EDUCATION AND RISK MANAGEMENT

ACHIEVING SAFER AND RELIABLE PRACTICE

www.medicalprotection.org

Introduction

Welcome to the Medical Protection education Achieving Safer and Reliable Practice workshop. This workshop has been developed to provide doctors with insights and communication skills to assist them to manage patient and team interactions.

Overview of today's workshop

- Reliability theory and research
- How to increase reliabilty
- Human factors science
- Theory into action
  - *Always*Checking™
  - A.L.I.V.E.© model
- Further resources

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Achieving safer and reliable practice

Safe healthcare requires the expert knowledge and technical skills of healthcare professionals AND reliable delivery and application of that knowledge and skill.

What do we mean by reliability?

Minimal **unwanted variability** in the care we have determined our patients should receive

Driving the need to increase reliability

- Society's expectations
- The complexity of team care
- The extent and cost of preventable harm
- A paradigm shift in funding
- Escalating consequences for clinicians

Benefits of increasing reliability

- Higher quality care
- Increased patient safety
- Greater efficiency
    - time
    - resources
- Decreased cognitive load
- Decreased risk of patient action against us
- Increased work satisfaction.

The good news....

We don't need to reinvent the wheel!
There is an established science for:

- ensuring necessary steps occur
- reducing unwanted variability
- achieving extraordinarily low 'failure' rates

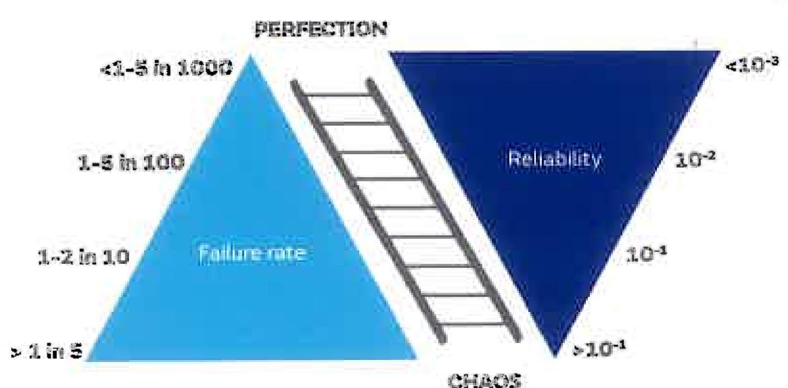
So what is reliability science?

The study and practice of **improving** improvement.

Notes/reflections

Reliability theory and research

How reliability is quantified?



Adapted from IHI Improving the Reliablity of Healthcare 2004

Reliability is often expressed in terms of failure rate as a power of 10.

For example, a procedure that is reliable 9 times out of 10 fails 10% of the time, or has 10^{-1} reliability. A procedure that fails 20% of the time has a reliability of $>10^{-1}$.

Systems that fall below 10^{-1} reliability are generally considered chaotic.

What level is achievable?

Other industries such as aviation and the nuclear industry have achieved reliability levels of 10^{-6} in critical processes. Healthcare has been successful in achieving this level of reliability in the induction of anaesthesia. Research suggests implementation rates in healthcare for standard procedures that impact on patient safety are between 50% and 70% or $>10^{-1}$.

Innovation vs Reliability

There is an interplay between reliability and innovation. The timescale needed to be assured of extremely high levels of reliability may be outweighed by the imperative to introduce less reliable but innovative developments.

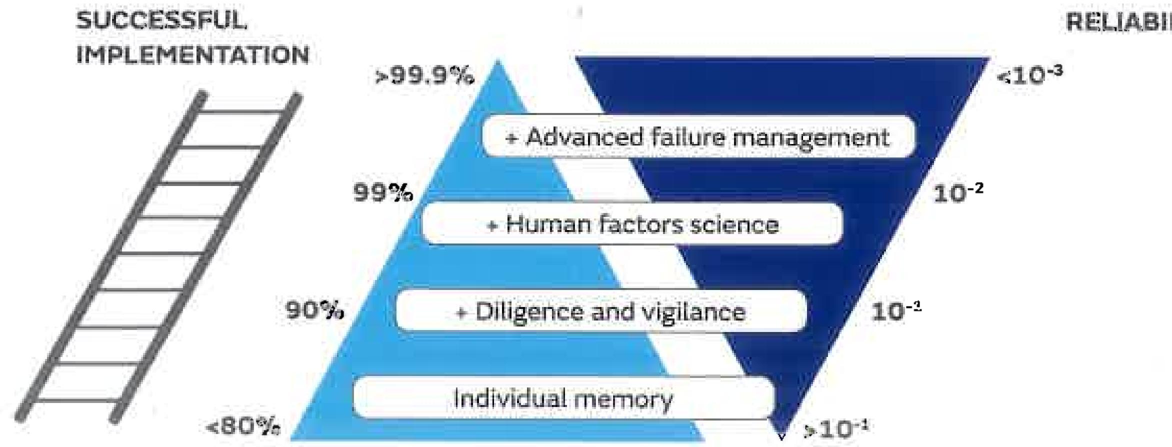
Many of the areas where patients suffer preventable outcomes are ones where no innovation is required. Improvements in patient safety and quality of healthcare can be improved by dramatically increasing our reliable implementation of many everyday healthcare activities.

Notes/reflection

How to increase reliability

Strategies to achieve levels of reliability

Different strategies are necessary in order to achieve various levels of reliability. These are summarised here.



Adapted from IHI Improving the Reliablity of Healthcare 2004

This table summarises the guiding principles for each level of reliability and the actions or understanding required to achieve these levels.

RELIABILITY	GUIDING PRINCIPLE	ACHIEVING
$>10^{-1}$	Trying to remember what to do	Remember what to do
10^{-1}	With: ▪ a high level of diligence and vigilance ▪ a collective understanding of the desired outcomes ▪ appropriate training ▪ a generally recognised way of doing things **chaos can be avoided**	▪ Maintain diligence and vigilance ▪ Communicate the rationale, outcome and benefits of increasing reliability ▪ Ensure all know what needs to be done and are trained ▪ Provide reminders ▪ Encourage the raising of concerns
10^{-2}	Improving to 99% reliability requires: ▪ creating a reliability culture ▪ designing and implementing reliable processes and systems, based on the insights of human factors science (HFS)	**People** ▪ Culture ▪ Individuals ▪ Teams ▪ Accountability ▪ Leadership **Processes and Systems** ▪ Process design ▪ Environment design ▪ Equipment design ▪ Checking

$<10^{-3}$	Achieving the highest levels of reliability is predicated on eliminating or mitigating failure in standard processes	▪ Increase the layers of checking
		▪ Ongoing
		  ▪ planning, training and simulation of advanced mitigation strategies
		  ▪ "watertight" detection and accountability for unwarranted variance
		  ▪ building of a culture of reliability

Exercise 1

A routine operation

10^{-1} strategies did not prevent this serious adverse outcome. Moving to 10^{-2} reliability and beyond requires implementation of the key understandings from human factors research.

Human Factors

People

- attitudes and behaviours
- predispositions
- limits

Processes

- design and implementation

Systems

- environment
- equipment.

In small groups, consider one of the questions below. Be prepared to share your answers with the whole group.

PEOPLE – Group 1

Identify specific "people" human factors that could have impeded the **Anaesthetist** from recognising and acknowledging the seriousness of the situation and taking the well-known corrective action they knew could prevent a catastrophic outcome.

PEOPLE – Group 2

This patient's life could have been saved by an emergency tracheostomy done within 5 minutes of the failure to intubate. This is the standard management of this situation and the Ear Nose and Throat surgeon knew this. Ear Nose and Throat surgeons are experts at doing tracheostomies.

Identify specific human factors that could have impeded the **Ear Nose and Throat** surgeon from recognising and acknowledging the seriousness of the situation and taking the well-known corrective action they knew could prevent a catastrophic outcome.

PEOPLE – Group 3

If you had quizzed the anaesthetists who came to help and the nurses in the theatre before the procedure all would have told you that a patient who cannot be intubated after a short period of time requires an emergency tracheostomy. It is possible that one or more of the anaesthetists who came to help had performed this procedure themselves in such an emergency.

Identify specific human factors that could have impeded the **Anaesthetists who came to help and the nurses in the theatre** from recognising and acknowledging the seriousness of the situation and taking the well-known corrective action they knew could prevent a catastrophic outcome.

Exercise 1

A routine operation

PROCESS – Group 4

There were established processes in the theatre for this emergency specifically designed to prevent this rare but catastrophic outcome.

Knowing as you do now the performance of the clinicians in this case, can you list as many possible reasons (human factors) that may have contributed to the established **process** proving to be ineffectual?

LEADERSHIP – Group 5

The theatre complex and hospital management teams.

What human factors in these teams may have prevented a safe and reliable outcome in this situation?

A. Theatre complex leadership and management team.

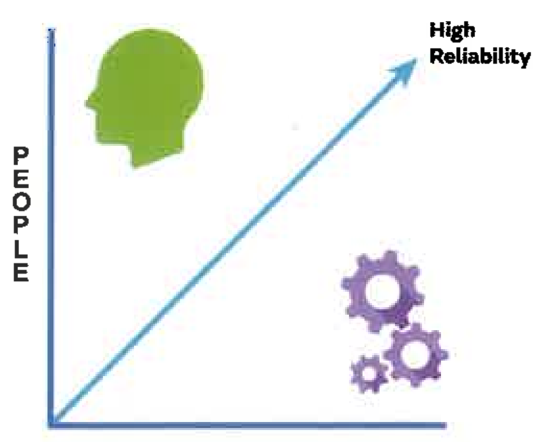
B. Hospital leadership and management team.

SYSTEMS – Group 6

What environmental or design factors in the operating theatre and the equipment used in this situation may have impeded the performance of the individual clinicians?

Human factors science

Reliability – the interplay of people and processes and systems



Notes

Some factors that can impede human performance: People

- Perceptual deficits under stress
- Fatigue
  - physical
  - decisional
- Poor interpersonal communication
  - transmission/reception
  - challenge
- Poor understanding of the nature of human error
  - causes
  - extent
  - the weakness of 10^{-1} strategies in prevention.

Some factors that can impede human performance: Processes and Systems

Inadequate:

- structured decisional support and checking tools
- measurement, feedback and accountability mechanisms
- briefing and simulation
- environmental design and control
- equipment design.

AlwaysChecking™

The Medical Protection *Always*Checking™ approach

The importance of 'Always checking'

- Healthcare has traditionally placed a high value on 'doing'
- Research in reliability shows the role of 'checking' is equally (if not at times more) important
- Checking strategies have high status in industries where safety is critical
- We may need to adjust the degree of importance we personally assign to the role of 'checking'
- 'Checking' involves action NOW

Not waiting for monitoring systems to identify poor outcomes.

PRINCIPLE WE ALWAYS CHECK:	STRATEGY
each other and welcome being checked	speaking Up
what we've agreed should be done	checklists
message sent is message received	repeatback/ readback
we know how to work together	briefing and simulation
always means always	measurement and accountability

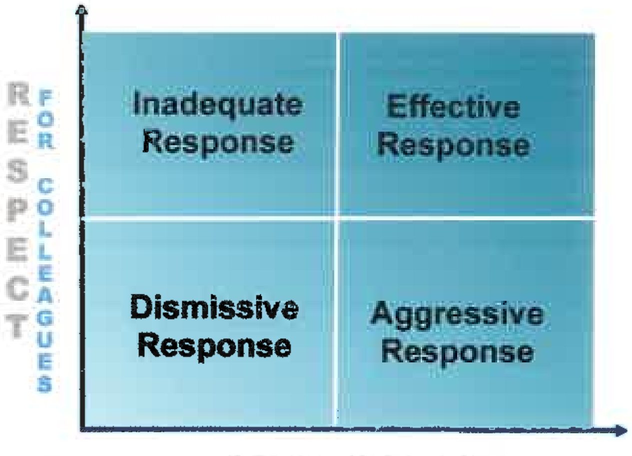
Speaking Up: we always check each other and welcome being checked

Q: What is the safest culture you can practice in?

A: One where every team member 'has your back'.

We need to remind ourselves:

- I will make a lot of errors – and some will be serious
- consequences (including devastating ones) can be avoided if a team member 'has my back'
- everyone (including the patient) is a team member
- one of the most collegiate, supportive, professional and ethical actions a team member can ever do for me is to 'have my back'.



"Frank, I know that you are vastly more experienced than me in this area. I really do believe that this blood loss is very significant. Can we pursue this until we are both satisfied that we are doing the right thing for this patient?"

"John, I know that you have known Mrs Elliott and her family for years and have treated her various ailments with huge skill and patience. I am concerned that this new drug may not work well with her other tablets. Could we discuss this further?"

Ensure others have your back by:

- Explicitly telling others of your hope and expectation that they will 'have your back'
- Profusely thank anyone who challenges you – especially when they are wrong!
- Engaging with those who are reluctant to 'speak up' to you.

Exercise 2: Please write down the EXACT words you would use.

A potentially lethal drug error has just occurred with one of your patients. The patient survived but is extremely unwell as a consequence. Your trainee has suggested that she felt the dose was incorrect but did not like to say anything at the time. How do you reply?

Whilst discussing a case with colleagues one of them interrupts and questions whether or not you have got some of the details correct. The notes are eventually found and it turns out that you were absolutely correct in the first place! What do you say to your colleague?

Checklists: we always check what we've agreed should be done

Checklists:

- reduce cognitive work
- facilitate concentration on first order concerns
- are critical in preventing 'never events'
- change the culture of your team
  - validate the importance of a safe process
  - empower team members to challenge
- are essential in achieving and maintaining 10^{-2}.

Checklists example: Central line infections

- Standardised process with checklist introduced
- Over 2 years
  - 43 infections prevented
  - 8 lives saved
  - $2 million saved
- Results replicated across many ICU's
- Now considered by many experts to be almost completely avoidable

Berenholtz et al 2004

Successful implementation of checklist saved lives and millions of dollars by eliminating central venous line infections.

The intervention involved education of staff, creating a dedicated catheter insertion cart, daily assessment as to whether catheters could be removed, implementing a checklist to ensure guidelines for preventing infections was followed, training and empowering nurses to challenge colleagues if they were not following the checklist.

Checklists example: Safe surgery checklist

- 8 country study
- 3733 patients undergoing non cardiac surgery
- 50% reduction in 30 day post op mortality rates
- 36% reduction in 30 day post op complications

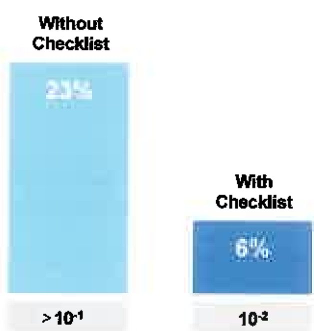
Haynes et al 2009

The nineteen point checklist used ensures appropriate communication between all members of the team at sign in, before knife is put to skin and at sign out and that patient identity and relevant patient information is known by all.

The power of checklists

Researchers found that the use of surgical-crisis checklists across three institutions significantly reduced the number of critical steps missed during operating room crises. The failure to adhere to critical steps in management was reduced by almost 75% by the use of checklists.

Critical steps missed



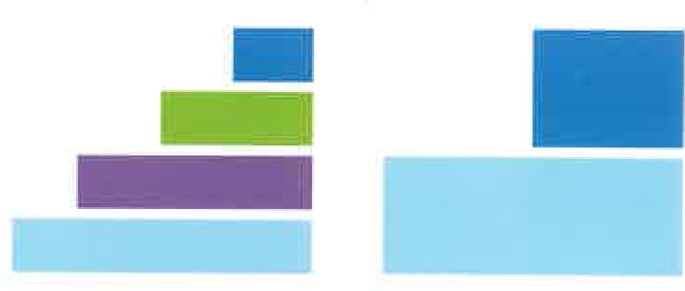
Arriaga et al 2013

A risk – experts with "checklist antibodies"

Designing good checklists

- Literature/research informed BUT team adapted/ modified
- Involve the whole team
- Pilot and review
- Limit elements to critical minimum
- If used frequently, create multiple versions

Critical steps: the higher the reliability of each step....the fewer you need



Human factors science

A CHECKLIST FOR CHECKLISTS

Development

- ❑ Do you have clear, concise objectives for your checklist?

Is each item:

- ❑ A critical safety step and in great danger of being missed?
- ❑ Not adequately checked by other mechanisms?
- ❑ Actionable, with a specific response required for each item?
- ❑ Designed to be read aloud as a verbal check?
- ❑ One that can be affected by the use of a checklist?

Have you considered:

- ❑ Adding items that will improve communication among team members?
- ❑ Involving all members of the team in the checklist creation process?

→

Drafting

Does the Checklist:

- ❑ Utilize natural breaks in workflow (pause points)?
- ❑ Use simple sentence structure and basic language?
- ❑ Have a title that reflects its objectives?
- ❑ Have a simple, uncluttered, and logical format?
- ❑ Fit on one page?
- ❑ Minimize the use of color?

Is the font:

- ❑ Sans serif?
- ❑ Upper and lower case text?
- ❑ Large enough to be read easily?
- ❑ Dark on a light background?

- ❑ Are there fewer than 10 items per pause point?

- ❑ Is the date of creation (or revision) clearly marked?

→

Validation

Have you:

- ❑ Trialed the checklist with front line users (either in a real or simulated situation)?
- ❑ Modified the checklist in response to repeated trials?

Does the checklist:

- ❑ Fit the flow of work?
- ❑ Detect errors at a time when they can still be corrected?

- ❑ Can the checklist be completed in a reasonably brief period of time?

- ❑ Have you made plans for future review and revision of the checklist?

Reproduced from The Checklist Manifesto (2009) with permiss

Repeatback/Readback

- Easy to do
- Becomes the way "we do business"
- Allows reflection by all on the
  - logic
  - adequacy and
  - appropriateness

of "message sent"

Briefing and Simulation
We always check we know how to work together

- Why do so many safety critical industries utilise briefing and simulation?

Briefing and simulation are critical strategies in driving higher team performance and reliability. They allow the identification and addressing of deficits in an environment where no harm will come to patients or clinicians and their resolution is not required in a time pressured and stressful live scenario.

Research shows benefits include:

- Higher team performance
- Exposing unrecognised people, process and system deficits
- Increased willingness and permission to speak up
- Shifting of the individual performance/stress decay point
- Critical time savings and decreased cognitive load from agreeing key actions and decisions in advance

Why simulation?

A critical mechanism for checking any process or environmental/equipment design element makes it

- Easy to do the right thing
- Hard to do the wrong thing

e.g.

- clutter
- sensory overload
- excessive choice
- proximity
- ambiguous communication
- over complexity
- warning fidelity and clarity

Measurement and Accountability

We always check always means always

- Measurement with benchmarked feedback drives self-regulation and improves reliability.
- Attaining 10^{-2} reliability requires individuals to be accountable for non-compliance to an agreed checking regimes rather than unintended error.
- "Special rules" for some are toxic and sabotage success.

Example: Hand Washing Programme

Year	Hand Washing Rate
2009	58%
2010	80%
2011	92%

- 30% reduction in serious hospital infections
- Estimated annual net savings of $4.5m
- Ten fold reduction in ICU central line infection rate (now one quarter of national benchmark)

Vanderbilt U.M.C.

The value of Briefing and a final word from Martin...

"Medicine seems to have a concept that knowledge will prevent mistakes – aviation knows this is just not true"

Commercial Aviation – per year

- 100 million pilot errors
- 100 incidents
- 25 accidents

Guy Hirst, former BA Training Captain Atrainability; Alberti and Wood 1997

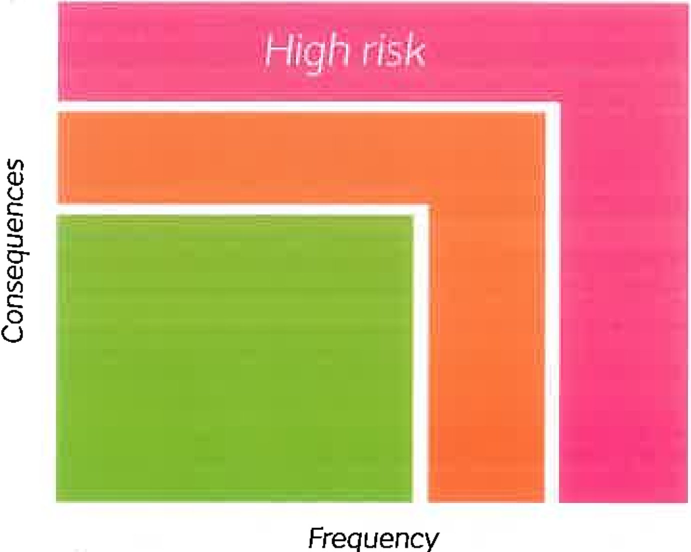
The A.L.I.V.E.© model

Theory into action: the A.L.I.V.E© model

A Assess
L Layout
I Implement
V Verify
E Embed

A.L.I.V.E.©- **ASSESS**

- Where reliability needs to be increased
- The level of reliability required



Some trigger questions...

- If I were a patient in our practice/unit/clinic what are the most preventable reliability issues I would be concerned about?
- What "never ever" event is most likely to happen in my practice/unit/clinic?
- What is the commonest preventable cause of harm in my practice/unit/clinic?

Some trigger questions...

- *Expert judgement balancing resource allocation and preventing harm*

What level of reliability is required?
A rough guide

- *$>10^{-1}$ Inconsequential if it fails*
- *10^{-1} Better if it didn't fail*
- *10^{-2} Should not fail*
- *$<10^{-3}$ Must not fail*

A.**L.**I.V.E.©- **LAYOUT**

- Design the process to improve reliability

Steps

- Form a team and identify a leader
- Generate ideas as to how reliability could be increased
  - brainstorming
  - process mapping
- Formulate a draft process
  - what
  - who
  - when
  - how
- Modify draft process based on reflection on human factors science
- Determine an appropriate monitoring system

Forecasting success: reliability maths

The higher the reliability of each step the fewer you need

This is a simple worked example of a general practice aiming to implement a system following a serious adverse outcome where a child suffered an anaphylactic reaction following the administration of a routine vaccination.

Layer	1	2	3	4
Strategy	Nurse to remember	Immunsiation checklist used at front desk includes checking with nurse that equipment has been checked	Booking system prompts parents to check with nurse that all equipment has been checked.	Immunisation fridge is locked and nurse has to sign that all is ready before accessing the key
Estimated failure rate	2/10	1/100	3/10	1/100
Cumulative failure rate	2/10	2/1000	6/10,000	6/1,000,000
Frequency of failure (1000 immunisations/year)	200/year or 1 every 1.3 working days	2/year or 1 every 4.3 months	0.6 or 1 every 1.66 years	0.006 or 1 every 166 years

A.L.**I**.V.E.©- IMPLEMENT

Convert your process into effective action

- Communicate goals and expectations
- Allocate resources and support needed
- Determine accountability mechanisms
- Establish mechanisms of review

Principles of effective implementation

- May require initial "slowing"
- Consider piloting changes on a small scale to
  - refine process
  - minimise initial resistance
- Leader holds individuals to account

A.L.I.**V**.E.©- VERIFY

- Measure impact
- Learn from experiences
- Adapt process
- Implement revised process and repeat

Some principles:

- Seek feedback from multiple sources
- Revisit the Layout and Implementation human factors prompts
- "Layout-Implement-Verify" cycle can be repeated

A.L.I.V.**E**.©- EMBED

- Continue to communicate goals and expectations
- Continue to measure success, monitor for variance and provide feedback
- Maintain/increase accountability mechanisms
- Demonstrate ongoing personal commitment

Some principles of embedding change:

- Changing climate is a prerequisite for changing culture
- Regression is most likely at 3-6 months
- Role modelling of commitment and response to unwarranted variability will have a powerful impact

Tools

The A.L.I.V.E.® Model template

Assess	Where does reliability need to be increased? What level of reliability is required?	
Layout	Generate ideas as to how reliability could be increased. • Brainstorming • Process mapping. Formulate a draft process • What • Who • When • How. Modify your draft process based on reflection on human factors science. Determine an appropriate measurement.	
Implement	Communicate the goals and expectations. Allocate the resources and support needed. Determine the accountability mechanisms. Establish the mechanisms of review.	
Verify	Measure the impact. Learn from the experiences of success and challenge to adapt the process and plan. Implement the revised process and repeat.	
Embed	Continue to communicate the goals and expectations. Continue to measure success, monitor for variance and provide feedback. Maintain/increase accountability mechanisms. Demonstrate your ongoing personal commitment.	

Tools

The A.L.I.V.E.® Model resource sheet

Assess

	Proactive	Reactive	A rough guide	Trigger questions
HIGH RISK Consequences High frequency	• Walk arounds • Group/ individual risk identification processes • Near misses • Reports from front line staff • Literature and expert scan • Patient interviewing	• Significant event audit • Patient complaints/ surveys • Morbidity and mortality meetings • Investigations • Error analysis • Outcome data	• $>10^{-1}$ **Inconsequential** if it fails • 10^{-1} **Better** if it didn't fail • 10^{-2} **Should** not fail • $<10^{-3}$ **Must** not fail	• If I were a patient in our practice/unit/clinic what are the most preventable reliability issues I would be concerned about? • What 'never ever' event is most likely to happen in my practice/unit/clinic? • What is the commonest preventable cause of harm in my practice/unit/clinic?

Layout

Human factors prompts

- What errors are individuals likely to make in this process and can we plan to eliminate or mitigate them?
- What are the most likely unexpected events or consequences that could occur and can we plan to eliminate or mitigate them?
- Can the patient be more involved in the process to increase reliability?
- When is our process most likely to fail and can we plan to eliminate or mitigate the risk?
- Have we made it easy to do the right thing and hard to do the wrong thing?
- Is a checklist required?
- Have we automated as much as possible to eliminate cognitive load?
- Is our process introducing unnecessary complexity?
- Are there more reliable steps that would eliminate multiple less reliable ones?

Implement

Human factors prompts

- Are there environmental or physical factors that will impede successful implementation?
- What is the appropriate level of accountability and reward?
- Would training and/or simulation improve our success?
- How will briefing and de-briefing occur?
- How can we empower all to raise any concerns of process failure, individual error or loss of situation awareness?
- Do we need read back for critical verbal information transfer?

Verify

Important reminders

- Seek feedback from multiple sources
- Revisit the Layout and Implementation Human Factors prompts to maximise the effectiveness of adaptations
- Implement-Verify cycle can be repeated.

Embed

Important reminders

- Regression is most likely at 3-6 months
- Individual role modelling of commitment and response to unwarranted variability have a powerful impact

Tools – Risk calculator

This template can be provided in an excel format, please email: education@medicalprotection.org

Expected number of actions or occurrences/year

Process step	Estimated failure rate	Cumulative failure rate	Cumulative frequency of failure – events per year
	/	/	
	/	/	
	/	/	
	/	/	
	/	/	
	/	/	

Tools

The A.L.I.V.E.® Model example

<table>
<tr><td>Assess</td><td>Where does reliability need to be increased?

What level of reliability is required?</td><td>A powerful and effective medication you prescribe regularly is potentially nephrotoxic. Checking of renal function is required every 4 weeks and any deterioration necessitates immediate cessation to avoid serious renal cortical damage.

After a serious incident where a patient suffered irreversible renal damage following 3 months of unmonitored administration you decide to ensure a repeat incident does not occur to a minimum of 10^{-2} reliability.</td></tr>
<tr><td>Layout</td><td>Form a team.

Generate ideas as to how reliability could be increased.
• Brainstorming
• Process mapping.

Formulate a draft process.
• What
• Who
• When
• How

Modify your draft process based on reflection on human factors science

Determine an appropriate measurement</td><td>BRAINSTORMING
• A medical colleague suggests patient should only be given a script for one month at a time
• Practice Manager suggests a register of all patients on the medication with staff to contact patients every 4 weeks and notify the doctor immediately if compliance cannot be confirmed
• A staff member is aware that another practice insists that repeats are held by one pharmacy close to the practice. They have agreed to phone her practice before dispensing repeats
• Receptionist suggests automatic email reminders could be scheduled from the appointment system
• You note that the laboratory tried once to notify you of an abnormal test while you were on leave.

Process map – draft new process

Patient is commenced on medication and told of the need for monthly blood tests.
→
Patient is given 12 month form for monthly blood tests, prescription for 1 month of medication with 5 repeats and asked to present all scripts to pharmacy located 50 metres from practice.
↓
Patient entered on register with staff to contact patient every 4 weeks and notify the doctor immediately if compliance with blood testing regime cannot be confirmed by them.
←
Patient receives repeat medication following agreement with the pharmacy only after confirmation from the practice manager that satisfactory test results have been sighted by the doctor. All orders for repeats to be held by the pharmacy.</td></tr>
</table>

Tools

The A.L.I.V.E.® Model example

Layout

Process map – final draft of new process

Patient is commenced on medication and told of the need for monthly blood tests.

→ Patient is given 12 month form for monthly blood tests and practice staff will deliver the prescription to the assisting pharmacy.

→ Patient asked to call for results monthly, to record the results in a small booklet provided by the practice and to cease medication immediately if result is above set parameters.

→ Patient entered on register with staff to contact patient every 4 weeks at the direction of the practice manager and notify the doctor immediately if compliance with blood testing regime cannot be confirmed. Doctor to sign off register at the end of every month.

→ Patient receives repeat medication following agreement with the pharmacy only after confirmation from the practice manager that satisfactory test results have been sighted by the doctor. All orders for repeats to be held by the pharmacy.

Determine a measure

Three month audit of practice register cross-checked to repeat prescriptions dispensed to ensure no lapses.

Determine

Layer	1	2	3
Strategy	Patient told of importance of routine testing and given recording book.	Practice register and checklist for enrolled patients.	Pharmacy holding script and only dispensing on verbal approval.
Estimated failure rate	2/10	1/50	1/75
Cumulative failure rate	2/10	2/500	2/37,500
Frequency of failure (600 repeats/year)	120/year or 1 every 2 working days.	2.4/year or 1 every 5 months.	0.032/year or 1 every 31.25 years

Tools

The A.L.I.V.E.® Model example

Implement	Communicate the goals and expectations Allocate the resources and support needed Determine the accountability mechanisms Establish the mechanisms of review.	▪ Team meeting to communicate the plan for a 3 month trial and expected action should they become aware of risk to patient welfare ▪ Process documented and register established ▪ Practice Manager to be incentivised for successful implementation ▪ Team to have monthly debrief for first 3 months ▪ Readback training and simulation for front desk staff.
Verify	Measure the impact Learn from the experiences of success and challenge to adapt the process and plan Implement the revised process and repeat.	▪ Patient acceptance and compliance with recording their blood results was extremely high ▪ 1 patient was not entered into the practice register ▪ 2 casual staff members were unaware of the register when questioned by a doctor in the practice. **Plan** ▪ Update manual created for all casual staff to be read on a fortnightly basis ▪ Enrolment procedures in patient register to be examined and amended ▪ Further 3 month implementation period with debrief planned at the end.
Embed	Continue to communicate the goals and expectations Continue to measure success, monitor for variance and provide feedback Maintain/increase accountability mechanisms Demonstrate your ongoing personal commitment.	▪ A new staff member demonstrated non compliance with the patient register on two occasions and was counselled on the consequences of recurrence ▪ A regular 3 month debriefing meeting was maintained to ensure all understood the ongoing commitment to high reliability of the practice ▪ Audit continued on 6 monthly basis indefinitely.

Resources

Resources

Human factors science

Clinical Human Factors Group
www.chfg.org

Risky Business Conference videos
www.risky-business.com

The Essentials of Patient Safety
2nd Edition, Charles Vincent.
www.cpssq.org

Redesign and process mapping

NHS Improving Quality
www.nhsiq.nhs.uk

Institute for Healthcare Improvement
www.ihi.org

The Joint Commission
www.jointcommission.org

NHS Scotland Quality Improvement Hub
www.qihub.scot.nhs.uk/default.aspx

"The Checklist Manifesto"
Gawande, A. *The Checklist Manifesto: How to Get Things Right*, New York, NY: Metropolitan Books (2009).

Culture change

"Why Hospitals Should Fly"
Nance, J.J. *Why hospitals should fly: the ultimate flight plan to patient safety and quality care*, Bozeman, MT: Second River Healthcare Press (2008).

The Francis Report
www.gov.uk/government/publications/mid-staffordshire-nhsft-public-inquiry-government-response.

Resources and tip sheets

10 patient safety tips for hospitals
www.ahrq.gov/qual/10tips.htm

7 steps to patient safety in primary care
www.nrls.npsa.nhs.uk/resources

The Health Foundation
www.health.org.uk/

Summary

Increasing reliability

- Has many benefits for clinicians and patients
- Requires "adding to" individual diligence and vigilance
- Is based on a body of science that is easily accessible
- To 10-2 is predicated on the utilisation of the insights from human factors science

You can commence the *Always*Checking™ strategies tomorrow!

Planning ahead

Please identify which of the *Always*Checking™ strategies or systems and process improvements you could commit to in your practice/unit/clinic in the next two months.

Use your workbook to record and reflect on improvement progress.

References

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Speaking Up

Can we overcome a culture of looking the other way?

WHY

Speaking Up is critical in building a strong **safety culture**[1]

However... **30%** or more[1-4] of hospital staff don't feel safe raising a concern

WHAT

Speaking Up Programme

HOW

Speaking Up For Safety™ Programme (SUFS)

Raising safety concerns face-to-face

- Enables staff to respectfully speak up if a patient is about to be harmed or the safety culture is threatened
- Encourages staff to welcome being spoken up to

SAFETY C.O.D.E.

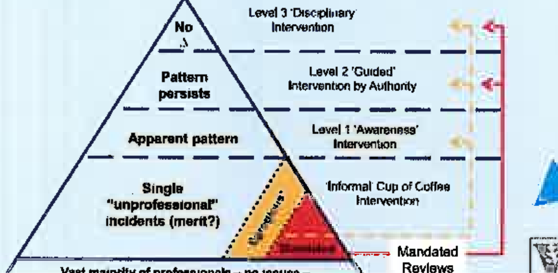
What if speaking up is:

- ☑ Not related to imminent harm
- ☑ Not possible
- ☑ Not safe
- ☑ Not effective

Promoting Professional Accountability Programme (PPA)

Addressing unprofessional behaviours that undermine a culture of safety

1. Staff speak up via a reporting tool
2. Organisation sends a trained peer to respectfully speak up on their behalf
3. Structured support, escalation and accountability framework for staff with a pattern of unprofessional behaviour[8]



Vanderbilt Center for Patient and Professional Advocacy

RESULTS

SUFS RESULTS

Knowledge and skills to speak up[5]

Before 56% → **After 94%**

Confidence to speak up[5]

Before 61% → **After 90%**

Intention to always speak up[5]

Before 64% → **After 93%**

LEARNINGS

Board, executive and clinical leader commitment and education is critical

Having a skilled project team and project champion is a key success factor

Communication of the programme to all staff is vital

Embedding speaking up 'reminders' into clinical processes can transform a team culture

PPA RESULTS

Reduced medico-legal claims and expenses by **greater than 70%**[6]

Improved hand hygiene practice to **greater than 95%** compliance[7]

Addressed behaviours that undermine a **culture of safety**[8].

IMPLEMENTATION

Speaking Up For Safety™ Programme

132+ hospitals

127,135+ staff trained face to face

382+ in-house presenters trained to deliver the programme

UNITED KINGDOM
SUFS 9,331 staff, 37 hospitals | PPA 9,331 staff, 37 hospitals

SINGAPORE
SUFS 7,231 staff, 3 hospitals | PPA 7,367 staff, 3 hospitals

AUSTRALIA
SUFS 87,191 staff, 79 hospitals | PPA 91,862 staff, 131 hospitals

NEW ZEALAND
SUFS 23,382 staff, 13 hospitals | PPA 22,495 staff, 15 hospitals

Promoting Professional Accountability Programme

186+ hospitals and day surgeries

Speak to **Louise Cuskelly** at the Cognitive Institute booth or visit **cognitiveinstitute.org**

TRAINING COURSE FOR MEDICAL EXPERTS

Auditorium, 1/F
Duke of Windsor Social Service Building
15 Hennessy Road, Wanchai
Hong Kong

CME points: Three points for each day

EARN CME

Jointly organised by
Medical Protection and
The Hong Kong Medical Association

PROGRAMME

DAY ONE – SATURDAY 25 AUGUST 2018	
	CHAIR Dr Ming Keng TEOH, Head of Medical Services – Asia, Medical Protection
13.00 – 14.00	REGISTRATION AND LUNCH
14.00 – 14.05	WELCOME **Dr Pardeep SANDHU,** Executive Director of Professional Services, Medical Protection and **Dr HO Chung Ping, MH, JP,** President, The Hong Kong Medical Association
14.05 – 14.15	OPENING ADDRESS **Dr CHUI Tak-yi, JP,** Acting Secretary for Food and Health
14.15 – 14.45	ROLE OF MEDICAL EXPERTS **Dr Ming Keng TEOH,** Head of Medical Services – Asia, Medical Protection
14.45 – 15.10	WHAT JUDGES WANT His Honour Judge Harold LEONG
15.10 – 15.40	UNDERSTANDING MEDICAL NEGLIGENCE **Chris HOWSE,** Howse Williams Bowers
15.40 – 16.00	UNDERSTANDING INFORMED CONSENT **Dr David KAN,** Howse Williams Bowers
16.00 – 16.15	TEA BREAK
16.15 – 16.45	LITIGATION PROCESS IN HONG KONG **Jaime LAM and William CHAN,** Mayer Brown JSM
16.45 – 17.30	CHALLENGING CLAIMS CASES – INTERACTIVE DEBATE **Facilitators:** **Dr David KAN,** Howse Williams Bowers and **Dr Ming Keng TEOH,** Head of Medical Services – Asia, Medical Protection **Panel:** **Jaime LAM,** Mayer Brown JSM and **Christine TSANG,** Kennedys
17.30 – 17.55	EXPERT REPORTS – THE BRIEF AND PREPARATION **Christine TSANG,** Kennedys
17.55 – 18.30	QUESTIONS AND ANSWERS SESSION **All speakers**
18.30	END OF DAY ONE

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TRAINING COURSE FOR MEDICAL EXPERTS

PROGRAMME

DAY TWO – SUNDAY 26 AUGUST 2018	
	CHAIR **Dr Pardeep SANDHU,** Executive Director of Professional Services, Medical Protection
12.30 – 13.30	**LUNCH AND REFRESHMENTS**
13.30 – 14.00	CLAIMS HANDLING – ETHICAL CONSIDERATIONS AND DIFFICULT DECISIONS **Dr Ming Keng TEOH,** Head of Medical Services – Asia, Medical Protection
14.00 – 15.00	EXPERT REPORTS BREAKOUT GROUPS – THE GOOD, BAD AND UGLY **Facilitators:** **Dr Bernard MURPHY and Oonagh TONER,** Howse Williams Bowers **Group leaders:** • **Tracy CHEUNG,** Kennedys • **Sandy CHO,** Kennedys • **Andrew LOVELL,** Kennedys • **Quincy NG,** Mayer Brown JSM • **Warren SETO,** Mayer Brown JSM
15.00 – 15.15	EXPERT REPORTS – SUMMARY OF LEARNING POINTS AND DISCUSSION **Dr Bernard MURPHY and Oonagh TONER,** Howse Williams Bowers
15.15 – 15.45	A MEDICAL EXPERT IN MEDICAL COUNCIL INQUIRIES, CORONER'S INQUESTS, CRIMINAL COURTS, TRIBUNALS AND OTHER SITUATIONS **Woody CHANG and Sally WONG,** Mayer Brown JSM
15.45 – 16.00	**TEA BREAK**
16.00 – 16.30	APPEARANCE IN COURT – COURTROOM SKILLS **Russell COLEMAN SC,** Temple Chambers
16.30 – 16.45	MEDIATION AND ALTERNATIVE DISPUTE RESOLUTION (ADR) **Tracy CHEUNG,** Kennedys
16.45 – 17.15	ROLE PLAY – COURTROOM SKILLS AND GIVING EVIDENCE IN COURT **Facilitators:** **Dr Bernard MURPHY,** Howse Williams Bowers and **Dr Danny LEE,** Consultant General Surgeon and Medical Protection Associate
17.15 – 17.30	QUICKFIRE QUIZ **Warren SETO and Sally WONG,** Mayer Brown JSM
17.30 – 17.55	QUESTIONS AND ANSWERS SESSION **All speakers**
17.55 – 18.00	PRIZE PRESENTATION AND CLOSING REMARKS **Dr Ming Keng TEOH,** Head of Medical Services – Asia, Medical Protection
18.00	**END OF COURSE – CERTIFICATES AND FEEDBACK FORMS**

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Medical Protection

Role of Medical Experts

Dr Ming Keng Teoh
MBChB, FRCSE, FRCS, ChM, MFFLM, MSc, LLM
Head of Medical Services – Asia

Role of Medical Experts

1. Why train medical experts?
2. Code of practice and guidance
3. The importance of having good experts
4. What is a good expert?
5. Recent developments

MPS Medical Experts Training
Self-assessment Quiz

1. What 3 conditions must be satisfied before a doctor is considered to be negligent?
2. What is the *Bolam Test*?
3. What is the highest court of appeal in HK?
4. What is the role of the Medical Council?
5. What is the aim of a coroner's inquiry?
6. How is civil law different from criminal law?
7. Why and when was MPS formed? How long has MPS been in HK? Name 3 things that is special about MPS?
8. What are *special damages* and *general damages*?
9. What is the difference between a *professional witness of fact* and an *expert witness*?
10. What is *vicarious liability*?

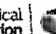
MPS Medical Experts Training
Self-assessment Quiz

11. What is the *standard of proof* in a criminal trial?
12. Can an apology be considered an admission of liability?
13. What do you understand by the term *Limitation period*?
14. When is a patient's consent not *valid*?
15. What is the difference between a liability expert and a quantum expert?
16. Is there a role for mediation or ADR in resolving claims? How is it used?
17. When is a doctor subject to criminal investigation / of *gross negligence manslaughter*?
18. When are *aggravated damages* awarded by the court?
19. What is a *pre-action protocol* in the context of a civil claim?
20. When is an application for a *Judicial Review* indicated?

Medical Protection

Why have Medical Experts?
Background

- In 1885 Dr David Bradley was wrongly convicted of assaulting a woman patient in his surgery
- Sentenced to 8 months hard labour
- Petition for expert evidence "*epileptic erotic delusions*"
- Received a full pardon on review – *had expert evidence been submitted.......*

Medical Protection 

Role of medical experts
Hong Kong legislation

Duty to the Court

Experts have an overriding *duty to the court* to help on matters *within his expertise*. The duty to the court overrides any duty to the person who has instructed him/her or pays him/her

Order 38, rule 35A Rules of the High Court (Cap, 4)

Medical Protection

What a medical expert is *not*

- A hired gun
- A medical heavyweight whose opinions will demolish all others'
- A friendly colleague or ex-mentor
- A fierce evangelist

But ...the problem

Medical Protection

Being an expert witness
Expectations of the Court

Aware of duty and role

Boundaries of expertise

Not an advocate

No hidden agenda

Being an expert witness
MPS and lawyer's perspective

Breach, causation, condition & prognosis

Thoroughness

Consistency

Advice on merits

Timeliness

Developments in medical experts role

- **Single Joint Expert**
  - The Court has the power to appoint a single joint expert if deemed to be in "interest of justice" in light of the circumstances of the case.
  - *Practice Direction 18.1, I Protocol for Commissioning Expert Reports*
- **Hot tubbing**
- **Certificate of Merit**

Conflict of interest

Involved in management of patient

Employment

Financial

Relationship

Advice previously sought by the other party?

Being a medical expert
Problems to avoid

Conflicts of interest

Patient confidentiality

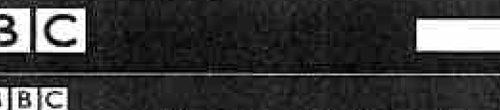
Inaccuracies in CV

Too passionate when providing evidence

Straying beyond expertise

Immunity for expert witnesses?

Medical Protection



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Page last updated at 00:03 GMT, Wednesday, 16 April 2008 01:03 UK

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Child doctors court witness fear

Paediatricians are being put off appearing as expert witness in court cases because of the heavy-handed approach by regulators, doctors say.

The GMC's "disproportionate" ban on two paediatricians for their conduct in child cases has led to a climate of fear among doctors,

Medical experts

Risk of criticism or claims from

Medical Protection

- Failure to provide reports on time
- Failing to properly understand the issues
- Failing to review all the documents
- Failing to identify or locate appropriate sources of information
- Failing to keep on top of developments in the relevant field
- Being pushed into concessions by the opponent's expert
- Changing an opinion without good reason

Medical Protection

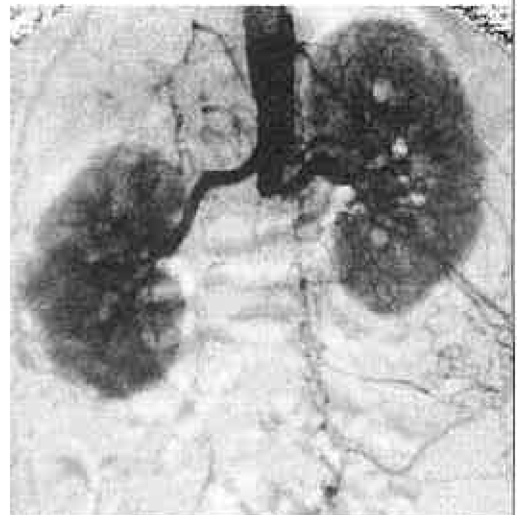
The perfect medical expert

- Honest opinion
- Given *early*
- Timely report supported by evidence
- Clear reasoning
- 'Persuasive' with ability to articulate argument
  - *In conference*
  - *In court*

Medical Protection

Benefits of working as an expert

- Improve knowledge
- Adds variety to career
- Financially rewarding
- Assists justice
- Challenging
- Being a better doctor



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Further support and information is offered on our website, in addition to our publications, booklets, factsheets and case studies.

medicalprotection.org

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Thank you

QUESTIONS?

www.medicalprotection.org

1. Objectives

- Brief overview of the legal principles in medical negligence in civil proceedings.
- Relevance of expert opinions in civil proceedings – why are they important?

2. The four requirements for a medical negligence claim in civil proceedings

1. ***Duty of care*** owed to the Patient by the Doctor.
2. ***Breach*** of that duty by the Doctor, i.e. negligence.
3. ***Causation***.
4. Injury or harm to Patient, i.e. ***Damages*** suffered.

Burden of Proof / Standard of Proof

- The Burden is on the Patient to prove each of the four elements. (but note *res ipsa loquitur)*
- Proof must be on the balance of probabilities, which is the civil standard of proof. (c.f. standard of proof in criminal proceedings.)

3. First Requirement – The existence of a duty of care

- In most cases this is straightforward – a legal duty of care arises if a healthcare professional agrees to treat a Patient.
- In private practice, the duty of care arises by virtue of a contractual relationship between the Patient and the Doctor.
- In the public system, the duty of care arises when a Patient presents for treatment.
- Special considerations:-
  - is the duty extended to relatives or other third parties?
  - is a practice or hospital holding itself out as offering emergency services
  - good Samaritans

4.1 Second Requirement - Breach of the duty of care

- The test is whether the Doctor's treatment has fallen below the required standard of care.
- The Bolam test: was the Doctor acting in accordance with a responsible body of medical opinion at that time?
- *"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man needs not possess the highest expert skill at the risk of being negligent. It is a well established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art."*

  Bolam v. Friem Hospital Management Committee [1957] 2 AER 118.

4.2 Special considerations

- A GP is not expected to provide the same standard of care as a specialist.
- If, however, a GP elects to perform specialist treatment, he must have the skills to undertake such treatment.
- No allowance is made for inexperience – the standard of care is defined objectively.
  Wikher v. Essex Area HA [1986] 283 BMJ 497.
- In an emergency or where there are inadequate facilities, a mistake may be forgiven where in normal circumstances a comparable mistake would not. (Consider why the facilities are inadequate - potential liability of the hospital).

5. Third Requirement - Causation

- The Patient has to prove that the breach of duty *caused* the injury.
- The "but – for" test is the primary filter.
- Where there are concurrent potential causes, the question is whether the Doctor's breach materially contributed to or increased the injury to the patient.
- Is the injury the reasonably foreseeable consequence of the Doctor's breach of his duty of care?
- Has an intervening act broken the chain of causation?

6. Fourth Requirement – Injury or harm to the Patient - Damages assessment

- The Court's purpose is to compensate the Patient, not to penalise the Doctor (exception: aggravated or exemplary damages).
- The intention of the Court is to put the Patient in the position that they would have been in if there had been no negligence by the Doctor, so far as this is possible.
- Financial compensation can be awarded on either a "Once and for all" basis assessed at the date of trial, or as ongoing financial compensation for continuing care (periodic payments).
- There is a duty on the Patient to take reasonable steps to mitigate his financial losses.

Categories of Financial Compensation

- ***Pain and suffering, loss of amenities***. (general damages)

  Current condition and future prognosis of the Patient.

- **Expenses items, past and future**. (special damages)

  The Court will adopt a common sense approach. There is a need for supportive evidence;

- Loss of earning capacity; loss of earnings.
- Interest.

7. Providing an expert opinion in practice

1. An expert's overriding duty is to the Court.
2. Identify issues to be addressed.
3. Identify legal tests, if necessary.
4. Check whether sufficient m.aterials have been provided.
5. Check the factual content of your report carefully, especially if you did not draft the factual summary.
6. Provide an opinion which is within your expertise; consider whether a range of opinions applies.

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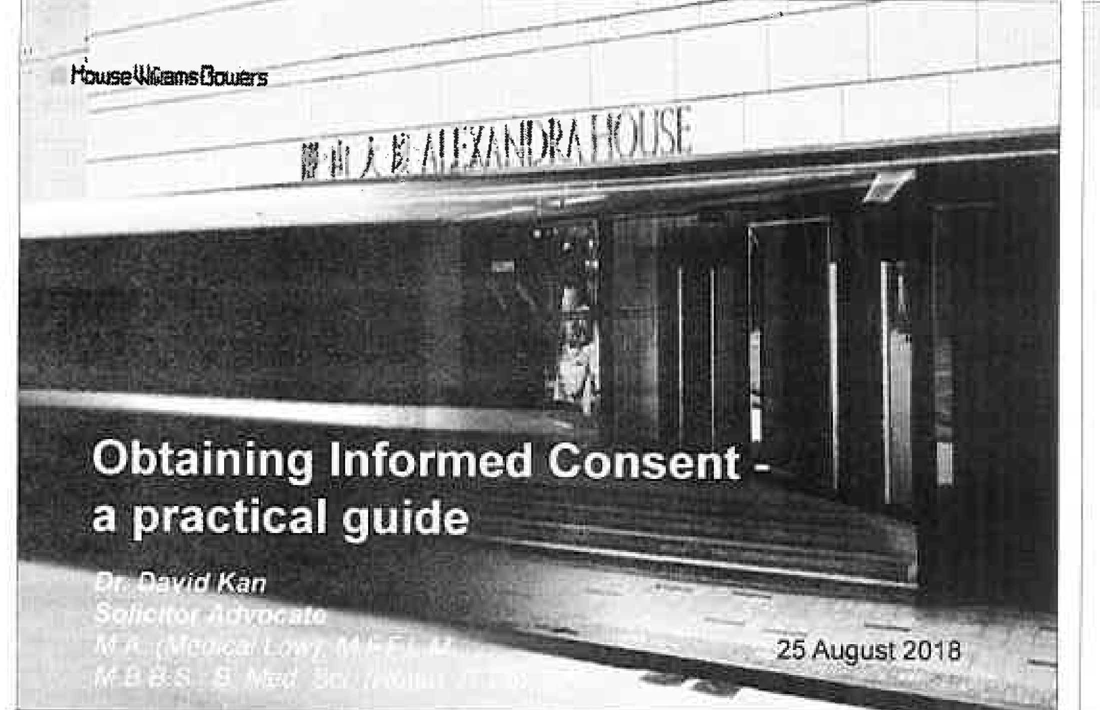

1.1 Importance of Informed Consent

- Fundamental legal/ethical principle.
- A process of pre-treatment communication.
- Applicable not just to surgical treatment.
- Relevant to all claims/complaints venues.
- Often the weakest link in a medico-legal defence.

1.2 Is the patient:-

- an adult?
- a minor?
- a Mentally Incapacitated Person (MIP)?
- unconscious?

1.3 Mental Capacity to Consent

- There is a presumption of capacity.
- It can be rebutted by long term incapacity, use of medication etc.
- For an adult patient of sound mind, only the patient can give valid consent.

2. What to cover?

- Standard of obtaining consent no longer judged by *Bolam*?
- Proper explanation regarding nature, effect, risks and other treatment options (including no treatment) (*MC Code*).

3. How much detail?

- Need to mention not only significant risks but risks of consequences even if the probability is low.
- Consider materiality of the risks.
  - magnitude and nature of the risk;
  - effect which its occurrence would have upon the patient;
  - importance to the patient of the benefits of the treatment;
  - alternatives available, and the risks involved in those alternatives.
- Assessment of materiality not to be reduced to %.
- Objective and subjective patient tests.

4. Written consent needed?

- Express and specific consent needed for invasive procedure and any treatment involving significant risks.
- Consent for surgical procedures involving general or regional sedation must be in writing.
- For written consent a reasonably clear and succinct record must be made on the form and witnessed by P & D at the same time.

5.1 Miscellaneous issues

- "Constructive dialogue".
- Use simple language, balance explanation.
- Use of proforma consent form.
- Information leaflet, visual aid, models, videos etc.
- Allow reasonable time to make proper decision.

5.2 Miscellaneous issues

- Check understanding, Q&A.
- "Causation" based on "but for" test.
- Beware of treatment that improves quality of life rather than saves life.
- What if patient refuses to be given information.
- Therapeutic privilege seldom applies.

5.3 Miscellaneous issues

- Duty to act reasonably and responsibly.
- Inform patient if any change of treatment plan.
- Beware that promise re anticipated outcome may lead to contractual obligations.
- Delegation to juniors, involvement of nursing staff.
- Training of medical and nursing staff.

Thank You

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The Litigation Process in Hong Kong

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25 August 2018

Outline

- Why a medical expert needs to understand the litigation process
- Brief overview of the judicial system in HK
- Overview of the litigation process in HK with emphasis on medical negligence claims

Why a medical expert needs to understand the litigation process

- Role as expert
- Nature of the expert report
- Nature and purpose of court documents asked to review
- Length of commitment
- Relationship between expert and instructing solicitors
- What is giving evidence in court about

Overview of the judicial system in HK

Court of Final Appeal

Court of Appeal of the High Court

Court of First Instance of the High Court

District Court

Magistrates' Courts   Coroner's Court   Small Claims Tribunal

Relevant Court rules and Practice Direction

- Civil Justice Reform (CJR) - active case management by the Court
- Rules of the High Court/District Court (e.g. O38 r 37B : Code of conduct for expert witnesses)
- Statement of Truth: "*I believe that the facts stated in this expert report are true and the opinion expressed in it is honestly held.*"
- Declaration of duty to Court: *"(a) I have read the Code of Conduct for expert witnesses in Appendix D of Order 38 of the Rules of High Court and agree to be bound by it; (b) I understand my duty to the Court; and (c) I have complied with and will continue to comply with that duty."*
- Practice Direction 18.1 for the Personal Injuries List

Practice Direction 18.1

- In relation to experts, the lawyers -

"*should also explain to their respective experts that the expert's **overriding duty is to assist the Court;** and partisanship and lack of independence on the part of the expert will devalue his role in the judicial process.*"

Pre-action investigation

- Pre-Action Protocol laid down by Practice Direction 18.1
- Patient investigates the merits of a possible claim
- Liability
  - medical negligence
  - causation
- Quantum
  - injury and prognosis
  - how much compensation
- Experts
  - liability expert
  - quantum expert (usually at a later stage)
- The potential defendant – doctor/hospital

Pre-Action protocol in PD 18.1

- Letter of claim / Letter before action
- Constructive reply
- Substantive reply
- Parties to explore settlement (if appropriate)

Commencement of legal action - which Court?

- Jurisdictional rise to take effect from 3 December 2018 onwards
- Small Claims Tribunal
  - not exceeding HK$75,000 (from HK$50,000)
- District Court
  - not exceeding HK$3 million (from HK$1million), subject to certain exceptions
- Court of First Instance of the High Court
  - exceeding HK$3 million (from HK$1 million)

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Writ and the pleadings

The Plaintiff needs to issue/file in Court :

- Writ of Summons
- Statement of Claim
- Statement of Damages

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Writ and the pleadings

Statement of Claim

- The document in which the Plaintiff sets out :
  - the facts relevant to the medical management of the Plaintiff by the Defendant and the injuries and loss the Plaintiff has allegedly suffered
  - the medical negligence alleged by the Plaintiff against the Defendant
  - causation
  - the injuries and loss the Plaintiff has allegedly suffered
  - the claim for damages

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Writ and the pleadings

Other documents to be served with the Statement of Claim

- A medical report on the updated condition of the Plaintiff
- A Statement of Damages which sets out, in detail and item by item, the compensation the Plaintiff seeks from the Defendant by way of damages
- Any expert medical report relied upon by the Plaintiff as to liability and causation (for all medical negligence cases)

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Writ and the pleadings

Defence

- A document which sets out the Defendant's specific and detailed response to the contents of the Statement of Claim
- Together with any expert report relied upon by the Defendant as to liability and causation (if available and not already served at pre-action stage, and insofar as this is practicable)

Reply

- A document which sets out the Plaintiff's response to the Defence

Writ and the pleadings

Answer to Statement of Damages

- A document which sets out the Defendant's response, in detail and item by item, to the damages sought by the Plaintiff
- In some cases, there may be a Revised Statement of Damages and a Revised Answer to the Statement of Damages

Check List Review hearing

- Appointment made when the Writ is issued
- Court reviews progress of the legal action
- Court (usually the PI Master/Judge) gives directions for the legal action to progress expeditiously
- Such directions include discovery, exchange of witness statements, expert reports etc.

Discovery of documents

- Mutual disclosure of relevant documents by List of Documents
- Concerns all documents relevant to issues in dispute
- Much already done at the pre-action stage
- The meaning of "documents"
- Continuing obligation of discovery

Commencement of legal action - which Court?

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  - not exceeding HK$75,000 (from HK$50,000)
- District Court
  - not exceeding HK$3 million (from HK$1million), subject to certain exceptions
- Court of First Instance of the High Court
  - exceeding HK$3 million (from HK$1 million)

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Writ and the pleadings

The Plaintiff needs to issue/file in Court :

- Writ of Summons
- Statement of Claim
- Statement of Damages

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Writ and the pleadings

Statement of Claim

- The document in which the Plaintiff sets out :
  - the facts relevant to the medical management of the Plaintiff by the Defendant and the injuries and loss the Plaintiff has allegedly suffered
  - the medical negligence alleged by the Plaintiff against the Defendant
  - causation
  - the injuries and loss the Plaintiff has allegedly suffered
  - the claim for damages

MAYER·BROWN JSM

Writ and the pleadings

Other documents to be served with the Statement of Claim

- A medical report on the updated condition of the Plaintiff
- A Statement of Damages which sets out, in detail and item by item, the compensation the Plaintiff seeks from the Defendant by way of damages
- Any expert medical report relied upon by the Plaintiff as to liability and causation (for all medical negligence cases)

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Relevant Court rules and Practice Direction

- Civil Justice Reform (CJR) - active case management by the Court
- Rules of the High Court/District Court (e.g. O38 r 37B : Code of conduct for expert witnesses)
- Statement of Truth: "*I believe that the facts stated in this expert report are true and the opinion expressed in it is honestly held.*"
- Declaration of duty to Court: "*(a) I have read the Code of Conduct for expert witnesses in Appendix D of Order 38 of the Rules of High Court and agree to be bound by it; (b) I understand my duty to the Court; and (c) I have complied with and will continue to comply with that duty.*"
- Practice Direction 18.1 for the Personal Injuries List

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Practice Direction 18.1

- In relation to experts, the lawyers -

"*should also explain to their respective experts that the expert's **overriding duty is to assist the Court**; and partisanship and lack of independence on the part of the expert will devalue his role in the judicial process.*"

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Pre-action investigation

- Pre-Action Protocol laid down by Practice Direction 18.1
- Patient investigates the merits of a possible claim
- Liability
  - medical negligence
  - causation
- Quantum
  - injury and prognosis
  - how much compensation
- Experts
  - liability expert
  - quantum expert (usually at a later stage)
- The potential defendant – doctor/hospital

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Pre-Action protocol in PD 18.1

- Letter of claim / Letter before action
- Constructive reply
- Substantive reply
- Parties to explore settlement (if appropriate)

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Court's Judgment

- Judgment reserved
- Handing down of Judgment
- Court may explain why expert evidence is accepted or rejected
- Appeal

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JSM
孖士打律師行

Thank You

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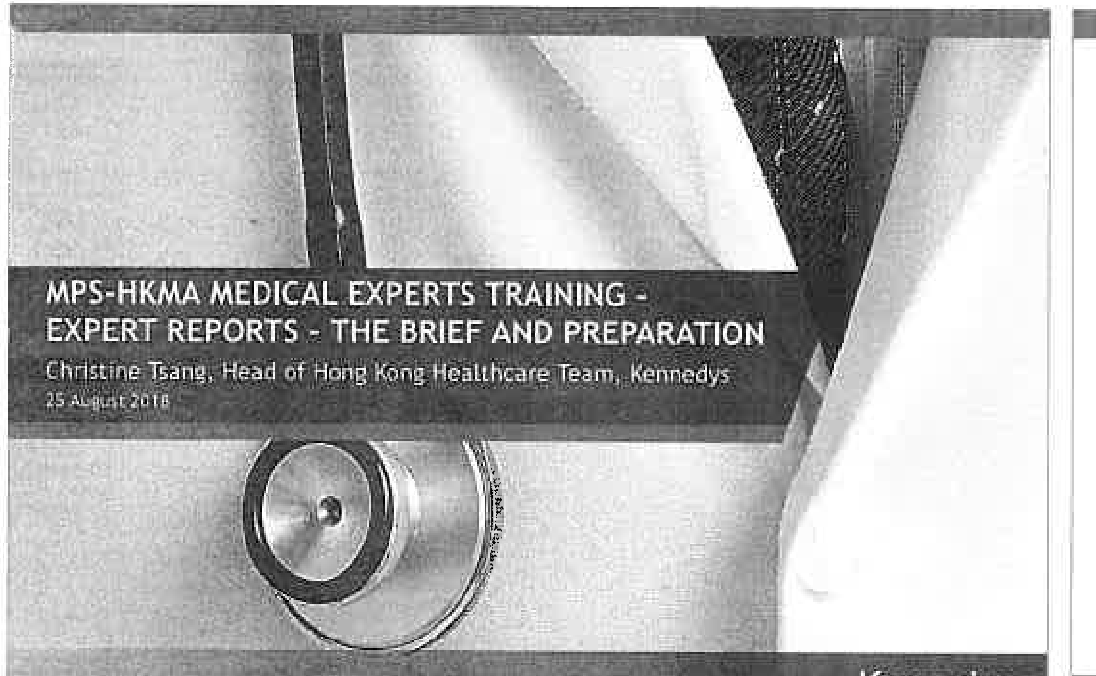
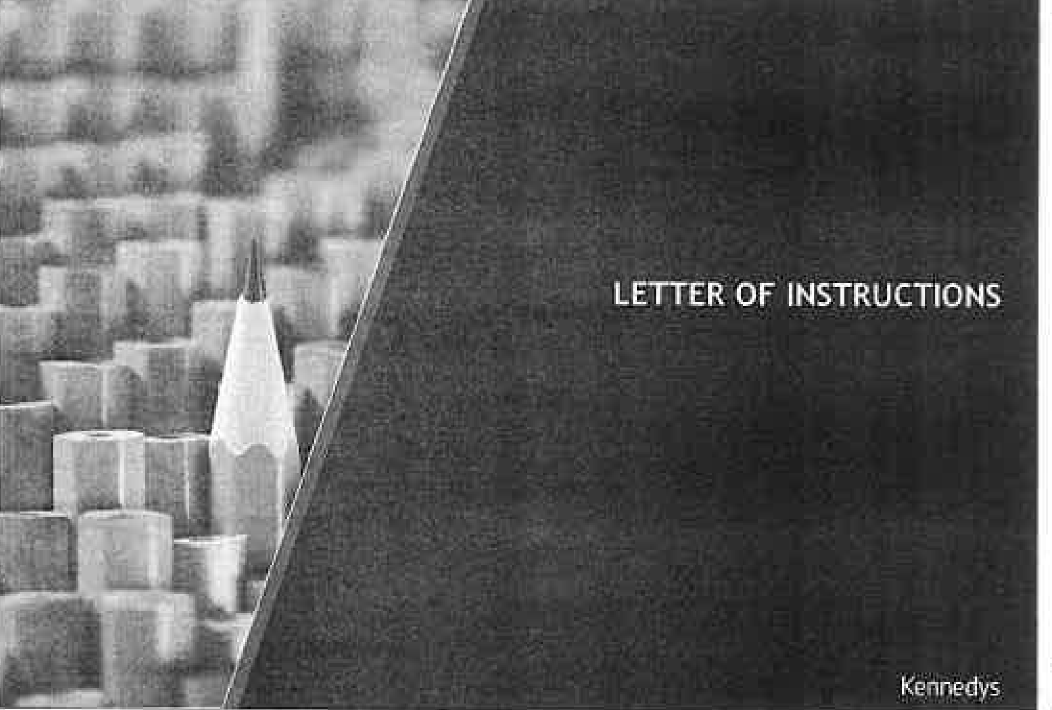


AGENDA

Letter of Instructions	3
What lawyers need?	6
How to prepare an Expert Report?	12
Example of a good Expert Report	21
Rules of Court and Code of Conduct	25
Privilege, Disclosure and Immunity	36



Instructions

1. Check if you are conflicted
2. Provide your CV, estimated fee and turnaround time
3. Receive letter of instructions from a party/law firm and bundle of documents for review
4. Consider facts
5. Review literature and protocols
6. Form an opinion
7. Prepare an expert report and send it to the party/law firm
8. Finalise and sign the expert report
9. Issue an invoice to the party/law firm
10. Receive further instructions (for example, compile a further report and/or attend Court to give oral evidence at trial if called upon to do so)

Instructions Letter

- Names of the parties
- Brief facts of the case
- Description of the documents which are enclosed
- Instructions on the contents of the expert report - matters which need to be investigated and issues which need to be addressed by the expert
- Instructions on the format of the expert report
- Code of Conduct for Expert Witnesses
- Format of the Declaration of Duty to Court
- Format of the Statement of Truth
- Deadline for you to complete the expert report

Kennedys

Medical negligence cases
Liability and Causation expert

1. Was there a ***breach*** of the duty of care?

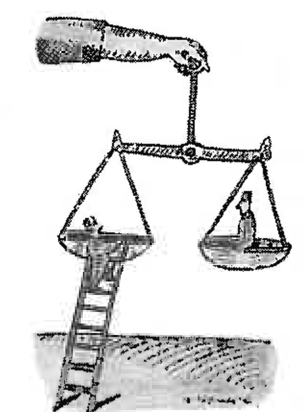
   - Bolam test: whether the doctor/hospital is or is not negligent? Did the doctor/hospital act in accordance with a practice accepted at the time as proper by a responsible body of medical opinion?
   - Judged by the speciality of the doctor: did the paediatrician act in accordance with a practice accepted as proper by a responsible body of paediatricians?
   - Judged at the time of treatment, not the date when you receive instructions and not based on retrospective wisdom

Kennedys

Medical negligence cases
Liability and Causation expert

2. Did that breach of duty ***cause damage***?

   - Judged on the balance of probabilities: greater than 50% likelihood, not certainty
   - Lower than the criminal burden of proof, which is judged beyond a reasonable doubt



Kennedys

Medical negligence cases

Quantum expert

1. Conduct an examination on the patient
2. Comment on:
   a) Extent of the injuries as a result of the alleged incident
   b) Whether the patient had any pre-existing condition unrelated to the alleged incident
   c) Prognosis
   d) Length of sick leave required as a result of the alleged incident
   e) Need for further treatment and its costs
   f) Whether the patient can resume his/her previous job or whether s/he is capable of undertaking any alternative employment
   g) Whether the conditions affect his/her daily living activities
   h) His/her life expectancy (if appropriate)

Kennedys

Death inquest cases

1. Cause of and circumstances connected with the death of a person (section 27 of the Coroners Ordinance)

2. May make recommendations designed to:
   - prevent the recurrence of fatalities similar to that in respect of which the inquest is being held;
   - prevent other hazards to life disclosed by the evidence at the inquest;
   - bring to the attention of a person who may have power to take appropriate action any deficiencies in a system or method of work which are disclosed by the evidence at the inquest and which are of public concern

   (section 44 of the Coroners Ordinance)

Kennedys

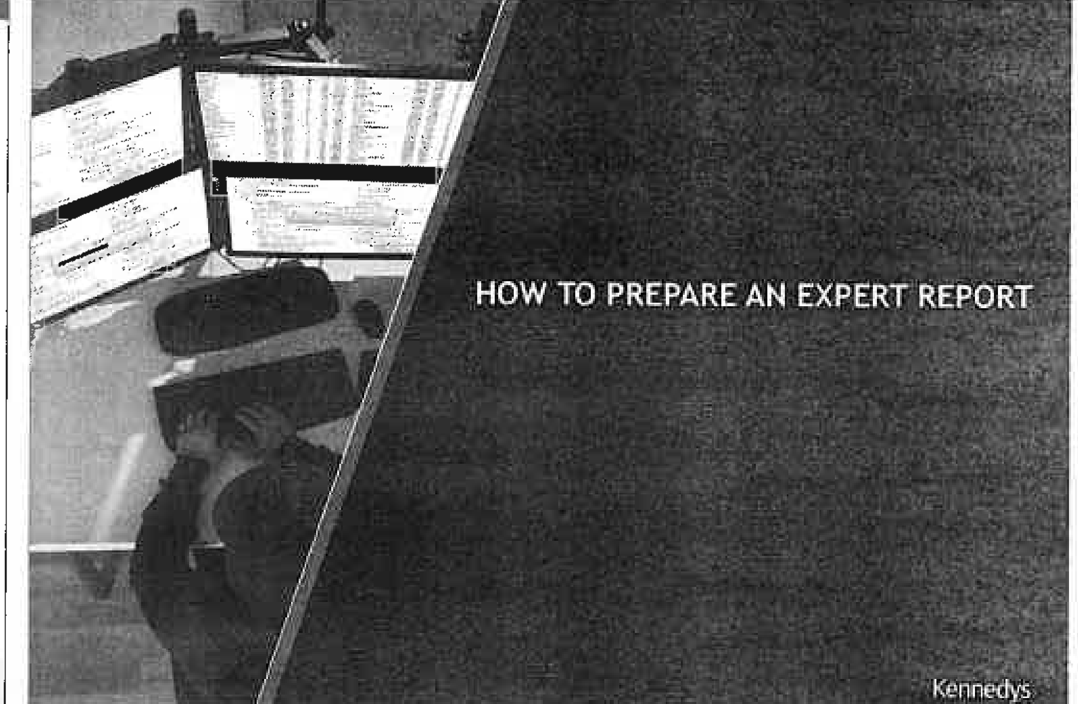
Medical Council cases

1. Whether the doctor commits misconduct in a professional respect?

   - "Misconduct in a professional respect" is not defined in the Medical Registration Ordinance but has been interpreted by the Court of Appeal as *conduct falling short of the standards expected among registered medical practitioners*.

   - It includes not only conduct involving dishonesty or moral turpitude, but also any act, whether by commission or omission, which has fallen below the standards of conduct which is expected of members of the profession. It also includes any act which is reasonably regarded as disgraceful, dishonourable or unethical by medical practitioners of good repute and competency.

Kennedys



A guide to writing Expert Reports

- Structure! Paragraphing, add page numbers
- Capable of being understood! Explain the technical terms and abbreviations

Structure of an Expert Report

Proposed sub-headings for a Liability and Causation Report

1. Instructions - a brief description of the identities of the parties and that you received instructions from which party to comment on liability and causation issues
2. Qualifications - a brief description of your qualifications including the current post and a summary of your past experiences
3. Documents for Review - set out the list of documentation that you have considered in the provision of your opinion
4. Chronology / Summary of Facts - set out all relevant facts in a chronological order

Structure of an Expert Report

Proposed sub-headings for a Liability and Causation Report

5. Opinion - comment on each allegation of negligence and provide reasons to support your views, refer to any published references that you have relied on
6. Conclusion - summarise the opinions reached
7. Declaration and Statement of Truth - followed by your signature, full name, your specialty and date the report

Form of an Expert Report

Points to note

1. Your duty to Court overrides any obligation you have to the party who instructed you. Your function is to provide independent assistance to the Court by way of an objective and unbiased opinion.
2. You should only comment on areas which are within the field of your expertise. You should make it clear if a particular question or issue falls outside your expertise.

Form of an Expert Report
Points to note

3. Please assess according to the medical information available to the medical team at the time, and not based on retrospective wisdom.

Form of an Expert Report
Points to note

4. Please apply the following standard:

   - The standard is the standard which prevailed at the time of the management.
   - The standard is that of a reasonable doctor exercising reasonable care. A doctor failing to provide the best care is not negligent.
   - In the case of a House Officer, although s/he was a trainee, the standard of his or her performance must nonetheless be that of a reasonable and qualified doctor exercising reasonable care.
   - In the case of a specialist, the standard is that of a reasonable specialist exercising reasonable care.

Form of an Expert Report
Points to note

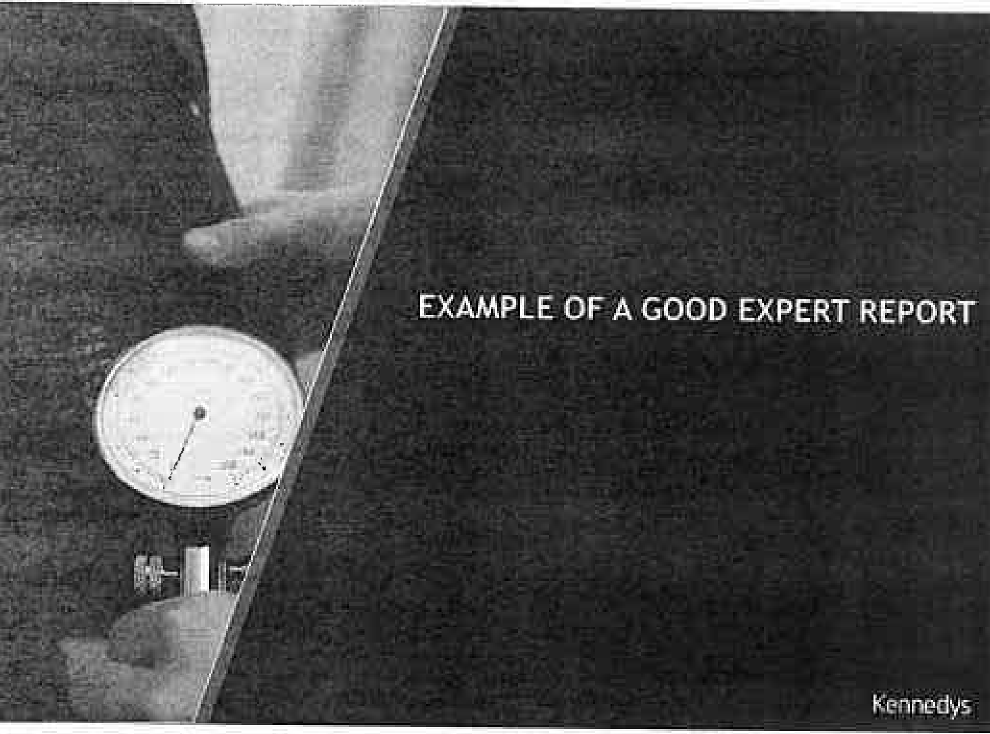
- Sometimes, there is more than one acceptable practice. So you need to say what were the acceptable practices (for example, both surgical and conservative managements could be acceptable even if the majority would have voted for surgical management) and whether the management was in accordance with a practice accepted as proper.

5. You should state the facts or assumptions upon which your opinion is based. You should not omit to consider material facts which could detract from your concluded opinion.

Form of an Expert Report
Points to note

6. If your opinion is not properly researched because you consider that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one. If you cannot assert that the report contains the truth, without some qualification, then that qualification should be stated in the report.

7. If, after completion of your report, you change your view on a material issue, such change of view should be communicated to the party who instructed you without any delay.



Good or Bad?

My personal sympathies are engaged to a greater degree than would probably be normal with an expert witness.

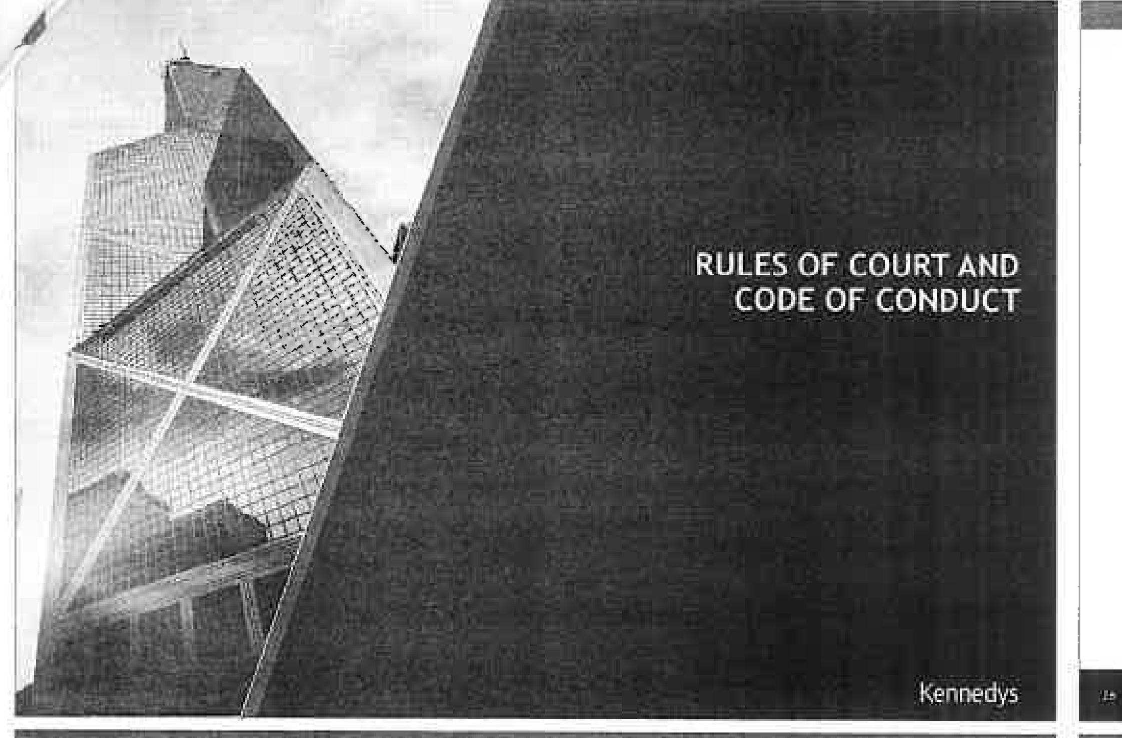
Liverpool Roman Catholic Archdiocesan Trust v David Goldberg QC (2001) held that expert evidence should not be admitted. The Court should disregard it as the expert was unable to fulfil the role of expert because of his close relationship with the defendant.

No authorities expressly exclude expert evidence of a friend of a party. But if there exists a relationship between the proposed expert and the party calling him which a reasonable observer might think was capable of affecting the views of the expert so as to make them unduly favourable to that party, his evidence should not be admitted.

Good or Bad?

CN is a rare form of brain tumour because it is rare no one neurosurgeon has any good experience. Let us review the treatment outcomes of CN in literature: reference 1 … reference 2 … reference 3 … reference 4 … reference 5 … in summary CN was a difficult to treat tumour and treatment carried a very significant mortality and morbidity. If you look into the mortality rate of a cholecystectomy the 30 day mortality rate was 0.15% but CN surgery 30 day mortality rate was 2% so it is 13.33 times higher a very high risk surgery. This patient survived with significant morbidity so this was expected. That means the doctor had provided appropriate care to this patient.

1. **Instructions** - a brief description of the identities of the parties and that you received instructions from which party to comment on liability and causation issues
2. **Qualifications** - a brief description of your qualifications including the current post and a summary of your past experiences
3. **Documents for Review** - set out the list of documentation that you have considered in the provision of your opinion
4. **Chronology / Summary of Facts** - set out all relevant facts in a chronological order
5. **Opinion** - comment on each allegation of negligence and provide reasons to support your views, refer to any published references that you have relied on
6. **Conclusion** - summarise the opinions reached
7. **Declaration and Statement of Truth** - followed by your signature, full name, your specialty and date the report



Bad experiences with experts...

- *Acting as advocate for own client*
- *Subjective in opinion, relying only upon what the client told them and fail to test their theory or challenge the client upon available evidence*
- *Compromising to avoid attending trial*
- *Getting cold feet close to trial*
- *Vulnerable to attack during cross-examination*
- *Change their opinions in Court!*

Siu King v Wong Chak Wing HCPI 479/2003

"It is the Plaintiff's case that she could not walk ... her condition cannot be explained by most if not all of the medical experts who had given evidence in Court or produced a report. Initially, the strongest evidence came from the report of Dr. K ... Dr. K opined that the Plaintiff suffered from SCIWORA in his 3rd Report. The diagnosis of SCIWORA has one marked feature, it would affect the upper limbs more severely than the lower limbs ... And it was found by all medical experts that the lower limb of the Plaintiff is affected more severely and her upper limb is relatively spared ... When cross-examined by Ms. Loh on this point, Dr. K could not give a good explanation.

When confronted by Ms. Loh on the various matters that could not be explained in his report, Dr. K finally accepted that he also had suspicion on the injury sustained by the Plaintiff ... if that is the case, he should have expressed his reservation in his report. Otherwise, any one reading the report would not be aware of his hidden observation.

Rules of the High Court

Order 38

- rule 35A - It is the duty of an expert witness to help the Court on the matters within his expertise. The duty ... overrides any obligation to the person from whom the expert witness has received instructions or by whom he is paid.
- rule 37A - An expert report disclosed ... must be verified by a statement of truth in accordance with Order 41A.
- rule 37C - An expert report disclosed ... is not admissible in evidence unless the report contains a declaration by the expert witness that - (a) he has read the code of conduct set out in Appendix D and agrees to be bound by it; (b) he understands his duty to the Court; and (c) he has complied with and will continue to comply with that duty.

Practice Direction 18.1

The Personal Injuries List

- para 8 - Practitioners should explain to their respective experts that the expert's overriding duty is to assist the Court; and partisanship and lack of independence on the part of the expert will devalue his role in the judicial process.
- para 74 - Any expert instructed by a party should be able to produce the expert report within a reasonable time of the instructions given and/or having regard to the case management timetable.
- para 75 - The case management timetable will be fixed according to such time as may reasonably be required for preparation of the case for trial rather than according to experts' diaries. Parties should not expect the Court to allow any prolonged timetable to suit the diary of any expert who is unable to conduct an examination and/or complete the report within a reasonable time.

Practice Direction 18.1

The Personal Injuries List

- para 76 - A party instructing an expert should secure confirmation in writing from such expert as to the date of examination of the injured person and the date by which the report will be completed and available.
- para 84 - A party who unreasonably fails to cooperate in instructing or arranging joint examination of the injured person and/or in preparing joint expert report will risk sanctions being imposed by Court as it deems fit, which may include refusal of leave by Court to adduce expert report prepared singly by such party's own expert and/or refusal by Court to allow costs for obtaining such report.

Practice Direction 18.1

The Personal Injuries List

- para 85 - To avoid unnecessary delay and/or minimise the need for supplemental reports, the party should ensure that all necessary information, documents and records are made available to the expert. The matters to be investigated and issues to be addressed by the expert should be clearly identified in the instructions.
- para 86 - An expert should be asked to specify the materials available to him, the matters to be investigated and precise issues to be addressed, where there is a range of opinion, a summary of such range of opinion and the reasons for his own opinion, and a summary of the conclusions reached.

Practice Direction 18.1
The Personal Injuries List

- para 87 - The parties' respective experts when preparing joint expert report should be asked to specify:
  - the common parameters upon which their opinions are based;
  - if different parameters have been used, the parameters upon which each expert opinion is based and the reasons for adopting different parameters;
  - issues on which the experts have reached a common opinion and what that common opinion is;
  - issues on which the experts have failed to reach a common opinion and their competing views on each such issue; and
  - reasons for an expert's disagreement with any opposing expert's views on each such issue.

Code of Conduct for Expert Witnesses

- para 2 - An expert witness has an overriding duty to help the Court impartially and independently on matters relevant to the expert's area of expertise.
- para 4 - An expert witness is not an advocate for a party.

Code of Conduct for Expert Witnesses

- para 12 - Experts' conference
  An expert witness shall abide by any direction of the Court to:
  - confer with any other expert witness;
  - endeavour to reach agreement on material matters for expert opinion; and
  - provide the Court with a joint report specifying matters agreed and matters not agreed and the reasons for any non-agreement.
- para 13 - An expert witness shall exercise his independent, professional judgment in relation to such a conference and joint report, and shall not act on any instruction or request to withhold or avoid agreement.

A "without prejudice" discussion refers to a discussion at which the experts discuss for the purposes of resolving or narrowing down issues in dispute. The parties and their legal representatives do not participate in the discussion.

Privilege and Disclosure

Between expert and a lawyer

- Communications exchanged for the purpose of seeking legal advice in anticipation/contemplation of litigation can be protected from disclosure
- Mark the draft report with the caption "SUBJECT TO LEGAL PRIVILEGE"
- Once the expert report has been disclosed, all the materials or references referred to in the report will no longer be protected by a claim of privilege. The Rules provide for the production of any document referred to in an expert report following notice requesting such production.

Whitehouse v Jordan [1981] 1 WLR 246

While some degree of consultation between experts and legal advisers is entirely proper, it is necessary that expert evidence presented to the Court should be, and should be seen to be the independent product of the expert, un-influenced as to form or content by the exigencies of litigation.

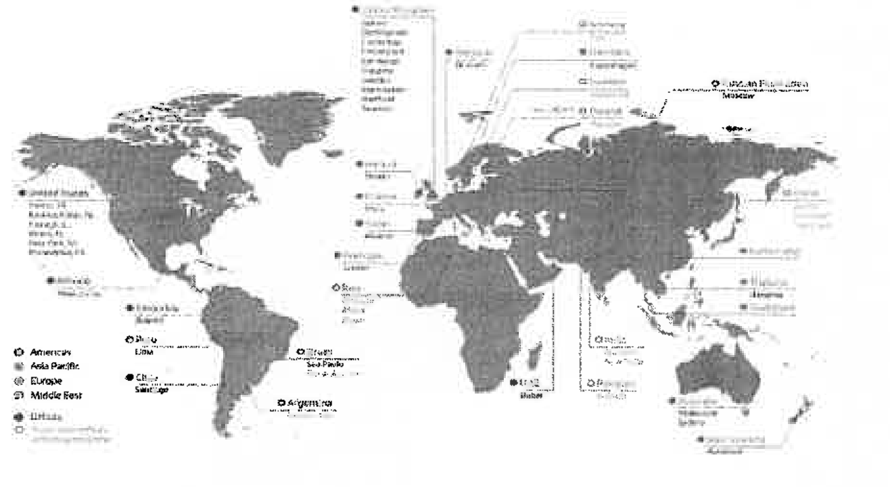
Expert immunity?

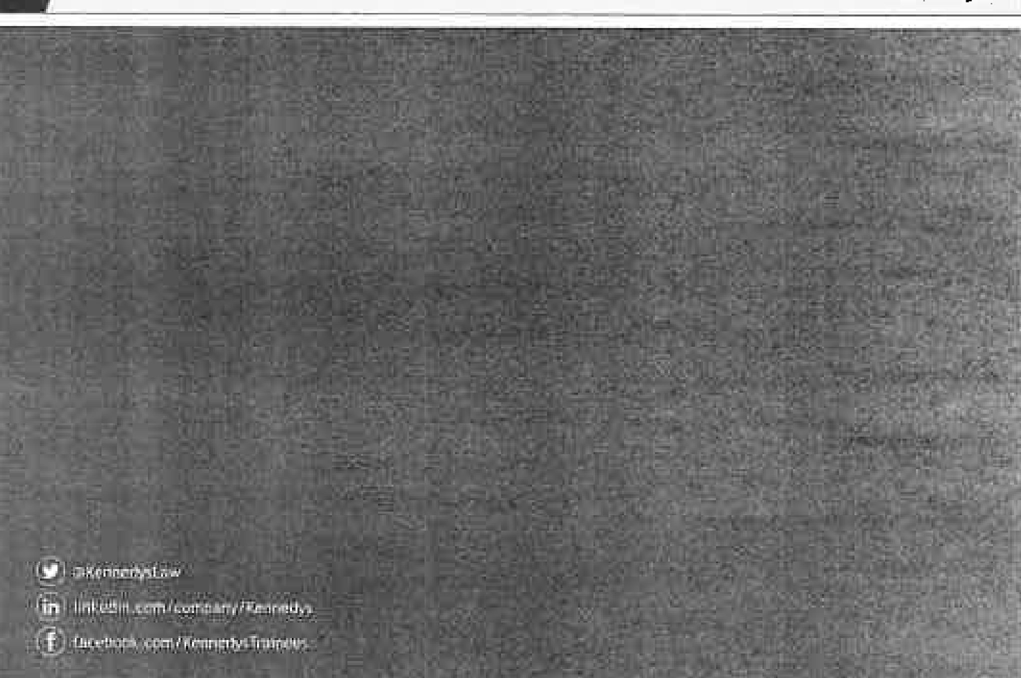
- Erasure of Prof M's name by the General Medical Council
  - Serious professional misconduct could include the giving of medical evidence in Court
  - Bad faith or moral turpitude were not requirements
  - A high degree of negligence or incompetence are sufficient

Expert immunity?

- Statement of Truth
  - It is a statement that the expert believes that the **facts stated** in the expert report are true and the opinion expressed in it is honestly held.
  - If a person has made a statement of truth falsely, proceedings for contempt of court may be brought against him by the Secretary for Justice or by a person aggrieved by the false statement with permission of the Court.

KENNEDYS WORLDWIDE





Medical Protection

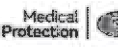
Claims management ethics

The wider impact of claims

Dr Ming Keng Teoh
MBChB, FRCSE, FRCS, ChM, MFFLM, MSc, LLM
Head of Medical Services – Asia

MPS claims handling ethos

1. The doctor's perspective
2. The indemnifier's perspective
3. MPS panel guidelines for claims management
4. Principles of good claims handling
5. Ethical dilemmas in claims handling



The current medicolegal landscape

Is there a compensation culture?

Perception

High public expectations

Medical mishaps not always avoidable (10%)

Blame culture

Doctors under increasing scrutiny

Facts

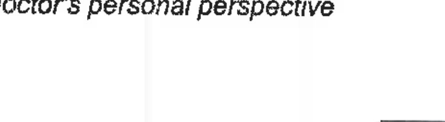
Doctors are the most trusted profession (92%)

<3% of patient sued after negligent mishap

Drs and patients want speedy and fair resolution

Professional effect of claims

Doctor's personal perspective

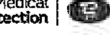


Intense negative emotional response

- *Stressed, anxious and angry*
- *Feelings of guilt*

Loss of trust in patients

Doctors look for support from spouses and colleagues



The hidden costs of claims on patients
Defensive medicine

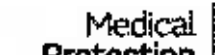
80% admit their treatment of patients is influenced by fear of being sued

71% felt that practice *costs had increased* from *defensive medicine*

Survey of 1,049 doctors in the UK

"Up to half of antimicrobial medicine prescriptions were unnecessary. in OECD countries"

David Morgan, OECD (The Straits Times, Singapore 27 March 2018)



Hidden costs of medicolegal risks and claims

Doctor's perspective
- Defensive medicine; adversarial approach, burnout

Hospital's perspective
- Expensive systems; blame culture; poor morale

Patient's perspective
- Poorer care; higher costs, low trust

Indemnifier's perspective
- Increased risks and higher subscriptions

Indemnifier risks
Uncertainty

Change in culture of litigation

Change in court awards

Change in approach by plaintiff lawyers

Change in calculation of compensation

Change in medical landscape

Medical
Protection

Cost of medical negligence claims

1. Compensation awards
2. Settlements
3. Legal costs – defence and claimants' costs; disbursements and fees

Rising costs from

Increasing claims frequency

Higher compensation awards

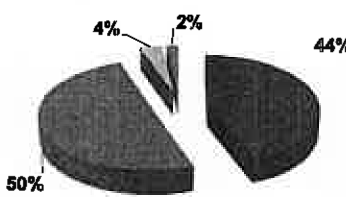
Higher legal fees

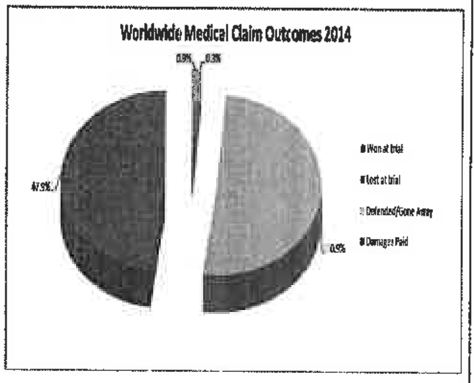
Uncertainty needs to be factored in

Medical Protection

Claim Outcomes
MPS Medical claims

Malaysia 2012-2016





9

Medical Protection

Claim management process
MPS checks and balances

MLA / solicitor and panel lawyers

- *Review medical reports, records, evidence*
- *Identify key clinical & professional issues*

Panel lawyers advice - *SRF*

Review strategy, brief for experts, counsel

Review expert reports

Discuss mandate with lawyer *and* member

Medical Protection

Claims management ethics
Ingredients for decision

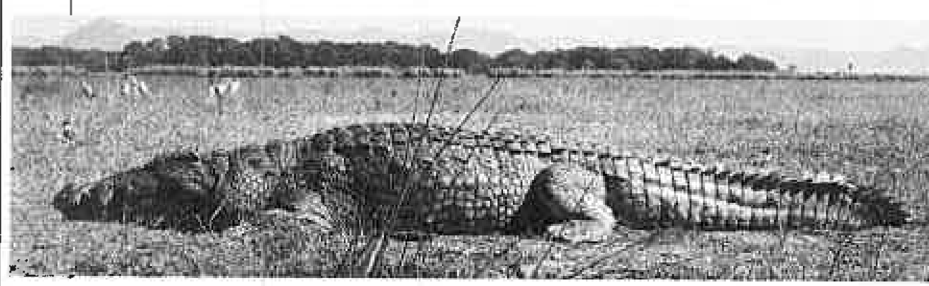
1. **Breach and causation**
2. **Expert opinion**
3. Adequate records
4. Reliable defendant
5. Member's interests and views
6. Wider profession's interests
7. MPS values - fair but firm

Medical Protection

Ethical case management

You have been asked to provide an expert opinion on a case where you strongly suspect one of the "contemporaneous" notes has been added later

Do you advise your instructing lawyer?



Ethical case management

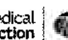
MPS has sought expert evidence on a claim. Two unsupportive expert opinions have been obtained

Is it reasonable to seek a third opinion?

Medical Protection

Ethical case management

- You are instructed by an MPS lawyer to examine a plaintiff.
- You find him to be far more injured than his own lawyers believe and subsequently the claim is potentially worth more compensation than they are prepared to accept.
- How would you report?

Medical Protection 

MPS claims handling
Unique features

Team approach – *legal and MLAs*

MPS panel guidelines for claims - *fair but firm*

Clinical and professional issues considered

Wider implications of claim – *member's views*

Support and counselling

Study underlying causes - *risk management*

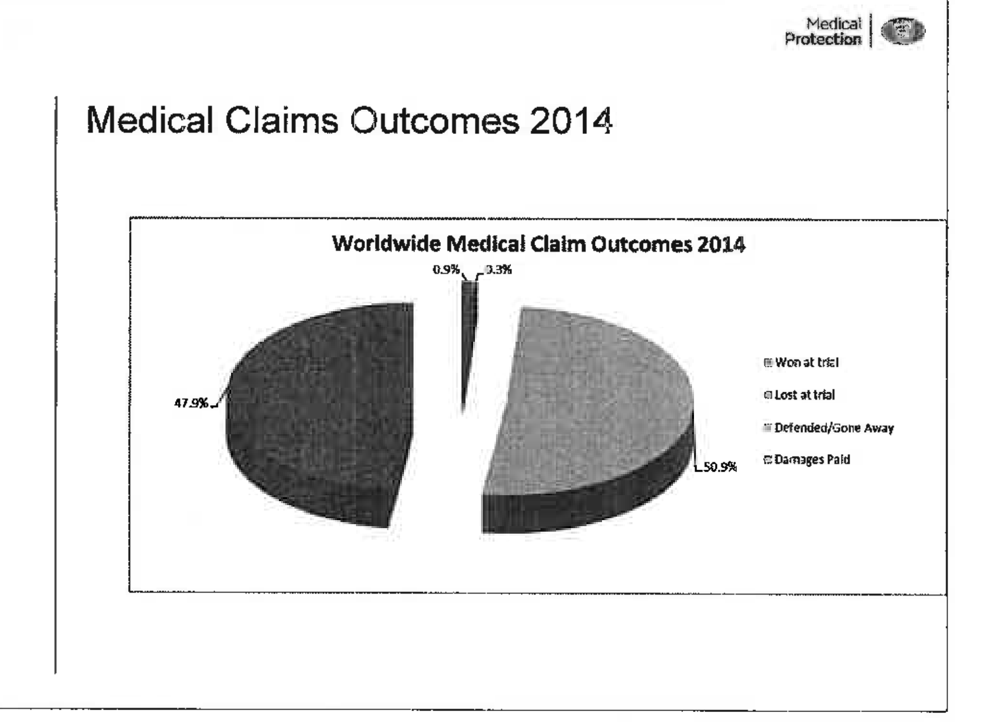
Medical Protection

Thank you

QUESTIONS?

www.medicalprotection.org

Medical Protection


Medical Protection
Medical Claims Outcomes 2014
Worldwide Medical Claim Outcomes 2014
0.9%
0.3%
47.9%
50.9%
Won at trial
Lost at trial
Defended/Gone Away
Damages Paid

Summary of Features of Good Report (Dr. Sam Proper)

1. Date, headings; paragraph numbering, page numbering.
2. Qualifications and relevant experience enabling you to comment on the issues.
3. Reference to CV which is attached to the report; no conflict of interest.
4. List of documentation considered, summarize the important facts and evidence relied upon.
5. State clearly the specific issues upon which you were asked to give an opinion.
6. Reference to Bolam test.
7. Your opinion justified by relevant facts and authority
8. Reference to supporting literature (attached to your report).
9. Justify your conclusion, summary of facts, declaration of truth.
10. Explain relevant technical terms and abbreviations.
11. Tables and graphs where appropriate to illustrate.
12. Short paragraphs.

Summary of Features of Report by Dr. Jack Stoke

1.
2.
3.
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7.
8.
9.
10.

Summary of Features of Report by Dr. James Genius

1.
2.
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9.
10.

House Williams Bowers

Thank You

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This is an example of a good expert witness report for your reference:

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223 University Drive Hong Kong
Tel:23345678 Fax: 24467888

Ms. Josephine Ma
House Lawyers

1 September 2017

Dear Ms. Ma

Re: Madam Sally Porsche

Introduction

1. I, Dr. Sam Proper, hold the post of Professor & Head of Obstetrics & Gynaecology (O&G) at the Miranda Hospital from 1 December 2000. My qualifications are as follows: MBBS, BSc(Med), BA, FRANZCOG and FRCOG.

2. I qualified as a doctor in 1975 from the Hong Kong University. I did General Surgery and Paediatrics for a year each till 1980. From that time on, I have been practicing Obstetrics & Gynaecology. I have since done at least 3000 deliveries per year from 1985 to now.

3. I have also authored more than 100 refereed papers in International Journals, 20 chapters and 50 conference paper.

4. My curriculum vitae is enclosed to his report. There is no conflict of interest in this case and I can provide an independent expert opinion.

Documentation

5. My report is based on my observations from the following documents sent to me by House Lawyers:
   (a) Copies of the clinical notes from November 2010 until April 2011;
   (b) CTG records of the patient;
   (c) Medical reports from Dr. Patrick Good and Dr. Holley McQueen;
   (d) Letter from the patient's parents listing their various allegations; and
   (e) Guidelines for neonatal standby at delivery for high risk pregnancies that was in force at the Hospital at the time of the delivery.

Summary of Facts

6. Mdm Sally Porsche is European, 25 years of age and was married for 6 months when she first booked to be seen in her pregnancy. Her antenatal course was uneventful. She had gone into spontaneous labour on 3 April 2011.

7. Mdm Sally Porsche was admitted to ABC Hospital at 1030 hours on 3 April 2011 with leaking liquor and pain. Examination revealed that the fetus was presenting by its head and there was definitely clear liquor draining. Dr. Zed ordered that a 10units Syntocinon drip be started for the patient.

8. At the review at 0930 hours, the CTG trace was normal. The membranes were ruptured and the syntocinon was continued. At 1720 hours, there was evidence of fetal tachycardia but no evidence that Dr. Zed was aware of this.

9. Mdm Sally Porsche had a fever of 39.2C at 1820 hours and there was a fetal tachycardia of 160 to 188/min as well. Panadol was ordered.

10. The fever was settled to 37.4C by 2020 hours but the fetal heart was still tachycardic at 180 to 200/min. There were shallow late decelerations according to the midwife and Dr. Zed was informed.

11. Dr. Zed reviewed the patient at 2045 hours. The patient's cervix was 9cm dilated. The CTG showed reduced variability with a baseline of 180 and contractions were 1 in 2 minutes but the liquor was still clear. At 2150 hours, the cervix was fully dilated and the head was at station 0. A decision was made to perform an emergency caesarean because of failed vacuum/ malposition and fetal distress.

12. The baby was delivered at 2240 hours. The Apgar scores were 3 at 1 minute and 3 at 5 minutes. Resuscitation efforts failed and the baby was pronounced dead at 2330 hours.

<u>Issues</u>

13. I have been asked to consider the following issues and my opinion is set out below. Kindly note that my views are given with regard to the standard expected of a reasonably competent practitioner in Hong Kong at the material time.

Issue: Whether the baby should have been delivered by Caesarean Section at 2045 hours

14. Given that the patient had a possible upper respiratory tract infection and fever of unknown cause, Dr. Zed's decision to deliver the baby vaginally was appropriate. A caesarean section is associated with increased maternal morbidity. Further, a caesarean section may involve using an endotracheal tube for intubation for general anaesthesia which can lead to aspiration and pneumonia thus endangering the mother's life. Please find annexed a copy of the relevant supporting literature. (*Landon MB. Casarean delivery. In: Gabbe SG, Niebyl JR, Simpson JL, ed. Obstetrics: Normal and Problem Pregnancies. 5th ed. New York, NY: Churchill Livingstone; 2007: Chap. 19.*)

15. At that time, the cervix was already 9cm dilated and it is reasonable to have attempted a vaginal delivery at this stage with the expectation of achieving delivery in the next 30 to 60 minutes.

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16. Dr. Zed had closely monitored the baby and with the fetal head descending well with each contraction, a vaginal delivery was appropriate. There is no obvious clinical signs that the baby could not cope with a vaginal delivery.

Issue: Whether the decision to perform an emergency caesarean section was taken at the appropriate time?

[Graph]

17. As can be seen from the cardiotocograph (CTG) trace above (which records the fetal heartbeat and the uterine contractions), at 1800 hours, the fetal heart rate was 180-200bpm, the CTG showed shallow to late deceleration. This CTG finding is commonly seen towards the end of labour due to head compression when the head was descending into the vaginal canal. However, at 1815 Hr, the deceleration had disappeared. The heart beat remained at 180bpm, with no deceleration remains until 1845 hours. During this period, the vagina is draining clear liquor.

18. In the absence of deceleration and the liquor was still clear and there is no meconium staining, the signs are that the fetus is still in good condition. In this case, Dr. Zed's decision to continue observation and further monitoring is acceptable and there was no necessity to deliver the baby at this stage.

Conclusion

19. Dr. Zed's decision to proceed with vaginal delivery was appropriate given that Mdm Sally Porsche was having a viral infection and the risks of maternal morbidity would be reduced with a vaginal delivery.

20. Based on the CTG trace, it is reasonable to observe the patient and the decision to expedite the delivery at 2150 hours was not delayed.

21. I believe that the facts stated in this expert report are true and the opinion expressed in it is honestly held".

22. I have read the Code of Conduct as set out in Appendix D of the Rules of High Court and agree to be bound by it. I understand I have an overriding duty to the Court and I have complied with and will continue to comply with that duty.

Yours sincerely,

Dr. Sam Proper
MBBS, BSc(Med), BA, FRANZCOG and FRCOG

Please critically review the following expert reports and discuss them in the breakout groups:

To Whom It May Concern

Re: Medical Negligence Case

Analysis of Clinical notes

It was written that in 1988 the deceased had suffered from chest discomfort in China and an Echocardiogram had apparently shown a Ventricular Septal Defect. A subsequent echocardiographic assessment on 20th April 1992 by Cardiologist, Dr. Heart reported Good LV function, a normal R heart and no Pulmonary Hypertension. VSD was considered to be not significant; mild aortic regurgitation was reported to be present. She was discharged from cardiology follow up in 2002.

She had vague chest discomfort on and of but maintained a good exercise capacity otherwise and from 2004 was largely asymptomatic cardiac wise. She was postmenopausal for 3 years not on HRT and was also on Lovastatin for hyperlipidaemia for a while. A D&C under G.A in 1989 was uncomplicated. Her previous pregnancies were uneventful.

In January 2008, she was confirmed to have an infiltrating ductal carcinoma of the right breast. By April 2008, she had undergone 4 cycles of neoadjuvant chemotherapy consisting of Adriamycin (total dose of 380mg) and Cyclophosphamide with positive response and partial regression of tumour. CXRs on January and July 2008 showed a normal heart size and clear lungs. ECGs done then did not disclose any significant abnormalities.

She was admitted on 16th July 2008 for elective right mastectomy. Preoperative assessment by the Medical Officers documented that she was fit and well without any cardiorespiratory symptoms. However in view of the past history and the presence of a heart murmur she was referred to the cardiologist. At that time, an immediate input was not available from the cardiology team and the patient was thus referred to Dr. Ace urgently on 16/12/2004 for an echocardiogram and assessment of ejection fraction.

Dr Ace's assessment

Dr. Ace was fully aware of the cardiac profile and diagnosis of the deceased that had been made by previous examiners. In the history and physical examination, he found the patient active and well. He had specifically looked for active cardiac conditions that would pose risks during surgery, including coronary syndromes, decompensated left and right heart failure from congenital or acquired conditions, significant cardiac arrhythmias, pulmonary hypertension, severe valvular disease, and in this case malignancy - associated cardiac complications. The CXR and ECG (RBBB as noted before) were unremarkable and he did not find any serious cardiac impairments. In his 2D echocardiogram examination, he found normal Left and Right function and a small hemodynamically insignificant ASD. There was no evidence of pulmonary hypertension or right ventricular overload. There was no VSD or aortic regurgitation as found previously. These mild lesions would pose no significant surgical or anaesthetic risks.

Comments

Cardiac patients undergoing noncardiac surgery are very commonly encountered in clinical practice. Clear guidelines exists on "Perioperative Cardiac Evaluation for Non Cardiac Surgery" for reference by Cardiologists and Physicians. Cardiologists are often involved in

preoperative assessment, but the final decision process must surely fall in the hands of the surgical and anaesthetic team.
The issue that we are concerned with is whether Dr. Ace's favourable assessment had affected the final prognosis of the patient leading to her death. Having ruled out unstable coronary syndromes, cardiac decompensation, arrhythmias, severe valvular disease, effects of malignancy and drug inducted toxicity (the patient had less than the toxic total dose of 450 mg of Adriamycin), Dr. Ace correctly deemed the patient to have good cardiac fitness. I have no reservations on the assessment skills and judgment of Dr. Ace who is a very senior, experienced and reputable cardiologist. Everyone holds him in high esteem and we all know him well. I agree that his recommendations were entirely appropriate and prudent. Neither am I worried about minor discrepancies in the diagnosis with any previous examinations as minor lesions are notoriously variable and sometimes operator dependent; these differences would not in any way have brought any significant sequalae. No possible foulplay is detected in the management of the diseased.
On the question as to whether the final demise was caused by a primary or secondary cardiac event it would be difficult and speculative to conclude, because of the problems of retrospective analysis, absence of complete data and refusal for a post mortem. However, suffice it is to state that the preexisting cardiac lesions were very unlikely the causal, predisposing or precipitating factors for the inevitable train of events and unexpected death.
Dr. Spade, visiting Cardiologist from HKU confirmed the ECG and CXR features did not substantiate the diagnosis of a myocardial infarction.
The exact cause of the acute and persistent hypotension was unclear, but the temporal circumstance of occurring just post induction with a relatively normal CVP despite persistent hypotension was not typical of central pump failure.
The eventual server cardiac failure could have been secondary to prolonged hypotension and from overload from massive fluid and blood transfusions over a short time. It is very unclear and I guess no one can really say.
The exact cause of death could not be arrived.

Dr. Jack Stoke
Consultant Cardiologist

Dr. James Genius
123 University Drive Hong Kong
Tel:22345678 Fax: 24567888

Ms. Josephine Ma
House Lawyers

1 September 2017

Dear Ms. Ma

Re: Madam Sally Porsche

Introduction

I refer to your letter and the enclosures regarding the patient treated by Dr. Zed.

I am glad for the opportunity to respond to the relevant issues in this matter and thank you for taking the time to meet me over dinner. The meal was delicious. I understand my overriding duty is to the Court and I am prepared to testify should this matter proceed to trial. I have prepared my report in compliance with my duty to the Court and will be charging a discounted fee of $1000 for my report.

Problems

At the outset, I must highlight certain issues I have with the matter:

(a) Why a fetal scalp pH was not done at 2000 hours;
(b) Clinical notes unclear if Dr. Zed was informed about the CTF readings prior to 2000 hours;
(c) Why the CTG monitoring was unavailable when the vacuum assisted delivery was going on;
(d) I have not seen the CTG trace; and
(e) The doctors' clinical records from 23 November 2010 5pm entry are illegible.

Summary of Facts

Mdm Sally Porsche is European, 25 years of age and was married for 6 months when she first booked to be seen in her pregnancy. Her antenatal course was uneventful. She had gone into spontaneous labour on 3 April 2011.

Mdm Sally Porsche was admitted to ABC Hospital at 1030 hours on 3 April 2011 with leaking liquor and pain. Examination revealed that the fetus was presenting by its head and there was definitely clear liquor draining. Dr. Zed ordered that a 10units Syntocinon drip be started for the patient.

At the review at 0930 hours, the CTG trace was normal. The membranes were ruptured and the syntocinon was continued. At 1720 hours, there was evidence of fetal tachycardia but no evidence that Dr. Zed was aware of this.

Mdm Sally Porsche had a fever of 39.2C at 1820 hours and there was a fetal tachycardia of 160 to 188/min as well. Panadol was ordered.

The fever was settled to 37.4C by 2020 hours but the fetal heart was still tachycardic at 180 to 200/min. There were shallow late decelerations according to the midwife and Dr. Zed was informed.

Dr. Zed reviewed the patient at 2045 hours. The patient's cervix was 9cm dilated. The CTG showed reduced variability with a baseline of 180 and contractions were 1 in 2 minutes but the liquor was still clear. At 2150 hours, the cervix was fully dilated and the head was at station 0. A decision was made to perform an emergency caesarean because of failed vacuum/ malposition and fetal distress.

The baby was delivered at 2240 hours. The Apgar scores were 3 at 1 minute and 3 at 5 minutes. Resuscitation efforts failed and the baby was pronounced dead at 2330 hours.

Issues

My opinion to the questions raised in your letter is set out below.

In relation to the first question, one should not immediately assume a caesarean section is warranted in all emergency type cases. It may have increased maternal morbidity. This is a fact that is well documented in medical textbooks and literature. At that time, the cervix was already 9cm dilated and it is reasonable to have attempted a vaginal delivery at this stage with the expectation of achieving delivery in the next 30 to 60 minutes. Dr. Zed had closely monitored the baby and with the fetal head descending well with each contraction, a vaginal delivery was appropriate. There is also no obvious clinical signs that the baby could not cope with a vaginal delivery.

Based on your brief, my view on the second question is that the CTG finding at 1800 hours where the fetal heart rate was 180-200bpm is commonly seen towards the end of labour due to head compression when the head was descending into the vaginal canal. However, at 1815 hour, the deceleration had disappeared. The heart beat remained at 180 bpm, with no deceleration remains until 1845 hours. During this period, the vagina is draining clear liquor.

Conclusion

I look forward to hearing from you on the above. It is an honour to help Dr. Zed who is a good friend of mine and is a very senior colleague that is well respected by all. I will be happy to assist if you have further queries and would love to take you for dinner to repay your kindness at our last meal.

Yours sincerely,

Dr. James Genius

MAYER·BROWN
JSM

A Medical Expert in Medical Council Inquiries, Coroner's Inquests and other situations

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26 August 2018

Outline

- Expert's role in :-
  1. Medical Council disciplinary proceedings
  2. Coroner's Inquests
  3. Other situations

What does the Medical Council do?

- Medical Registration (Amendment) Ordinance 2018 (came into effect on **6 April 2018**)
- Amongst others, it is the licensing body for doctors, so has the power to revoke the registration
- Disciplinary power triggered usually by

  (a) conviction in Hong Kong or elsewhere of criminal offence punishable by imprisonment

  (b) misconduct in a professional respect

What does the Medical Council do?

Meaning of "misconduct in a professional respect" :

- Conduct, whether by commission or omission, which has fallen below the standards of conduct expected amongst doctors
- includes any disgraceful, dishonourable or unethical act
- not limited to conduct involving dishonesty or moral turpitude

What does the Medical Council do?

- Range of sanctions: (one or more of following -new)
  - Warning letter, reprimand, removal of doctor's name from the General Register and/or Specialist Register indefinitely or for a period of time (with or without suspension of the sentence for a period of time not exceeding 3 years)
  - If a specialist is removed from GR, he will be automatically removed by Registrar from SR too (new)
  - No compensation of money to complainant
  - May award costs to Secretary, complainant etc. in theory (never happened?)

What does the Medical Council do?

- Not to be confused with civil proceedings
  - Deals with negligence
  - Sanction is usually monetary compensation
- FAQ: Is there a difference between "negligence" and "misconduct in a professional respect"?

What does the Medical Council do?

- Negligence – breach of duty – clinical aspects (diagnosis, treatment, advice etc)
- Professional misconduct – conduct problem – may be non-clinical (e.g. advertising and canvassing, improper association with beauty centre, improper financial arrangement with non-doctors etc)
- What about carelessness, honest mistake, error of clinical judgment etc.? (see interesting remarks in a recent MCHK case)

What does the Medical Council do?

- <u>Recent MCHK case -</u> Charge against a paediatrician (D) – Failing to properly transfer an infant to ICU or a hospital capable of providing proper neonatal intensive care
- Infant was in dire condition. BP was dangerously low. Yet BP was not regularly monitored after D had left hospital at 0430. Readings were very low between 0500 and 0900 (even reaching BP of 10 mmHg). D was not informed until he reassessed the infant at 0945 during morning round... Nurses in the hospital had repeatedly failed to carry out D's standing orders and to alert him of abnormal vital signs. This raised a concern as to whether appropriate neonatal intensive care could be provided to the infant in the hospital. MCHK agreed with D that infant's condition had to be stabilized before the transfer. But it was ultimately an analysis of the risk and benefit between an earlier and later transfer.

What does the Medical Council do?

- "We are of the view that Dr. [D] ought to have considered the transfer of the Patient to a hospital with neonatal intensive unit capable of providing proper and effective neonatal intensive care for treatment and/or care at a much earlier time than he did. Dr. [D] had made a wrong clinical judgment. However we accept that wrong clinical judgment is not always to be equated with professional misconduct.
- Accordingly, we are not satisfied on the evidence that Dr. [D]'s conduct has fallen below the standard reasonably expected of medical practitioners. We therefore find him NOT guilty of the amended charge"

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The composition of the Medical Council

- Before the Amendment Ordinance, **28** Council members
- After the Amendment Ordinance, **32** Council members

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The composition of the Medical Council

- 32 members
  - Director of Health, or his/her representative (ex officio member)
  - 2 nominated by HKU (app by CE)
  - 2 nominated by CUHK (app by CE)
  - Chief Executive of HA, or his/her representative (ex officio member)
  - **4 lay members app by CE**
  - **3 lay members elected by patient organisations**
  - **1 lay member nominated by Consumer Council**
  - 2 nominated by Academy of Medicine (app by CE)
  - 2 Fellows nominated and elected by Fellows of the Academy of Medicine
  - 7 members of HKMA nominated and elected by HKMA Council
  - 7 elected by all doctors

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Committees of the Medical Council

- Health Committee
- Ethics Committee
- Licentiate Committee
- Education and Accreditation Committee
- Preliminary Investigation Committee

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Committees of the Medical Council

The "gate-keeper" : Preliminary Investigation Committee = PIC

- Serious case backlog; around 6 years on average to complete a complaint case from receipt to disciplinary inquiry
- Reform of the PIC as a result of the Medical Registration (Amendment) Ordinance

Committees of the Medical Council

After the Medical Registration (Amendment) Ordinance :

- More than 1 PICs
- In each PIC, 7 members, comprising 4 doctors and 3 lay persons
- 4 medical PIC members will be either a member of the Medical Council or a medical assessor
- 3 lay PIC members will be either a lay member of the Medical Council or a lay assessor
- Chairman and Deputy Chairman of each PIC are doctors
- Quorum : 3 (majority must be doctors; at least 1 lay member)

Committees of the Medical Council

Medical assessors & lay assessors

- The assessors are individuals who are not members of the Medical Council but have been appointed to sit in Inquiry and hear cases
- Before the Amendment Ordinance, assessors could only sit in Inquiry and could not participate in PIC.
- After the Amendment Ordinance, assessors can sit in both PICs and Inquiry Panels.

Committees of the Medical Council

Medical Assessor	Lay Assessor
Nominated by the following **8 nominating authorities** : (i) the Director of Health (ii) HKU (iii) CUHK (iv) Hospital Authority (v) Hong Kong Academy of Medicine (vi) Hong Kong Medical Association (vii) Hong Kong Doctors Union; and (viii) Hong Kong Public Doctors' Association	Nominated by the following **6 nominating authorities** : **(i) Patient Organisations** (ii) Hong Kong Bar Association (iii) The Law Society of Hong Kong (iv) Hong Kong Council of Social Service (v) Hong Kong Institute of Certified Public Accountants; and (vi) Secretary of Food and Health
Each organisation can nominate 2 to 10 medical assessors	Each organisation can nominate 2 to 10 lay assessors
Total number : 16 to 80	**Total number : 12 to 60**

Disciplinary Procedures at the Medical Council

Letter of complaint / Information

↓ (1st stage of screening)

Chairman or Deputy Chairman Preliminary Investigation Committee ("PIC") → may dismiss complaint if both Chairman and Deputy Chairman agree the case is **frivolous or groundless** and should not proceed further (after consulting a lay member's view)

↓ (2nd stage of screening)

PIC notice to doctor (with or without setting out the allegations)

↓

Meeting of PIC → no inquiry is to be held

↓ (public inquiry)

Inquiry Hearing → not guilty of professional conduct

↓

Found guilty - conviction and sentencing

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Disciplinary Procedure at the Medical Council

- Inquiry Panels (newly introduced)
  - Same disciplinary powers as the Medical Council
  - More than one Inquiry Panels (IPs)
  - Each IP will have 5 members, comprising 3 doctors and 2 lay persons.
  - The 3 medical IP members will be either a member of the Medical Council or a medical assessor. The 2 lay IP members will be either a member of the Medical Council or a lay assessor.

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Disciplinary Procedures at the Medical Council

- Inquiry hearing
  - Attended by a Inquiry Panel acting as "Judges" and assisted by a Legal Adviser
  - "Prosecutor" is the Secretary of the Medical Council assisted by a Legal Officer from the Department of Justice
  - "Mini trial" with witnesses, experts etc. for both sides
  - Press is invited

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Disciplinary Procedures at the Medical Council

Recent legal challenge against Medical Council
Law Yiu Wai Ray v. Medical Council of Hong Kong (2016)

- Minimized the initial screening role of Chairman and Deputy Chairman
- Restricted the role of PIC in screening cases
- PIC may only refuse to refer a case for inquiry if the complaint has no real prospect of being established
- High Court Judge: ***"It is not the role of the PIC to resolve any conflicts of evidence"***

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Role of Expert in MCHK proceedings

Depends on the charge against the doctor :-

- Usually no expert is needed for :-
  - Dangerous drugs records, prescription labelling, sick leave certificate management, practice promotion
- Expert may be needed for :-
  - Informed consent issues, appropriateness of treatment, management of patients, non-conventional treatment, indecent assault

Coroner's Inquests

Objectives :-

- Identify the deceased
- Investigate into cause of, and circumstances relating to, death
- Enter a verdict regarding cause of death (examples)
- Make recommendations if there are "dangers in the system"

No jurisdiction to find fault, negligence or responsibility (in theory)

Coroner's Inquests

Role of expert :-

- Opinion on the medical cause of death / management issues
  - On the basis of available evidence: medical records / reports, autopsy report, witness statements
- Suggestions to prevent future risks
  - Identify any "dangers in the system"
  - Avoid opining on individual doctor's clinical judgment / decision

Role of Expert in Other Situations

Personal Injury Claims and Mediation

- Expert opinion required to ascertain position in negligence (i.e. whether there was breach of duty)
- Examine patients for giving opinion on quantum (often involving orthopaedic surgeons, neurologists or psychiatrists etc.)

Criminal cases

- Expert is basically under the same onerous duty as in civil cases

Role of Expert in Other Situations

Probate cases :-

- Mental capacity examination (beware! Recommend referral to specialists)

Test of testamentary capacity

1. whether the testator understood the nature of the act and its effect; and
2. whether the testator understood the extent of the property being disposed; and

Role of Expert in Other Situations

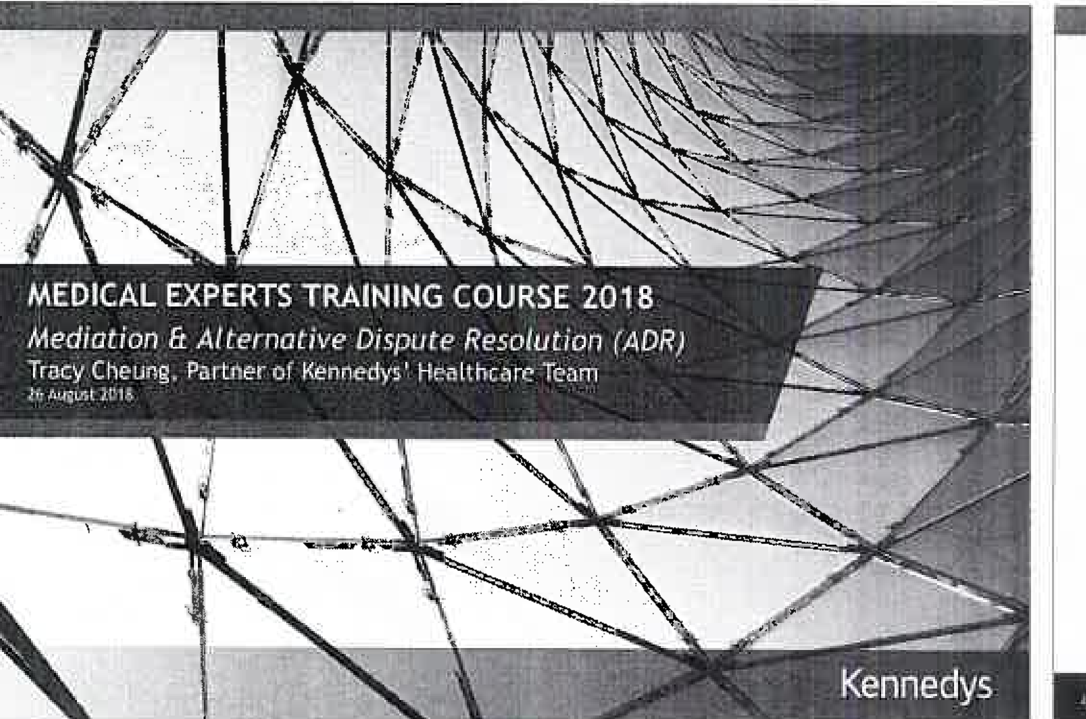
3. whether the testator's mind is sound to be capable of forming the testamentary intentions embodied in the will; and
4. whether the testator is affected by any disorder or disease of the mind which would influence his decisions.

Good attitude of experts

- Not to act as advocate for a party
- Not to be unduly critical
- Do not assume facts
- Avoid using hindsight wisdom

Thank You

-



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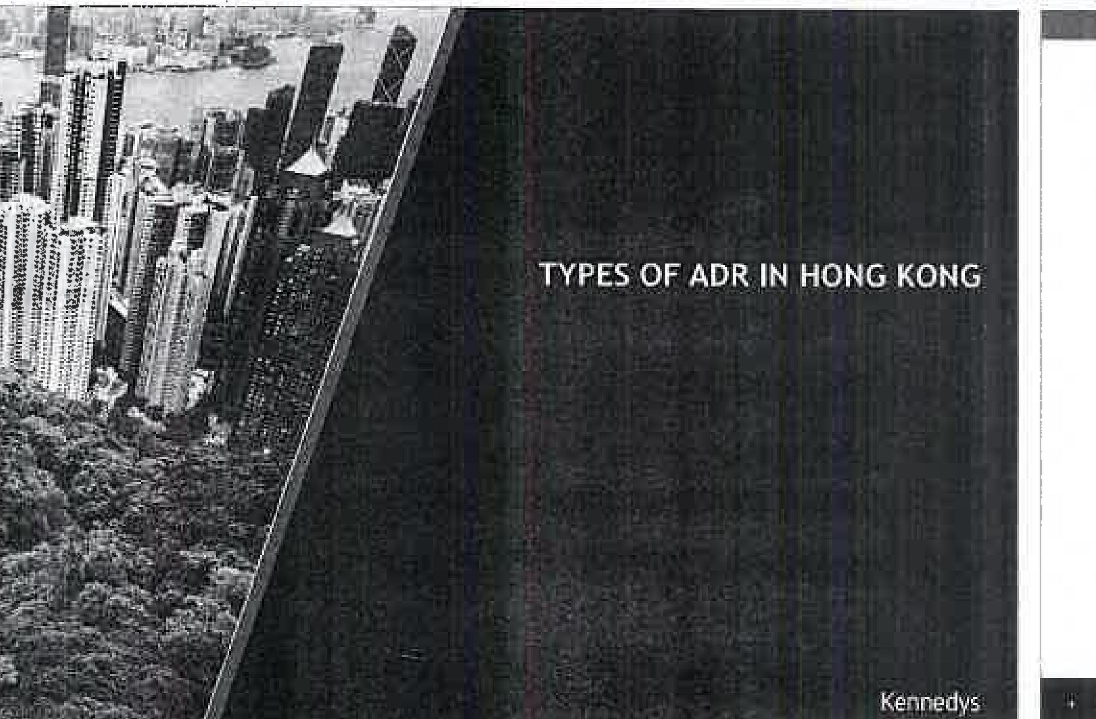

Types of ADR in HK

- *Alternative Dispute Resolution (ADR) refers to any means of settling disputes outside of the Courtroom*

Negotiation
Conciliation
Mediation

to achieve the important underlying objective of the Rules of the High Court & District Court to facilitate the settlement of disputes.

MEDIATION IN MEDICAL NEGLIGENCE LITIGATION AND PRE-ACTION PROTOCOL

Kennedys

Mediation

s.4 of the Mediation Ordinance

Mediation is a structured process comprising one or more sessions in which one or more impartial individuals, without adjudicating a dispute or any aspect of it, assist the parties to the dispute to do any or all of the following-

(a) identify the issues in dispute

(b) explore and generate options

(c) communicate with one another

(d) reach an agreement regarding the resolution of the whole, or part, of the dispute

- **Mediation Ordinance** - Passed on 22 Jun 2012
- **Practice Direction 31 on Mediation** - implemented on 1 Jan 2010
- **Practice Direction 18.1** - implemented on 2 Apr 2009
- Mediation is *not* mandatory in litigation but a party can be penalised on costs where it refused to attempt mediation without a reasonable explanation *(Wu Yim Kwong Kindwind v Manhood Development Limited, DCCJ 3839/2012, decision handed down on 24 July 2015)*

- Mediator - not a judge, impartial 3rd party
- Increase in medico-legal claims - in many cases arise from miscommunications and break down in dialogue between doctors/hospitals and patients/family members
- Mediator's role and process to assist parties to communicate & restore relationship
- Parties *must* agree to participate in mediation

Mediation Statistics for Civil Justice Reform related cases

- Summary of Mediation Reports filed in the **Court of First Instance**
  - In 2011, out of the mediated cases, 38% had resulted in agreements while 62% of the mediated cases did not lead to any agreement.
  - In 2017, out of the mediated cases, 48% had resulted in agreements, 52% of the mediated cases did not lead to any agreement, but out of which 102 cases eventually disposed of within 6 months. So, ultimately, the settlement rate was **61%**.

	2011	2012	2013	2014	2015	2016	2017
Total cases	[illegible]	766	779	805	833	778	1019
Cases which attempt mediation	421	575	637	632	645	666	780
Cases with full or partial agreement after mediation	159 (38%)	217 (38%)	286 (45%)	305 (48%)	294 (46%)	319 (48%)	376 (48%)
Cases with no agreement	262 (62%)	358 (62%)	351 (55%)	327 (52%)	351 (54%)	347 (52%)	404 (52%)
Cases not settled through mediation but disposed of within 6 months		49 (taking this into account -> 46%)	77 (taking this into account -> 57%)	106 (taking this into account -> 65%)	104 (taking this into account -> 62%)	104 (taking this into account -> 64%)	102 (taking this into account -> 61%)
Cases settled/ withdrawn/ discontinued without mediation	132	191	139	172	186	111	239
Others (e.g. mediation adjourned)	4	0	3	1	2	1	0

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Mediation Statistics for Civil Justice Reform related cases

- Summary of Mediation Reports filed in the **District Court**
  - In 2011, out of the mediated cases, 48% had resulted in agreements while 52% of the mediated cases did not lead to any agreement.
  - In 2017, out of the mediated cases, 43% had resulted in agreements, 57% of the mediated cases did not lead to any agreement, but out of which 52 cases eventually disposed of within 6 months. So, ultimately, the settlement rate was 58%.

	2011	2012	2013	2014	2015	2016	2017
Total cases	[illegible]	1712	1597	1479	1550	1369	1119
Cases which attempt mediation	259	349	441	397	388	361	343
Cases with full or partial agreement after mediation	124 (48%)	147 (42%)	186 (42%)	178 (45%)	185 (48%)	163 (45%)	147 (43%)
Cases with no agreement	135 (52%)	202 (58%)	255 (58%)	219 (55%)	203 (52%)	198 (55%)	196 (57%)
Cases not settled through mediation but disposed of within 6 months		33 (taking this into account -> 52%)	54 (taking this into account -> 54%)	78 (taking this into account -> 65%)	59 (taking this into account -> 68%)	54 (taking this into account -> 60%)	52 (taking this into account -> 58%)
Cases settled/ withdrawn/ discontinued without mediation	806	1362	1154	1078	1158	1003	773
Others (e.g. mediation adjourned)	5	1	2	4	4	5	3

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Mediation track record

Speed - most mediations last for one day

Outcome - over 75% settle on the day

Of the mediations that do not settle on the day, many settle shortly afterwards

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Litigation Vs Mediation

Litigation	Mediation
Adjudicative	Consensual
Compulsory	Voluntary
Binding outcome	Outcome by agreement
Rules	Flexible
Rights	Interests
Retrospective	Present/future
Lawyer-centred	Client-centred
All or nothing	Range of options
Years	Weeks
Open to public	Confidential

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Mediation in medico-legal claims

- An underlying objective of the rules of the court is to *facilitate settlement of disputes*
- Parties to file *Mediation Certificates* indicating if they are willing to attempt mediation
- Applicant to file a *Medication Notice* proposing how he wishes to conduct the mediation (including choice of mediator, venue, date & timings, mediation rules etc)
- Respondent to file a *Mediation Response*
- Parties to compile a *Mediation Minute*
- Mediation - settlement agreement, if any.
- Parties to file a report to the Court on the outcome

Advantages of mediation

- Expedites resolution of disputes through open dialogue between the parties with a mediator as a neutral facilitator
- All communications at mediation are kept *confidential*
- Promotes communications, expressions of empathy & goodwill
- Saves on legal costs
- Non-adversarial process
- Psychological benefits: venting, acknowledgment of feelings, acceptance & enable parties to move on.
- Can *restore* the doctor-patient relationship and ***re-establish trust***

During the mediation...

The Mediator will:

- Encourages open & free communications in joint sessions
- Get parties to do most of the talking, if appropriate
- Help generate options for settlement that meet both sides' objectives
- Draft and ensure all points are covered adequately in a settlement agreement

Parties can ask for separate sessions with the Mediator

To prepare for mediation the following are *helpful* documents/aids:

- Chronology of dispute
- List of main legal/other issues
- List of objectives
- Possible outcomes
- Best/worst case alternatives
- Costs implications of the alternatives
- *"What is their final position or bottom line?"*

HONG KONG MEDIATION CENTRE

Hong Kong Mediation Centre (HKMC)

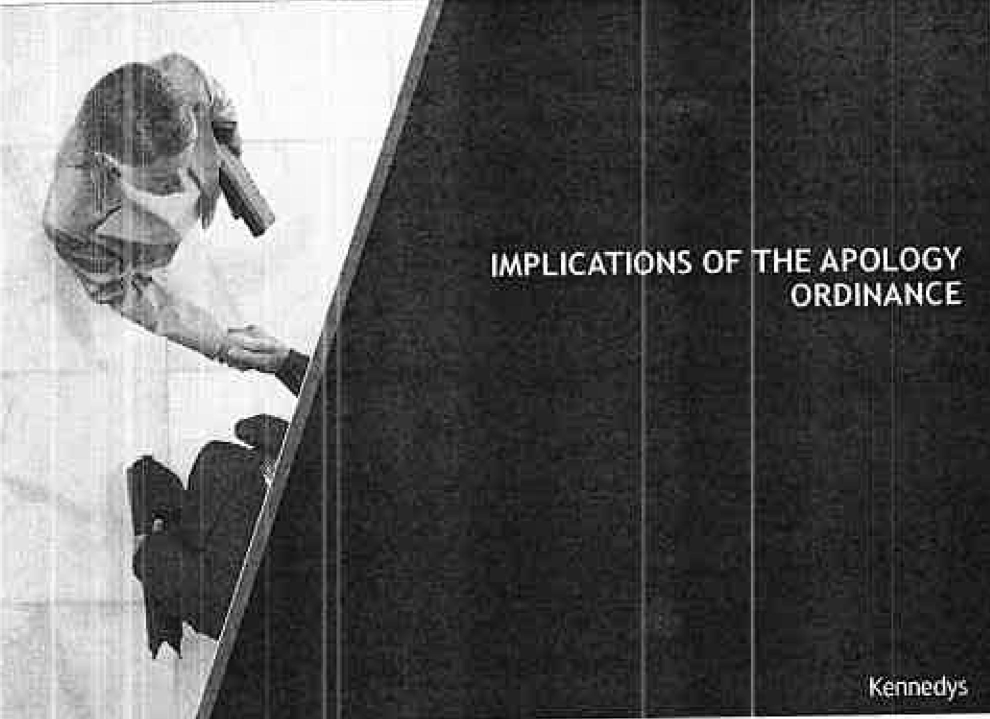
- Established in 1999 as the first non-profit corporate mediation institution with charitable status in Hong Kong
- To promote mediation & development of mediation services, particularly in community mediation, through education and use to resolve disputes
- 800 General Accredited Mediators in HKMC from different professions including healthcare.
- Provides professional training for accredited panel of mediators & ensures quality through continuing professional development
- Provides English and Chinese mediation services

- The Council and working committees formulate HKMC's policy, direction and make important decisions
- Will continue to be committed to the development within China, Hong Kong, Taiwan and Macau.
- To strengthen the co-operation with the mediation and arbitration organisations in the Mainland, facilitate the development and exchange of ideas between the Mainland and Hong Kong through the newly established *"Guangdong, Hong Kong and Macau Commercial Mediation Alliance"*, in order to extend mediation in Hong Kong throughout China.
- HKMC will promote Hong Kong as a major mediation centre within Asia-Pacific through the close connection and collaboration with overseas mediation organisations and arbitration bodies in the region.

MEDIATION IN COMPLAINT RESOLUTION

Mediation in Complaint Resolution

- Principles of mediation and facilitative model
- Adopt mediation as a life-long skill and way of life to resolve disputes
- Early mediation at complaint stage
- Focus on interests, rather than positions
- Encourage open communications and disclosure to explore options beneficial to both parties going forward to achieve a "win-win" situation



Implications of the Apology Ordinance

- The Apology Ordinance will come into operation on 1 Dec 2017

Purpose

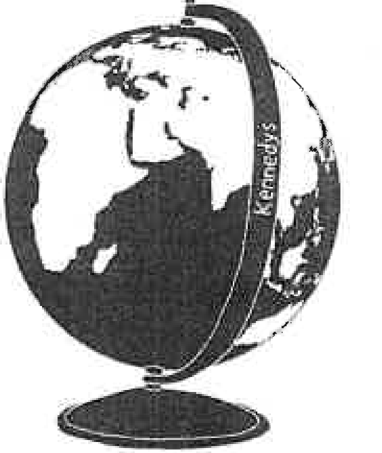
- *"To promote and encourage the making of apologies with a view to preventing the escalation of disputes and facilitating their amicable resolution"* (s.2)

Definition

- Distinguishes an apology from liability in law
- An apology is made by or behalf of a person in connection with a matter and means an *expression of the person's regret, sympathy or benevolence* in connection with the matter (s.4)
- It does not constitute an express/implied admission of a person's fault or liability and must not be taken into account in determining fault or liability (s.7)

- But the decision maker of the judicial, disciplinary and regulatory proceedings has the *discretion to admit a statement of fact contained in the apology as evidence* in the proceedings, *but only if s/he is satisfied that it is just and equitable to do so, having regard to the public interest or the interests of the administration of justice* (sections 8(2) and (3)).
- An apology may be *oral, written or by conduct* made after the commencement date of the legislation in *applicable proceedings* (s.6)
- It will *not* void or affect any insurance cover, compensation or other form of benefit under the contract of insurance/indemnity regardless of whether the contract was entered into before or after commencement date of the legislation (s.10)
- http://www.kennedyslaw.com/article/apology-legislation-passed/
- http://www.kennedyslaw.com/article/apology-legislation-update/
- Implications of the

Kennedys worldwide



Kennedys is an international law firm with specialist expertise in litigation/dispute resolution and advisory services. Our growing network of offices delivers straightforward legal solutions to our clients.

Our healthcare team provides dedicated advice for Medical Protection Society, Hospital Authority, doctors, hospitals and other healthcare practitioners on clinical negligence and health law issues. Apart from Hong Kong, we also advise doctors, hospitals and insurers in the United Kingdom, Australia, Ireland, Spain, Singapore and USA, Latin America and the Caribbean.

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HowseWilliamsBowers

ALEXANDRA HOUSE

Role play - Courtroom skills and giving evidence in court

Medical Experts Training Course
26 August 2018

HowseWilliamsBowers

Examination in Chief vs Cross examination

Evidence in Chief	Cross examination
Questions from your instructing lawyer	**Questions from the opposition's lawyer**
You will be asked to go through your qualifications and expertise	You may be challenged on your expertise
You will be taken through your expert report and asked to confirm its contents	**You may be asked to clarify answers given in examination in chief or challenged insofar as those answers are not consistent with the report**
You will be asked about the basis of conclusions reached in your expert opinion e.g. breach of duty, causation, extent of injuries etc.	You may be challenged on the basis of how you came to your conclusions e.g. whether there is sufficient evidence basis

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Cross examination Role Play

- Refer to Dr. James Genius' expert report about the Defendant Dr. Zed's management of the Plaintiff Madam Sally Porsche dated 1 September 2011
- Whilst Dr. Genius is being cross examined by Counsel for the Plaintiff, try to identify learning points on the following themes:
    - Conflict of interest
    - Credentials, expertise and documents relied upon
    - Evidence basis

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Cross examination Role Play

Conflict of Interest

- There may not be a conflict of interest even if the expert witness has previously worked with the Defendant.
- As each case is different, discuss with your instructing solicitors at the time of being instructed if you are concerned that there could be conflict.
- Be prepared to explain to the Court why there is no conflict of interest.

Cross examination Role Play

Credentials, expertise and documents relied upon

- There should be no surprises during cross-examination with respect to your credentials if your report/CV are accurate.
- Do not stray beyond your area of expertise.
- If you have referred to additional documents since writing your expert report then provide a supplemental report where possible and during your evidence make it clear that you referred to those documents when preparing your report/supplemental report.

Cross examination Role Play

Evidence basis

- Justify your supporting evidence for your opinion or the lack of it.
- Avoid attacking the opposition's expert and acknowledge that there may be alternatives where appropriate.
- Try to use contemporaneous evidence as a basis for your opinion i.e. evidence from around the time of the incident.
- Be prepared to discuss the Bolam standard.

Cross-examination Dos and Don'ts

Do:

- Read your report before you attend court
- Remember that it is not a personal attack
- Be prepared to justify your evidence
- Remain courteous
- Be objective and acknowledge that there may be alternatives
- Do say that you don't know or admit that something is beyond your area of expertise where appropriate
- Address the judge appropriately
- Seek assistance from the judge e.g. where you have been asked several questions at once ask if you can answer one at a time

Cross-examination Dos and Don'ts

Don't:

- Don't be evasive or aggressive
- Don't get into an argument when justifying your evidence
- Don't talk about irrelevant matters when giving answers
- Don't be lead into giving answers which are beyond your area of expertise

Howse Williams Bowers

Thank You

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MORE THAN DEFENCE

A Guide to Writing Expert Reports

Advice correct as of October 2017

HONG KONG

As an expert you should be aiming to produce a report which is free standing – from which the reader can glean the key issues in the case, understand the evidence available and reach a clear understanding of the range of expert opinion, without needing to look at any other document.

What should a good report include?

1. A title page – including:
   - the date of the report
   - the date of the examination
   - the identity of the parties to the action
   - the full name (and date of birth) of the plaintiff
   - the party providing the instructions
   - the nature of the report.
2. Numbered pages, short numbered paragraphs and appropriate subheadings.
3. Your personal details, name, current post and summary of previous experience.
4. Statement of the opinion you have been asked to provide and details of your relevant knowledge/experience enabling them to comment on the issues.
5. List of documentation considered and relied upon in reaching your opinion on the case.
6. Chronology and summary of the relevant evidence:
   - Giving exact dates wherever possible.
   - When referring to important parts of the records, quoting relevant entries verbatim, if possible (identifying it as a direct quote – eg, by the use of italics).
   - Identifying disputed facts and stating the sources of the information set out eg, "history given on admission to hospital on 01.02.2005".
   - Explaining relevant technical terms and abbreviations.
   - Reviewing the evidence for a sufficient period of time before and after the incident/period of alleged negligence – to put the events in context and highlight other relevant features of the history.
7. Where you have undertaken an examination or performed other investigation(s):
   - say who carried out any examination, measurement, test or experiment which you have used for the report, give qualifications of that person, and say whether or not the test or experiment has been carried out under your supervision
   - record relevant positive and negative findings
   - maintain a clear distinction between the history given, the history recorded in the records, your own findings and your interpretation of those findings
   - focus on the significance of the findings for the plaintiff's everyday life
   - give timescales for probable improvement/deterioration, treatment options available etc
   - refer back to the claimant's pleadings, if appropriate, to ensure that all relevant matters have been addressed.

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8. The opinion

- Comment on each question or allegation of negligence separately quoting the question or allegation whenever possible.
- Where the question/allegation appears to repeat or overlap with another or seems misdirected, explain why and refer to other relevant paragraphs.
- Justify the conclusions reached by reference to the evidence in the case, your specialist knowledge and any published references you relied on.
- When dealing with an issue on which there are a range of opinions, provide reasons for the view expressed and state those opinions.
- Where you take sides in an area of factual dispute, give an explanation of why you favour one version over another.
- Where there is evidence undermining your opinion, outline that evidence and explain why it is not persuasive.
- When commenting on the opinions of other experts:
- summarise the areas of agreement and disagreement
- point to evidence supporting or undermining the views given
- avoid giving a view on matters outside your area of expertise
- remain focused on the facts of the particular case
- confine your report to the scope of your instructions and your own expertise
- distinguish between questions of fact and of opinion
- distinguish clearly between known facts and assumptions made.

9. The concluding paragraph:

- Avoiding further repetition of the facts but summarising the opinions reached.
- Returning to the issues you have been asked to consider and/or the pleadings, to make sure that an opinion has been given on all relevant matters with proper attention to the legal tests to be applied.
- Conclude with a statement of truth.

For medicolegal and membership enquiries: T 800 908 433 (Freecall) | E querydoc@medicalprotection.org

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Howse Williams Bowers, T (2) 803 3688

Kennedys, T (2) 848 6300 | F (2) 848 6333

This factsheet provides only a general overview of the topic and should not be relied upon as definitive guidance. If you are an MPS member, and you are facing an ethical or legal dilemma, call and ask to speak to a medicolegal adviser, who will give you specific advice.

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MPS Medical Experts Training Quiz

Test your knowledge – how much do you understand of medical law and of the medicolegal world? Do you know the answers to these questions?

1. What 3 conditions must be satisfied before a doctor is considered to be negligent?
2. What is the *Bolam Test*?
3. What is the highest court of appeal in HK?
4. What is the role of the Medical Council?
5. What is the aim of a coroner's inquiry?
6. How is civil law different from criminal law?
7. Why and when was MPS formed? How long has MPS been in HK? Name 3 things that is special about MPS?
8. What are special damages and general damages?
9. What is the difference between a *professional witness of fact* and an *expert witness*?
10. What is vicarious liability?
11. What is the standard of proof applied in a criminal trial?
12. Can an apology be considered an admission of liability?
13. What do you understand by the term *Limitation period*?
14. When is a patient's consent not valid?
15. What is the difference between a liability expert and a quantum expert?
16. Is there a role for mediation or ADR in resolving claims? How is it used?
17. When may a doctor be at risk from a criminal investigation/of gross negligence manslaughter?
18. When are aggravated damages awarded by the court?
19. What is a pre-action protocol in the context of a civil claim?
20. When is an application for a Judicial Review indicated?

These are some of the areas covered during the medical experts training. I suggest you test yourself again at the end of the training to see if you have learnt something!

How much have your scores improved?

TRAINING COURSE FOR
MEDICAL EXPERTS

Your opportunity to ask Medical Protection a question.

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What should we do:

Start doing?

Continue doing?

Stop doing?

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Workshop Feedback

Please complete each section and pass it to your presenter before leaving.

Event ID
203849

About you	Place an X in the relevant boxes to indicate which of the following most closely corresponds to your current role		
Professional status	General practitioner ☐	General practitioner in training ☐	Hospital doctor in training ☐
	Consultant/Specialist in either a hospital or private practice ☐	Non specialist hospital/private doctor ☐	Nurse ☐
		Other role (please specify): ☐	

Please place an X in the relevant box for each of the following statements	Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
The presenter was able to effectively convey the concepts and ideas	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The event's learning objectives were met	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The overall organisation of the event was of a high standard	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The presenter's explanation and handling of exercises and activities were effective	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The overall quality of workbooks/course materials was of a high standard	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
I am likely to change something in the way I practise as a result of this workshop	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
I would consider undertaking future Medical Protection educational events	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The presenter showed a high level of skill in managing the group	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The event's content was interesting	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The event's content was relevant to me	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
I would recommend this Medical Protection educational event to my colleagues	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The booking process was easy	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
The presenter was courteous and respectful	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
This event was worthwhile attending and met my learning needs	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐

How likely would you be to recommend Medical Protection to your professional colleagues?

Very Unlikely										Very Likely	
0	1	2	3	4	5	6	7	8	9	10	No viewpoint
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Have you completed both sides?

Please turn over

Please place an X in the relevant boxes to indicate your scheduling preferences			
When would be the most suitable time to attend future events?	Morning ☐	Afternoon ☐	Evening ☐
	Weekday ☐	Saturday ☐	Sunday ☐

Please place an X in the appropriate box for each of the following questions			
Was the duration of the session/activity	Too long ☐	Just right ☐	Too short ☐
Was the pace of the session/activity	Too fast ☐	Just right ☐	Too slow ☐
Was the level of difficulty of the content	Too easy ☐	Just right ☐	Too difficult ☐

We would appreciate any comments you would like to make regarding the handling/management of the workshop by the presenter.

Do you have any comments on the content of the event?

Any other comments on how we can improve the event?

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Tel: +61 (0)7 3511 5055 | Email: apeducation@medicalprotection.org | Website: medicalprotection.org

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HKMA-MPS Medical Experts Training Course 2018 – Lecture Feedback Form

Thank you for attending the Medical Experts Training Course 2018. Your comments and feedback will be most valuable for the Association to review our Programme.

Date of lecture attended: ____________________

1. On a scale of 1-5 with 5 indicating maximum convenience/ quality/ suitability/ usefulness, how would you rate the lecture in the following areas?

Please tick

About the lecture	5	4	3	2	1
a. Clarity of message	□	□	□	□	□
b. Whether content is up-to-date	□	□	□	□	□
c. Usefulness of message	□	□	□	□	□
General arrangements					
e. Time	□	□	□	□	□
f. Venue	□	□	□	□	□
g. Quality of catering service	□	□	□	□	□
h. Other facilities: e.g. car parking, transportation	□	□	□	□	□

2. What was the highlight of the training course?

____

3. What other CME topics would you suggest for future CME lectures?

____

4. What other venues/time/day would you suggest for future CME lectures?

Venue/Area : ____________________

Time : ____________________

Day *(Please tick)* : □ Mon □ Tue □ Wed □ Thu □ Fri □ Sat □ Sun

5. Please indicate other areas of improvement we can make in future lectures.

____

Please indicate your type of practice. *(Please tick)*

1. □ In Private Practice
   □ In Public Service
   □ Others (Pls state): ____________

2. □ GP
   □ Specialist
   Specialty: ____________________

Thank you for your valuable comment.

Please return the evaluation sheet to the registration counter after the lecture.

MPS Medical Experts Training Course 2018

Quickfire Quiz Answer Sheet

Instructions : Let's see how much you have picked up in the two-day training course!

There are 20 multiple choice questions in this Quickfire Quiz. Please put a tick in the box next to the correct answer. After you have completed the Quiz, please exchange your completed Answer Sheet with your neighbour for marking. The answers will be read out. Prizes will be given to the top scorers!

Level 1

1. Before a complaint is referred to the Medical Council for an inquiry, it is first considered by?

- ☐ (a) The Health Committee
- ☐ (b) The Ethics Committee
- ☑ (c) The Preliminary Investigation Committee
- ☐ (d) The Education and Accreditation Committee

2. Which of the following is a form of Alternative Dispute Resolution?

- ☐ (a) Mediation
- ☐ (b) Arbitration
- ☐ (c) Negotiation
- ☑ (d) All of the above

3. Which of the following tests are considered by the Court in determining whether there was a breach of the doctor's duty of care in treating a patient?

- ☐ (a) The reasonableness test
- ☑ (b) Bolam test
- ☐ (c) The common sense approach
- ☐ (d) Montgomery test

4. What is the definition of "misconduct in a professional respect"?

- ☑ (a) The doctor's conduct has fallen short of the standard expected among doctors.

☐ (b) The doctor's conduct has violated the Code of Professional Conduct issued by The Medical Council of Hong Kong.

☐ (c) The doctor's conduct has fallen short of the standard expected by a reasonable patient.

5. In which of the following situations a party may be allowed to change his medical expert?

☑ (a) The issue is outside the expertise of the original expert.

☐ (b) The expert is not supportive of the instructing party.

☐ (c) The expert fee is too high.

Level 2

6. You are instructed to be an expert for a Coroner's Inquest involving a private doctor and a public hospital. The patient's family has raised concerns about the private doctor's management. Which of the following is correct?

☐ (a) To address the family's concerns, you may comment on whether there was any negligence on the part of the private doctor.

☐ (b) Regardless of the family's concerns, you should remain neutral and comment on the liability of both the private doctor and the public hospital.

☑ (c) The purpose of the Coroner's Court is not to determine issues of liability.

7. What should a liability expert in a medical negligence claim comment on?

☑ (a) Whether the doctor's clinical management has fallen below the reasonable standard

☐ (b) How much the patient should be paid

☐ (c) The patient's prognosis

☐ (d) Whether there was professional misconduct on the doctor's part

☐ (e) All of the above

8. What should an expert do when there is a factual dispute between the plaintiff and the defendant?

☐ (a) Comment on which factual account is more likely true

☑ (b) Comment on clinical management based on the factual accounts of both the plaintiff and the defendant

☐ (c) Avoid commenting on the issue

9. What is the appropriate thing to do when experts preparing a joint report have different views?

☐ (a) The experts should try their best to come to a consensus except in special circumstances.

☑ (b) The experts can separately state their views giving reasons for their disagreement.

☐ (c) The experts should prepare separate individual reports detailing their reasons for their disagreement.

☐ (d) The experts should seek direction from the Court to resolve their differences.

10. In what circumstances would the Chairman and the Deputy Chairman of a Preliminary Investigation Committee dismiss a complaint without issuing a PIC Notice to the doctor?

☐ (a) If the complaint is too vague

☐ (b) If the complaint is brought against the doctor beyond the statutory limitation period

☑ (c) If the complaint is frivolous or groundless

☐ (d) If the complainant could not be identified

Level 3

11. The Estate of a deceased patient intends to bring a medical negligence claim for HK$2.7 million next year. In which Court should the claim be brought?

☐ (a) Small Claims Tribunal

☑ (b) District Court

☐ (c) Court of First Instance of the High Court

☐ (d) Coroner's Court

12. Which of the following is a sanction that the Medical Council CANNOT impose?

☐ (a) Order the removal of the doctor's name from the Specialist Register permanently

☐ (b) Reprimand

☐ (c) Costs order against the defendant doctor

☑ (d) Order the removal of the doctor's name from the General Register and that the order be suspended for 42 months

13. To comply with the pre-action protocol in the Court's Practice Direction, what must a patient do before commencing a medical negligence claim against a doctor?

☐ (a) Instruct solicitors

☐ (b) Lodge a complaint to the Medical Council

☑ (c) Send a letter of claim to the doctor

☐ (d) Request copies of the doctor's clinical records

14. Under the Apology Ordinance, an apology is still admissible as evidence in :

☐ (a) Civil proceedings

☑ (b) Criminal proceedings

☐ (c) Medical Council disciplinary proceedings

☐ (d) Judicial review

☐ (e) None of the above

15. Which of the following is not a duty of the jury in a Death Inquest?

☐ (a) To identify the name of the deceased

☐ (b) To reach a verdict on the cause of death

☑ (c) To ask witnesses questions about the witnesses' evidence

☐ (d) To make recommendations on how the system can be improved

Level 4

16. Claims for medical negligence should generally be commenced in which Court List?

☐ (a) The Tort Action List

☐ (b) The Civil Action List

☑ (c) The Commercial Action List

- [ ] (d) The Miscellaneous Proceedings List
- [x] (e) None of the above

17. Which Practice Direction is applicable to claims of medical negligence?

- [ ] (a) Practice Direction 1.8
- [ ] (b) Practice Direction 8.1
- [ ] (c) Practice Direction 18
- [x] (d) Practice Direction 18.1

18. In 2000, a baby was born with cerebral palsy due to a doctor's negligence and has remained mentally incapacitated. When is the latest the baby can bring a civil claim for medical negligence against the doctor?

- [ ] (a) 2003
- [ ] (b) 2018
- [ ] (c) 2021
- [ ] (d) 2022
- [x] (e) None of the above

19. An expert report used in civil proceedings must be verified with a Statement of Truth. Which of the following would be an appropriate Statement of Truth?

- [x] (a) I believe that the facts stated in this expert report are true and the opinion expressed in it is honestly held.
- [ ] (b) I declare that the opinion expressed in this report is true and unbiased.
- [ ] (c) I solemnly swear that the opinion expressed in this report was prepared based on true facts in an impartial manner.
- [ ] (d) This is a true and honest copy of my expert report.
- [ ] (e) In the capacity of an expert witness to the Court, I hereby honestly and impartially verify this expert report with a Statement of Truth.

20. Which of the following about the new composition of the Medical Council after the Medical Registration (Amendment) Ordinance 2018 is NOT correct?

- [x] (a) 3 lay members will be nominated by the Patient Organisations.
- [ ] (b) 1 lay member will be nominated by the Consumer Council.

☐ (c) 2 medical members will be nominated by the Academy of Medicine and appointed by the Chief Executive.

☐ (d) the Director of Health and the Chief Executive of the Hospital Authority (or representatives chosen by them) will be members of the Medical Council.

- End of the Quickfire Quiz -