

## Expert Meetings in Civil Cases: Three Case Studies

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### ABSTRACT

The innovative practice in UK Civil litigation of preparing a Joint Statement between two opposing medico-legal experts to help reduce evidential conflict is described and discussed. Key areas of common disagreement are identified. Key factors and processes for producing a joint statement are discussed with reference to three different and illuminating case studies, plus reference to recent judicial commentary.

### KEY WORDS

Joint Statement; Psychological Injuries; Expert Meetings; Civil Litigation; Judicial Comment.

### INTRODUCTION

The complexity of obtaining evidence in personal injury medico-legal cases and the associated areas of evidential unreliability were described in an earlier publication [1]. A previous analysis described how the potential conflict between two opposing experts could be addressed via the Court's direction to describe and produce a Joint Statement [2]. Preparation of Joint Statements is now an accepted part of the UK Civil Litigation culture and widely recognised throughout the world as an innovation and effective method of resolving Civil claims.

This paper identifies via the use of three case studies the several issues which need to be addressed when two experienced experts meet to discuss a Joint Statement.

### MATERIALS AND METHODS

The introduction of the Civil Procedure Rules (CPR) in 1999 paved the way for clearer roles and responsibilities for experts when producing opinions in personal injury cases. Each expert is expected to discharge his/her responsibility to the Court by producing a robust and independent report based on available information, plus subsequent clarifications or amendments when questioned or provided with additional

evidence. The pre-CPR practice of obtaining both claimant and defendant-instructed opinions continued with the increased use and expectation of 'opposing' experts 'meeting' to produce a joint opinion [3].

The aims of joint opinions are to help the Court clarify both experts' opinions, in terms of level of agreement and disagreement. Where there is disagreement, experts are expected to explain whether this is substantive or not. As a result, the need to call the experts to court, and its attendant costs, can be reduced.

In this paper, we have itemised and discussed some of the key issues which are pertinent to the apparent or real clinical differences in opinions of two psychologist or psychiatrist experts in the same case.

The typical time line for the involvement of two same-professional experts is:

- Expert 1 (instructed by claimant - side) - 1<sup>st</sup> Assessment.
- Expert 1 (instructed by claimant - side) - 2<sup>nd</sup> Review Assessment.
- Expert 2 (instructed by defendant - side) - 1<sup>st</sup> Assessment.

The time gap between (c) and either a) or b) can result in 'like-for-like' comparisons being difficult and less reliable, and result in different opinions based on fluctuation of symptoms/disorder with/without treatment or the effects of additional life events.

If the two experts are instructed at the same time, then the two resulting opinions can be compared 'like for like' as the claimant would be expected to present and report symptoms similarly to both experts. However, although no time-line difference exists, one other variable may occur which can predict differing opinions - that of either claimant or defendant - instructed expert adopting a style which reduces his/her objectivity and reliability by being over-accepting ('claimant-oriented') or over-suspicious ('defendant-oriented'). This effect has been significantly reduced since 1999 with most experts developing an independent nonpartisan, robust approach to providing balanced opinions [4].

### **AREAS OF POTENTIAL EXPERT DISAGREEMENT WHICH TYPICALLY OCCUR FALL WITHIN THE FOLLOWING TEN CATEGORIES**

#### **Pre accident vulnerability**

Experts may disagree about the relevance and significance of early developmental history from childhood and adolescence of, for example, depression and anxiety, emotional and physical abuse, alcohol and drug abuse.

Not with standing single case exceptions, the following guidelines are suggested:-

A1) Any vulnerability prior to 18 (i.e., during childhood and adolescence) is generally unlikely to be of medico-legal significance in assessing/attributing post-event symptoms at age 30 (approximately) and over.

A2) Between ages 18-30, it is important to clarify if any pre - 18 vulnerability has resulted in 'active symptoms' during the 18-30 period especially in the 12-24 months immediately prior to the index event(s).

A3) Family history (e.g. alcohol misuse, depression) and associated claimant vulnerability is rarely of significance when a careful and detailed index-event history has been taken, unless 'active' symptoms are detected in the immediate pre-index event period.

#### **Pre-existing symptoms**

Given the 'demand characteristics' of the claimant attending an interview which, in their view, will ultimately contribute to assessing a level of compensation, it is not unusual for pre-accident symptoms to be given less emphasis by the claimant. This is accentuated by the 'recency' effect of the index event. It behoves the expert, therefore, to be clear about the exis-

tence/absence symptoms during the preceding 6-12 months, Reference to GP attendance during the preceding 6-12 months is essential to validate the presence/absence of symptoms during this period. Claimant recall is understandably less than perfect (due to anxiety, memory and motivational factors) [5].

B1) Areas of particular relevance are: The presence of prior 'diagnosed and treated depression': The NICE guidelines summarise the available research well when they state:

1) The history of one diagnosed and treated episode of depression is predictive of a 50% chance of a further episode later in life.

2) The history of two or more episodes is, predictive of a 90% chance of a further episode later in life.

However, the court and its experts must also take the claimant 'as he finds him/her' with his/her egg skull', and explain how an index event has/has not precipitated a psychological disorder.

B2) The relevance of previous and recent similar index events: In the case of a recent prior road traffic accident, it is appropriate to state that there is a prior vulnerability to travel anxiety which over the next 3 years increases the likely adverse reaction to a subsequent accident'. It is often difficult to obtain clear and reliable information about actual travel behaviour and confidence/anxiety just prior to an index event which occurred possibly 1-2 years ago. Careful behavioural analysis can help this.

#### **Range of opinions in Psychological/Psychiatric opinions**

There are typically five areas of potential evidential conflict.

These are: diagnosis, prior history, additional life events, duration of index event-linked symptoms, prognosis and treatment. Conflict arises for two main reasons:-

#### **Presence/ Absence of information**

Given the single 'snap-shot' context of most medico-legal assessments, it is not uncommon for there to be incompleteness of information about, for example, life stresses and events. The typically later-appearing defendant-instructed expert has the opportunity to quality control/update the accuracy and completeness of the chronology of events, both related and unrelated to the index event(s)

#### **Interpretation of information**

If the index event occurs in isolation of any other life events or stresses (eg 12-24 months before or after), then the expert's job of attribution is relatively simple and uncontroversial. However, in most circumstances, there are one or more intervening or preceding events of relevance. This is a significant source of potential variation in interpretation by each expert.

### Post-accident symptoms, diagnosis and attribution

In personal injury cases such as road traffic accidents, the range of possible disorders falls into three main categories as reflected in DSM-V and ICD-10:

- 1) Stress Disorders such as PTSD, acute stress disorder, adjustment disorders, phobic and obsessional-compulsive disorders and generalised panic disorders.
- 2) Depressive disorders including bipolar disorders.
- 3) Pain Disorders.

It is not unusual for two clinician/experts to use a slightly different diagnostic category for a cluster of symptoms. This can occur due to a claimant's different emphasis at interview, and sometimes caused, as stated earlier, by a different time lapse of interview from index incident.

The significance of this can vary, sometimes being of relatively minor importance (e.g. when one expert diagnoses an adjustment disorder with depression and the other, a depressive disorder) and at other times having greater relevance (e.g. when one expert diagnosis a psychological disorder whereas the other does not).

In the absence of other related or un-related events after an index event, attribution of psychological symptoms to an index event is relatively straight forward using the 'But for' theory.

This becomes more complex when other events occur. Typically broad approximations such as "minimal, 10%, 25%, 40%, 50%, material contribution, 75%, predominantly " are used.

### Severity of diagnosis

In many cases experts found evidence of sufficient symptomatology to meet the criteria for a recognised psychological disorder but disagreed on the diagnosis, to an extent which reflected a significant difference in severity. This had important implications for prognosis, treatment and employability. The variance between the two experts could be explained by:

- a) Differing thresholds for assessing symptoms.
- b) Differing thresholds for assessing 'Marked Distress' and level of disruption.
- c) Time lapses between assessments.

### Minor differences in 'diagnostic label'

In a small number of cases, both experts agreed on presence of a recognised psychological disorder, or agreed severity but used different diagnosis labels. This often indicated a slight difference of emphasis in terms of differential focus on depressive symptoms, phobic symptoms or post concussion symptoms. Such differences seldom had implication for the resolution of the claim.

### Differences in prognostic and treatment requirements reflected the following

- Experience of psychological intervention and belief in psychological therapies, especially brief cognitive behavioural therapies and multidisciplinary pain management approaches.
- Underlying model of post trauma recovery (optimism vs chronicity).
- Availability of psychological therapy services in expert's geographical area.

### Employability issues reflected opinions not dissimilar to those above, namely

- Underlying belief in individual's ability to overcome trauma and return to part time or full time paid or voluntary work.
- Relevance of brief structural therapy to enhance motivation to return to some form of employment. Ability to maintain distance from claimant's own helplessness concerning recovery and employment.
- Implication of a return to work of four to eight weeks or more for apparent recovery.
- Arguably, one of the more problematic areas for discussion and resolution was the presence or absence of relevant pre-accident history and its contribution to post-accident injury and recovery. Differences tended to centre on three causes: Interpretation of GP attendance records; relevance of claimant's own description of pre-existing psychological difficulties with greater agreement being found with proximity of symptoms (pre-accident) to date of accident itself, ie. prior three months; prior six months; prior twelve months and beyond; and adequacy of exploration of pre-accident history and life events.

Reliability assessment, although frequently commented upon, is often inadequately addressed. Experts typically find a claimant to be reliable, sometimes inconsistent and unconsciously magnifying symptoms, occasionally unreliable and 'expedient with the truth'. Although frequently asked by a defendant to consider if the claimant is 'malingering', few clinicians use this label as its only clinical relevance is found in the diagnosis of 'malingering disorder' which is a severe psychopathic presentation which is usually 'screened out' initially by a lawyer.

### Interpretation of pain and its cause: the role of vulnerability and somatization

The explaining of pain (single site or multi site) following an index event can cause orthopaedic experts a quandary in that their medical model may only explain the pain for an approximate time period. Psychologist and psychiatrists with expertise in the psychological aspects of pain diagnosis and management will debate the possible diagnoses of:

- 1) Pain disorder with psychological factors

- 2) Pain disorder with no psychological factors
- 3) Pain tolerance adversely affected by stress-related psychological disorder or depressive disorder.

They will also consider and debate the level of reliability and/or truthfulness they found at interview and/or when viewing surveillance evidence.

The final piece of the diagnosis 'jigsaw' in the presence/absence of a somatoform disorder defined as many, multi-site physical complaints over several years before and/or after an index event, with some medical inexplicability [6].

### Effects of 'personality' disturbance (including alcohol misuse)

A problematic factor for experts is to what extent a claimant's underlying personality and general lifestyle including alcohol use 'colours' a reaction to a traumatic event or the way it is described to the expert.

The 'but for' theory is often helpful to differentiate index event-related problems from personality traits or lifestyle difficulties, however this is often not easy.

### Treatment and Prognosis Issues

Any claimant must try and 'mitigate his/her losses' by availing themselves of any appropriate treatment. Similarly the expert should be making recommendations for the best available treatment to reduce a claimant's disability if this has not already been offered by treatment agencies. It is incumbent on the experts to be up to date in discussing and agreeing on appropriate psychological and psychiatric treatments.

### Multi-disciplinary Joint Opinion

Typically joint opinion discussions takes place between experts of 'like discipline', however it is not uncommon for cross-specialty joint opinions, to be requested by the Court. This is most typically in areas of chronic or atypical pain in which any two of the following specialists may be needed: rheumatologist, orthopaedic, psychologist, psychiatric and anaesthetics/pain management. The two experts maybe on the same legal side or opposing legal side.

### The Joint Opinion Process

Experts have different methods for producing a joint opinion. Typically and logically it should, involve the following: -

- a. Logical summary of areas of agreement and disagreement from both reports (produced as a written draft by one expert).
- b. Discussion by email and telephone or face to face.
- c. Revision of summary (as many times as is necessary).

To reinforce our opinion stated at the outset, the main aim of the joint opinion is to present the Court with a clear and relatively unambiguous summary of what the two experts be-

lieve and also, having highlighted any disagreement, to try and explain why such disagreement pertains.

Early discussion between experts of their findings is important as it reduces the risk of views becoming entrenched in lengthening litigation, and preventing appropriate short-term treatment interventions being offered either for symptoms relief or, as importantly, a rapid return to part-time or fulltime employment.

Preparation of joint schedules is based on a frank, open and honest exchange of clinical opinions between two experts who hopefully respect each others views, experience and credibility. There is room to manoeuvre in such discussions to clarify and, in part, explain apparent or real differences between opinions.

It has been argued elsewhere that in addition to the typical 'same speciality' joint opinion preparation (eg psychologist-psychologist or psychiatrist), other cross-speciality joint opinions have merit, eg psychologist-orthopaedic, psychologist, pain specialist: [5].

Before signing an agreed joint schedule it is often wise to request both solicitors' advice, if not already given, on the comprehensiveness of the information agreed to prevent the occasional circumstance of a joint schedule being agreed and signed and sent to both sides and one/both sides then requesting further clarification or consideration of an issue not included in discussion already.

As a final point in this section, the request for the most rapid joint schedule occurred on one occasion in court. Neither side had initiated any between expert discussions prior to the hearing. The first intervention the judge made was to 'ask' the two sets of experts (psychological/psychiatrist (2), Orthopaedic (3)) to sit outside the court and prepare joint opinions. Within two hours, I and my opposing colleague were released having produced an 80% agreed opinion!

In the next section, three case studies are presented which illustrate the above issues in practical detail.

## RESULTS

Three case studies are presented here with the relevant leading points at the end of each study.

### Case Study 1

The claimant was a passenger in a car involved in a head on collision. In addition to a variety of physical injuries, the claimant suffered from a cluster of stresses, anxiety and mood disturbance – this cluster was the subject of an expert meeting to produce a Joint Statement for the Court.

The two experts (one psychiatrist, one psychologist) discussed by telephone and by email the following issues:-

1. Pre-accident vulnerability:- the debate centred on whether early life adverse events (bullying; anger management) were of relevance given the lack of psychological symptomology in the 12 months immediately prior to the index accident.
2. Nature, severity and diagnosis:- differences of self-report was described and possible reaction for this, as was the appropriateness and type of diagnosis.
3. Attribution to the index accident:- The relevance of non-accident factors include social, housing and financial problems was debated.
4. Duration of accident ref. symptoms:- Taking into account different timings of the two experts reports and also the date in treating clinical's letters, a range of duration was described.
5. Prognosis and need for further treatment:- The need for further treatment and the appointment of treatment delivered and further treatment required was debated.
6. Surveillance Evidence:- There was agreement over the lack of overt pain behaviour or impairment in mobility consistent with observations at both interviews.

Relevant learning points: There was a high level of agreement between the two experts in their case. The key issues were as to whether the claimant had a pre-exerting problem prior to the index accident and how severe the post-accident reaction was. The different expert professions (Psychology/Psychiatry), in all probability accounted for some of this difference.

### Case Study 2

The claimant was a passenger in a car when it hit a truck in the road. She was hospitalised with multiple injuries and off work for several months.

The two experts, both clinical psychologists, discussed their respective opinion by telephone and by email. The following issues were discussed:-

1. Different time scale of interviews: The experts interviewed the claimant 4 years apart. This inevitability explains some differences in symptoms self-report by the claimant, plus the percentage time had resulted in significant improvement, which in time affected recall.
2. PTSD – type symptomology – the life threatening nature of the index event was agreed as was the lack of overall PTSD diagnosis.
3. Diagnostic agreement:- The experts agreed as to the diagnosis of a specific phobia (of travelling) attributable to the index accident.
4. Pre-existing vulnerability:- The experts agreed on the existence of earlier predisposition to mood disturbances, but also agreed on the lack of acute symptoms in the 12 month period prior to the index accident.

5. Duration:- It was agreed that with psychotherapy, the claimant's psychological symptoms would have receded after a total of approximately 24-30 months.

Relevant learning points: Again this study reflects the high degree of agreement between the two experts (both psychologists).

### Case Study 3

Psychologist (Dr Y)/Pain management Specialist (Dr X) Joint Statement

The points of agreement are as follows:

- 1) Type of Accident:-

Mrs X is a 34 year old who was in a traffic accident on 25/12/2012

- 2) Nature of any psychiatric/psychological symptoms and medical condition post-index event:

- a) Mood Disturbance

- Exacerbation of pre-existing Anxiety
- Social Withdrawal
- Ongoing pain (back)

- b) We agree she has developed significant disability as a consequence of her pain, consistent with a Pain Disorder with some psychological factors (DSM IV 307-89).

- 3) There was relevant pre-accident history which impacted on her accident-related problems.

- 4) It was agreed that X has a longstanding pattern of difficulties coping with pain symptoms, which dates back to her adolescence with referrals to clinical psychologists specialising in pain management for help with the psychological aspects of her pain between 2000 - 2010.

In Dr X's opinion, the pre-existing psychological problems in relation to chronic pain meet the diagnostic criteria for a somatic symptom disorder, which fluctuated between moderate and severe in severity during the years before the index accident. In Dr X's opinion this somatic symptom disorder exacerbated distress and disabilities due to medical problems and caused episodes of apparent medical distress and disability due to psychosocial stress both before and after the index accident.

In Dr Y's opinion, her pre-existing coping problems did not amount to a somatic symptom disorder. He notes that in the 12 month period prior to the index incident there was no evidence of maladaptive pain coping problems (self-report and GP records)

In Dr X's opinion, there has been a complex interaction between Mrs X's medically caused pain due to a variety of complaints between 2000 and 2010 and that this complicated interaction between psychosocial stress and medically-caused

pain has persisted since the index accident.

In Dr Y's opinion, there was an interaction between her psychological state and her pain tolerance post accident.

We agree that the relative contribution of pre-existing and accident related medical problems and their contribution to Mrs X's medical pain and to its exacerbation of his psychological symptoms, is a matter for Mr D and Mr E, the orthopaedic experts.

5) It was agreed that a combined and multi-faceted treatment approach is warranted involving pharmacological (drugs), face joint injections, behavioural activation with physiotherapy, and a psychological approach (cognitive behavioural).

The cost of an initial assessment by a pain consultant with regard to medication is likely to be in the order of £150 - 200, with a 3-4 subsequent visits (at around £1 50/visit) necessary to establish an effective analgesia regime.

Thoracic face joint injections may be undertaken at a cost of £2000, with a subsequent denervation procedure (if benefit is significant but short lived) a further £2500. These should be undertaken with a course of physiotherapy (up to 8 sessions)

6) Dr Y (psychologist) suggested a series of 8 — 10 sessions of pain coping CBT therapy (cost on private basis approximately £1 75 per session, total £1 750 approximately).

7) It was agreed that, with treatment, the claimant's condition could improve. If she did not increase incrementally her activity level or have some form of therapy, then her condition was likely to remain unchanged.

8) It was agreed that at the conclusion of any pain management treatment program, a further reassessment by both experts was recommended.

Relevant learning points: This innovative Joint Statement reflected the Court's wish to understand how two different professionals (Psychiatrist and Pain Specialist) viewed the claimant's pain symptomology [6].

### Recent Judicial Comment on Joint Statement Agendas

In the judgment of Mrs. Justice Yip, on the case of David John Saunders v. Central Manchester University Hospitals NHS Foundation Trust (2018) EWHC343 (QB) the issue of the agenda for joint reports was raised, and how it can or should be neutral, impartial and non-confrontational. In this clinical negligence action, arising from surgery to reverse an ileostomy, the judge was critical of the joint report/albeit arising from 'high standard' individual reports. The criticisms were as follows:

- Excessive length (60 pages) which did not narrow or agree issues.
- Two separate agendas with repetitive questions, and lack of

agreement for a single agenda.

- Lack of common sense, collaborative approach.

As Exall (2018) clearly summarised, the Civil Justice Council (CJC) Guidance for the instruction of experts in civil claims gives clear direction as to the purpose of discussions between experts (71) to identify, discuss and narrow the issues under debate, but not to seek to settle the proceedings i.e. not to resolve disagreement. In Practice Direction 35, guidance indicates the utility of an agreed agenda which helps experts to focus on the key issues. More detailed guidance from the CJC supporting discussions should be proportionate to the value of cases, with telephone discussion and email exchange being appropriate for small claims and fast-track cases. In addition, the agenda should summarise concisely what is agreed and what matters are in dispute [7].

Sensible and experienced experts are well able to construct and agree an agenda to work on which adequately and appropriately addresses the key issues in any one particular case. This may either be available at the outset before any deliberation between the two experts, or arise during the discussions. However, it is also very helpful and appropriate for the two instructing parties to agree, prior to the experts deliberations, on key issues to address which they believe the court would find helpful. Typically there will be specific issues relating, for example, to particular aspects of causation, loss of employment, multi-factorial disability. More general advice or suggestion as to key, superordinate or general categories on diagnosis, prognosis and attribution are typically not required or helpful as all parties are cognisant and that these should be addressed.

The comments in Mrs. Justice Yip's judgement concerning conciseness, length and lack of repetition are well taken and, although obvious, are often needing to be repeated.

### DISCUSSION AND CONCLUSION

The foregoing analysis exemplified by the three case studies illustrates the significant professional maturity involved in the preparation of Joint Statements. Since the introduction of CPR rules in 1989/9, experts have debated their medico-legal opinion in an increasingly sensible and constructive manner, helping the Courts to understand the high level of agreement between experts and also understand logically and helpfully when disagreement does occur. To report a comment made at the outset of this paper, the use of the Joint Statement in idiosyncratic to the UK law system and should be applauded and recognised [8].

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