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The Scottish Patient – the bare bones of pursuing a medical negligence claim

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Introduction and outline

- Why do patients become clients, what do they want?
- What sources of evidence and material are available to assist with investigations
- Legal tests that require to be proved in medical negligence cases
- Brief overview of changes to Court procedure
- Complications due to Covid, prospects for claims
- Some recently decided cases of interest
- Future developments – PPOs, Consultations on mode of hearings, Scottish Patient Safety Commissioner, No Fault Compensation

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Documents

- ✓Pursuer's or relative's statement of events – particularly important where there are discrepancies with the notes
- ✓Complaints procedure – letters of response after internal investigation
- ✓Investigation reports, Duty of Candour, SAER, LAER, SPSO
- ✓GMC proceedings or FAI investigations
- ✓Guidelines and protocols relevant to the procedure from the hospital, the health board, or applicable nationally, SIGN, NICE - both at the time of an event and current versions
- ✓Medical records - DPA by injured person or representative, Access to Health Records application for deceased's records by NOK for relevant incident and previous medical history as well as current relevant records

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Obtaining an expert report

- Registers of experts - APIL, Avma, Academy of Experts, the Expert Witness Institute, Specialist Info Directory, Inspire Medilaw database, Resolve, agencies – but be aware irrecoverable fees
- The Law Society of Scotland's database and code of practice
- https://www.lawscot.org.uk/members/business-support/expert-witness/
- Linked In, colleagues, word of mouth
- Ensure they have relevant experience and ability by examining their CV and can ask for sample report

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Conflict of interest

- In breach of duty case, it is likely to exist if there is personal knowledge of the doctor being criticised, or a history of having worked together in practice or been on the same committees
- Not appropriate if expert works in same geographical location
- Can ask expert to check the medical practitioner criticised – their profile and website for any possible links, or with their colleagues; check patient not previously treated by them or their practice;
- Exp v Barker [2017] EWCA Civ 63 – example of too close a relationship of medical professionals
- Dr Zuber Bux – too close a relationship to solicitor's firm

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Relevant experience is critical

- Expert must have appropriate clinical practice
  - Have been practising at the time of the incident
  - Equivalent expertise as a peer and in area of medicine will be scrutinised – *Hamilton v Lanarkshire HB [2020] CSOH 24.* General surgeon, with sub speciality in colorectal work, and who attended upper GI emergencies when on call preferred as direct comparator, and not senior medico legal expert
  - Criticism of expert due to retirement by the time of giving evidence – *LT v Lothian HB [2018] CSOH 29*

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Helen Coyle v Lanarkshire Health Board [2013] CSOH 167

"Her written report …. had certain curious features including having no signature or reference to the name of its author, and it was not clear Dr Lee had been appraised of and understood the duties to the court of a person called as a skilled witness. As she gave evidence I formed the clear impression that she did not have the expertise to qualify her to give expert evidence on the standard of care reasonably to be expected of a midwife responsible for a high risk labour such as that of the pursuer"

St Helens Council v M and F 2018 – expert not paid as felt so strongly about diagnosis of fractures in children but had no expertise of children

Armstrong v ERS [2018] SAC (Civ) 28 – doctor's independence and impartiality questioned due to payment on a contingency basis, neither report nor evidence compelling, inadmissible

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Salutary Lessons from civil cases

- ***Thimmaya v Lancashire NHS Foundation Trust 30 Jan 2020 Manchester C C***
  - Claimant's expert spinal surgeon ordered to pay £89,000 of defence costs – unable to articulate test of breach of duty in clinical negligence claim. Exceptional case – English test "improper, unreasonable or negligent conduct".
- ***McCulloch v Forth Valley HB [2020] CSOH 40 ; [2021] CSIH 21***
  - Expert consultant cardiologist had 2 versions of report in circulation, both with same date – Lord Tyre said "entirely inappropriate course of action for solicitors and Dr X to take", however did not affect assessment of evidence given at proof
- ***Hamilton v Lanarkshire HB [2020] CSOH 24***
  - Consultant general surgeon looked up the internet during lunch break in evidence; said to have given speculative opinions, disagreed with 3 other experts
- ***Dr J M McLennan v GMC [2020] CSIH 12***
  - Covert recording of examination by claimant showed inaccuracies in the expert report produced, knew it would have been relied upon and removed from the Register

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Different types of report

1. Factual - condition and prognosis from independent perspective or from treating physician, but only in limited circumstances
2. Breach of duty - to address the *Hunter v Hanley* test
3. Consent – to address the *Montgomery* requirements
4. Causation – to address the “but for” test
5. Fatal Accident Inquiry
6. Cases relating to care during Covid pandemic

Role of the expert is to be independent, thorough and reasoned

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Hunter v Hanley 1955 SC 200; 1955 S.L.T. 213

Lord Pres. Clyde: *"The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill and care would be guilty of if acting with ordinary care."*

"To establish liability by a doctor where departure from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a **usual and normal practice**; *secondly it must be proved that* **the defender has not adopted that practice**; *and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which* **no professional man of ordinary skill would have taken if he had been acting with ordinary care**"

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Competing evidence and Causation

- It is not sufficient as a pursuer to have supportive expert evidence on breach of duty, if the defender also has supportive evidence, it is necessary to prove the opposing view is based on a misunderstanding of the facts or has no basis in logic
- Bolitho 1998 AC 232 , approved by Lord Hodge in Honisz v Lothian Health Board, 2006 CSOH 24 and subsequently
- It is not the function of the court to prefer one school (of responsible medical practitioners) over the other, there must be a logical basis for the opinion, must be reasonable and responsible
- Thereafter, it is necessary to prove on a balance of probabilities that the breach of duty caused, or made a material contribution to, the eventual outcome

Consent cases – test in Montgomery

Para 87 - An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken.

The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

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Montgomery Para 89

It follows from this approach that the assessment of whether a risk is material cannot be reduced to percentages.

The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives.

The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.

Consent cases

- *Montgomery v Lanarkshire Health Board [2015] UKSC 11* changed the landscape in terms of the test to be applied to the health professional
- Not based on *Hunter v Hanley* but the expert does still have a factual role in determining whether an informed decision has been made by a patient in conjunction with a doctor
- Recent developments in the Court of Session in the mesh cases debates, *Jerry Taylor v Dailly Health Centre, McCulloch v Forth Valley HB 2020 + 2021,* courts assessing what should be disclosed in the exercise of professional judgement, as opposed to basis of decision in *Montgomery*

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Case management rules

- Chapter 42 ordinary actions raised < 1 March 2020
- Summons signetted, served, defences, adjustment period automatically allowed of 8 weeks, followed by extensions until Record closed. Within a couple of weeks written Statement of proposals lodged then By Order Adjustment Roll hearing at which proof fixed, with pre proof timetable issued.
- Chapter 42A ordinary actions raised > 1 March 2020
- As soon as practicable after Record closes, Case Management Hearing fixed no sooner than 16 weeks later and detailed timetable of steps to be taken in the interim
- Proof not fixed until the CMH 4 months > Closed Record

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Chapter 42A.5 from closed record

- 42A.5 (2) 3 weeks later, parties must exchange all draft reports of experts and statements of witnesses
- (3) 4 weeks after that parties must exchange provisional valuation and vouching, proposals for further procedure, note of disputed issues, list of relevant documents, joint meetings considered
- (4) 2 weeks later, pursuer sends defender a joint minute including “all matters”, glossary of terminology, heads of damage, chronology of events, paginated joint bundle of all records
- (5) 3 weeks later, defender sends pursuer revised documents
- Nothing lodged, must not be put in evidence unless agreed

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Chapter 42A procedure to proof

- 42A.6 Documents to be lodged 14 weeks after record closes
- 42A.7 Case Management hearing proceeds and judge can determine whether proof can be fixed and fix that date
- 42A.8 Pre proof timetable with steps for lodging all the usual documents working from 6 months before proof, pre trial meeting not less than 3 months before proof and additional hearings
- Judge can order the timetable be varied on cause shown, make any order necessary, and compel a party to appear to explain if there has been non compliance

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Reports examining care during the pandemic

- 1. Covid related claims – claiming that Covid has been contracted negligently causing loss eg unsafe working practices, failure to provide appropriate PPE during employment, lack of safe environment, compulsion
- 2. Patients removed from hospital into care homes then contracting Covid in the care home; also care home residents contracting Covid due to infectious patients sent from hospital
- 3. Patients contracting Covid whilst in hospital for an unrelated condition
- 4. Clinical negligence claims due to lowering of standards eg. Delay in diagnosis of cancer claims

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Clinical negligence claims

- Legal test for consent in remote consultations, assessing patients, medical records still require to be accurate and full
- Can *Hunter v Hanley* still be applicable in unprecedented situations? Question of what the "normal and usual practice" was will vary depending on the state of knowledge of the government and scientific community. Causation verging on impossible to prove?
- Relevant Guidelines and updates – Government, Royal Colleges, NICE, SIGN, local health boards and organisations
- Any expert instructed to provide an opinion must have been ~~working in the pandemic to comment; cannot use hindsight~~

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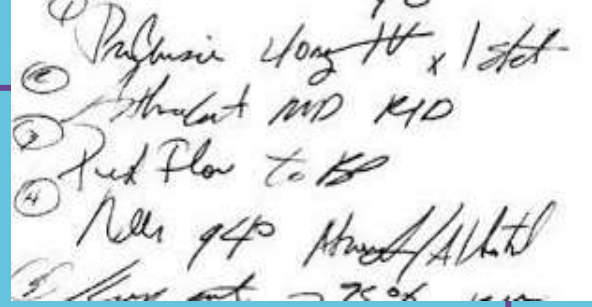
Recent cases – reconciling records with a patient's recollection



- *George Andrews v GGHB [2019] CSOH 31* – contemporaneous notes that "patient would like to go home" flatly contradicted by patient's widower, former not deemed accurate reflection, pursuer's case strengthened by complaint procedure documents
- *Allan Johnstone v Grampian HB [2019] CSOH 90* – consent case and no witness inherently more or less reliable than another, documentary evidence outweighed pursuer's oral evidence
- *Ismail v Joyce [2020] EWHC 3453 QB* – "inherent unreliability of memory". Medical records are key but not conclusive in solving factual disputes, cannot be comprehensive, but memories are fluid

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Future developments

- **1. Clinical negligence pre action protocol** – draft Rules now finalised, will be in force soon. PAP deals with recovery of documents and timetable for exchange of information
- **2. PPOs** – still to be enacted, court can impose a Periodical Payment Order on parties without consent provided that the continuity of payments is reasonably secure. Advantageous if life expectancy disputed, if care costs a large element of claim, avoids a lump sum potentially undercompensating pursuer
- **3. Scottish Civil Justice Council consultation** on draft rules on mode of attendance for hearings

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And finally…..

- Default position for proofs to be heard remotely, unless significant issue of credibility of party or witness
- Procedural hearings – advantages in virtual hearings
- However concerns around accessibility, digital poverty, assessment of reliability, administrative burden on solicitors, costs
- **4. Scottish Patient Safety Commissioner** - proposal to address perceived gaps in current network of bodies, statutory duties and organisations that exist
- **5. No Blame Redress Scheme** – following on from No fault compensation review group report 2011 – M I A

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