Whiplash reform programme: Consultation on independence in medical reporting and expert accreditation

A response by
The Chartered Institute of Legal Executives

1 October 2014

For further details

Should you require any further information, please contact;

Louise Tyrrell
Policy and Law Reform Officer
ltyrrell@cilex.org.uk
01234 845764

October 2014

Introduction

1. The Chartered Institute of Legal Executives ('CILEx') is the professional association and governing body for Chartered Legal Executive lawyers, other legal practitioners and paralegals. We represent around 22,000 members including approximately 7,500 qualified lawyers.

2. We work closely with Government and the Ministry of Justice ('MoJ') and we are recognised as one of the three core branches of the legal profession.

3. Chartered Legal Executives offer legal businesses and clients a combination of practical knowledge and experience, together with specialist academic legal knowledge. They make an important contribution to the delivery of effective legal services. Chartered Legal Executives tend to develop expertise in specific areas of law.

4. Of our members working in personal injury they represent both claimants and defendants.

Proposal 1: Independence in the commissioning of reports

5. We commend the principle of removing potential conflict of interests from the system of instructing medical experts. We understand that the current proposal will not prevent claimant law firms, for example, owning medical reporting organisations, but do not think that the proposal is necessary to achieve what the Government requires.

6. The conflict of interest issue is already addressed by the independence of the individual medical expert, established under the Civil Procedure Rules. A medical expert already has a duty to the court, which overrides any duty to the person from whom (s)he has received instructions or by whom they are paid.[1]

7. This should be sufficient for the purposes of medical reports for personal injury claim. The proposal to apply filters to ensure there is no financial link between those commissioning the report and medical expert producing the report is wholly unnecessary for the purposes for which it has been proposed. This may cause unnecessary complications in setting up the portal.

8. This issue could also be addressed by including within the accreditation process a requirement that the medical experts sign a declaration to confirm they would have no financial stake in the matter (save for reasonable

[1] Rule 35.3 Civil Procedure Rules

expectation of payment), and have no direct or indirect commercial involvement with any parties involved within the process.

9. We have concerns regarding the larger conflict of interest, with the start-up costs for the portal being funded by the Association of British Insurers (ABI).

10. We recognise there is no Government funding available for the start-up costs of the portal. Were alternative forms of funding considered? Why was it ultimately decided that the ABI would fund the portal? Have the Government and/or ABI taken any steps to eliminate the obvious conflict of interest? It is difficult to be satisfied of the scheme's independence with the current funding arrangements.

11. The above reservations aside, we are pleased that practitioners will be able to participate in a significant programme of user testing prior to the launch of MedCo. We would expect that to include a wide range of practitioners, from different types and size of firms.

Question 1: Do you agree that the proposed amendments to paragraphs 7.1A(1) and 7.32A of the pre-action protocol and miscellaneous amendments to the CPR in annex C are sufficient to ensure that claimant representatives comply with the requirement to commission an initial fixed costs medial report from an accredited expert via the MedCo Portal?

12. It is clear by the proposed amendments that a medical report should be commissioned through the MedCo portal. However, we do not accept the use of the word 'allocate'. Claimants have a right to choose a medical expert, and this should remain. 'provided' may be a more appropriate term throughout.

13. However, we say this with the reservation that the rules have been drafted without knowing how exactly the MedCo portal will work. There may need to be changes to reflect the workings of the portal once it is live.

14. There are a number of issues which have not been mentioned throughout the consultation, which may affect the instruction of an appropriate expert, and require some further consideration. Which include:

    a. What will happen in the instances where English is not the claimant's first language? Will there be a filter or a way to deal with the availability of a translator? What happens with the associated costs?

    b. What happens if there are no medical experts on the panel in the claimant's area? How far is a claimant expected to travel, and who will

fund this? What happens if a Claimant is unable to travel and find an expert who will travel to them?

c. Before any constructive consideration can be given to the portal, practitioners need to know the turnaround time expected between commissioning the report and the medical examination, and between the examination and the production of the report. What if the predicted turnaround for the report is for a time which is not acceptable to the claimant or claimant's representatives? There is the potential that recommended treatment could be delayed. This could disadvantage both the claimant and the defendant (or rather their representative).

d. Member engagement has revealed that there are claimant firms who will often arrange appointments with local experts during weekends or out of normal office working hours. This helps further losses to be kept at a minimum, and reduces disruption. Will such appointments be available through MedCo? Will this be a requirement through the accreditation process?

15. Potentially, to remove links between a claimant representative and the medical reporting organisation ('MRO') or expert producing the report, could be a disadvantage. If claimant representatives are prevented from having service level agreements in place with the organisations or experts they instruct, it will mean they lose control over instructing experts who they know will deliver reports at the same high standards they can today.

16. Experts will be instructed differently by all firms. Any expert who is accredited must ensure that they are able to deal with instructions however received, and still provide an acceptable service and produce a meaningful and independent report. It must not turn into a 'tick box' exercise.

Question 2: It is anticipated that access to the MedCo portal will be available to litigants in person. Do you have any views on whether use of the MedCo Portal should be mandatory for litigants in person?

17. If the MedCo portal is intended to be used by litigants in person, the MoJ must ensure that it is user friendly to those who do not work in the personal injury field. Any legal terminology or partisan language must be kept to an absolute minimum or removed altogether.

18. There must be an added safeguard. A litigant in person must read and accept information, prior to commissioning the report, which makes it clear they have an absolute right to seek independent legal advice, and are entitled to instruct a lawyer to assist them with their claim.

19. Claims should not settle without an independent medical examination, so it follows that the portal should be used by litigants in person. They should be required to go through the same process as a claimant who is represented. All of the issues raised at paragraph 14 above, also need to be taken into account, together with the safeguard mentioned above.

Question 3: The results of a search in the MedCo portal can be displayed in different ways. Do you have any views on whether the MedCo search results should offer commissioning practitioners a choice of named medical experts and/or medical reporting organisations?

20. Ultimately, the claimant should retain the right to choose the expert they wish to instruct.

21. Different practitioners and firms work in different ways, and with differing technological capabilities, case management systems or ways of instructing medical experts.

22. When the portal is live it should enable those commissioning the report to choose whether they wish to receive the details of individual named medical experts, or medical reporting organisations.

23. To enable the claimant to make a legitimate and informed choice, the results provided should include additional information about the distance from the claimant's home address (or any appropriate address from where they will be travelling), details of the likely time frame between instruction and examination, and then the production of the report, together with details of availability for evenings/weekends for appointments.

24. This should all form part of the testing process when practitioners participate in the programme of user testing. Once again, we would expect the testing to include a wide range of practitioners, from different types and size of firms.

Proposal 2: Accreditation for experts writing reports

25. The consultation document states the Government is 'working closely with stakeholders to develop appropriate accreditation criteria and processes'. How are these discussions taking place, and which representative stakeholder groups are involved?

Question 4: Do you agree that the proposed amendments to paragraphs 1.1(a1), and 1.1(10A) of the pre action protocol, rules 45.19, 45.29l of Part 45 and miscellaneous amendments to the CPR in annex C are sufficient to ensure that only accredited medical experts are instructed to provide fixed costs

medical reports in whiplash cases? Do you agree that the transitional provisions in paragraph 4.7 are appropriate?

26. The proposed changes to the rules make it clear that only accredited experts are to be instructed on these occasions. This is, once again, without knowing how the portal will work. Because of the lack of information, this can only be deemed a temporary response.

27. The transitional provisions in paragraph 4.7 appear satisfactory.

Question 5: The Government is working closely with stakeholder representatives to develop a proportionate accreditation process; we would welcome any views or suggestions relating to standards, criteria or training.

28. Which stakeholders are the Government working with? Is there fair representation from all viewpoints? Of the stakeholders that are practitioners, are both large and small firms represented? The Government should make it clear what steps they are taking to ensure there is no bias or preferred input from the ABI simply because it is funding the project. This should perhaps be overseen by an independent arbiter, or should be considered in partnership with claimant practitioners to achieve a balanced outcome.

29. Will there be further consultation regarding accreditation after initial stakeholder discussions?

30. When setting the level of fee for accreditation (and eventually reaccreditation) the MoJ must ensure that the fee is not set at a level which is prohibitive to individual medical experts who may wish to join the scheme. This would limit the number of experts arbitrarily.

31. There should be a safeguard in place to cover the eventuality that, once the scheme is running, of accreditation applications, and therefore the fees, falling and not covering the cost of the scheme. There should also be the ability to change any requirements for accreditation or reaccreditation through a proper process.

32. Any training necessary for accreditation must strike a balance between being sufficient and not being too onerous, so it does not deter medical experts from applying for accreditation or reaccreditation.

33. For accreditation itself, the medical expert must have expertise in the appropriate medical discipline, and have experience in the treatment or management of the types of injuries intended for inclusion in this scheme.

34. The Government should, if it has not already, consider consulting with the GMC and other such bodies to consider appropriate accreditation and reaccreditation processes.

35. Medical experts seeking accreditation should require a relevant licence to practice from a recognised body. Any revocation (however this may occur) should result in instant loss of accreditation.

36. Finally, the proposal to allow all medical experts to join without accreditation, and then provide a length of time (not yet decided) to apply for accreditation, undermines the entire accreditation process. The accreditation process should be in order before allowing medical experts to join.

Proposal 3: Data sharing to fight fraudulent claims

37. We have long called for data sharing as a way to prevent potential fraudulent or unmeritorious claims, whilst still enabling those with genuine claims, access to justice.

38. However, the obligation for data sharing should not rest solely with the claimant representatives. Members have previously reported to us that defendant representatives have waited to report suspicions of fraud until proceedings have been issued, and a defence is presented.

39. The Government should ensure there is an obligation on defendant representatives to report fraud, or suspicions of fraud at the earliest possible stage and to disclose to claimant practitioners the data obtained which has led to such an allegation. This will allow appropriate and timely investigations to be made.

40. Alternatively, claimant practitioners could be permitted direct and full access to the Claims and Underwriting Exchange database to enable them to determine potential fraudulent claims for themselves. Potential fraudulent claims can be identified at an early stage. Or at least a claimant representative will be able to make an informed decision around whether to represent a claimant having determined for themselves the potential veracity of the claim.

41. We are disappointed the Government has not used this opportunity to address issues of third party capture and pre-medical offers. These practices contribute to fraudulent claims, and add detrimental public perception around low value compensation claims. By doing no more than ‘strongly discouraging’ insurers from making pre-medical offers, the Government is allowing these cases to side-step any checks and balances within the legal process. Banning

such practices would have been a significant and genuine step to reducing fraudulent claims.

42. Without further details, it can only be assumed that claimant representatives will have access to a limited version of the Claims and Underwriting Exchange database. It is not clear how claimant representatives will be expected to prove they have undertaken such searches.

43. The proposal states the IT interface will allow claimant representatives to 'obtain data on the number of previous **personal injury** claims made by potential claimants…' [Emphasis added].

44. Data should not be gathered on any personal injury claims as a whole. These could include matters such as employer liability claims or public liability claims. Data should only be gathered on RTA claims.

45. It is not clear exactly what data will be available. Claimant representatives must be in a position to make an informed decision. Details of dates of accidents would be helpful. There must also be an element of discretion, so claimant representatives can consider whether, for example, a potential claimant has simply been unfortunate in experiencing a number of accidents.

46. Entries on the IT interface should not all be assumed to be fraudulent.

Question 6: Do you agree that the proposed new paragraph 6.3A is the pre action protocol is sufficient to ensure that claimant representatives undertake a 'previous claims' data search prior to accepting new claims?

47. Yes, the proposed paragraph makes this clear. Although that agreement is made at a time we do not know exactly how the process will work so this can only be deemed to be a temporary or limited response.

48. A major concern throughout these proposals is that the rules have been drafted before the portal system is up and running, and before anyone really knows how it is going to look or work.