



## **Clinical Negligence Seminar**

**Royal College of Surgeons**

**09<sup>th</sup> June 2011**

CPD Ref: AWW/CHRW

12 King's Bench Walk, Temple, London EC4Y 7EL,  
Tel: 020 7583 0811, Fax: 020 7583 7228, Video Conferencing: 020 7583 4190  
E-mail: [chambers@12kbw.co.uk](mailto:chambers@12kbw.co.uk), Website: [www.12kbw.co.uk](http://www.12kbw.co.uk), DX 1037 Chancery Lane



# **Clinical Negligence in Trauma and Orthopaedics 2011**

**Robert Carew**

CPD Ref: AVV/CHRW

12 King's Bench Walk, Temple, London EC4Y 7EL,  
Tel: 020 7583 0811, Fax: 020 7583 7228, Video Conferencing: 020 7583 4190  
E-mail: [chambers@12kbw.co.uk](mailto:chambers@12kbw.co.uk), Website: [www.12kbw.co.uk](http://www.12kbw.co.uk), DX 1037 Chancery Lane

**Introduction**

My experience of clinical negligence is, to date, limited to my work as an NHS Consultant in Trauma and Orthopaedics (T&O). Whilst I do work independently at a number of private hospitals, clinical negligence is an experience I have so far avoided on a personal level in my private medical practice. I have been a Consultant in T&O for 9 years, I was appointed in 2002 with a specialist interest in spinal surgery at Basildon University Hospital. In 2009 I was appointed as the Clinical Director (CD) or Head of the Orthopaedic department. One of the responsibilities that comes with that position is all the clinical negligence claims brought against the T&O department pass through the hands of the CD for comment.

**The Clinical Perspective on Negligence**

Clinical negligence seems to a clinician on a day to day basis to be an increasing issue but in fact only a very small number of the patients treated each year feel they have been sufficiently disadvantaged to bring a clinical negligence claim. In my department there are 11 Consultants. In the 12 months; April 2010 – March 2011 there were over 15,000 new patient and nearly 25,000 follow-up consultations and over 6,000 operations were carried out, over 2,400 day case operations, 1,400 inpatient operations such as hip and knee replacements and over 2,300 trauma operations. In that same period the department received 11 claims for clinical negligence and in the preceding 12 month period April 2009 – March 2010, 15 claims. The actual level of claim is therefore very low.

**Assessment of the Standard of Treatment**

When looking at an individual case, I would expect the medical records in any trauma or elective orthopaedic case to demonstrate that the following standards have been met. If there is absence of such evidence in the records then it may be reasonable to question if at some point the medical or surgical care fell below the expected and required standard.

- I:       **Appropriate Investigations**
- II:       **Appropriate Review of Results**
- III.       **Appropriate Information**
- IV:       **Appropriate Treatment**
- V:        **Appropriate Time**
- VI:       **Appropriate Standard**
- VII:      **Appropriately Qualified**

**Clinical Scenarios**

In surgery; claims appear to arise as a consequence of either work in outpatients, or as a result of surgery. In the 2 years I have been CD, a claim has not arisen as a consequence of medical treatment as an inpatient. The areas of clinical risk seem therefore to be;

- I:        **Acute Trauma Admission**
  - IA:       **Major Trauma**
  - IB:       **Isolated Limb Trauma**
- II:       **Acute Non-Trauma Admission**
- III:      **Elective Surgery**

## Major Trauma/High Energy v Isolated Lower limb/Low Energy Trauma

The expectation might well be that the more serious the accident that resulted in injury the more probable that the treatment an individual received, might at some point fall below the acceptable standard, i.e. the patient who suffered multiple injuries in a high energy accident would be more likely to bring a claim than the individual who sustained an isolated upper or lower limb injury in a low energy incident. However, in the experience of my department for the last two years that has not been shown to be the case.

Area	Major Trauma	Isolated Limb Trauma
	High Energy	Low Energy
Upper limb trauma 2009.2010	0	5
Upper limb trauma 2010.2011	0	1
Lower limb trauma 2009.2010	0	6
Lower limb trauma 2010.2011	0	3
Spinal Cord Injury 2009.2010	0	0
Spinal Cord Injury 2010.2011	0	0

### IA: Major Trauma/High Energy Trauma

Over the last two decades the management of major trauma cases has been standardised throughout the United Kingdom on Advanced Trauma Life Support (ATLS) principles. This is a systematic process of assessment, treatment and documentation on all patients admitted to the Accident and Emergency Department (AE) after involvement in an incident of high energy trauma.

The patient undergoes on admission an immediate primary survey; involving the assessment of the airway, breathing and circulation. If any of these core systems are affected, immediate treatment is undertaken to stabilise that system and only once all the core systems are stable can the clinician move onto the secondary survey. This involves exposure and examination of the patient from head to toe. Its team based with senior clinician involvement throughout.

**Phase 1 Primary Survey: A, B, C, Airway, Breathing, Circulation**

**Phase 2 Secondary Survey: D, E, Disability, Exposure**

This process should be fully documented in the medical records. Inadequate or incomplete assessment may arise when the patient's core injuries are such that they remain unstable to initial resuscitative treatment. In such as case the patient may still be in phase 1 when they are transferred from AE to Theatre or ITU. If that isn't clearly documented that phase 2 has not been done or only done incompletely then that can be quickly overlooked. The patient's condition stabilises, they are transferred to a ward, it's assumed that both phases 1 and 2, the primary and secondary survey have been done, when phase 2 has not and an injury can be overlooked.

When reviewing the medical records in a major trauma case, one would look for the records to clearly document that either the primary and secondary survey was completed whilst the patient was in AE or that it was recorded that the secondary survey was incomplete and the patient managed accordingly until such time as the secondary survey could be completed.

If the records do not document that this process was not followed, completed and documented accordingly and the patient has a poorer than expected outcome, a more prolonged recovery or further surgery some date after the index date then it would reasonable to look carefully at the records to understand if there had in fact been a lapse in the process, if the patient had slipped through a crack in the ATLS process.

## **IB: Isolated Limb Trauma/Low Energy Trauma**

I was surprised to see that all the claims brought in the last two years fell into this group. The basis of the claims brought centred not mainly on the standard of treatment, although in lower limb injuries that was the basis of several claims but the main reasons were:

- Delay between the date of injury and the date of definitive treatment.
- Prolonged rehabilitation.
- Surgery was not of an adequate standard.

## **Upper Limb Trauma**

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| • 2009.2010 Clavicle Fracture        | Delay in Treatment                    |
| • 2009.2010 Clavicle Fracture        | Delay in Treatment                    |
| • 2009.2010 Elbow/Olecranon Fracture | Delay in Treatment                    |
| • 2009.2010 Hand Fracture            | Delay in Treatment                    |
| • 2009.2010 Hand Fracture            | Delay in Diagnosis/Delay in Treatment |
| • 2010.2011 Hand Laceration          | Unnecessary Treatment                 |

The claims brought were for less severe injuries than I would have been expected. No claims were for the more complex limb fractures of the shoulder, elbow or wrist or intra-articular fractures of these joints leading onto early post-traumatic arthritis and no claims were brought for poor outcome following surgery.

5 of the 6 claims were brought because a significant period had elapsed between the date of injury and the date of definitive surgery and that was interpreted as an indication of inadequate initial assessment. In 3 of these cases; (1), (2) and (4) the diagnosis was established with appropriate tests at presentation and the decision made to treat the patient medically. The fractures failed to unite and the patients had surgery at a date substantially after the date of injury, resulting a much longer period of absence from work. In case (4) the delay was measured in days but the patient believed this had resulted in the development of infection in the elbow at a later date.

The common factors which linked all the cases where;

- Injury to the dominant upper limb arm in patients with manual or active jobs.
- Definitive treatment was delayed by several months by unsuccessful medical treatment.

## **Lower Limb Trauma**

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| • 2009.2010 Ankle Fracture         | Delay in Treatment                    |
| • 2009.2010 Ankle Fracture         | Delay in Treatment                    |
| • 2009.2010 Ankle Fracture         | Inadequate Internal Fixation          |
| • 2009.2010 Compartment Syndrome   | Delay in Diagnosis/Delay in Treatment |
| • 2009.2010 Compartment Syndrome   | Delay in Diagnosis/Delay in Treatment |
| • 2010.2011 Femoral Fracture       | Delay in Treatment                    |
| • 2010.2011 Achilles Tendon Injury | Delay in Treatment                    |

Claims were again brought for less severe injuries than I would have expected. There were no claims more complex limb fractures of the hip, femur, knee, lower limb, ankle or foot.

The first 4 claims in 2009.2010 were for simple ankle fractures, the diagnosis was established with appropriate tests at presentation in all cases and in the first two cases the decision was made to treat the patient medically, reduction was lost at a later date and surgery followed. The second two cases were operated on at presentation and then required further surgery at a later date. The basis of claim in the first two cases was that if they had been offered surgery at presentation they would have recovered more quickly and returned to work at an earlier date. The basis of claim in the second two cases was simply that the surgery had not been done to an adequate standard.

The next two cases were for compartment syndrome the condition were pressure builds within the tissues of the upper but more typically lower limb following injury, either due to a general crushing injury to the soft tissues causing swelling or due to bleeding within the limb from a fractured bone. The effect of both being that pressure rises in the limb and it does so arterial perfusion is gradually occluded. The basis of the claims again a delay in the provision of appropriate and needed treatment.

The pattern of claims perhaps reflects, I believe the situation where the less severely injured patient is given an expectation of a straight forward and reasonably predictable recovery and when that is interrupted by either the need for an operation at a later date, distant to the date of injury or by a further operation after the initial operation then their concern is raised that their treatment has not been of an appropriate standard.

In cases where the claim resolves around a perceived delay in appropriate treatment. The evidence to support a claim would as ever rest within the written medical and some extent within the radiological records. If the records show the injury had been appropriately investigated at presentation and the nature and severity of the injury fully understood and explained to the patient then a failure of the initial treatment would be in all probability be very defensible.

If however, full and appropriate investigation was not undertaken at the outset and once completed showed new evidence which altered the recommended treatment then a case could be made that the patient had not received the appropriate treatment that they needed at the appropriate time.

If the medical documents did not document that at presentation the patient was given clear and understandable information about the probable period that recovery would take and the factors which might delay recovery then it may be possible to make a case that the patient did not receive appropriate information at the outset and if they had been given that information they would have elected for surgery at the outset and of course barring complication caused by that surgery would have recovered in all probability at an earlier date.

In cases of isolated lower limb trauma the times when concern may be raised about the standard of treatment could be

- If the patient was not given appropriate information.
- If the patient had surgery some time after the date of injury.
- If the patient required a second operation, at a later date.

## **II: Acute Non-Trauma Admissions**

- **Joint Infection Actual/Suspected**

One of the commonest non-trauma admissions would be a patient with a suspected bacterial infection of a joint. They may be admitted from AE or from the outpatient clinic. The inflammatory exudate produced within an infected joint is very damaging to the articular cartilage and requires prompt diagnosis and the commencement of prompt treatment to minimise the long term residual effects.

On admission one would expect to see evidence of prompt investigation that the patient had undergone basic blood investigations; a full blood count (FBC) to look at the white cell count (WBC) and a C-reactive protein (CRP) test. Both the WBC and CRP would be expected to rise quickly with bacterial infection of a joint. If the patient had an elevated temperature, blood cultures should be taken to see if it is possible to identify the bacteria released into the circulation.

On admission one would expect to see evidence of prompt treatment; if the joint was swollen that should have aspirated before antibiotics were started and the aspirated sample sent for urgent microscopy, culture and sensitivity and then if the clinical indication were this was in all probability a bacterial infection that broad spectrum antibiotics were started without delay and plans made if necessary for the patient to go to theatre for washout of the infected joint under general anaesthetic.

This is now both very standard and basic treatment for suspected joint infection, it would be unusual indeed for an adult not to be assessed and managed according to this pathway. The situation in children is more difficult and their presentation may be much more variable with relatively minor symptoms from a serious underlying infection of the bone or joint. It is more probable therefore in the children that investigation and treatment may not meet the required standard.

- **Cauda Equina Actual/ Suspected**

This is the syndrome where the nerves to the bladder and bowel become compressed by a large central disc prolapse or herniation from one of the lower lumbar discs usually L4/5 or L5/S1. The patient typically presents with either acute low back pain and or sciatica and altered bladder and bowel control, altered perineal and perianal sensation and reduced anal tone.

The syndrome is well understood and the index of suspicion should be high when an individual presents with the above symptoms. The only reasonable clinical position to adopt is that the patient has cauda equina syndrome, has a large central disc prolapse with consequent compression of the sacral nerve roots until proven otherwise and the only way to that is with an MRI scan of the lower back.

It would be therefore unusual to see patients with such a suspected problem not to have had an MRI scan done urgently. When a claim is brought the basis of claim is almost always on one of two possible grounds; when the diagnosis is suspected on admission but there is then a delay between presentation and diagnosis or a delay between the time the diagnosis is made and surgery carried out. There is however, little evidence in the literature to support the belief that either of these factors are of material significance in respect to prognosis. Where negligence may arise is when for whatever reason the diagnosis is not initially considered. In my first year as a Consultant I had a patient referred with chronic cauda equina syndrome who had been an inpatient on the mental health unit. Their double incontinence had been attributed to their severe mental health condition and not their massive central disc prolapse.

#### **Elective Admissions**

- 2009.2010 THR Dislocation
- 2010.2011 THR Vascular Injury
- 2009.2010 TKR Metal Sensitivity
- 2009.2010 TKR Infection
- 2010.2011 TKR Infection
- 2010.2011 TKR Infection
- 2010.2011 TKR Vascular Injury
- 2010.2011 Foot Ineffective Surgery

Almost all the claims brought as a result of inpatient elective surgery was because of poor outcome or perceived poor outcome in cases of lower limb joint replacement surgery. This is perhaps not too surprising as these are operations carried out solely to improve a patient's quality of life and therefore if a patient suffers a complication and the quality of life improvement from their joint replacement is reduced they might quite reasonably believe that this arose as a result of substandard medical or surgical care. However, all the claims brought in hip or knee replacement cases, other than possibly the case for metal sensitivity were for well recognised complications of joint replacement surgery.

In hip replacement those would be; infection, dislocation, sciatic nerve injury causing foot-drop, DVT, PE, leg length inequality, stiffness, periprosthetic fracture of the acetabulum or femur, vascular injury and ultimately the need for revision. In knee replacement those would be; infection, DVT, PE, stiffness, nerve and or vascular injury and ultimately the need for revision.

The incidence of such complications is low, perhaps 1- 2%. All joint replacement surgery is carried out under standardised conditions. All THR and TKR operations are done in lamina flow/ultra-clean air flow theatres. All patients will receive prophylactic antibiotics before and after surgery. In every 100 cases you would therefore expect to see perhaps 1 or 2 cases of infection, dislocation, sciatic nerve injury.

It is improbable therefore that such complications occur because of sub-standard medical practice but the main question or area of concern would be centred on the issue of consent.

## **Consent**

Was the patient fully informed of the nature of the possible complications associated with their replacement operation before the surgery was carried out and in sufficient time before surgery for them to reflect on and fully understand that information and whether there is clear evidence of the same in their medical records?

The material questions in mind would be has the consenting doctor established comprehension on the part of the patient in respect to the Mental Capacity Act 2005 and can it be demonstrated that patient has truly given informed consent.

In my spinal surgery practice my approach is to separate the consultation and consent process and to provide the patient with a procedure specific risks and complications letter which details the nature of the proposed operation, the probable level of benefit, the probable period required for rehabilitation and all the possible risks of that operation.

The proposed operation is discussed in detail with the patient in clinic and the patient is listed for surgery. The patient is however, not consented at that consultation. The patient and their GP are sent a procedure specific risks and complications letter. If the patient fully understands the information detailed in the letter and wishes to proceed they are required to sign and return this letter which is then included in their medical records. They sign the hospital consent form when they are admitted for surgery after all of the above has been re-confirmed.

In respect to the basis of a claim that the complication or poor outcome was the result of sub-standard medical treatment then one would need to look first at the process and pathway of that operation and if that was normal then in all probability it would not be so. The next question would be was the patient fully aware of the probable risk and understood the consequences if one or other complications developed and that would in most cases be a much more difficult question to answer? I have attached a sample risks and complications letter as an example of the letter that I send to patients which I believe provides the necessary information on the benefit and risk of an operation as well as the probable period required for rehabilitation.

DDI:

FAX:

RIC/PS/

NHS No:

Dear

Operation: Instrumented Fusion L5-S1.

I am writing to you following your consultation with me at Orsett Hospital on . I have recommended to you that you have an L5-S1 instrumented fusion performed on your lower back to treat the back pain that you are suffering from at this time. The aim of surgery is to perform a fusion on the lower back to reduce the level of low back pain that you currently suffer from and prevent any increase in that complaint that might have occurred.

I would insert special spinal screws into the vertebrae at the L2-S5 levels connected together with rods. Bone graft may be taken from the back of your pelvis and placed at the back of the spine adjacent to the rods and screws to cause the bones of the lower back to fuse together. The bone graft may be enhanced with other compounds that stimulate bone formation.

The results of low back surgery of this nature are more variable than other kinds of orthopaedic operations, fusion being an effective treatment for low back and/or leg pain in approximately 50-60% of cases. Effective reduction in pain being considered to be in the order of 50% such that if it were to occur it would be my expectation that the procedure had been successful.

It is important that you understand that there are alternatives to surgery, we can continue to manage your back and leg pain with conservative therapy, that being anti-inflammatory and analgesic medication, physiotherapy and if appropriate spinal injection therapy. It is possible that if that treatment was continued, that over time a gradual improvement in your condition might occur and there would certainly be no significant expectation that any serious deterioration in your condition would result from continuing with such non-operative therapy.

If we do proceed with surgery, it is important that you are aware that there are complications to the procedure and only if you understand and are prepared to accept the associated complications should we proceed with the operation. Every effort is made to avoid such complications, but they are an ever-present risk and it important to note that if you were unfortunate to suffer a complication then it is possible that your long-term outcome following surgery would be less satisfactory than if you had continued with non-operative treatment alone.

The complications associated with surgery on the lower back are as follows:

- Misplacement of pedicle screws causing nerve root compression and post-operative pain going down the leg. This might require screw replacement and by definition, therefore, a second operation. An image intensifier (a form of X-ray available on a TV screen) is used throughout the procedure to minimise this risk, together with every possible clinical precaution taken to ensure the screws are correctly placed. Despite this, very occasionally a screw can veer from its intended path of insertion.
- The spinal cord is exposed during the procedure. There is a particularly delicate covering around the spinal cord called the 'dura'. This can, on occasion, be torn and this is called a 'dural tear'. If this occurs it would be repaired at the time, but would necessitate a period of strict bed rest for up to three days following the operation. This is an infrequent complication, but would delay your rehabilitation.
- There are two further conditions that can occur as a consequence of a dural tear, the first is the gradual development of a collection of cerebrospinal fluid under the skin and muscle of the back, during the initial phase of rehabilitation after the operation, this is called a pseudomeningocele and such a condition would normally be associated with headaches and feeling generally unwell. The second would be the development of a connection between the dura and the skin; this is called a cerebrospinal fluid

- fistula and may cause similar symptoms to the above as well as being associated with an increased risk of infection. Both conditions are a rare occurrence following surgery of this nature; the treatment of both would be further surgery to repair the dural membrane.
- Nerve root injury can occur during the operation, which would result in altered sensation or weakness in part of the lower leg. This is an infrequent complication; the effects in the majority of cases are temporary but if such injury were to occur it cannot be guaranteed that full sensory and motor recovery would occur and in very occasional cases such a deficit could be permanent.
- Nerve root injury can occur affecting the nerves that supply sensation and power to the bladder, bowel and sexual organs. These nerves are called the Cauda Equina and such a complication is called Cauda Equina Syndrome. If such a complication develops it can result in impairment or loss of bladder and bowel control and of sexual sensations and functions. The risk of Cauda Equina Syndrome is low 1 – 2% or less but if it occurs the neurological damage can be permanent.
- Extensive internal fixation of the spine using metal plates and screws is associated with the risk of infection. Again, this is a rare complication occurring in less than 1% of cases. Every possible precaution is taken to minimise the risk of infection, but that risk cannot be eliminated. If infection were to occur then this would require further medical treatment, quite possibly as an inpatient and in severe cases further surgical treatment. A further operation would involve debridement or cleaning of the wound until the infection had been eliminated and this may require surgery on more than one occasion.
- There is a risk the procedure will not be effective in terms of relieving your back or leg pain. There are no certainties with surgical intervention and I am not able to define a risk factor for the operation not working as there are various grades of success. Some people have complete relief of their pain, although this is uncommon, a vast majority experience partial pain relief such that they are able to return to more normal activity and reduce their requirement for painkillers.
- It is the intention of the fusion operation to eliminate movement in those levels of the spine that are operated on and by doing so, hopefully producing a reduction in the level of low back pain that you experience. An inevitable consequence of this stiffening is that it, of course, increases load onto the lumbar intravertebral disc immediately above the fused level of the lumbar spine, but in certain cases, this can result in accelerated degeneration of that disc, so called transition disc degeneration. A consequence of such degenerative change may be that at some point in the future; perhaps in 5-10 years time from the date of this operation, you may develop low back pain as a consequence of this transitional disc degeneration, which would be sufficiently severe to require further medical or surgical treatment.
- There are other rare complications such as injury to the abdominal blood vessels and or abdominal viscera (intestines)> if such a complication occurred then abdominal surgery would be likely to be required to treat the complication. Both of these complications are rare but very significant if they occur.
- Further complications can occur, thrombosis (clots) in the legs (DVT) when a clot migrates from the leg to the lung, chest infection, urinary tract infection which are all complications of major surgery. A thrombosis may cause discomfort or swelling in the calf and or thigh, an embolus is a very serious event and can pose a very grave risk to health and in occasional cases can be fatal. Complications of this nature are fortunately rare and every effort is made to prevent them from occurring, however, as with all the above, you need to be aware of the risk of each complication, which although extremely small, does remain a potential risk associated with surgery.

The rehabilitation from surgery of this nature does vary from patient to patient; the average inpatient stay would be between seven to ten days. Following the operation, you would be fitted with a removable lumbar corset to support your lower back which you would be required to wear at all times when you were not lying on your back. You can mobilise with the physical therapist and once your pain is reasonably controlled and you are safe and independently mobile you would be allowed to go home.

You will be seen in clinic at six, twelve, twenty-four and fifty-two weeks after the operation to assess your progress. The lumbar corset that you are fitted with would be worn for six to twelve weeks after the operation depending on your progress and at either your first or second outpatient attendance if we were happy with the progress that you were making you would be referred for physical therapy. Improvement can be expected to occur for up to eighteen months after the operation as the fusion matures so it may take that length of time before it can be decided that the procedure has been effective or not. If you are currently unable to work because of your low back complaint, no guarantee can be given that

this operation would result in your complaint resolving to the level that you could return to your previous occupation, although the hope would clearly be that even if you are not able to return to work of the nature that you were previously employed in you may be able to return to work of some lighter alternative nature.

I enclose two copies of this letter, if you understand all the above points and you still wish to proceed with surgery I would ask you to sign one copy and return it to me at your earliest convenience. If you have any further questions then please do not sign the letter until you have had the opportunity to discuss your concerns with myself. I will be happy to see you again in clinic in that regard if you should so desire. If having read this letter, you decide not to proceed with surgery then I would be most grateful if you could inform my secretary at your earliest convenience so your name can be removed from the waiting list.

With kind regards

Yours sincerely

Mr R I Carew FRCS (Eng) FRCS (Orth)  
Consultant Orthopaedic & Spinal Surgeon

Patient Name

.....

Patients Signature

.....

Date

.....

cc GP

## **A new chapter opens post Jones v Kaney**

**Henry Charles**

CPD Ref: AWW/CHRW

12 King's Bench Walk, Temple, London EC4Y 7EL,  
Tel: 020 7583 0811, Fax: 020 7583 7228, Video Conferencing: 020 7583 4190  
E-mail: [chambers@12kbw.co.uk](mailto:chambers@12kbw.co.uk), Website: [www.12kbw.co.uk](http://www.12kbw.co.uk), DX 1037 Chancery Lane

## A NEW CHAPTER OPENS POST-JONES v KANEY

1. There are no apologies for looking at this issue a year on from William Fetherby QC's presentation at the 12 King's Bench Walk 2010 clinical negligence seminar. For we now have the decision of the Supreme Court in *Jones v Kaney* [2011] UKSC13.
2. Until very recently it had been almost blithely assumed that experts in civil proceedings enjoyed the sort of immunity from suit that advocates used to enjoy prior to *Arthur JS Hall v Simons* [2002] 1 AC 615HL, and then some.
3. The immunity may not have been quite so wide as was popularly believed. In *Palmer v Durnford Ford* [1992] QB 483 Chadwick LJ set out the then state of the case law in these terms:

*"(i) an expert witness who gives evidence at a trial is immune from suit in respect of anything which he says in court, and that immunity will extend to the contents of the report which he adopts as, or incorporates in, his evidence;*

*(ii) where an expert witness gives evidence at a trial the immunity which he would enjoy in respect of that evidence is not to be circumvented by a suit based on the report itself; and*

*(iii) the immunity does not extend to protect an expert who has been retained to advise as to the merits of a party's claim in litigation from a suit by the party by whom he has been retained in respect of that advice, notwithstanding that it was in contemplation at the time when the advice was given that the expert would be a witness at the trial if that litigation were to proceed.*

*What, as it seems to me, has not been decided by any authority binding in this court is whether an expert is immune from suit by the party who has retained him in respect of the contents of a report which he prepares for the purpose of exchange prior to trial – say, to comply with directions given under RSC, Ord 38, r 37 - in circumstances where he does not, in the event, give evidence at the trial; either because the trial does not take place or because he is not called as a witness."*

4. So an advisory report (for example a negative opinion whether it was Bolam negligent to perform an operation) would have been actionable.

5. The Supreme Court held, by a majority, that the reasons for preserving immunity were not well-founded. Experts would not be reluctant to provide their services if they might be sued by their clients. They would not be inhibited. It was accepted that if immunity was to persist then it must apply to views expressed not only in court, but in contemplation of, or at least preparation for possible proceedings – recognising that the vast majority of personal injury claims settled without getting near the doors of a court. So the immunity has been stripped away by *Jones v Kaney* in its entirety (save for defamation, where absolute privilege remains common to both advocates and experts).
6. So far, so good, or at least, so clear.
7. However, what is the standard of care? Part 35 provides some guidance, but in matters medical are we looking at *Bolam / Bolitho*, or will there be jurisprudence as to the standards expert witnesses should abide by? In *Jones v Kaney* the alleged failings of the expert were only tangentially related to medical expertise. The allegations sound much closer to lack of preparation, inexperience and a failure to stand firm.
8. There is another, potentially major, issue. Lady Hale, one of the two dissenting voices, cautioned against removal of the immunity, citing what amounted to the law of unintended consequences. There is a shading of that concern in what Lord Collins had to say at paragraph 71:  
  
*“This appeal is concerned only with the liability of the so-called “friendly expert” to be sued by the client on whose behalf the expert was retained. The facts raise directly only liability to be sued for out of court statements, but any immunity in relation to such statements is a necessary concomitant of the immunity for things said in court, and the same principles must apply equally to each.”*
9. Whilst factually correct in terms of what happened in *Jones v Kaney*, the majority judgments do not make such a distinction and it is difficult to see how the immunity could remain for the “adverse” expert. For example, where the adverse expert scurrilously or negligently misleads the friendly expert as to an examination or medical records.
10. The adverse expert may also be vulnerable to third party proceedings. For example, if a psychiatrically vulnerable Claimant is seen by a clinician for medico-legal purposes and produces a report wrongly stating that the Claimant will never recover, or has some socially devastating condition,

resulting in a major and chronic depressive state, the defendant's insurers are going to query why they should pay the entire bill. Whilst in some cases the *Rahman v Arearose* [2000] 3 WLR 1184 separate damage type approach may enable the respective proportions of causative damage to be assessed as between defendant and (hopefully formerly instructed) expert that will be unlikely to be the case with psychiatric injury. See *Dickins v O2* [2008] EWCA Civ 1144 on indivisibility of psychiatric injury. It would clearly be beneficial to have all claims dealt with at the same time.

11. That raises the issue of what a defendant should do when it is suspected that a claimant's expert is behaving ludicrously with the potential for damage to the claimant to ensue; the answer is probably a warning shot across the bows. That should in turn lead to applications to replace the relevant expert if the defendant's allegations are not fanciful. Such cases have the potential to become a real headache for the courts (and claimants) in terms of case management.
12. Other, less controversial issues are likely to arise.
13. For example it seems more likely that the claimant's expert may often get joined when the claimant sues his former legal representatives. For although a medical expert is engaged to provide a medical opinion there is still skill and judgment to be exercised by the legal team in respect of (a) appropriate field of expertise (b) application of experience to the report to be relied upon. To take an extreme example, if an orthopaedic and trauma surgeon provides a report stating that it was acceptable for an orthopaedic and trauma surgeon to remove the wrong leg, whilst the reporting surgeon looks well and truly in the frame so do the legal team if they blithely accepted such advice and discontinued the claim.
14. Similarly, accepting and relying upon a report from a psychiatrist who trespasses into orthopaedics is likely to involve fault on both lawyers and psychiatrist.
15. *Jones v Kaney* also has implications for those clinicians undertaking medico-legal work who manage to end up treating claimants. Many will have experience of treating clinicians who cannot believe that their stellar treatment can fail, and who blame the patient when things do not turn out as expected. Now such clinicians are vulnerable on two fronts and it may be easier to proceed on breach of duty as an expert.

16. It would be wrong to suggest that there is going to be a major new field of legal endeavour as a result of Jones v Kaney, or that floodgates have opened, but there probably are going to be an appreciable number and variety of claims.

**Henry F. Charles**