Guide To Best Practice At The Interface Between Rehabilitation And The Medico-Legal Process

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11 St Andrews Place, London NW1 4LE

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Foreword

For many who have suffered personal injury, initial clinical recovery is followed by a long drawn out process of assessments and reports by numerous people. Many find this process confusing and draining. They often feel that conflicting advice on how to make the best of things has been given by their various NHS & legal advisors. This is not in their best interests. People who have suffered injuries need rehabilitation to maximise their independence and potential to return to their previous lifestyle, and need this rehabilitation to be provided in a timely and co-ordinated manner, irrespective of whether it is to be provided via statutory (NHS) or private resources.

I am delighted to write a foreword for this Guide. The document highlights potential pitfalls and provides sound, clear succinct advice on how to manage the rehabilitation and recovery process in everyone's best interests. It will be a valuable resource and I anticipate that copies will be well-thumbed on all our bookshelves.

Vera Neumann
President
British Society of Rehabilitation Medicine

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The Development

In recent years solicitors acting for Claimants have increasingly engaged with insurers to consider funding for rehabilitation with the common aim of optimising recovery prospects for Claimants. However, regardless of best intentions, the process of implementing medico-legal recommendations for further rehabilitation (in addition to that provided via the NHS) can cause confusion amongst clinical teams and can occasionally be distressing for Claimants.

In view of these difficulties, discussions were set up between rehabilitation professionals, solicitors and insurers' representatives with the aim of finding out how legal and rehabilitation teams could work more closely together. These were based upon the proposition that there was a common objective of maximising the Claimant's prospects for personal independence and quality of life. The first draft of the Guide was produced.

The British Society of Rehabilitation Medicine (BSRM) Executive Committee proposed that the Guide should cover all aspects of injury (neurological, spinal injury, limb loss, multiple trauma and complex pain issues) and set up a small advisory group to work alongside lawyers on its development. The Joint Liaison Committee for Rehabilitation Medicine of the Royal College of Physicians also participated in discussions as the Guide was developed.

It was felt that, to have real impact, the Guide needed wide support from APIL, FOIL and the Insurance Industry and a draft was therefore shared with these organisations. APIL advised that the content would be useful to members when dealing with NHS rehabilitation professionals and agreed to adopt the Guide.

The draft was also the subject of detailed discussions with FOIL and with some of the larger insurers. As a result, a number of amendments suggested by FOIL and separately by two leading insurers Norwich Union Insurance and Royal Bank of Scotland Insurance Group were incorporated. Thus, the text has been debated and considered by rehabilitation professionals, lawyers and insurers, and now has significant cross-industry support.

It has always been recognised and understood that Solicitors and Insurers must be free to choose how they conduct litigation. Therefore, the Guide does not seek to restrict the behaviour of the parties in the litigation process, nor to influence decisions likely to be made by the Courts. Furthermore, we seek to avoid placing additional burdens on busy NHS rehabilitation teams.

It is generally agreed that there are often gaps in service provision, particularly when patients are discharged from NHS hospital care into the community. At this point there are opportunities for solicitors and insurers to co-operate to provide funding. However, to achieve the best outcome for those who have sustained injury, it is vital that additional rehabilitation funded in this way is discussed and planned with the clinicians already involved in an individual's care.

It is our hope that this Guide will facilitate this process and hence enable those whose lives have been affected by injury achieve better outcomes in terms of independence and quality of life.

Co-Chairmen

Professor Michael Barnes
Professor of Neurological Rehabilitation,
Newcastle Upon Tyne

and

Grahame Codd
Partner
Irwin Mitchell

1. Introduction

This guide is written to direct best practice with regards to the assessment and management of Claimants/patients (hereafter referred to as 'Claimants') who are involved in the medico-legal process after suffering serious injuries and are under the care of NHS rehabilitation specialists. It is designed to provide a framework within which channels of communication can be established between solicitors, Claimants, Defendant, insurers or compensators and treating rehabilitation specialists within the NHS.

This guide does not seek to legislate, but rather to point the way in terms of good practice. It is designed to encourage the proper use of the NHS rehabilitation services which are available, and to ensure that, where additional services are procured for the Claimant, these are properly integrated with any NHS provision. The guide is written in the context of ensuring that the parties involved in the medico-legal process, their legal representatives and the treating specialist in the NHS all work with the common objective to act at all times in the best interest of the injured Claimant, which will enable the Claimant to optimise his/her recovery and quality of life.

The guide assumes that the Claimant has the mental capacity to instruct a solicitor and to make decisions regarding his/her care. Where this is not the case, interpretation of the recommendations must take account of the greater responsibility and obligations of the NHS specialist under the Mental Capacity Act 2005 for decisions regarding medical care.

2. Claimants undergoing NHS treatment

a. Where the Claimant is undergoing treatment under the clinical management of an NHS specialist, then any recommendations made by any party involved in the compensation process or by medical or other experts, should be referred back to the NHS specialist for consideration.

b. Where additional or alternative treatment is proposed, the Claimant's solicitor should inform the NHS specialist, who will advise as to whether such additional or alternative treatment is likely to be reasonable, beneficial and in the best interests of the Claimant, whether it might be available in the NHS and, if so, within what timescale. Advice should also be sought regarding the type and location of the facility to be used for the delivery of such additional treatment. The response of the NHS specialist should then be communicated to the Claimant so that he/she can make an informed decision. Subject to the Claimant's consent, that decision, and the information provided to the Claimant upon which that decision is based, should then be communicated to the Defendant's insurer or compensator with a view to seeking an interim payment of damages.

c. Funding may also be secured through the compensation process to provide a range of support services for the Claimant including personal care, aids and equipment, transport and housing. It is good practice for the Claimant's solicitor to keep the NHS team informed about any planned provision in relation to such issues. Discharge planning and on-going health and social assessments undertaken through the NHS and statutory services should be copied to the Claimant's solicitor and, subject to the Claimant's consent, disclosed to the Defendant's insurer, compensator or solicitor.

d. Wherever a decision is made to seek a separate assessment of rehabilitation needs whether under the Rehabilitation Code or otherwise, with a view to considering additional or alternative rehabilitation treatment, such decision should only be made after proper and full consultation with the NHS specialist.

e. If the Claimant has engaged a private clinical case manager, funded through the medico-legal process, the clinical case manager should consult with the NHS rehabilitation specialist(s) and, if appropriate, with the Claimant's solicitor and (subject to the Claimant's consent) the Defendant's insurer/compensator or their nominated clinical expert. If the clinical case manager makes recommendations, then the Claimant should be informed to what extent the NHS team has contributed to those recommendations.

f. Duties of confidentiality exist in relation to the Claimant's treatment at all times, and this must be respected so as to ensure that information concerning the Claimant is not disclosed to third parties without the Claimant's written consent.

g. If the Claimant agrees to undergo private rehabilitation treatment, with the support and approval of the NHS specialist and rehabilitation team, then the NHS specialist should retain overall clinical responsibility until such time as the Claimant is discharged from NHS treatment. It would be normal practice for clinical responsibility to transfer to an appropriately qualified medical practitioner at the private facility once transfer is complete. If therapy or other treatment is provided to the Claimant in the community, the NHS specialist may wish to review the benefit of such treatment from time to time. The NHS specialist may still wish to give advice and guidance on such private rehabilitation treatment in conjunction with the Claimant's General Practitioner and the clinicians involved in the delivery of the private treatment.

h. In circumstances where the Claimant wishes to receive private rehabilitation treatment outside the NHS, and the NHS specialist or rehabilitation team disagree with the proposals being made, then the ultimate decision shall rest with the Claimant (subject to provisions under the Mental Capacity Act 2005). However, the Claimant's solicitor should encourage the Claimant to carefully consider the advice received from the NHS specialist and rehabilitation team. If such conflict arises, it is desirable that the NHS specialist should be able to consult with the private specialist directly in order that, if possible, a compromise or agreement can be reached that is still in the best interests of the Claimant.

3. Claimants who have been discharged from NHS clinical management

a. Where the Claimant has been discharged from treatment under the NHS and further treatment is recommended by any expert instructed within the medico legal process, it is good practice for the solicitor to ensure that a qualified medical practitioner or other appropriately qualified therapist or nurse (other than one retained for medico legal purposes by either party) is prepared to accept clinical responsibility for management of the treatment programmes. The Claimant's solicitor and/or the Defendant's insurer or compensator (subject to the Claimant's consent) may wish to ask the Claimant's former NHS specialist, rehabilitation team or his General Practitioner for advice in this regard.

b. If the Claimant requests his solicitor to arrange private rehabilitation treatment, then the solicitor should satisfy himself that such treatment will be provided under the care and control of a properly qualified medical practitioner, therapist or nurse. It is clearly inappropriate for the solicitor or any other non-clinically qualified individual to take responsibility for management of such treatment.

c. Records created in the course of the Claimant's private rehabilitation treatment are subject to normal rules with regards to confidentiality and should be only disclosed to third parties with the Claimant's written consent.

4. Medico-legal assessments and reports

a. A solicitor should clearly act in the best interests of the Claimant at all times, aiming to assist the Claimant to optimise rehabilitation potential and thus improve quality of life. Should either party involved in the compensation process receive an expert comment which may assist the NHS specialist or rehabilitation team with the provision of treatment, then, subject to the consent of the Claimant and of the expert, that comment should be forwarded to the relevant NHS clinician. Thereafter, that correspondence should form part of the Claimant's medical records and should be available for proper disclosure, save that disclosure does not apply to the Initial Needs Assessment report obtained by the parties involved in the medico legal process pursuant to the Rehabilitation Code, unless the parties agree otherwise.

b. The above general obligation is subject to the overriding duty of a solicitor acting for a Claimant to advise his client as to legal rights in pursuing the compensation claim, and then to act in accordance with the Claimant's instructions.

c. In appropriate cases the parties may ask a medico legal expert to contact the relevant NHS specialist in order to discuss recommendations that have been made for treatment rather than simply send the written report. With consent of the Claimant or his/her solicitor the Defendant's medical expert should be permitted to speak to the treating NHS specialist in order to discuss recommendations that have been made for treatment. A note of any such communication should be retained on the treatment records.

d. It is good practice for the solicitor or medico-legal expert to inform the NHS rehabilitation team of any medico legal appointments and to allow them to liaise with the medico-legal expert in relation to the timing of such appointments so that there is not undue interference with the Claimant's ongoing rehabilitation programme. For example, where neuropsychological examination is appropriate, the timing of psychometric testing should be discussed with the NHS team so as to reduce or eliminate the practice effects caused by repeat testing. Both parties should be encouraged to share such test results where appropriate.

e. It would be unusual for a medico-legal expert to play an active part in the clinical treatment, rehabilitation and care of a Claimant in respect of whom he/she has been asked to provide a medico-legal report, or otherwise retained for medico-legal purposes. However, in fields of clinical practice where the number of rehabilitation specialists is very limited, and in geographical areas where specialist rehabilitation services are in short supply, it may be necessary for an expert to take on such a role.

f. In circumstances where a medico-legal expert or any clinical specialist, either within the NHS or in the privat sector, should make a recommendation for rehabilitation services to be provided by a particular rehabilitation facility, provider or agency, then he/she must declare any direct or indirect financial interest in that facility, provider or agency.

5. NHS clinical and therapeutic assessments

a. Assessments carried out by the NHS rehabilitation team as part of the NHS rehabilitation process can often inform and help the medico-legal expert in preparing his/her report. Such assessments should normally form part of the medical records and therefore be made available, subject to the Claimant's consent, whenever rehabilitation of the Claimant is under consideration. However, such assessments do not enjoy the same status as medico-legal reports. They are prepared for the purpose of the Claimant's ongoing treatment and not for the purpose of advising the Court.

b. Where the Claimant is continuing to undergo rehabilitation under the care of an NHS rehabilitation specialist, it is often very helpful to the Claimant's solicitor and also to the Defendant's insurers or compensator in developing an understanding of the clinical issues and the Claimant's rehabilitation needs, for the NHS rehabilitation specialist to be instructed to prepare a preliminary assessment report. At this stage of the Claimant's rehabilitation, the instructions to the NHS rehabilitation specialist, either from the Claimant's solicitor or from the parties jointly, should make it clear that the preliminary assessment report should describe the nature and extent of the Claimant's injuries, the history of treatment to date and the Claimant's current status. Those instructions may also go on to request advice from the NHS specialist in relation to the Claimant's immediate rehabilitation needs. However, at this point in time, it should be expected that, in preparing this report, the NHS rehabilitation specialist would defer offering any opinion in relation to longer term prognosis.

c. Whenever an NHS rehabilitation specialist is requested by the Claimant's solicitor or by the parties jointly, to produce a report which would not normally have been prepared by the NHS specialist for the purposes of treatment of the Claimant (for example providing advice in relation to the Claimant's future treatment), such a report would not form part of the Claimant's medical records but would be subject to rules of legal professional privilege. That report may be treated as an expert report in the context of the medico-legal process. The specialist should make a proper professional charge for the provision of such a report.

6. Conclusions

This guide is simply designed to ensure best practice at the interface between NHS rehabilitation and the medico-legal process. If followed, these guidelines should ensure that additional rehabilitation services are properly integrated with NHS provision. By adhering to this guide the parties involved in the medico-legal process will demonstrate that they are working with the common objective to act in the best interests of the Claimant by enabling efficient access to rehabilitation services and by aiming to optimise recovery and quality of life.

Addresses

British Society of Rehabilitation Medicine (BSRM)
c/o Royal College of Physicians
11 St Andrews Place, Regent's Park, London NW1 4LE
Tel: 01992 638865
www.bsrm.co.uk

Royal College of Physicians - Joint Specialty Committee in Rehabilitation Medicine
11 St Andrews Place, Regent's Park, London NW1 4LE
Tel: 020 7935 1174
www.rcplondon.ac.uk

Association of Personal Injury Lawyers (APIL)
11 Castle Quay
Castle Boulevard
Nottingham
NG7 1FW
Tel: 0870 609 1958
www.apil.com

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