FORMAL RESPONSE

TO LSC CONSULTATION

ON EXPERTS

Response of AvMA to LSC Use Of Experts Consultation.

Introduction

Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

AvMA is proud of the key role it has played in making clinical negligence a specialism within legal practice. It continues to accredit solicitors for its specialist panel (without membership of AvMA's or the Law Society Panel a law firm is not entitled to a clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors.

Given AvMA's direct experience of clinical negligence, the focus of our response will be seen from this perspective. Whilst we accept that many of our comments may apply equally to other areas we wish to confine our comments to clinical negligence which falls within our own knowledge and expertise. We have benefited from constructive informal discussions with the LSC and from discussions with specialist clinical negligence solicitors. Our response has also been informed by a survey we conducted with a selection of medico-legal experts representing a cross-section of all the key disciplines of relevance to clinical negligence claims. We have received 250 responses to the survey.

Our response comprises three sections:

- Summary
- An overview
- Detailed comments and answers to questions for consultation which have implications for clinical negligence

Summary

- AvMA believes that capping expert fees will detrimentally affect the ability of claimants in clinical negligence cases to instruct experts of appropriate calibre or skill. This means that a claimant will be denied access to experts of equal calibre to the defence. This is inequitable.

- The proposals relating to accreditation are not appropriate for clinical negligence. Already, experts are closely monitored either through the expert database maintained and compiled by AvMA or through panel firms maintaining their own list of suitable experts. We do not believe accreditation to be necessary. Nor do we believe that it will enhance quality assurance – it would be easy to envisage that unreliable experts could still achieve accreditation.

- In practice an individual will not attain AvMA panel status if they cannot demonstrate a robust approach to the instruction of experts.

- Clinical negligence work is effectively managed both through the LSC franchising requirements and by the court (both through case management itself and through the costs assessment process). This feeds into both quality assurance and is an effective mechanism with which to control costs.

Overview

Expert Fees

The core purpose and vision of the LSC encapsulated in one of the four parts of their vision statement is to make "***quality*** legal services happen" and to make "quality legal services ***accessible***." (our emphasis). Capping fees that clinical negligence experts can charge to bring them in line with charging rates in crime is going to lead to a significant depletion of experts who will agree to act for claimants in publicly funded clinical negligence cases. This will make the provision of high quality experts by claimants on legal aid *inaccessible.* Further we do not think that it will save the LSC money so far as clinical negligence is concerned because as the LSC well knows the majority of claims result in full recovery of expenditure. If, the LSC were to insist upon capping at the rates proposed the only experts that might be willing to act for claimants under legal aid will be those consultants/registrars at the junior end or retired consultants; alternatively, clinicians just cutting their teeth on medico-legal work. Many respondents to our survey independently agreed. One said:

"If not thought out and discussed with the medical profession it is likely to result in denying claimants/defendants (sic) the benefit of the right of medical opinion."

One respondent to the AvMA survey stated:

"…These proposals will encourage the "quick= dirty" and good old "liars for hire."

Another said:

"Experts are not standard. You will get a dumbing down of expertise which will impact on the quality of advice to the courts."

Those esteemed experts who both sides often "race" to get (particularly in the disciplines where medico-legal experience is scarce) will decline instructions from the claimant and wait until the defence approach them. This has serious implications for

fairness and justice. Claimants will be denied access to the best or most appropriate expert without similar restraints imposed on the defence.

Cases being investigated with significant expert input may in the future be wrongly declined on the basis of erroneous expert advice. Conversely, some cases may be taken forward on apparently strong medico-legal evidence on the say-so of a less experienced expert who lacks the gravitas of the defence expert and capitulates later on in the day (particularly in the expert meeting). This will be wasteful of public funds, will not result in high quality legal services, will decrease accessibility and will not provide value for money.

Accreditation

AvMA has concerns about a body such as the CRFP having a role in the accreditation of clinical negligence experts. This body is simply not geared up to dealing with a discipline such as clinical negligence that is a highly specialist area requiring experts of the highest calibre. Many experts concur. One said:

"***Forensic council is not an appropriate accreditation body. All of us have professional accreditation. That plus reputable legal support-such as AvMA-should be enough. Most doctors do this work in their spare time-partly as a perceived public service to deserving patients. I could earn more in private practice***…"

An important pre-requisite for a clinical negligence expert is an open mind- to see both sides- and an ability and willingness to recognise a fellow professional has done wrong and not be afraid to say so. Any accreditation process will need to ensure that experts report in a fair and balanced way and that no expert is either a "defendant only" or "claimant only" one. We have other concerns as well (see below). We would resist any move by the LSC that would require a claimant clinical negligence lawyer to choose a CRFP accredited expert over another selected by the claimant lawyer. AvMA maintains its own database of experts and we believe that our own system of continued monitoring

of experts and rigorous assessment prior to an expert being added to the database (or, indeed removed) is the gold standard.

There are other issues relating to accreditation that we raise and these are dealt with in the body of our replies to the consultation questions to which we now turn. It needs to be emphasised that AvMA will restrict our response to the field of clinical negligence and will not comment on areas outside our expertise.

4.2: Do you view services under the CLS and CDS (legal aid) as public services like the NHS?

The LSC is an executive non-departmental public body "sponsored" by the DCA. To that extent it differs from other public bodies like the NHS. However, through the CLS, the LSC is charged with helping "people who are eligible for legal aid to protect their rights." Therefore, should a person's right be infringed at the hand of any public body, including the NHS, then subject to a person's eligibility (finance and merits) the CLS is there to support him/her to seek redress of some nature.

We do not fully understand the question directed but as a public service funded by the taxpayer we would agree that the LSC must deliver services of quality at best value. However, within the clinical negligence field we feel strongly that this is broadly being achieved. The franchising system ensures that no firm can undertake work of this nature without either an AvMA or Law Society panel member in the firm. Further, lawyers are subject to stringent cost controls. The LSC recovers a high degree of its expenditure on clinical negligence arising from successful cases. The LSC has acknowledged on many occasions that clinical negligence expenditure is well controlled and provides good quality and value.

4.3: Do you consider that accreditation will generally raise the quality of forensic services provided by experts?

Quality

AvMA accepts that in some legal disciplines the quality of expert reporting can vary widely. Some experts have been known to find expert witness work so lucrative as to make a career out of it. This certainly needs to be acknowledged and AvMA certainly would not support or encourage the avaricious expert making money out of victims of a medical accident. Such a trend is not prevalent in the field of clinical negligence. At the same time good experts who recognise their responsibilities must be appropriately rewarded. Many experts instructed in the clinical negligence field are of good quality who exhibit mastery of their specific discipline and commitment to their profession. Some experts also feel humbled when they face the reality of damaged lives following medical or clinical error. AvMA believes that it is morally, socially and ethically important for doctors to be prepared to act for patients in these cases. Most of these experts recognise that the stakes are enormously high for our clients. They do not advise recklessly or "off the cuff."

The AvMA Database

AvMA has made a very significant contribution to this state of affairs. Since its establishment, AvMA has worked with members of the medical profession in order to engage them in advising and supporting patients following an adverse incident. AvMA has maintained and compiled a database of experts willing to undertake claimant clinical negligence work. An expert is not placed on our database without rigorous checks being made first. An expert must have held a consultancy post for a minimum of five years in a respected institution. They must be well-qualified and preferably have a research background. We audit anonymised medical reports. Further, the database relies on feedback from our lawyers, reporting back on the quality of the report, satisfaction etc. No expert is removed or placed on the database without the report being audited first.

We employ two medical advisors dedicated to maintain and update the database. We get approximately 100 *written* enquiries every week from lawyers requesting experts, many ask for a multiplicity of experts relating to multiple cases at the same time in one letter (we get many telephone enquiries also). We have 2,500 experts on our database covering the range of disciplines; from paediatric neurologists to radiologists.

Key to the integrity of our database is that no expert gets on the database by paying us to do so. Key to the authenticity of the register is the feedback that we get from lawyers following recommendation of an expert. We also get feedback from solicitors about new experts that they have experience of. Solicitors who are experienced practitioners and panel members rarely instruct an expert on a case without giving a great deal of thought to the issue. Many solicitors firms have their own directory of experts that they resort to and we know from panel applications that we review that they frequently instruct following consultation with other colleagues.

For some time (and prior to publication of this consultation), AvMA has been engaged internally in discussions about the recruitment of new experts to our database. In particular, the focus has been on the younger consultants, to ensure that there is adequate and additional provision of experts, particularly in the highly specialist areas of clinical practice where experts can be very thin on the ground. However, we feel that even those experts who demonstrate potential need to be mentored in some way and peer reviewed before we can “hand-on heart” recommend them. We are continually developing the service. A specialist training day for experts is in the planning process, scheduled for May 2005 as well as re-instatement of the “expert day” on the second day of our annual conference. AvMA is also developing an expert service that will disseminate relevant case/procedure to experts through a newsletter and expert support group meetings.

AvMA believes that with the NHSLA small claims scheme coming on line from April this year and REDRESS in the pipeline, the pressure on experts will be increased while the waiting list times in obtaining reports extended. Diminution to the reserve of experts will

prejudice justice in the long run. It will be of particular concern if experts themselves refuse to “buy in” to accreditation, finding the system too burdensome administratively and time consuming.

What Will Accreditation Achieve?

There is also the issue of whether in clinical negligence there is a problem that requires fixing that accreditation would actually address. Although there may be a mechanism to remove an expert off the “accredited list” we all know how the reality might be in practice.

Accreditation will be meaningless unless experts have to undergo some quality assurance checks that are truly measurable of their skills as an expert and their credibility as a clinician. Training will be important but the quality of the training needs to be assured. Further, accreditation ought not to mean that a certificate issued that warrants an expert’s skills is never to be revoked. A worrying feature of accreditation is whether proactive monitoring will take place. If not, then the system will be less an assurance of quality than the current one that broadly functions very well. Experts are not automatons and at the end of the day, they are providing an opinion based on their clinical experience and expertise – they are not always going to get it right. There are a lot of variables as to why an expert gets it wrong which accreditation will probably not capture. The bad ones are weeded out by AvMA and the legal practitioners, a key skill for specialist practitioners being the ability to assess experts.

The proposal also does not take into account the “one off” expert that ordinarily does not undertake clinical negligence work but happens to be renowned in his/her field of expertise and is one of only a handful of people who understand/practice in that field of work. It is not uncommon for AvMA to get appeals from solicitors for an expert who fits an extremely esoteric bill and for us to make special enquiries based on in-house medical experience and expertise as well as contacts.

Therefore, we would be very worried if the LSC were to insist on accreditation with a body like CRFP or other as a pre-requisite to instruction of an expert. Further, we do not believe that CRFP or another would run the system as well as we do; not without significant resources. Accordingly, we do not believe that accreditation will generally raise the quality of experts in relation to clinical negligence cases.

AvMA does not believe that accreditation with the CRFP or other similar body will be adequate assurance of the quality of an expert in a clinical negligence case. AvMA recommends that in relation to clinical negligence cases solicitors need to demonstrate that they utilise resources which help ensure the quality and appropriateness of experts to be instructed, such as AvMA's service.

4.4 Do you agree that the bodies identified by the Commission for the quality assurance function are the most appropriate? Are there any other bodies that should be considered as quality assurance bodies?

Please refer to our response to 4.3 above. We re-iterate our concern for the CRFP to undertake an accreditation function for clinical negligence cases.

4.5 What is your professional body and do you consider that it would be practicable for it to work with the CRFP to develop a post-qualification forensic work specialism as we propose?

We do not have a professional body. We run our own database of experts that is exceedingly resource intensive. We are planning our own scheme of training and mentoring for experts as set out at section 4.3 (above).

4.***6 Do you agree with the commission's view that, even in the long term, compulsory accreditation is not practicable?***

Yes. We agree.

4.7 To what extent do you support the commission's quality assurance proposals and are they equally applicable to all types of proceedings?

For reasons stated above at 4.3 and below (4.8) we do not support the commission's quality assurance proposals as they relate to clinical negligence. We believe that key to quality is the provision of expert training and mentoring particularly in relation to understanding the anatomy of a civil action, procedures and processes, the legal test in establishing liability and causation and its application, relevant case law and application. AvMA is working on devising an induction pack for experts in clinical negligence clarifying the duties and responsibilities of the expert and clarification of the expert commitment as well as explanation of the legal process and the law.

It is also AvMA's belief that lawyers, barristers and solicitors, bear some responsibility in ensuring that experts are well informed about not only the facts of the case but the law to be applied to ensure that the expert is well appraised of these matters and does not go astray, particularly in the expert meeting.

Linked to quality assurance is the issue of expert accountability. AvMA wants experts to be accountable. For this reason, we believe that an agreement/protocol needs to be devised between the legal and medical professional bodies to set out the duties and responsibilities of a medico-legal expert. We suggest that it is vitally important that the GMC buys into this. The integrity and performance of a medico-legal expert reflects on the profession as a whole. The protocol might be best mediated through the Civil Justice Council. The GMC might also consider the performance of the medico-legal expert as part and parcel of the GMC revalidation process.

So far as the pilot scheme initiated in the North West of England is concerned we do not see that such an expert panel scheme can be transposed to clinical negligence because the spectrum of clinical disciplines is enormous and highly specialist.
AvMA welcomes the study being commissioned by the Civil Justice council and, like the commission await the publication of the report.

4.8 Do you agree that experts' fees for services under the CLS and CDS should be lower than in privately funded cases?

We certainly do not agree. When AvMA was first established 22 years ago, clinical negligence claims were thin on the ground because claimants could not find doctors willing to give evidence against a fellow professional. This contrasted with the position of the defence, who could find any number of "experts" willing to defend any criticism that followed an adverse incident to the hilt. Inadvertently then, if changes to fees goes ahead, claimants and their representatives will find that the clock has gone back 20 years: Defendants not subject to the cost constraints to be applied to publicly funded claimants (although it is likely that defendant lawyers will use these proposals as a lever to exercise some price controls on their side) will simply be the more commercially attractive partners for clinicians to work with. This has serious implications for fairness and justice.

Many, experts that we have consulted with have indicated in no uncertain terms that they will withdraw from undertaking clinical negligence claims where the claimant is legally aided unless the fees that they can charge are comparable with those of private practice including private medico-legal work.

It will be nigh impossible for claimants to match the level of expertise that the defence will have access to as experienced consultants are unlikely to agree to work for rates that are significantly less than those they could attract doing private clinical work or

medico-legal work for the defence. Ironically, the proposals might prove detrimental to the defence in the long run if the experts they instruct undertake only defence work they will lose credibility with the court (lack of objectivity/impartiality).

It is for this reason that AvMA argues that it would be quite wrong for the LSC to act single-handedly as the driver to reducing expert fees. AvMA would like to see some regulation in the level of fees that experts can incur as fees can be variable. In some disciplines this is not immediately understandable. We would readily concede that in specialist disciplines, particularly where the source of expert is limited, higher fees may be entirely justifiable. Some respondents to our survey felt that standardisation of fees might be acceptable provided that fees were set at the right level and provided account was taken of level of expertise/seniority. Others categorically stated that they would refuse to work under such a regime. What seems clear however is how inequitable it is for the LSC to drive the change and impose it on legally aided claimants unilaterally. The net effect then if these proposals went through would be to introduce inequality of arms and reduce the service to a second rate one-contrary to the LSC's stated vision.

Accordingly, AVMA recommends that regulation of expert fees be tackled in association with other key stakeholders involved in the clinical negligence field to include the NHSLA and other Medical Defence Organisations, including the BMA to ensure parity between claimant and defence. We suggest that this work might be best vested in the CJC which is currently involved in this piece of work. Alternatively, the Clinical Disputes Forum could be charged with this piece of work in relation to clinical negligence claims specifically.

4.9 Do you agree that an expert should charge less in less serious crime cases?

This is not within AvMA's expertise

4.10 Do you agree that proportionality should affect experts' fees in civil cases?

We do not see how expert fees can be curtailed in the lower value cases unless the reports are concomitantly reduced and this is impossible unless corners are substantially cut. In a clinical negligence the value of the case unfortunately bears no relationship to complexity. For example, a problematic labour that results in a still birth child (low value) will require exactly the same amount of work-up as the case of a profoundly disabled child on similar facts. The expert(s) must still go through exactly the same process.

It may be that the small claims scheme being proposed by the NHSLA (where experts will work for a much reduced fee in return for an "overview" report dealing with issues in less depth) will take up the greater proportion of lower value cases-it remains to be seen (but such a scheme will not be applicable to private health cases or cases involving GPs in any event).

4.11 What are your views on "proportionality" of costs in family cases?
This is outside of our expertise.

4.12 Do you agree that, like lawyers, experts should keep a detailed record of the work they perform (and of the time taken?) and what do you think are the benefits and drawbacks of doing this?

We broadly agree. The benefits are that if medical experts start doing this as a matter of routine it will introduce more transparency into the process. In particular it must not be forgotten that the statutory charge might "bite" in relation to expert fees that may not be recoverable at the end of the day. The client has a vested interest in knowing how the level of fees was arrived at. The same is true for cases funded on CFAs where the

claimant might have to fund the costs of investigation. It would be good practice to introduce this as an approach.
The disadvantages might be that the administration becomes over burdensome and this might put experts off from undertaking this work. Any record must therefore be simple and not over-regulated. A proforma could be devised for solicitors to send out with instructions.

4.13 Do you appreciate the commissions difficulties in dealing with applications for prior authorities in cases not managed under individual case contracts? If so, do you agree that abolishing prior authorities and publishing guideline fees is a reasonable way of dealing with this issue?

Many solicitors that we consult would not object to abolition of obtaining prior authority before instruction of an expert. However, the publication of guideline fees will only be acceptable if the fees are meaningful (see our comments above). Solicitors will also need to be reassured that should the fees be outside the guidelines, provided it is justifiable (they need to document the reasons and what alternatives there were, if any) the fees will be recoverable. Ultimately, the client needs to be protected because of the impact of the statutory charge and therefore needs to be advised and kept informed.

4.14 Do you agree that for (a) civil and (b) family proceedings, the guideline rates for experts should have (i) a lower minimum and ii) a higher maximum? And if not why not?

Standardisation of expert fees at the level suggested by the LSC in the annex to the consultation paper will not be acceptable for the reasons stated above. As we have indicated if there is to be any regulation of expert fees it is completely unacceptable to unilaterally impose a tariff for experts advising in publicly funded cases without

recognising the severe impact that it will have on the ability of a claimant to pursue a claim successfully.

4.15 Which view of an expert's obligation to the court do you feel most accurately reflects the current position? If neither, please state your view of the obligation?

An expert's overriding obligation is to the court whether undertaking work in the criminal or civil arena.
So far as terms of appointment are concerned, we welcome the idea of a protocol. However, the obligations of the expert need to be more tightly defined: "timely manner" is too non-specific, a specific time scale needs to be established. Experts should be specifically required to read all the records. How many times have we noted entries that went unremarked upon by an expert?

An expert ought to be reminded that if they delegate the organisation of records or enlist the assistance of another in any way, the instructing solicitor needs to be informed (this has been known to occur) and permission given. Experts need to be reminded of their duty of confidentiality.

Another sticking point is likely to be the issue of payment and the retention of 25% of the fee pending the cost assessment. Most of our survey respondents said they would find this term of engagement unacceptable. Many felt that they would have to increase the hourly rate to take account of late /non-payments. Many would find this to be an added disincentive to taking on publicly funded work.

As to cancellation fees, there needs to be some uniformity in approach and experts need to be reasonable. We believe that this issue ought to be picked up at the same time as the issue of expert fees in the relevant forum (see above).

4.**16 Do you agree that, in criminal proceedings, the prosecution and defence should work to the same guidelines for experts' fees?**

This is not within our expertise

4.17 Do you agree, given the width of crime guideline rate bands in the regulations, it is appropriate to introduce guidance on fees within the bands and to divide the bands.

This is not within our expertise.

4.18 Do you consider that additional specialisms need to be included in the crime guideline bands? If so, what are they, and what group do you consider they should be in?

This is outside our expertise.

4.19 Do you agree that the number and cost of expert reports in public law Children Act cases have increased significantly in recent years? Do you consider that the assessment work undertaken (or not) by local authorities and the approach of a local authority towards payment of expert fees has a significant impact? If so, please explain by reference to examples

This is outside of our expertise.

4.20 Do you consider that in public law children Act cases, the court should pay for the expert services it approves/requires (in the same way that the court pays for professional and expert witnesses attending court to give evidence in criminal cases)?

This is outside of our expertise.

4.21 Should solicitors and experts be able to disapply any of the proposed standard terms of instruction in cases under the CLS and CDS?

The key obligations and responsibilities of the respective parties are really non-negotiable. Our views relating to the terms of engagement regarding cancellation fees and the level of fees that can be charged or indeed retained until the conclusion of the case has been discussed in detail elsewhere (see above). If an agreement is reached following the work of the CJC or CDF regarding standardisation of the terms of engagement and expert fees then the standard terms ought not to be departed from unless there are justifiable and extenuating circumstances.

4.22 Do you consider that more detailed guidance than that proposed about fees is necessary and, if so, in which group should they appear?

For the reasons argued above we do not accept that guidance relating to expert fees in clinical negligence cases is necessary or equitable unless standardisation of fees is applied to all parties involved in clinical negligence claims by agreement with the relevant professional bodies.

4.23 What are your views on the categories of expert proposed in the fees guidance? Have you others to suggest and, if so, in which group should they appear?

Our views on the fees guidance have been stated at length (see above).

4.24 To help experts with questions about commission-funded legal services do you consider that the commission's web-site www.legalservices.gov.uk could usefully include a section for experts?

This would be useful.

Conclusion

We hope that our observations and comments will be seen as useful. AvMA is a strong advocate of public funding to promote access to justice and supports the aims and objectives of the LSC, with whom we enjoy a constructive relationship. Should there be any issues arising from this paper or otherwise that the LSC requires further clarification on, we would welcome the opportunity to develop or discuss them further.

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25/2/05