

Compass Chambers






Practical tips about medical records and
expert evidence in PI and medical
negligence litigation

Compass Conference 2025

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Objectives

- Make the documents do the heavy lifting 
- Medical records: from recovery → proof 
- Choose, brief, and manage experts who help (not hurt) 

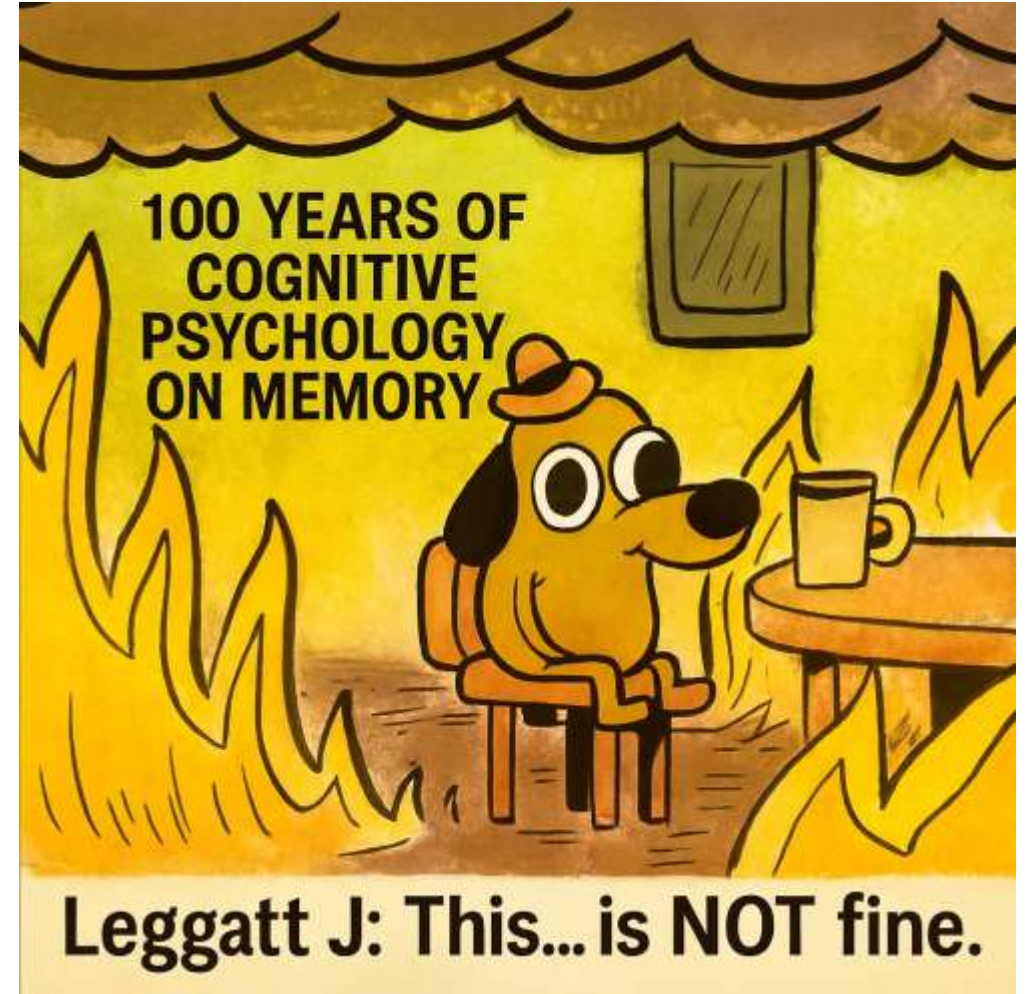


Gestmin SGPS SA v Credit Suisse (UK) Ltd [2013] EWHC 3560 (Comm)

- Why memory is not your main witness:

“While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony”


Leggatt J at [15-22]



“Everyone knows that memory is fallible...”

Leggat J, Gestmin

- Memory is reconstructive.
- Remembering is rewriting.
- The process of litigation reshapes what people think they remember.
- Confidence and detail are terrible predictors of accuracy – be skeptical!
- Primary weight should be on contemporaneous documents.
- Use oral evidence to test documents and understand witnesses’ practices and motivations.

A blue, furry Muppet character with large white eyes is sitting at a wooden witness stand in a courtroom. The stand has a nameplate that says "Cookie". A speech bubble is coming from the character's mouth.

Me no trust memory. Me need to see crumbs.

Cookie

The Shadow of Gestmin: What have judges actually done?

- Gestmin is used as a reminder to be cautious with historic lay recollection. **HHJ Platts in Pinnegar**: “*helpful reminders, not new legal principle*”.
- **Dean v Armstrong Oiler Co Ltd [2023] EWHC 3445 (KB)**
 - Notes say: “*no asbestos exposure*” but must be read in clinical context
 - Brief GP / hospital entries; copy-forward; obvious errors
 - Medical records are anchors, not holy writ
- Gestmin is a **mindset and toolkit** – not a guillotine where “*document beats witness*” every time.



When the evidence is too thin

Evans v SoS for Health & Social Care [2024] EWHC 496 (KB)

What the estate says / what the paperwork says

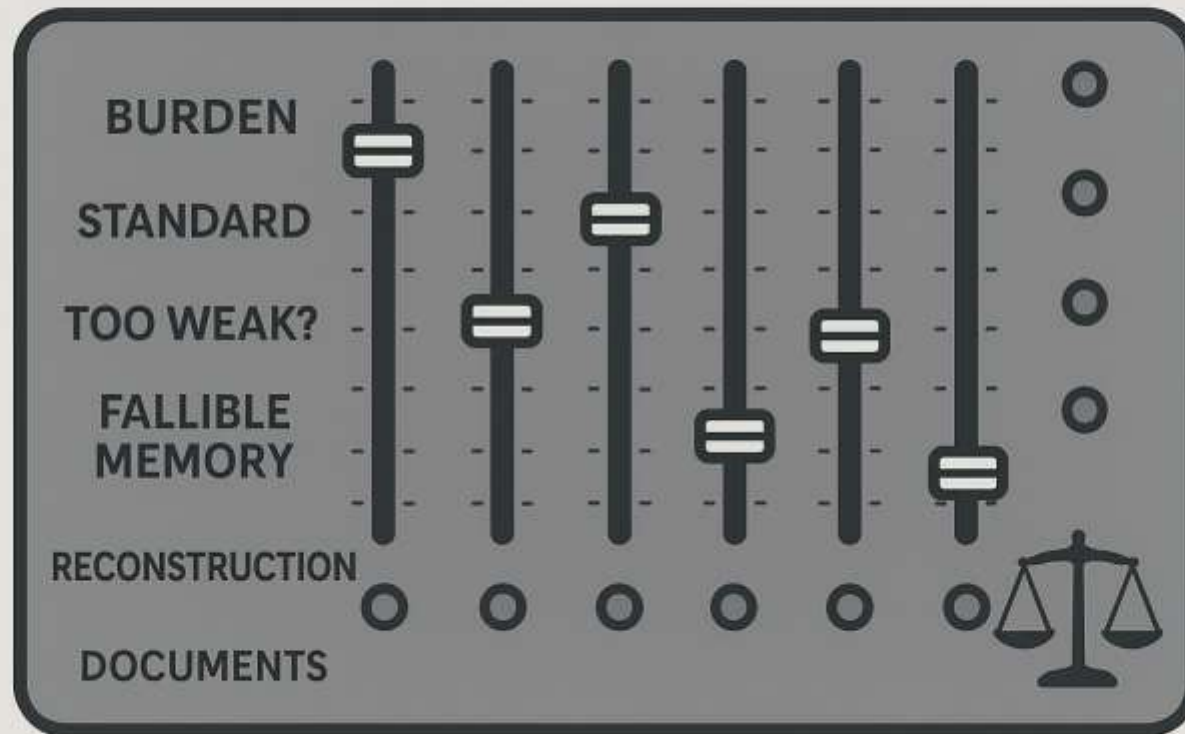


Visible clouds of dust
in hospital corridors,
every day.



- Denies occupational exposure
- Secondary exposure from husband's overalls

What the judge is actually fiddling with in *Evans*





Sympathy

Tragic facts, sad story,
big 😞 energy



Proof

Detail, corroboration,
exposure evidence

Sympathy does not replace proof.

Dramatic, sympathetic historic narratives
still have to fit the reliable material.
The narrative must fit the evidence.



Gestmin in the real world of PI & clin neg

- **Medical records as anchors, not gospel**
Use notes as the best contemporaneous material, but always in context and with explanations for gaps/errors.
- **Experts and reconstructed narratives**
Be wary when experts are invited to “remember” what they’d have done or thought years ago.
- **A grown-up way to talk about memory**
 - Take memory seriously as evidence, especially when it’s all we’ve got.
 - Test it hard against the best contemporaneous material.
 - Remember both witnesses *and* records sit in context: who asked, why, and under what pressure.
- **Lay witnesses at consultations**
How we precognosce what was said / understood, especially on consent and safety netting.



Putting Gestmin to work: 5 practical habits

1. Start with a neutral chronology

Build the timeline from records, rotas, imaging times, theatre lists, referrals and policies *before* you draft statements.

2. Take better precognitions

Early, detailed, anchored to the chronology; separate “what you actually remember” from “what you’re inferring from the letters”.

3. Treat records as anchors, not scripture

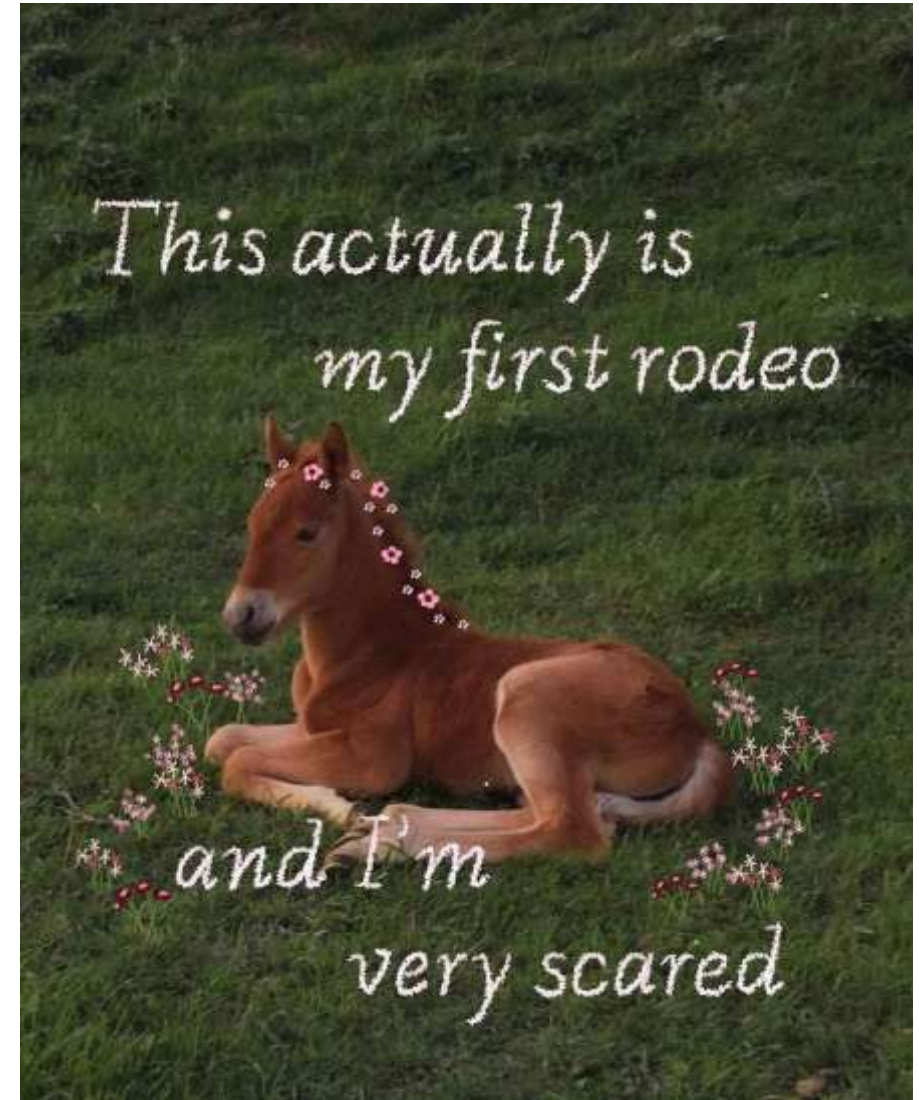
Read notes in context (purpose, template, copy-forward, errors). Explain gaps where you can; accept the bad points where you can’t.

4. Brief experts in a Gestmin-aware way

Ask them to base opinions on records and usual practice. Spell out where they’re assuming, reconstructing, or relying on guidelines.

5. Frame submissions around weight, not magic words

Invite the court to prefer your version because it best fits the reliable material – not simply because “Gestmin says documents win”.



Medical records in a Gestmin world

•Not administrative wallpaper

Medical records are primary evidence and part of the standard of care – record-keeping and consent are in the dock with the clinician.

•Recover wide, recover early

GP, hospital, private, OH, physio, mental health, imaging, labs – and pre-accident GP notes in psych cases.

•Sort quality and structure

Insist on legible, complete copies; paginate and index once; build a neutral chronology (times, decision points, supporting documents) and keep it updated.

•Turn records into working tools

Key-documents pack for conference and proof; experts to cite page numbers, state assumptions, and say how their opinion changes if facts are found differently.

•Keep the bundle disciplined

Clean, paginated, indexed records, neutral chronology and slim key-docs pack behind the expert's logic: the records do the heavy lifting and everything else fits around that spine.



Make sure they
know difference
between their arse
and their elbow



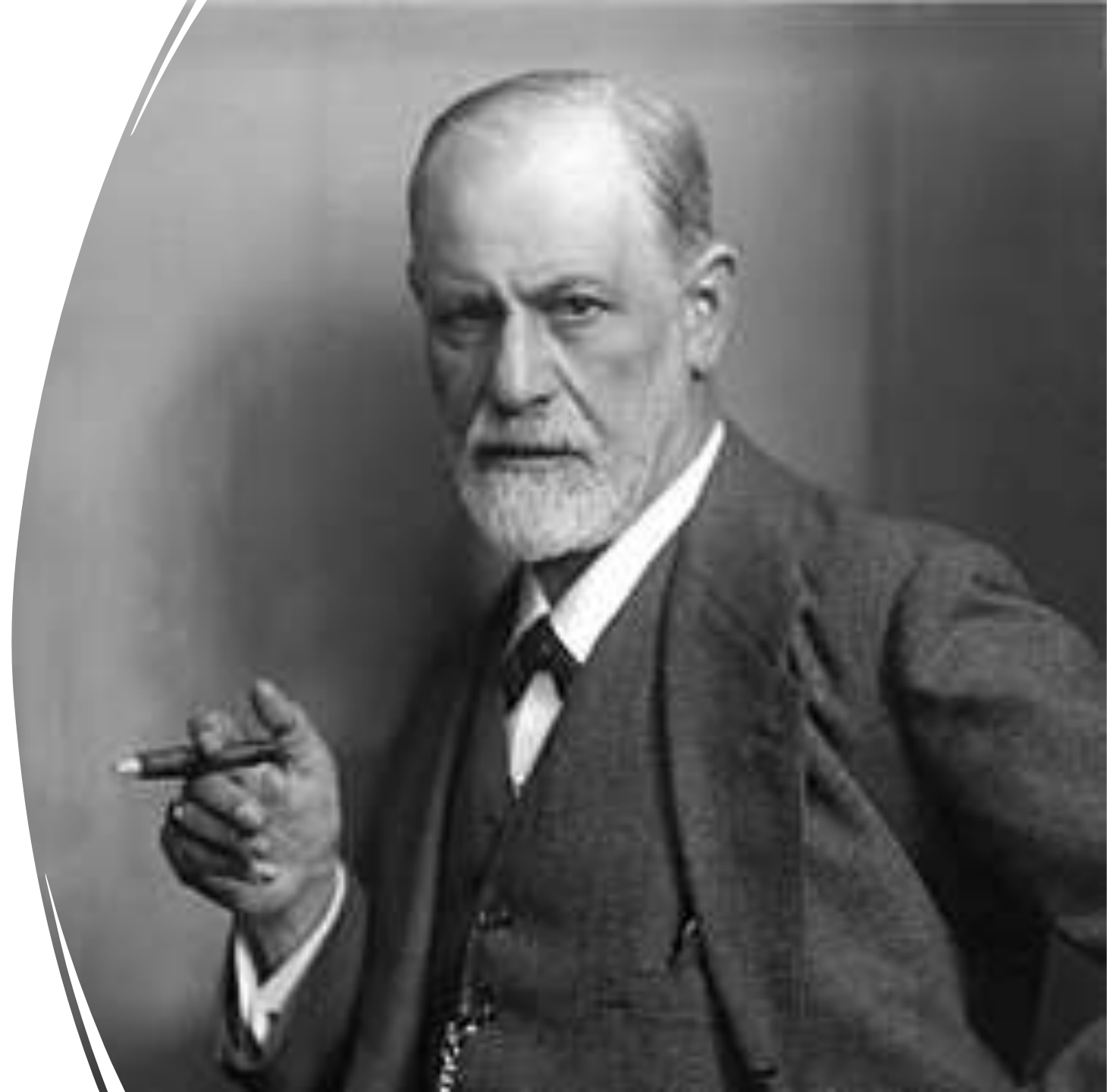
" HE DOES'NT KNOW HIS ARSE
FROM HIS ELBOW "

Parts of the body

- Do you have the right expert for the injury sustained?
- Orthopaedic and sub-specialisms
- General surgeons – upper GI / colorectal/gynaecological surgeons
- Radiologists – musculoskeletal/interventional/neuro radiology/cancer specialists etc, etc
- Oncologists - medical (chemotherapy) / clinical (radiotherapy) / surgical/neuro-oncologists



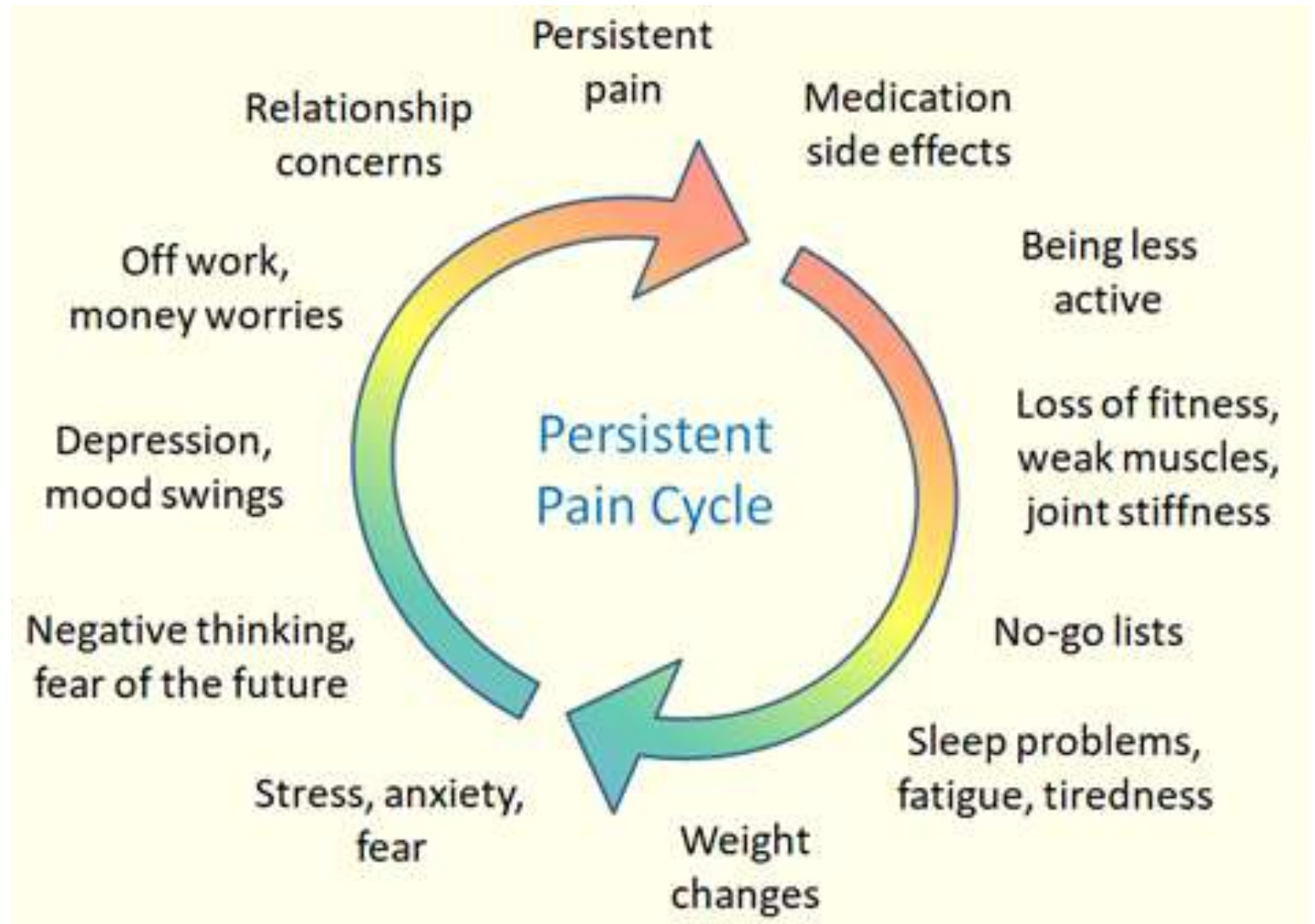
Psychologist
or
Psychiatrist??



Is one better than the other?

- Often pursuers go to psychologists.
- Probably cheaper and quicker
- Might be fine if doesn't involve significant psychological symptoms
- But they are not medical doctors and cannot provide an opinion on pharmacological treatment
- Use psychiatrist if the symptoms and/or medical history require it – more serious mental health disorders
- What to do if one side has a psychologist and the other side has a psychiatrist
- Neuropsychologist v Neuropsychiatrist
- Private referrals?

Chronic Pain Expert – The Bridge



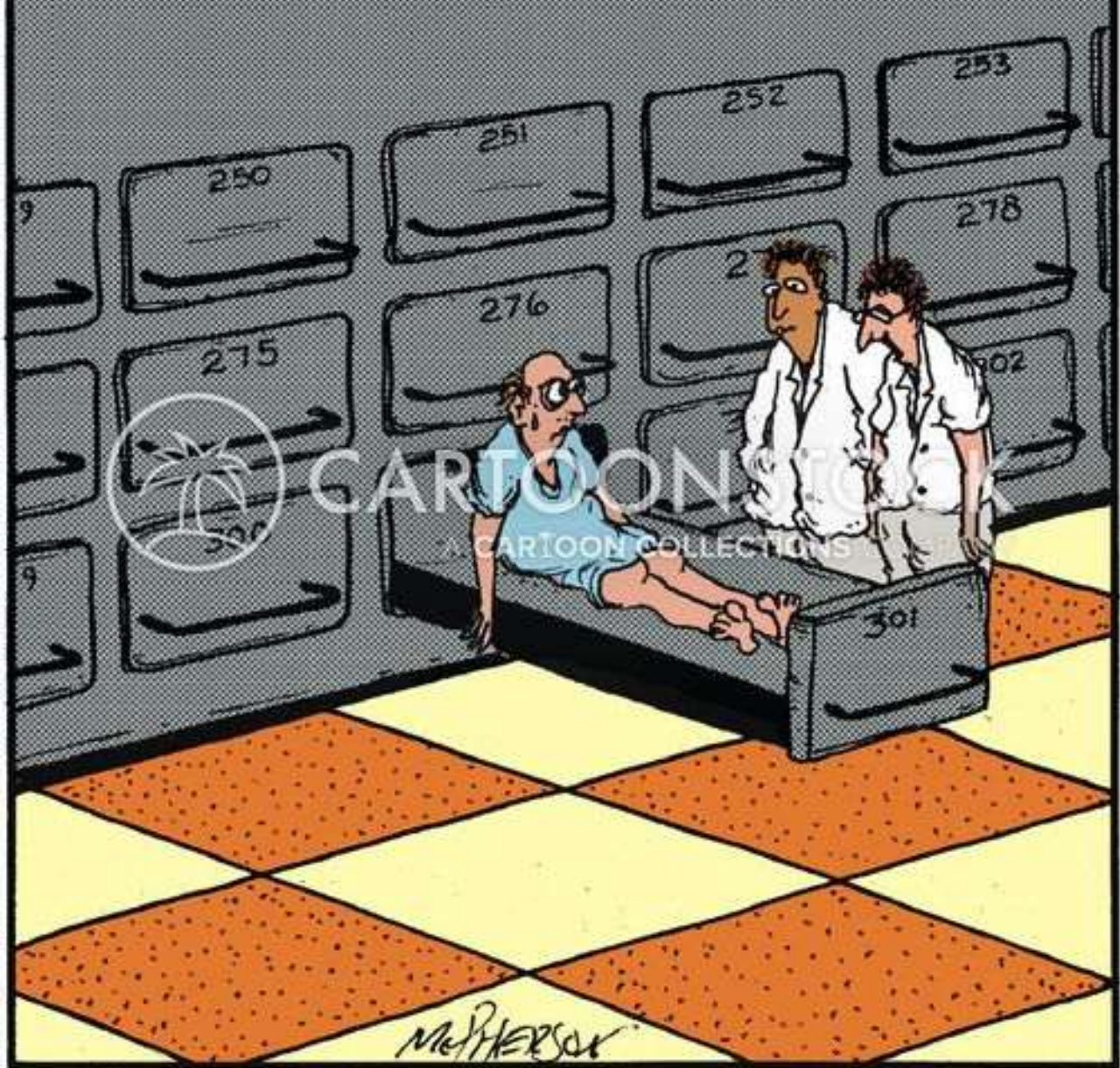
When to instruct such an expert?

- If a pursuer has not made as good a recovery as might have been expected
- If no other medical treatment, especially surgical treatment, is recommended
- Particularly if they also are suffering with mental health symptoms
- The report can often provide the bridge connecting the physical and psychological injuries
- Private pain management referral?

Condition and prognosis

- Not a desktop report generally
- Ideally in person but not always required – e.g psychiatric
- Get them to comment on your heads of claim
- Especially loss of earnings
- And whether the case merits instructing a care expert

Negligence and breach of duty



“Anyway, to make a long story short, the medical examiner who performed your autopsy was fired.”

Medical Negligence

- Again, get the right expert
- Needs to be able to step into the shoes of clinician under attack
- Are they too specialised?
- What type of doctor/surgeon?
- Where was the negligence?
- District hospital
- Community hospital
- National and local guidelines
- Make sure they are truly independent

The correct test of negligence

- As per Hunter v Hanley :
- “To establish liability by a doctor where departure from normal practice is alleged, three facts require to be established. First of all it must be proved that **there is a usual and normal practice;** secondly it must be proved that the **defender has not adopted that practice;** and thirdly (and this is of crucial importance) it must be established that the **course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care**”

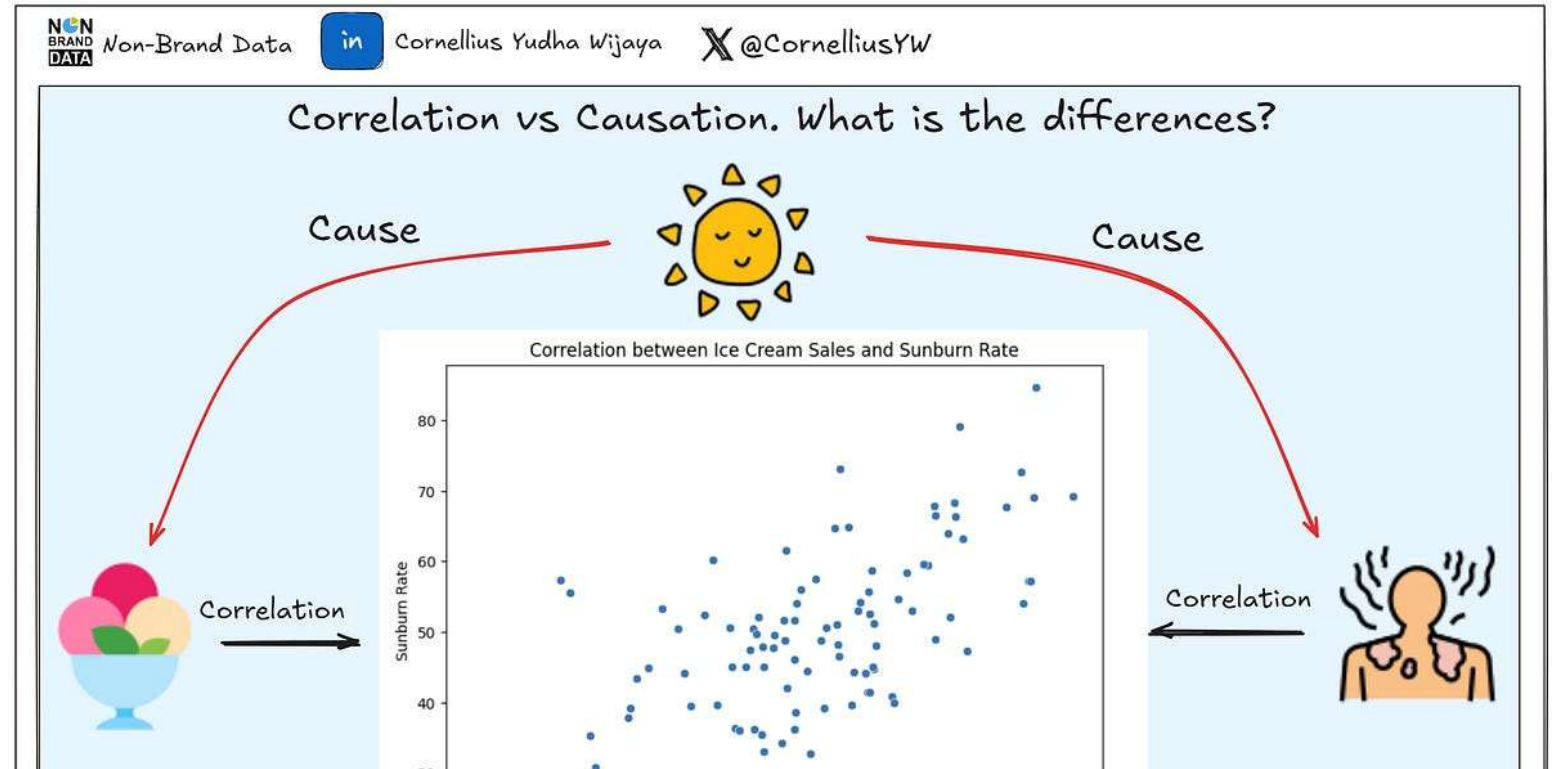
So, what's not the correct test? 🤔

- “Unreasonable”
- “Unacceptable”
- “Sub optimal or sub par”
- “incompetent” probably equals HvH
- Is there actually a normal and usual practice?
- Remember Bolitho.....

Non-medical negligence cases

- Nurses
- Advanced Nurse Practitioners
- Radiographers and sonographers
- Physiotherapists / osteopaths/ chiropractors

Causation

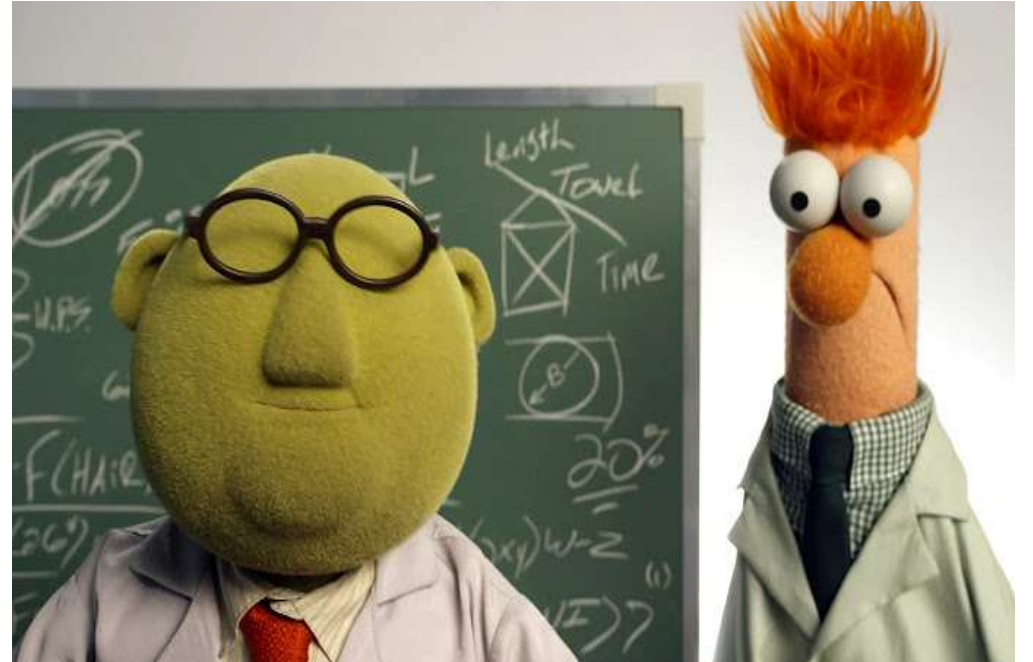


Proving causation

- Often the most contentious issue especially in medical negligence cases
- May not be the same expert as breach of duty
- In certain cases, can consider “material contribution” to establish causation
- Benevolent patient test - *Keefe v Isle of Man Steam Packet Co Ltd* [2010] EWCA Civ 683
- Complex cases
- Cancer
- General surgery which goes wrong

Building the counterfactual

- **Ask the right question**
 - Not “what would happen in an ideal world?” but:
 - “what would probably have happened if ordinary care had been taken in the real system at the time?”
- **Fix the starting point from the records**
 - What did the clinician actually know at each decision point?
 - Presentation, observations, red flags, working diagnosis.
 - Pin to times, places and named staff.
 - If notes are sparse, say plainly what can and cannot be shown.
- **Anchor to guidance and pathways in force then**
 - Use contemporaneous guidelines/pathways as the map of ordinary competent practice.
 - Be precise about timing and logistics: mode of transfer, realistic travel and handover times.
 - Be clear where the clock starts (ED, AAU, theatre, etc.).
- **Map the real sequence of care**
 - Triage → senior review → imaging / key tests → referral → acceptance → intervention.
 - Factor in out-of-hours realities, rotas, bed state and theatre lists.



The counterfactual: what *should* have happened (Dr. Bunsen Honeydew)... versus what *actually* happened (Beaker).

Experts, probability and common pitfalls



- **Make expert assumptions explicit**
 - What factual assumptions do they need?
 - Which documents support them?
 - No leaps like “earlier scan = better outcome” without feasibility, timing and clinical thresholds spelled out.
- **Quantify probability where you can**
 - Ask for the range of reasonable outcomes.
 - Why, for this patient on this timeline, is the more likely outcome on one side of the line?
- **Be realistic about transfer and timing**
 - Road vs air, distance, activation-to-arrival, and actual availability on the date in question.
- **Avoid classic pitfalls**
 - Don’t smuggle hindsight with documents the decision-maker never saw.
 - Don’t rely on aspirational transfer times.
 - Don’t treat a theoretical option as if it were genuinely available at that site on that day.
 - Keep the expert anchored to thresholds, timings and effect on outcome – not grand narratives.



Kes

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