action against medical accidents

LAWYERS SERVICE NEWSLETTER

JUNE 2015

EDITORIAL

INSIDE THIS ISSUE

In the last edition of the Newsletter we referred to a possible judicial review of the government's decision to impose a 600% rise in civil court fees. The campaign was led by the Law Society with AvMA as one of its partners, despite issuing a pre action protocol letter subsequent advice from counsel meant that a decision had to be taken not to proceed with the action.

Separately we asked the LAA to confirm how they were going to respond to the fee increases, we were told: ***"The LAA is reviewing the operational implications of the new court fees for money claims and will update providers on any changes in due course".*** By way of update I can report that the LAA has since told us they are dealing with increases to cost limitations in clinical negligence cases on a case-by-case basis. The LAA maintains that dealing with cases in this way ***"has allowed us to understand the impact of the fees better prior to making any changes to our procedures. However, we are now in a position to amend the funding checklist for Clinical Negligence to take in account the increased fees, and the updated document will be published on our website by the end of the month."*** I would like to hear from any firms who have experienced difficulties in getting the LAA to approve costs increases for the purposes of issuing proceedings.

Thank you to all of those firms who have sent in evidence of experts refusing to work at LAA rates, please do continue to send in letters from both medico legal and quantum experts as these will be useful when we get a date from the MoJ to meet and discuss this matter. I have been told by the MoJ that the reason they have not yet met with us to discuss this issue is that they have not yet recruited a suitable person to fill the post that was left vacant in February. In the meantime they have stated that they have started a review of the rates currently being paid to experts although this is at an early stage, AvMA has provided them with letters from some of the experts who have written saying they will not work for legal aid rates. We have also asked the MoJ to provide details of the information they relied upon when they assessed that the current expert rates would be reasonable and workable.

Experienced clinical negligence practitioners have long recognised the crucial

EDITORIAL

role the medico legal expert plays in helping to bring a successful claim. It is particularly important for experts and lawyers to work together to ensure that time limits are met especially now that it is clear that any delays in complying with court directions can have severe consequences. Recently, it appears that more cases are going to trial rather than settling, as a consequence the way the expert communicates his or her opinions and gives evidence is now more important than ever. With these difficulties in mind I recommend the article found in this edition of the Newsletter entitled **"What kind of expert is yours? Tough lessons from the court room and can they be avoided?"** by Giles Eyre. Giles is a barrister specialising in clinical negligence and personal injury work at 9 Gough Square, his article gives a good overview of the difficulties experts can encounter with reference to recent cases.

The case of **Montgomery v Lanarkshire Health Board [2015] UKSC 11** is one of the most significant cases of recent times, Jim Duffy's article on "***Montgomery*, and the doctor-patient relationship: Re-thinking the paradigm"** is a good overview of the facts of the case and the history of informed consent. Jim is a barrister at 1 Crown Office Row although at the time the case was argued he was the Judicial Assistant to Lord Reed and Lord Hodge; it is worth pausing there to point out that Lord Reed gave one of the leading judgments in Montgomery along with Lord Kerr with Lady Justice Hale concurring. Jim's article is very helpful in the way it succinctly and carefully sets out the key issues arising from the case, it concludes with 10 points for the practitioner to consider when looking the issue of consent particularly when drafting the client's witness statement and examining the medical records.

There is little argument amongst practitioners that cases arising from negligent treatment at birth which cause severe neurological injury such as cerebral palsy attract some of the highest awards of damages. The recent case of ***Robshaw v United Lincolnshire Hospitals NHS Trust [2015] EWHC 923 (QB)*** represents the highest final court award following trial of the action. The overall award is in the region of £14.6 million, as Jonathan Godfrey, barrister at Parklane Plowden points out in his article **"Everything but the kitchen sink – an analysis of *Robshaw v United Lincolnshire Hospitals NHS Trust"*** the case is important not just because of the level of the award but because Foskett J offers his reflections on so many of the items of damage claimed. The judgment runs to 113 pages, Jonathan's article is considerably shorter than that and highlights the most important aspects, looking at amongst other things, the commentary on life expectancy, accommodation as well as the claim for a home pool.

The case of **Radwan Hamed v Dr Peter Mills and others [2015] EWHC 298 (QB)** is a tragic example of the injury that can be caused by a failure to follow up on suspicious test results. Radwan was a talented 17 year old footballer signed to Spurs, the medics responsible for providing medical services to the club breached their duty to Radwan by failing to diagnose or warn about a potentially fatal heart condition Hypertrophic Cardiomyopathy (HCM). The damages have yet to be assessed but are ex-

EDITORIAL

pected to be in the region of £7 million. Radwan was represented by William Featherby QC at 12 Kings Bench Walk; William's case report clearly sets out the salient points and emphasises the importance of proper diagnostic protocols, clear communication and record keeping.

Cosmetic surgery is becoming increasingly common and with it, an increasing number of people are bringing claims for botched treatment. Rebecca Richardson is a barrister at Hardwicke chambers whose clinical negligence practice has a particular focus on claims arising out of cosmetic surgery; Rebecca recently spoke at the London Lawyer Support Group (LSG) meeting on the growing culture of cosmetic surgery litigation. Her article "**A new era of regulation for cosmetic surgery"** appears in the Newsletter on page 9.

Rebecca's article provides an opportunity to draw to your attention the public consultation on the GMC's draft Guidance for doctors who offer cosmetic interventions. The consultation closes on 1st September 2015, here is a link to the consultation:-

https://gmc.e-consultation.net/econsult/consultation_Dtl.aspx?consult_Id=590&status=2&criteria=I

Duty of Candour Update:

Peter continues to campaign for the duty of candour As you may recall the statutory duty of candour has been introduced in 2 parts, the first part was introduced in November 14 [The Health and Social Care Act 08 (Regulated Activities) Regulations 2014], this requires that NHS Trusts must advise "service users" of any notifiable safety incidents including incidents which in the opinion of a health care professional **COULD** result in or **APPEAR** to result in significant harm.

The second phase of the statutory duty of candour was introduced on 1st April 15 [The Health and Social Care Act 08 (Regulated Activities) (Amendment) Regulations 2015) this has effect on primary care and private care. However, unexpectedly the test for this group is different to NHS Trusts and only relates to those incidents which **HAVE RESULTED** in harm. The reference to "could" result in harm has been omitted.

Although at first sight it might appear that the distinction is not very significant, in practice it could have a very significant effect. For example, take a child who has suffered a hypoxic event at birth. If the child was born in an NHS Hospital then the health care professionals would have to advise the family that the event COULD give rise to significant harm. This family would be able to take this into account as the child grew up, it may be relevant information if the child failed to meet the usual milestones. Contrast the family whose baby was born in a private hospital, they could be completely unaware that there had been a hypoxic event. In that case the family may have no red flag in place regarding the need for additional interventions, they may be delayed for many years in establishing the truth of what happened at birth.

EDITORIAL

AvMA is looking at bringing Judicial Review proceedings in relation to the different tests, a pre action protocol letter has been served and we will continue to update you on this.

AvMA Panel Membership: AvMA is going to be doing some "road shows" on applying for AvMA Panel Membership in the Autumn, the talks will last about 45 minutes with time for questions and will be tagged on to the LSG's. Liz Thomas and I will be speaking about the requirements for AvMA Panel Membership including: the criteria for membership, what we look for in an Applicant, the assessment procedure and so forth. We encourage anyone who is thinking of applying for panel membership or who has been practising as a clinical negligence lawyer for around 5 years to come along to these meetings. The aim is to give presentations in London, North West, North, Midlands and South West between September and December 2015, the dates are in the process of being finalised and will be sent out to Lawyer Service Members in the near future, we will also be posting the dates on our website.

We look forward to seeing you at the annual conference on 25th June in Leeds.

Best wishes

Lisa

Lisa O'Dwyer
Director Medico-Legal Services

What kind of expert is yours?

Tough lessons from the court room and can they be avoided?

A clinical negligence claim stands – and falls – on the quality of the expert evidence, and more particularly, the quality of the expert themselves. Sometimes that quality is apparent at an early stage in proceedings, or in conference when under close scrutiny, or in the fallout from a joint discussion and a weak joint statement. But sometimes, as reported cases continue to demonstrate, it is not until trial that it all goes wrong. It is surely reasonable to assume that in each of the examples referred to below the party seeking to rely on the expert believed that their case would be supported by the evidence of that expert.

That experts on occasions have difficulty with legal principle and in applying legal tests, and have difficulty in understanding what carries weight with the court and what does not, is not entirely surprising given the nature of the required training and qualifications of medical experts – nil training and nil qualifications other than medical (although some form of accreditation will be introduced next year for low value whiplash claims). Part 35 to the CPR, the Practice Direction to Part 35 and the Guidance[1] do not address these issues. Experts therefore acquire this necessary knowledge through experience or through voluntary specialist training or self-study.

The *Bolam* test is of course at the heart of a clinical negligence claim if the standard of care is in issue. It is easy to state as a test, particularly in the process of writing a report, but somewhat more difficult to apply on the facts of any particular case. However the test remains the test, and if seeking to establish that no reasonably competent doctor would have failed to take some particular step, it is not helpful for your expert to explain, under questioning in court, that it would have been "wise" and consistent with the standard of a "good doctor" to do so, or that "it was not mandatory but the wise doctor would have done it"[2]. Many doctors, while critical of another doctor's actions or inactions, may find it difficult in court, orally and on oath, to castigate a colleague for failing to do something which no reasonably competent doctor in that field would have failed to do, whatever criticism they may have been prepared to make in their report or in conference. Therefore it is essential to ensure in a face to face meeting that your expert, however experienced, really does understand *Bolam* and that the words of the test really reflect their opinion before relying confidently on their report.

Developing or expanding the expert opinion at the joint discussion, let alone at trial, is rarely a good idea. The thinking, the court not unreasonably considers, should have been done and the reason-

---

[1]Guidance for the Instruction of Experts in Civil Claims 2014 referred to in the Practice Direction to Part 35 of the Civil Procedure Rules 1998

[2]Ali Shah v North West London Hospital NHS Trust [2013] EWHC 4088

What kind of expert is yours?

Tough lessons from the court room and can they be avoided? Cont..

ing provided before the joint discussion, even more so if there have been 2 previous reports from the same expert. An obstetrician who, following 2 reports, introduced the concept of "non-reassuring" and/or "atypical" accelerations for the first time at the joint discussion (and who was unable or unwilling at the meeting to disclose the origins of these terms) cannot be surprised if the judge forms the view that all of the evidence should be treated with "considerable caution", a position made worse by the expression of other non-orthodox views in evidence[3]. If your expert has something significant to add to the opinion reflected in the written reports, having seen the other side's report and considered it, then that should be carefully considered, and provided in writing before the joint discussion[4].

The expert must be independent[5]. An easy concept, you would have thought, and yet instances continue to come to light, following oral evidence, in which a judge is left doubting the expert's independence, and so rejects the expert's evidence in its totality. A midwife was found to be "overly keen to find arguments to support the Claimant's case", and to seek unfairly "to nit-pick at the care given the quality of [the midwife's] note-taking without making any allowance for the fact that standards of note-taking etc were somewhat different 24 years ago"[6]. An obstetrician (different to the one referred to in the previous paragraph) "appeared to forget his duty to the court and seemed illegitimately to stray into creative advocacy for the Claimant's cause … tailored his evidence to argue the case … sought to side-step the evidence"[7]. Once under cross-examination there is little that can be done to control your expert but the expert who understands that the written report should contain all of the points to be made and the reasoning in support of them should not enter into such "unchartered waters".

An expert who puts forward, in support of his opinion, a medical paper without revealing that it has subsequently been the subject of substantial criticism, particularly if that is a matter of which he must by implication have been aware, seriously damages any appearance of independence[8]. While the legal team might not automatically carry out research to ascertain such criticism, the team's expert witness can be expected to do so.

---

[3]Chappell v Newcastle upon Tyne Hospitals NHS Foundation Trust [2013] EWHC 4023

[4]Where experts significantly alter their opinion, the legal team must inform the other parties as soon as possible –para 66 of the Guidance

[5]Para 11 Guidance for the Instruction of Experts in Civil Claims

[6]Sardar v NHS Commissioning Board [2014] EWHC 38

[7]Sardar – see above

[8]EXP v Barker [2015] EWHC 1289

What kind of expert is yours?

Tough lessons from the court room and can they be avoided? Cont..

Related to the need for independence is the need for the expert to avoid a conflict of interest or the appearance of possible bias. The specialist medical world is small and inevitably experts know one another or even know the doctor the subject of criticism in the litigation. It is therefore important for expert and lawyer alike to identify any potential conflict of interest. Not to reveal that the defendant's expert had worked with the defendant doctor for many years and had "guided and inspired his practice" was unforgivable, even more so you might think where the defendant doctor had recommended the expert to his legal team. The burden is on the party instructing that expert to provide details of the connection "from the outset" – it is not for the opposing party to have to investigate for a potential conflict[9]. The consequence of such a conflict of interest is not necessarily that the evidence will be ruled inadmissible, but it is unlikely to carry much weight in the light of a conflict of opinion[10].

What is perhaps most difficult to guard against is the expert's nature and manner, particularly when under pressure. Leading professionals in many fields are not always the easiest people to get on with, let alone disagree with, whether it is in a robing room, a multi-disciplinary team meeting, a joint discussion or the courtroom. Personal attacks on the other side's experts, failing to engage with the medical issues, obfuscation and withdrawing from the joint discussion are not to be recommended and a judge's finding that the expert's evidence "was not given in a manner consistent with an expert witness seeking to engage seriously with evidence being put forward" can only result in that expert's evidence being rejected by the court[11]. Failing to answer questions in the joint discussion and in cross-examination will not endear the expert to the court[12].

The medical expert must understand fully the role and the duties of a court expert, and must demonstrate a "medico-legal mind"[13]. Acting as an expert medical witness is not merely an extension of medical practice. An expert, and the legal team, would be well-advised to (re-) read the words of Lord Justice Stuart Smith in *Loveday v Renton*[14] which gives insight into a judge's decision making process when considering expert evidence, and causes surprise (and consternation) in

---

[9]EXP – see above

[10]The standard court direction in clinical negligence claims in the High Court includes the direction that:

> "13 Experts shall, at the time of producing their reports, produce a CV giving details of any employment or activity which raises a possible conflict of interest."

[11]Siegel v Pummell [2014] EWHC 4309

[12]Shah – see above

[13]An expression used by this author and explained in more detail in *Writing Medico-Legal Reports in Civil Claims – an essential guide* (Eyre & Alexander) (www.prosols.uk.com)

[14][1990] 1 Med LR 177 at 125

What kind of expert is yours?

Tough lessons from the court room and can they be avoided? Cont..

experts when they see the wide range of factors a judge will take into consideration:

> *'The court has to evaluate the witness and the soundness of his opinion. … this involves an examination of the reasons given for his opinions and the extent to which they are supported by the evidence. The judge also has to decide what weight to attach to a witness's opinion by examining the internal consistency and logic of his evidence; the care with which he has considered the subject and presented his evidence; his precision and accuracy of thought as demonstrated by his answers; how he responds to searching and informed cross-examination and in particular the extent to which a witness faces up to and accepts the logic of a proposition put in cross-examination or is prepared to concede points that are seen to be correct; the extent to which a witness has conceived an opinion and is reluctant to re-examine it in the light of later evidence, or demonstrates a flexibility of mind which may involve changing or modifying opinions previously held; whether or not a witness is biased or lacks independence […] There is one further aspect of a witness's evidence that is often important; that is his demeanour in the witness box."*

Accidents will of course (unfortunately) continue to happen. It is not enough for the lawyers instructing medical experts to understand what should not happen. It is essential for the medical expert to be provided with the skills, knowledge and understanding to reduce the risk of them happening in the first place.

Giles Eyre

9 Gough Square

London EC4A 3DG

Giles Eyre is a barrister specialising in clinical negligence and personal injury claims. He is a contributing editor to 'Clinical Negligence Claims - A Practical Guide' (2015). He is a mediator and was appointed a Recorder in 2004. He is in chambers at 9 Gough Square, London.

Giles is co-author of a manual for medico-legal experts and those instructing them, 'Writing Medico-Legal Reports in Civil Claims - an essential guide' (www.prosols.uk.com). He frequently gives seminars and workshops, and provides training for medical experts and those instructing them in medico-legal report writing, giving evidence and other medico-legal issues.

A new era of regulation for cosmetic surgery?

Rebecca Richardson

Hardwicke

Regulation of cosmetic surgeries was first considered as far back as 2005 when Sir Liam Donaldson, then Chief Medical Officer, published a report concluding that regulation of the industry was necessary, and making a series of recommendations for the same. There was little, if any, change. Now, ten years later, is regulation finally on the horizon?

With the vast majority of cosmetic surgeries being carried out in the private sector, any doctor can hold themselves out as a 'cosmetic' or 'plastic' surgeon without any specific, specialist, surgical training. Despite the growing number of surgical cosmetic procedures available, this area remains largely unregulated. No common qualification or accreditation is required to perform cosmetic surgery, and there is no accredited public register of cosmetic surgery practitioners.

In this highly commercial market, there have been growing concerns about the number of surgeons who are working solely in the private cosmetic industry having reached no more than a basic level of training, and without being on the GMC's specialist register. These surgeons could not become consultants in the NHS given their lack of expertise, but are nonetheless able to conduct what can be highly invasive cosmetic surgeries in the private market. While cosmetic surgery clinics argue that their surgeons will have years of experience in the procedures they do, which makes them just as good as any NHS consultant, and that the clinics themselves have to meet the standards of the Care Quality Commission, there is a clear need for a degree of standardisation and regulation when it comes to undertaking cosmetic surgery if patients' well-being is to be safeguarded.

One of a number of recommendations made by the 2013 Keogh Review was that the Royal College of Surgeons (RCS) should establish an Interspeciality Committee on Cosmetic Surgery to investigate the above issues. While many of the Keogh recommendations have not been taken up by government, the RCS pushed forward and set up the Cosmetic Surgery Interspeciality Committee (CSIC), which has recently consulted on a number of recommendations for regulation.

CSIC proposes that patients paying privately for cosmetic surgery should have access to clear, unbiased and credible information about the surgeon, care provider, procedure and likely outcomes. It suggests that there should be new standards of training for cosmetic surgeons to become certified and included on a register, which will be made publicly available to employers and patients. Surgeons must be on the GMC's specialist register in the area of training that covers the operations they wish to perform. In order to achieve certification surgeons must be able to demonstrate 1) that they have undertaken a minimum number of procedures within the relevant region of the body in a recognised facility; 2) that they have the appropriate skills to undertake cosmetic surgery; and 3) they will have to provide evidence of the quality of their surgical outcomes. Certification will only

A new era of regulation for cosmetic surgery? Cont.

allow surgeons working in the private sector to undertake cosmetic surgery on the areas of the body that relate to the speciality they trained in.

While CSIC's recommendations are currently subject to consultation, it is heartening that firm steps are being taken towards establishing standards for training and practice in the cosmetic surgery field. However, it seems unlikely that standards are likely to be in place any time soon given it has taken two years since the Keogh report just to get to the CSIC consultation phase. However, if the recommendations do become reality, what could this mean for patients?

At present there are still a number of grey areas in the proposals. While applicants for certification will need to have undertaken a minimum number of procedures 'in a facility recognised by the regulator' it is not clear which 'regulator' is envisaged, what standard of facility is likely to be appropriate, what the minimum requirement will be or what the position will be if applicants have undertaken the minimum number of procedures outside the UK (likely to be a particular issue given the number of foreign surgeons who currently have practising rights in the UK). It is also unclear what the mechanism for keeping any formal register up to date will be, including what the process might be for checking and removing practitioners who have fallen below the appropriate standards.

The GMC has also raised concerns about limiting certification to doctors on the Specialist Register. While they broadly support the approach, they take the view that consideration will have to be given to the position of a small number of individuals who may be able to demonstrate the relevant competencies for certification but who are not currently on the Specialist Register (again, potentially an issue for overseas practitioners). It would seem right that people who are able to demonstrate the relevant competency *should* be able to apply for certification, as surely the whole point of having a system for certification is that people can apply to be part of it. If this is not an option then, as the GMC points out, there is a risk of parallel systems developing which could become confusing for patients and providers. This would surely defeat the purpose of having a standardised certification process.

Perhaps the biggest question which remains to be answered is whether the public will, in fact, use such a register. Rather frighteningly cosmetic surgery is often something people rush into, guided by unrealistic hopes and expectations of how surgery might change their lives, or without a real understanding of what is involved. Anecdotal evidence has shown that people will be swayed by offers and inducements and not necessarily stop to investigate fully what they are undertaking, only realising when things go wrong that what they have been sold is not necessarily what they were expecting or what they have ended up with. There have been steps to restrict advertising and clamp down on how procedures are sold (including putting a stop to financial inducements for multiple procedures and time sensitive financial inducements), and the general guidance that there should be at least a 14 day 'cooling off' period between consultation and procedure.

A new era of regulation for cosmetic surgery? Cont.

It may well be the case that only when patients are prevented from being able to rush into surgical procedures are they likely to take the time to investigate exactly who they are putting their looks into the hands of. However, even if a register is not routinely 'consulted' by consumers, a standardised certification process can only be a good thing. When things go wrong with cosmetic procedures, patients' lives can be devastated, and the industry surely owes a duty to make sure that only competent practitioners can be in a position where they are able to wield such power over what are often a vulnerable group of consumers with little understanding of the potential for their cosmetic surgery dreams to become a nightmare.

****

Montgomery, and the doctor-patient relationship: Re-thinking the paradigm

Jim Duffy

1 Crown Office Row

'*Doctor knows best*': a mantra that has faced a slow but steady erosion ever since the dawn of the law of clinical negligence. The spring of 2015 saw it washed away still further by the Supreme Court's judgment in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

The case consolidates, clarifies and redefines the law pertaining to the advice a doctor offers to his or her patient. It looks inwards at our own confusing and conflicting case law built up over forty years, whilst reaching outwards to the foreign jurisdictions that have long placed greater store on the autonomy of the patient in consenting to treatment.

The facts

The case started in central Scotland. Nadine Montgomery gave birth to her son, Sam, on 1 October 1999 at Bellshill Maternity Hospital. As a result of an occlusion of the umbilical cord caused by shoulder dystocia, Sam's brain was starved of oxygen for some twelve minutes. Consequently he was born with a dyskinetic form of cerebral palsy. He also suffered an avulsion of the brachial plexus, rendering his arm useless.

Mrs Montgomery is five feet tall. She suffers from insulin-dependent diabetes mellitus. Maternal

Montgomery, and the doctor-patient relationship: Re-thinking the paradigm

Cont..

diabetes is likely to result in a larger foetus, with a concentration of weight around the shoulders. In Mrs Montgomery's case, these factors combined so that when the foetal head emerged, the shoulders became stuck behind the pelvis. The first instance court heard that where a diabetic woman gives birth via vaginal delivery, there is a 9 to 10% risk that the obstetric emergency of shoulder dystocia will occur.

The responsible obstetrician, Dr McLellan, had not warned Mrs Montgomery of the risk of shoulder dystocia, or offered her a caesarean section as an alternative. This was in accordance with her own clinical practice and her assessment that, even in diabetic women, the risk of a grave problem for the baby was very small. According to Dr McLellan, if women were advised of the risk of shoulder dystocia they would opt for a caesarean which, to her mind, was not in the maternal interest.

Significantly, during the latter stages of her pregnancy Mrs Montgomery had raised concerns about the size of the baby, and the risk that it might be too big to be delivered vaginally. Dr McLellan told the first instance judge that Mrs Montgomery had not asked her about exact risks.

The Scottish courts' decisions

At first instance, the Lord Ordinary (Lord Bannatyne) applied the decision of the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital & Maudsley Hospital* [1985] AC 871, holding that the scope of a doctor's duty to warn a patient of the risks of treatment was normally to be determined by reference to whether the doctor acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion: *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582. *Bolam* was itself an application of the *dicta* of Lord President Clyde in the Scottish appeal court case of *Hunter v Hanley* 1955 SC 200, 206.

The risk of shoulder dystocia was significant, but the Lord Ordinary held that it did not *itself* require to be the subject of a warning, as in the vast majority of cases it could be dealt with by "*simple procedures*". The chance of severe injury to the baby was tiny. If the patient asked questions about specific risks, then that was different: the doctor must answer. But the Lord Ordinary did not accept that Mrs Montgomery had done so.

The decision was upheld on appeal to the Inner House of the Court of Session. Supported by the GMC, which intervened, Mrs Montgomery took her fight to the Supreme Court. Suddenly the law of consent in Scotland, England and Wales found itself in the judicial headlights.

The pre-*Montgomery* landscape

Reflecting its importance, *Montgomery* was heard by a bench of seven Justices, including the Court's President, Deputy President and both Scottish members. Their first task was to try to make sense of the mixed messages in *Sidaway*.

The majority in that case (Lord Scarman dissenting) held that the question of the scope of the duty to warn of inherent risks of proposed treatment was to be determined by an application of the *Bolam* test. This was subject to a possible exception described by Lord Bridge, namely where the proposed treatment involved a substantial risk of grave adverse consequences. In such circumstances, a judge could conclude, notwithstanding any practice to the contrary, that a patient's right to decide whether to consent was so obvious that no prudent medical practitioner could fail to warn of

Montgomery, and the doctor-patient relationship: Re-thinking the paradigm

Cont..

the risk, save in an emergency or where there was some other cogent clinical reason:

> "*The kind of case I have in mind would be an operation involving a substantial risk of grave adverse consequences, as for example the 10% risk of a stroke from the operation which was the subject of the Canadian case of* Riebl v Hughes."

Lords Bridge and Diplock placed emphasis on the patient's lack of medical knowledge and vulnerability to making irrational judgements, as well as the important role of clinical judgement in deciding how best to communicate with the patient.

In his prophetic dissent, Lord Scarman took a different starting point: the patient's right to make his own decision. He emphasised that a doctor had medical objectives, but that a patient might have other concerns. The question of what he should be warned about was thus not simply a matter of medical opinion. The duty was confined to "*material risk*", but this involved asking whether the "*reasonable patient*" would attach significance to it.

Fourteen years later, in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR p 53, Lord Woolf gave *Sidaway* something of a wide berth. For him, the question was whether there was "*a significant risk that would affect the judgement of a reasonable patient*" – a test more closely aligned to Lord Scarman's approach than to that of the majority in *Sidaway*.

The march towards recognising patient autonomy continued apace. In 2003, Lord Justice Sedley was considering a case in which there was a risk of around 1% that chickenpox during pregnancy might result in brain damage. In *Wyatt v Curtis* [2003] EWCA Civ 1779 he noted:

> "*Lord Woolf's formulation refines Lord Bridge's test by recognising that what is substantial and what is grave are questions on which the doctor's and the patient's perception may differ, and in relation to which the doctor must therefore have regard to what might be the patient's perception*."

But by that time, a key moment in terms of where the law on consent was heading had already happened, albeit on the other side of the world. In *Rogers v Whitaker* (1992) 175 CLR 479, 486-487, the Australian High Court adopted a "*material risk*" test, with such a risk defined as follows:

> "*[I]f, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk would be likely to attach significance to it, or if the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it."*

The Supreme Court

These and other cases gave the Supreme Court plenty to think about in considering where the law of consent stood in 2015. Lords Kerr and Reed gave the leading judgment, with Lady Hale issuing a concurring judgment.

On breach of duty, the Court concluded that Dr McLellan ought to have advised Mrs Montgomery – considered a highly intelligent person – of the substantial risk of shoulder dystocia. The Court of Session had concentrated on the relatively small *consequent risk* of grave injury to the baby. But

Montgomery, and the doctor-patient relationship: Re-thinking the paradigm

Cont..

shoulder dystocia was itself a major obstetric emergency, and the contrast with the tiny risk to the woman and baby involved in an elective caesarean was stark.

As for causation, the courts below had had in mind the supposed reaction of Mrs Montgomery if advised on the minimal risk to the baby of a grave injury consequent on shoulder dystocia; they ought to have focused on her likely reaction if advised of the risk of shoulder dystocia itself. Dr McLellan had given evidence of her unequivocal view that Mrs Montgomery would have chosen a caesarean if so advised – indeed, this was precisely why she withheld the information.

Montgomery: The Key Points

At the centre of Lord Kerr's and Lord Reed's reasoning are the following observations:

- Since *Sidaway* it has become clear that the paradigm of the doctor-patient relationship has ceased to reflect reality. Patients are not uninformed, incapable of understanding medical matters, or wholly dependent on information from the doctors. This is reflected in the GMC's long-standing guidance.

- Courts are increasingly conscious of fundamental values such as self-determination. Societal and legal changes – in particular, the advent of the Human Rights Act 1998 – point towards an approach to the law which treats patients, so far as possible, as adults capable of understanding that medical treatment is uncertain of success and may involve risks, of accepting responsibility for risks affecting their lives, and of living with the consequences of their choices. Patients are "*persons holding rights*". They have access to a wealth of information not available in previous times, particularly via the internet.

- This entails a duty on doctors to take reasonable care to ensure that a patient of sound mind is aware of material risks inherent in treatment, and of reasonable alternatives. This is not dependent on medical learning or experience, and so applying the *Bolam* test to this question is likely to result in the sanctioning of differences in practice attributable not to divergent schools of thought in medicine, but simply to divergent attitudes among doctors as to the degree of respect owed to their patients.

- Assessing materiality of risk is fact-sensitive and cannot be reduced to percentages.

- In order to advise, the doctor must engage in a dialogue with the patient. There is something unreal about placing the onus of asking upon a patient who may not know that there is anything to ask about.

- The therapeutic exception, whereby information can be withheld from a patient in certain circumstances to protect his or her health, remains but is limited.

The Court added that *Sidaway* was not an unqualified endorsement of the application of the *Bolam* test to the giving of advice about treatment – only Lord Diplock had seen it that way. And in referring to percentages and grave adverse consequences, Lord Bridge had merely been giving an example, yet his words had been taken to be the relevant test. The Supreme Court noted that the courts had tacitly ceased to apply the *Bolam* test in relation to advice given to patients and have effectively adopted the Lord Scarman approach. It approved the Australian High Court's formulation

Montgomery, and the doctor-patient relationship: Re-thinking the paradigm

Cont..

in *Rogers v Whitaker*.

The key passage of the judgment is to be found at paragraph 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.*"

A consent revolution?

The judgments of Lord Kerr, Lord Reed and Lady Hale describe more of an evolution than a revolution. It is clear, nonetheless, that many aspects of *Sidaway* are now firmly confined to history. Medical paternalism is replaced with self-determination. The patient is no longer a passive recipient of medical treatment, but a partner in the provision of that treatment. The forum in which the decision-making process around what needs to mentioned in terms of risk is not the clincian's own mind but the space between the doctor and the patient. So too a blinkered focus on potentially catastrophic outcomes is rejected in favour of a need to examine the risk of intervening events and complications that might occur along the way.

Gone is the old objective test of the reasonable doctor – the courts will apply an objective test focused on the reasonable patient, but this must be coupled with a subjective assessment of the circumstances, concerns, personality and idiosyncrasies of the particular patient. In considering "*materiality*", doctors can no longer take refuge in percentages, and there is no need for the patient to prompt the flow of information through questioning.

Practical impact: 10 questions

These are undoubtedly major departures from the House of Lords' analysis in *Sidaway*. What they mean for prospective claimants will depend on the facts of individual cases. But claimant lawyers may wish to ask themselves the following ten questions when taking witness statements and examining clinical records surrounding the consent process:

1. Has the clinician taken **full notes** documenting the consent process?

2. Have reasonable **alternatives** been discussed?

3. From the notes, does it appear that **adequate time** has been set aside for a meaningful consent process?

4. What steps has the clinician taken to understand the particular concerns and wider circumstances of the **individual patient** before imparting his or her advice? For example, does he or she have other medical conditions that might affect the risk-benefit analysis? Are his or her family circumstances relevant?

Montgomery, and the doctor-patient relationship: Re-thinking the paradigm

Cont..

5. Is there evidence of a genuine **dialogue** between the doctor and patient around consent?

6. Has the clinician done any more than simply express magnitude of risk by reference to **percentages**?

7. Have the risks of possible distressing, painful or dangerous **intervening events** been explained to the patient, in addition to the risks of adverse final outcomes?

8. If the clinician has consciously decided not to share certain information with the patient in a purported exercise of the **therapeutic exception**, do the circumstances justify that approach in the light of the respect to be accorded to patient autonomy?

9. Is it clear that the patient fully **understood** the advice given?

10. Is there any impression of **lip service** having been paid to the consent process? For example, does it appear that it consisted of the provision of a leaflet and not much more?

In issued claims, lawyers might also wish to consider whether *Montgomery* might add anything to the consent case. If so, thought might be given to an application to amend the particulars of claim. The redefining of the law of consent might also impact upon the circumstances in which criminal liability for assault or battery might arise.

The future

Those who act for defendants might see *Montgomery* as the death knell to any consent defence. Equally, claimant lawyers might welcome it as a something of a panpharmacon for any consent case.

The reality is likely to be somewhere in between. The early High Court decisions post-*Montgomery* have not told us much in terms of how it will be interpreted in the medium and long term[1]. But what is clear is that the Supreme Court has offered a greater opportunity than ever before for victims of medical accidents to obtain redress for failures to properly advise them. *Montgomery* is perhaps the clearest expression ever of a reality that has been a long time in the making: patients are "*persons holding rights*".

Jim Duffy was the Judicial Assistant to Lord Reed and Lord Hodge when* Montgomery *was argued. The views expressed are his own.

[1]See the judgments available at the time of writing (1 June 2015): *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038; *FM v Ipswick Hospital NHS Trust* [2015] EWHC 775; *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058; and *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339 (QB).

Everything but the kitchen sink – An Analysis of Robshaw V United Lincolnshire Hospitals NHS Trust [2015] EWHC 923 (QB)

Jonathan S Godfrey

ParkLane Plowden Chambers

Leeds and Newcastle

INTRODUCTION

Robshaw v United Lincolnshire Hospitals NHS Trust [2015] EWHC 923 (QB) is noteworthy for not only being the highest final court award resulting from a fought clinical negligence or personal injury trial (the overall award is likely to be in the region of £14.6 million), but also for the judicial scrutiny and consideration of a myriad of heads of future loss. Nearly all heads of future loss were in dispute in a quantum only hearing lasting 11 days , so much so, that the judgment of the trial judge, Foskett J ran to 113 pages and prompted him to remark *" … I have had to consider important issues such as life expectancy, accommodation …….. and some aspects of the care regime as well as some, frankly trivial issues such as whether there should be a cord operated curtain rack in James' new home …… As it is, the fact that so little has been agreed has led to a very lengthy judgment ".*

The judgment , albeit , that the facts are specific to each case, reads as a veritable treasure trove of matters pertaining to future loss in cases of this type. A comprehensive review of the judgment is a must for those practising in cases of this type. In the meantime, I have sought to set out those matters which I consider to be of particular interest to the practitioner with a license left to revert to the judgment for the full plethora of contextual detail.

THE FACTS

It was not disputed that the Claimant's birth in 2002 had been negligently mishandled . The result was that the Claimant sustained cerebral palsy leading to significant disability. Judgment for damages to be assessed had been entered on 31st January, 2013. As at the date of the quantum trial, the Claimant was 12 years and 4 months old.

One area where agreement had been reached prior to trial, subject to the court's approval, was assessment of general damages for pain, suffering and loss of amenity in the sum of £290,000. Such sum indicated the severity of the brain damage and the disability.

LIFE EXPECTANCY

The " vexed " issue of life expectancy was firmly in dispute. The Claimant contended for a life expectancy of 70-71. The Defendant contended for a significantly reduced figure of 53.

Everything but the kitchen sink – An Analysis of Robshaw V United Lincolnshire Hospitals NHS Trust [2015] EWHC 923 (QB) Cont..

Unfortunately, the Defendant's paediatric neurologist , Dr Ferrie, was unable to attend to give evidence at trial in respect of his views as to life expectancy. Dr Rosenbloom gave evidence on behalf of the Claimant .The experts in their memorandum of agreement and disagreement had concluded that *" in spite of the extent of the difference between us we each accept that the other's estimate is reasonable whilst preferring our own ".* Foskett J considered the task of trying to reconcile or choose between opposing views that were recognised by experts in their field to be reasonable as being even more difficult than choosing between two views that each opposing proponent regards as unreasonable or unsustainable. The temptation was of course to simply split the difference, but Foskett J made it clear that it was accepted that " *ultimately I must make an assessment based upon all the evidence that I consider goes to the issue ".* In so doing, Foskett J approached his assessment of the Claimant's life expectancy based upon a consideration of all the pertinent evidence, namely statistical data and expert and factual material.

In the deliberations , regard was had as to whether the Claimant should be categorised a " self fed " or " fed by others " for the Strauss data and the applicability of " favourable economics " . Favourable economics refers to the argument that a claimant who receives a large award of compensation and is consequently able to pay for good quality care, accommodation , treatment and equipment is in a much better position than those in the same grouping but without recourse to similar funds. In the former case, Foskett J considered that the Claimant fell between the two Strauss categories, and in the latter case, deemed " favourable economics " applicable (with a consequent increase in life expectancy).

Foskett J's findings resulted in his assessment of life expectancy for the Claimant of 63.

VALUATION OF ASPECTS OF THE CLAIM

The starting point was not at issue : a Claimant is entitled to damages to meet his or her " reasonable requirements " or " reasonable needs " arising from the negligently caused disability see ***Sowden v Lodge [2004] EWCA Civ 1370*** and should receive full compensation. Where however there is in fact a range of " reasonable " options to meet the needs is the court permitted or obliged to cheapest option or that which the claimant advances ?

In ***Whiten v St George's [2011] EWHC 2066 QB*** Swift J adopted the following approach :

" The claimant is entitled to damages to meet his reasonable needs arising from his injuries. In considering what is " reasonable " , I have had regard to all the relevant circumstances, including the requirement for proportionality as between the cost to the defendant of any individual item and the extent of the benefit which would be derived from the claimant for that item ".

Foskett J had regard to *Whiten* and also to the decision of Warby J in ***Ellison v University Hospitals***

Everything but the kitchen sink – An Analysis of Robshaw V United Lincolnshire Hospitals NHS Trust [2015] EWHC 923 (QB) Cont..

of MorecambeBay NHS Foundation Trust [2015] EWHC 366 (QB) , in which , the defendant had sought to widen the scope of Swift J's judgment in *Whiten* by contending for a more general proposition that an item should be disallowed if the cost of the item was disproportionate to its benefit. Warby J rejected the contention advanced and emphasised that what Swift J had in mind *" in determining whether a claimant's reasonable needs require that a given item of expenditure should be incurred, the court must consider whether the same or substantially similar result could be achieved by other , less expensive means … ".*

Foskett J remarked that he was disinclined to express any concluded view of his own on any issue of principle as it was difficult to find any head of claim in the case at hand that could be affected by the resolution of any such issue of principle. He did however " tentatively " express agreement with Warby J's analysis of Swift J's formulation in *Whiten* as the correct test.

At Paragraph 166 of the judgment, Foskett J went on to state (and the citing of the full paragraph is necessary to relay the position) :

"to my mind , in assessing how to provide full compensation for a claimant's reasonable needs, the guiding principle is to consider how the identified needs can reasonably be met by damages – that flows from giving true meaning and effect to the expression " reasonable needs ". This process involves , in some instances, the need to look at the overall proportionality of the cost involved, particularly where the evidence indicates a range of potential costs. But it all comes down eventually to the court's evaluation of what is reasonable in all the circumstances: it is usually possible to resolve most issues in this context by concluding that solution A is reasonable and, in the particular circumstances, Solution B is not. Where this is not possible, an evaluative judgment is called for based on an overall appreciation of all the issues in the case including (but only as one factor) the extent to which the court is of the view that the compensation sought at the top end of any reasonable cost will, in the event, be spent fully on the relevant head of claim . If, for example, the claimant seeks £5,000 for a particular head of claim, which is accepted to be a reasonable head of compensation , but it is established that £3,000 could achieve the same beneficial result, I do not see that the court is bound to choose one end of the range or the other : neither is wrong , but neither is forced upon the court as the " right " answer unless there is some binding principle that dictates the choice. It would be open to the court to choose one or other (for good reason) or to choose some intermediate point on the basis that the claimant would be unlikely to spend the whole of the £5,000 for the purpose for which it would be awarded and would adopt a cheaper option or for some other reason".

LOSS OF EARNINGS

The claimant will never be able to work.

Everything but the kitchen sink – An Analysis of Robshaw V United Lincolnshire Hospitals NHS Trust [2015] EWHC 923 (QB) Cont..

But for his injuries , what kind of employment would the Claimant have been capable of achieving ?

Foskett J heard evidence in relation to the pattern of employment in the Claimant's family, which was based around the engineering world. Taking into account the 2014 ASHE average annual gross earnings for various engineering professions it was considered that a realistic figure for the Claimant's annual gross earnings over his working life from age 22 was £42,000.

A minimal deduction of £300 was made to reflect expenses in connection with employment.

Retirement age was held to be 70. The Defendant had contended for 67.

A modest award of £7,500 was made to reflect earnings as between 16-22 arising from part time earnings at weekends and holidays.

As an aside from the Robshaw case, it is worth noting that consideration of potential loss of earnings should be had in all cases involving young children, and specifically also taking into account those cases where the injured child is from a disadvantaged background and who at first blush has limited employment prospects ***see Tate v Ryder Holdings [2014] EWHC 4256 (QB).***

ACCOMMODATION

At issue was whether the claimant's property should be demolished and a new property built or whether the existing property should be adapted. The " ball park " cost of demolition followed by a new build was £50,000. The Claimant contended for the rebuild as it would enable the construction of a purpose built , energy and cost effective property ; the timing and cost could be assessed more accurately and there would be savings in VAT. The Defendant simply contended that the additional expenditure should not be something for which it should be responsible. In cross examination, the Defendant's accommodation expert candidly acknowledged that he " probably would want to knock it down and start again ". Foskett J determined that a £50,000 increase in spending could achieve a very considerable saving in annual costs and would provide an " ideal " home being designed with the claimant's needs in mind, and accordingly such a proposition made the immediate cost of demolition and building from scratch reasonable and a legitimate sum to claim from the Defendant.

HOME POOL

It was agreed as between the parties that swimming was a beneficial activity for the claimant. Dr Rosenbloom and Dr Ferrie agreed that for the Claimant to undertake a water based activity he required an accessible pool with a suitable hoist or graded wheelchair access, suitable changing facilities and warm water. The swimming pool close to the Claimant's home (some 40 minutes drive away) kept the water at 29 degrees C, which was too cold . A temperature of 32 degrees C was needed. Seating for the pool hoist at the public pool was deemed inappropriate. On behalf of the Claimant it was con-

Everything but the kitchen sink – An Analysis of Robshaw V United Lincolnshire Hospitals NHS Trust [2015] EWHC 923 (QB) Cont..

tended that home based provision of a pool was needed to allow for his love of swimming.

The Defendant contended that the evidence in support of home pool provision fell short of those situations where the courts had previously been persuaded that a home pool was reasonably required (more usually a hydrotherapy pool). There was no clinical or therapeutic need for it.

Foskett J considered that the other cases did not provide the answer to the question in this case. The need for a home based pool was made out *" on the basis of the real and tangible psychological and physical benefits* " that would be provided to the Claimant from swimming and which could not be obtained in a convenient local public facility.

The size of the pool allowed was slightly smaller than that claimed on behalf of the Claimant.

The location and provision of adequate facilities at a public swimming pool will be paramount in establishing any claim in this regard.

MISCELLANEOUS ISSUES

Perusal of the remainder of the judgment refers to items that are readily claimed in cases of this type, namely care, gardening , occupational therapy equipment, deputyship costs etc , but it is also interesting to note the miscellany of other items claimed, including amongst others, a claim for an adapted motor home. The claim for the adaption to the motor home succeeded on the basis that the Claimant came from a family with a particular penchant for camping and caravanning.

CONCLUSION

Whilst cognisance has to be had to each case being dependent upon its own facts, the detailed and very reasoned judgment of Foskett J in relation to disputed items of heads of loss provides a very accessible ready reckoner to assist in preparing and advancing cases of this genre. And yes, an award was made for a cord operated curtain track, albeit that at Paragraph 272 (iii) of the judgment it is recognised that it was not actively opposed by the Defendant.

Radwan Hamed

v.

Dr Peter Mills

Tottenham Hotspur Football Club & Athletic Club Limited

Dr Charlotte Cowie

Dr Mark Curtin

This was a clinical negligence action brought by a catastrophically brain-injured young footballer against those responsible for his medical care, including a Premier League football club, when he was a teenager.

The risk of sudden cardiac death in young footballers – as with all young athletes – has been recognised for decades. Sudden cardiac death among fit, young people has been called the silent killer. The list of British sporting deaths in the last two decades is tragically long. Among footballers are:-

John Marshall – aged 16 – Everton, junior international player of the year (1995)

Marc Vivien Foe – aged 28 - West Ham and Manchester City (2003)

Daniel Yorath – aged 15 – Leeds United (1992)

David Longhurst – aged 25 – York (1990)

Ian Bell – aged 16 – Hartlepool (2001)

In March 2012, Fabrice Muamba, then 23, suffered a cardiac arrest during a televised F.A. Cup match between Bolton and, ironically, Tottenham Hotspur, from which he recovered despite his heart having stopped for 78 minutes. Following medical advice, he announced his retirement from professional football in August 2012.

Diagnostic and early-warning protocols are – or should be – in place to screen for potentially life-threatening heart disease among young athletes. The protocols are there, of course, to codify and supplement the duties of care doctors owe to their patients and employers owe their employees.

The Football Association is a powerful and influential organisation. It is the governing body of English and Welsh national and international football. The youngsters who generate the billions in English soccer should be entitled to the very best care that the money they generate can provide. The F.A. is responsible for the protocols dealing with the health of young professional footballers.

Radwan Hamed v. Dr Peter Mills, Tottenham Hotspur Football Club & Athletic Club Limited, Dr Charlotte Cowie, Dr Mark Curtin Cont..

Radwan Hamed was a highly talented youth player. He emerged from a football academy and signed as a professional for Spurs as a seventeen year old.

Tottenham Hotspur, who were one of the defendants to this claim, are a very wealthy club. Their value is readily found on the internet. They ended the 2004/05 season (when Radwan's cause of action arose) ninth in the Premiership, and last season fifth. They have massive – one might say eye-watering – resources with which to look after the health and safety of their young players who are, after all, their employees.

Dr Peter Mills is a consultant cardiologist who accepted instructions from football clubs to screen dozens of young players for incipient cardiac disease.

Dr Charlotte Cowie was the doctor in charge of Spurs medical arrangements at the time.

In an athlete in his teens or twenties exerting himself, HCM can cause the heart to fibrillate, depriving the body's organs, especially the brain, of enough oxygen-infused blood to function properly. Common outcomes are death or severe brain damage, the latter in Radwan's case.

A comprehensive cardiological check should involve a host of investigations depending on the suspicion of disease the cardiologist has, including: taking a history of symptoms and a personal history; taking a family history; family screening; arranging an echocardiogram, an electrocardiogram, an MRI scan and a 24 hour 'Holter' monitor; exercise testing; and arranging a period of detraining to see if the heart changes physiology.

In Radwan's case the only clinical tests Dr Mills carried out were an echocardiogram and an electrocardiogram. They raised suspicions but were never followed through. Radwan and his parents were given no information about them.

The upshot was that Radwan and his parents (he was seventeen at the time) never had an opportunity to consider whether Radwan should give up football rather than accept the admittedly small risk that he might suffer a cardiac arrest. The defendants all contended that Radwan would have accepted the risk and played on, but they abandoned that defence after they heard Radwan's parents say movingly in evidence (as they had maintained in their witness statements) that they would never have permitted their son to gamble his life and health if they knew he had a latent heart condition.

As it was, Radwan continued to play football for Spurs's youth team for a year after he had been seen by Dr Mills. A year after Dr Mills saw him, he collapsed during a youth match he was playing for Spurs in Belgium. His heart went into fibrillation and he suffered irreversible brain damage.

Radwan Hamed v. Dr Peter Mills, Tottenham Hotspur Football Club & Athletic Club Limited, Dr Charlotte Cowie, Dr Mark Curtin Cont..

Radwan Hamed's case concerned his cardiac collapse and subsequent brain damage. His case was that the consultant cardiologist charged with diagnosing him – Dr Mills – and his employers – Spurs, who had signed him on as a young professional footballer – disastrously let him down. Spurs, in turn, sued their own in-house doctors as third parties.

The essence of Radwan's case was that Dr Mills, to whom Spurs had sent Radwan for a routine cardiological check-up, failed to diagnose or warn about a latent and potentially fatal heart condition known as hypertrophic cardiomyopathy (HCM), a congenital weakness in the heart. He asserted that Dr Cowie failed to recognise or react to the signals Dr Mills was sending her.

All the defendants denied liability. They sought to palm off responsibility for Radwan's disastrous injury on each other. Indeed, the cardiologist – strikingly – denied that he owed Radwan any duty of care at all. Radwan Hamed's case was that, between them, these the defendants could and should have acted in such a way that his grave injury would never have happened.

Dr Mills contended that he had done enough to alert Spurs's doctors to the possibility that Radwan might have a sinister latent condition and that they should arrange more tests. Dr Cowie, the doctor then in charge at Spurs, claimed that Dr Mills did not do enough to alert her to Radwan's possible diagnosis. (Dr Curtin was absolved of liability.)

The case involved experts in cardiology and experts who could speak to the standards to be expected of doctors in sports medicine. It also involved, by way of preparation, a thorough reading of many hundreds of articles in specialist cardiological journals relevant to the issue of the cardiology of young athletes.

The case was tried by Mr Justice Hickinbottom in the High Court in London in February 2015. The trial lasted five days.

A couple of days into the trial, Dr Mills admitted, through his lawyers, that he owed Radwan a duty of care after all, that he had been in breach of that duty and that his breach caused or contributed to Radwan's injury. That left the judge only having to decide whether Dr Cowie (and hence Spurs) were liable to Radwan and, if so, the apportionment of liability between Dr Mills and Dr Cowie.

The judge found that Dr Cowie had failed to discharge her duty of care to Radwan as a specialist sports doctor in failing to pick up the suspicion Dr Mills had tried, inadequately, to communicate to her. He found that Dr Mills was 30% to blame and Dr Cowie (and hence Spurs) 70% to blame.

The judgment can be found at http://www.bailii.org/ew/cases/EWHC/QB/2015/298.html.

Radwan Hamed v. Dr Peter Mills, Tottenham Hotspur Football Club & Athletic Club Limited, Dr Charlotte Cowie, Dr Mark Curtin Cont..

Radwan's damages have yet to be assessed. The judge described his predicament as "tragedy writ large".

Radwan's case emphasises yet again the critical importance of thorough and meticulous cardiological testing of young athletes, especially those who expect to undergo considerable physical exertion such as footballers. Many tragic deaths and catastrophic injuries can be easily and inexpensively avoided by having proper diagnostic protocols in place, and by then following them clearly and to the letter. Clear communications between, and meticulous record keeping by, medical personnel caring for young athletes are essential. One can only hope that Radwan's case has alerted cardiologists who examine young athletes and sports doctors generally to re-examine their procedures to ensure that they are fit for purpose.

William Featherby Q.C.

12 Kings Bench Walk

Tees Law LLP get dirty for AvMA

Mucky Races - 9th May 2015

On Saturday 9th May, six members of the Clinical Negligence and Personal Injury teams of Tees Law LLP opted for a change of scenery; replacing a clean and dry offices for the wet and muddy Cambridgeshire countryside.

At only 3/5 on the Mucky scale, Janine Collier, Paul Taylor, Annabel Wright, Nicola Williams, Alex Coles and Katheryn Riggs were looking forward to a 5km run through the countryside, with the added excitement of obstacles and a bit of mud and water.

Tees Law LLP get dirty for AvMA Cont..

After a quick warm up, Team Tees all set off together towards the first muddy, water-filled ditch. Some took the cautious option and carefully stepped into the water and up the opposite bank, whilst others got stuck right in and went for the muddy bottom-slide. It soon became apparent that any attempts at keeping our T-shirts white and our hair clean were short lived.

The 5km course involved many wooden walls, hay bale jumps and tyre runs. They waded their way through stretches of muddy river whilst trying to keep heads above water in the mud lake, Janine taking the plunge insisting that it was easier to just swim! As well as being wet and muddy, a mucky crawl under a rope net left everyone smelling suspiciously like manure… YES MANURE!

Team Tees successfully worked through the Mucky Races as a team and together completed the course in one hour 19 minutes, still with big smiles on all their faces!

The team would like to give a big thank you to everyone who generously sponsored them with donations to AvMA and a special thank you to the diners in the pub afterwards for letting them sit near them!

They have so far raised £280 and if you still wish to sponsor them and donate to AvMA, please follow the link https://mydonate.bt.com/fundraisers/tees .

Career Opportunities

Clinical Negligence Lawyer (Hampshire)

swain&CO solicitors LLP

(Salary Dependent on Level of Experience)

Exciting position for an experienced Claimant Clinical Negligence lawyer looking for a new challenge.

Busy south coast firm with expanding clinical negligence department seeks dynamic and dedicated lawyer with excellent grounding in litigation and solid clinical negligence experience. Must have a proven track record of meeting and, preferably, exceeding time recording and financial targets.

Some management experience is desirable but not essential.

This role would suit a results driven individual with the ambition and determination needed to continue the expansion of the department and contribute to its' future success.

Qualifications:-
Qualified Solicitor, FILEX or equivalent. 3 years + PQE.

Knowledge
Experience in Clinical Negligence (not necessarily exclusive area of practice). Exclusively Claimant lawyer. Extensive knowledge with regards to civil procedure and funding.

Skills
IT Literate, Microsoft Office, Case Management, Client Care skills. The ability to run cases by CFA, Legal Aid or alternative funding where appropriate.

Experience
Experience in handling own caseload.

Other attributes
A strong influencer and ability to engage with team members. General enthusiasm towards work.

Applications by CV submission to: HelenAsh@swaincohavant.uk.com

FORTHCOMING EVENTS FROM AVMA

For programme and registration details on all of our forthcoming events, plus sponsorship and exhibition opportunities, go to **www.avma.org.uk/events**, call the AvMA Events team on 0203 096 1140 or e-mail conferences@avma.org.uk.

If you have not already booked your place at the Golf Day or Annual Clinical Negligence Conference, you still have time to do so!

AvMA Annual Charity Golf Day

25 JUNE 2015, RUDDING PARK, HARROGATE

The eleventh AvMA Charity Golf Day will take place on Thursday 25 June 2015 at the stunning Rudding Park in Harrogate. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening in Leeds (30 minutes' drive away) so the Golf Day offers the perfect start to the essential event for clinical negligence specialists.

We will be playing Stableford Rules in teams of four and you are invited to either enter your own team or we will be happy to form a team for you with other individuals. The cost is only £98 + VAT (total £117.60) per golfer, which includes breakfast rolls on arrival, 18 holes of golf and a buffet and prize-giving at the end of the day. All profits go directly to AvMA's charitable work.

FORTHCOMING EVENTS FROM AVMA

Annual Clinical Negligence Conference 2015

26-27 JUNE 2015, ROYAL ARMOURIES MUSEUM, LEEDS

The Annual Clinical Negligence Conference (ACNC) is ***the*** **event that brings the clinical negligence community together** to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law. The programme this year has an obstetrics theme, whilst also still covering many other key medico-legal topics.

As ever, it will be an event not to be missed, with the usual high standard of plenary presentations and focused breakout sessions that you would expect from this event, ensuring that you stay up to date with all the key issues and providing 10 hours CPD (SRA, Bar Council and APIL). As well as providing you with a top quality, thought provoking, learning and networking experience, the success of the conference helps AvMA to maintain its position as an essential force in promoting justice.

Sponsorship and Exhibition Opportunities at ACNC 2015

The unique environment of the ACNC offers companies the ideal opportunity to focus their marketing activity by gaining exposure and access to a highly targeted group of delegates and experts. Contact us for further details on the exciting opportunities available to promote your organisation at ACNC 2015.

Legal, Ethical & Clinical Issues in Dentistry

24 September 2015, De Vere Holborn Bars, London

This essential conference will tackle the medico-legal, ethical and clinical issues facing dentistry and discuss how to improve patient safety and learn from mistakes to ensure a safer workplace. The conference has been designed for lawyers involved in dental cases, dentists, hygienists, therapists, technicians and the whole dental team, as well as those concerned with clinical governance, risk management, patient safety and complaint management in dentistry, both in NHS and private practice. The programme will be available and booking will open in June/July.

Medico-Legal Issues in Diabetes

1 October 2015, De Vere Holborn Bars, London

Many people with diabetes have multiple and complex health problems and, with this significant risk in mind, the potential delay or missed diagnosis of the patient can have serious consequences. This conference looks at the condition in detail, types of diabetes, risk factors and complications of treatment, co-morbidity, including gestational diabetes, cardiac complications, peripheral vascular disease and diabetic neuropathy and retinopathy. The impact of diabetes on causation arguments will also be discussed highlighting how the condition affects the way the clinical negligence practitioner looks at injuries. The programme will be available and booking will open in June/July.

FORTHCOMING EVENTS FROM AVMA

Medico-Legal Issues in Oncology
15 October 2015, College of Anaesthetists of Ireland, Dublin
This popular AvMA conference is coming to Dublin for the first time and will provide in-depth knowledge and understanding of Oncology in a medico-legal context relevant to your case load. The day combines a mix of presentations from leading experts to cover types of tumour; staging and classification; diagnostic tools and treatments; medico-legal issues in the delay of diagnosis; advances of surgery and causation issues arising in cancer claims. The programme will be available and booking will open in July.

AvMA Specialist Clinical Negligence Panel Meeting & Christmas Drinks Reception
3 December 2015, De Vere Holborn Bars, London
The annual meeting for AvMA Specialist Clinical Negligence Panel members provides the opportunity to meet, network and discuss the latest key developments and issues facing clinical negligence law. This year's meeting will take place on the afternoon of Thursday 3rd December - registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at 17.30. The programme will be available and booking will open in September.

AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting, also at De Vere Holborn Bars. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer!

Medico-Legal Issues in Accident & Emergency Care
10 December 2015, Doubletree by Hilton Hotel, Leeds
Emergency Care Services are facing intense pressures to sustain its high-quality urgent and emergency care system (The King's Fund, 2014). With the current changing NHS climate there is a vital need to continually monitor these services and ensure high quality care remains consistent throughout all NHS Trusts. With this in mind, this conference will examine the current standards, issues, roles and responsibilities, investigations and management of key areas in accident and emergency care. The programme will be available and booking will open in September.

Clinical Negligence: Law Practice & Procedure
28 - 29 January 2016, Copthorne Hotel, Birmingham
This is ***the*** course for those who are new to the specialist field of clinical negligence. The event is especially suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence. Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective. Places are limited to ensure a focused working group. The programme will be available and booking will open in October.

Tel **0203 096 1140** e-mail **conferences@avma.org.uk** web **www.avma.org.uk/events**

AvMA Medico-Legal Webinars

- Webinars tailored for the Clinical Negligence practitioner
- AvMA medico-legal format: combining medico and legal expertise
- The only webinar library with 100% Clinical Negligence focus
- Run by AvMA, with 30 years of excellence in Clinical Negligence events

Our webinars are designed to be a learning hub where you can watch high quality audio-video presentations at a time convenient for you. You can replay the sessions and also download speakers' notes and extra learning materials.

AvMA Medico-Legal Webinars are an excellent, cost-effective way to train and develop your Clinical Negligence team as it reduces time away from the office and fits around your working day. You can even transform your commuting time into a learning experience!

AvMA Lawyers' Service Rate:

Single Viewer	Multiple Viewer	Subscription
£49.00 + VAT	£150.00 + VAT	£1,200.00 + VAT
Webinar access for 60 days	Webinar group access for 60 days	Group access to all webinar library content for 12 months

Standard Rate:

Single Viewer	Multiple Viewer	Subscription
£65.00 + VAT	£195.00 + VAT	£1,900.00 + VAT
Webinar access for 60 days	Webinar group access for 60 days	Group access to all webinar library content for 12 months

Our on-demand webinars are available now, to be accessed from your desktop, laptop, tablet or mobile phone.

On-demand webinars:

Medico-Legal Issues in Laser Eye Surgery
Understand the issues surrounding Laser Eye surgery. This session will cover the types of laser surgery, contra-indications to treatment, consent issues, vision threatening complications and negligent and non-negligent treatment.
Presented by: Mr Damian Lake, Consultant Ophthalmic Surgeon, Queen Victoria Hospital, East Grinstead
CPD Accreditation: 1 hour Bar Council & APIL

Medico-Legal Issues in Maxillofacial Injuries
This webinar will give solicitors involved in medico-legal cases an understanding of the concerns in relation to maxillofacial surgery. This session will discuss nasal, cheek bone and orbital fractures and the failure to diagnose and treat appropriately as well as missed or delayed diagnosis of maxillofacial cancers.
Presented by: Mr Laurence Newman, Consultant Maxillofacial Surgeon, Queen Victoria Hospital, East Grinstead
CPD Accreditation: 1 hour Bar Council & APIL

Medico-Legal Issues in Anaesthesia
This webinar will discuss the issues surrounding the care of patients under anaesthesia and will cover pre-op checks, consent issues, anaesthetic awareness, patient monitoring and post-operative care.
Presented by: Dr David Levy, Consultant Anaesthetist, Nottingham University Hospitals NHS Trust
CPD Accreditation: 1 hour Bar Council & APIL

Understanding Biochemistry Test Results
This webinar will give solicitors involved in medico-legal cases an understanding of how biochemical test results are used to monitor patients' vital functions and how failure to request/monitor may impact on the patient's outcome.
Presented by: Dr Ken Power, Consultant in Anaesthesia and Intensive Care and Lead Consultant for Critical Care Services, Poole Hospital NHS Trust
CPD Accreditation: 1 hour Bar Council & APIL

Inquest - Post Mortem
New Coroners Rules and Regulations came into force in July 2013. Some of the issues affecting Inquests into death following medical treatment arise from changes related to post-mortem examinations, what is considered "natural death" and how this will affect further investigation. Watch this webinar to get some practical guidance on how to deal with the issue of post-mortem examination, when to request post-mortem imaging and how to fund it and what is considered "natural death".
Presented by: Professor Peter Vanezis, Professor of Forensic Medical Sciences; &
Dr Peter Ellis, Barrister, 7 Bedford Row & Assistant Coroner, West London Coroners Court

Hospital Acquired Infections - the current state of play
This webinar will update solicitors on medico-legal challenges around hospital acquired infections. During the session you will hear about the common hospital acquired infections, pre-hospital admission monitoring, hospital infection policies/infection control meeting, new generation of antibiotics and issues surrounding delay in treatment.
Presented by: Professor Peter Wilson, Consultant Microbiologist, University College Hospital
CPD Accreditation: 1 hour Bar Council & APIL

Blood Pressure - Implications and Outcomes
Blood pressure is an important clinical measurement. This online session will give solicitors involved in medico-legal cases an understanding of what blood pressure is and why it is important to control it.
Presented by: Dr Duncan Dymond, Consultant Cardiologist, St Bartholomew's Hospital, London

Pressure Sores – A Nursing Perspective
According to research, the cost of treating pressure sores is higher than the national cost of heart disease; an astonishing finding when considering that 95% of pressure sores are avoidable. Understand the issues surrounding pressure sores, identify the risk groups for development of pressure sores and differentiate between negligent and non-negligent prevention and management of this life-threatening injury.
Presented by: Cathie Bree-Aslan, Tissue Viability Nurse & Expert Witness, Wound Healing Centres
CPD Accreditation: 1 hour non-accredited CPD

How to Interpret Blood Test Results
This one hour interactive session provides an overview of the importance of blood tests when looking at medical records and to identify appropriate blood tests that should have been performed routinely with certain conditions.
Presented by:
Professor Samuel Machin, Consultant Haematologist, University College London

CPD Accreditation: 1 hour non-accredited CPD

Oncology & GP Referral
This webinar will discuss the duties of a GP in the treatment of cancer patients. At the end of this webinar you will be able to identify when cancer should be suspected and when a referral should be made.
Presented by: Dr Nigel Ineson, General Practitioner

Loss of Chance in Clinical Negligence
The aim of this webinar is to give you an understanding of pitfalls and limitations of the complex legal principle of loss of chance in clinical negligence. The session will discuss the scope of loss of chance in causation and the increased importance of loss of chance in quantification of damages, in particular in respect to loss of earning in clinical negligence cases

Presented by: Stephen Glynn, Barrister, 9 Gough Square Chambers

CPD Accreditation: 1 hour non-accredited CPD

Medico-Legal Issues in Foot and Ankle Surgery
This webinar will give solicitors involved in medico-Legal cases an understanding of the concerns in relation to foot and ankle surgery. This session will discuss the types of fractures and dislocation of the ankle and foot, achilles tendon disorders and the failure to diagnose and treat appropriately, foot surgery focusing on hallux valgus surgery, podiatric surgery and consent issues.
Presented by: Mr Bob Sharp, Consultant Orthopaedic Surgeon, Oxford University Hospitals

Medico-Legal Issues Arising from Bariatric Surgery
The rising rates of obesity is being followed by raising levels of bariatric surgery which is reported to have increased 30 fold over the last 10 years. Currently, NICE recommends the procedure should be considered as first-line treatment option for adults with BMI of 50 plus.
Join the webinar to learn about consent issues, what is considered negligent and non-negligent bariatric surgery, what are the complications arising from the treatment and negligent aftercare.
Presented by: Mr Marcus Reddy, Consultant Gastrointestinal Surgeon, St George's Healthcare NHS Trust, London & Mr Omar Khan, Consultant Gastrointestinal Surgeon, St George's Healthcare NHS Trust, London
CPD Accreditation: 1 hour non-accredited CPD

The Annual Clinical Negligence Conference 2015
26-27 June 2015, Royal Armouries Museum, Leeds

AvMA wishes to thank the following

sponsors and exhibitors for their support:

1 COR
ONE CROWN OFFICE ROW

Contact Matthew Phipps, Senior Clerk at matthew.phipps@1cor.com
Telephone: 020 7797 7500
Visit us on Stand No: 8

42 BEDFORD ROW

Contact Tony Charlick, Commercial Manager at TonyC@42br.com
Telephone: 020 7831 0222
Visit us on Stand No. 22

Byrom Street Chambers

Contact Terry Creathorn, Senior Clerk at terry@byromstreet.com
Telephone: 0161 829 2100

FLETCHERSSOLICITORS
Medical Negligence Specialists

Contact Alison Pye, Talent and Resourcing Specialist at alisonpye@fs.co.uk
Telephone: 01704 503 111

Visit us on Stand No. 4

Contact Stephanie Lawrence, Events & Marketing Co-ordinator at stephaniel@no5.com
Telephone: 0845 2105 555

Contact Andy Grosvenor, Marketing Manager at Agrosvenor@serjeantsinn.com
Telephone: 020 7427 5000
Visit us on Stand No: 11

Contact Christine Collett, Marketing Assistant at christine.collett@temple-legal.co.uk
Telephone: 01483 514 410
Visit us on Stand No. 5

Contact Andrea La Pietra, Director at andrea@qlp.ltd.uk
Telephone: 0207 220 7759
Visit us on Stand No. 9

PUTTING PROFIT BACK INTO LEGAL COSTS.

Contact Lisa Newman, Group Marketing Communications Coordinator at lisa.newman@picosting.co.uk, Telephone: 01302 343 666.
Visit us on Stand No: 16

Contact Kaushal Sampat, Account Manager at K.Sampat@abbeylegal.com
Telephone: 0870 607 8999

Visit us on Stand No. 21

AmTrust Europe Legal

An AmTrust Financial Company

Contact Charlotte Djukanovic, European Marketing Assistant at Charlotte.Djukanovic@amtrustgroup.com
Telephone: 020 7 152 1351
Visit us on Stand No. 14

Brownbill ASSOCIATES LTD
Case Management and Community Care Services

Contact Fiona Green, Business Director at office@brownbill.com
Telephone: 01844 212153
Visit us on Stand No. 17

BURCHER / JENNINGS
LEGAL PRICING & COSTS CONSULTANTS

Contact Michelle Barron, General Manager at michelle.barron@burcherjennings.com
Telephone: 0870 7777 100
Visit us on Stand No. 1

BUSH & COMPANY
REHABILITATION

Contact Laura Langthorne, Marketing Co-ordinator at llangthorne@bushco.co.uk
Telephone: 01327 876210
Visit us on Stand No. 7

Claim Finance

Contact Michael Corner, Partner at mcorner@claimfinance.com
Telephone: 0345 051 3900
Visit us on Stand No. 3

Clinical Connexx
Clinical Negligence Legal Software

Contact Sajid Hussain, Managing Director at sh@outspiregroup.co.uk
Telephone: 0870 0610018
Visit us on Stand No. 2

Contact Hannah Fraser, Marketing Executive – Events at events@das.co.uk
Telephone: 0870 241 1345
Visit us on Stand No. 10

MedBrief

Contact Bethan Williams, Manager – Marketing and Business Manager Bethan.Williams@millnet.co.uk
Telephone: 0207 422 8850
Visit us on Stand No. 41

Contact Neil Whiteley at neil.whiteley@medicalclericalbureau.com
Telephone: (01752) 568990
Visit us on Stand No. 13

Contact John Hocking, Managing Director at john.hocking@nwlcosts.com
Telephone: 01244 317 543
Visit us on Stand No. 12

Contact Krissi Fletcher, Operations Manager, at krissi@photofileltd.co.uk
Telephone: 01285 658111
Visit us on Stand No. 6

Contact Paul Eeles, Senior Civil Clerk at peeles@7br.co.uk
Telephone: 020 7400 7345
Visit us on Stand No. 39

Contact Beth Williams, Marketing Administrator at beth.williams@39essex.com
Telephone: 020 7832 1111
Visit us on Stand No. 32

Contact Pamela Irving, Marketing Manager at enquiries@neat-legal.co.uk
Telephone: 01228 672 220
Visit us on Stand 34

Contact Glynis Moss, Marketing Assistant at glynis.moss@arag.co.uk
Telephone 0117 917 1694
Visit us on Stand No. 24

Contact Mary Porch, Head of Marketing Communications & Business Development Advisor at Mary.Porch@ashtonkcj.co.uk
Telephone: 01842 768 725
Visit us on Stand No. 35

Contact Amy Pullen, Marketing Assistant at Amy.Pullen@blatchford.co.uk
Telephone: 01256 316687
Visit us on Stand No. 45

Contact Meg Pollack, Administrative Assistant at Meg.Pollock@civilandcommercial.com
Telephone: 020 7842 5964
Visit us on Stand No. 19

Contact Grant Cumbley, Sales & Marketing Director at gcumbley@costsrecovery.com
Telephone: 07899 872396
Visit us on Stand No. 31

Contact Belinda Burnett, Office and Accounts Manager at accounts@connectcosts.co.uk
Telephone: 01904 559 710
Visit us on Stand No. 28

Contact Kim Walker, IT Marketing & Operations Co-Ordinator at kimw@dorset-ortho.com
Telephone: 01425 481 756
Visit us on Stand No. 25

Contact Paul Scrutton, Head of Business Development at paul.scrutton@frenkeltopping.co.uk
Telephone: 0161 886 8000
Visit us on Stand No. 38

Contact Aga Lesniak, Clinical Support at Aga.Lesniak@harrisonassociates.org
Telephone: 020 8998 2992
Visit us on Stand No. 30

HUGH JAMES
expert legal advice

Contact Sarah Davies, Marketing Manager Claimant - Business Development at Rhian.Riley@hughjames.com
Telephone: 029 2039 1035
Visit us on Stand No. 46

Independent Living Solutions Ltd
Case Management and Rehabilitation Services

Contact Shauni Burt, Marketing Assistant at shauni.burt@indliv.co.uk
Telephone: 01722 742 442
Visit us on Stand No. 36

KINGS CHAMBERS

Contact Alice Smedley, Marketing at ASmedley@kingschambers.com
Telephone: 0161 819 8273
Visit us on Stand No. 15

mcc
Medical Collation & Chronology

Contact Juliet Young, Director at juliet@collationandchronology.com
Telephone: 0161 929 8807
Visit us on Stand No. 29

Medical Records UK

Contact Adéle Coates-Lyon, Managing Director at adelecoates@medicalrecordsuk.com
Telephone: 01242 603 088
Visit us on Stand No. 23

mrn
SOLICITORS

the Costs Experts

Contact Michael Joseph, Head of Client Care and Business Development at mj@costexperts.co.uk
Telephone No: 0161 830 8474
Visit us on Stand No. 46

Contact Nicola Blair, Office Manager at nicola.blair@medicalrecordcollation.com
Telephone: 0161 928 1636
Visit us on Stand No. 42

Contact Annette Moore, Manager at annette@orderorder.org
Telephone: 0114 250 7100
Visit us on Stand No. 27

Contact Julie Burton at gillian.young@penningtons.co.uk
Telephone No. 01256 407100
Visit us on Stand No. 47

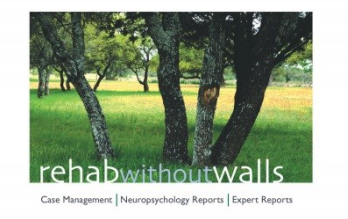
Contact Mark Hewitt, Managing Director & Adam Fletcher, National Sales Manager at mark@picalculator.co.uk; adam.fletcher@picalculator.co.uk
Telephone: 0114 266 3300
Visit us on Stand No. 43

Contact Jocelyn Doe, Office Manager at jocelyn@plg.co.uk
Telephone: 0333 577 0809
Visit us on Stand No. 18

Contact Lynsey Smith, Group Executive Assistant at lynsey.smith@premex.com
Telephone No: 0844 811 8546
Visit us on Stand No. 40

PURE LEGAL COSTS CONSULTANTS

Contact Emma Case, Marketing Assistant at emma.case@purelegalcosts.co.uk
Telephone No: 0151 481 4469
Visit us on Stand No. 37



Contact Claire Baxter, Case Management Support & Marketing Manager at claire@rehabwithoutwalls.co.uk
Telephone: 01908 560041
Visit us on Stand No. 33

somek&associates
medico-legal consultancy

Contact Natalie Stratton, Reports Administrator at n.stratton@somek.com
Telephone No: 01494 799 997
Visit us on Stand No. 20

CRC Press
Taylor & Francis Group

Contact Matthew De Bono, Senior Marketing Manager (Medical) at matt.debono@tandf.co.uk
Telephone: 0207 55 19391

PFP
PERSONAL FINANCIAL PLANNING LTD

Contact Lesley Leek at lesley@pfp-planahead.co.uk on Telephone: 01270 759 786

PUTTING PROFIT BACK INTO LEGAL COSTS

PIC - CLINICAL NEGLIGENCE LEGAL COST SPECIALISTS

For 20 years PIC have been the primary Clinical Negligence claimant-only specialist in the market.

We have a proven track record for delivering the highest level of customer service for our clients and we offer the following benefits

- Cost Budgeting
  - No win no fee
  - All fees deferred
  - Full cost & case management service

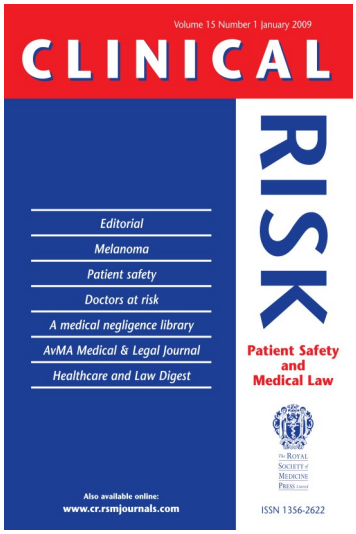
- Consistent high recovery of costs for NHSLA
- High hourly rates achieved
- Payments on account achieved quickly and efficiently

PIC provide regional coverage with dedicated teams to release your lock up in the shortest possible time.

For further information:
T: 03458 72 76 78
E: info@picosting.co.uk
www.picosting.co.uk

PIC
PUTTING PROFIT BACK INTO LEGAL COSTS.

NOTICEBOARD



Clinical Risk is a leading journal published by the Royal Society of Medicine, which aims to give both medical and legal professionals an enhanced understanding of key medico-legal issues relating to risk management and patient safety. Containing authoritative articles, reviews and news on the management of clinical risk, our quarterly journal aims to keep you up-to-date on current medical legal issues and covers a wide range of recent settled clinical negligence cases. The journal includes both the *AvMA Medical and Legal Journal* and the *Healthcare and Law Digest*.

AvMA members firms and barristers are entitled to a discount to subscribe to Clinical Risk.

Please email norika@avma.org.uk for a subscription form.

Clinical Risk is an essential read for anyone working within the medical negligence fields or providing healthcare to the general public, both within the UK and abroad.

For more information see http://www.uk.sagepub.com/journals/Journal202179 or click here

AvMA

Freedman House

Christopher Wren Yard

117 High Street

Croydon

CR0 1QG

DX: 144267 CROYDON 24

NOTICEBOARD

Everyclick gives you lots of ways to raise money for Action against Medical Accidents (AvMA)

SEARCH	– search the web and generate funds for free
SHOP	– buy favourite brands from hundreds of retailers
DONATE	– give online, direct to your charity of choice
SPONSORSHIP	– collect sponsorship for fundraising events
eVOUCHERS	– send an online donation as a gift

HELP SUPPORT AvMA TODAY WITH EVERYCLICK

JUST GO TO: http://www.everyclick.com/actionagainstmedicalaccidents

LOOK AFTER THE PENNIES...

Raise money for us by searching the web with everyclick.

Every click is a search engine similar to Google; the difference is that part of it's advertising revenue is donated to your chosen charity.

So, with no effort you can raise money for us. Select AvMA as your chosen charity, make everyclick your home page and Voilà! Every search you make will generate a penny for AvMA. It is amazing how those pennies will turn into to pounds!