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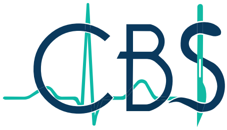

The Confederation of British Surgery

SURGICAL ADVISORY SERVICE

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This document is an edited and updated version of the paper originally written by Professor John MacFie entitled "*Managing the surgeon in difficulty*"

This publication was based on a meeting of the Surgical Forum of GB and Ireland held at the Royal College of Surgeons of Edinburgh in 2015. In addition to the Presidents, or their representatives, of the four Royal Colleges and the 10 Surgical Specialty Associations (the FSSA) , BOTA and ASIT were represented, as was the English College Patient Liaison Group.

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Surgical Advisory Service (SAS)

1. BACKGROUND: why do doctors need an advisory service?

1.1. There are almost 250,000 doctors registered in the UK and Ireland and approximately 50% of whom work in the NHS and Community Health Service. Their duties and responsibilities are clearly defined in *Good Medical Practice* published by the UK's sole regulator of the medical profession, the General Medical Council. According to NHS Workforce Statistics there were almost 21,000 Consultants in surgery related specialty practice in the UK in July 2021 with a similar number of doctors in training and other non-consultant grades. As registered doctors they must practice in accordance with GMC guidelines and in addition, the Surgical Colleges have produced specific recommendations for the practice of surgery, e.g., *Good Surgical Practice*, (RCS Eng 2014). Documents such as *Good Surgical Practice* provide a baseline of standards for individual surgeons to demonstrate in their practice.

1.2. Surgery is not a solitary activity. Patient safety and good practice depend not only on individual surgeons but also on effective team working. A surgeon will work with many teams within a normal working week making it essential that surgeons demonstrate effective relationships with both their clinical and non-clinical teams and for them to consistently demonstrate high quality leadership with patient care at the core.

1.3. Doctors may be accused of failing in their duties in a variety of ways but there is remarkably little in the medical literature examining the optimal means by which a 'failing' doctor/surgeon might be identified, let alone what represents single best practice in terms of managing such an individual. The absence of consensus is one factor which has led to a

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plethora of mechanisms to assess and manage a doctor perceived to be ‘in difficulty’: these include the GMC, the Practitioner Performance Advice service (formerly NCAS), the Deaneries, Colleges, Specialty Associations as well as individual Trust HR departments and Medical Directors. Not infrequently, doctors may find themselves the subject of investigations from more than one organisation at any one time. Occasionally, there may be media and legal involvement as well.

1.4. Not surprisingly, doctors in surgical specialities who are subjects of complaints or concerns are usually in unfamiliar territory and often confused about the differing processes being employed.

The SAS has been established by CBS to assist and advise surgeons who, for whatever reason, find themselves concerned they are in jeopardy. CBS, of which SAS is a wholly owned subsidiary, is a registered trade union and, in contrast to Colleges and Associations, CBS and SAS are able to legitimately advise on these issues and matters relating to terms and conditions of employment. This advice comes from experienced consultants, backed up by legal and other experts in relevant fields.

1.5. SAS is not, and does not purport to be, a substitute for surgeons ensuring they have adequate medical indemnity for all aspects of their practice.

1.6. The expertise drawn upon by SAS is primarily focussed on doctors working in areas related to provision of surgical services, including anaesthetists and is particularly relevant for doctors who are in non-training grades.

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2. Why do doctors working in surgical teams get into difficulty?

Personal & Organisational Issues:

Among the many possible reasons why consultants may find themselves under external scrutiny are: (the order reflects the frequency that they occur):

- **Communication difficulties with patients**
- **Dysfunctional relationships with colleagues**
- **Health issues affecting professional practice**
- **Behavioural issues**
- **Issues relating to clinical competence**
- **NHS and Private practice are going through constant changes that affect circumstances**
- **Patient Complaints**

For additional consideration, *there are more examples in Appendix 1a*

Working Conditions & Environment:

The working environment and culture can have a huge impact on surgical performance, *for examples see Appendix 1b*

Morale:

There are multiple factors that have eroded the morale of surgeons over the last 20 years, *see examples in Appendix 1c*

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Professional Performance: (Definition accepted by Surgical Forum of Great Britain and Ireland March 2015)

'The professional performance of doctors represents the successful deployment of a range of factors that include elements related to the individual such as health (all aspects physical and mental including cognition), personality and the possession of sufficient clinical knowledge and skills; elements related to the workplace such as leadership, climate, culture and team dynamics and elements related to education from medical school selection through the undergraduate curriculum to the ability to maintain and improve performance by way of continuing professional development'.

Whilst there is no doubt that some, or all, of these factors may be contributory factors in individual cases, the reality is that robust evidence to support any of the above is lacking. This must explain, to some extent, the lack of a consistent approach to the problems raised by doctors in difficulty in the surgical team.

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3. Surgical Advisory Service: modus operandi

Any CBS member is entitled to contact CBS to request assistance.

CBS as a trade union and SAS as an advisory service will play differing roles depending upon the situation a member finds themselves in (see tables below).

Where do CBS, as your trade union, and SAS, as your advisory service, have roles to play?

	CBS Role	SAS Input
Issues relating to:		
Contracts	✓	
Job Planning	✓	
GMC	✓	
Negligence - NHS	✓	✓
Negligence - Private	✓	✓
NHS Trust investigation	✓	✓
MHPS	✓	✓
Employment	✓	
Coroner	✓	✓
ICO	✓	
CQC	✓	✓
Criminal - GNM/ABH	✓	✓

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In what situations does CBS have a role to play as your trade union?

	Pastoral support	Liaison with NHS	Liaison with Indemnifier
Issues relating to:			
Contract	✓	✓	
Job Planning.	✓	✓	
GMC	✓	✓	✓
Negligence - NHS	✓	✓	✓
Negligence - Private	✓		✓
NHS Trust investigation	✓	✓	✓
MHPS	✓		✓
Employment	✓	✓	
Coroner	✓	✓	✓
ICO	✓		✓
CQC	✓		✓
Criminal - GNM/ABH	✓	✓	✓

See Appendix 2 for more explanation of the SAS process.

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4. How may a doctor in the surgical team become a Doctor in Difficulty?

- **By being an outlier in Surgeon/Anaesthetist specific outcome data**
- **Receiving a letter of complaint from a patient or relative**
- **Receiving a solicitor's letter threatening litigation**
- **By being directed by the Trust to undergo conduct and/or capability procedures under MHPS (maintaining high professional standards)**
    - The MHPS process has multiple different ways with which to deal with differing situations, the initial choice of which (eg conduct vs capability) may influence the outcome (see Appendix 2a). ***Please get advice early!***
- **By being involved in a Professional Invited Review Mechanism (IRM)**
    - When a Trust or hospital needs an external expert opinion, the Royal Colleges of Surgeon of England and of Edinburgh can provide an established confidential, bespoke review service – the Invited Review Mechanism (IRM). This mechanism addresses a range of issues such as patient safety concerns at an individual or service level, service delivery, service reconfiguration and requirement for independent expert opinion on the management of a specific case or series of cases. The aim of the invited review is to support, but not replace, existing procedures.
- **By being reported to the Practitioner Performance Advice (PPA) service of NHS resolution.**
- **By being reported to the GMC**
- **By becoming the subject of hostile publicity**
- **As a result of an adverse Coronial finding, resulting in GMC referral and/or action at local Trust level.**

For guidance on what to do about these circumstances refer to Appendix 3

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5. Management of colleagues in difficulty

If you suspect a professional colleague is in difficulty, we recommend the following:

- Always act if you have concerns: early identification of issues facilitates successful remediation.
- If you feel a patient is in immediate danger, intervene to stop the individual from operating/anaesthetising wherever possible and if it is safe to do so.
- Get early third-party advice. SAS can assist with this.
- Encourage the surgeon to obtain advice and representation.
- Ensure there is constructive doctor/Trust engagement.
- Encourage participation in audit, MDTs, M&M meetings;
- Encourage audit and presentation of verified results and with PPA.
- Don't place unrealistic conditions on practice.
- Have realistic remediation plans.

6. Dealing with potential 'Bad Press'

Doctors who find themselves in difficulty are naturally concerned about possible bad press and public vilification. If you find yourself facing an imminent crisis, CBS/SAS can put you in touch with experts who can offer strategies and support based on extensive experience in managing the run-up to, and the fallout from, reactive news stories, as well as maintaining social media channels before and/or after broadcast or publication.

7. The Surgeon as a Witness

If you are called to be a witness, SAS is here to support and advise.

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APPENDIX 1a.

Additional circumstances.

- Shortened, narrowly focussed training programmes providing more restricted practical experience
- NHS non-clinical managers may have limited insight into the complexity of surgical practice and be unable to analyse the nuances of outcome metrics
- An NHS mentality which can prioritise population outcome measures over individual patient care putting them at odds with a clinician's priorities
- The complexity of modern NHS structures
- Patients who have greater and sometimes unrealistic expectations of outcomes
- The perceived 'shame and blame' culture within the NHS
- The 'Target' mentality, which may erode professional priorities
- Surgeons who have qualified outside the UK and may have specific additional challenges and obstacles in the NHS system
- Erosion of the surgical 'firm', which destroyed the 'team' approach to care
- A lack of incentives to inspire high quality performance.
- A lack of team-based rewards and incentives for good teams led well.
- The consultant contract and EWTD which prioritise time worked to the detriment of flexibility and professionalism.
- Fallout from the Covid pandemic
- Lack of knowledge of the legal environment in which surgeons practice.
- Naïve use of social media.

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APPENDIX 1b.

Working conditions: The working environment and culture have a huge impact on performance of doctors working in the surgical arena in the short and in the long term. Some of this is under the influence of consultants but employers and providers also have a legal obligation to provide adequate and appropriate resources to achieve a safe working environment. "The team" can only be as good as its weakest link but this is not always recognised by the NHS, especially during disputes.

Working environment: Disrupting clinicians' familiar routines and places may have a profound impact on performance. This may be either positive or negative and are not under the direct influence of the clinician. Similar challenges exist with the introduction of new technologies or the re-deployment of key members of staff

For examples of these circumstances, please refer to the results of the CBS Survey on Caring for Doctors, Caring for Patients available on the CBS website: www.cbsgb.co.uk

APPENDIX 1c

Medical workforce morale: By common consent it is recognized that morale is at an all-time low. Expectations from politicians, managers and patients continue to rise exponentially in an increasingly complex subspecialized environment. Individually and collectively, we are challenged to deliver more with less in an environment of chronic underfunding. Seven-day working, moving to a digital environment with inadequate support, enforced changes to the structure of teams and recently Covid pressure have all led to the feeling that we are considered to be underperforming despite our best efforts. Exhortations to "Do more with Less" are ceaseless. A demoralized workforce cannot perform at their best.

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APPENDIX 2

Surgical Advisory Service: modus operandi

An SAS request form outlining details of concerns will need to be completed. This form also explicitly gives SAS access to confidential personal information. Once agreed with the individual, this form is sent to the core advisory group.

The core group discusses the case and may make several recommendations:

- One of the group will act as the individual's CBS mentor. The designated mentor will liaise closely with the CBS member
- The mentor will offer advice and produce an action plan based on the available information
- Professional legal advice will be sought when necessary
- Professional clinical advice (through FSSA) will be sought when necessary

As case experience grows, other individuals may be identified who will be appropriate to join the core group.

As SAS grows it is likely that requests will be received seeking advice about clinical reviews. It would be appropriate that these requests are associated with a fee for service.

In essence, therefore, the primary role of SAS is a means of "signposting" surgeons in difficulty to appropriate experts to ensure the member gets the correct help at the correct time wherever possible. Additionally, it is hoped that unnecessary anxiety for the member will be minimised by being able to advise members in timely fashion.

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APPENDIX 3 - Guidance

Being an outlier in Surgeon/Anaesthetist-specific outcome data

Much of modern surgical practice relies upon close cooperation between teams of clinicians, nurses and other healthcare professionals. It also relies upon complex infrastructural, managerial and administrative arrangements within provider units. Whilst the availability of high-quality performance and outcome data relating to all individual team members is important in order to ensure that a team is functioning well, it is not the most helpful information to make publicly available. It is important to recognise that much post-operative morbidity and mortality comes about because of 'failure to rescue', a factor that may not be influenced by the original operating surgeon. Some argue that publication of individual data can also lead to risk-averse behaviour and is not in patients' best interests as it results in surgeons collectively adopting a 'lower risk' practice and patients being denied the opportunity of operations that might benefit them.

There is no evidence to confirm that surgeon specific outcome data is a reliable and robust means of identifying the surgeon in difficulty. Nevertheless, any surgeon finding themselves under investigation as a result of one of these audits should:

- Check the veracity of data entered (often done by audit clerks)
- Compare to previous 5 years. If data is not available for 5 years, or large numbers not available, then any conclusions are suspect
- Seek comparison to other individuals in unit
- Inform MD and clinical director. Seek to correct any deficiencies in practice that are management or resource related
- Is it patient selection?
- Involve a colleague / friend / SAS to have full and open discussion.

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Receiving a letter of complaint from a patient

Within the NHS, the recognised process for dealing with a letter of complaint is through PALS (patient advice and liaison service). Most frequently complaints are directed directly to them but on occasion may be directed to the surgeon directly.

Do not act or respond without taking advice. Always seek advice from your Medical Insurance Indemnifier, the Trust and SAS before sending any responses.

Receiving a solicitor's letter inferring impending litigation

1. The first step in litigation is the claimant's solicitor producing what is called a "pre-action letter of claim". This outlines the facts of the case and may allege poor care and/or negligence. Such letters require prompt action as time limits apply and delay may compromise any defence.

2. **DO NOT** communicate with potential claimants or their representatives without guidance from your medical indemnity provider otherwise you risk compromising your indemnity cover. Allegations of poor care can be a significant emotional challenge at an individual and unit level and even when they are not, responding without objective professional advice is taking an unnecessary but very real professional and financial risk. Indemnity providers may advise limiting an initial reply to a simple acknowledgement or alternatively drafting a detailed rebuttal of all allegations. SAS will assist you in dealing with what for most doctors is a very unfamiliar and emotionally challenging set of circumstances and assisting with personal support and liaison with all other parties.

3. If a claim is pursued, a "Letter of Claim" will follow and you will need to work closely with your medical indemnity provider. In general, you will be advised to admit actions which cannot be defended but where there are areas of dispute, you should use your specialist expertise to provide arguments and evidence, including literature to support your views.

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Being required to undergo MHPS (Maintaining High Professional Standards) procedures

The standard and accepted HR framework for managing NHS employed doctors in England is set out in a document published by the Department of Health called *Maintaining High Professional Standards in the Modern NHS* (MHPS). Analogous, albeit different, procedures exist in the other home-nations. However, not all concerns are addressed by MHPS.

MHPS describes the procedures, which Trusts in England have to follow for handling concerns about conduct, performance and health. MHPS procedures are not mandated for Foundation Trusts, but usually will have been formally incorporated into doctors NHS Terms & Conditions by employers through the Consultant Contract.

MHPS covers Capability (Conduct) and Health, but not all issues.

MHPS has clearly defined pathways:

- Part I: Action when a concern arises.
- Part II: Restriction of practice and exclusion.
- Part III: Conduct hearings and disciplinary matters.
- Part IV: Procedures for dealing with issues of capability.
- Part V: Handling concerns about a doctor's health.

Conduct hearings (Part III) are stressful and intimidating. Doctors working in the surgical arena should be aware that sometimes they may be inappropriate. Possible reasons for this include the incorrect categorisation of concern, failure to determine if the matter has a professional element, factors relating to conduct outside the employing Trust and a failure to distinguish conduct as opposed to capability issues (see below).

Medical defence organisations try to get everything seen as a capability issue that should not be handled under conduct procedures (as it is harder to dismiss someone via this route), whereas an employer will often try to pursue conduct rather than capability for the opposite reason. The truth is usually somewhere in between.

Few will find themselves at part IV of the MHPS process. In these circumstances it is important to consider some key factors: is there a

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distinction between conduct vs capability? Is the evidence available robust? Have attempts been made at remediation and has Practitioner Performance Advice service (formerly NCAS) been involved? At this stage the question of capability vs incapacity may arise together with whether the doctor should be referred to the GMC.

Conduct or Capability?

A concern about a doctor's practice can be said to have arisen where the behaviour of the doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes or appears to behave persistently in a manner inconsistent with the standards described in *Good Medical Practice*.

Concerns include any aspect of a doctor's performance which poses a threat or potential threat to patient safety, or exposes services to financial or other substantial risk, undermines the reputations or efficiency of services in some significant way, or where activities are outside acceptable practices, guidelines and standards.

Whilst the doctor in difficulty often has issues with both conduct and capability, it is useful to distinguish these factors:

- Conduct issues include expected standards for specialty/grade, standards set by employer or commissioner and organisational rules and code of conduct.

- Capability issues are defined by 'fitness for purpose' (i.e. is this person able to fulfil the contract they have been employed to operate under?) or 'fitness to practise', which is regulated by GMC and informed by college/faculty.

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Level of Concern (can be useful to define in discussions) in the MPHS document. *From NHS Support Team, March 2013*

Key	**Low-level indicators**	**Moderate-level indicators**	**High-level indicators**
What reputational risks exist?	Organisational or professional reputation is not at stake but the concern needs to be addressed by discussion with the practitioner.	Organisation or professional reputation may be at stake.	Organisational or professional reputation is at stake.
Does the concern impact on more than one are of *Good Medical Practice (GMP)*?	Concern will be confined to a single domain of *GMP.* May include one of following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action.	Concern affects more than one domain of *GMP.* May include one of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action.	May include a serious untoward incident or complaint requiring a formal investigation. This includes criminal acts and referrals to the GMC.
What factors reduce levels of concern?	De-escalation from moderate to low. Reduction to low	De-escalation from high to moderate:	

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	or minimal impact.		
	Reduction in the likelihood of recurrence. Evidence of completion of effective remediation.	Reduction in impact to moderate. Reduction in the likelihood of recurrence. Evidence of insight and change in practice.	
What factors increase levels of concern?		Escalation from low to moderate: Increase in impact to moderate. Likelihood of recurrence is certain. No evidence of insight or change in practice.	Escalation from moderate to high: Increase in impact to severe. Increase in likelihood of recurrence. No evidence of remorse, insight or change in practice.
How much intervention is likely to be required?	Insight, remorse and change in practice will be evident.	Insight, remorse and change in practice may be evident. Remediation is	

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	Remediation is likely to be achieved with peer support. The individual doctor has no other involvement in outstanding or unaddressed complaints or concerns	likely only to be achieved through specialist support. The remediation plan should take no longer than three months to address.	Remediation will only be achieved through specialist support. The remediation plan will take upwards of three months to address and may include a planned period of supervised practice.
Could the problem have been predicted?	Unintended or unexpected incident		
What degree of interruption to service occurred?	No interruption to the service.		Significant incident which interrupts the routine delivery of accepted practice (as defined in *Good Medical Practice*) to one or more persons working in or receiving care.
How likely is the problem to recur?	Possibility of recurrence but any impact will remain minimal or low. Recurrent is not likely or certain.	Likelihood of recurrence may range from low to certain	Likelihood of recurrence may range from low to certain.

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How significant would a recurrence be?		Low-level likelihood or recurrence will have a moderate impact where harm has resulted as a direct consequence and will have affected the natural course of planned treatment or natural course of illness and is likely or certain to have resulted in moderate but not permanent harm. Certain level likelihood of recurrence will have a minimal or low impact.	Low-level likelihood of recurrence will have a high impact (where severe or permanent harm may result as a direct consequence and will affect the natural course of illness such as a permanent lessening of function including non-repairable surgery or brain damage).
How much harm occurred?	No harm to patients or staff and the doctor is not vulnerable or at any personal risk. No requirement for treatment beyond that already planned	Potential for harm to staff or the doctor is at personal risk. A member of staff has raised concerns about an individual which requires discussion and an action plan.	Patient, staff or the doctor have been harmed.

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Being involved in a Professional Invited Review Mechanism (IRM)

When a Trust or hospital needs an external expert opinion, the Royal College of Surgeons of England and of Edinburgh can provide an established confidential, bespoke review service – the Invited Review Mechanism (IRM). This mechanism addresses a range of issues such as patient safety concerns at an individual or service level, service delivery, service reconfiguration and requirement for independent expert opinion on the management of a specific case or series of cases. The aim of the invited review is to support, but not replace, existing procedures.

The Colleges' IRM are a partnership between the college, the specialty associations and lay reviewers representing the patient and public interest. The IRM, as a form of peer review, is now regarded as a highly valuable resource to help Trusts and hospitals deal with concerns before they develop into more serious problems.

The IRM is not disciplinary and is totally independent of GMC or NCAS. IRM reports are the property of the employing Trust who remain responsible for managing the situation being reviewed at all times.

Referrals to the IRM are usually from a Chief Executive or a Medical Director.

A criticism of the IRM process is that visits could be perceived as being one-sided. If two surgeons and a lay person arrive at a Trust to investigate a surgeon in difficulty over two days by interviewing nominated colleagues behind closed doors and then undertaking a case review, often of a dozen or more cases, there is little chance for the surgeon to challenge or rebut the evidence against (almost always) him/her or explain the context of the various issues which have been complained about at the time of the review. **The Surgical Advisory Service can assist you with this.**

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The Practitioner Performance Advice – PPA (formerly NCAS)

NCAS was a national service, established in April 2001 and is now an operating division of the NHS Resolution, Practitioner Performance Advice

The Practitioner Performance Advice (formerly the National Clinical Assessment Service, NCAS) was established in 2001, now delivered as part of NHS Resolution.

Practitioner Performance Advice provide a range of services to NHS organisations and others in England, Wales and Northern Ireland (e.g., advice, assessment and intervention, training courses etc).

Where the working environment gives rise to performance concerns, PPA is available to provide advice or support to help resolve the situation.

There is no minimum threshold for seeking advice and PPA encourages healthcare organisations and practitioners to contact them as early as possible when concerns come to light.

PPA states that it believes 'organisations should foster a just and learning culture which balances fairness, justice and learning when things have not gone as planned'.(please see 'Being fair').

Being reported to the GMC

The GMC is the sole UK regulatory authority.

Anyone, including the patient, a manager, another doctor or even the newspapers**,** can report a doctor to the GMC,

After receipt of a complaint the GMC instigates an investigation which involves both a medically qualified and non-medical case examiner. SAS will support you in this but you must inform your indemnity provider and any response agreed with them to maintain their support in the event that matters progress. You can comment at this stage if you wish and, if you feel the case in your defence is strong then a carefully worded and detailed rebuttal may be sent in discussion with

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your medical indemnity provider.

There are four outcomes open to GMC Case Examiners at the conclusion of the investigation:

- To conclude the case with no action, possibly in conjunction with advice;
- To offer a Warning, a sanction which remains on your record for five years, essentially to reflect an isolated departure from the principles of Good Medical Practice but where no other fitness to practise issue arises;
- To invite the practitioner to agree to Undertakings, in respect of performance and/or health issues;
- To refer the matter for consideration by a Medical Practitioners Tribunal.

At any stage during the investigation, the Case Examiners may refer the case for consideration by an Interim Orders Tribunal, which may impose interim conditions or suspend the practitioner's registration while the investigation takes place.

Referral to a Medical Practitioners Tribunal ("MPT") is a lengthy process, at the conclusion of which the Tribunal has a range of sanctions at its disposal, up to and including erasure. The conduct of a practitioner's defence at an MPT is a specialised area and a separate topic in itself, although representation and support is essential.

APPENDIX 4

The Surgeon as Expert CPR 35 regarding roles and responsibilities (service for the future in terms of the development of SAS)

An expert witness may be described as 'one who has made the subject upon which he speaks a matter of particular study, practice or observation'. Expert evidence in England and Wales is presented primarily in the form of medicolegal reports. These can have a profound influence on the conduct and outcome of cases, both for claimants and defendants. The lawyers on both sides of a case will study the medical- expert evidence before making decisions on whether and how to proceed with a claim and on what terms to attempt

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to settle it. Medical experts, therefore, have a pivotal role in the litigation process. It must be emphasised that the primary duty of the ‘expert witness’ is not to be an advocate for their client’s position; it is actually to inform and assist the decision-maker, which is usually the court.

In this country, as well as many others, there are remarkably few restraints on doctors of any speciality writing an expert report. Responsible solicitors, particularly those who work closely with the defence organisations, will usually only instruct doctors who are regarded as experts, have a CV to confirm this and have a track record of producing cogently argued reports in line with the requirements of the Civil Procedure Rules section 35. Unfortunately, however, there are many firms of solicitors, some of whom work exclusively for the complainant on a ‘no win no fee’ basis, for whom the standards of medical expert may be less than ideal. Solicitors can easily access the names of doctors willing to write expert reports from a number of freely available websites. There is no policing of this activity. The GMC has issued guidelines on medical report writing but it is extremely uncommon for doctors to be reported to the GMC for breach of duty in this regard.

There is an increasing realisation among barristers that one way of destroying their opponent’s case is to discredit their expert witness. This is easily achieved if the witness has no academic or professional pedigree justifying their role as expert in the particular case.

The responsibilities of expert witnesses have been clearly and comprehensively defined by the General Medical Council (GMC) and many others (See DOI: 10.1308/rcsbull.2016.66). All expert witnesses must be aware of their obligations under Section 35 of the Civil procedure Rules and be aware of the legal framework in which they are working in the courts. If not, they may face charges of contempt of court, and have damages awarded against them if found wanting.

An expert witness should at all stages in the procedure – on the basis of the evidence as he understands it – provide independent assistance to the court and the parties by way of objective unbiased opinion in relation to matters within their expertise. This applies as much to the

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initial meetings of experts as to evidence at trial. An expert witness should never assume the role of an advocate.

An expert witness should make it clear when a particular question or issue falls outside their expertise.

If an expert's opinion is not properly researched because he or she considers that insufficient data are available, then this must be stated with an indication that the opinion is no more than a provisional one.

If, after exchange of reports, an expert witness changes their view on a material matter – having read the other side's expert's report, or for any other reason – such change of view should be communicated (through legal representatives) to the other side without delay and (where appropriate) to the court.

They should cooperate with the expert from the other party or parties in attempting to narrow the technical issues in dispute at the earliest possible stage of the procedure and to eliminate (or place in context) any peripheral issues. He or she should cooperate with the other expert(s) in attending (without prejudice) meetings as necessary and in seeking to find areas of agreement and defining precisely areas of disagreement to be set out in the joint statement of experts ordered by the court.

The expert evidence presented to the court should be – and be seen to be – the independent product of the expert and uninfluenced as to form or content by the exigencies of the litigation.

An expert witness should state the facts or assumptions upon which his or her opinion is based. He or she should not omit to consider material facts that could detract from his or her concluded opinion.

Where an expert is of the opinion that his or her conclusions are based on inadequate factual information, he or she should say so explicitly

Experts should avoid the use of wording that might be regarded as pejorative or pre-judgemental. Experts must be cautious about describing care as 'negligent or substandard'. The standard that defines negligence or substandard care remains defined as 'that of a

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reasonable average; the law does not require of a professional man that he be a paragon, combining the qualities of polymath and prophet'. This relates to the well- known 'Bolam' test, which states that 'if a doctor reaches a standard of a responsible body of medical opinion, he/she is not negligent'. But potential experts should be aware that in recent years the law has moved from this position to one where the defence must be reasonable in terms of logic, where the judge can provide reasons for rejecting medical opinion and where, as a consequence, expert evidence is now under greater scrutiny. Experts should also be aware that 'Bolam' has now been superseded by the Montgomery ruling (2015) on issues relating to consent. It is no longer acceptable to argue that a consent process was in accordance with a responsible body of medical opinion. Patients must now be made aware of any 'material' risks involved in a proposed treatment and of reasonable alternatives. These legal judgements serve to emphasise that doctors wishing to act as experts would be well-advised to familiarise themselves with these and related matters.

Expert witnesses are not immune from criticism or, indeed, sanction in the courts. Expert witnesses have no immunity from prosecution.

Medical expert witnesses are asked to provide expert opinion in their area of clinical expertise. They are not expected to be experts in the law. Nonetheless, experts make themselves very vulnerable to criticism if they fail to understand the legal implications of "Bolam", "Bolitho" and "Montgomery", or have failed to acquaint themselves with GMC documents on Good Clinical Practice or College guidelines on Surgical Practice.

In summary, an expert must be impartial, independent and truthful, and must only comment within the bounds of their own knowledge and expertise where necessary and supported by evidence. Experts should be logical and rational, not governed by emotion and fully aware of their responsibilities under the law.

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