Medico Legal Committee
Expert Witness Conference Report
Friday, 9 June 2023, BMA House, London

Effective courtroom and communication skills for expert witnesses
Mr Michael Walsh, Barrister, Serjeants' Inn Chambers

Mr Walsh's talk centred on dos and don'ts. He opened his talk by emphasising the importance of preparation. To start with, when writing up the report, an expert needed to identify all the right issues, be impartial, objective, clear and concise. The expert was there to assist the courtroom and their duty was to the court. The report needs to address breach of duty, causation, appropriate legal test and include a list of documents considered . Information must be balanced, the expert must persuade the courtroom that they are right and the other side are wrong. Communicate effectively, present your evidence and take your audience with you so that you will all come to the same conclusion and if not, you need to work out why. In the courtroom you need to demonstrate you have mastered your brief and understood your role. Clarify where required and look at all the evidence beforehand. You can't rely on those giving you the information to present it all to you. Look at all sources of information and find any deficits. You are in court to give evidence, you need to be able to cover all scenarios. Listen, reflect, concede where necessary.

Mr Walsh also touched upon the basics of courtroom etiquette e.g. levity in a courtroom was unwise. Appearance matters so don't wear causal or colourful clothes. Arrive early especially as there could be more documentation for you to see. Be aware of non verbal communication, a lot of communication is non verbal. Make eye contact with the judge, coroner and jury. Do not cross your arms if you are a bit bored. Rolling your eyes may be tempting but it is never justified. The presentation of the report was important too and speak in layman's terms, consider having a glossary for which the court and jury will be grateful. They will gravitate towards you if you know what you are doing. Give reasons for your opinions. You may be up against someone who says the opposite to you and if they haven't done their preparation, you may be able to undermine them. However, don't be obstructive, you do not want to appear unwilling to listen to counter arguments and you need to prepare for what they say no matter how irrational the argument is. If you change your view, tell the court as soon as you are able. Do not be persuaded to say something on the periphery of your expertise. You are there to help but don't get pushed a bit too far this will make you vulnerable and undermine your credibility. Don't forget supporting literature, provide it with your first report. Questions may be open or closed; do not be fooled – if questions are non binary let them know they shouldn't be asking them. Don't jump in to help either, the majority of questions are asked to elicit clarification. Your focus is to explain the issues. Use diagrams, pictures if you think it will assist you and reduce information to bite size pieces. Be aware of overload and don't overestimate their intellect and experience.

Ultimately, don't be afraid of appearing in the witness stand. You shouldn't be because everything should be in your report which is the backbone of your decision and reasoning is at the core. If you answer what is put to you honestly you will be fine, and take note, humility and flexibility are strengths.

Writing a good medico legal report
Dr Tom Boyd, GP and Expert Witness

Dr Boyd noted honesty and consistency were the fundamental aspects when writing a report. You also need to be impartial. When you write and consider your report, ask yourself whether it would be the same if you were writing for the other side? You may actually know the other parties in court. Make sure this doesn't affect your objectivity. You also need to differentiate between fact and opinion. The facts are for the judge and your opinion will carry much more weight if it contains contemporaneous opinion.

Your report should be written in lay language i.e. suitable for the intelligent lay person and the judge. You need to be thorough and conscientious in reviewing the evidence and obsessional in your approach to documents.

Writing medico legal reports is complex and beset with minefields. Find a mentor and work with good lawyers. Dr Boyd noted before 2011, an expert couldn't be sued. There was in fact a lot of experts who weren't particularly good and the buck stops with the expert.

Be prepared to make variations to your report, what you write will be updated as the case unfolds; you should be guided by a legal advisor. Some essential features of a good report include setting out your qualifications tailored to the case, a summary of your instructions, reference to all the necessary documents including witness statements and pleadings, a logical and coherent structure, setting out reasoning supported by evidence, the numbering of pages and paragraphs, referenced pagination and correct dates. Other tips included brevity versus 'documentary carpet bombing' as judges and senior lawyers always ask for short reports. Also, avoid unverifiable, unreferenced and undated internet sources e.g. Dr Boyd also noted how tempting despatching a report once it was complete. He strongly advised sleeping on it and re-reading your report the next day as you may find it difficult to change your mind later.

In summary, be independent and impartial, recognise your area of expertise and do not stray outside it. Do the job thoroughly and properly. Finally, enjoy it!

Writing a coroner's report
Mr Leslie Hamilton, Consultant Cardiac Surgeon

Mr Hamilton noted you could write a report for three types of jurisdictions including criminal cases (involving criminal procedure rules funded by the state, civil cases (for clinical negligence funded by the opposing parties), and coroner's cases (which are inquisitorial and funded by the local authority).

In 2003 the Harold Shipman Inquiry concluded the need for radical reform of the Coronial system. The Coroners and Justice Act of 2009 clarified the role of the chief coroner. The Coroners and Justice Act of 2013 noted the Chief Coroner would professionalise the service, give guidance and bring consistency, undertake compulsory training, be full time, salaried and retire at the age of 75. Doctors could no longer be appointed as coroners, but from 2024 senior medical doctors could work as medical examiners who would be contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. If a coroner stated an investigation was necessary, they owned and decided if a post mortem would be held. Section 5 of the coroner and justice act of 2009 noted the matters to be ascertained i.e. who the deceased was, how, when or where the deceased came by his or her death and the particulars (if any) required by the 1953 Act to be registered concerning the death.

Article 2 of the European Convention on Human Rights included the right to life, the duty to refrain from unlawful killing, the duty to investigate suspicious deaths and the positive duty to prevent foreseeable loss of life on the part of the state. State detention must also provide equivalent care / prevent loss of life (suicide). The family is at the heart of the inquest process

An NHS inquest was a public hearing and the press were able to attend. There were no "parties" / sides, the inquiry was factual. The coroner decided who were interested persons and therefore entitled to disclosure and ask questions. Their job was to help the coroner with the inquest process. The family may instruct a barrister, the Trust may send legal representation and if a doctor was an interested party, they would need representation from the MDU.

In an expert's report the Coroner expected the cost to be funded by local authority, timeliness (i.e. the inquest needed to be completed as soon as practicable), the setting out medical issues in lay language, options for treatment, and a standard of care. In court, the following were expected: preparation (knowing the medical records), an oath or affirmation, lay language to be used with the family, an explanation of the medical issues / decisions, what did happen and what should have happened, guidelines, a balanced opinion, and a single expert. He recommended the Royal College of Surgeon's 'The Surgeon as an Expert Witness' and the Academy of Medical Royal College's 'Acting as a Witness or a Professional Witness' as further reading.

Clinical negligence & no fault compensation
Mr Umo Esen, Consultant Obstetrician and Gynaecologist

Equity in healthcare delivery and the provision of comprehensive health to all, free at the point of delivery was at the NHS's core principles. Dr Esen noted the NHS was currently failing to provide equity of care and not all injured patients received compensation. Conditions for successful clinical negligence compensation included the clinician breaching the duty of care owed and the breach causing the harm to the claimant. The claimant must also demonstrate the standard of care provided by the defendant had fallen below the required standard that of a reasonably skilled and experienced doctor and that the defendant's breach, on the balance of probabilities, caused the damage.

There was widespread dissatisfaction with the current scheme. In 1999 the Healthcare Financial Management Association (HMFA) stated 48% of Trusts were in deficit with over £75million debt as a result of negligence claims. Various bodies were seeking urgent reform of the clinical negligence system in England as the figures were currently unsustainable - if it continued unchecked, the NHS would go bankrupt. Obstetrics had the highest expense, maternity pay outs were costing twice the price of the care itself. The NHS was presently spending £1million a week on failed legal battles and lawyers were taking 40% of the money from upheld claims.

The current system (tort) has been variously described as adversarial, expensive, outdated, arbitrary and taking a long time to resolve. Few claimants were successful in winning compensation. Research showed claimants didn't want others to suffer in the same way, they wanted an apology and an explanation, compensation, a referral to the GMC and they wanted to be heard. The current system wasn't delivery this. To get compensation somebody needed to be blamed and doctors could become scapegoats. Tort promoted defensive medicine which was expensive and might not serve the patient. It was a prolonged process and proof of negligence may be difficult to demonstrate. Only those who could prove fault received compensation and if you were poor, you received less.

Dr Esen noted the most successful systems considered the patient's needs separately from failure of an institution or individuals to help eliminate harmful consequences and a tendency to cover up. He finished his talk by suggesting the UK adopt a scheme like that of the New Zealand which passed an Accident Compensation Act in 1972. The Act set up the No Fault scheme for compensation, provided assistance with the cost of treatment and rehabilitation for all personal injuries, regardless of fault in exchange for bans against suing for compensatory damages. In this way it aimed for a fair and sustainable scheme for managing personal injury. He concluded by noting it met the patient's needs, maintained the doctor patient relationship, led to a speedier resolution and although payments were smaller, it was more equitable.

What are the legal profession's expectations of doctors as expert witnesses?
Rosemary Ainslie, head of special crime division, Crown Prosecution Service

Special Crime Division is one of three specialist casework divisions, where cases may be referred to by Coroner or directly from the police. Rosemary provided an explanation of gross negligence manslaughter (within the parameters of R v Adomako 1995 1 AC 171; which sets out caselaw and the principle ingredients of manslaughter. The SRC would need a medical expert within prisons or immigration and detention removal centres (IDRC). Rosemary explained the criteria for grossness; is it truly appalling, is it something that should never happen in medical practice. The grossness question is always founded by a jury, with input from a medical expert.

Rosemary noted that accepted medical practice at the time, within the context of the time at the incident occurred, is important to determining negligence (for example, opioid treatment in society 10 years ago). Rosemary noted the personal qualities of an expert witness, and extrapolated on the expectations of expert witnesses with medical backgrounds. One item that needed to be determined, was if there was a conflict of interest. This could be having a previous knowledge of the individual. Another matter could be determining

whether the individual holds the right expertise, and/or if another expert is needed. Rosemary explained the differences in experts in a criminal, civil, and coroner court. While evidence may be objective, an expert should only be giving opinion based on the facts.

With the report by the expert, is the terms of instruction including the reports provided instructing a witness. Clarity of instruction is absolutely key. Within an expert conference, this may be to see if a case should be charged and would seek opinion about understanding reports and fully exploring and clarifying the expert's opinion. In expert meetings, the aims of this are identifying the areas of agreement and disagreement and drafting joint heads of agreement. There may be some adversarial element in a criminal case. Furthermore, disclosure around a criminal case is key. This is to ensure the fairness of the trial.

Rosemary gave frank, advice for giving evidence including taking the time, repeating answers and speaking in a clear language a lay-person may understand. There was also importance put upon referring to documents and understand the importance of being the expert (and that counsel is NOT the expert).

Maintaining high standards of practice under challenging circumstances

Dr Andrew Hoyle and Elizabeth Jenkins, assistant director of legal, General Medical Council

Dr Hoyle set the scene explaining public confidence and the Medical Act 1983 (reminding attendees of the higher standard they are held to rather than the ordinary public, including looking into the actions of doctors not immediately pertaining to patient safety). The GMC has 350K on its register and receive 9000 complaints per annum, and they investigate each one. Of those, only 250-280 go forward to the Medical Practitioners Tribunal Service (MPTS), and of those 163 had actions on their registration. There are three concerns that the GMC can investigate - patient safety, public confidence, and professional standards. In the last 10 years the GMC have only removed seven doctors from the medical register for purely clinical reasons.

To do a Fitness to Practice process, the GMC firstly triages their cases. This closes 82% of cases, which are either vexatious, unfounded, and the ones that continue are only concerned with serious or persistent issues that pose a risk to the public or departure from Good Medical Practice. There is then a provisional enquiry, which aims to eliminate further frivolous complaints. It aims to avoid a full investigation, is much quicker, and from this a further 400 cases are removed, leaving approximately 1200 cases which are then fully investigated. The biggest delay to the case is due to obtaining third party information. Case examiners examine the case (both a lay and medical examiner who is a practicing doctors), who then apply the realistic prospect test. The GMC only follows through with cases demonstrating 'current impairment'. Examiners do not hear oral evidence and for clinical concerns the GMC always asks for a medical report. The GMC will always ask a medical expert witness if the clinical actions of a doctor should go forwards, and do not solely rely on the views of the medical case examiners. They then only take forward cases that are fall 'seriously below' standards.

Liz Jenkins took over and spoke more about evidence, including the importance of neutrality. Expert reports should allow the case examiner to make a decision the GMC can rely on and see through the whole case. Internally, staff at the GMC will know what questions to ask and ensure they are asked in the best way to get to the right expert. There was a push to increase diversity on the experts panel at the GMC. There would be a push to better represent the profession later in 2023. Liz asked that interested individuals get in touch should they wish to become medical experts.

Unconscious and cognitive bias in decision-making
Lee Curley PhD, lecturer in psychology, Open University

Lee gave a short definition of heuristics, which is the foundation for decision making (essentially making short cuts in our brain). Heuristics can be used for many reasons including lack of motivation, subject matter is complex, time and pressure, and reduced cognitive capacity (alcohol or malaise). This can be a problem as they can deviate from rational norms, as the decision itself is based upon bias using a subset of information which often can be non-relevant, subjective personal experience, or lack of experience.

The three basic heuristic is a representative bias (racial, gender and class bias, often used by jurors); availability heuristic (the ease of which it comes to mind); anchoring and adjustment heuristic. Lee explained that everyone, including experts can be subject to cognitive bias. In fact, experts may have the additional burden of expertise bias (including the paradox of expertise – where experts rely on automatic process and tunnel vision due to rigid thinking). Bias can be overridden by incorporating different viewpoints and using a bottom-up approach. In fact, sometimes heuristics are learned 'on the job' through schemas.

Hired expert witness can influence conclusions, known as adversarial bias or 'the hired gun bias', where experts who were told they were hired by the prosecution were proven to take a higher degree of confidence of public risk to the defendant.

Lee gave some suggestions to stop bias including avoiding subjectivity; thinking about alternative positions or counter-arguments. By challenging beliefs, we can further erode our bias and reflect on some of the evidence presented. There is always the option to get a second opinion who does not know your conclusions.

Lee took questions from attendees on how to eliminate bias in an organisation and training. He noted that horizon scanning is shown to be better than training, which may be limited. Therefore horizon scanning and learning about bias might be a better way forward. Lee was asked about personalities and neurodiversity being subject to bias, he noted that while there is some limited differences between individuals, there are heuristics and bias among everyone.

Closing remarks

The Medico Legal Committee chair, Simon Minkoff, thanked attendees (both online and in-person), the speakers and staff members for the day. He then officially closed the conference