Guidance for GMC experts

Expert Report Template

Cover sheet

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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 document ID as listed in the materials section of the instruction letter]) Enclosed with letter of instruction:

1. Complaint/referral correspondence
2. Doctors comments dated [date]
3. Patient AB’s Medical Records
4. Trust report, dated [date]
5. X-Ray images for Patient AB

Received since the letter of instruction:

1. Additional Medical Records for Patient AB
Experience

[Please outline your experience in the treatment/procedure]. I have experience in carrying out this type of procedure. I carry out approximately \([X]\) number of these procedures per year.

[Please explain the usual procedure, referring to all relevant guidelines, which you should annex to your report].

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

Patient AB [Patients Name] [DOB] [DOD (if applicable)]
[List further patients if applicable]

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)

[Please ensure you list all relevant consultation dates, initialise other medical professionals’ names and list grade/specialty, define all acronyms]
Patient AB

01/02/2012 – Patient AB GP records - first Consultation between Dr C and Patient AB.

The GP records note ‘complaining of chest pain and SOB (shortness of breath). Referral for chest X-ray.’ In her complaint letter, Patient AB 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 AB Hospital records/X-ray images – Patient AB undergoes x-ray
- x-ray indicates [state relevant entry and findings quoted on X-ray, with explanation of medical terminology].

30/03/2012 – Patient AB 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 AB’s X-ray results or a further chest examination or discussion of diagnosis/treatment options recorded.

14/04/2012 – Patient AB 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 AB from Dr C’s Surgery (illegible – poor photocopy). It should be noted that there is no further consultation between Patient AB 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.

[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:
Patient AB

1. During the consultation on 01 February 2012, please address whether Dr C:

   a. adequately considered Patient AB’s medical history

   Dr C did not adequately consider Patient AB’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 examined Patient AB

   Dr C did not carry out an adequate assessment of Patient AB 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].

   If Dr C did not examine Patient AB’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 AB’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 AB’s chest.

[Continue for each patient in multi-patient cases]

[Please do not to provide opinion on the care provided by other doctors or medical professionals. If you do identify concerns, please provide a separate email or word document listing concerns].
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 as per the letter of instruction]:

   a. State the specific aspects that were below the standard but not seriously below;

   Dr C failed to adequately consider Patient AB’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 AB 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 as per the letter of instruction]:

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

   If Patient AB’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 AB’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 as per the letter of instruction] and your reasons for this overall conclusion.

[If there are multiple patients, please provide an overall standard of care for each patient separately].
[Please consider all issues when providing your overall standard].
[If there are differing versions of events, please provide an overall standard of care in the alternate].

Other Issues

6. Any other issues you consider relevant.

[Please include any issues you have identified which we have not asked you to consider but you feel are relevant].
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.’
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## Part 6 - Documents Appended to the Report

**Appendix A** - Expert Report Checklist

**Appendix B** - An up to date copy of my Curriculum Vitae

**Appendix C** - [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]