

Medico Legal Case Commentary: Interface Between Clinical Opinion and Legal Case Reporting in Personal Injury Litigation

Hugh Koch¹

¹Chartered Clinical Psychologist and Director, Hugh Koch Associates, Cheltenham, UK.

Corresponding Author: Hugh Koch, Chartered Clinical Psychologist and Director, Hugh Koch Associates, Cheltenham, UK,

Tel: 0039-050-2216837; **Email:** hugh@hughkochassociates.co.uk

Received Date: 01 Apr 2016

Accepted Date: 15 Apr 2016

Published Date: 28 Apr 2016

Copyright © 2016 Koch H.

Citation: Koch H. (2016). Medico Legal Case Commentary: Interface Between Clinical Opinion and Legal Case Reporting in Personal Injury Litigation. M J Case. 1(1): 005.

ABSTRACT

The history of clinical and medico-legal report case preparation is summarised. The development of an innovative medico-legal commentary is described as a method of exploring the interface between clinical opinions and legal case reports in the field of UK civil and criminal litigation. A pilot study to develop the process of documenting psychologically-relevant commentaries is illustrated with a subsequent plan for its development outlined.

KEYWORDS

Clinical Reporting; Medico-legal Reporting; Civil Litigation; Criminal Litigation; Medico-legal Commentary.

INTRODUCTION

The science of medicine and its related professions has an interesting relationship with the laws of evidence. Medical experts attempt to show the relevance of their clinical experience to litigation and occasionally the court room, drawing on their work in assessment and treatment within a clinical setting. Clinically, concepts of 'proof' and 'causation' exist but not to the same level of evidential stringency as they do in litigation. Effective treatment is predominantly linked to more accurate current symptoms assessment than to background history taking, although of course the latter is also important a motivated 'patient' with current symptoms can utilise therapeutic intervention to good effect despite its chronicity. However, as the clinician moves into the medical-legal context, the issues of causation, attribution and reliability come much more into sharp focus and, here, they have had much to learn from the legal colleagues. Whereas clinicians thrive on multiplicity of disease theories and treatments, lawyers typically aim for uniformity and avoidance of disparity, regarding numerous medical viewpoints as contradictory and confusing.

Clinicians are experienced in preparing clinical reports in order to communicate individual patient care findings to other clinicians, their patients and other appropriate organisations.

These reports typically include symptom description, development and causation, diagnosis, course and duration, and prognosis and treatment. Guidelines for psychological clinical case reports, in particular, are available in the literature [1]. Clinicians also communicate their clinical findings to other clinicians via case reports published in professional journals. Guidelines are frequently available on how to prepare these reports [2].

When working in a medico-legal context either in civil or criminal proceedings, clinicians acting as 'expert witnesses' produce medico-legal reports attesting to the extent of physical or psychological injuries which may or may not have caused by a negligent act of another or others (e.g. road accident, work accident, medical accident). In the purely clinical report, emphasis is placed more on diagnosis and treatment. In the medico-legal report, requiring a more independent and impartial stance, greater emphasis may well be placed on causation and attribution, in addition to diagnosis, treatment and prognosis.

From a legal perspective, cases which in the UK are brought within a context such as employment law, family law or personal injury law at various levels of Magistrates Courts, County Courts, Crown Court, High Court and Court of appeal are frequently written up and published ([www.bailii.org/ew/cases](http://www.bailii.org/ew/cases;);

www.PIBULJ.com) to illustrate ‘precedents’ or ‘authorities’. In common law legal systems, a ‘precedent’ or ‘authority’ is a principle or rule established in a legal case that is either binding on or persuasive for a court or other tribunal when deciding subsequent cases with similar issues or facts. Common law legal systems place great value on deciding cases according to consistent rules so that similar facts yield similar and predictable outcomes. More details of this can be found in Wikipedia and Black’s Law Dictionary. For example, a short summary of a case in 1999 is given below (Figure I).

Figure I

Pre-Existing Difficulties

Thrul v Ray (Burton J) 1999 unrep Queen’s Bench Division.

Claimant injured in a road traffic accident, had pre-existing learning difficulties, personality disorder and schizophrenia. Mental state unaffected by accident. Consideration of extra cost to assist socialisation, taking the claimant ‘as one found him’.

This interesting case clearly has pertinent psychological issues including diagnosis, pre-existing disorder and duration, ‘thin’ or ‘crumbling’ skull issues, cognitive appraisal of symptoms and prognosis.

Therefore, in the medico-legal field of personal injury and medical negligence litigation, there is the circumstance that lawyers and clinicians within their own independent professions deliberate and publish their findings to further educate and inform their colleagues but do so separately. Typically, however, the language and phraseology used by each, respectively, does not translate as easily as might be desirable to facilitate cross-fertilisation of information, procedures and logicity.

Towards the Medico-Legal Commentary.

A group of clinical psychologists experienced in conducting medico-legal psychological assessments in the UK typically in the area of personal injury and medical negligence litigation have begun a pilot study to develop a process by which psychological theory and practice can be considered and applied to the understanding of the psychological implications of legal case precedents, authorities and general descriptions of cases.

This pilot study followed earlier publications of psycho-legal issues in 1999 and 2000 when the author published two litigated cases, one clinical (covering somnambulism, the features of sleep walking, and issues of agreement (see Figure II) and one civil case [4]; Jointly instructed expert, chronic pain, reliability of evidence, see Figure III).

Figure II

Somnambulism – simple and complex behaviour – effect of alcohol – duty of care – rigorous psychological assessment. (Somnambulism: Regina .V. Turner). January 1999
Mr Kevin Jones of Howells, Sheffield, for the defendant.

This case arose out of a crown prosecution for driving under the influence of excess alcohol for which the defence was somnambulism (‘sleepwalking’). The case law in this area historically has suggested mixed fortunes for such a defence.

The Accident

The defendant, a female aged 28 at the time of the accident, was involved in a road traffic accident at 1:00am on 27 June 1998 in Rotherham. She was found by the police in a distressed and incoherent state with multiple cuts and abrasions. Weather and road conditions were fine. No other vehicle was involved. She was breathalysed and later provided a blood specimen, both of which were positive for excess alcohol. The defence claim was of involuntary sleepwalking.

The Evidence

Expert psychological evidence (Dr H Koch) found no evidence prior or current (post-accident) psychological disorder and no pre-existing stresses. There was a history of sleepwalking within the confines of her home involving simple motor behaviour e.g. walking, dressing. She had been aware that alcohol intake increased the frequency of this behaviour.

The following characteristics were typical of sleepwalking: the accident occurred during the first third of her night’s sleep; she was unresponsive to communication shortly after the accident, and unaware of her surroundings and had minimal recall of the antecedents of the accident. Differential diagnoses were:

1. Non-insane automatism/somnambulism (sleepwalking)
2. Dissociative state
3. Malingering

A dissociative state was rejected as no personality disorder existed and the duration of the episode was brief and there was no previous dissociative-like behaviour. Malingering was rejected as there were no overt or covert signs of untruthfulness or unreliability and no magnification of evidence. The evidence was consistent with somnambulism. The ‘duty of care’ issue, and 3mm her pre-accident drinking, was not thought relevant as she had never before preformed ‘complex’ motor tasks whilst asleep and therefore did not feel her previous sleepwalking was a significant problem.

The Outcome

It was argued that the appropriate outcome should be an acquittal on the grounds of non-insane automatism/somnambulism. The expert evidence after due consideration, and presumably expert review, was accepted and the prosecution case dropped.

Comment

Defences of sleepwalking are being constructed in other areas of behaviour e.g. sexual behaviour, indecent assault. Somnambulism is a discreet condition which requires careful assessment as do duty of care issues.

Figure III

Jointly Instructed Experts

(From an article in PMILL 2000 by Dr Hugh Koch).

Bishop -v- Doves Plc (30 March 2000 – unreported).

The claimant, a Motor Vehicle Technician, slipped in December 1995, at work, and lost his balance, feeling a wrenching sensation. He worked for two months and he was then signed off work.

Fifteen medical reports presented a mixed picture ranging from physical injury, ‘employment disadvantage’, needing psychological treatment, at one end, to ‘Problematic Diagnoses’, no identifiable physical causes for ongoing symptoms, inconsistent findings, and ‘exaggeration of symptoms’, at the other end.

I am experienced in Chronic Pain and was jointly instructed by both parties to examine the claimant as a pain specialist had suggested psychological treatment might help the claimant cope more successfully with his symptoms, and ultimately, return to work.

At interview, there was considerable pain behaviour (verbal complaints, non-verbal gasps, facial grimaces, impaired standing and sitting) linked to his report experience and display of ‘significant chest discomfort’. He tended to ‘protect’ himself with his arm ‘in case’ he felt pain on movement.

There was evidence of mood disturbance reactive to continuing pain with symptoms of sleep disturbance, treated by his General Practitioner with antidepressants. He reported social withdrawal due to pain. He described an interaction between his pain tolerance and general stress e.g. arguments made his pain experience worse, as did the ongoing litigation. His pain ratings and use of pain coping strategies if taken at face value, were consistent with an overall diagnosis of a ‘Pain Disorder with mixed psychological and physical factors, (DSM IV 307.89)’, attributable to the accident. Cognitive Behavioural Psychotherapy was recommended within the context of a pain management approach. A return to work in 6-12 months was predicted.

This diagnosis was based on interview data with the caveat of being open to reconsideration if any other ‘external information’ became available.

Video surveillance emerged which illustrated the Claimant walking near his house and in a supermarket. The overt pain behaviour seen at interview was not evident in this video evidence. In the light of this discrepancy, I had to question the reliability of the data made available to me and I concluded that although the Claimant had a physical pain experience interacting with mood variability, it no longer met the criteria for a Pain Disorder.

At the Court Hearing, the author (Hugh Koch) was questioned in detail by both Counsel. The Claimant’s Counsel suggested:

1. There was little or no difference between the interview presentation and the video data. Hugh Koch disagreed.

2. The claimant was not a malingerer. Hugh Koch agreed, but with reference to DSM IV Definition of a Malingering Disorder.

Counsel for the Defendant suggested:

1. There was a significant difference between the interview presentation and the video data. Hugh Koch agreed this in part.
2. The Claimant was a malingerer. Hugh Koch acknowledged exaggeration but not a diagnosis of Malingering Disorder.
3. The Claimant could work and did in fact try for work. Hugh Koch agreed.

During Hugh Koch questioning by both Counsel and the Judge, Hugh Koch briefly outlined a dimension of Chronic Pain/Reliability, which is outlined below:

High Pain: High Psychological Problems, High Consistency. ‘Pain Disorder’.

Some Pain: Some Psychological Problems, Inconsistencies, Exaggerations. ‘Mixed Cluster. No Clinical Disorder’.

No Pain: No Post-Injury Emotional Trauma, Malingering. ‘Malingering’.

Hugh Koch robustly argued that the Claimant fell into the middle category.

HH Judge McIntyre’s found as follows:

1. The Claimant suffered Orthopaedic Injuries resulting in his giving up his job, but after 5 months, he should have recovered sufficiently to be able to look for further employment.
2. After approximately 5 months, he began to consciously exaggerate his symptoms of chest pain and breathlessness.
3. ‘But for’ this exaggeration, he could have returned to work with the help of Psychotherapy.
4. There was a significant discrepancy between his Court Room presentation and the disability claimed.

Increasingly, focus will be on the role and relative merits of having jointly instructed experts. This case highlighted the utility of such joint instructions. Experts, so instructed, will need to be as competent as ever, if not more so, in presenting a range of opinions and balanced assessment of available data and evidence.

Jointly instructed experts are increasingly being used. Clear instructions from solicitors are essential. The early or late disclosure of surveillance material to the expert needs to be carefully judged.

The current Pilot Study has been based on a process which follows closely with the publication of a legal case, identified key psychological issues which are then discussed with reference

to the appropriate research or publications. The first one has been published by Koch and Newns [5] in the internet-based Personal Injury Law Journal (www.pibulj.com) and is summarised in Fig IV below. It is part of a series called 'Legal Mind Case and Commentaries'.

Figure IV

Legal Mind Case and Commentary: No.1

Psychological Disorder: Sudden shock or series of distressing events (Koch and Newns [5])

Case: Liverpool Women's Hospital NHS Foundation Trust V Ronayne [2015] Court of Appeal, London: 2015

EWCA Civ 588 was a case of a claimant claiming damages for psychiatric injury consequent on seeing the condition of a loved one brought about by the negligence of a defendant. Of the four requirements for recovery, the decision focused on whether Claimant's illness had been "induced by a sudden shocking event". Three issues were at the heart of the case: (1) whether C had suffered a recognised psychiatric illness, (2) whether there had been "an event" and (3) how "shocking" the event must be. In brief, C's wife became extremely unwell due to the negligence of Defendant. C claimed he had suffered psychiatric injury as a result of the shock seeing his wife's sudden deterioration and appearance in hospital. The Court of Appeal confirmed that courts should pay close attention to diagnostic criteria, that whether an event is 'horrifying', must be judged by objective standards and by reference to persons of ordinary susceptibility and that for an event in a hospital to be 'shocking' required something "wholly exceptional in some ways so as to shock or horrify". It also considered what was meant by an 'event' and 'sudden' finding that C had not been exposed to one event ("a seamless tale with an obvious beginning and an equally obvious end") but a series of events with no "inexorable progression". What had happened was not sudden, it had not caused an "assault upon the senses" but at each stage C had been conditioned for what he was about to perceive.

In summary, the following issues were raised in this judgment:

Differences between seamless flow of events and distinct, discrete events

Clarity and validity of psychological diagnoses made.

Classification of events as 'horrific' and/or 'shocking'.

Consideration of 'extreme anger' rather than classic Post Traumatic Stress Disorder symptoms.

Commentary:

Psychological trauma can arise as a result of a series of events, or as a result of stressful (but not necessarily horrifying or shocking) life events. In this case the judge accepted that a psychological injury had occurred (although did not accept that this was PTSD). The judgement, though, has made it clear that certain

criteria must be met when considering claims by relatives impacted upon by the effect of an injury or negligence on a loved one.

The Court of Appeal Judgement states that the 'index' event must be 'shocking' (as defined above) rather than a series of adverse events, albeit stressful but not 'shocking'.

When we assess Claimants as psychological expert witnesses we would want to aid the court by ensuring that we are clear regarding the cause of any psychological/psychiatric injury – whether it is one or a series of events, and the exact nature of the trauma itself. It is also pertinent when assessing such cases to consider how the claimant has been prepared by the hospital for the potential shock of the presentation of their relative (the judge stated that at each stage, Mr Ronayne was conditioned for what he was about to see, and that his wife's life was in danger and therefore he considered that there was nothing sudden or unexpected about seeing his wife "looking like "the Michelin Man" (as the claimant described her).

Clinical psychologists are well trained and experienced in diagnosing psychological/psychiatric injury following traumatic events, and tort law cases such as this one can aid the expert when preparing a report for the court in ensuring that all of the points raised in this judgement are considered when assessing a claimant.

Source of Court of Appeal Judgement: [6,7]

Background publications related to issues raised here: [8]

The Pilot Study is currently developing the following commentaries: -

1. Causation (House fire; attribution; unlikely causes).
2. Duty of care and mental impairment (pre-existing mental illness; differentiation between physical and psychological impairment).
3. Material contribution of damage ('but for' causation; definition of 'material').
4. Dishonesty (Inconsistency of evidence; unreliability; assessment of fraud).
5. Expert Evidence (Supreme Court; regulation of expert evidence; opinion evidence and experts evidence of fact).
6. Expert Immunity (Supreme Court; Responsibilities of experts; changing opinion; land mark ruling).

It is not the intention to make 'quasi-legal' comment or analysis of legal causes per se but rather to apply psychological theory, practice and experience to the main points raised in legal cases which have relevance for psychologists and psychiatrists acting as expert witnesses, in order to further develop the robustness of opinions provided, as discussed previously [9]. This is in line with several other publications by this author

and colleagues on the interface between Law and Psychology [10,8].

It intends to highlight issues of causation, vulnerability, diagnosis and differential diagnosis, factors maintaining impairment, and the many issues affecting prognosis and treatment.

The Woolf Reforms and subsequent Civil Procedure Rule in 1999 changes offer the legal and medical-legal professions alike an opportunity to preserve and reinforce their respective best practice and, at the same time enhance, the efficiency and effectiveness of personal injury litigation. This can be helped by a change of culture in litigation in which there is clearer definition of agreement and disagreement, and new techniques and approaches to mediation, and mutual understanding between lawyers and experts. This qualitative study and innovative practice will significantly help this process of mutual understanding. Within the medical-legal context, lawyers (and barristers) and medical experts have, at times, regarded each other with suspicion due to the differences, real or apparent, between science and law. Often a valid criticism of each has been the insufficient account they have taken of each other's working practices. Lawyers aim to resolve issues of fact and to peacefully resolve disputes and grievances by negotiation, mediation and arbitration, ultimately in court. The fact finding may be helped by scientific or expert inquiry. Adversarial activity may compete with fact finding. It is anticipated that these medico-legal commentaries will facilitate dialogue between lawyers and experts on legal and psychological factors relevant to civil and criminal cases.

REFERENCES

1. Virues-Ortega J and Moreno-Rodriguez R. (2008). Guidelines for clinical case reports in Psychology. *International Journal of Clinical Health Psychology*. 8(3), 765-777.
2. Kirthi V. (2011). How to write a clinical case report. Royal College of Physicians. 23.9.11.
3. Koch HCH. (1999). RV. Turner. Somnambulism. *Association of Personal Injury Lawyers Newsletter*. 9.3.99
4. Koch HCH. (2000). Chronic Pain – Doves v. Bishop. *Personal and Medical Injury Law*.
5. Koch HCH and Newns K. (2016). Psychological Disorder: Sudden Shock or Series of Distressing Events. *PIBULJ*.
6. www.bailii.org/ew/cases/EWCA/civ/2015/588
7. www.pibulj.com/content/law-journal-summaries [Ian Miller, 11.1.15].
8. Koch HCH, Bird D, Hetherington J and Williams J. (2012) PTSD: Overview and the way forward. *British Journal of Wellbeing*. 1(1).
9. Koch HCH. (2015). Robust Opinions need robust reasoning: 15 medico-legal postulates. *Solicitors Journal*. 159(18), 35.
10. Koch HCH and Diesen C. (2015). Contemporary 21st Century Therapeutic Jurisprudence in Civil Cases: Building bridges between Law and Psychology. 2(1), 13-26.
11. Koch HCH. (2015 b). Is Hot Tubbing right for my case? *Practice Notes*. *Solicitors Journal*. 2.2.16, 23.