

PROFESSIONAL PRACTICE / UNITED KINGDOM

Principles of Medicolegal Activity in the UK

Expert practice, professional independence
and a sustainable medicolegal service

Mr Peyman Bakhshayesh

MD, PhD, MBA

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A practical handbook for doctors entering, developing or governing a medicolegal practice. Select a chapter or section to navigate.

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Preface

Medico-legal practice begins with a change of question. In the clinic, the doctor asks what can be done to help the person in front of them. In legal work, the doctor must also ask what can reasonably be concluded, from which evidence, for which purpose, and within which limits. The same clinical knowledge serves both activities, but the relationships, responsibilities and documents are different.

My approach to trauma has always placed the injured person within a wider picture. A fracture is an anatomical event, but its consequences extend into mobility, employment, family life, independence and confidence. A satisfactory operation and a satisfactory recovery are not always the same thing. Medico-legal assessment requires the discipline to describe that difference without exaggeration, and the humanity to recognise that the person is more than a bundle of records.

Understanding must be followed by organisation. A practice that produces sound opinions but cannot control its instructions, protect its information or collect its fees will eventually become unreliable. Good administration creates the conditions in which independent clinical judgement can be exercised properly. It gives the doctor time to read, the examinee time to explain, and the instructing party a realistic understanding of what will be delivered.

This book therefore follows the whole professional activity: choosing an appropriate role; recognising the relevant legal system; building expert skills; assessing the evidence; explaining an opinion; developing a reputable practice; arranging protection; agreeing terms; and obtaining payment for work actually undertaken. It is written primarily for doctors establishing or developing medico-legal work, with particular relevance to trauma and orthopaedics. It also gives solicitors, practice managers and other instructing professionals a clear account of the systems a dependable expert practice needs.

The guiding proposition is simple: professional success should follow the quality and independence of the work. A doctor is paid for time, expertise and careful reasoning. Payment does not purchase a favourable conclusion. Equally, independence does not require the doctor to accept vague instructions, indefinite credit or work outside a clearly agreed scope.

The United Kingdom does not have one uniform set of court procedures. England and Wales, Scotland and Northern Ireland must be distinguished, and civil, criminal, family, coronial and tribunal work require attention to their own rules. The book uses England and Wales as the principal worked framework while identifying where a different jurisdiction or professional role requires different arrangements.

The material has been organised from my practice documents, training records and professional background, alongside current public guidance. Historical documents have informed the discussion, but historical fees, course bookings, insurance quotations and directory entries are not treated as evidence of current entitlement or cover. Clinical case files have not been reproduced. The worked examples in this book are constructed teaching examples.

My intention is to make medico-legal activity understandable as a coherent professional service: clinically informed, legally aware, properly protected, commercially organised and worthy of trust.

Mr Peyman Bakhshayesh, MD, PhD, MBA

Consultant Trauma & Orthopaedic Surgeon; Clinical Lead for General Trauma, Leeds Teaching Hospitals NHS Trust; Honorary Senior Lecturer, University of Leeds.

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How to use this book

This first edition is an educational practice handbook, with public sources checked on 14 October 2026. It distinguishes binding rules, professional guidance and recommended operating methods. The practical templates are starting points for adaptation; they are not case-specific legal advice, insurance confirmation or a substitute for the applicable court order. Obtain appropriate professional advice before adopting contractual clauses, deciding tax treatment or buying cover.

Read the chapters on roles and jurisdiction before accepting a new type of instruction. Use the training and referral tables to plan professional development, then use the operational chapters to design an instruction pathway that matches your competence and capacity. Return to the templates when preparing a particular engagement, and verify the current source before signing a declaration or beginning recovery proceedings.

Training providers and instruction channels are a selected, verified directory rather than an exhaustive market survey or endorsement. A programme can be available without a place being available on a particular date. Fees, membership criteria, course titles and application windows change. Follow the linked provider pages before booking or applying. Inclusion in this book does not imply that I hold every listed membership, undertake every category of work, or recommend a provider for every reader.

References appear under short labels at the point of use and in source lists. Public links lead to the issuing organisation wherever possible. Author-held records are identified in the final source note without exposing private document links, personal financial details or identifiable case material. The book is a personal professional publication; it does not imply endorsement by an employer, hospital, university, insurer or court.

CHAPTER 1

About the author and my medico-legal practice

A clinical foundation

I am Mr Peyman Bakhshayesh, MD, PhD, MBA, a Consultant Trauma and Orthopaedic Surgeon. My NHS practice is based at Leeds Teaching Hospitals, where my work includes major trauma, complex fractures and foot and ankle surgery. My clinical interests include non-union, malunion, pelvic and acetabular injuries and complex articular fractures. These areas are recorded in the Trust's public consultant profile. [A1]

My professional development has crossed several healthcare systems. Following medical education in Shiraz, I trained in Sweden and undertook specialist fellowship experience in Germany and the United Kingdom. My UK training includes pelvic, acetabular and hip surgery at Imperial College and limb reconstruction and foot and ankle surgery at the Royal London Hospital. I completed my PhD at Karolinska Institute in 2020. My private clinical practice is at Huddersfield Private Hospital. [A2, A5]

I am also an Honorary Senior Lecturer at the University of Leeds. The university records my areas of expertise as trauma research, trauma and orthopaedics, medical statistics and three-dimensional research. That academic background supports an approach in which evidence must be understood in context, measurements must be interpreted carefully, and the strength of a conclusion must match the strength of its foundation. [A3]

The work I offer

My professional website describes medico-legal work in orthopaedic trauma and foot and ankle injuries, including expert witness reports, medical negligence reporting and assistance with insurance claims. Enquiries are assessed against the specific questions, clinical subject and available evidence before an instruction is accepted. [A4]

The natural centre of this work is the relationship between injury, treatment and function. A lower limb injury may have implications for walking distance, standing, stairs, driving, employment and participation in family life. A complex reconstruction may achieve union while leaving stiffness, weakness or reduced tolerance of physical work. A foot and ankle condition may interact with a pre-existing deformity or degenerative change. The expert task is to separate these elements, explain their relationship and state what cannot reliably be attributed to the event in question.

This does not mean accepting every musculoskeletal instruction. The proper scope of an individual report depends on the issue being investigated, the date and nature of the treatment, the expertise required and my current relevant practice. An injury may require parallel opinions from a neurologist, psychiatrist, pain specialist, occupational therapist, rehabilitation physician or another surgical specialist. A broad clinical background helps identify those boundaries; it does not remove them.

For potential instructions, the useful starting information is the jurisdiction, purpose of the report, anatomical region, questions requiring opinion, principal dates, records available, deadline and any hearing dates. This allows an initial assessment of competence, conflicts, capacity and likely work. Identifiable records should follow only after an appropriate secure route has been agreed.

My medico-legal training

My retained training records include Expert Witness Institute core training and specific report-writing and legal modules. The following table describes the evidence held for this edition. Attendance and continuing professional development are described as such; they are not presented as an independently verified current membership grade or an assessed certification designation. [A6]

Training record	Evidence retained	Relevance to practice
EWI Core Training	Attendance certificate recording 20 CPD hours; the extracted certificate does not give a completion date	A structured foundation in expert work
Report Writing I	Attendance certificate dated 10 March 2021; 7 CPD hours	Organisation and presentation of an expert report
Report Writing II	Attendance certificate dated 17 March 2021; 7 CPD hours	Further development of report-writing skills
Law for Experts, England and Wales	Attendance certificate dated 12 February 2021; 4 CPD hours	The legal setting in which expert opinion is used

Some modules may form part of a wider package; their hours should not simply be added to the package total. The value of training also depends on application, reflection and updating. A certificate from an earlier year does not establish familiarity with rules introduced later. This is why the book returns repeatedly to continuing development, peer review and the current procedural source.

A philosophy of fair interpretation

My clinical background leads me to begin with mechanism, chronology and consequences. What force acted on the body? What was recorded at the time? What treatment followed? What changed during recovery? What is the present limitation, and what other explanations need consideration? These questions provide a disciplined structure without predetermining an answer.

The account of the injured person matters. So do the original records, imaging, examination findings and the possibility that recollection changes over time. Respect for the person and scrutiny of the evidence can coexist. A discrepancy is a reason to investigate and explain, not an invitation to assign a character judgement beyond the available evidence.

In medico-legal work, the court or other decision-maker needs a transparent route from evidence to conclusion. An unexplained assertion of experience is inadequate. An opinion should identify the supporting observations, distinguish assumptions from established facts, consider

relevant alternatives and show the effect of missing information. If a conclusion changes when an assumption changes, that dependency should be visible.

Function is especially important in trauma and orthopaedics. Range of movement, radiographic appearance and the integrity of an implant are useful clinical observations. Their practical significance depends on the person's activities. The requirements of sedentary work differ from those of repeated lifting, climbing or prolonged standing. The report should explain those distinctions and recognise where another expert is needed to assess care, vocational options or economic loss.

An organised and independent service

My historical practice terms show a consistent concern with written instructions, relevant records, a defined professional fee, supplementary work, attendance arrangements and timely payment. They also explicitly recognise that the expert's duty to the court takes priority over the interests of the instructing party. The operational chapters develop those principles into a more systematic practice framework. [A7]

This book is not a replacement fee schedule. Different archived versions contain different attendance rates, and old insurance documents include quotations or hospital-specific requirements. A current engagement must therefore rely on a dated quotation and terms accepted for that instruction. The same discipline applies to training status, reporting capacity and insurance confirmation: each should be established from its current evidence.

A well-run service makes independence easier to maintain. The expert knows what has been commissioned, the administrative team knows what can be promised, and the instructing party understands when more information or a revised budget is required. The person being examined receives a clear explanation of the appointment and its purpose. Neither rushed work nor unlimited commitments are a sign of professionalism.

Contact and professional information

The current professional website is peymanorthopaedics.world, with medico-legal enquiries described on its [medico-legal services page](#). The published practice contact is admin@ankleandfootsurgeryleeds.co.uk and 07427 297799. GMC number: 7007972. Use the practice's current published contact route to confirm availability and secure document transfer. [A1, A4]

Clinical and academic appointments are provided as professional background. This book and private medico-legal instructions are not representations of the views of Leeds Teaching Hospitals or the University of Leeds. Personal public engagement must not determine the treatment of an examinee or the content of an independent opinion.

CHAPTER 2

Understanding the different forms of medicolegal work

Medicolegal practice begins by identifying the decision that another person or institution must make. The same diagnosis can generate several different assignments. An ankle fracture may require a treating surgeon's account, an independent prognosis for a personal injury claim, an opinion about alleged delay in treatment, a return-to-work assessment, or evidence at an inquest. These assignments draw on overlapping clinical knowledge but do not share the same purpose, instructions, audience or procedural rules.

A doctor should therefore define each instruction by four questions: **What role am I performing? What question am I answering? Who is entitled to receive the answer? Which legal or administrative process governs the work?** A description such as “medical report” is insufficient. It does not establish whether the doctor is describing personal involvement, assessing someone independently, advising privately on a potential claim, or preparing evidence that may be tested in court.

The treating doctor and the witness of fact

A witness of fact describes what happened within their knowledge: the examination performed, the findings recorded, the treatment recommended, the decision made and the reasons for it. Contemporaneous records should anchor the account. A recollection formed years later must be identified as a recollection, while usual practice must not be presented as proof that a particular step occurred. The GMC recognises that a treating professional may also give evidence about a patient's current condition and care needs; terminology such as “professional witness” varies between proceedings. The scope must be clarified rather than assumed. [L1]

For example, a surgeon can explain that swelling prevented immediate definitive fixation and describe the clinical reasoning recorded at the time. That account does not automatically make the surgeon an independent assessor of whether the whole hospital service met the required standard. The doctor may be an important source of evidence while also having personal involvement in the disputed events. A factual statement, an independent expert report and a response to allegations should be commissioned and drafted as distinct documents.

Independent expert evidence

An independent expert supplies specialist reasoning on questions outside the ordinary knowledge of the decision-maker. Clinical seniority is relevant but does not, by itself, establish competence in every medicolegal subject. Expertise must fit the actual issue. Detailed knowledge of reconstructive surgery may support an opinion on post-traumatic function, while an assessment of psychiatric injury, care costs or vocational retraining may require another professional.

The Academy of Royal Medical Colleges distinguishes the expert role from the professional witness role and expects relevant training, continuing development and inclusion of expert work

within appraisal. Its guidance also emphasises familiarity with the standards and circumstances at the time of the events. A modern preferred treatment should not simply be imposed retrospectively on care delivered in an earlier period. [L2]

A practical map of available activities

Activity	Typical question	Main output and boundary
Factual or professional witness	What did you observe, decide and do?	Statement based on involvement and records; clarify any opinion requested.
Personal injury expert	What injury occurred, what caused it, and what consequences follow?	Independent condition, causation and prognosis report; do not decide legal liability.
Clinical negligence expert	Was care below the relevant standard, and what difference did that make?	Separate breach, causation and condition/prognosis analysis within the instructed expertise.
Advisory or screening expert	Is further investigation medically justified?	Preliminary advice with limitations; clarify intended use and potential future disclosure with the solicitor.
Criminal expert	What can medical findings establish about a disputed event or clinical issue?	Specialist evidence governed by the relevant criminal process.
Family proceedings expert	What medical evidence is necessary to resolve the authorised issues?	Court-authorised assessment/report where required; specialised competence is essential.
Coroner's or fatal accident inquiry witness	What happened, and what medical evidence assists the death investigation?	Factual or independent evidence within the investigation's scope.
Tribunal or regulatory expert	What does specialist evidence show about the statutory or professional issue?	Report aligned to the tribunal's own test, directions and procedure.
Employment, pension or insurance assessor	What functional limitation or medical condition is relevant to the decision?	Purpose-limited report; distinguish clinical advice from the decision-maker's contractual or legal judgment.
Capacity-related assessment	Can this person make this particular decision at the relevant time?	Decision-specific assessment under the applicable jurisdiction's framework.
Forensic clinical work	What care and evidential examination are required?	Clinical documentation and, where relevant, forensic samples/evidence under specialist protocols.
Independent review, investigation or mediation support	What clinical lessons or technical explanations are needed?	Agreed advisory product; do not describe it as court evidence unless commissioned accordingly.

This table is a planning tool, not a statement that every doctor is qualified to undertake every activity. Its value is to separate markets that are often combined under one commercial heading.

Personal injury and clinical negligence

In personal injury work, the orthopaedic questions commonly concern injury, recovery, continuing symptoms, treatment needs and future function. A useful assessment links anatomy to daily life: walking tolerance, stairs, lifting, sleep, travel, employment and care. The report should describe what the person can do, what they cannot do, and the evidential basis for that distinction. A diagnosis alone rarely answers the whole instruction. The England and Wales personal injury pre-action protocol provides the procedural context for many such instructions. [L3]

Clinical negligence adds a different analytical task. An adverse outcome is not itself proof of substandard care. The analysis must distinguish the alleged departure from the relevant standard from the harm said to result. NHS Resolution identifies breach of duty and causation as separate elements that must be established for compensation. The clinical disputes protocol promotes sufficient early information to investigate and, where appropriate, resolve the claim. [L4, L5]

For a hypothetical delayed diagnosis of a fracture, the questions should therefore be separated: what should reasonably have been recognised at the first attendance; what investigation or treatment should then have followed; and what would probably have happened with that alternative course? The eventual deformity cannot simply be attributed to delay without explaining the causal pathway. Conversely, the fact that an injury was severe does not establish that every later difficulty was unavoidable. This disciplined comparison is a method of reasoning, not an invitation to advocate for either side.

Criminal, family and death investigation work

In criminal work, recording an injury and expressing an opinion about its cause are different evidential tasks. The Crown Prosecution Service explicitly distinguishes these situations. A doctor who moves from “I observed bruising” to an opinion about the likely mechanism may be providing expert evidence. The medical opinion should explain the support and limitations of the findings; the court determines guilt and the applicable legal categorisation. [L6]

Family work may involve injury interpretation, developmental conditions or other specialist assessments. Adult trauma experience is not a substitute for competence in paediatric injury interpretation or safeguarding. In England and Wales, expert evidence is controlled by Family Procedure Rules Part 25 and related directions; in children proceedings permission is also required for instruction and specified examinations or assessments. Current rules include regulated-expert requirements, with defined exceptions. [L7, L8]

At an inquest, treating clinicians may explain their care while an independent expert addresses a technical issue identified by the coroner. Expert evidence is not required in every case; the coroner determines its necessity and scope. In Scotland, a fatal accident inquiry is a distinct process intended to establish circumstances and help prevent further deaths. Neither role should be approached as a routine claimant-versus-defendant report-writing exercise. [L9, L10]

Tribunals, occupational assessments and other roles

“Tribunal work” is not a single discipline. Professional regulation, employment, social entitlement and immigration proceedings raise different questions. The Medical Practitioners Tribunal Service publishes a specific expert witness protocol through its hearing resources. The First-tier Tribunal Immigration and Asylum Chamber has its own practice direction, including focused requirements for expert reports. A report template designed for one forum should not be exported unchanged to another. [L11, L12]

Employment, insurance and pension reports often support administrative decisions rather than litigation. The GMC requires clarity about the examination and disclosure, relevant information and appropriate consent; it also addresses offering patients access to employment or insurance reports before release, subject to specified exceptions. These requirements should not be confused with giving the examinee a right to rewrite an independent litigation opinion. [L13]

Forensic clinical practice may combine urgent healthcare with evidential responsibilities. Where an activity falls within the Forensic Science Regulator's statutory code in England and Wales, the applicable quality requirements must be checked. Version 2 of that code took effect on 2 October 2025. Its existence does not mean that every independent medical report is a regulated forensic science activity. [L14]

CHAPTER 3

Independence, jurisdiction and the expert's duties

The most valuable expert is not the one who always agrees with the instructing party. It is the one whose reasoning can survive informed challenge. Professional independence is visible in the handling of inconvenient facts, the recognition of uncertainty and the willingness to change an opinion when the evidence changes.

England and Wales: civil proceedings

Civil Procedure Rules Part 35 makes the duty to assist the court paramount over obligations to the instructor or payer. Expert evidence is restricted to what is reasonably required. Court permission governs reliance on expert evidence; a solicitor's instruction is not itself permission to put the report before the court. Part 35 also covers single joint experts, written questions and expert discussions. [L15]

Practice Direction 35 requires independent, objective opinion, consideration of material facts that may weaken the conclusion, and acknowledgment of matters outside expertise or insufficiently supported. It specifies report contents and the required declaration and statement of truth. The current wording should be taken from the live direction when a report is finalised. A copied historic template may be out of date. [L16]

England and Wales: other proceedings

Criminal Procedure Rules Part 19 governs expert evidence in criminal proceedings, including duties to the court, report requirements and disclosure of matters affecting reliability or impartiality. It should be read with the applicable Criminal Practice Directions. A civil report's declaration is not automatically the correct declaration for a criminal case. [L17]

Family Procedure Rules Part 25 uses a necessity test for permission. As updated in July 2026, the framework generally restricts instruction in specified children proceedings to regulated experts, subject to exceptions. A doctor must check the particular order, permitted questions and current PD25B requirements, including evidence of regulated status where applicable. [L7, L8]

The Court of Protection has its own rules, with expert evidence addressed in Part 15 and accompanying practice directions. A capacity assessment requested outside proceedings and an expert report commissioned for Court of Protection proceedings may concern similar clinical matters but need different procedural handling. [L18]

Scotland

The England and Wales CPR are not the procedural code for Scotland. Scottish civil cases proceed under the relevant Court of Session or sheriff court framework and case-specific orders. [L24] In *Kennedy v Cordia (Services) LLP* [2016] UKSC 6, a Scottish appeal, the Supreme Court identified assistance to the court, relevant expertise, impartiality and a reliable knowledge base as central considerations for skilled evidence. The decision also stresses that the expert assists rather than replaces the court's decision-making. [L19]

For Scottish criminal instructions, the Crown Office and Procurator Fiscal Service publishes an expert witness guide. Its May 2026 version addresses independence, distinguishing facts from assumptions and revelation of relevant material to the Crown. A Scottish instruction should be checked for the applicable disclosure obligations and procedural expectations, not treated as an England and Wales case with different place names. [L20]

Northern Ireland

Northern Ireland also has its own court rules and directions. The High Court guidance published on 17 December 2024 addresses instruction, reports, joint experts, discussions and attendance. It must be read with relevant practice directions, including the clinical negligence protocol and expert directions. It contains its own expert declaration. Unlike the more qualified wording of the 2014 England and Wales guidance, the Northern Ireland document expressly forbids expert fees contingent on the nature of the evidence or the case outcome. [L21]

Forum	Starting point for procedural checking
England and Wales, civil	CPR Part 35, PD35, applicable pre-action protocol and court orders
England and Wales, criminal	Criminal Procedure Rules Part 19, Criminal Practice Directions and orders
England and Wales, family	FPR Part 25, relevant 25-series directions, legislation and orders
England and Wales, Court of Protection	Court of Protection Rules Part 15 and applicable directions
Scotland	Relevant Scottish court rules, orders and Scottish expert evidence principles; COPFS guidance for Crown work
Northern Ireland	Relevant Northern Ireland rules, High Court expert guidance and applicable practice directions
Inquests and tribunals	The forum's own legislation, guidance, directions and instruction

Managing conflicts before accepting work

A practical conflict check should identify the person to be examined, treating organisations, named clinicians, parties and relevant business relationships before detailed confidential material is circulated. A previous treating relationship, close professional connection, financial interest or earlier involvement may require disclosure and may make the instruction unsuitable. Disclosure does not automatically cure a conflict. The seriousness of the connection and the nature of the requested opinion matter.

An original practice rule is useful: ask whether the relationship could reasonably cause a reader to question the fairness of the reasoning. If so, document it, obtain appropriate advice and resolve the issue before substantive work. Repeat the check when new parties or previously unknown connections emerge. A practice can maintain a confidential conflicts register without placing unnecessary clinical information in a general enquiry database.

Commercial independence also deserves attention. A practice that relies heavily on one introducer may experience subtle pressure to reproduce that introducer's preferred conclusions. Monitoring concentration of instructions is a sensible business safeguard. An instruction should never promise a favourable report, a successful claim or a particular damages outcome. The product is a competent assessment and an explained opinion.

CHAPTER 4

From instruction to a defensible report

The following workflow is a suggested practice method. It translates the need for clear scope and reliable reasoning into a sequence that a small medical practice can operate consistently.

Establish the assignment

Request a written instruction identifying the issues, forum, parties, deadlines, records available and intended report use. The Civil Justice Council guidance provides a framework for agreeing scope, timetable, fees and the material needed. It also distinguishes preliminary advice from evidence intended for proceedings. A label such as “privileged” should not be treated by the doctor as a guarantee against future disclosure; that question belongs with the instructing legal adviser. [L22]

Create a one-page case brief in plain language. For an orthopaedic instruction it might read: “Assess the consequences of the right tibial injury, distinguish pre-existing limitations where the evidence permits, address future treatment within orthopaedic expertise, and answer the questions listed in the letter.” Beside that statement, record the important exclusions. This prevents an initial condition-and-prognosis assignment from gradually becoming an unpriced and unsupported opinion on every aspect of a person's life.

At acceptance, also confirm a realistic report date. The examination is only one component of the job. Records review, image access, writing, source checking, correction and any anticipated meeting must fit within the allocated time. A sustainable practice reserves capacity for supplementary work and court dates instead of allocating every available hour to new examinations.

Build an evidence inventory

Before constructing a narrative, list the material received. Record document dates, source, page or bundle references, periods covered and material gaps. Distinguish an original imaging study from the radiology report, a contemporaneous note from a later summary, and a witness's recollection from an agreed fact. Do not write “the records show” when the proposition actually comes from one party's instruction letter.

A suggested chronology has four columns: date; event or proposition; source; significance or uncertainty. The final column should remain analytical. It is a place to ask whether a delay matters, whether records conflict, or whether the apparent sequence changes when an original timestamp is examined. Merely copying thousands of entries creates length without necessarily improving understanding.

Missing evidence should generate a specific request: identify what is missing and explain which question it affects. “Please provide all records” may be justified initially, but a later targeted request is more useful than repeatedly stating that the bundle is incomplete. If the missing material cannot be obtained, the report can explain the resulting limitation and, where appropriate, provide alternative opinions based on clearly stated assumptions.

Conduct a purposeful assessment

The examination should follow an explained agenda. Verify identity, clarify the assessment's purpose and recipients, and document the arrangements for consent, interpretation, accompaniment or chaperoning as applicable. A medicolegal examination is not automatically a treatment consultation. The examinee should understand that the report may include findings that do not support their account or expectations.

Questions should establish the sequence of symptoms and recovery rather than merely reproduce a list of complaints. For a lower-limb injury, explore the practical meaning of walking limitation: surface, distance, pace, aids, rests and after-effects. Distinguish a capability demonstrated once from an activity that can be sustained over a normal working day. Record the person's own description and the examiner's observations separately.

If urgent clinical concerns emerge, the assessment process needs a clear route to appropriate care and communication. Such action should be recorded and should not silently convert the encounter into a continuing treatment relationship. Routine recommendations for further investigations should explain why they are needed for the opinion and who will arrange them. Do not perform a remote assessment merely because it is administratively convenient when the disputed issue requires physical examination.

Make the reasoning visible

A strong report enables the reader to follow the route from evidence to conclusion. Use a consistent sequence: identify the question; identify the relevant evidence; discuss competing explanations; give the opinion; state its limitations. The clinical narrative and the medicolegal analysis are related but should remain recognisable as different parts of the report.

Consider a fictional person with continuing knee pain after an accident. The records document earlier intermittent discomfort, immediate post-accident swelling and later imaging showing degenerative change. An unhelpful report might say that all pain is traumatic because symptoms worsened after the accident. An equally unhelpful report might attribute everything to degeneration simply because it appears on imaging. A better assessment asks what changed, whether the proposed mechanism fits, what the examination and imaging establish, and what the available history suggests about the likely course without the accident.

The answer may involve an injury superimposed on pre-existing disease, temporary exacerbation or an inability to distinguish contributions reliably. Those are different propositions and should not be used interchangeably. If there is insufficient evidence to provide a defensible period of acceleration, the report should not manufacture one. A numerical estimate gains no scientific authority merely by being expressed in months.

The legal question may require an opinion on the balance of probabilities, but that does not turn every clinical statement into a greater-than-50-percent calculation. Ask the instructor to define any specialised legal test. Explain medical plausibility, competing explanations and evidential strength in terms the court can use. Do not replace a reasoned analysis with a ritual statement of certainty.

Separate causation, prognosis and need

Causation asks how the relevant condition arose or changed. Prognosis asks how it is likely to develop. Treatment need asks what intervention is clinically justified. Functional consequence asks what the condition means for activities. These questions should be connected without being collapsed into one another.

A recommendation for surgery does not establish that surgery will occur, that it will succeed, or that all future impairment will disappear. If future treatment influences prognosis, describe reasonable scenarios and their assumptions. Where another discipline is required, formulate the question that the other expert should address. “Psychiatric opinion required” is less informative than identifying the unresolved issue of trauma-related symptoms and their possible contribution to work capacity.

For major trauma, the report should avoid treating a complex person as a collection of unrelated percentages. Explain how limitations interact. Upper-limb impairment may affect crutch use; pain, sleep disturbance and lower-limb disability may jointly affect endurance. At the same time, stay within the permitted expertise and avoid duplicating another expert's work.

Construct a report that can be used

A suggested report architecture is: identification and purpose; relevant expertise; instructions; material considered; chronology; reported history; examination; investigations; reasoned answers; conclusions; limitations; references; and the declarations required by the forum. Use numbered paragraphs, descriptive headings and precise source references. Place a short summary near the beginning, but ensure it does not overstate conclusions qualified later in the report.

PD35's formal requirements include qualifications, relied-upon literature or material, material instructions, the distinction between personal knowledge and other facts, relevant details of examinations or tests, treatment of a range of opinion, a conclusions summary and required statements. The checklist should be checked against the actual direction, rather than treated as a substitute for it. [L16]

Before release, read the questions again and confirm that each has been answered or explicitly deferred. Check the side of injury, dates, units, names and internal consistency. Check that cited articles actually exist and support the propositions attributed to them. Remove text inherited from a template that has no relationship to the case. Sign only the version personally reviewed and approved.

CHAPTER 5

After the report: maintaining quality through the life of the case

Corrections and changes of opinion

A practice should distinguish three events. A factual correction repairs an error. A clarification explains an existing opinion. A material change of opinion responds to new evidence or reconsideration and must be identified as such. The distinction helps everyone understand whether the reasoning has changed or its expression has simply become clearer.

Keep a version register with the date, status, recipient and reason for each substantive revision. A signed report should not be overwritten without preserving what was sent. For a material change after a civil report, PD35 requires prompt communication to all parties and, when appropriate, the court. [L16] When a change is necessary, identify the affected paragraphs and explain its significance. Independence is strengthened by a justified correction; it is weakened by hiding the route by which the conclusion changed.

Questions, discussions and oral evidence

Under CPR35, written questions and expert discussions are part of the evidence process, not an optional after-sales service. Unless the court permits or the parties agree otherwise, the rule limits written questions to clarification, normally once and within 28 days of service. Case-specific orders must be checked. Experts' discussions and any resulting statement concern the areas of agreement and disagreement and their reasons. [L15]

A useful preparation method is to build an issue table with four columns: question; own view; other expert's view; reason for difference. This often reveals that disagreement arises from different assumptions or records rather than clinical principle. Resolve the source difference where possible before debating conclusions. The aim is accurate assistance, not bargaining to preserve a position or secure an artificial middle ground.

For oral evidence, prepare the report, sources, chronology and changed opinions. Know where the important documents are located. Listen to the whole question, answer it directly and distinguish inability to recall from inability to conclude. Acknowledging an appropriate proposition does not surrender independence. If a question presents a false choice, explain the additional possibility briefly and clearly.

Technology, delegation and authorship

Administrative assistance can improve consistency, but the doctor remains responsible for the opinion signed. A secretary may format a chronology; an approved system may help locate records; neither can determine what the evidence means on the expert's behalf. Maintain a clear distinction between clerical support and clinical or scientific judgment.

Artificial intelligence requires particular care with confidentiality, fabricated references and loss of source context. The Civil Justice Council's June 2026 update still described expert evidence as

an area requiring further consideration and discussed possible proportionate transparency. That is not a universal permission to use any tool with confidential files, nor a blanket statutory disclosure rule. Check current rules, orders and contractual arrangements for the case. [L23]

As a practice policy, verify every substantive statement against the underlying source, use approved secure systems and record significant analytical assistance. Never allow software to invent an examination finding, recollection, reference or rationale. If an output cannot be independently checked and explained by the signing expert, it should not enter the report as that expert's conclusion.

A learning system for the practice

Review a small sample of completed cases at regular intervals. Useful questions include whether instructions were clear, additional evidence was requested early, deadlines were met, important amendments were needed and invoices matched agreed work. Clinical peer discussion can improve reasoning if confidentiality and appropriate permissions are respected. Audit should identify repeated process weaknesses rather than merely count reports produced.

Maintain a learning record of courses, relevant literature, feedback and difficult issues. Seek feedback on clarity and responsiveness, not on whether the report helped someone win. Preserve enough time for current clinical knowledge and reflective review. A practice becomes reliable through repeatable habits: accepting suitable work, organising evidence, reasoning transparently, and remaining available to explain the opinion when it is challenged.

CHAPTER 6

Professional development: choosing courses, assessment and continuing education

Medicolegal competence is a combination of clinical knowledge, legal understanding and disciplined communication. Clinical seniority provides an important foundation, but it does not automatically confer the ability to prepare a court-compliant report, distinguish fact from assumption, analyse a legal question or participate constructively in a meeting of experts. Training should therefore follow the work the doctor intends to undertake. A personal injury expert, a clinical negligence expert, a forensic physician and an occupational health adviser may need overlapping skills, but their training pathways are not interchangeable.

The practical objective is to build a demonstrable chain from education to performance: learn the relevant rules; practise the task; obtain feedback; undertake appropriately scoped instructions; and review the quality of the resulting work. A collection of attendance certificates is useful evidence of engagement. It is not, by itself, evidence that every aspect of practice has been assessed.

Four descriptions that should remain separate

Description	What it establishes	What must still be checked
Course attendance or CPD	Participation in specified education, sometimes with a knowledge test	Whether practical work was assessed, whether the learning is current, and whether it covers the intended jurisdiction
Assessed certificate	Completion of the named provider's assessment requirements	The actual award, scope, assessment components and any renewal requirements
Professional membership	Admission to a stated membership grade	Whether the grade is introductory, vetted, assessed or entitled to a public directory listing
Accreditation for a defined scheme	Satisfaction of that scheme's requirements	The activities and legal processes to which that accreditation applies; it is not a general licence for all medicolegal work

The Cardiff University Bond Solon certificate illustrates the importance of precise terminology: Cardiff describes its role as assessment, quality assurance and certification, and expressly states that the certificate is not a credit-bearing Cardiff University award. EWI likewise distinguishes Associate, Full, Fellow and Certified status. Accurate wording protects both the reader and the expert's professional reputation. [T1, D1]

A working catalogue of courses and programmes

The following catalogue was checked against official provider pages on **14 October 2026**. It is a practical selection, not an exhaustive ranking. A course appearing in a current catalogue does not guarantee a place on a particular date. Some individual modules below also form part of a larger programme: the reader should avoid paying twice for overlapping content.

Course or programme	Intended use and format	Selection points
1. Cardiff University Bond Solon Expert Witness Certificate	Civil, criminal or family pathways for England and Wales; five training days with three assessments; public delivery described as virtual	A structured assessed pathway for new or practising experts. Includes report writing, courtroom skills, cross-examination and the relevant law/procedure course. The civil route is the most directly aligned with ordinary personal injury and clinical negligence practice. [T1, T2]
2. University of Aberdeen Bond Solon Expert Witness Certificate	Programme for experts working in Scotland	Choose the jurisdiction-specific pathway where Scottish instructions are intended; do not assume an England and Wales course teaches all Scottish procedure. Obtain the current programme and assessment schedule from Bond Solon. [T3]
3. Bond Solon: Report Writing for Expert Witnesses	One-day course, offered publicly or in-house	Useful for developing a report structure and testing how a report will be read and challenged. May also contribute to a certificate pathway. [T3, T4]
4. Bond Solon: Courtroom Skills and Cross-Examination Day	Two separately listed one-day courses	Practical oral-evidence preparation. Check sequencing and preparation requirements before booking; attendance at one day should not be described as completion of both courses or of the full certificate. [T3]
5. Bond Solon: Civil Law and Procedure	Two-day public or in-house course	Appropriate for understanding the legal framework of civil instructions. Separate criminal and family versions are listed where those are the intended fields. [T3]
6. EWI: Core Training for Experts	Modular webinars covering Law for Experts, Basics of Report Writing, Advanced Report Writing, and Expert Discussions and Joint Statements	Law modules distinguish England and Wales from Scotland. Published CPD durations are respectively four, 6.5, seven and two hours. The package is a training route; EWI membership and certification are separate questions. [T5]
7. EWI: Confidence in the Courtroom	Further practical training listed alongside the core programme	A development step once instructions begin, particularly where oral evidence is foreseeable. Select it to practise explaining, qualifying and defending a reasoned opinion rather than to learn advocacy for a party. [T5]
8. The Academy of Experts: Foundation Course	Intensive introduction to the expert's responsibilities, report, instructions and procedure	The published November 2026 intake runs across four online morning sessions, 17-20 November. Suitable for establishing foundations or refreshing infrequently used skills. Training does not automatically grant Academy membership. [T6]

Course or programme	Intended use and format	Selection points
9. The Academy of Experts: Understanding Law & Procedure	Introductory procedural course; the calendar lists two online sessions on 19-20 October 2026	A targeted option for strengthening legal and procedural knowledge. Confirm that the content matches the intended courts and case type. [T7]
10. SpecialistInfo: Expert Witness Foundation Day - Personal Injury	Foundation training for medical professionals preparing personal injury reports	The provider's current portfolio includes this course. Check the next intake and available online/in-person format rather than relying on an old event advertisement. [T8]
11. SpecialistInfo: Expert Witness Foundation Day - Clinical Negligence	Medical expert training covering breach of duty, consent, report writing and related expert tasks	A distinct subject-specific day, which can be taken separately from the personal injury day. Appropriate where negligence instructions are planned within the doctor's clinical competence. The published course description awards five CPD points. [T9]
12. University of Strathclyde / Inspire MediLaw Expert Witness Certificate	Healthcare-focused pathway combining two-day training, online modules and final assessment	The provider describes a report-writing exercise with individual feedback, an MCQ assessment and simulated cross-examination. The two-day course alone is not the whole certificate. Confirm the jurisdiction and total package cost. [T10]
13. Inspire MediLaw: Online Expert Witness Training	Four modules with self-paced material and practical learning	An option for doctors needing a flexible learning schedule; the report-writing component offers feedback. Clarify which elements count towards the assessed certificate and which are standalone education. [T11]
14. MedCo initial accreditation and ongoing CPD	Online accreditation for experts producing reports within the MedCo scheme	MedCo states that initial training takes approximately 30-40 hours and must be completed within nine months of registration. This is a defined reporting route, principally relevant to the first fixed-cost reports in the applicable low-value road traffic injury processes, rather than a universal orthopaedic expert qualification. [T12]

Other useful education may be found through the **Royal Society of Medicine Clinical Forensic & Legal Medicine Section**, particularly for wider legal medicine interests. However, its section page showed no future events when checked for this edition. It is therefore an educational resource to monitor, not a confirmed upcoming expert-witness course. [T13]

Fees: use a dated budget, not a permanent promise

Published prices are snapshots and may change. The CUBS page showed **£2,115 plus VAT when the days are booked together**, or **£2,350 plus VAT if booked separately**, including its stated marking and certification charge. The Academy calendar showed the November Foundation Course at **£525 for members and £700 for non-members**, and Understanding Law & Procedure at **£225 and £300** respectively; confirm VAT treatment and the final booking price. Inspire MediLaw's page listed a **6 November 2026 assessment at £1,295 plus VAT**; that is an assessment listing and must not be mistaken for the total cost of the entire pathway. [T2, T7, T10]

A realistic training budget also allows for preparation, absence from clinical work, travel where relevant, report assessment, resits, membership and subsequent updating. The lowest advertised ticket price may represent a single component rather than the intended outcome. Ask the provider for a written breakdown of the whole pathway before committing.

Turning education into reliable practice

For a trauma and orthopaedic surgeon, a sensible development sequence begins with civil expert duties and report writing, then adds personal injury causation, functional prognosis and clinical negligence analysis as the proposed workload requires. Joint-statement and courtroom practice should be scheduled before a difficult case makes them urgent. A mentor or appropriately experienced reviewer can help identify overstatement, unexplained assumptions and missing reasoning in anonymised practice material. Any use of real case material for training or review requires proper confidentiality arrangements.

The author's retained course records provide a useful starting point. His archive documents bookings in 2021 for Law for Experts (England and Wales), Report Writing I, Report Writing II, and Experts Discussions & Joint Statements. An attendance certificate separately records four hours of Law for Experts CPD dated 12 February 2021. Those records should be catalogued by **booked, attended, assessed, and renewed** status. Booking confirmations must not be converted into claims of attendance or certification, and historic training should be supplemented by evidence of current learning.

An annual review should ask which part of the actual caseload is most difficult: causation, prognosis, interpretation of records, legal tests, joint discussions, oral evidence or administrative control. Training should address those gaps. MedCo participants must also meet the scheme's specific requirements: its 2026-2027 notice states six CPD hours for the year running 1 June to 31 May, with mandatory modules additional where required. Other professional schemes may impose different requirements. [T14]

The test of successful development is improved work: clearer instructions, more transparent reasoning, fewer avoidable corrections, better explanation of uncertainty and reports that remain intelligible when read several years later.

CHAPTER 7

Professional visibility: memberships, directories and instruction channels

A doctor entering medicolegal practice needs access to appropriate instructions. Describing this simply as finding patients can obscure the relationship. In many cases the commercial client is a solicitor or reporting organisation, the examined person is the claimant or other subject, and the expert's overriding obligation is to the relevant court or tribunal. The marketing message should therefore explain the medical expertise offered and the quality of the service, without promising a favourable opinion.

There are several distinct routes to visibility. Professional bodies can provide support and a graded directory presence. Commercial directories publish searchable profiles. Medical reporting agencies manage instructions and administration under their own contracts. Scheme registration gives access to a defined process. Direct professional relationships may produce instructions without an intermediary. These routes can coexist, but their costs, obligations and degree of control differ.

The BMA identifies recommendations, expert directories, professional bodies, contact with law firms and local law societies, professional writing, a website and social media as potential ways to obtain work. None removes the need to assess competence and conflicts when an instruction arrives. [D13]

Twelve websites and routes to consider

The entries below were reviewed on **14 October 2026**. They are options for investigation, not endorsements, guarantees of instructions or claims that the author is already a member. In particular, a commercial listing must not be described as court approval.

Organisation and website	Type of route	Entry route and practical relevance
1. Expert Witness Institute - ewi.org.uk	Professional membership and searchable directory	Apply for the grade supported by the evidence. EWI explains that Full and Fellow members are vetted; Certified status adds assessment of expert meetings and courtroom performance; Associate status indicates core training with practice quality not yet vetted. A useful professional-support route as well as a source of visibility. [D1]
2. The Academy of Experts - academyofexperts.org	Professional body, accreditation and expert register	Membership grades reflect qualifications and expert experience. Its process includes legal references and, for full membership, report samples. The pre-application questionnaire can help identify the appropriate grade. [D2]
3. UK Register of Expert Witnesses - jspubs.com	Commercial register with professional support resources	The application offers vetted and unvetted status. Check the distinction, reference requirements, listing package and annual cost. This is a private register, not a government register of licensed experts. [D3]

Organisation and website	Type of route	Entry route and practical relevance
4. Expert Witness - expertwitness.co.uk	Commercial directory and publishing platform	Offers directory placement through its Join Us route. Ask what the subscription includes, how specialty searches work and whether useful enquiry data are available. Advertising presence and assessed competence are different claims. [D4]
5. SpecialistInfo - specialistinfo.com	Medical directory, medicolegal CV listing and Faculty of Expert Witnesses grades	The current services page allows listed doctors to upload a medicolegal CV free of charge. It distinguishes Associate, Member and Fellow criteria; the Fellow description includes independent review of an anonymised report. The author's own archive already identifies this provider. [D5]
6. Action against Medical Accidents - avma.org.uk	Assessed medical expert database supporting its Lawyers Service	Experts cannot pay for inclusion: applications are assessed. Its focus is clinical negligence, and recommendations are provided to Lawyers Service members rather than as a general public booking directory. Particularly relevant for doctors whose clinical expertise and report quality fit that field. [D6]
7. National Register of University Certificated Expert Witnesses - register.bondsolon.com	Certificate-linked directory	The register's application identifies the accepted Bond Solon certificate categories, including CUBS and UABS. Successful course attendance alone is insufficient. The registration page describes free entry for eligible certificate holders and an expert-witness CPD commitment. [D7]
8. MedCo - medco.org.uk	Registration, accreditation and search system for defined medical reporting	Relevant where the intended work falls within its prescribed process. Decide whether this work suits the practice before registering. MedCo status is not required for every form of personal injury reporting and should not be promoted as accreditation for unrelated clinical negligence work. [T12, D8]
9. TLA Medicolegal - tla-medicolegal.com	Agency and managed expert instruction route	Its services cover personal injury and clinical negligence, including complex cases; the site provides a route for experts wishing to join. The author's archive identifies TLA as an organisation of interest. Request the expert agreement, payment terms and expected workload before joining. [D9]
10. Medical Expert Witness Alliance (MEWA) - mewa.org.uk	Expert panel and instruction intermediary	Its official indexed pages describe a medical expert panel and enquiry route. The author's archive identifies MEWA. Detailed recruitment criteria and financial terms were not publicly verified for this edition; obtain them directly before treating it as an available appointment or membership. [D10]
11. Premex Services / Premex+ - premexservices.co.uk; premexplus.co.uk	Medical reporting agency panels	Premex publishes a Join Our Panel route. Premex+ describes vetting for report quality, specialty and relevant communication experience. These are commercial panel arrangements; agree fees, administration and payment responsibility explicitly. [D11]

Organisation and website	Type of route	Entry route and practical relevance
12. Speed Medical - speedmedical.com	Medical assessment and reporting panel	Its registration-of-interest form asks for specialty and consulting location; the panel supports several sectors, including medicolegal reporting. Clarify the precise service being offered and separate assessment/reporting obligations from any treatment work. [D12]

Inspire MediLaw also describes a member directory and professional support; it may be considered alongside its training pathway. RSM membership is principally an education and professional-networking option, and should not be treated as a predictable source of medicolegal referrals. [D14, T13]

Selecting channels for a consultant orthopaedic practice

For a practice with major trauma, lower-limb reconstruction and foot-and-ankle interests, the most useful profile is specific enough to permit proper matching. It should identify the injuries and questions the expert can address, the limits of the proposed service, the available examination arrangements and the relevant jurisdiction. A long list of every operation ever encountered is less helpful than a precise account of current expertise.

A practical initial portfolio could combine one professional body, a carefully maintained medical directory profile, and a small number of agency relationships whose case mix fits the practice. Direct relationships with instructing solicitors can then develop through reliable work and useful educational contributions. The purpose is not maximum exposure at any price; it is a manageable flow of appropriate instructions.

Before joining a panel or paying for a listing, consider the following questions:

1. **Fit:** Does it reach the solicitors, claims and geographical area the practice can serve?
2. **Entry evidence:** What qualifications, references, report samples, insurance and training are required?
3. **Commercial terms:** Who contracts with the expert, who owes the fee, and when does payment fall due?
4. **Scope:** Are supplementary reports, questions, joint meetings, conferences and court attendance paid separately?
5. **Control:** Who books appointments, receives records, edits administrative content and releases the signed report?
6. **Information governance:** How are identity, records, transfers, retention and incident reporting managed?
7. **Independence:** Can the expert qualify an opinion, request further evidence and decline an unsuitable instruction without improper pressure?
8. **Exit:** Are there notice periods, automatic renewals, restrictive clauses, profile-removal procedures or outstanding-case obligations?

These are proposed due-diligence questions for the practice; they are not a statement that any listed organisation has problematic terms. Ask for the actual agreement and assess it against the intended service.

Measuring whether membership and marketing work

Keep a simple channel register. Record the annual cost, number of enquiries, proportion within scope, accepted instructions, fees invoiced, fees actually collected and time spent. Add reasons for declining instructions and any repeated administrative difficulties. This separates useful visibility from activity that merely increases email volume.

Review channels after a defined period, allowing for the long timescale of legal proceedings. A low-volume directory may still be valuable if it brings suitable complex cases. A high-volume panel may be unsuitable if the work does not fit the expert's competence or if its timetable cannot be delivered alongside clinical commitments. Independence and report quality remain non-negotiable even where one introducer supplies a large share of income.

The most durable professional reputation comes from an opinion that is understandable, properly bounded and reliable. Marketing can make that service visible; it cannot substitute for it.

CHAPTER 8

Marketing a medicolegal practice: making competence visible

Marketing begins with a clear account of what the doctor can contribute. In medicolegal practice, the service is a careful, independent medical opinion produced through a dependable professional process. The aim is to make suitable instructing parties aware of that service, help them judge its relevance, and make the first enquiry straightforward. Reputation is then sustained by the quality of the work.

For a trauma and orthopaedic surgeon, the strongest positioning is grounded in the injuries and decisions encountered in clinical practice: major trauma, complex lower limb injury, foot and ankle conditions, reconstruction and the consequences for daily function. A useful account moves beyond naming a fracture. It explains the doctor's ability to assess the injury, treatment, recovery, residual limitation and prognosis within the precise limits of current expertise. This connects marketing to the human purpose of the work: helping legal decision-makers understand what happened to the person and what may follow.

Instructions and treatment are different services

A person seeking treatment and a solicitor seeking an expert report have different needs. The treatment patient wants clinical assessment and advice directed towards their care. The solicitor needs an appropriately qualified independent expert, a defined scope of work, an estimate, a realistic timetable and a report suitable for the relevant proceedings. An individual may also make a legitimate direct enquiry about expert evidence, but the practice must clarify the proposed role, legal setting and instruction route before accepting work.

These differences should be visible on the website. A clinical appointment button should lead to treatment information. A medicolegal enquiry button should lead to an instruction form and the expert's professional profile. The latter should ask for enough information to screen the matter, without encouraging the immediate upload of entire medical records to a general contact form. A short account of the injury, the legal issue, the proposed deadline, the instructing organisation and the parties needed for conflict checking will usually support an initial discussion.

An expert examination is not an ordinary treatment consultation. Appointment information should explain its purpose, who commissioned the assessment, who will receive the report and how confidential information will be handled. Any immediate clinical concern arising during an examination still requires an appropriate response. The practice should have an agreed route for doing so.

An evidence-based professional profile

The GMC requires professional communications, including advertising, to be honest, accurate and not misleading. Relevant limitations must not be concealed, and opinion must not be presented as established fact. Public communications must preserve confidentiality and avoid exploiting vulnerability. These standards apply to a website, a directory entry, an introductory email and a social media profile. [MO1]

A practical profile should include a dated CV; verified qualifications and current appointments; the clinical fields within which instructions are considered; geographical and examination arrangements; professional contact details; and a clear process for requesting terms and availability. Training, accreditation and directory membership should be described using their actual names and current status. Attendance at a course does not establish competence in every kind of litigation. Nor does membership of a commercial directory amount to judicial approval.

Objective promotional claims require evidence under the CAP Code. Superlatives such as “the leading expert”, numerical claims about report volume, and promises of exceptional speed should be supported before publication. The same principle applies to the advertised usefulness of a book or course. [MO2] A measured statement of scope is usually more helpful than a broad claim of excellence. For example, a description of expertise in complex lower limb trauma tells a solicitor more than a claim to handle “all medical negligence”.

The practice should keep a small evidence file behind its public profile. This can contain the current CV, training certificates, membership confirmations, permission to use any institutional marks and the source of any numerical claim. Review the website whenever an appointment, location or credential changes. Clinical employment and academic affiliation may be stated accurately; neither should be presented as endorsement of a private medicolegal service without permission.

Independence is part of the service

The GMC's witness guidance requires integrity and objective evidence within the witness's competence. Commercial presentation should therefore make independence clear. [MO3] Avoid advertising a claimant “success rate”, favourable opinions or an ability to maximise compensation. A case outcome reflects many matters beyond the medical evidence and is a poor measure of the expert's quality. A better promise is a disciplined process: clear reasoning, transparent limitations and timely communication.

Do not offer referral inducements that compromise, or appear to compromise, professional judgement. Paid directory listings and transparent administrative services need to be distinguished from payments intended to influence clinical decisions or the content of evidence. The GMC's current conflicts guidance emphasises openness about interests and prohibits exploitation of professional position for financial gain. [MO4] Any referral or agency arrangement should be assessed for its effect on independence, its contractual terms and the rules applicable to the activity; a description as a “marketing fee” does not resolve those questions.

An expert may hold strong personal, political or religious convictions. Those convictions must not influence the treatment of an examinee, the selection of evidence or the conclusions of a report. Public professional communication should make it possible for a reader to distinguish personal advocacy from expert opinion and from the views of an employer. A professional

website can describe wider public engagement while keeping the medicolegal instruction process focused on competence, impartiality and confidentiality. The same approach protects trust when this book is made available through more than one of the author's websites.

Building useful professional relationships

For a specialist practice, a small number of well-matched professional relationships can be more productive than indiscriminate advertising. Suitable activities include educational meetings with solicitors, contributions to professional events, articles explaining injury mechanisms and recovery, and participation in appropriate expert networks. A short teaching session on the functional consequences of a severe ankle injury may demonstrate expertise more convincingly than a stream of promotional posts.

Educational material should explain clinical reasoning without predicting the result of a particular claim. Illustrative examples should be fictional or genuinely anonymised; changing a name may leave an unusual injury, occupation or accident readily identifiable. Do not use material from a live case as promotional content without a properly considered confidentiality and legal basis. Even where permission is obtained, ask whether publication could undermine dignity, independence or proceedings.

Testimonials, if used, should address the service actually delivered and should not imply that favourable litigation outcomes are purchased. CAP requires evidence that testimonials are genuine; testimonials do not by themselves substantiate objective claims. [MO5] A practice may reasonably decide that a dated CV, clear scope and useful educational publications provide a stronger foundation than case testimonials. Never respond to a public review by disclosing whether the reviewer was examined or what the medical records contain.

Direct outreach: permission depends on the recipient and channel

Electronic marketing requires attention to PECR as well as data protection law. The ICO distinguishes corporate subscribers from individual subscribers. Marketing email to a corporate body does not require consent under the PECR electronic-mail rule, but the sender must be identifiable and provide a valid opt-out address. Sole traders and certain partnerships are treated as individual subscribers: consent or a valid soft opt-in is normally needed. A public email address is not automatic permission to market. Social media direct messages can fall within electronic mail. [MO6]

Where a named business contact's personal information is processed, a UK GDPR lawful basis is still necessary. If legitimate interests is proposed, assess the purpose, necessity and balance of interests; do not assume that describing a campaign as business-to-business resolves the issue. Where PECR requires consent, legitimate interests cannot be used to bypass it. [MO7] Keep a suppression record so that an opt-out is respected. Do not recycle a clinical patient list into a solicitor-marketing database.

Before sending an introductory message, establish the organisation's legal form, the relevance of the recipient's role and the source of the contact information. A concise message can state the clinical scope, link to a dated CV and invite an enquiry about availability. Avoid pressure, repeated unsolicited follow-ups and attachments containing patient examples. Telephone marketing and website or email tracking have their own rules; assess the intended method

against current ICO guidance rather than extending the corporate-email exception to every channel.

Measure the service, not merely website attention

The most useful marketing measure is the number of suitable enquiries that become accepted, properly scoped instructions and are delivered well. Search impressions and website visits sit earlier in that process. They cannot show, by themselves, whether an instruction was suitable, a report was completed or a fee was paid. A recently launched website with a short reporting period provides a baseline for observation, not a reliable estimate of acquisition performance.

Maintain an aggregate monthly dashboard: enquiries by source; suitability for the declared scope; instructions accepted; reasons for declining; time to first response; turnaround against the agreed date; repeat instructions; time spent; and cash received. Keep individual case information in the case-management system rather than in a marketing platform. This is a proposed management method, not a regulatory requirement. It helps identify whether a weak result reflects visibility, poor matching, limited capacity or an administrative bottleneck.

Review marketing expenditure against the quality and sustainability of work obtained. High enquiry volume may be unhelpful if most cases are outside competence. Growth should follow capacity to examine, analyse, write and respond. A dependable practice is one in which the next instruction can be accepted without reducing the care given to the previous one.

CHAPTER 9

Indemnity: protecting the doctor and the integrity of the service

An independent medical opinion may influence compensation, rehabilitation, employment, professional reputation or a judicial decision. Protection must therefore be designed around the work actually undertaken. A certificate saying that a doctor has “medical indemnity” does not, by itself, establish that every examination, report, conference and court appearance is covered.

The GMC requires appropriate and adequate insurance or indemnity across the full scope of practice, including expert witness work. This is a continuing obligation: cover should be reconsidered when the doctor changes specialty, workload, business structure or type of instruction. [C1]

Start with a map of the work

Before requesting a quotation or renewing membership, write down the services provided. A trauma and orthopaedic practice might undertake personal injury condition-and-prognosis reports, clinical negligence screening, breach-of-duty and causation reports, supplementary opinions, joint discussions, court attendance and factual reports about former patients. These are distinct activities. An indemnifier needs a sufficiently accurate description to assess them.

Add the jurisdictions served, examination locations, projected income, annual report volume, use of remote assessments, work through agencies, and whether instructions are accepted personally or through a company. Explain any supervision, locum arrangements or subcontracted administration. A proposal that describes only “orthopaedic consultations” may not describe the exposure created by an expert witness business.

The useful question is precise: “Does this arrangement cover my independent expert work, including the examinations and financial-loss allegations that could arise from my reports?” Retain the written answer alongside the policy schedule, endorsements and membership terms. Marketing descriptions are an introduction to a product, not a substitute for its operative wording.

Four different protection questions

Exposure	What needs checking
Injury associated with examination or treatment	Whether the examination, location and any additional clinical intervention fall within medical malpractice cover
An allegation that a negligent report caused financial loss	Whether independent expert services, rather than clinical treatment alone, are expressly included
A complaint, GMC investigation or criticism in proceedings	Whether advice, representation and relevant defence costs are available; on what terms and with what exclusions
Business interruption, data loss or an accident at premises	Whether separate cyber, public liability, employers' liability or other business arrangements are needed

These questions are a purchasing framework, not a statement that every practice requires four policies. One arrangement may answer several; another may leave substantial gaps. The Financial Ombudsman distinguishes professional indemnity from other forms of business protection. The label attached to a policy is less informative than the risks it responds to. [C2]

The author's collected materials illustrate why different documents must be kept distinct. Hospital practising-privileges requirements describe the cover a hospital requires for permission to work there. A historical expert-witness quotation describes a proposed product at a particular time. Neither, by itself, establishes that a present instruction is insured. That requires the current schedule, operative terms and confirmation of the declared activities. Historical hospital limits or run-off periods must not be presented as universal legal minimums, and an expired quotation is not evidence of cover in force.

NHS employment is not a safe basis for assuming that privately commissioned reports are covered. The GMC has specifically highlighted the need to consider additional protection for non-NHS work, regulatory or disciplinary matters and contractual disputes when assessing state-backed arrangements. For an employed doctor asked for factual evidence arising from NHS care, clarify the employer's role and representation arrangements separately from privately commissioned expert work. [C3]

Occurrence cover, claims-made cover and run-off

With occurrence-based protection, the relevant starting point is the event during the covered period, even if a claim arrives later. With claims-made protection, the timing of the claim and notification matters; past work also needs to fall within any agreed retroactive cover. Wording varies. The BMA distinguishes these structures and emphasises the need for run-off where claims-based protection ends. [C4]

For example, a report written in year one may be challenged in year four. The doctor should be able to identify which arrangement would respond in year four, rather than simply produce the year-one receipt. A change of provider, retirement, company closure or a temporary cessation of work can expose an unnoticed gap.

Before switching or stopping, obtain a written account of the retroactive date, excluded known circumstances, notification requirements, run-off availability, duration and cost. Clarify whether run-off is automatic or must be requested, whether it covers the individual and company, and

whether an extended reporting period also restricts the types of earlier work covered. Run-off allows protection for past work under its terms; it should not be mistaken for permission to undertake new work after the active policy ends.

The same care applies when reducing work. “Retired from surgery” may not mean “retired from expert reporting”. Tell the provider exactly what continues. Plan the preservation of reports, instructions, examination notes and correspondence so that a later allegation can be investigated. Record retention should follow the applicable legal, professional and insurance requirements, with documented review, rather than an arbitrary universal period.

Contractual insurance and discretionary assistance

Ask whether the protection is a contractual insurance entitlement, discretionary assistance under membership rules, or a combination. Understand who decides whether assistance will be provided and what complaint or review route exists. Do not treat a high headline limit as proof of equivalent protection between arrangements.

Compare the limit per claim with the annual aggregate; check whether defence costs sit inside or outside that limit; identify the excess, territorial restrictions, jurisdiction exclusions and notification conditions. Ask whether subcontractors, administrative mistakes, data incidents, defamation allegations and alleged breaches of professional duty are within scope. Check separately for regulatory representation, coroners’ proceedings and criminal investigations. The fact that assistance is available in one setting does not establish that it is available in all settings.

There is no universally adequate indemnity limit for every orthopaedic expert. A provider should assess the actual practice, including the complexity and potential consequences of its opinions. Annual turnover alone does not measure the size of a possible allegation. Obtain advice on the individual practice rather than copying another consultant’s limit.

Notification and the first response to a concern

A useful internal rule is to route any threatened claim, formal complaint, regulator correspondence or material allegation promptly to the doctor and the relevant indemnifier. Policy conditions may require notification before a formal claim exists. The precise threshold must be read and built into the practice’s procedure.

Preserve the original record and the version of the report actually issued. Do not overwrite an earlier report or remove awkward correspondence. Prepare a factual chronology, identify approaching deadlines, and seek advice before making admissions of liability or negotiating compensation. This does not remove the need to communicate honestly, correct an error or respond to an urgent clinical risk. The purpose is to make an accurate, coordinated response.

Administrative staff should know where an urgent message goes if the doctor is operating, abroad or unwell. A named alternative contact, a shared deadline register and accessible policy details are practical protections. A sophisticated policy has limited value if a claim is left unread in an unattended inbox.

Finally, separate defence from prevention. Insurance does not replace competence, careful examination, evidence-based reasoning or reliable systems. The practice’s strongest protection is a report whose source material, reasoning, uncertainties and limits can be explained calmly.

CHAPTER 10

Terms of engagement: making independence commercially workable

A clear engagement agreement establishes what work is being commissioned, who is responsible for payment and how the parties will manage change. It gives the expert space to work independently because expectations are settled before the opinion is known.

The author's source materials contain separate charges for professional time, reports, supplementary work, court attendance, cancellations and expenses. They also emphasise timely provision of medical records and payment within a stated period. Those documents provide a useful organisational model. They are not reproduced here as a current tariff: versions differ, and historical wording should not become a public offer merely because it appears in a book.

Identify the contracting party before identifying the debtor

An instruction may pass from a claimant to a solicitor, through an agency, and then to a doctor. This creates several relationships, not a single interchangeable "client". The person examined is not automatically responsible for the expert's fees. An insurer or funder may be expected to provide money without becoming the contractual debtor.

The engagement record should identify the legal name and address of the customer, the capacity in which the intermediary acts, and the party that has expressly accepted payment responsibility. If the arrangement is ambiguous, resolve it before undertaking substantive work. An agency's trading name, a fee-earner's email signature and the claimant's name are inadequate substitutes for this exercise.

The recommended commercial position is that the identified customer pays by the agreed date independently of settlement or reimbursement. However, this must be agreed; an expert cannot unilaterally transform an intermediary into a debtor after the report is delivered. If deferred payment is considered, define the maximum period, credit risk and any independent payment trigger. Do not base fees on the opinion expressed or success of the case.

Define the assignment in stages

Distinguish an advisory screening opinion from a report intended for disclosure, and distinguish condition and prognosis from breach of duty or causation. Identify the questions, available evidence, expected examination and required jurisdiction. Specify whether the initial fee includes records review, imaging, examination, report preparation and a defined allowance for clarification.

A staged budget is usually more useful than an unexplained global estimate. Use separate lines for initial review, assessment and report; further records; formal written questions; joint discussions; conference; preparation for testimony; and attendance. Identify what would trigger a revised estimate. The Civil Justice Council's guidance supports agreeing appointment terms at the outset, including services, timetable, charging basis, expenses, cancellation, payment and funding constraints. [C5]

A page count alone is a poor estimate of complexity. Three thousand duplicated pages may be quicker to understand than a short but contradictory record. Agree assumptions about pagination, chronology, legibility and imaging access. If the bundle changes materially, explain the additional work and obtain agreement before exceeding the authorised budget where practicable. The doctor remains responsible for reviewing what is necessary to answer the questions competently.

Independence, questions and court obligations

Commercial terms must preserve the expert's overriding duty to the court in proceedings governed by CPR Part 35. They cannot make an unfavourable opinion a contractual failure or purchase a desired conclusion. Formal questions, joint discussions and reports are subject to the relevant procedure; the agreement must not redefine those duties. [C6]

Make payment independent of the outcome. The Civil Justice Council strongly discourages contingency arrangements for experts, and the safest ordinary practice is to reject them. If a customer asks for "no report fee unless we win", the practical answer is an ordinary fee arrangement or a decision not to accept the instruction. [C5]

Resolve payment risk at the start. Do not rely on a blanket right to withhold evidence or ignore a court date if a bill is unpaid. Any proposal to suspend work or withdraw needs assessment against the court's directions, professional responsibilities and likely prejudice. Discuss the position promptly and seek legal or indemnifier advice where necessary.

Cancellation, delays and consumers

Reserved court time has an opportunity cost, but a cancellation clause should explain the basis of the charge. Distinguish tentative availability from a confirmed booking; define working days; identify the applicable notice period; and account for costs avoided or time reasonably reused. An automatic full fee for every cancellation, regardless of circumstances, is difficult to justify as sound practice.

Where an individual contracts as a consumer, use appropriately drafted consumer terms. Services must meet statutory standards, and the CMA requires fair, transparent terms. Excessive cancellation fees, unrestricted unilateral changes and sweeping liability exclusions are particular problems. A business contract should not simply be relabelled "patient agreement". [C7, C8]

For remote consumer contracting, obtain advice on applicable pre-contract information and cancellation requirements. The Consumer Contracts Regulations contain a healthcare exclusion, but its application turns on the service; it should not be assumed to cover every legal report supplied by a doctor. If cancellation rights apply and work is to start early, the necessary request and acknowledgements should be captured properly. [C9]

Adaptable clause bank

Illustrative drafting only: jurisdiction-specific lawyer review is required before adoption. These clauses have not been legally approved and do not constitute the author's live terms. Replace all placeholders and review the agreement as a whole.

1. Parties and responsibility for payment. “The service provider is [legal person and address]. The customer is [legal person and address]. The customer confirms whether it instructs as principal or agent. The party accepting responsibility for payment is [name], as expressly agreed in the acceptance below. Payment by a funder or another person does not change that responsibility unless all relevant parties agree in writing.”

2. Scope and limits. “The instruction covers [defined questions and services] in connection with [matter and jurisdiction]. It excludes [specified work]. If additional expertise, information or services are required, the expert will explain this and propose the appropriate next step. Acceptance remains subject to competence, availability, conflict checks and suitable protection.”

3. Independent opinion. “The expert will exercise independent professional judgement. No particular opinion, litigation result or financial recovery is promised. Where applicable, duties to the court or tribunal take priority over the interests of those instructing or paying the expert. Neither the amount nor payment of the fee depends on the substance of the opinion or the outcome.”

4. Fees and authorisation. “The agreed charging basis is [fixed fee or hourly rate], with [defined inclusions]. The estimate is [amount and assumptions]. The expert will notify the customer when material changes are likely to require additional expenditure and seek written authorisation for the revised scope. VAT will be added where legally chargeable and shown separately.”

5. Records and timetable. “The customer will provide the instructions, relevant records, imaging and procedural deadlines through the agreed secure channel. The proposed delivery date is [date], based on receipt of the specified material by [date]. If relevant material is missing or the timetable becomes unrealistic, the parties will address this promptly. No provision of this agreement overrides a court order.”

6. Further work and correction. “New questions, additional evidence or a further examination may require a separately agreed fee. The expert will distinguish that work from correction of an error for which the expert is responsible. Requests to alter an opinion will be considered on their evidence and merits, without any promise of a particular amendment.”

7. Payment and disputes. “Invoices fall due [period] after [defined event]. Please identify any disputed item and its reasons promptly so that it can be investigated. The parties will discuss payment of any undisputed amount. Nothing in this clause removes statutory rights or a lawful right to dispute charges.”

8. Cancellation and reservation. “Confirmed bookings and the applicable cancellation schedule are recorded in [schedule]. Any charge will take account of the work performed, reasonable committed costs and the applicable contractual and legal requirements. The practice will explain its calculation and consider reasonable steps to reduce loss.”

9. Confidentiality and records. “Information will be handled for the agreed professional purpose and in accordance with applicable confidentiality, data-protection and disclosure obligations. The privacy information and secure transfer arrangements are provided separately. Retention, access and disposal will follow the documented policy and any legal hold.”

10. Ending the engagement. “Either party may raise a concern about continuation. Before suspending or ending the engagement, the parties will address outstanding work, deadlines, records and professional or court obligations. The expert will give appropriate notice and obtain directions or advice where required. Fees for properly performed work remain subject to the agreed terms and applicable law.”

The completed agreement also needs complaints handling, business details, governing law, jurisdiction and suitable limitation provisions drafted for the actual service. Do not insert a generic exclusion of all liability or a clause purporting to waive a patient's or consumer's statutory rights. Keep a dated master and preserve the version accepted for each instruction.

CHAPTER 11

Fees, VAT and getting paid

Good credit control begins with a clear instruction and ends with a reconciled account. It should be a routine administrative process. A doctor should not have to become confrontational to obtain payment for properly commissioned work, and an injured person should not receive a demand simply because their case is the easiest one to identify.

Price the service that is actually delivered

The fee must support records review, reflection, research, examination, writing, checking, administration and the continuing responsibilities of the instruction. Pricing only the examination creates pressure to compress the work that determines the report's quality. Equally, a minimum charge should be explained before acceptance and should correspond to an identifiable scope or reservation.

Set a fee schedule with sufficient detail to prevent repeated negotiation over predictable tasks. Record professional time contemporaneously, using short, intelligible descriptions. Avoid billing the same task twice through both an inclusive fee and a separate time entry. If an examination is cancelled after substantial records work has been performed, identify that completed work separately from any cancellation charge.

For publicly funded or court-controlled work, obtain the applicable rate, budget or prior-authority position before commitment. A commercial fee agreed between two parties is not necessarily the amount recoverable from an opponent or funder. This distinction belongs in both the quotation and the practice's cash-flow planning.

VAT depends on purpose

Medical qualification alone does not make a service exempt from VAT. HMRC's purpose-based approach distinguishes care protecting, maintaining or restoring health from work principally enabling a third party to make a decision. Its guidance treats medico-legal examinations, reports and testimony for the judicial system as standard-rated. The standard VAT rate is currently 20%. [C10, C11, C12]

For a UK-established business, compulsory registration generally arises when taxable turnover exceeds £90,000 over the preceding twelve months, or is expected to exceed that amount in the next thirty days alone. Exempt clinical income is excluded from that taxable-turnover calculation, but other taxable services may need to be included. The rolling test is not the same as the accounting year. [C13]

Ask an accountant to map the actual supplies and the legal person making them. A mixed clinical and expert practice may have input-tax and partial-exemption questions. Cross-border instructions, agency arrangements, deposits and recharged expenses may need separate analysis. Do not charge VAT merely because work is theoretically taxable if the supplier is not registered or otherwise required to account for it; conversely, do not omit it after registration because an instructing party prefers a round total.

A simple dashboard should show taxable turnover by rolling month, invoiced work, receipts, overdue balances and tax reserved. Keep gross invoice value separate from net professional revenue. If £1,000 of fees attracts £200 VAT, the £1,200 receipt is not £1,200 available for spending. Income tax, corporation tax and pension treatment are separate questions from VAT.

An invoice that is easy to process

The invoice should identify the supplier and customer, carry a unique number, state supply and invoice dates, describe the service, and show charges, applicable VAT and the total. Add the agreed due date, matter reference, purchase order if required and verified payment method. For a VAT invoice, include the additional legally required information and registration details. [C14]

Keep descriptions proportionate: “Orthopaedic report, matter reference ML-014” is generally more appropriate for an accounts inbox than a diagnosis or an extensive clinical history. Send the report through its agreed confidential route. Payment correspondence need not become another channel for sensitive medical material.

Illustrative invoice calculation - fictional figures, not the author’s tariff

Item	Quantity	Rate	Net amount
Records review and report preparation	5 hours	£200	£1,000
Agreed supplementary analysis	1 hour	£200	£200
Net professional fees			£1,200
VAT, if chargeable at 20%			£240
Total due			£1,440

Supplier: [legal entity, address and contact]. Customer: [contracting debtor and address]. Invoice: [unique number]. Supply date: [date]. Invoice date: [date]. Payment due: [agreed date]. Matter reference: [reference]. VAT number: [if registered]. Payment instructions: [verified details supplied securely].

A proportionate collection sequence

The following is a suggested office workflow, not a statutory timetable.

1. **At engagement:** confirm debtor, accepted terms, billing contact, reference and budget. For new or high-risk commercial relationships, consider an agreed advance or staged billing.
2. **On invoice:** send promptly and record delivery. Check that an invoice portal or purchase-order requirement has not been missed.
3. **When overdue:** reconcile receipts first; send a courteous reminder and a copy invoice. Ask whether there is an administrative query or substantive dispute.
4. **If unresolved:** contact the responsible fee-earner and accounts team, document any promise of payment, and obtain a realistic date. Investigate a genuine challenge to the work or amount.

5. **Before legal action:** verify the debtor, the contract, jurisdiction, limitation position, interest basis and relevant pre-action process. Consider negotiation or mediation and the likely recoverability of the debt.
6. **If proceedings are justified:** use the appropriate court route with a proportionate evidence bundle. Review enforcement prospects before spending more to obtain a judgment.

Avoid repeatedly moving a promised deadline without explanation. If instalments are agreed, record the balance, schedule, treatment of interest and consequences of default. A practical arrangement that is honoured may be more valuable than an immediate demand for the full amount that produces no payment.

First reminder. “Our records show that invoice [number], for [amount], fell due on [date]. Please confirm payment arrangements or send the remittance reference if it has already been settled. A copy is attached. If an item is disputed or further information is needed, please identify it so that we can review it promptly.”

Second reminder. “Invoice [number] remains outstanding following our earlier reminder. Please confirm by [reasonable date] either the proposed payment date or the specific basis of any dispute. We would welcome a discussion to resolve the position. Any interest or recovery charges will be identified separately with their contractual or statutory basis.”

These reminders are deliberately factual. They do not claim that a judgment exists, threaten regulatory action as a bargaining tool or represent themselves as formal pre-action documents.

Commercial late-payment interest

For qualifying business-to-business debts, statutory late-payment interest is generally 8 percentage points above the relevant Bank of England reference rate. An enforceable contractual remedy can change the position; do not add contractual and statutory interest together for the same period. The reference-rate mechanism must be applied correctly rather than taking whichever base rate happens to appear in today’s news. [C15, C16]

For illustration only, if the applicable total annual rate were 12%, interest on £2,000 for thirty days would be $£2,000 \times 0.12 \times 30 \div 365 = £19.73$. This is arithmetic, not a statement of the current rate for any particular debt. Keep the calculation, starting date and legal basis with the account.

Qualifying commercial debts can also attract fixed recovery compensation:

Debt amount	Statutory fixed sum
Up to £999.99	£40
£1,000-£9,999.99	£70
£10,000 or more	£100

The fixed sum is not a fresh charge for every reminder. Additional recovery costs require a proper legal basis and must not duplicate compensation already recovered. [C17]

Where no payment date has been agreed, the statutory timing generally uses thirty days after receipt of the invoice or provision of the service, whichever is later. Government guidance describes usual agreed limits of thirty days for public authorities and sixty days between businesses, with longer business terms requiring fairness. [C18]

The author’s archived terms contain a monthly contractual interest provision. It should be reviewed before reuse, including its fairness, enforceability, interaction with statutory rights and the customer’s status. It is not presented here as a recommended rate. Nor should the commercial statutory regime be applied automatically to a consumer who commissions a report personally.

Pre-action procedure is not uniform throughout the UK

In England and Wales, the Debt Claims Protocol generally applies when a business pursues an individual, including a sole trader. It does not ordinarily govern a business debt owed by a limited company. A protocol letter to an individual needs the required information and enclosures, and ordinarily at least thirty days for a reply. Requests for documents or advice can require further time. Use the current protocol and forms, not a seven-day demand copied from an old template. [C19]

An amendment effective from 1 October 2026 changes the electronic-contact requirement: where the creditor has a personal email address, the letter should also be sent there; otherwise, if other personal electronic contact details are held, at least one of those methods should be used. Read this with the protocol’s postal-delivery provisions and explicit-request exception. [C20]

For a company debtor, applicable general pre-action requirements still matter. Sending “final demand” at the top of a letter does not itself satisfy every procedural obligation. A useful draft pack includes the accepted engagement, invoice, delivery evidence, statement of account, relevant correspondence and an explanation of interest. Exclude unnecessary clinical records; obtain advice about confidentiality if medical material becomes relevant to a contested claim.

Jurisdiction	Ordinary starting point for a modest unpaid-fee claim
England and Wales	County Court money claim; the small-claims track is normally relevant for an ordinary claim not exceeding £10,000, subject to allocation rules
Scotland	Sheriff Court Simple Procedure for eligible monetary claims of £5,000 or less
Northern Ireland	Small claims procedure generally for eligible claims not exceeding £5,000

These are route-finding thresholds, not a promise that every claim qualifies. Procedures, service, expenses, limitation or prescription, and enforcement differ. Check the debtor’s location and the contract before filing. Older descriptions of Northern Ireland’s £3,000 limit should not be used in place of the current official guidance. [C21-C24]

A judgment establishes liability; it does not guarantee funds. Insolvency, contested liability, cross-border enforcement and the cost of further action can change the commercial decision. Use legal advice where the balance or complexity warrants it. Debt recovery should protect the practice’s resources without compromising its professional conduct or the independence of its evidence.

CHAPTER 12

Information governance and the dependable medicolegal office

The strength of a report depends partly on the organisation around it. A missed document, an uncontrolled draft or a letter sent to the wrong person can damage an otherwise careful opinion. Information governance is therefore part of the professional work, not a separate administrative exercise.

The practical objective is to know what information has been received, why it is held, who may use it, which version is authoritative and what must happen next. A modest practice can achieve this with disciplined procedures; complexity is not a substitute for control.

Define responsibility before exchanging records

A solicitor's instruction does not automatically make the expert a data processor. Under the ICO's approach, status depends on who determines the purposes and means of the particular processing. An independently practising expert may have controller responsibilities; administrative or technology suppliers may perform processor functions. Record the analysis for the actual arrangement rather than relying on the heading of a contract. Check the obligation to pay the ICO data protection fee and any applicable exemption. [MO8, MO9]

Map the main information flows: enquiry, conflict check, instruction, records transfer, appointment, report, questions, hearing, invoicing and archiving. For each stage, identify the necessary information and the permitted recipients. Separate clinical records from marketing contacts and keep finance staff's access proportionate to their work. A ledger rarely needs a detailed account of an injury.

Health information requires both a lawful basis under Article 6 of the UK GDPR and an applicable Article 9 condition. Article 9(2)(f) may support processing necessary for establishing, exercising or defending legal claims, including relevant prospective proceedings. It does not remove the requirement for an Article 6 basis, necessity, proportionality or confidentiality. A health-care condition should not be selected automatically merely because the person processing the data is a doctor. [MO10, MO11]

Consent to an examination, authority to release records and the lawful basis for data processing address related but different questions. Explain them clearly. A signed form should not be used as a universal answer to every information-governance issue. Where information is requested for employment, insurance or similar purposes, the GMC's specific confidentiality guidance should be applied to that role. [MO12]

Explain the process to the examinee

Provide accessible privacy information describing the practice, its purposes, lawful bases, information sources, recipients, retention approach and relevant rights. The ICO requires information when data is collected directly; where it comes from elsewhere, specified timing rules and limited exceptions apply. Simply placing a notice somewhere on a website may be insufficient unless people are made aware of it and can reach it easily. [MO13]

The appointment letter should explain practical arrangements in plain language: expected duration, identity checks, access needs, interpreters or chaperones where appropriate, and what the examinee should bring. Before the examination, clarify the role and the intended report recipient. Record any relevant limitation, including inability to examine a particular movement safely or difficulties obtaining a reliable history. An organised process creates space to listen; it should not turn the person into a checklist.

Secure records and reliable versions

The proposed operating standard is a dedicated professional system with individual accounts, multifactor authentication, current device security, appropriate encryption and controlled sharing. Do not share a single password among the doctor, secretary and external typist. Use a secure transfer method for records and reports, verify recipients, and check attachments before release. Backups should be tested, with a recovery process that does not depend on the availability of one person. These measures reflect the practical approach of the NCSC's small-organisation guidance. [MO14]

Keep a case index identifying the instruction, agreed scope, relevant dates, record bundle versions, missing material, drafts and issued reports. Preserve the issued version and record any later amendment with its reason and date. A new PDF should not silently replace an earlier opinion. Where a factual correction changes the analysis, make the change in reasoning clear.

Use a documented release check: correct case, correct recipient, complete pages, consistent dates and laterality, accurate quotations, traceable references, appropriate declarations and no tracked changes or unrelated material. This is a recommended quality process. It is especially valuable for trauma records, in which multiple admissions, transfers and operations can produce similar documents with different dates.

External transcription, cloud storage and administrative support require due diligence. Where a supplier acts as a processor, the necessary contractual safeguards include documented instructions and appropriate controls over confidentiality, security and further processors. Assess overseas access and transfers where relevant; the location of a company's head office alone does not establish where data is processed. [MO15]

Retention, access and incidents

There is no single UK GDPR retention period for every medicolegal file. Establish a written schedule by record type and purpose, taking account of the relevant legal setting, professional advice, contractual commitments and potential claims. The ICO requires retention to be justified by need and reviewed. [MO16] A continuing complaint, investigation or litigation hold may require preservation beyond a routine deletion date. Record the reason and review it; indefinite retention of every document is not a substitute for a policy.

Have a process for access, correction and deletion requests. Recognise that a request may engage different rights and exemptions; neither “the solicitor owns the report” nor “the patient owns all the information” is a sufficient legal analysis. Do not promise automatic deletion of a medicolegal file on request. Preserve the audit trail of a correction rather than rewriting the historical record without explanation.

A breach may involve loss, unauthorised access, misdirection or other compromise, even without a malicious attack. Contain the incident, preserve useful evidence, assess the risks and obtain advice promptly. Under ICO guidance, report a breach where required without undue delay and, where feasible, within 72 hours of becoming aware; high risk to individuals also requires notification to them without undue delay. Record the assessment, including a reasoned decision where notification is not required. [MO17]

AI assistance and professional accountability

AI may assist with low-risk tasks such as formatting a blank template or improving the clarity of non-identifiable educational text. Its use with case material requires a different level of scrutiny. Do not upload identifiable patient information, medical records or confidential instructions into unapproved consumer tools. Removing a name is not necessarily anonymisation: a rare injury, date, occupation and location can identify a person in combination.

Before approving a system, assess its intended use, contractual controls, security, retention, provider access, model-training use, subprocessors and transfers. Consider whether a data protection impact assessment is required. ICO guidance treats AI as capable of increasing security and minimisation risks; deployment should be assessed against the actual information flow rather than a reassuring product label. [MO18]

The following is a proposed practice rule: the doctor remains responsible for every statement issued in their name. An AI-produced chronology must be checked against the records. Clinical and legal citations must be opened and verified. The system must not invent missing findings, infer an examination that never occurred, supply an unsupported diagnosis or decide causation in place of the expert. Any material uncertainty should remain visible.

Keep an appropriate record of material AI assistance and follow the applicable court, professional and contractual requirements for disclosure. Do not assume that every jurisdiction has an identical disclosure rule. Confidentiality and legal professional privilege should be considered before using external services, with advice from the instructing solicitor where needed. A polished paragraph has value only if its facts, reasoning and provenance can be defended.

CHAPTER 13

A ninety-day plan for an organised practice

The following plan is a suggested implementation sequence. It is not a promise of instructions, a regulatory timetable or a substitute for the time needed to acquire competence. An established practitioner can use it as a review of existing arrangements.

Days 1-30: define the practice and remove ambiguity

Begin with a written scope of practice. Identify the injuries, procedures and questions that fit current expertise, the activities requiring further training, and the matters that should be declined or referred to another specialty. A trauma and orthopaedic surgeon may contribute substantially to complex injury assessment while needing additional experts for psychiatric, neurological, vocational or other issues. The boundary should be explicit before the first instruction arrives.

Review the CV, training record and continuing professional development plan. Match courses to the intended work and legal jurisdiction. Obtain written confirmation that indemnity arrangements cover each proposed medicolegal activity, then review terms of engagement, cancellation provisions, invoicing and the procedure for changes to scope. Establish a workable diary allowance for records, writing, questions and hearings, rather than budgeting solely for the examination.

Complete the information map, privacy notice, secure transfer arrangements, retention schedule and supplier review. Test the process using a fictional case from enquiry to archive. Check that someone can identify a missing record, recover the current draft and locate a deadline without relying on the doctor's memory. The output of this month is a practice that can explain what it offers and carry out one instruction reliably.

Days 31-60: make the service discoverable

Prepare a dedicated medicolegal web page and dated downloadable CV. Check every qualification, affiliation and claim. Provide a clear enquiry route, accessible appointment information and a statement that acceptance depends on scope, conflicts, capacity and terms. If several websites carry the profile, maintain a single authoritative version and review the copies together.

Evaluate the professional organisations, training bodies, directories and agencies described elsewhere in this book. Select them by relevance, membership requirements, visibility to appropriate instructing parties and contractual terms. Membership is a business and professional-development decision; it does not guarantee casework. Avoid joining many paid services before establishing how their enquiries will be tracked.

Prepare one useful educational contribution in the doctor's area of strength. For this author's practice, a discussion of the distinction between radiological healing and functional recovery after complex lower limb trauma would fit the clinical focus. It should explain how evidence is

assessed and where uncertainty remains. Plan any outreach using the recipient and channel checks described in the marketing chapter.

Days 61-90: audit delivery and adjust capacity

Review the first completed workflow, or a further fictional exercise if there have been no suitable instructions. Examine whether the scope was clear, the records were complete enough, the report answered the questions and the timetable was realistic. Seek feedback on clarity and administration without inviting pressure to change an independent opinion. Identify one improvement and assign responsibility for implementing it.

Review commercial performance alongside professional quality. Compare estimated with actual time, invoices with cash received, and overdue work with the capacity committed. Set a manageable limit on concurrent cases. A delay in records or a hearing commitment should trigger communication and replanning before it becomes a missed deadline.

At ninety days, retain what has worked and revise what has not. Continue appropriate training, peer discussion, appraisal and professional review. The objective is a sustainable practice in which the doctor can remain attentive to the person, rigorous with the evidence and reliable to the legal process. Organisation makes that possible; independence gives it purpose.

Appendix A. Working checklists

These checklists are original practice aids. They support, but do not replace, the case-specific rules, directions, professional judgement or advice discussed in the chapters.

Before accepting an instruction

1. Identify the precise role, questions, forum and jurisdiction.
2. Check the parties, clinicians, organisations and previous relationships for conflicts.
3. Confirm that each question falls within current relevant competence.
4. Establish the evidence available, material gaps and whether an examination is needed.
5. Check the timetable, hearing commitments and capacity for follow-up work.
6. Confirm protection for the activity, entity, location and jurisdiction.
7. Identify the contracting customer, payment responsibility and authorised budget.
8. Agree dated terms, secure transfer arrangements and the next action in writing.

Before signing and releasing a report

1. Check identity, laterality, dates, chronology and the intended recipient.
2. Distinguish reported history, contemporaneous evidence, personal findings and assumptions.
3. Answer every authorised question or explain why it cannot yet be answered.
4. Explain the reasoning, alternatives, uncertainties and limits of expertise.
5. Verify every reference and remove unsupported template statements.
6. Apply the current declarations required by the particular forum.
7. Check all pages, tables, attachments and the signed version.
8. Release through the agreed route and preserve the issued document and source inventory.

Before renewing insurance or indemnity

1. Update the scope, income, volume, locations and jurisdictions of work.
2. Identify the individual and any company that need protection.
3. Confirm expert-report and examination risks, including relevant financial-loss allegations.
4. Review limits, aggregates, excesses, defence-cost treatment and exclusions.
5. Check notification obligations and access to advice or representation.
6. Confirm retroactive protection, continuity, run-off and retirement arrangements.
7. Retain the current operative wording and written scope confirmation.
8. Brief the administrative team on urgent notification and absence cover.

Before escalating an unpaid invoice

1. Reconcile receipts and confirm the correct debtor and amount.
2. Locate accepted terms, authorisation, delivery evidence and the invoice.
3. Investigate any genuine dispute and distinguish it from an administrative delay.
4. Calculate interest and recovery charges only on an applicable lawful basis.
5. Identify the jurisdiction and correct pre-action procedure.
6. Consider negotiation, advice, proportionality and enforcement prospects.
7. Protect confidentiality and avoid unnecessary clinical disclosure.
8. Preserve the expert's professional and court obligations independently of the payment dispute.

Appendix B. A source and document system for the practice

The purpose of classification is to make the authoritative document easy to find. It is not enough to gather every file into one large folder. A certificate, a course advertisement, a report draft and a signed contract answer different questions. A useful catalogue records document type, owner, date, current status, review date and the location of the original.

Document class	What it establishes	Suggested status fields
Professional identity	Qualifications, registration, appointments and relevant experience	Verified date; current or historical; public wording approved
Training and membership	Attendance, assessment, membership grade and renewal	Booked; attended; assessed; current; expired
Insurance and indemnity	Proposed or operative protection for a defined scope	Quote; bound cover; period; endorsements; renewal; run-off
Terms and fee schedules	The offer and agreement for specified services	Draft; legally reviewed; issued; accepted; superseded
Provider and panel information	Application routes, criteria and commercial arrangements	Enquiry; applied; accepted; renewed; terminated
Case records	Instructions, evidence, analysis and issued opinions	Received date; version; deadline; recipient; legal hold
Finance	Authorisation, invoice, payment, dispute and balance	Due date; reconciled balance; action owner; next review
Public education	Books, articles, teaching and website material	Source-checked date; edition; published location; review trigger

Maintain a short index rather than duplicating sensitive material into multiple systems. A public CV can be derived from a private professional record, but the public document should omit home addresses, personal identifiers that serve no professional purpose, bank details and third-party private contact information. Marketing systems should contain channel information and aggregate results, not medical bundles.

Give each issued fee schedule and template a version date. Preserve the version accepted in the individual case even after the general master changes. A newly edited master must not silently alter an existing contract. Likewise, keep an original signed report with the explanation of every subsequent correction or change.

For future editions of this book, review the legal framework by jurisdiction, the professional guidance, the training and directory links, and the author's factual profile separately. Update changes in the body as well as the references. A refreshed access date alone does not make an old passage current. Preserve the earlier edition for traceability and publish a clear edition date on the replacement.

Appendix C. Short glossary

Term	Meaning in this book
Breach of duty	The alleged failure to meet the legally relevant standard; separate from whether harm resulted
Causation	The connection between an event or departure from care and the outcome under consideration
Condition and prognosis	Assessment of present medical condition and likely future course
Controller	The organisation or person determining the purposes and means of a particular use of personal data
CPD	Continuing professional development; participation is distinct from an assessed qualification
CPR / FPR	Civil Procedure Rules / Family Procedure Rules for England and Wales
Indemnity	Protection against specified liabilities or costs under the applicable insurance or membership arrangement
Joint statement	A document recording experts' agreement, disagreement and reasons following their discussion
Legal hold	A direction or documented requirement to preserve relevant material rather than routinely delete it
MedCo	A defined medical-reporting registration, accreditation and search system; not a universal expert licence
PECR	Privacy and Electronic Communications Regulations, relevant to electronic marketing and related activities
Processor	A party processing personal data on behalf of a controller under the particular arrangement
Quantum	The valuation of a claim; medical evidence contributes to questions of loss without deciding the legal award
Run-off	Protection, under agreed terms, for claims relating to earlier work after active practice or cover has ended
Single joint expert	An expert instructed jointly in accordance with the applicable process, owing the same independent duty
Statement of truth	The prescribed verification attached to a document in the relevant proceedings; use the current required wording
UK GDPR	The United Kingdom's General Data Protection Regulation framework, applied with relevant domestic legislation

The glossary is explanatory rather than a set of statutory definitions. Where a legal or scheme-specific meaning controls an instruction, use that source's current definition.

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- **D6.** AvMA, Get listed as a medical expert: <https://www.avma.org.uk/information-for-professionals/get-listed-as-a-medical-expert/>
- **D7.** Bond Solon, Register application: <https://register.bondsolon.com/register.aspx>
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