing leads to diagnostic yields as low as 2%[3,13], significant costs and resource implications, ionising radiation risks, CT delays for non-AAS patients and the burden of 'incidentalomas'. Clinicians therefore need to use CTA selectively, yet despite several being proposed, there is no validated clinical decision tool for this scenario,[14-16] and none that has been studied in undifferentiated ED populations. All clinical decision tools have low diagnostic yield for AAS, modest specificity and lead to higher rates of CTA. D-Dimer has been suggested as a rule-out biomarker in low pre-test probability patients[17-18] and is part of the ADD-RS clinical decision tool, but it is currently unclear whether any AAS clinical decision tools have sufficient sensitivity to be acceptable to clinicians, which is the most accurate, and whether AAS clinical decision tools are likely to lead to over-investigation with CTA and D-Dimer.

Even the best risk guidance or clinical decision tool is meaningless unless applied to the correct patients. Clinicians must understand which of the myriad of presentations could be the 'needle in a haystack' manifestation of AAS and any diagnostic work-up must be able to be applied to an all-comer population of patients with potential AAS symptoms. With these challenges in mind, our group has recently completed the DAShED study[19], aiming to describe the characteristics of ED attendances with possible AAS, and to assess clinical decision tools in our undifferentiated ED population with a view to informing future research in this area and hopefully help ED clinicians to make this most difficult and most terrifying of diagnoses.

## Summary

AAS is rare, devastating and often misdiagnosed, missed, or delayed in diagnosis, due to lack of consideration, lack of awareness, atypical presentations, mimics of other disease, clinicians being falsely reassured by a normal CXR, or lack of typical clinical signs. Its clinical features are highly unreliable but sudden and/or severe pain must always be taken seriously. AAS is a dynamic process and symptoms may come and go. We can improve things with better education, i.e., who to consider AAS in, and better detection strategies, i.e., once AAS is a consideration, how do you rule it out without investigating everyone with a CTA. The current focus[20-21] will hopefully do this and mean that fewer AAS patients suffer misdiagnosis, missed or delayed diagnosis in future.

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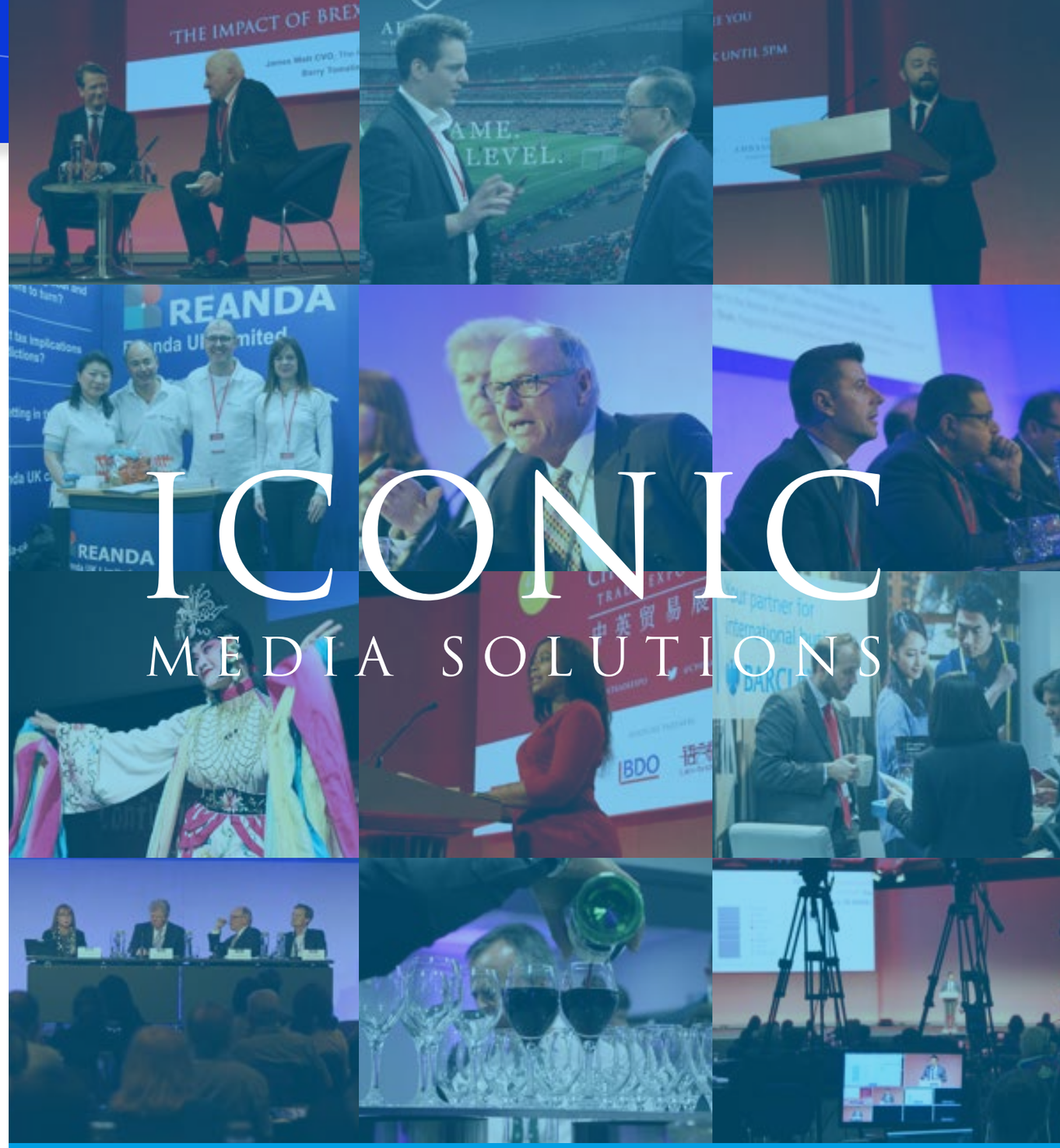

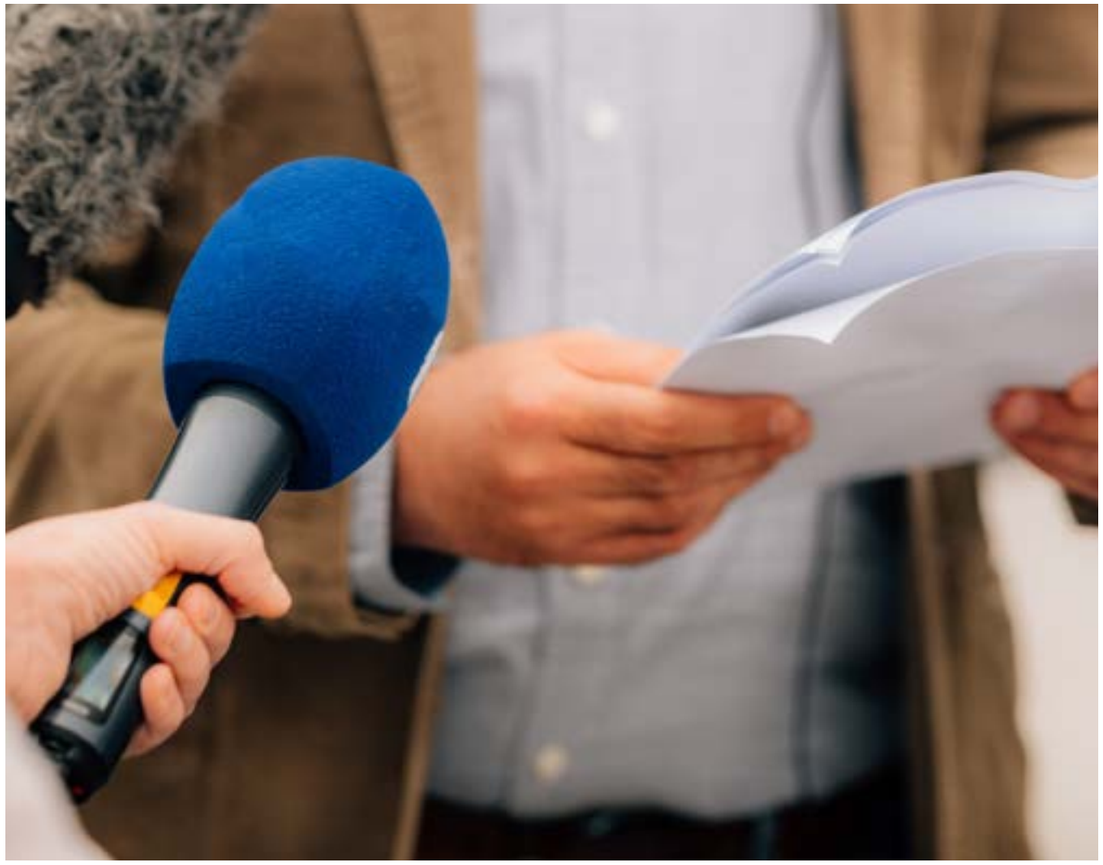

# WHISTLEBLOWING IN AN NHS IN CRISIS

**By Dr Megan Smith,** LLB, Barrister, MBBS, FRCA, Consultant Anaesthetist, Guy's and St Thomas's NHS Foundation Trust, Head of Law and Policy, EveryDoctorUK

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Whatever one's political allegiance, it is fairly common ground that the NHS is at breaking point; many of those who work in it would say it is already well and truly broken. In my view, and that of EveryDoctor (the NHS advocacy and campaign group that I work for part-time), it can be fixed; the how and the why is another article for another day, but we firmly believe that with the right political will and appropriate funding, maintaining the overwhelming mandate for a publicly funded, publicly provided, not for profit NHS is completely possible.

The NHS has suffered from the perfect storm of more than a decade of real terms underinvestment, Brexit, COVID and industrial disputes with the current government. These factors have seen the service understaffed to the tune of around 150,000 people, and has meant that 7.5 million patients now languish on waiting lists. Almost all other government-set targets are being missed; ambulance arrival times, A&E waiting times, cancer waiting times, the list goes on and on; and behind the numbers are those that are at the very core of what the NHS exists for, our patients.

When a system is allowed to fail like this, patients and patient safety are casualties. In the last couple of years reports of patients dying in the back of waiting ambulances and on trolleys in A&E have become all too familiar. In January this year the Norfolk coroner's office issued a Preventing Future Deaths Report to the government warning of the risk to patients' lives posed by the inability of ambulances to transfer patients from their vehicles to A&E departments for care. This must not be allowed to become normalised; on the basis that access to healthcare is a fundamental human right (something which both I and Everydoctor believe at our core), this is wrong anywhere in the world, but in a wealthy Western nation such as ours, it is an outrage.

Safety critical industries that take these matters seriously (think aviation, rail, oil and gas, nuclear power) actively encourage reporting of safety issues and take action to rectify and learn from problems. Cynics would say that they have to because its the company's reputation and bottom line at stake; there is some validity in this, but the counter argument is that whilst the NHS is a not for profit organisation, it is funded by the taxpayer who feels the bottom line in their pocket when they receive their payslip, as opposed to a company shareholder who feels it when this year's dividends are smaller than they hoped for. In any event, money should not be the driver for whether safety is taken seriously.

## Speaking up in the NHS

Sadly (and perhaps unsurprisingly given the political football that it represents) the NHS and its associated institutions have a chequered track record when it comes to the treatment of those flagging up concerns.

There is a clear pattern of treating whistleblowers badly in order, it would appear, to protect institutional (some might argue individual) reputations. Even when they adhere to internal procedures and policies, whistleblowers are frequently victimised and retaliated against.

A particularly notable case is that of Dr Chris Day, a junior doctor who raised concerns about patient safety incidents after two patient deaths in the Intensive Care Unit at Lewisham and Greenwich NHS Trust. Rather than address the concerns raised, the Trust dismissed him and Health Education England ("HEE") removed his national training number, effectively stymying his ability to complete his training. This has resulted in 8 years of litigation (which is still ongoing) and has cost the taxpayer over £1 million.

Rather than addressing the substantive patient safety issues, HEE ran the argument that it was not Dr Day's employer (nor that of 54,000 other junior doctors). Ultimately, the Court of Appeal disagreed with HEE and ruled that they were bound by legislation that confers protection on those raising concerns which I examine in more detail later in this article.

The merits of Dr Day's case are beyond the scope of this article, however it is illustrative of the fact that healthcare professionals who raise concerns are often adversely treated. This operates as a significant deterrent and there is clear evidence that when staff are fearful about adverse treatment and retribution they do not report, learning does not occur and patient safety remains compromised.

In another case from 2022, the senior management at a West Suffolk Hospital were strongly criticised for attempting to "hunt" a whistleblower who had raised patient safety concerns. Their behaviour went so far as to request handwriting samples and fingerprints from staff in order to identify who had raised the alarm. This type of intimidatory (and, almost certainly unlawful) behaviour is unconscionable and must not be tolerated. In any other safety critical industry this is simply unacceptable. The same should be true in the NHS.

It is vital that NHS staff feel empowered and safe to speak up when they feel that patient safety is

in jeopardy and, in the face of the aggressive and intimidatory type of behaviour described already, the protection that the law offers them is of paramount importance.

## EveryDoctor's whistleblowing platform

EveryDoctor is a campaign organisation that advocates for doctors, patients, other NHS staff and the NHS more generally. It is unashamedly an anti-NHS privatisation organisation. EveryDoctor is a not-for-profit company limited by guarantee rather than shares. The founding documents of the organisation prohibit the retention of a profit by any of the directors or employees of the company. Any surplus must be reinvested in the clearly stated, legally binding objects of the organisation.

Many healthcare professionals have approached Everydoctor in the last four years asking for advice, support and assistance in relation to safety concerns that they wished to raise. We have helped them on a case-by-case basis. Some of our recommendations have been to speak to an internal manager, others have involved advice to approach a "*prescribed person*" as defined by statute (see below). However, in some cases and for various reasons, the appropriate course of action is to raise the concerns with a non "*prescribed person*" external to their own organisation.

Rather than continue to deal with these cases on an "as and when" basis, and against the backdrop of the growing crisis in the NHS, EveryDoctor has established a secure whistleblowing platform that can be accessed by healthcare workers, patients and members of the public. Reports can be made anonymously or as a named individual.

The platform went live on 7th June 2023 and can be accessed here: https://www.everydoctor.org.uk/whistleblower-portal

We have partnered with the developers of a widely used, industry standard, secure software platform which forms the basis of the portal through which anyone can report.

Once made, the disclosure will be assessed by the EveryDoctor team and a plan for how to proceed will be made with the whistleblower. This may simply involve signposting them to their organisation's internal procedure and helping to guide them through that. Similarly, it may involve advising them about the appropriate *prescribed person* set out in law to whom they should disclose their concerns.

However, and as discussed already, in our experience, staff are sometimes reluctant to do this for fear of retribution and victimisation. EveryDoctor has extremely close links with skilled and experienced investigative journalists who have dealt with matters such as these for many, many years. They have helped government whistleblowers, public body whistleblowers, whistleblowers in the military and others to make their concerns known in the wider interest of the public. They fully understand the gravity of the potential consequences for whistleblowers and are skilled and highly experienced at dealing with these scenarios; we trust them and their exceptional professionalism implicitly.

## The legal framework

Most hospitals and community based institutions have internal "whistleblowing" policies and guidance. These tend to seek to summarise and echo the provisions of the Public Interest Disclosure Act 1998 ("PIDA") and the Employment Rights Act 1996 as amended by PIDA (the "ERA"). I will refer to the ERA for the rest of this article to mean that statute as amended by PIDA.

Broadly speaking, the ERA makes it unlawful to subject a worker to negative treatment or dismiss them because they have raised concerns; in law, the facts underpinning whistleblowing are referred to as '*protected disclosures*'.

In order to be protected, the following requirements of the ERA must be met:

- There must be a "qualifying disclosure" within the meaning of the ERA.
- The disclosure must be in the public interest.
- It must be made to an appropriate or prescribed person or body as defined by statute and case law.

## What is a qualifying disclosure?

In summary, in relation to healthcare, a *qualifying disclosure* means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following has happened/is happening/is likely to happen:

- A criminal offence.
- Failure to comply with any legal obligation.
- That the health or safety of any individual is in danger.
- That the environment is being damaged.
- Deliberate concealment of any of the foregoing.

## What is a reasonable belief?

The worker does not necessarily have to be correct about the concerns that they raise; it is sufficient if they have reasonable grounds to believe that the information that they disclose is substantially true and they honestly believe it to be true.

## What is in the public interest?

Again, the worker must reasonably believe that the disclosure that they are making is in the public interest. In healthcare this requirement is likely to be satisfied provided that the person making the disclosure is not simply seeking to resolve a personal grievance (e.g. in reality the complaint is about bullying or discrimination that affects only them rather than other members of the public).

## What or who is the correct body or person?

This will usually be the worker's employer (i.e. an internal "person"), however disclosure can be made to an external body or person in certain circumstances and the worker will still enjoy the protection of the ERA.

In most (though not all) cases, the external body or person must fall within a list of "prescribed persons" as set out in the statute.

The legislation adopts a 3-step approach; it is not mandatory to proceed stepwise through each of the 3 steps, however protection becomes harder (though not impossible) to attract if a whistleblower deviates from this sequence. The possibilities for disclosure are:

1. Internally - usually to a line manager.
2. Externally to a "*prescribed person*" as defined by legislation.
3. Externally to a non-prescribed person.

## Internal disclosure

This will usually be to the whistleblower's employer. Internal whistleblowing guidance ordinarily recommends disclosure to a line manager and, if the disclosure relates to the whistleblower's line manager, a more senior manager. Institutions usually have Freedom to Speak up Guardians who can also be approached.

## External disclosure to a *prescribed person*

The Secretary of State has set out the prescribed persons for healthcare purposes, the most relevant of which at the date of publication are:

- Care Quality Commission
- Healthwatch England
- National Guardian's Office
- General Medical Council
- Healthcare Improvement Scotland
- Health Education England
- NHS England
- Nursing and Midwifery Council
- Secretary of State for Health and Social Care
- Medicines Healthcare Products Regulatory Agency
- Health Inspectorate Wales

If a whistleblower reasonably believes that the information they are disclosing falls within the remit of the relevant prescribed person/regulator and they reasonably believe that the information disclosed is substantially true, then they are eligible for ERA protection.

Often whistleblowers will take this approach rather than approaching an internal manager because they are worried about retaliation by their employer, or because they (or a colleague) have already raised similar concerns and no action has been taken by their employer.

## External disclosure to a non-prescribed person

This is usually relevant where a whistleblower wishes to disclose information to the press, but it can include disclosure to any non-prescribed person, for example a union representative, relatives of a patient (see the West Suffolk case above), a regulatory body not included in the statutory list, etc. It is possible to do this and still benefit from ERA protection but the legal test is more stringent.

Cases of "wider disclosure" (as they are often called) require the whistleblower to satisfy various requirements. We will examine each in turn.

### *Truthfulness*

As already mentioned, the whistleblower must reasonably believe that the information being disclosed is substantially true. This does not mean that the information is actually true, rather that it is reasonable to believe that it is.

### *No personal gain*

The disclosure must not be made for personal gain; this means that in the case of disclosure to the media it must not be for payment or any other sort of benefit.

### *Precondition of victimisation, cover up, previously raised concerns and/or exceptional seriousness*

At least one of these preconditions must be met when disclosure is made to an external, non-prescribed person or body.

### Victimisation

The whistleblower must reasonably believe that they will be victimised by their employer if they disclose information to them or to a *prescribed person*. This is usually the case where others who have raised concerns have been adversely treated. Whilst the appropriate next step would be to disclose to a *prescribed person*, it may be that the employer has an unusually close relationship with them, or that the *prescribed person* has been notified previously, has failed to act, and the whistleblower reasonably fears that they will be victimised for making a disclosure to them as well.

### Cover up

No prescribed person exists and the whistleblower reasonably believes there is likely to be a cover-up of the information that they wish to disclose.

### Same information already disclosed

Where the same (or substantially the same) information has previously been shared with the employer or a *prescribed person* (and usually no action has been taken, though this is not a specific requirement) then a whistleblower can disclose the information in this way.

### Exceptionally serious in nature

In healthcare terms this is usually likely to be because the information relates to a situation where a patient has already suffered harm or is likely to suffer harm and the disclosure is made in an attempt to prevent this.

## Conclusions

There is no doubt that the crisis that the NHS currently faces is having an adverse effect on patient care and patient safety.

There is relatively little that clinical staff can do to address what is a politically driven systemic problem. One of the steps they can take, however, is to speak up when they see that patients are suffering. No healthcare worker should ever be mistreated or victimised for doing so.

At present, in part due to political ideology, in part due to crippling funding constraints and in part due to the desire of those in higher positions in the NHS nationally, regionally and locally to protect their/their organisation's/the government's reputation, being a whistleblower in the NHS is a potentially risky business. Both I and Everydoctor would encourage any healthcare professional or patient who is concerned about safety to contact us via the whistleblowing portal, safe in the knowledge that we will deal with the issues raised in their best interests, always in line with their wishes and fully in accordance with the law.

# CONFIDENTIALITY & CONSENT: WHAT IS EXPECTED, AND WHEN IS IT SAFE TO OVERRIDE THEM?

**By Stephen Hooper,** Senior Associate, Clyde & Co LLP, London - Stephen.Hooper@clydeco.com

Patient consent and confidentiality are at the heart of every clinician's day-to-day practice. The opening paragraph of the GMC's guidance document, Decision Making and Consent[1], sums up their importance: "Consent is a fundamental legal and ethical principle. All patients have the right to be involved in decisions about their treatment and care and to make informed decisions if they can. The exchange of information between doctor and patient is essential to good decision making. Serious harm can result if patients are not listened to, or if they are not given the information they need - and time and support to understand it - so they can make informed decisions about their care."

In many situations, these concepts, well-known to all clinicians (not least following the well-known *Montgomery* judgment[2] in 2015), are easy enough to abide by, at least in principle. All clinicians will do their utmost to respect their patients' wishes, their right to self-determination about the care they receive, and the life decisions they make. But what about the occasions where the lines are blurred and a patient's right to make their own decisions puts them, or others, at risk of harm or suicide? When is it acceptable to override patient confidentiality or consent, in the best interest of the patient or others? It is worth reviewing the key legal principles, in order to try and navigate what can be difficult issues.

## Issue 1: Does the Patient Have Capacity?

This will often be the determining factor in deciding what to do (or indeed not do). Section 1(2) of the Mental Capacity Act[3] 2005 (MCA) states that all people over the age of 16 must be assumed to have capacity, unless it is established that they lack it. Capacity is time and decision specific, meaning that even a person who lacks capacity for certain matters, might still have capacity for the particular issue under consideration. Someone might be incapable of managing their financial affairs, but nevertheless be able to make their own decision about whether to undergo surgery or not. Capacity can also fluctuate, so it would be wrong to assume that just because a patient lacks capacity today, they will lack it tomorrow.

A person is not to be treated as lacking capacity because of a lack of intelligence or a disability which renders them unable to process information as quickly or thoroughly as the average patient. The expectation is that the clinician will exhaust all practicable steps in helping the patient to make their own decision (for example by arranging for an interpreter, Speech & Language Therapist or Advocate to assist), before determining that they lack capacity (s.1(3) MCA).

Of crucial importance, a patient is not to be deemed to lack capacity just because they make what might objectively be seen as poor life choices (s.1(4) MCA). That means there will be occasions where a clinician is confronted with a patient who has decided not to eat, not to take their medication or even to take their own life, and that decision has to be respected.

A person is 'unable to make a decision for himself' if he is unable to (a) understand the information relevant to the decision; (b) retain that information; (c) use or weigh that information as part of the process of making the decision; or (d) communicate his decision whether by talking, using sign language or any other means (s.3(1)). An inability to undertake any one of these four aspects will be sufficient to deem the patient to lack capacity, provided the inability is because of the impairment/disturbance of the mind.

Whatever the outcome of the assessment, clinicians should ensure that it has been thoroughly considered and that it is clearly documented in the patient records. A simple note of "the patient lacks capacity", with no explanation as to how that decision has been arrived at, is unlikely to stand up to scrutiny, particularly if judicial intervention (for example, via an application to the Court of Protection) is made.





## Issue 2: Imposing Treatment on a Patient Who is Unable to Consent

If a patient is deemed to lack capacity, where appropriate and necessary, treatment can be imposed without their consent. This will typically apply in one of two circumstances:

1. They lack capacity under the Mental Capacity Act 2005; or
2. They are detained under the Mental Health Act 1983 and the treatment falls within the terms of s.63 or s.58 of that Act;

A Deprivation of Liberty Order (DOL) might also be required, for example where the patient needs to be kept in a particular care home or hospital against their will, or regularly restrained for the purposes of administering treatment.

If a patient who lacks capacity is in hospital, Section 63 of the Mental Health Act allows for treatment to be provided in the patient's best interests, where consent is not required " *for any medical treatment* ***given to him for the mental disorder from which he is suffering****…if the treatment is given by or under the direction of the approved clinician in charge of the treatment".* The key is that the treatment administered must be required as a result of the mental disorder which robs the patient of their capacity. For example, a patient who refuses to eat because they have a mental health disorder which impairs their mind and compels them to refuse food, might justifiably be fed against their will, via a nasogastric tube. That principle is set out in Section 145(4) MHA, where "medical treatment" is *"a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations."* The key principle underpinning all of this is that the treatment administered must be in the patient's best interests.

## Issue 3: the Patient Who Has Capacity, But Makes Poor Choices

This can be the most distressing and complex of circumstances for any clinician to face. The malnourished teenager who refuses to eat; the diabetic man who repeatedly fails to take his insulin injections; the bed-bound resident with chronic psoriasis in the care home, who refuses to allow the staff to move him in order to tend to his bed sores; the patient with Emotionally Unstable Personality Disorder who expresses repeated suicidal thoughts, but refuses to engage in counselling or take her medication. Clinicians may find themselves in a situation where they offer advice or treatment, see it refused and are unable to do anything about it, other than signpost the patient to the support services available, and hope that they choose to avail themselves of those services. The patient's right to confidentiality also means that, unless the clinician has the patient's consent to share the information, they might not be in a position to disclose their concerns to someone who might help, for example another clinician or a relative.

Are there situations where a patient's right to consent and confidentiality can be overridden? The answer is yes, but only in rare circumstances. The GMC's guidance document, Confidentiality: Good Practice in Handling Patient Information[4], advises that it may be permissible to breach patient confidentiality where it is "balanced against duties to protect and promote the health and welfare of patients who may be unable to protect themselves" (paragraph 50). The emphasis in such cases is often on the potential harm to others, rather than the patient whose information is to be disclosed, for example where there are child protection issues (paragraph 51). There may be occasions where the disclosure is required by law, for example if the patient in question is known or considered to be at risk of abuse or neglect (paragraph 53); or where the clinician receives information which raises concerns about the potential spread of infectious diseases, or acts of terrorism (paragraph 61). In such circumstances, the clinician must:

1. be satisfied that the disclosure is indeed required by law;
2. only disclose information relevant to the request or legal requirement; and
3. tell the patient about the proposed disclosure wherever possible, unless doing so would undermine the purpose of the disclosure.

What about the patient who has capacity, discloses a real risk of harm, or even suicide, to a clinician, but denies permission for that information to be shared? The guiding principle is that that patient's confidentiality and capacity to consent should be respected. The GMC advises clinicians to explore the reason for the patient refusing consent, encourage them to consent and warn them of the risks of not doing so, but ultimately concludes: "You should, however, usually abide by the patient's refusal to consent to disclosure, even if

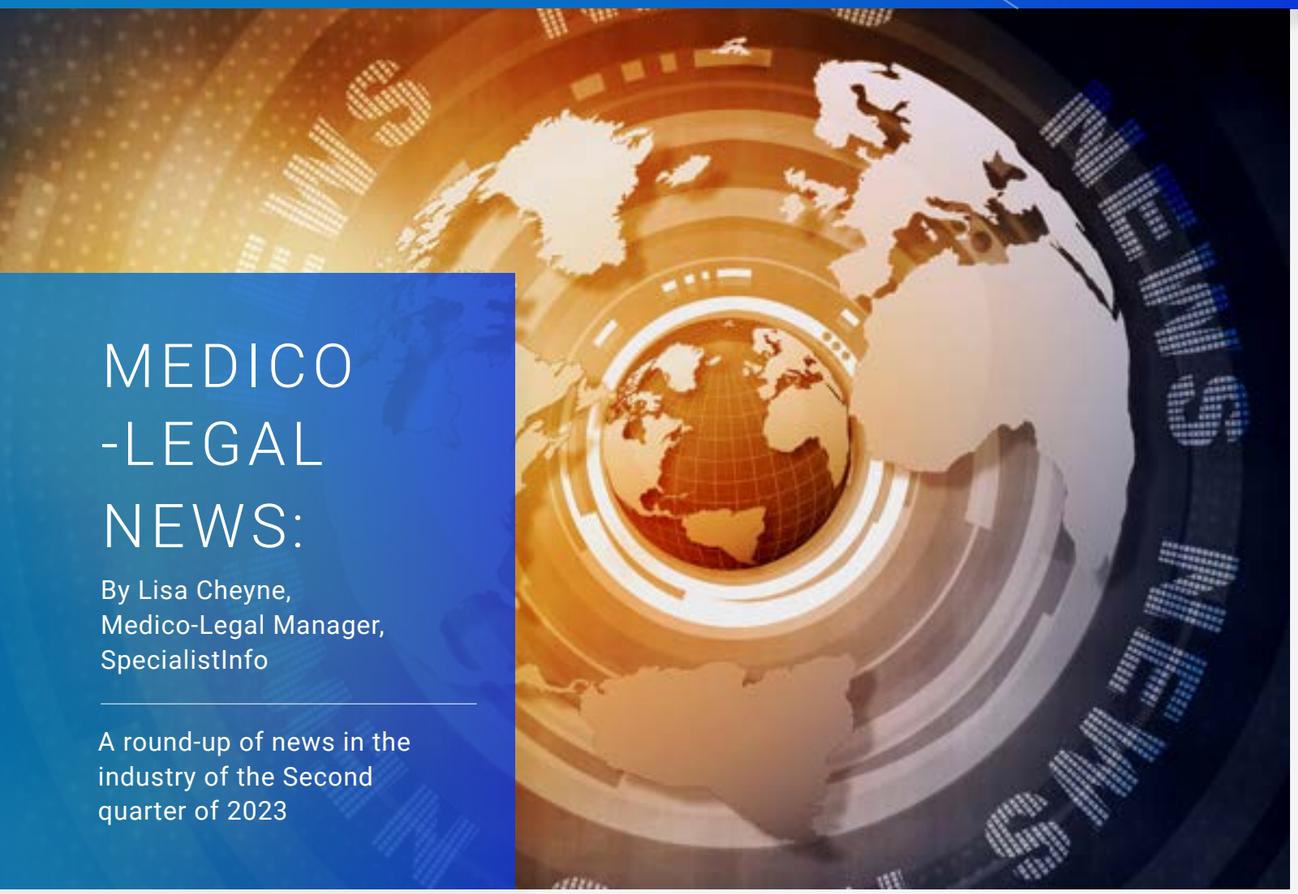
their decision leaves them (but no one else) at risk of death or serious harm. You should do your best to give the patient the information and support they need to make decisions in their own interests – for example, by arranging contact with agencies to support people who experience domestic violence. Adults who initially refuse offers of assistance may change their decision over time".

Practitioners may therefore find themselves in a position where a patient has advised them that they are contemplating suicide or self-harm, but because they have capacity and have told the clinician neither to act on nor disclose those matters, the clinician can do nothing to intervene, beyond offering and signposting appropriate support. In August 2021, a consensus statement was issued on Information Sharing and Suicide Prevention[5], pooling the combined views of multiple bodies including the Royal College of Psychiatrists and Royal College of General Practitioners. The consensus view is that confidentiality must be respected, save for exceptional circumstances such as where there is a "substantial public interest" in sharing data concerning the suicide risk of an individual, or in an emergency situation where "it might be more harmful not to share data than to share it". Such a situation may arise where there is an immediate risk of serious harm or death to the individual concerned, or to someone else. In such circumstances, "[t]he immediacy of the suicide risk will be affected by the degree of planning a person has done, the type of suicide method planned or already attempted, and circumstances such as being left alone, refusing treatment, drinking heavily or drug use". There may be circumstances where the very fact that a person has expressed suicidal planning might cast doubt over their capacity at that moment, but this will need to be a thoroughly considered, well-documented clinical judgement made on a case-by-case basis, and only the minimum amount of information relevant to mitigate the risk should be disclosed. This may mean that where a patient with a history of self-harm or suicide attempts, expresses thoughts of possibly taking their life at an unspecified time in the future, without indicating any clear plans as to how they will do so and with a clear instruction that the information should be kept private, the clinician may be powerless to do anything other than offer advice, assurance and appropriate support. It will then be for the patient to decide whether to avail themselves of that, and for the clinician to hope that they do.

Issues of consent and confidentiality can be thorny, problematic, and at times quite distressing for practitioners to deal with. At times, the answer will be obvious and straightforward, but there will be occasions where complicated, and sometimes life-or-death decisions will be difficult to make. Look at each situation individually, and if in doubt, seek advice, be that from colleagues, defence organisations or a lawyer, to ensure you put yourself in the best possible position to navigate what can be a professional minefield.

**References:**

[1] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent/about-this-guidance
[2] https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf
[3] https://www.legislation.gov.uk/ukpga/2005/9/contents
[4] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality
[5] https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention



# MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry of the Second quarter of 2023

NEWS

## Rowbottom v The Estate of Peter Howard, Deceased & Anor [2023] EWHC 931 (KB), A Case with Expert Witness Bias

A sad case of a serious RTA between a car and a motorcycle where both drivers claimed that the other was on the wrong side of the road.

An excellent case summary can be accessed via the link below from Gordon Exall, at Civil Litigation Brief, involving an expert wrongly favouring evidence that supports "his" claimant, when the first rule of giving expert evidence is one's duty to the Court.

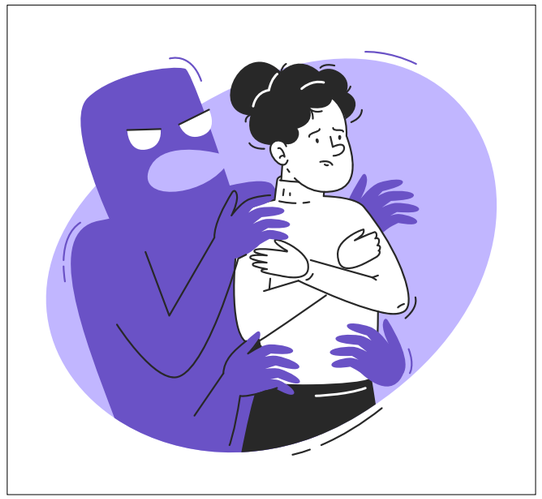
HHL Sephton KC (sitting as a High Court Judge) was critical of the role of one of the experts in the case:

"A second reason why I do not feel able to rely upon Mr Green is that he did not appear to me to understand the obligation of an expert fairly to deal with all the evidence and not simply to address the points that support his hypothesis. Mr Hunter's criticism is fair that Mr Green was happy to emphasise the witness evidence that supported his theory whilst remaining silent about those witnesses whose evidence did not."

Read more: https://www.civillitigationbrief.com/2023/04/26/beware-of-over-eager-experts-an-expert-that-simply-addresses-the-points-that-supports-their-hypothesis-is-heading-for-trouble/







## An MPS Survey Finds up to a Third of Doctors Experience Suicidal Thoughts During GMC Investigation

The Medical Protection Society (MPS) sent a survey to over 900 doctors who had been investigated by the GMC in the past five years and of the 197 who responded nearly a third (31%, 61) admitted they had suicidal thoughts during their GMC investigation.

Most of those who responded said the investigation caused them stress and anxiety, and found the process negatively impacted their mental health, citing the length of the investigation and the tone of communications from the GMC as major factors.

Dr Rob Hendry, Medical Director at Medical Protection, said: "We understand the GMC exists to protect the public, and must investigate serious complaints. But there is no reason why it cannot operate and communicate with doctors under investigation with more compassion. Finding out your fitness to practise is being called into question can be devastating, and it is easy to see how quickly a doctor's mental health could deteriorate if they feel they are considered 'guilty' from the outset.

"The GMC has made many improvements to its initial communication with doctors, but more is needed. For example, the first letter to a doctor could alleviate some anxiety by setting out the GMC's legal requirement to investigate all complaints and its policy for dealing with any malicious complaints – which are a huge source of stress for doctors and can take months to resolve.

"Above all else however, the Government and the GMC must ensure fewer doctors are dragged through this extremely stressful process unnecessarily. For the Government this means progressing GMC reform with urgency to give the regulator more discretion to not take forward investigations where allegations clearly do not require action.

"Reform should also reduce the number of doctors who are pursued by the GMC on the vague and ill-defined basis that action will 'protect public confidence in the profession', when investigations should surely be focussed on doctors who potentially pose a risk to patient safety."

SpecialistInfo are launching a new training course in July 2023, which should be helpful for doctors worried about being the subject of a GMC investigation: **A Risk Management Toolkit for Medical Professionals**, with course leader, Caroline Bennett, former Head of Regional and International Claims at the MPS:

*"With the right toolkit you will be better placed to prevent the occurrence of an adverse event, but if one should occur you will also be better equipped to minimise the chance of a claim ensuing or, if it does, manage yourself through the process to achieve the best outcome. Forewarned is forearmed!"*

More information and booking page here: https://www.specialistinfo.com/ml-risk-management-toolkit

Read more: https://www.medicalprotection.org/uk/media-policy/campaigns/gmc-investigations

## Extending Fixed Recoverable Costs

The amending Statutory Instrument for FRCs will be laid before Parliament, following ministerial approval, in late May 2023. It reflects the draft changes to the Civil Procedure Rules (CPR) agreed by the Civil Procedure Rule Committee (CPRC) on 31 March 2023. The draft changes to the CPR and related practice

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directions, have been approved by the CPRC, but the rules have not yet been made nor approved by MoJ ministers.

The MoJ has confirmed that the rules will state that clinical negligence claims must be allocated to the multi-track, and so excluded from FRC, except where the claim is one which would normally be allocated to the intermediate track and breach of duty and causation have been admitted.

In summary, From 1 October 2023, FRC will be extended across the fast track, and in a new intermediate track for simpler cases valued up to £100,000 damages.
The following case types will be allocated to the multi-track rather than the new intermediate track, and will thereby be excluded from FRC:

- A mesothelioma claim or asbestos lung disease claim;
- One which includes a claim for clinical negligence, unless both breach of duty and causation have been admitted;
- A claim for damages in relation to harm, abuse or neglect of or by children or vulnerable adults;
- [Claims against the police involving an intentional or reckless tort, or relief or remedy in relation to the Human Rights Act 1998. This exclusion does not apply to a road accident claim arising from negligent police driving, an employer's liability claim, or any claim for an accidental fall on police premises.]

The Government's proposals on introducing FRC for clinical negligence cases up to £25,000 has being taken forward separately by the Department of Health and Social Care (DHSC) and are not being introduced as part of this package of reforms. The Law Society have raised concerns about the possible capping of expert fees at £1,200: this could prevent high-quality evidence being collected, and a single joint expert giving evidence for both parties: this could be unfair to one side.

At the time of going to press, this information was still a draft version of one that will be published when the amending Statutory Instrument is laid before Parliament, following ministerial approval, in May 2023.

Read more: https://www.legislation.gov.uk/uksi/2023/572/pdfs/uksi_20230572_en.pdf

and https://www.justice.gov.uk/__data/assets/pdf_file/0003/177645/cpr-156-pd-making.pdf

## Do Not Resuscitate (DNR) and Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) Order Misuse

A 2021 investigation by the care watchdog, the Care Quality Commission, found there may have been more than 500 breaches of individual human rights due to the misuse of DNR decisions.

The decisions are not legally binding, but they can be appropriate if a person is unlikely to withstand the resuscitation procedure. Crucially, the order should only be activated after they've consulted with the patient, or their family.

An Essex University study suggests potential confusion around orders. In a small study of 262 care professionals, most of whom had responsibility for applying the 2005 Mental Capacity Act, researchers found:

17% said they'd seen instances of DNACPR decisions informing care and treatment decisions beyond their intended use;

28% said they'd seen DNACPR forms added to medical notes due to blanket decisions, such as the age of a resident;

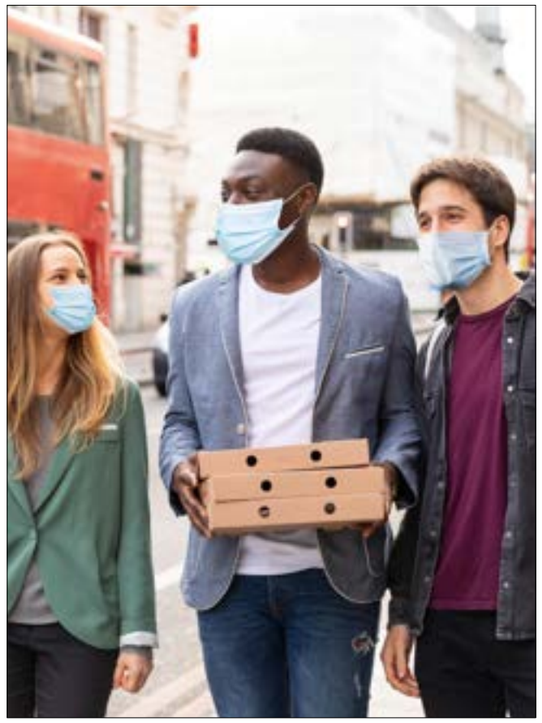
55% reported witnessing decisions being made without consultation with the resident or their family.
Prof Wayne Martin, who led the research said:

"That's what we call mission creep – it's not what these forms were designed for. It's really a violation of both law and people's rights to care.

"They look like they're an order, when they're not legally binding."

Researchers are calling for better training for medical and care professionals, as well as new standardised documentation, based on consultation, a person's individual circumstances, and a clear understanding of the law.

Read more:
https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcad078/7160963?login=false



## NHS Response to COVID-19: Stepping down from NHS Level 3 Incident

NHS England reported on 18 May that significant changes on covid reporting are coming at the end of June.

Amanda Pritchard, NHS Chief Executive, announced that the following will change:

COVID-19 Patient Notification System (CPNS) will no longer be collecting data where an individual has died from COVID-19. COVID-19 deaths will be recorded using the death certification process, which is the same as other infectious diseases.

The acute COVID-19 data collection process will be stood down with a subset of data incorporated into the existing UEC data collection.

The outbreak reporting process will be changing (details TBC).

The National and Regional Operations Centres will continue to operate, but with reduced hours of operation. She added:

"Stepping down the incident is of course done in the knowledge that COVID-19 as a health issue itself, as well as the wider long-term impact of the pandemic, will continue to be significant for years to come. New waves and novel variants will continue to impact on patient numbers, as well as staff absences, and we will also need to continue to provide services for those suffering the effects of 'long COVID'."

Read more: https://www.england.nhs.uk/long-read/nhs-response-to-covid-19-stepping-down-from-nhs-level-3-incident/

## Lawyers Advised not to Get Involved in Expert Joint Statements

A new edition of the King's Bench Division Guide published in May contains a new paragraph relating to the instruction of experts:

"Whilst the parties' legal advisers may assist in identifying issues which the joint statement should address, those legal advisers must not be involved in either negotiating or drafting the experts' joint statement. Legal advisers should only invite the experts to consider amending any draft joint statement in exceptional circumstances where there are serious concerns that the court may misunderstand or be misled by the terms of that joint statement. Any such concern should be raised with all experts involved in the joint statement."

This confirms what expert witnesses should already know, that their duty is to the court and their instructing law firm or agency must not influence their evidence in any way.

Read more: https://www.judiciary.uk/guidance-and-resources/the-ninth-edition-of-the-kings-bench-guide-is-now-available/

## Khan -v- Aviva Insurance Ltd (2022): Travel Anxiety Question (Issue 22 Medico-Legal Magazine)

A reader asks, after the Medico-legal News article in the last issue on claim layering, Khan v Aviva (Issue 22 medico-legal magazine), "in the link to the judge's opinion was the statement that as travel anxiety was not a recognised psychological condition that there was no need for a psychological report. I have been under the mistaken belief that significant travel anxiety did warrant a psychological report as it 'was outside my area of expertise'. I suspect that many of my medico-legal colleagues have thought the same. So, is there some legal authority to clarify this that I can quote apart from Khan v Aviva or is this enough?"

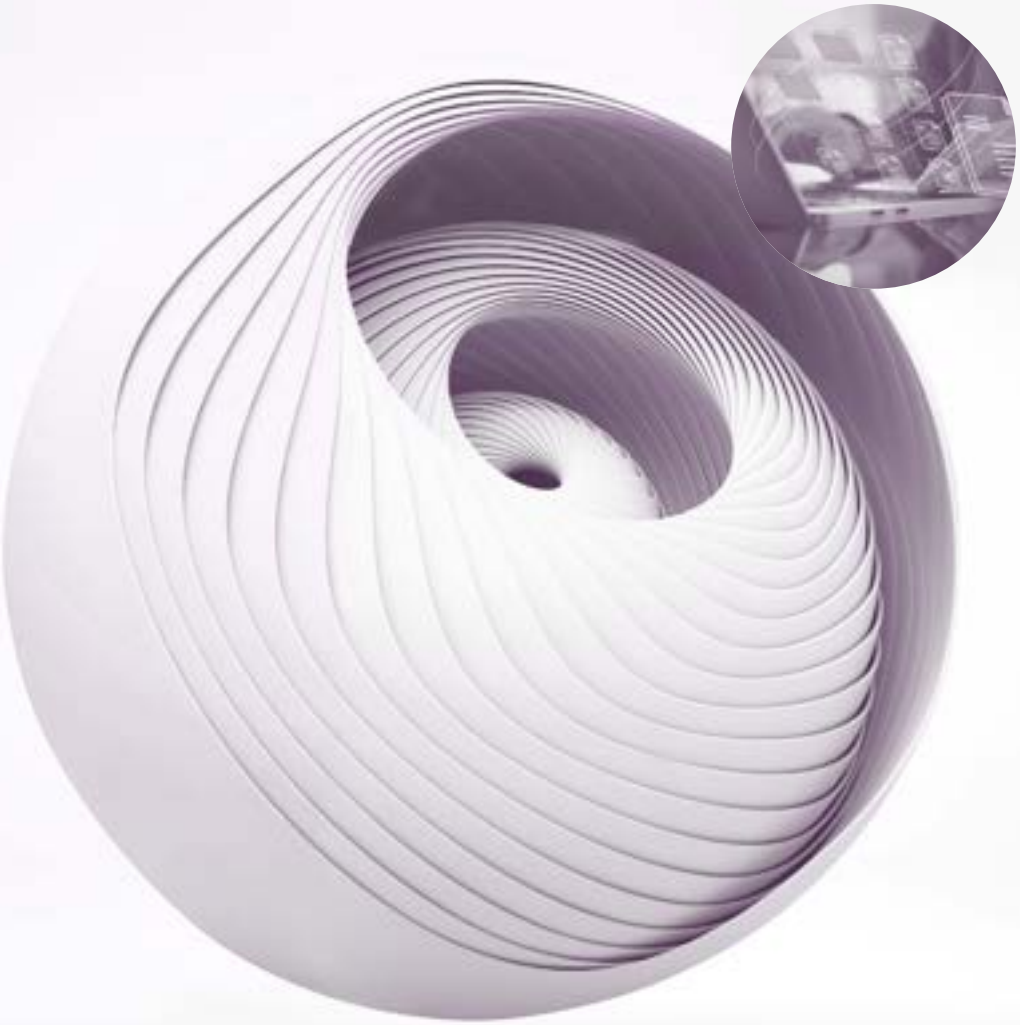
### Andrea Barnes, Barrister and SpecialistInfo Medico-legal course leader replies:

Experts should not be overly concerned with this judgment. CPR rule 35 makes it clear an expert should highlight symptoms or history they are told which falls outside of their expertise, which he has done as an orthopaedic expert being told of potential psychological/psychiatric symptoms. He will not know whether they amount to a recognised psychological/psychiatric injury; travel anxiety or otherwise. His duty to is to assist the court and he should therefore flag up any issue he cannot answer within his field of expertise. We recommend all he needs to do is state:

*"X tells me they have experienced the following xxxx symptoms following the incident. These appear to be psychological/psychiatric in nature and fall outside my area of expertise. [Note - if you are told by the Claimant they are having a serious/significant impact on their lifestyle you may wish to add X tells me that these symptoms are impacting on their day to day activities]. I leave it those instructing me to consider whether the symptoms reported require psychological/psychiatric assessment."*

It may slightly more complicated if he has been asked to consider an organic cause for an orthopaedic injury which he believes is actually psychological/ psychiatric in nature or has an underlying/overlapping psychological/ psychiatric element. In that case he should clearly state this and state that he would defer to a psychological/psychiatric opinion on this point.
If you are an expert witness interested in foundation or advanced training with Andrea and her colleagues from Normanton Chambers, then please take a look at our training calendar:

https://www.specialistinfo.com/course-calendar-2023



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