How to get the best from your medical expert in clinical negligence cases

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> *He was very free with his allegations of professional negligence against a number of doctors and surgeons, all of which have been shown to be without foundation. These allegations were based upon a superficial reading of the relevant notes and records and a totally inadequate appreciation of matters which were well-known to those who have up to date responsibility for the day to day care of spinal injuries but which were unknown to him ....*[1]

1. An expert's "*overriding duty*" is, according to CPR 35.3, to the Court. This is a somewhat optimistic statement of the expert's duty. After all, in clinical negligence cases each party has their own breach of duty and causation experts whose evidence is being relied upon precisely to support the party's case. However, as the quotation above demonstrates failure to pay adequate attention to the logic of the expert's opinion, to the thoroughness of the analysis and to the qualifications of the expert will prove fatal to the case as well, possibly, to the expert's future flow of medico-legal work. Credibility is paramount.

1 *Scott v Bloomsbury Health Authority* [1990] 1 Med LR 214.

Experts Must Be Persuasive

2. In *Morwenna Ganz v Dr Amanda Jillian Childs, Dr John Lloyd, Kingston Hospital NHS Trust* [2011] EWHC 13 (QB), the Claimant, 14 at the time, alleged that the Defendants had been negligent in their treatment of her so that they were liable for permanent brain damage sustained through her developing mycoplasma pneumonia.

3. What is of interest in Foskett J's judgment is his focus not only on Professor Kirkham's expertise (the Claimant's neurological expert) but on her presentation as a witness. It is suggested that if an expert does not present as someone who could potentially be "*authoritative*", "*cautious*", "*thoughtful*", "*well-balanced*" and "*non-partisan*", then they should not be instructed. Foskett J, in dealing with Professor Kirkham, stated:

> *197. I will deal with Professor Kirkham first. Her CV demonstrates that she is a highly qualified and highly distinguished paediatric neurologist who has been a Consultant for about 20 years with clinical experience at Great Ormond Street Hospital and Southampton General Hospital. She was a senior lecturer in Paediatric Neurology at the Institute of Child Health for approximately 16 years prior to her appointment as Professor of Paediatric Neurology at the Institute in October 2006. Her written contributions to medical literature, both in textbook form and article form, is very extensive and her particular research interest has been in the detection and prevention of brain damage in acutely sick children. Her recent Doctor of Medicine thesis at the University of Cambridge was entitled 'Cerebral Haemodynamics in Normal Subjects and Children in Coma'. She was eminently well-qualified to offer an opinion on relevant issues in this case.* ***So far as her presentation as a witness was concerned, I thought she was authoritative when she felt she could be, cautious when she felt she had to be and entirely thoughtful and well-balanced in her approach. She was, in my view, an extremely impressive witness upon whom I felt I could place reliance. I detected no basis for thinking that she was partisan or that she was attaching herself to some document or piece of information "because it suited her case" ...*** *[emphasis added].*

4. Consider, by way of further example *Williams v Jervis* [2008] EWHC 2346 QB where Roderick Evans J had this to say about Dr Gross, the Defendant's neurological expert:

119 ... In my judgment the criticisms made of him on behalf of the claimant are justified. Although Dr Gross has dealt with the claimant's case voluminously there are clear indications of a lack of thoroughness and a failure to spend adequate time in properly analysing the case. It may be that his heavy workload and high documentary output has prevented this. It is equally likely in my judgment that he approached the case with a set view of the claimant and looked at the claimant and her claimed symptomology through the prism of his own disbelief. From that unsatisfactory standpoint he unfortunately lost the focus of an expert witness and sought to argue a case. I am driven to the conclusion that I am unable to place reliance on Dr Gross's evidence in this case.

5. *Williams v Jervis* illustrates an all-too-common problem, that of producing reports of huge length often at high cost but without sufficient analysis. This is often achieved via typesetting means, ie large font, double spacing and wide margins. It is suggested that such an approach is indicative, albeit not determinative, of a reluctance to analyse.

6. Rather, what is required is a succinct report that summarises relevant material in a sophisticated way and reaches comprehensible and clear conclusions. Voluminous reports often bat off conclusions to a further report pending further investigation or review of further records. In such cases the experts themselves may lose the thread of the material.

7. Experts will be assisted by a comprehensive set of well-ordered and indexed medical records and should be referred to relevant entries. Specific issues which the expert should address should be raised in the letter of instruction albeit with the proviso that the expert need not limit themselves to those issues. Similarly, if there are issues which the expert should not address, eg breach of duty if that is admitted, then this should be made clear.

8. Clear analysis of the material is often demonstrated by an expert's willingness to include a summary of the key views at the commencement of the report. After

all, if an expert demonstrates by such means an interest in communicating then that suggests an intention to analyse.

9. The key to a good report is that it must be persuasive, both to the parties and, if the case gets that far, to the judge. This requires close examination of the logic of the position held and condescension to and examination of the details of the case. Lawyers are adept at these skills and should assist the expert in the furtherance of this aim. As set out in the Protocol:

> *15.2 Experts should not be asked to, and should not, amend, expand or alter any parts of reports in a manner which distorts their true opinion, but may be invited to amend or expand reports to ensure accuracy, internal consistency, completeness and relevance to the issues and clarity. ...*

10. Being involved in this process will significantly enhance the ability to assess the opposing party's expert evidence and to put informed questions to the experts. What is required is a clear reasoning within the report, backed up, where appropriate, with reference to medical literature. Bald assertion is of little assistance.

Appropriate Expertise

11. If an expert is to be credible then they must have appropriate expertise. In a recent case in which I was involved the central allegation was of negligent failure to undertaken initial hip replacement surgery after the Claimant had sustained a serious fracture to her leg rather than fixation of the fracture which fixation subsequently failed requiring revision hip replacement surgery. The expert stated that he had "*relevant*" experience when in fact he was a general orthopaedic surgeon with only minimal experience in hip surgery. This was clearly insufficient, the expert was swiftly and forcefully out-ranked and the case dropped.

12. Experts should be asked to specify exactly what experience they have. Assertions as to expertise should not be taken at face value but should be probed before instruction.

13. Caution should be exercised in relation to professional experts, ie experts who spend more time working as experts than in practice. Such experts may demonstrate less independence (since their income depends largely on medico-legal work) and will likely possess a less firm grasp on current practice; see, for example *Melhuish v Mid-Glamorgan Health Authority* [1999] MLC 00145 where the Claimant suffered amniotic fluid embolism in the womb just before birth resulting in hypoxia and acute brain damage. Thomas J assessed the medical experts (and preferred the defendants') as follows:

> *Although Professor Rubin [consultant physician] and Professor Halligan [consultant obstetrician and gynaecologist] were younger than Mr Clements [consultant obstetrician and gynaecologist] and Professor Rosen [consultant physician] and thus had less experience, I do not consider that that relative lack of experience in any way counted against them. Although Professor Rosen and Mr Clements had considerable medico-legal experience, Professor Rubin and Professor Halligan had the advantage of being at the front line of current medical practice and did not spend an undue amount of their time in medico-legal work. In contrast, Professor Rosen had retired and Mr Clements spent a considerable portion of his time away in risk management and medico-legal work. It was somewhat surprising that both Professor Rosen and Mr Clements had been ignorant of the seminal work of Professor Clark on AFE until their involvement in this case.*
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> *I preferred the evidence of Professor Rubin and Professor Halligan to that of Mr Clements and Professor Rosen wherever it conflicted;*

14. Caution should also be exercised where an expert has retired from clinical practice or, if a case is likely to take a number of years to conclude, where the expert may retire in the interim and become unavailable. Consider, for example, *Toth v Jarman* [2006] EWCA Civ 1028, CA where the Defendant GP attended the Claimant's five year old son who had suffered a hypoglycaemic attack at home. Rather than administering an intravenous glucose injection immediately

the Defendant sent him to hospital. The issue was one of causation and the nature of the respective experts' clinical experience proved pivotal:

In our view the judge was plainly entitled to prefer the evidence of Professor Hull [retired paediatric specialist] over that of Professor Marks [largely retired consultant and lecturer in clinical pathology], based on his experience and the substance of his evidence, as well as the manner in which he gave it. Despite his eminence as a clinician and an expert on hypoglycaemia, Professor Marks had limited experience and, as he accepted, little expertise in treating children and in particular any with glycogen storage disease, in contrast with the considerable experience of Professor Hull in treating children generally and some experience in caring for children with glycogen storage disease. Professor Marks conceded that he was rarely concerned with day to day management of patients but, when he was, he had treated adults rather than children and had in any event retired from clinical practice in 1995. His involvement in treating children had ceased 35 years previously and he had never had any day to day responsibility for the management of children such as Wilfred with GSD. He had only ever seen 3 or 4 cases of GSD (and then not as the treating doctor) and had no personal experience of the death of a child with GSD from hypoglycaemia. He conceded that he would not be competent to address the question of irreversible brain damage occurring in a 5 year old child in the absence of fitting. Professor Hull on the other hand, was an experienced paediatrician who had had consultants' responsibility for children with hypoglycaemia and with GSD. He did not accept that Professor Marks was an expert on treating children with hypoglycaemia, describing him as a distinguished chemical pathologist. Given that the experts were not of the same discipline, and given their differences in experiences and expertise, the judge was entitled to reach the conclusions he did in assessing their evidence.

Citation of Literature

15. The Oxford Centre for Evidence-Based Medicine provides a table setting out levels of evidence[2]. The highest level of evidence consists of systematic reviews ("SR") of randomised-control trials ("RCT") (an analysis of many separate RCTs), then come RCTs with narrow confidence intervals, followed by all or none studies[3], then SR of cohort studies (which link risk factors with health outcomes), then individual cohort studies and so on.

16. The very lowest level of evidence of the 10 identified is that which the legal profession largely rely upon.

2 http://www.cebm.net/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/
3 For an explanation see http://www.bmj.com/rapid-response/2011/11/01/all-or-none-studies

Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"

17. Accordingly, any additional factor which an expert may contribute to their opinion will be of significant value. This may include:

(a) Citing peer-reviewed literature in support of the opinion reached. In this regard experts should be instructed to undertake literature searches on medical databases.

(b) Citing international, national or local guidelines as to the practice adopted and referring to their applicability within the relevant clinical setting.

(c) Appending literature and guidelines cited to the report or otherwise making them available; see CPR 35 PD 3.2(2). In *Breeze v Ahmad* [2005] EWCA Civ 223, the defendant's expert cited literature but did not provide it. On appeal, the claimant contended that the literature had been misinterpreted. The appeal was allowed.

18. Consider *Nasir Hussain v (1)Bradford Teaching Hospital NHS Foundation Trust and (2) Doctor Keith Jepson* [2011] EWHC 2914 (QB) in which the Claimant suffered Cauda Equina Syndrome ("CES") whilst a patient in the Bradford Royal Infirmary. The central question for Coulson J was the issue of causation. The judge attacked the Claimant's orthopaedic expert's credibility, his reasoning and his failure to review relevant literature:

66. Unhappily, for a number of reasons, I found Mr McLaren to be an unsatisfactory expert witness, and I could not conclude that his minority view should prevail over that of the majority.

67. First, there was his unsatisfactory evidence relating to the Second Defendant (paragraph 22 above). Secondly, there was his (only) report of 12 November 2010, which I consider to be a superficial examination of the Claimant's claim which does not address, except in very general terms, the critical causation issue.

...

71. The third difficulty with Mr McLaren's evidence on this point was that, although there was a good deal of literature on the subject of CES, and a number of papers dealing with when surgery should be performed, Mr McLaren did not rely on any of that published material in his report. He only referred to it to dismiss the literature altogether. Although in his oral evidence he attempted to suggest that reference to those papers was implicit in his report, I do not accept that: he deliberately did not seek to rely on the literature in his report. Instead, he sought to rely on his own experience which, because it was both contradictory and undocumented, could not be the subject of meaningful research or comment by the defendant's experts. Neither the number (15 or 40), nor the precise condition of his former patients at the time of surgery, could possibly be verified by anyone else.

19. Publications may also be helpful in relation to whether your expert really is an expert. Inevitably, an expert who has published in the area will have greater authority in Court.

20. Expert evidence is pivotal in clinical negligence cases. Although lawyers are not experts in any field aside the law they do possess the key analytical skills necessary to assess expert evidence and can avoid, with reasonable diligence, the situation faced by Leggatt J in *Hirtenstein and Another v Hill Dickinson LLP* [2014] EWHC 2711 (Comm) (a commercial case):

Mr Chettleborough's valuation approach effectively involved putting the available information into a black box from which a figure emerged based entirely on his gut feel. The problem with a valuation pronounced ex cathedra in this way is that it is not capable of being tested or subjected to any rational scrutiny. It amounts to saying "trust me, I am an expert valuer". However, unless the expert is able to point to some objective evidence to demonstrate the reliability of his judgment – which Mr Chettleborough was not – it is not acceptable in the context of litigation to be asked to take an expert's opinion on trust. Experts' opinions, if they are to be accorded any weight, need to be supported by a transparent process of reasoning.

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