MEDICAL REPORT

ON

JOHN SMITH

OF

DATE OF BIRTH: xxxx

PREPARED BY

Mr Atul Khanna MBA MBBS FRCS FICS Dip Eur B (Plast) FRCS (Plast)
CONSULTANT PLASTIC, RECONSTRUCTIVE & HAND SURGEON

Date xxx REPORT NO. AK/JB

CONTENTS

1 INTRODUCTION

1.1 This report is entirely independent and has been prepared for the court on the instructions provided by Solicitors following an injury sustained by Mr Smith on xxxx and details his treatment, condition and prognosis. Mr Smith was xxx years old at the time of the injury and now is xxx years old. His occupation at the time of the injury was that of a xxxx. His occupation now is that of a xxxx. His hobbies at the time of the injury were going to gym and travelling. His hobbies now are going to the gym in a limited capacity and walking. Mr Smith is right-handed.

1.2 This report is based on interview and examination of Mr Smith carried out on the xxxx at the Apollo Surgery, 619 Kings Road, Great Barr, Birmingham B44 9HW. No one else was present at the time of the interview. Mr Smith has provided me with a credit card as means of identification.

1.3 I have been provided with the following documentation at the time of preparation of this report:

1.4 General Practitioners notes.

1.5 Notes from xxxx Hospital.

1.6 Photographs taken after the injury.

1.7 Osteopathy records from xxxxx Clinic.

1.8 Records from xxxx Chiropractic clinic.

1.9 Rehabilitation assessment prepared by occupational therapist.

2 SUMMARY OF INSTRUCTIONS

2.1 I have received the following written instructions from xxx Solicitors. I have been asked to prepare a full and detailed written report. This should deal with relevant pre accident medical history, the injury sustained, treatment received and the present condition, dealing in particular with the capacity for work and giving a prognosis.

3 HISTORY

3.1 On xxx Mr Smith was working as a xxxx looking after cows. He was using a JCB telehandler and a hip clamp. Unfortunately his colleague who was using the apparatus pressed a button and this resulted in a pin coming into contact with Mr Smith's left middle finger. He sustained a significant injury to his left middle finger. This was an amputation of his finger. He was then taken to the Accident and Emergency Department at xxxx Hospital in xxxx. He informed me that he was advised to have a terminalisation procedure. The area was initially dressed, and he was discharged and a few days later had a surgical procedure under local anaesthetic that involved terminalisation of his left middle finger. Unfortunately, post-operatively he had some problems with healing and two months later he had another surgical procedure that involved another terminalisation and shortening of the finger. He states that this was carried out with no anaesthetic. He informed me that following this he has had hand therapy and has been discharged from the care of the Orthopaedic Surgeons that have been treating him.

3.2 He could not return to work for three months following the injury. He could not return to the gym for one year following the injury. He required regular analgesia for seven months following the injury. He required assistance in performing certain day to day activities at home for six months following the injury.

4 REVIEW OF MEDICAL RECORDS

4.1 On review of the General Practitioners notes there is an entry in the notes dated xxx stating that he had traumatic amputation of his left middle finger. He was requesting analgesics. Entries in the notes confirm his attendance at xxxx Hospital in xxxx and at xxxx Hospitals. The last entry is dated xxxx.

4.2 On review of the discharge summary from xxxx Hospital in xxxx it is noted that he was admitted on xxxx and discharged on the same day. He had traumatic amputation of his left middle finger and he had terminalisation of the left middle finger done under local anaesthetic as a day case. He was provided with a course of antibiotics, and it was arranged for him to be seen in a week's time. He was reviewed in the Accident and Emergency Department at xxxx Hospital in xxxx on xxxx. It was noted that he had a mid-finger left hand post-operative infection. They arranged for a dressing to be performed and it was arranged for him to be seen at xxxx Hospital. He was seen by the Plastic Surgery Team again on xxxx and he had shortening of his left middle finger in the minor operation theatres that day. It was arranged for him to be reviewed further. The x-ray report from the xxx shows amputation of the left middle finger at the base of the intermediate phalanx. There was no definitive radiological sign of osteomyelitis infection. He was then seen on xxxx in the plastic surgery clinic at xxxx Hospital. It is noted that he had a terminalisation performed on xxxx. This is stated as a terminalisation to the level of the middle phalanx. Post-operative course was complicated by both a wound infection and breakdown in addition to neuropathic pain. He had further bone shortening on xxxx requiring dressings. It was advised for him to have analgesics that would include Gabapentin and Amitriptyline for neuropathic pain post-operatively. It is stated that he was due to be seen again in clinic.

4.3 I have been provided with photographs that have been taken of Mr Smith's finger in the distal part showing an amputation at the middle of the left middle phalanx middle finger.

5 CURRENT COMPLAINTS

5.1 Concerned about the appearance of left-hand middle finger.

5.2 Has reduced grip left hand and reduced strength left hand due to injury and tends to drop objects.

5.3 Psychological problems including flashbacks, poor sleep, anxiety and body image disturbance related to trauma.

5.4 Needs to be careful while at the gym and returned in a limited capacity.

5.5 Has difficulties working as a xxx. He needs to use his left hand while fertilising the cows which is now difficult.

5.6 Has problems with cold intolerance.

5.7 He also has problems with pain in his left hand in the heat.

5.8 Pain in left hand that is not linked to temperature.

5.9 Sensitivity on tip of left middle finger.

5.10 Has difficulty opening jars and bottles, lifting weights at the gym, carrying shopping in his left hand.

5.11 He has difficulty using his left animals to inject animals, restrain animals with his left hand, diagnose pregnancy in cows or washout cows uterine infections.

5.12 He also has difficulties cutting meat while holding a fork in his left hand, moving his hand in cold weather, typing emails and letters on his computer.

5.13 He has difficulties carrying out DIY tasks, maintaining his car and picking up items from flat surfaces.

5.14 He also struggles driving a manual car due to having to grip the gearstick. He currently drives an automatic car which he finds much safer and easier.

6 PAST MEDICAL HISTORY

6.1 Mr Smith had a left arm fracture in xxxx and right arm fracture in xxxx. I do not believe that these injuries are relevant to the index injury that was sustained in xxxx.

6.2 He fell off a shed roof on xxx, six weeks before the index accident. He fell off a shed roof at home. He injured his back and went to see a chiropractor on xxxx where he had only one appointment. After the index injury he went to see an Osteopath on xxxx. During this it was noted that Mr Smith had an injury to his right shoulder, and it was suggested to him that he had damaged his rotator cuff. This is not believed to be related to falling from the roof. It was felt that the right shoulder injury was caused by Mr Smith lurching backwards as he was holding the clamp in his right hand during the index injury. He was also seen by the osteopath on xxxx, xxxx, xxxx, xxxx, xxxx and xxxx. At this stage he was discharged.

7 EXAMINATION

7.1 This examination is specifically for this report and is confined to an assessment of the scars and deformity that Mr Smith has following the injury that he sustained in xxxx. On examination of his left hand, he has a significant shortening of his left middle finger. The distance from the tip of the right middle finger is 10cm and the same distance on the left is 6cm. Mr Smith has lost 4cm in the length of his finger. Clinically it feels he has a small remnant of the PIP joint as he managed a flicker of flexion at this level. He has an area of scarring on the tip of his finger that measures 1cm x 1cm. This is indented and is somewhat hyperpigmented. He has got full range of movement both active and passive of the MCP joint of this finger. He is unable obviously to make a full fist due to the lack in length of his left middle finger. His grip is reduced on the left hand compared to the right by 30%. He has a reduced sensation on the tip of his left middle finger and cannot appreciate the two-point discrimination at 5mm. He has some thickening in the palm in the line of the middle finger, but this is not convincing of Dupuytren's disease. There is no obvious triggering of his left middle finger.

8 COMMENTS AND PROGNOSIS

8.1 **Summary**

xx year xxx months ago Mr Smith sustained a significant injury to his left middle finger. He had an amputation of his left middle finger. This initially required a terminalisation procedure. Following this he had an infection and had another surgical procedure that involved a further terminalisation. Following this he has had hand therapy. The injury sustained is consistent with the mode of injury that has been described. He could not return to work for three months following the injury. He could not return to the gym for one year following the injury. He required regular analgesia for seven months following the injury and required assistance in performing certain day to day activities at home for six months following the injury. This would not be unreasonable in view of the injury that has been sustained. Currently he is concerned about the appearance of his left hand middle finger. He has reduced grip on the left due to the injury and tends to drop objects and psychological problems. He has difficulties returning fully to his hobby of going to the gym. He has difficulties working as a xxxx. He tends to use his left hand whilst fertilising the cows which is now difficult. He also has problems with cold intolerance and has problems with pain in his left hand in the heat and pain in his hand which is not related to temperature. He has sensitivity on the tip of his left middle finger and reduction in strength of the left hand.

8.2 **Comments regarding injury to left middle finger**

Mr Smith has lost 4cm in length of his left middle finger. According to the figures stated from the American Academy of Orthopaedic Surgeons booklet of disability ratings Mr Smith has lost 25% function of his left middle finger. The middle finger is responsible for 15% function of the hand. This loss is permanent. He has problems with reduced grip and reduction in strength of the left hand. This will persist indefinitely. He has reduced sensation of the tip of his let middle finger and cannot appreciate two-point discrimination of 5mm. It is unlikely on balance of probability that there will be any real change in the problems that he has with sensation from hereon. He has an area of scarring on the tip of his finger. This is

indented and somewhat hyperpigmented. Scars have a tendency in maturing over two to two and a half years and I would anticipate that over the next one and a half years there will be some improvement in the appearance of this scarring, but this degree of improvement will be slight. The scarring that he has is permanent and will persist indefinitely. He is unable to make a fist, and this will persist indefinitely. He has problems dropping objects and again this will persist indefinitely.

8.3 He has problems with cold intolerance and problems with cold intolerance following an injury of this sort can persist for several years following an injury and it is difficult to predict the cause of cold intolerance following an injury of this sort.

8.4 It is unlikely on balance of probabilities that any surgical intervention will help the function of Mr Smith's left middle finger or the scarring that he has. Similarly surgical intervention will not help the problems that he has with cold intolerance. Surgical intervention will not help the problems that he has with reduced grip and reduced strength.

8.5 He has had problems with pain in his right shoulder. The causation of this can be discussed by an Orthopaedic Surgeon.

8.6 I do not anticipate any deterioration in Mr Smith's hand condition in the future. I do not believe that any treatment would be helpful in helping Mr Smith's hand function, scarring, cold intolerance, grip or strength.

8.7 **Comments regarding psychological problems**

Comments regarding the psychological problems can be made by a psychologist. He has significant psychological problems following the injury. These include flashbacks, poor sleep, anxiety, and body image disturbance.

8.8 **Comments regarding employment prospects, hobbies and day to day activities**

This injury has affected Mr Smith's employment prospects, the ability to partake in his hobbies and day to day activities. This impairment is permanent, and his difficulties do amount to a disability under the Equality Act 2010. On the balance of probabilities Mr Smith would find himself handicapped on the open labour market due to his injuries following the injury. Rather than working as a xxxx he has been working as an xxxx. This has resulted in a reduction in his earnings. In my view on the balance of probabilities the change in jobs was reasonable due to the injury. It is unlikely on balance of probabilities that he will be able to work full time as a Herdsman due to the significant injury he has had to his left middle finger as it is unlikely on balance of probability that he will be able to perform certain tasks such as fine tasks.

8.9 Mr Smith would benefit from the use of a prosthesis to the tip of his left middle finger. This would on the balance of probabilities improve the appearance of his hand but not necessarily the function. As assessment by a prosthetist would be helpful in this regard.

9 EXPERTS DECLARATION

9.1 There is a body of medical evidence/opinion with respect to the prognosis of injuries of this nature and my views expressed in this report reflect that body of medical evidence/opinion.

9.2 I understand that my duty to the Court is to provide independent assistance to help the Court on the matters within my expertise and I have complied with that duty. I understand that this duty overrides any obligations to those by whom I have been instructed or by whom I am paid. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all

matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

9.3 I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.

9.4 I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.

9.5 I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

9.6 At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9.7 I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

9.8 I confirm that I have no conflict of interest of any kind, other than any which has been disclosed in this report.

9.9 I confirm that I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issue on which I have given evidence.

9.10 I confirm that I will advise the party by whom I was instructed if, between the date of my report and the trial, there is any change in circumstance which affects my answers to either of the above two points.

9.11 I understand that my duty is to the Court and have complied and will continue to comply with it.

9.12 I am aware of the requirements of part 35 and practice direction 35, this protocol and the practice direction on pre-action conduct.

9.13 I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

..... 2024

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APPENDIX 1

MR ATUL KHANNA - CV

I qualified in 1983 and trained in surgery in general from 1983 to 1989. I commenced training in Plastic, Reconstructive and Hand Surgery in 1989. I have been in Consultant practice since 1998 and have been a Consultant Plastic Surgeon at Sandwell and West Birmingham NHS Trust since June 1999. My work involves the treatment of all types of hand surgery, burns, facial and soft tissue injuries, elective hand surgery, breast surgery, scars and deformities, skin cancer and cosmetic surgery**.** I have prepared a chapter for the Encyclopaedia of Forensic & Legal Medicine entitled "Medical Malpractice in Cosmetic and Plastic Surgery"

Qualifications:

M.B.B.S
Osmania University July 1983

F.R.C.S.
Royal College of Physicians and Surgeons of Glasgow November 1989

F.I.C.S
International College of Surgeons June 1994

M.B.A
Open Business School, Open University December 1994

F.R.C.S(Plast)
Intercollegiate Board in Plastic Surgery March 1997

Dip. Eur. B(Plast)
European Board of Plastic Reconstructive and Aesthetic Surgery
(EBOPRAS) November 1998

Present Position

Consultant in Plastic, Reconstructive and Hand Surgery
Sandwell General Hospital
Sandwell and West Birmingham Healthcare NHS Trust
Lyndon, West Bromwich, West Midlands B71 4HJ

Posts held concurrently:

1. Council member of the British Association of Aesthetic Plastic surgeons(2002-2005)
2. Chairman, BMA, Birmingham division(2002-2003)
3. College Tutor for surgery Sandwell General Hospital (2002-2005)
4. Representative (from Sandwell General Hospital) on the Regional Specialists and Consultants committee- West Midlands (2000-2003)
5.Honorary Secretary of the West Midlands Regional Specialist Advisory Committee in Plastic Surgery (2002- 2012)
6. Chairman Wound care action group- Sandwell Hospital (2000-2002)
7. Clinical Director for Plastic Surgery services Sandwell and West Birmingham NHS Trust- 2009-2013
8. Cosmetic Surgery representative Spire Little Aston hospital Medical Advisory committee (2006-2014)
9. Assigned educational Supervisor Plastic Surgery SWBH NHS Trust (2016-

Membership of Associations

British Association of Plastic, Reconstructive and Aesthetic surgeons
British Medical Association
Society of Expert Witnesses

Courses attended

Report writing after Woolf- A guide for Experts- 1999 MLTS
Expert witness report writing- 2001 Bond Solon
The clinical negligence process-2002 Bond Solon
Annual Premex expert witness conference 2014
Medicolegal Expert Witness course- Clinical Negligence November 2015
Annual Premex Expert Witness Conference November 2018

Publications in peer reviewed journals:

The Changing face of Streptococcal Myositis, Journal of Accident and Emergency Medicine November 1998, Vol 15 No 6 p 425-426.

Case Report: Reconstruction of an Ischial Pressure Sore with a Sartorius Musculocutaneous Flap, Journal of Wound Care, March 1994, Vol 3, No 2, p76-78

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Indian J Plast Surg. 2013 May;46(2):393-400. Review.

Publications in Books :

Medical malpractice: Plastic and Cosmetic surgery
Encyclopaedia of Forensic and Legal Medicine,
Copyright 2005
ISBN 0-12-547970-0
A. Khanna

Plastic Surgery Trauma- A Handbook of acute management-Kindle edition
Contributor to the following chapters
Chapter 1: General Principles and approach to Plastic Surgery trauma
Chapter 5: Bites, Extravasation injury, severe soft tissue infection and systemic disorders

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