MEDICO LEGAL

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Welcome to the Medico-Legal Magazine

Welcome to Issue 28 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This first issue of 2025 contains the following articles:
Prof Graeme Poston, Emeritus Professor of Surgery, shares his experience of attending court as an expert witness over several decades; and

Frances Fraser, Midwife and Expert Witness, describes how she entered the medico-legal world; and

James Gould and Shoshana Mitchell, Barristers and Mediators at Normanton Chambers, summarise a recent case of negligence in sport; and

Dr Edoardo Cervoni and Miss Francesca Cervoni, GP and Law Student, discuss the recent assisted dying debate from the perspective of a physician and the law: and finally

Hannah Cheesebrough, Regulatory, Crime & Professional Solicitor, Hempsons, advises medical professionals when they should tell their regulator about being involved in a criminal investigation.

In our Expert Witness Directory we showcase more featured experts, who are available for instruction now.

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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- **Jonathan Dingle** – Barrister and Specialist Personal Injury & Clinical Negligence Mediator (Head of Chambers at Normanton Chambers)
- **Andrea Barnes** - Specialist Personal Injury & Clinical Negligence Mediator (Normanton Chambers)

Please be aware: *Rules for expert evidence have changed since 2020 and it is recommended that all experts book an updating session to ensure they are compliant.*

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THE COURTROOM EXPERIENCE – ADVICE FOR EXPERT WITNESSES

By Professor Graeme Poston, Emeritus Professor of Surgery, Liverpool

Professor Poston has maintained an active medico-legal practice since 1995, initially working in the field of personal injury, but more recently predominantly in the field of clinical negligence. He has provided over 800 reports to the Court dealing with issues of liability, causation, condition and prognosis on cases of alleged clinical negligence. His areas of expertise in these cases include abdominal surgery, surgical gastroenterology and in particular the surgery of the liver, gallbladder and bile ducts, the acute abdomen, hernia surgery, and lastly loss-of-chance in cases of missed cancer diagnosis. His personal injury cases relate to soft tissue injuries and post-traumatic hernia.

In giving evidence as an expert witness, although thankfully infrequent, you must be prepared to present your evidence under oath to the Court and be cross-examined on your opinions. Such hearings include those to the civil courts, the criminal courts, the coroners' courts, the General Medical Council, and increasingly since the pandemic, giving evidence virtually by video link. When starting a medico-legal practice, in addition to attending courses on report writing, it is absolutely essential to attend courses on presenting your evidence in court under mock cross examination before your peers. Even experienced medico legal experts should periodically attend update courses on report writing and courtroom skills as the law not infrequently changes.

CIVIL COURT

If a civil claim proceeds to litigation, then it is possible if you and your opposite number cannot agree your opinions that it might end up in Court. It is possible that the claim is of such low value that the parties might agree a commercially based settlement without accepting liability, in order to avoid prohibitive courtroom legal fees. However, as litigation proceeds and the possibility of going to Court increases then about 12 months before the potential trial, you will be asked to provide your dates of non-availability (with good explanations) within a 2–3-month trial window.

Once the availability of all essential parties is agreed then the Court will establish the trial dates (usually over 3-5 days for a clinical negligence claim) and you will then receive a witness summons. Failure to heed this summons will result in criminal charges of contempt of court. You must clear your diary for the trial dates, take unpaid leave since if the trial proceeds, then you will be paid your agreed daily rate (+/-VAT) for attending court (and make sure your pre-trial cancellation terms are clearly stated when you take initial instruction, including cancellation fees 8-14 days pre-trial and cancellation fees 1-7 days pre-trial). If after the preparation of the experts' Joint Statements, there are still significant differences between you and your opposite number then the claim is likely to proceed to trial and you will need to attend a pre-trial conference with Counsel. You can and may have to attend the whole trial, which in clinical negligence cases are usually in public.

At trial, make sure that you have fully familiarised yourself with the paginated trial bundle containing all the witness statements, expert reports, references contained within the reports, Particulars of Claim and the Defence. These bundles usually involve several A4 lever arch files to which each party will have access, as will the judge, and a further bundle will be beside you in the witness box.

Either take the appropriate oath or affirm, and when giving evidence, address the judge, not the barrister examining you. Give your evidence very slowly, as the judge will either be writing it down long-hand or typing it as you speak, and address the judge as 'Judge'. When examined, give short answers, not long rambling responses. Don't get into arguments with the opposing barrister. Remember, you are there to give an independent expert opinion to the Court, not as an advocate for your instructing party (that is Counsel's job). When taking a break while giving evidence (lunch or overnight) you must not discuss your evidence with anyone at all, including instructing lawyers, family or friends.

Remember, it is opposing Counsel's job to try and catch you out and they will structure their questions around your written evidence in such a way as they will expect single one-word answers of yes or no. if you disagree with the opposing Counsel then be prepared to explain your position directly to the judge, not Counsel.

There are a number of pitfalls that Counsel might set at the start of your evidence in order to damage your credibility to the Court. The first relates to Part 35 of the CPR, to which you will have stated at the end of your Part 35 compliant disclosed report that you understand the duty that you owe to the Court, that you have complied with that duty, and will continue to comply with that duty. You are aware of the requirement of the CPR Part 35, Practice Direction Part 35, the Practice Direction on Pre-Action Conduct and the Protocol for the instruction of Experts to give evidence in Civil Claims. Therefore, it is not unreasonable for Counsel to preface your cross-examination by asking you to explain your understanding of Part 35 of the CPR to the Court, so make sure that you have read it immediately before giving your evidence.

Furthermore, you will have signed your Statement of Truth that you confirm that you have made clear which facts and matters referred to in this report are within your own knowledge and which are not. Those that are within your own knowledge you confirm to be true. The opinions you have expressed represent your true and complete professional opinions on the matters to which they refer. You understand that proceedings for contempt of Court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Lastly, regarding civil clinical negligence trials in England and Wales, make sure that you are fully conversant with the Bolam test, Bolitho test and the Montgomery Ruling of the Supreme Court, since again, these are questions that opposing counsel can legitimately test your understanding. Similarly, if giving evidence in a Scottish Court then make sure you understand the principles of Hunter versus Hanley and likewise in an Irish Court, the Dunne Principles.

CRIMINAL COURT

You may be attending the criminal court either as a witness to fact or as an expert witness. As with civil hearings, criminal court proceedings are usually (but not necessarily) in public. As with a civil trial, having affirmed or taken the appropriate oath, give your evidence slowly to the judge, not the examining barrister or the jury. You may or may not be cross examined, but as with civil cases, you are there as a witness, not an advocate for either side. As with civil trials, you may be called or recalled at any point during the trial, which unlike civil clinical negligence trials can last many weeks, so don't book any holidays during the anticipated trial dates.

CORONERS COURT

As with civil trials, hearings are heard in public. Again, as with civil and criminal hearings, you will be giving your evidence under oath and give your evidence slowly. This hearing may be about a deceased patient who was under your care, in which case you might be well-advised to have legal representation (provided either by your NHS employer or your medical defence organisation). On the other hand, if you are giving expert evidence to the coroner then you do not need your own legal representation. In any event, the family of the Deceased might have legal representation by either a solicitor and/or a barrister who may examine you under oath. You are there to advise the coroner in reaching a verdict on the cause of death. You can be critical of the treatment received by the Deceased, but you are not there to opine on issues of breach of duty and/or causation. Furthermore, remember that coroner's budgets are limited, so don't overcharge!

THE GENERAL MEDICAL COUNCIL

The GMC's Medical Practitioners Tribunal Service (MPTS) is based in Manchester and runs all medical practitioner tribunal hearings for doctors registered in the UK. Many hearings are heard virtually, and most are heard in public. When instructing you to give evidence, the MPTS will take your availability into account when scheduling the hearing, usually 4-5 weeks before the hearing is due to be held. The MPTS will usually ask you to keep several days free until they know the exact date and time of your attendance, so if you are employed by the NHS then arrange appropriate leave and cover. If it is a face-to-face hearing then on arrival at the MTPS reception, you will be taken to the main witness waiting area where you will meet the GMC's instructed barrister. Remember, the doctor under investigation may also be seated in this area. Do not discuss your evidence with anyone else seated in the waiting area. You will be giving your evidence to 12 members of the GMC's MPTS, usually 6 doctors and 6 lay (usually lawyers) seated at the top of a single table, with the GMC's legal team seated down one side and the doctor under investigation and their legal team down the other side. Address your evidence to the Chair. The doctor under investigation and/or their legal representative(s) have the right to ask you questions about your evidence.

GIVING EVIDENCE TO A VIRTUAL HEARING

Virtual hearings are a product of the pandemic and while the structure of the hearing follows that of face-to-face hearings in the civil, criminal and coroner's courts, there are certain ground rules that are necessary to follow. Firstly, in civil trials, there will be a virtual pre-trial conference with Counsel, and on each day of the trial, there may be a short pre-trial and post-trial virtual conference with Counsel to go over that day's proceedings. Avoid using Wi-Fi if at all possible. Connect your laptop to the router with a cable. Ideally, lock the door of the room you are using to give evidence. No one must listen in. Seat yourself in a well-lit room in front of as blank a wall as possible. The Court does not want to be distracted by pictures of your family, pets etc. Make sure you are properly dressed both above and below the waistline! Remember, you may be required to stand when the judge enters or leaves. However, cross examination is less daunting in virtual hearings since you are being examined over a video link and not face-to-face in an open courtroom.

Remember, in all roles as an expert witness, your duty is to the Court.

For more information about training as a medical expert witness please see the SpecialistInfo range of CPD courses, including Courtroom Skills:

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FOUL PLAY: TACKLING NEGLIGENCE AND BREACH OF DUTY IN SPORTS

By James Gould and Shoshana Mitchell, Barristers and Mediators at Normanton Chambers, London
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The High Court decision in *Elbanna v Clark* [2024] EWHC 627 (KB) ("*Elbanna*") serves as a useful reminder, and a warning, that sportspeople can be held legally responsible for tackles on the pitch. This article will explore the decision that resulted in a sportsperson being held liable in negligence for a collision during a rugby match. This article will then consider the most recent developments in this matter, *Elbanna v Clark* (Re Consequential Matters) [2024] EWHC 1471 (KB) ("*Elbanna (Consequential Matters)*").

Facts

The Claimant and Defendant were participants in an amateur rugby match, played under Rugby Football Union laws. Unusually, this particular match was being filmed to train the match referee. During this match, the Defendant ran and collided into the Claimant. As a result, the Claimant sustained a serious spinal injury at the C5/C6 level. The Claimant sought damages for the injuries he sustained as a result of the Defendant's alleged negligence. Prior to the trial, the Defendant had admitted causation in so far as the Claimant had suffered an acute injury as a result of the collision. The trial proceeded on the preliminary issue of liability.

The Claimant's Case

The Claimant's case was that the Claimant did not move significantly before the collision and the Defendant had deliberately impacted the Claimant from behind.

The Defendant's Case

The Defendant maintained that he ran forward to try to get the ball after it had been kicked and he had tried to avoid the Claimant. The Defendant's evidence was that, just before contact, the Defendant had moved to the right to avoid a collision as the

Claimant had "*moved into his path*". The Defendant contended that if the Claimant had not moved, then he would have run straight past him. The Defendant denied that the collision was deliberate.

The Experts' Opinion

Both parties called experts to give evidence as to the relevant laws of the game and their application to the collision. The experts focused on Law 10.4(e) characterises "*playing an opponent without the ball*" as dangerous play. The experts also provided their commentary on the video footage with each coming to different conclusions on what they saw. The Claimant's expert considered that the Defendant intended to collide with the Claimant's back in a targeted move. The Defendant's expert concluded that the collision was caused by the Claimant moving in a perpendicular direction.

Judgment

Mr Justice Sweeting held that the Defendant had breached his duty of care. In forming this decision, the Judge made a number of findings. In particular:

1. The Judge held that the Claimant had stayed perfectly still during the Defendant's run towards him;
2. The Judge found that a collision between the players was not inevitable, but it required the Defendant to reduce his speed or alter his line;
3. The Judge held that the Claimant could not have seen the Defendant running towards him and did not have the opportunity to prepare for the impact;
4. The Judge rejected the Defendant's evidence that he had moved to his right as it "*lies uneasily with what can be seen on the video recording*"; and
5. The Judge preferred the evidence of the Claimant's expert who concluded that: 5.1. A "*player of the Defendant's stated experience should have known how to avoid contact with the Claimant*"; and 5.2. The video showed the Defendant made "*no attempt to slow down, deviate away from the Claimant or soften the contact*".

The Judge held that running at full speed directly at the Claimant and colliding with him was both deliberate and reckless. The Judge held that this amounted to playing an opponent without the ball in contravention of the laws of rugby and courted the risk of injury.

Useful Principles Arising from the Decision

This decision reminds us of the following principles:

1. Sportspeople, including amateur players, are not immune from findings of negligence for their actions "*on the pitch*";
2. As per *Czernuzka v King* [2023] EWHC 380 (KB) the requirement to establish recklessness is not required for a breach of duty of care. The test in a sporting context is whether the Defendant failed to exercise such degree of care as was appropriate in the circumstances; and
3. In accordance with *Fulham v Jones* [2022] EWHC 1108, a breach of the rules of a sport will not necessarily result in a finding of negligence. Indeed, "*the Rules on the Game of Association Football have not been drafted with civil liability in mind*". However, a breach of the rules is one relevant factor to consider in determining whether there was a breach of duty.

An Attempt to Appeal

Elbanna appears to be the case that keeps on giving. *Elbanna (Consequential Matters)* provides guidance in respect of applying for permission to appeal.

The parties were told that the judgment in *Elbanna* would be handed down on 20 March 2024 following a draft judgment being circulated some days before. On the same day as the hand down, the Defendant's Solicitor sent an e-mail to the Court that there were other matters to be addressed and suggesting that the hand down was delayed until another day. There was, in this e-mail, no indication that the Defendant was seeking permission to appeal or an extension of time for doing so. On 10 April 2024, the Defendant filed a Notice of Appeal with the Court of Appeal without having finalised the Order with the Claimant. In an attended hearing on 7 June 2024, the lower Court held that:

1. The Notice of Appeal was lodged at the end of the 21-day period for appealing;
2. There is firm guidance in *Re T (A Child)* [2022] EWCA Civ 1736 that the usual course should be that an application for permission to appeal is made before the trial judge;
3. The Claimant's Solicitor was not copied into e-mail correspondence between the Court of Appeal by the Defendant's Solicitor contrary to Civil Procedure Rule 39.8, which required any communication with the Court to be copied to the other party save in limited circumstances;
4. Following *McDonald v Rose* [2019] 1 WLR 2828, a party wishing to apply to the lower court for permission to appeal should do so at the decision hearing itself. The Judge held that hand down on 20 March 2024 was the 'decision hearing'. Furthermore, the email sent on 20 March 2024 by the Defendant's solicitors did not address the appeal issue. As such, the court no longer had jurisdiction to hear an application for an extension of time or for permission to appeal; and
5. In any event, even if the Judge were wrong, permission to appeal would have been refused on the basis that he had been entitled to reach his own findings of fact on the evidence before him at trial.

The Part 36 Offer

The Claimant made a Part 36 offer as follows: "The Claimant will settle the issue of liability in this claim on the basis that the Defendant will accept 75% of the Claimant's claim for damages to be assessed". The Judge held that the offer was not effective so as to give rise to the Part 36 consequences which would otherwise follow from the Claimant's success at trial. In reaching this decision, the Judge held that the reference in the offer to "liability in the claim" may refer to both issues of breach of duty and causation. There was a need for precision about exactly what the offer related to. This was compounded by the Claimant's failure to provide clarification about the offer, when the Defendant's Solicitor informed the Claimant a few days after the offer was made that the offer was not clear.

Thoughts

The following are some key takeaways from the case of *Elbanna* and *Elbanna (Consequential Matters)*:

1. **Do not underestimate the value of evidence.** As with most negligence claims, liability turns on its facts and, accordingly, evidence is key to establishing the facts. This Judgment hinged on both video footage and expert evidence. It is imperative to ensure timely recovery of CCTV and other visual/audio footage that may assist your client. The Judge ultimately preferred the Claimant's expert evidence as it was in line with the video footage. Generally, experts should be shown key pieces of evidence, such as video footage, and asked to comment upon the same in their report.
2. **Ensure you are familiar with the legal process and procedural issues surrounding appeals.** This case emphasises the importance of complying with procedural requirements, particularly those in respect of applications for permission to appeal. Indeed, practitioners should be wary of not seeking permission to appeal from the trial judge and, in any event, must ensure compliance with the 21-day appeals period. As always, a failure to comply may result in cost implications.
3. **Communicate, communicate, communicate!** This case illustrates the consequences of failing to communicate. It is trite that draft orders should be drafted and agreed as soon as practicable. It is advisable, in practice, to communicate timeframes with other parties in order to prevent matters becoming drawn out and/or overlooked. In respect of communications with the Court, other parties should be copied into any such correspondence save for exceptional circumstances. Finally, the Claimant's failure to provide clarification of the Part 36 offer when asked to do not only demonstrates the lack of communication but also the costs consequences of the same.

Don't fall foul of the formalities for a valid Part 36 offers. This decision reminds parties of the need for clear wording in Part 36 offers. Offers should be clear as to whether it extend to breach of duty, causation or both. For more guidance on Part 36 offers, please read "*The Dos and Don'ts of Part 36 Offers*" – https://www.normantonchambers.com/wp-content/uploads/2021/05/Shoshana-Mitchell_Part-36-Offers-Article.pdf.

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WHEN SHOULD I TELL MY REGULATOR ABOUT A CRIMINAL INVESTIGATION?

By Hannah Cheesebrough, Solicitor, Regulatory, Crime & Professional, Hempsons, London
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Being subject to a criminal investigation can be overwhelming, particularly for a professional of good character. It is therefore understandable that professionals often fail to comply with their disclosure obligations due to the pressure of the situation or a lack of familiarity with the process. Whilst it may be easily done, not controlling how and when your regulator is informed of a criminal investigation can lead to further complications. These difficulties can often be avoided by controlling the narrative presented to your regulator from the outset.

Who does this apply to?

Many professions are subject to oversight by regulatory bodies. For instance, medical professionals are regulated by the General Medical Council (GMC), and dental professionals by the General Dental Council (GDC). I would urge any professional who finds themselves being investigated for a criminal offence to carefully consider which organisations they may have professional duties of disclosure to. The earlier, the better.

It is crucial to familiarise yourself with your obligations to disclose a criminal investigation to your specific regulatory body. Instructing a solicitor to advise on the requirements of a specific regulator can provide valuable assistance and offer reassurance during what is usually a challenging time.

Whilst it does not negate the need to check your regulator's specific requirements, professions generally impose broadly similar requirements. This means many considerations concerning when to disclose a criminal investigation transcend specific professions.

When should I notify my regulator?

Strictly speaking, you are not always required to inform a regulator simply because you are subject to a criminal investigation.

Your obligation to disclose typically arises when you are charged with a criminal offence, or formally admit guilt, such as by accepting a cannabis warning, police caution, or community resolution, or if the matter is resolved by an antisocial behaviour order (e.g., a Criminal Behaviour Order or a Community Protection Notice). Thereafter, you are also ordinarily obliged to inform them if you are found guilty of a criminal offence.

However, it is often in your best interests to notify your regulator as soon as you become aware of a criminal investigation. This is quite simply because they are likely to find out anyway, and proactively informing them can be beneficial to your defence in any subsequent regulatory proceedings. Demonstrating transparency and insight by notifying them early can strengthen your defence strategy.

How would my regulator find out about a criminal investigation?

Your regulator could become aware of a criminal investigation through various channels. Common scenarios include a complainant in the criminal proceedings also reporting their grievance to the regulatory body, or the police contacting the regulator directly. Additionally, regulators often have agreements with other organisations to collaborate in achieving their respective objectives.

As a result, your regulatory body could be alerted to the investigation due to your compliance with additional disclosure obligations, such as those to your employer, the NHS, or the Care Quality Commission (CQC). These obligations may require you to report the investigation earlier than you would to the regulatory body itself.

It is also important to consider other early disclosure obligations, such as informing your professional indemnity insurer and, importantly, any defence organisation you belong to, as they will ordinarily be able to offer you valuable support during the process.

How should I tell my regulator about a criminal investigation?

Whilst it is often preferable for the notification of an investigation to come from you as the professional, this can include someone instructed to act on your behalf. Professionals sometimes think that involving lawyers increases the seriousness of a matter. In my view, this thinking is particularly dangerous in this context, where the content of the report is more likely to have a pivotal impact upon any future proceedings than where it originated from.

If you are being investigated for a criminal offence, the criminal process is likely to be your primary focus. Therefore, it is understandable that, when self-reporting a matter to a regulator, professionals can tend to emphasise the lack of criminal conduct. However, reporting without advice risks inadvertently making admissions to conduct which could prompt regulatory proceedings for misconduct, which could persist even if the criminal investigation concludes with no further action. This is because conduct that does not necessarily constitute a criminal offence, or which may not be provable to the criminal standard of beyond reasonable doubt, is regularly found to amount to professional misconduct (where the standard of proof is often lower).

It is therefore prudent to instruct solicitors as soon as you become aware that you are suspected of an offence. Your solicitor will be able to advise and assist you in navigating the intertwined criminal and regulatory processes in a way that considers your overall defences strategy in both arenas.

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ASSISTED DYING: A MEDICO-LEGAL CROSSROADS

By Dr Edoardo Cervoni, General Practitioner, The Grange Surgery, Birkdale and Miss Francesca Cervoni, Second Year Law Student, University of Leeds - e: cervoni@nhs.net

The debate surrounding assisted dying is a perennial ethical and legal dilemma, raising profound questions about individual autonomy, the sanctity of life, societal values, and the evolving roles of healthcare and law. Writing from two distinct yet complementary perspectives—a seasoned general practitioner and an aspiring legal professional—we aim to explore this contentious issue with the nuance it demands.

On 29th November 2024, the UK Parliament voted to legalise assisted dying for terminally ill patients with six months or fewer to live. This landmark vote represents a pivotal moment in the nation's approach to end-of-life care. The proposed legislation requires oversight by two doctors and a High Court judge, placing the UK alongside nations such as Canada, New Zealand, and Spain.

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The debate continues to polarise. Proponents argue that the law provides a compassionate option for those facing unbearable suffering, while opponents warn of potential abuses and unintended societal consequences. Here, we present the case for and against assisted dying, incorporating medical and legal insights, relevant case law, and reflections on societal impacts.

The Physician's Perspective: A Call for Caution

As a medical practitioner with over three decades of experience and direct care for more than 500,000 patients across three different continents, I have witnessed the complexities of end-of-life care. While advances in palliative care have eased suffering for many, I remain deeply troubled by the ethical implications of assisted dying.

I identify 4 key points:

1. *Vulnerable Populations at Risk:* The normalisation of assisted dying may inadvertently pressure vulnerable individuals—elderly, disabled, or economically disadvantaged—to perceive death as a duty rather than a choice. This societal shift risks creating an implicit expectation that choosing to die alleviates the "burden" on loved ones or public resources.
2. *Lessons from the Gosport Inquiry and Beyond:* Over the years, I have observed a concerning trend in end-of-life care, particularly the liberal use of opioids administered via syringe drivers[1,2]. While intended to relieve suffering, these measures can unintentionally hasten death. This blurring of lines between compassionate care and life-shortening interventions raises urgent questions about consent, intent, and the societal value placed on human life. The 2018 report on Gosport War Memorial Hospital highlighted the dangers of blurred lines between symptom control and life-shortening interventions. The liberal use of syringe drivers containing opioids hastened death for many patients without proper consent. If such abuses occurred under the guise of compassionate care, how can we ensure the rigorous safeguards required for assisted dying?
3. *Black Swan Events:* Rare but catastrophic events, such as systemic misuse or sociological shifts devaluing life, are potential risks[3]. Technological innovations like AI-driven healthcare decisions may further complicate this landscape. A robust ethical and regulatory framework is non-negotiable to prevent these risks.
4. *Erosion of Palliative Care:* Assisted dying could divert attention and resources from palliative care, undermining efforts to provide comprehensive, compassionate end-of-life support. The medical profession must prioritise comfort and dignity while safeguarding the sanctity of life.

The Legal Perspective: A Push for Autonomy

The legal argument for assisted dying rests on the principles of autonomy, dignity, and justice. Denying an individual the right to choose the timing and manner of their death imposes the values of the majority on those whose suffering is personal and profound.

1. A Legal Evolution

Key legal precedents underscore the evolving approach to end-of-life decisions. In *Pretty v United Kingdom* (2002), the European Court of Human Rights upheld the UK's prohibition on assisted suicide, emphasising state interest in protecting vulnerable populations[4]. However, more recent cases like *Nicklinson v Ministry of Justice* (2014), reflect growing judicial willingness to question the blanket ban on assisted dying[5]. The court acknowledged the tension between individual autonomy and state obligations, leaving Parliament the task of reform.

2. Safeguards in Law

The proposed UK legislation incorporates stringent safeguards: medical assessments by two doctors, judicial oversight, and explicit consent.

These measures aim to prevent misuse and ensure decisions are well-informed and voluntary. International experiences—such as Canada's MAiD (Medical Assistance in Dying) programme—offer valuable lessons on implementing effective safeguards while respecting autonomy[6].

3. Respecting Personal Agency

Legalising assisted dying acknowledges that individuals, not the state or society, are best placed to determine what constitutes intolerable suffering. Denying this choice risks undermining the fundamental principle of self-determination—a cornerstone of modern legal systems.

4. Equity and Access

The current system forces many to seek assistance abroad, disproportionately disadvantaging those without financial means. Legal reform would address this inequity, providing a regulated and accessible framework within the UK.

Finding Common Ground

While our perspectives differ, we agree on the necessity of open, informed dialogue grounded in ethics, law, and compassion. Assisted dying is not a binary issue; it is a complex, multifaceted challenge requiring robust debate and rigorous safeguards.

The medical community and legal system must collaborate to ensure that end-of-life care remains humane, equitable, and reflective of societal values. Investment in palliative care, public education, and transparent oversight mechanisms are crucial to any legislative framework.

Conclusion

The UK's decision to legalise assisted dying marks a turning point in healthcare and law. As the debate continues, we urge policymakers, professionals, and the public to engage with this issue thoughtfully, balancing individual rights with societal responsibilities. The stakes are profound, and the path forward requires wisdom, courage, and compassion.

We urge colleagues, researchers, and policymakers to engage in this dialogue with the seriousness it warrants. We are on the verge of a cliff on which the role of healthcare providers may shift from healers to facilitators of death, potentially eroding trust in the medical profession.

Societal values and legal precedents may shift, potentially leading to situations where individuals feel pressured to choose death due to a perceived burden on society or family.

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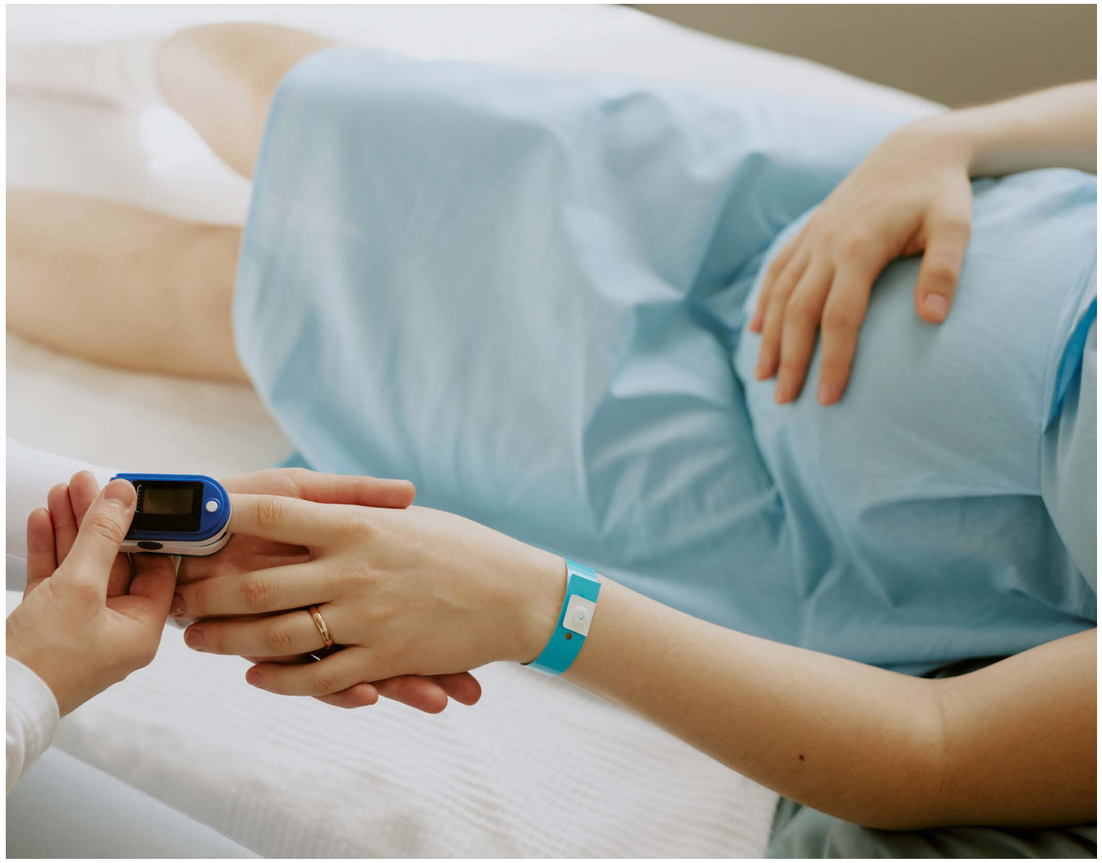
Authors' Contributions

The authors have equally given substantial contributions to the conception, design, acquisition, analysis, and interpretation of the data. The authors have drafted the manuscript and revised it critically. The authors read and approved the final version of the manuscript.



AN EXPERT MIDWIFE'S JOURNEY

By Frances Fraser, Midwife and Expert Witness, Norfolk
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Frances Fraser is a midwife who qualified in 2010. She has worked in all clinical areas of maternity, with much of her experience in labour and birth care. Supporting women birthing at home, in the midwifery led unit and high-risk consultant led unit. Frances has a deep passion for supporting maternal choice, as well as her involvement in emergency sims training of staff.

I was first introduced to the role of a midwifery expert by a senior midwife I had the pleasure of working with early in my career. Not only did we share a surname, but also, it turns out, an ability to understand the nuances of midwifery practice enough to have the privilege to be considered an expert. Fast forward 12 years and this woman continues to mentor me, but now passing on her expertise as a witness as opposed to her clinical wisdom.

My role as an expert witness has certainly been a learning curve, a clinical midwife at heart, whose

career majority has been spent with women giving birth. I seem to have stepped into a parallel universe, where clinical conduct is considered and discussed from the comfort of an office chair.

I am being facetious, although I admit that there is some truth to this, I often find myself thinking about the working environment the clinicians involved in the cases I comment on are working in and how I have walked in their shoes; twelve-hour shifts, no break, fetal heart traces, emergency buzzes, more women than staff to care for them. This can certainly be lost when we experts look back at what was recorded in the black and white.

This experience of the midwifery perspective comes easily to me and is an integral part of my role. The formulation of an argument with the application of the legal tests – Bolam, with Bolitho and Montgomery was not something my midwifery training had prepared me for. Two years down the line I certainly have developed a better understanding of relevant law and procedure, I am learning and improving upon this all the time.

This is part of what I really enjoy about the expert role, I can feel challenged in another way. Of course, the majority of cases have sad outcomes, and I take no pleasure in this, but I see myself as able to make a difference in another way, which is what led me to midwifery in the first place. I have always been passionate about maintaining high standards of care and the process of learning through multi-disciplinary collaboration to understand when things have gone wrong, this motivation has lent itself perfectly to my role as an expert.

I am still practising as a midwife, not only do I bring this expertise to my expert role, but I can also bring my insights as an expert to my clinical role. Most notably in my documentation, as I have never been a supporter of the adage 'if it's not written down, it didn't happen' because in practice this is not only impossible, due to the workload, but also, I question whether it is necessary. I note this reasoning has been the focus of some debate; however, a judge is likely to resolve a clinical negligence factual issue in favour of evidence in the clinical records (Ford, 2019)[1].

I am starting to relate; when reviewing clinicians' records becoming frustrated by the lack of well documented thought processes in decision making, which would certainly make my role as an expert easier, I now understand where the formulation for the above reasoning was born, in litigation proceedings. I can be torn between understating the context of the clinical environment and how it impacts upon documentation, but on the other hand how factual evidence can support an action or a perceived omission.

When I was a midwife in training we were told not to 'write defensively' as this was not the intention for the records. This is an idea that as a practising midwife I became challenged by and certainly as I have become an expert witness now disagree with, although perhaps worded in a different way the sentiment is the same. We should be writing our records in a way that supports rationale for decisions, clearly outlining information shared with women when they have been offered choice, to provide evidence of their consent to treatments and interventions. The current maternity climate calls for this transparency and perhaps there may be opinion that this approach is 'defensive', I pose the counter that it's 'reflective'.

Reflective of the standard of care provided, never allow your reasoning for decisions to be left to presumption. How has this affected my midwifery practice? I certainly write clearer records, document thought processes, and provide my rationale for decisions, all of which I can hope would give evidence of my competence, as acting with logic and reason.

I will continue my work in this dualled reality, on both sides understanding my influence:

- as a clinician maintaining a high standard and ensuring my records reflect this;
- as an expert maintain my impartiality, continue to understand the legal tests applied and remembering it is not always black and white.

For midwifery experts in the making, my advice is to ensure that when accepting a case, the issues of such fall within your remit. You must know and preach from the Civil Procedure Rules[2] (CPR) 35 and the supporting Practice Direction, and ideally have a mentor with experience. Access some initial training to get started and then maintain CPD as you would for your clinical role, the medico-legal practices are very different.

References:

[1] Ford (2019) https://www.capsticks.com/insights/medical-records-if-its-not-written-down-it-didnt-happen

[2] https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part35

If you are interested in expert witness training suitable for nurses and midwives, then go to the SpecialistInfo.com website, where you can find details of our 2025 CPD training. Use code NURSE20 at checkout to benefit from a 20% price reduction for nurses and midwives:

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MEDICO LEGAL MAGAZINE

A MEDICO-LEGAL AGENCY VIEW ON THE ONGOING EXPERT FEE BREAKDOWN DEBATE

By Andy Davies, CEO, Quality Medical Group Services

The recent case of JXX v Archibald provided the latest update on the (increasingly frequent) topic of whether there should be a breakdown of agency fees when instructing experts.

As the CEO of a medical-legal agency who instruct on thousands of expert reports each year, the topic has come up increasingly frequently in conversation over the past 12 months, and I thought the perspective of an agency might be an interesting one to explore.

First, a whistlestop history lesson on the emergencies of Medical Reporting Organisations (MROs).

When where agencies born?

As with so many things, the advent of the internet played a crucial part in the establishment of medical-legal agencies. Due to restrictions on advertising before 1986, solicitors relied largely on word of mouth to generate business. They would, therefore, only require a pool of *local* experts whom they would instruct directly.

The combination of this restriction lifting and the internet coming to prominence meant that firms could suddenly advertise for work in a much wider range of areas, hence the need for agencies who could provide access to experts in these locations.

This context is important as it feeds into one of the key points in the ongoing debate – namely that agency fees should not *'exceed the reasonable and proportionate cost of the work if it had been done by the solicitors'* (Stringer v Copley in 2002).

In the scenario described above, access to experts was no doubt the primary time & cost saver for solicitors who would have very few ways by which to access experts in areas outside of their locality.

Whilst it's the case that this is much easier in 2025 than in 1986, there is still a significant amount of work undertaken to build & maintain a panel of high-quality experts, in addition to the time spent instructing and liaising with experts and managing the overall complexities of cases that run for years.

Recent developments

Whilst the debate around agency fees has been ongoing for a long time, the past couple of years have seen a proliferation in cases, often with differing takes on the breakdown of agency fees. A few of these are highlighted below.

April 2023 - *Sephton v Anchor Hanover Group*, the court concluded that a fee for an MRI was *'reasonable and proportionate'* and so was recoverable without knowing the apportionment between agency and expert.

March 2024 - *Amini-Edu -v- Esure Insurance Company Ltd* it was determined that agency fees should be disclosed and that *"despite protestations to the contrary, medical agencies should be able to provide at least sufficient indicative information as to the proportion of the medical invoice that reflects the true value of their commission"*.

June 2024 - *Craven -v- Henley*, in relation to a composite fee of £750 it was stated that *"even if it was all the doctor's fee, I am satisfied that £750 would be a reasonable and proportionate fee for this report"* and so no breakdown was required. However, *"if the costs claimed were something in the order of £10,000 or more, I might very well take a different decision."*

July 2024 - *Chaudry -v- AXA Insurance Plc* it was said that *"the court is entitled to require transparency from those whose fees form part of claimed and potentially recoverable costs"*

And most recently in January 2025 we have a further update in JXX v Archibald. Exactly how this interpretation plays out only time will tell, but Judge Rowley stated that the claimant could choose between having costs assessed either on the basis that the breakdown is provided and assessment made on both the work of the expert and the MRO, or that no breakdown is provided, and assessment is made on the hypothetical basis that no MRO was involved.

This leans on the Craven v Henley decision in positing that there are situations where the composite fee would be considered proportionate in and of itself, whilst at the same time giving Claimants the option to provide a breakdown where they feel it might add extra weight.

Where does this leave things?

This will no doubt continue to rumble on. For me, it's clear that there is a balancing act. On the one hand, it is, at best, unrealistic and, at worst, a waste of time to demand every fee is broken down.

On the other, agencies should clearly be a cost-efficient way to outsource specialist skills and to help speed up workflow & remove administrative burden, and transparency should be a key criterion of a successful relationship between MRO and solicitor. At QMGS we make sure that every firm (and expert, should they ask) we work with knows exactly what we are charging from the outset so that when they receive the report they already know the breakdown. This uplift is fixed & reasonable, and we are always comfortable justifying that it costs less (often significantly) than if done by a solicitor.

Additionally, we employ doctors, midwives & nurses who all can provide 'value-add' to the firms we work with through pro-bono advice, as well as training for the firms we work with. Whilst it's not possible to attribute this directly to the fee breakdown, it's a benefit that should not be ignored.

That said, I know smarter people than me who think this is a slippery slope and could simply open up a race to the bottom, devaluing the service of agencies and, by extension, experts.

I certainly don't have the answers but am fascinated to see how things unfold this year and always keen to hear perspectives on this, so please don't hesitate to get in touch with me if you'd like to discuss!

MEDICO LEGAL

MAGAZINE

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Mr Chukwuemeka was the Royal College of Surgeons' Regional Specialty Advisor and served on the Medical Technologies Committee at NICE. He serves on the NHSE - Clinical Reference Group for Cardiac Services, NHSE - London Clinical Senate Council and the Medicines and Healthcare products Regulatory Agency (MHRA).

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David Simon Costain is a Podiatric Consultant and Gait Specialist, based in Harley Street, London. He has over 45 years of experience in Podiatry and is the CEO of the Gait & Posture Centre.

He specialises in the analysis of gait related musculo-skeletal problems relating to foot and leg malfunction, dividing his time between his private practice and expert witness work. He focuses on Personal Injury cases where approximately 75% of his work is for the claimant, and 25% for the defendant.

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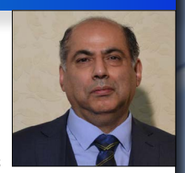

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Mr Khanna is a substantive NHS Consultant in Plastic, Reconstructive and Hand Surgery at The Sandwell and West Birmingham NHS Trust and has been involved in medical legal work since 1998. In this period he has provided over 4000 medical reports. He has prepared a chapter for the Encyclopedia of Forensic & Legal Medicine entitled "Medical malpractice in Cosmetic and Plastic Surgery".

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- Hand surgery: Sequelae of hand injuries and surgery
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- Burns management: Sequelae of disability following burns injury, scarring and surgery
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Mr Kumar, is a Consultant Orthopaedic Surgeon, specialising in trauma and upper limb conditions, with a focus on medicolegal practice since 2011. He serves on the trauma rota at the Royal Lancaster Infirmary. He holds an LLM in Medical Law & Ethics and is on the Medicolegal Committee of the British Orthopaedic Association. He performs assessment of doctors for the General Medical Council and examines for the Royal College of Surgeons. With regulatory experience, he has advised the CQC. He provides concise medical reports for clinical negligence and personal injury cases, with clinics in Manchester, Lytham, Bolton and Lancaster.

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MEDICO LEGAL MAGAZINE

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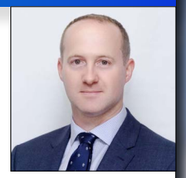

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Mr McCann is a full time Trauma and Orthopaedic surgeon at University Hospitals Bristol and Southmead Hospital Bristol. He has a Specialist interest in:

- Fractures of the clavicle, shoulder, humerus and elbow
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- Primary and Revision Shoulder replacement surgery
- Management of post traumatic, degenerative and sports-related
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With his modern tertiary referral practice and extensive research portfolio, Mr McCann is able to provide comprehensive medicolegal reports (full reports and desktop screening reports) for both personal injury and clinical negligence cases.

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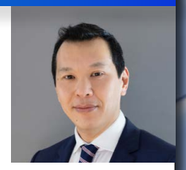

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Dr Neil Mo is a consultant rheumatologist and clinical lead in Swansea Bay University Health Board. He was previously a consultant in Charing Cross and Hammersmith Hospitals. He has received training in report writing and courtroom skills, and has produced over 300 medicolegal reports. He provides comprehensive, authoritative and well balanced reports with a quick turnaround time.

He has expertise in all areas of adult rheumatology, and maintains his clinical and medicolegal knowledge to deliver an up to date expert opinion. He is experienced with risk management within the NHS and has undergone training with NHS resolution.

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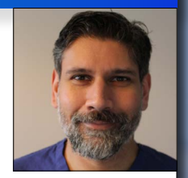

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Areas of particular expertise:

- anaesthesia for children in the district general hospital
- paediatric preoperative assessment
- TIVA in children

In addition to:

- all aspects of adult perioperative care, including preoperative assessment
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- anaphylaxis
- shared-decision making

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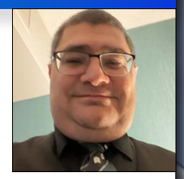

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My name is Professor Panayiotis (Panos) Kyzas. I am a consultant in OMFS/Head and Neck Surgery with a clinical specialty interest in ablation and reconstruction of head and neck cancer and facial skin cancer. I am the Editor-In-Chief of the main UK scientific journal for my specialty, a pst that commenced in 2024 for 5 years. I held the post of the chair for the OMFS Specialty Training Committee and the regional research advisor. I have acted as the national OMFS representative on the TIG H&N fellowship committee and the Quality Assurance Lead from 2019 to 2023. I have recently graduated my law degree with honours. I currently hold a Bronze National Clinical Excellence Award for my services to the NHS. I am the Chief Investigator of the MANTRA trial, a with multimillion pounds NIHR funding. In August 2023 I have been appointed as a visiting Professor in OMFS H&N Surgery at Edge Hill University.

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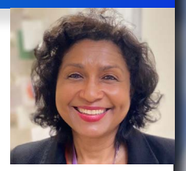

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Her medico-legal practice includes medical negligence, second opinions, decisions on escalation and resuscitation, coroner reports, ethical situations, inappropriate/ harmful testing and treatments, and breeches in communication. She can provide comprehensive case reviews and expert opinion on the quality of the care provided at the different stages of care.

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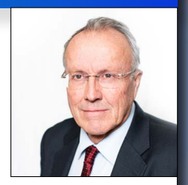

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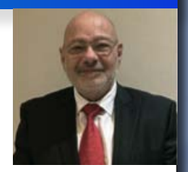

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Mr Sarwat Sadek has been practising as an ENT Consultant for nearly 40 years and is currently Consultant Otolaryngologist and Head & Neck Surgeon at the Nuffield Hospital, Taunton.

Areas of interest:

- Military noise induced hearing loss
- Noise induced hearing loss
- Occupational rhinitis
- Facial & neck trauma
- Traumatic loss of sense of smell and taste
- Deafness, tinnitus and vertigo as a result of road traffic accidents

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- Resuscitation
- Trauma, Burns, Sedation & Acute Pain
- Musculoskeletal injuries
- CPR Part35 trained
- MEDCO accredited
- Up to date medico-legal CPD portfolio
- Reports vetted by solicitors
- Consultation Venues at: Chester (Cheshire, Northwest & North Wales), Guernsey & Jersey
- Happy to provide pro-bono opinion

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MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry of the fourth quarter of 2024

NEWS

Expert Witnesses Demand Fairer Treatment from Solicitors

The Annual Expert Witness Survey, produced by Bond Solon in association with Law Society Gazette, was published in November.

The majority of expert witnesses surveyed felt there should be stronger sanctions, involving the Solicitors Regulation Authority, against solicitors who intentionally lead experts to breach their duty to the court.

Experts were also frustrated by some agencies and law firms' refusal to follow agreed terms and pay fees in a timely manner.

Read more: https://www.lawgazette.co.uk/news/survey-expert-witnesses-berate-solicitors-for-bias-pressure-and-late-payment/5121462.article

DHSC Proposals to Introduce Professional Regulation for NHS Managers

Since the Darzi review in 2024, NHS England is continuing to:

"Develop a leadership and management framework, which will introduce a code of practice, a set of core standards and a development curriculum for managers. This will support managers and leaders to undertake further training to improve their effectiveness and to progress in their careers."

A Department of Health and Social Care (DHSC) consultation is currently underway to:

"Seek views from all stakeholders, including health and care organisations, regulators, professional bodies, health and care managers and senior leaders, the public, patients and other health and care staff on the most effective way to strengthen oversight and accountability of NHS managers.

We are seeking views from stakeholders on:

- the type of regulatory system that would be most appropriate for managers
- which managers should be in scope for any future regulatory system
- what kind of body should exercise such a regulatory function
- what types of standards managers should be required to demonstrate as part of a future system of regulation"

You can respond using their online survey through the link below. **The consultation runs for 12 weeks and closes at 11:59pm on 18 February 2025.**

Read more: https://www.gov.uk/government/consultations/leading-the-nhs-proposals-to-regulate-nhs-managers/leading-the-nhs-proposals-to-regulate-nhs-managers

NHS Maternity Survey 2024

Results of the maternity survey, recording the experiences of pregnant women and new mothers who used NHS maternity services in 2024, were published at the end of November.

The survey showed areas of improvement including access to antenatal mental health support and improvements in communication with midwives about antenatal care decisions. However, satisfaction with postnatal care in hospital and after leaving hospital has declined. There has been a 5-year downward trend in the number of people reportedly able to get timely help from staff during labour and birth.

Read more: https://www.cqc.org.uk/publications/surveys/maternity-survey?utm_source=Twitter&utm_medium=social&utm_campaign=Orlo&utm_content=Maternity+Survey+2024

NEWS
MEDICO LEGAL MAGAZINE

New Patient Safety Principles from the Patient Safety Commissioner

The new Patient Safety Principles have been developed as one of the Commissioner's statutory duties following a public consultation. They provide a framework for decision making, planning and collaborative working with patients as partners in a just and learning culture and are for everyone working in the healthcare system. A summary is below:

1. Create a culture of safety
2. Put patients at the heart of everything
3. Treat people equitably
4. Identify and act on inequalities
5. Identify and mitigate risks
6. Be transparent and accountable
7. Use information and data to drive improved care and outcomes

Click below to view the full details of the Patient Safety Principles and for a toolkit on how to use the Principles.

Read more: https://www.patientsafetycommissioner.org.uk/principles-of-better-patient-safety/

Martha's Rule Pilot a Success

Martha's Rule is a major patient safety initiative providing patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to.

Martha Mills died in 2021, aged 13, after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and a coroner ruled that she would probably have survived had she been moved to intensive care earlier.

During the pilot year, running until March 2025, 143 sites will test and implement the 3 components of Martha's Rule:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital

NHS data shows that some patients have already received potentially life-saving treatment as a result of the pilot scheme.

Read more: https://www.england.nhs.uk/patient-safety/marthas-rule/

Whiplash Injury Regulations: Publication of the Lord Chancellor's Review

On 21st November 2024, The Rt Hon Shabana Mahmood, Lord Chancellor and Secretary of State for Justice, completed her report of the first statutory review of the Whiplash Injury Regulations 2021.
In summary she decided to:

- maintain the existing split structure of the tariff (whiplash only and whiplash plus minor psychological injury) and to provide additional guidance on defining minor psychological injury;
- uprate the tariff by around 15% to account for actual Consumer Price Index inflation to May 2024 and for forecasted inflation to May 2027 - the likely date of the next review;
- keep the allowable judicial uplift for exceptional injuries or circumstances at its current level of up to 20% of the tariff award; and
- make no changes to the definitions on what constitutes appropriate medical evidence and who may provide it for the purposes of the ban on seeking/making an offer to settle a whiplash claim without evidence.

She will now commence a consultation on these decisions with the Lady Chief Justice.

Read more: https://questions-statements.parliament.uk/written-statements/detail/2024-11-21/hcws241

In addition, she made the following Damages (Personal Injury) (England and Wales) Order 2024 changes to the discount rate from the 11th January 2025, so that the prescribed rate of return will be 0.5%.

The Explanatory Note:

"This Order prescribes 0.5% as the rate of return which, under section A1(1) of the Damages Act 1996 (c. 48), courts are required to take into account when calculating damages for future pecuniary loss in an action for personal injury. As this is the second review of the rate of return since the commencement of Schedule A1 to the Damages Act 1996, the procedure set out in paragraph 3 of Schedule A1 to that Act applies."

Read more: https://www.legislation.gov.uk/uksi/2024/1261/made

GMC Regulation of PAs and AAs Begins

In December, the GMC published the results of its consultation ending in May 2024 on how it will regulate physician associates (PAs) and anaesthesia associates (AAs).

Feedback from the consultation and patients was considered by the GMC, and from 13 December 2024 it began regulating PAs and AAs alongside doctors. Regulation will begin with a small selection of Associates, which will be extended to those on existing voluntary registers by the end of January 2025. From December 2026 it will be an offence to practise as a PA or AA in the UK without GMC registration

The changes to the GMC's initial proposals, based on feedback in consultation responses, include:

An initial proposal for a single GMC case examiner to make decisions on fitness to practise cases involving PAs or AAs has been changed. Instead, there will now be two case examiners.

A specific requirement has been included for course providers to ensure student PAs and AAs inform patients when they are involved in their care. This builds on standards required of practising PAs and AAs to introduce themselves and explain their role.

Behaviours indicative of serious misconduct have been expanded to include cases where a PA or AA has deliberately misled patients or others about their registered status. This mirrors the approach taken with doctors.

A new provision that confirms the GMC cannot ask PAs and AAs to provide evidence of reflective practice when applying to join, leave or re-join the GMC register. GMC Chief Executive Charlie Massey said:

'Regulation is a vital step towards strengthening patient safety and public trust. It will provide assurance to patients, employers and colleagues that physician associates and anaesthesia associates have the right level of education and training, meet the standards we expect, and can be held to account if serious concerns are raised.'

Read more: https://www.gmc-uk.org/about/get-involved/consultations/summary-of-our-consultation-on-pa-aa-rules-standards-and-guidance

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If you are a medical expert interested in joining our panel or you are a company looking for a quality expert, please contact Lisa Cheyne lisa@specialistinfo.com 01423 787 984