GMC Expert report prepared by: [Expert name]

Regarding: [Doctor name]

Case reference: C1-[number]

Date:
Part 1 - Introduction

Summary of Instructions
This report was prepared on the instructions of GMC Legal contained in a letter dated [date].

The issues to address were summarised in the letter of instruction as:

[Insert copy of ‘issues to address’ section from letter of instruction]

List of Documents provided by GMC Legal (Document ID: [Insert number])
Enclosed with letter of instruction:

1. Complaint letter of Patient A
2. Complaint letter of Patient B
3. Medical Records of Patient A
4. Medical Records of Patient B
5. Trust report, dated [date]
6. X-Ray images for Patient A
7. X-Ray images for Patient B

Received since the letter of instruction:

1. Letter from the Trust providing additional information regarding Patient A and response to allegations from Dr C, dated [date] – received via post on [date]
Experience

I have experience in carrying out this type of procedure. I carry out approximately \[X\] number of these procedures per year.

Ordinarily, this procedure should be carried out by [explain the usual procedure, referring to all relevant guidelines, which you should annex to your report].

It should be noted that I have only limited experience in carrying out this type of procedure on paediatric patients, having only carried out \[X\] amount of this procedure on young children throughout my career, the last being approximately [date]. The method for carrying out this procedure on children has/has not changed since this time and differs in that [explain how].

Conflict of Interest

Having reviewed the relevant documents and sections of the GMC guidance for experts, I confirm that I do not have a conflict of interest, and see no reason why I am unable to prepare this report.

OR

I have advised the GMC of the following matters [insert any details you have given us about your knowledge of the doctor or anyone else involved]. Having discussed this with the GMC, I confirm that I do not consider I have a conflict of interest in preparing this report.
Part 2 - Background

Summary of Facts
The facts in this case [as set out in the Letter of Instruction and/or I have taken from my own reading of the case are as follows]:

[Provide a brief summary of the key concerns. You should indicate whether this is taken from the ‘background’ in the letter of instruction or your own reading of the documents.]

Chronology (per patient)

Patient A

- 01/02/2012 – Patient A GP records – first Consultation between Dr C and Patient A. The GP records note ‘complaining of chest pain and SOB (shortness of breath). Referral for chest X-ray.’ In her complaint letter, Patient A states that Dr C did not examine her chest at this consultation. In his response to this allegation, Dr C says he did listen to her chest and detected no abnormality, and that there was no history of chest complaints. I note that Dr C omitted to record this in the records.

- 25/02/2012 – Patient A Hospital records/X-ray images – Patient A undergoes x-ray – x-ray indicates [state relevant entry and findings quoted on X-ray, with explanation of medical terminology].

- 30/03/2012 – Patient A GP records – consultation with Dr C. The GP records note ‘On examination: well, apyrexial. Pulse rate 52 beats per minute. Pulse regular. Pulse character normal. Heart sounds normal. No cardiac murmur. Discussed options.’ I note that there appears to be no further explanation of Patient A’s X-ray results or a further chest examination or discussion of diagnosis/treatment options recorded.

- 14/04/2012 – Patient A GP records – consultation with Dr C. the GP records note ‘Chesty cough. Has purulent sputum [Define term]. Few scatters basal creps [Define term]. Prescribed amoxycillin’. I note this to be the first recorded chest exam

- 03/06/12 – nursing records for Patient A from Dr C’s Surgery (illegible – poor photocopy). It should be noted that there is no further consultation between Patient A and Dr C and so I would advise obtaining a clear copy of these notes, as they may indicate further treatment indirectly by Dr C.

Patient B [continue for each patient]
Part 3 – Opinion

Issues to Address
Below I have outlined my opinion in relation to each ‘issue to address’ set out in the letter of instruction. Where I have been asked to answer for multiple patients/instances of treatment, I have clearly separated my answer for each patient/instance:

Patient A

1  During the consultation on 01 February 2012, please address whether Dr C:
   a  adequately considered Patient A’s medical history

   Dr C did not adequately consider Patient A’s medical history at this consultation in that he did not [provide answer with full explanation]. In my opinion, this is below, but not seriously below, the standard expected of a reasonably competent General Practitioner because [provide reasons for this conclusion]

   b  adequately assessed Patient A

   Dr C did not carry out an adequate assessment of Patient A during this consultation in that he did not [provide answer with full explanation]. In my opinion, this was seriously below the standard expected because [provide reasons for this conclusion]

Patient B

2  During the consultation on 25 February 2012, please address whether Dr C:
   a  adequately considered Patient B’s medical history
Dr C did adequately consider Patient B’s medical history at this consultation in that he [provide answer with full explanation].

b adequately assessed Patient B

There is a difference in the account of Patient A and Dr C regarding the assessment which took place at this consultation.

If Dr C did not examine Patient A’s chest, as she alleges in her complaint letter, then Dr C did not carry out an adequate assessment. This would be seriously below the standard expected because [provide reasons for this opinion].

If Dr C did examine Patient A’s chest as stated in his response to the allegation, then Dr C did carry out an adequate assessment during this consultation.

There is no entry in the medical records to indicate that Dr C did examine Patient A’s chest.
Part 4 - Conclusion

Standard of care

Below

3. Where aspects of the care were below the standard expected of a reasonably competent [doctor grade and specialty]:

   a. State the specific aspects which were below the standard;

   Dr C failed to adequately consider Patient A’s medical history during the consultation on 1 February 2012. There was a clear history of chest pain in the notes. Dr C did not consider this because he noted no previous history of chest complaints in his record of this consultation. Had Dr C considered the patient medical history of chest complaints this may have led to an urgent referral.

   b. Explain why they were below, but not seriously?

   However, this failing was not seriously below the expected standard because Dr C did refer Patient A for a chest x-ray, although this was not done urgently. So although the consultation was inadequate, the action taken was correct.

Seriously below

4. Where aspects of the care were seriously below the standard expected of a reasonably competent [doctor grade and specialty]:

   a. State the specific aspects which were seriously below the standard;

   If Patient A’s account is accepted, that Dr C failed to perform a full chest examination during the consultation on 1 February 2012 on a patient with a history of smoking, aged 60, complaining of chest pain and shortness of breath; this represents care seriously below the expected standard.

   b. Explain why they were seriously below?

   Such an examination would be routine with any patient presenting with Patient A’s symptoms. If Dr C would have carried out a chest examination this could have revealed vital information to share with the patient and to include on the x-ray referral. For these reasons, this failing was therefore seriously below the expected standard.
Overall standard

5. Please explain whether the overall standard of care was not below, below or seriously below the standard expected of a reasonably competent [doctor grade and specialty] and your reasons for this overall conclusion.
Part 5 - Statement of Truth

1 I understand that my primary duty in written reports and giving evidence is to the Medical practitioners tribunal or the decision maker rather than to the party who engaged me.

2 I have endeavoured in my report and in my opinion to be accurate and to have covered all relevant issues which I have been asked to address.

3 I have endeavoured to include in my report those matters of which I have knowledge or of which I have been made aware that might adversely affect the validity of my opinion.

4 I have indicated the sources of all information that I have used.

5 I have not, without forming an independent view, included or excluded anything that has been suggested to me by others (in particular my instructing lawyers).

6 I will notify those instructing me immediately and confirm it in writing if, for any reasons, my existing report requires any correction or clarification.

7 I understand that:
   
a my report, subject to any corrections before swearing as to its correctness, will form the evidence to be given under Oath or Affirmation;

   b I may be cross examined on my report by a cross examiner assisted by an expert;

   c I am likely to be subject to public adverse criticism by the tribunal if it concludes that I have not taken reasonable care in trying to meet the standards set out above.

8 I confirm that I have not entered into any arrangements where the amount of payment of my fees is in anyway dependent on the outcome of the case.

9 I confirm that, insofar as the facts stated in my report are within my own knowledge, I have made clear which they are and I believe them to be true and that the opinions I have expressed represent my true and complete professional opinion.’

Signed:

Dated:

Part 6 – Documents Appended to the Report

Appendix A – an up to date copy of my Curriculum Vitae

Appendix B – [Insert all further material referred to or relied upon in your report, which was not provided to you by us eg. copies of any guidelines referred to]