What do Personal Injury solicitors expect of case managers?

An exploratory study into the expectations personal injury solicitors have of case managers and to what extent these are met, with implications for future case management practice.

by

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Contents

Abstract

Case managers work in several settings. Concerns have been raised regarding their status in the field of catastrophic injury claims where judicial guidance states they should be working independently, in the best interests of their client. The aim of this study was to conceptualise the expectations that personal injury solicitors have of case managers (CMs) and establish the extent to which those expectations were met. Those data were cross-referenced to the Competencies and Standards set by BABICM (2013) and the CMSUK Standards and Best Practice Guidelines (2009) in order to gauge current consistency of case management practice with the Standards set by its two professional societies.

Data were gathered from the legal context through semi-structured interviews and analysed thematically, utilising a template analysis approach (King, 2011). Participants included four claimant, three defendant solicitors, one funder, one barrister and one deputy. Nine themes were identified from the data and three further integrative themes.

Solicitors' expectations concerning specific areas of case management practice were present in both professional association standards. The need for a professional case management qualification and appropriate training in litigation process was recognised to mitigate against high levels of suspicion and mistrust found in the study. A standardised system of documentation was strongly encouraged by the industry to ensure consistency of all reports.

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List of Abbreviations

ABI	Acquired brain injury
BABICM	British Association of Brain injury Case Managers

BABICM definition of case management: *Case management is an active process devoted to the co-ordination, rehabilitation, care and support of people with complex, clinical needs and their families. It aims to facilitate their independence and improve their quality of life whilst acknowledging safety issues* (BABICM, 2013: p.3).

CMSUK	Case Management Society UK

CMSUK definition of case management: *A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individuals health, care, educational and employment needs, using communication and available resources to promote quality cost-effective outcomes* (CMSUK, 2009: p.10).

CQC	Care Quality Commission
HCPC	Health and Care Professions Council
INA	Initial Needs Assessment Report
PI	Personal Injury
TA	Template analysis

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Chapter 1

Introduction

Clinical case management in the personal injury arena has become a growth industry in the past decade, notwithstanding its lack of statutory regulation and formal qualification process (CMSUK, 2012). Case managers should work independently of the legal process in the best interests of their client, the claimant involved in litigation for personal injury damages (The British Association of Brain Injury Case Managers [BABICM], 2013; The Case Management Society UK [CMSUK], 2009). It has been suggested that case managers are "the servants of too many masters;" the possible influence of the clinical case manager with the "process of damages' valuation and evidence construction" in the field of catastrophic injury claims has been questioned (Underwood, 2010: p.1). Further conceivable ethical considerations arise in tensions identified between the professional background of the case manager, where the focus is to optimise all functional potential of the injured party, and the interest of litigation, which is to maximise a claim for loss of function (Edwards, 2009).

The views of personal injury solicitors, gleaned from various presentations attended by the researcher in the past eight years, are polarised and experiences reported at either end of the scale of 'good' and 'bad' case management. It appears that not only is there a marked discrepancy between many solicitors' expectations of case managers and to what extent these are met, but also a lack of consistency in the way different case managers work. No formal study has been carried out at this

litigation interface in the past and it is hoped that identification of the complexity in this arena will direct future research towards more specific research topics.

The study will first set in context the nature of personal injury (PI) claims and highlight some of the more spurious reports concerning a 'compensation culture' before exploring the origins of case managers, their professional status and the ways in which they work with people who are catastrophically injured. The expectations of case managers held by seven PI solicitors, an insurance funder, a barrister and a Deputy were sought in semi-structured interviews. Those data will be presented and subsequent findings then discussed with reference to the Competencies and Standards set by BABICM (2013), the CMSUK Standards and Best Practice Guidelines (2009) and a barrister's view of the law and practice of case management (Sharp, 2012).

Conclusions will be drawn from the main themes identified and related to recent UK judgements and emerging trends identified in the European context of care, with implications for the future practice of all case managers working in the PI arena.

1.1 The Personal Injury Claims Process

1.1.1 Claims for Damages

While this is not a legal paper, it is important to be clear about the setting in which most case managers work, although they are not part of the formal litigation process.

Personal injury[1] law involves injury which is caused accidentally by another's failure to use reasonable care and the onus lies with the claimant to prove his or her case 'on the balance of probabilities' (Whiteley and Wright, 2006: p.77). The

[1]The expression "personal injury" includes any disease and any impairment of a person's physical or mental condition, and the expression "injured" shall be construed accordingly (Law Reform [Personal Injuries] Act 1948, Section 3)

Courts provide substantive legal process for the application of those principles of tort law which have been 'crafted and refined in the crucible of the common law over a very long time' (Dyson, 2013: p.8).

Three features are essential in order to pursue a successful personal injury claim. Firstly, liability must be established and the defendant shown to have breached a legal duty that he or she owes to the claimant. Secondly, causation whereby the claimant must be able to prove that the 'act of negligence or breach of statutory duty' has led to the injury and loss claimed.

Thirdly, quantum which is the measure of how much the claimant has lost (Whiteley and Wright, 2006: p.78). As long ago as 1880 Lord Blackburn encapsulated the essential function of damages:

> *"where any injury is to be compensated by damages, in settling the sum of money to be given for reparation of damages you should as nearly as possible get at that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been if he had not sustained the wrong for which he is now getting his compensation or reparation"*

(Livingstone v The Rawyards Coal Company (1880) 5 App.Cas. 25: cited Lewison, 2008: p.2).

In order to restore the injured party to the point he would have been, had he not sustained 'the wrong', the Court will award damages in three distinct areas. Firstly, that of pain, suffering and loss of amenity which will vary according to the severity of injury. Secondly, special damages are 'those measurable financial losses' incurred up to the resolution of the case, such as loss of earnings or the cost of care. Thirdly, general damages for future losses which are 'an estimate of the reasonable losses and expenses the claimant will bear in the future' because of the injury sustained (Whiteley and Wright, 2006: p.78).

Recently there have been moves to replace this traditionally adversarial process with one of mutual communication and consensus and such collaborative claims'

handling is more readily seen in the practice of catastrophic injury practitioners dealing with high-value claims. Different initiatives, such as the Rehabilitation Code (Stevens, 2007) and the Multi Track Code (2012) have tried to regularise best practice. However, neither of these codes are yet compulsory although any compensators not wishing to follow rehabilitation assessment proposals must justify their refusal (Stevens, 2007). Recent research identified that the Rehabilitation Code is now a fully-established part of the claims process, 'widely recognised and used'. The biggest drawback noted was cost, with many critical of the services given by rehabilitation providers and case management companies (International Underwriters Association; Association of British Insurers, 2013).

The Multi-Track Code was formed during 2005 as a joint initiative between the Association of Personal Injury Lawyers (APIL) and the Forum of Insurance Lawyers (FOIL), representatives from various insurers and the Motor Insurance Bureau (MIB). It was developed with the common aim of attempting dispute resolution as early as practicable. The Code is aimed at high value claims where damages exceed £250,000 and the accident occurred after 1 July 2008. The scheme currently excludes clinical negligence and disease claims. An interim report noted "the aim of greater trust on both sides has been achieved. All of the benefits together have helped to create a smoother, less fractious claims process for those participating within it" (Multi-Track Code, 2012: p.3). Support at the 'highest level within the judiciary' came from Lord Justice Jackson who acknowledged the success of the Multi-track Code; he endorsed his support of its aims and welcomed the progress that had been made (McKenna, 2012: p.5).

1.2 Compensation culture?

During the past decade the media have depicted a society preoccupied with litigation and compensation claims, where, apparently, 'people can absolve themselves from any personal responsibility for their own actions, with the spectre of lawyers only too willing to pounce with a claim for damages on the slightest pretext' (David Cameron, HM Government, 2010: p.5).

Lord Dyson countered in the Houldsworth Club Lecture that "a desire to sue somebody who has caused you a loss arising from their blameworthy conduct is not unreasonable. It is in fact the basis of our law of tort, and in particular of negligence." (Dyson, 2013: p.3). Building on previous findings that the compensation culture is 'a myth; but the cost of this belief is very real' (Better Regulation Task Force Report, [BRTF], 2004: p.3), Lord Young agreed that "the problem of the compensation culture prevalent in society today [was] one of *perception* rather than reality" (HM Government, 2010: p.19: author's italics)

Lord Dyson challenged the perception of a compensation culture through a measured analysis of our justice system. He cited the case of *Tomlinson v Congleton Borough Council & Others (2003)* when the claimant was injured as a result of diving into a flooded sand quarry and tragically breaking his neck on the bottom of the quarry. Mr Tomlinson sued the local council. The House of Lords rejected the claim and Lord Dyson vigorously directed the media to Lord Hoffman's judgement on the Tomlinson case, lest they "consider we are heading towards a compensation culture". Lord Hoffman said

> *The law does not provide such compensation simply on the basis that the injury was disproportionately severe in relation to one's own fault or even not one's own fault at all. Perhaps it should, but society might not be able to afford to compensate everyone on that principle, certainly at the level at which such compensation is now paid. The law provides compensation only when the injury was someone else's fault* (cited in Dyson, 2013: p.10).

Lord Dyson made two important points in his lecture: firstly, that a compensation culture is predicated on the notion that compensation is being sought "improperly because the claims do not rest on the application of any legal principles, such as the need to establish a duty of care, negligence or causation" (Dyson, 2013: p.3). And secondly, that the law requires 'a duty of care, breach and causation of loss. These are not always straightforward matters to establish... for a compensation culture properly to take hold, there would have to be a major shift in our substantive law' (ibid: p.10).

There has been no such 'shift in our substantive law'; however, concerns have been raised that Lord Young's Report inappropriately dealt with all PI claims, claimants and lawyers as one body. One solicitor noted that 'a person claiming for a whiplash injury from a rear end shunt cannot possibly be compared to a child rendered paraplegic by a combination of circumstances, involving several possible defendants and who will have very specific needs and issues when bringing a claim' (Luscombe, 2010: p.1). Every claim is different; this is certainly the case where more severe injuries are incurred and it is at this level where case managers work.

1.3 Catastrophic injury and major trauma incidence

The distinction must be drawn between the cases of serious catastrophic injury where the claimant and their family's lives will be unutterably altered as a consequence of life-changing injury, such as brain or spinal cord injury, and other personal injury claims whereby the claimant is awarded compensation to pursue a period of rehabilitation and returns to a life much as it was before. This study deals with case managers who are working with people 'whose lives will never return to anything like the normality that they knew before their injury, and where the award they receive will condition to a large extent the quality of life that they and their families have until death' (Aldous, Andrews, McKechnie and Lee, 2010: p.xlv).

Figures from the most recent report concerning major trauma care in England from the National Audit Office (NAO) estimated that there are at least 20,000 cases of major trauma each year in England resulting in 5,400 deaths and many others resulting in permanent disabilities requiring long-term care. A further 28,000 cases which, although not meeting the precise definition of major trauma would be cared for in the same way. The most common cause of major trauma is a road accident (NAO, 2010). Clearly fielding the claims arising 'from this amount of injury is a major task requiring considerable skill and dedication' (Aldous et al, 2010: p.xlv).

A recent report explored the nation-wide use and demand for rehabilitation services (Hawe, Schaffer and Baillie, 2013; OHE Consulting: commissioned by Irwin Mitchell). Focusing on brain and spinal injuries and those who have been seriously injured in road traffic collisions, it echoed earlier findings by the NAO (2010), that:

- There exists a widely perceived lack of capacity for the specialist rehabilitation of major trauma patients (NAO, 2010: p.7:par 14)
- Leading to patients with complex injuries remaining unnecessarily on general acute wards, and being cared for by staff without the specialist skills required to appropriately manage them. It also leads to delays to treatment which may impact on recovery, and reduce bed availability for elective surgery (NAO, 2010: p.26:par 3.17)
- The availability of rehavilitation services varies widely across the country and currently lacks coordination. This variation may refelect the fact that existing services have developed on the basis of local geography and expertise, and that the actual needs of different groups of patients have not been systematically appraised (NAO, 2010: p.27:par 3.19) [cited in: Hawe et al, 2013: p14-15].

More disturbingly, despite a large body of evidence that suggests early, co-ordinated and intensive rehabilitation for brain injury not only leads to improved recovery prospects for the patient, but can generate significant savings to the NHS of between £0.7 and £1.6mn per patient, existing rehabilitation services may now be at risk in the face of further NHS cutbacks; rehabilitation was described as an 'NHS Cinderella service' and the UK has fewer rehabilitation specialists per head than any of its European counterparts (Hawe et al, 2013).

It is clear that in the field of catastrophic injury a major coordinating role is required to ensure the injured party's complex needs are identified and met. It was from similar complexity that the role of the case manager originally evolved.

Figure 1.1: The Case Manager's Creed

To be a case manager, one must be courteous, diplomatic, caring, shrewd, persuasive, creative, supportive, understanding, responsible, slow to anger, adaptable, a Sherlock Holmes, a motivator, up-to-date, good looking, have a good memory, acute business judgement, emotional stability and the embodiment of virtue, but with a good working knowledge of sin and evil in all its forms. A case manager must understand insurance, electricity, chemistry, physiology, mechanics, architecture, physics, book keeping, banking, merchandising, selling, shipping, contracting, claims adjusting, law, medicine, real estate, horse trading and human nature. A case manager must be a coordinator, clinician, coach, therapist, educator, consumer, advocate and administrator. A case manager must be a mind reader, a hypnotist, and an athlete, must be acquainted with machinery of all types and materials of all kinds, and must know the current price of everything from a shoestring to a skyscraper, an aspirin to an amputation. They must know all, see all, tell nothing and be everywhere at the same time. They must satisfy their client, their client's family, their office, their client's solicitor, the Care Standards Commission [Care Quality Commission], the Public Guardianship Office, in a compensation claim, the claimant's and the defendant's experts, the local health and social services, local rehabilitation services and Headway

(Adapted from Nursefinders 1992, cited in Johnson, 2006: p.129).

Chapter 2

Case management

2.1 Background

The roots of case management are now more than a century old and current practice is embedded in those beginnings, (together with some of the flexibility and diversity of the Creed listed in Fig 1.1). This innovative approach to managing and coordinating patient care originated in the USA with public health nurses and social workers seeking the best way to manage people with complicated needs; it is now widely used in various other countries, including Australia, Canada, New Zealand and South Africa (Tahan 1998). Following World War II, insurance companies began to employ nurses and social workers to assist with the co-ordination of care for soldiers who suffered complex injuries requiring multidisciplinary intervention to optimise their recovery (Tovell-Toubal, 2007).

In the early 1970s formalised case management evolved with pilot projects within the American public health system and was initially concerned with "hard to reach and treatment-resistant groups" (Clark-Wilson, 2006: p.16). Case management cut across "professional affiliations... the emphasis for service delivery [was] directed towards the client's wants and needs" and not on how the system was organised to deliver services; the promotion of 'independence and accountability' guided the aims of case management (Krupa and Clark, 1995; cited in Lloyd and King, 2002: p.538).

Case management evolved differently in the UK due to the existence of the NHS and social services departments. However, a clear need for a specialist service to underpin the reintegration of people with a brain injury back into the community was recognised following the Warwick Report's finding that this 'hard to reach' group was experiencing "social isolation, restricted mobility and a loss of meaningful activities or satisfying social roles" following their injury (Stilwell, Stilwell, Hawley and Davies, 1999: p.289).

A brain injury case management steering group was established in 1992 (Clark-Wilson, 2006). BABICM was established in 1996 to promote the development of case management in the field of acquired brain injury. CMSUK was formed in 2001 as a result of concerns driven by both the insurance industry and case managers at the lack of standards or structure to case management in the UK, primarily in the personal injury arena. More recently, case management is also being used in statutory services as a cost-effective response to the challenges posed by "people with complex long-term chronic illness increasingly [absorbing] by far the largest share of health and social care budgets" (Goodwin, 2011).

Clinical case management and a systems or managed care model are posited as the two main models of case management utilised according to the context of the client. The systems model is firmly set in the organisational structure of large administrations, such as the NHS, social services departments, healthcare organisations and insurance companies (Clark-Wilson, 2006).

Case managers working in the NHS have a "systematic approach to identifying high-cost patients, assessing potential opportunities to co-ordinate their care, developing treatment plans that improve quality and control costs, and managing patients' total care to ensure optimum outcomes" (Fisher, 1987: p.287; cited in Clark-Wilson, 2006, p.24). They all have a previous clinical qualification (usually in nursing or occupational therapy) and are regulated directly by a statutory body (Department of Health, 2005).

Clinical case management has been described as "an intervention to address the overall maintenance of the client's physical and social environment ... applicable to specialised case managers who work with challenging brain injured clients with complex physical, cognitive, emotional, behavioural and social needs resulting from their brain injury" (Clark-Wilson, 2006: p.23).

2.2 Professional status?

Most independent case managers come from occupational therapy, nursing or social work backgrounds. They are regulated by their first clinical registration, supported by the evidence base of their different established professional bodies and experience learned from working with people with acquired brain or spinal cord injury. The role of qualified, regulated and experienced professionals is emphasised by BABICM and the professional standard required of a Brain Injury Case Manager is clearly presented in terms of qualification, registration, competency and training in order to meet the demands of coordinating care and support for people with complex, clinical needs (BABICM, 2013: p.27 Standard 6).

The assiduous practitioner does not work in a professional vacuum, as shown in Table 2.1 of the Standards expected of an Occupational Therapist (OT) Brain Injury Case Manager who is a member of both BABICM and CMSUK and registered with the Care Quality Commission (CQC).

Case management is not a profession *per se*. It has been suggested that for a profession to achieve maturity, the nine infrastructure components of Table 2.2 should be present.

> *A recognised body of knowledge; professional societies; a code of ethics; a professional education system; accreditation of educational programmes; skills development for those entering practice; continuing professional development programmes; certification of professionals by the profession and government licensing of professionals* (Pour et al, 2000; cited in Tuner, 2011: p.319).

Table 2.1: Standards to Meet (OT Brain Injury Case Manager)

Registered Body Professional Membership	**Corresponding Standard**
Health and Care Professions Council (HCPC, 2013) *Protected titles: Occupational Therapist*	Professional Body Regulatory Standards
College of Occupational Therapists Specialist Section: Independent Practice (COTSS-IP)	Professional Body Best Practice Standards Extended Scope Practice (COT, 2009)
BABICM: Registered/Advanced Practitioner	Peer review Competencies & Standards for case management practice (BABICM, 2013)
CMSUK Member	Standards & Best Practice Guidelines (CMSUK, 2009) Code of Ethics for Case Managers (CMSUK & BABICM, 2008)
CQC & HCPC	Memorandum of Understanding between the Care Quality Commission and the Health and Care Professions Council (2012)
UK Rehabilitation Council	PAS 150 (UKRC, 2010)

Case management is an evolving area of practice and still has some distance to travel along the trajectory towards achieving the status of a profession in its own right: *see Table 2.2.* However, the advent of the BABICM Practice Standards is seen as a step towards case management becoming a registered profession now that 'achievable and recognised minimum standards' are in place (BABICM, 2013: p.19).

Table 2.2: Case management as a profession?

Component	**Current Status**
Recognised body of knowledge	**Present:** Competencies Framework and Standards for case management practice (BABICM, 2013) **Present:** Standards and Best Practice Guidelines (CMSUK, 2009)
Professional societies	**Present:** Two professional associations: BABICM & CMSUK
Code of Ethics	**Present:** Joint Code of Ethics (CMSUK & BABICM, 2008)
Professional education system	Very early stages with BABICM Competencies Framework & Standards for practice
Accreditation of educational programmes	Educational accreditation programmes have only recently appeared in the form of a MSc course at Brighton University (now discontinued), and a two year part time taught Brain Injury Case Management MSc programme at the University of Birmingham, School of Psychology which began in October 2010 (University of Birmingham, 2012).
Skills development for those entering practice	Informal skills development mentoring pathways available in larger case management organisations Use of Competencies Framework for development
Continuing professional development	Informal continuing professional development programmes are offered by both BABICM & CMSUK Use of Competencies Framework for peer review, appraisal

Certification of professionals by the profession	BABICM membership criteria now reviewed to represent a more structured, robust and transparent membership framework: Corporate: *professional organisations, companies and groups with an interest in case management* Affiliate: *clients, family members, other interested parties* Non Registered Practitioner: *those actively practising as case managers but who do not hold a registered professional qualification* Registered Practitioner: *Candidates eligible for the Registered Practitioner category will have qualified and practised and be registered in a relevant profession with one of the following statutory qualifications: Chartered Psychologist, Doctor of Medicine, Registered Nurse, Occupational Therapist, Physiotherapist, Social Worker, Speech & Language Therapist* Advanced Registered Practitioner: *Candidates will be a current Registered Practitioner member of BABICM and have a minimum of the equivalent of three years working full time as a brain injury case manager.* *Candidates must submit evidence to their peer reviewers to demonstrate that their practice is commensurate with the current BABICM Standards and the Competency Framework at Levels 2 & 3*
Government licensing of professionals[1]	There is no statutory regulation in place for case managers

[1]BABICM Chair's Address reported the current Government is 'moving away from costly regulation' and instead proposed a system of voluntary registration to be developed for professionals and occupational groups which are currently not subject to statutory regulation. "The Health and Social Care Act 2012 has given a new function to the newly-named Council for Healthcare Regulatory Excellence (CHRE) who will set standards for organisations that hold voluntary registers for people working in health and social care occupations and they will accredit the organisation's register if the organisation meets those standards. There has been Consultation around the proposed standards with groups that had indicated that they were interested in forming Voluntary Registers which has now closed, and which we [BABICM] unfortunately missed" (Dean, 2012[b]: p.1).

BABICM have now reviewed their membership framework to identify those members who are registered practitioners, and those who do not hold a registered professional qualification: *See Table 2* (Haysom, 2013). A membership of 476 was reported as of May this year; however, during investigative review of the membership, 22 brain injury case managers were identified in two randomly-selected case management companies who were not BABICM members at all (Haysom, 2013: p.5). CMSUK reported a membership of 503 as of July 2013: a 20% increase from the previous July (CMSUK, 2013). Meanwhile both organisations continue to support their membership, with BABICM working towards accreditation and regulation and also collaborating with CMSUK on an ongoing initiative to raise the profile of case management (Dean, 2013).

During a CMSUK Study Day both claimant and defendant solicitors were invited to give their perspectives on the role of case manager. Each solicitor highlighted the need for specific practice standards; the defendant emphasised case managers should be regulated by a single body with the profession adopting appropriate training in order to achieve consistency of approach, objectivity and transparency (CMSUK, 2010).

More recently, CMSUK commissioned an investigation 'to identify to what extent there is a need for a standardised, accredited or certified professional pathway for case managers in the UK' (CMSUK, 2012; Harrison Training, 2012). Findings showed 'over-riding support for better regulation of case management' with 'a formal professional pathway [seen] as beneficial in evidencing experience, assessing case management skills, giving credibility to practice and monitoring quality of service provision' (CMSUK, 2012: p.2).

2.3 'Co-ordinator, clinician and coach'

Despite case management being relatively young in terms of professional status, its framework of assessment, planning, implementation and evaluation facilitates the broader approach that addresses all the complexity of need inherent in the brain-injured or other catastrophically-injured person. 'Resource identification; advo-

cacy; coordination; monitoring and evaluation of care; data collection and analysis and documentation of multiple outcomes, including cost, quality and client status' are all part of the inherently collaborative process of clinical case management involving the client, family and other members of the healthcare team (White and Hall, 2006: p.100).

A good case manager has been described as "worth their weight in gold" (Ettinger, 2013), somebody who has 'done all the hard work' so that when it comes to 'presenting the compensation claim' the lawyers have the comparatively easy task of presenting 'a sensible life care plan' instead of theorising 'about an uncertain future' (Braithwaite, 2011: p.7)

2.4 'The elephant in the room' and judicial guidance

Presenting the alternative view, Underwood (2012) warned that case managers are being asked "to stand in the shoes of the injured claimant in a highly complex, highly costly and adversarial arena ... where [case management] decisions made can have a direct correlation to the value of the claim at settlement or trial" (p.6). He urged "accountability and professional responsibility" and warned that "case managers will be held to account for their decisions and will be sued if they get it wrong"; that there should be no intervention carried out without "clinical governance" (ibid). Statutory demands for evidence-based practice have arisen on the back of past clinical decisions where the dominant concern has been the "evaluative question ... of those who see themselves bearing the costs, monetary or personal, of inferior judgements and decisions" (Alaszewski, 1998: p.151).

Judicial guidance, from which the responsibilities and duties of a case manager can be inferred, was provided by *Wright v Sullivan [2005] EWCA Civ 656* where 'novel issues' were determined by Lord Justice Brooke 'in relation to the status of a claimant's clinical case manager in the context of contested litigation' (Brooke, 2005: par 2). Essentially, the case manager is a witness of fact and has a duty

to the claimant only and none other, regardless of the referral or funding source. Lord Justice Brooke said:

It seems to me inevitable that the clinical case manager should owe her duties to her patient alone. She must win the patient's trust and if possible her cooperation in what is being proposed, and while it will be in her patient's interests that she should receive a flow of suggestions from any other experts who have been instructed in the case, she must ultimately make decisions in the best interests of her patient and not be beholden to two different masters (par 26).

The judge referred to the then-current BABICM *Principles and Guidelines for Case Management Best Practice* (BABICM, 2005) for the role of a clinical case manager and quoted these directly in his exposition of what a case manager is and what they do (par 20). He noted BABICM's position regarding joint instructions that 'can lead to conflicts of interest and are not recommended' (par 20 [f]). While joint instruction was considered inappropriate, 'a spirit of openness [was] to be encouraged' (par 32) to promote the open exchange of information with both parties' representatives and avoid the suspicion and mistrust generated by 'failures in communication' (par 31).

However, 'suspicion and mistrust' continue around the role of the case manager. At a recent CMSUK Study Day an insurer and a defendant solicitor separately presented their views on *Who Owns Case Management* (Fisher, 2013; Hibbert, 2013). The lack of early, meaningful vocational rehabilitation was deprecated; the risk of the case manager stepping beyond her remit as the independent advocate for the claimant and becoming too involved with the claimant's legal team was highlighted. It was emphasised that the case manager's role is therapeutic only and not one that should be concerned with the outcome of litigation. The danger of conflict of interests was noted, in terms of the case manager, subconsciously or otherwise, complying with the claimant solicitor in order to ensure future instruction. With reference to 'helping millionaires lead impoverished lives' (Scheepers, Thorneycroft, Perry-Small, 2009), the suggestion of maximising damages at 'the cost of life chances' was levelled against some case managers (Fisher, 2013).

The 'Good' case manager was upheld as the practitioner who paid meticulous attention to the client budget and who had a good understanding of the litigation dynamic but demonstrable independence from it. Above all, the importance of thorough documentation and regular, clear communication with all parties was emphasised. On the negative side, the case managers who did not incorporate those positive points into their practice, who ignored clinical advice and who were poor communicators were deplored (Hibbert, 2013). The practice of 'wrapping [claimants] in cotton wool' was totally condemned with warnings of 'escalating costs of care' that were becoming unsustainable (Hibbert, 2013).

2.5 Aims of study

In a complex and adversarial arena, case management has become a growth industry, mirrored by escalating costs of care in the UK. There is no statutory regulation of case management, nor is it a profession in its right. In a field of potentially conflicting interests, ethical tensions and lack of consistency of practice, the clinical case manager should act in the best interests of the claimant at all times. Both defendant and claimant solicitors have given polarised views of good and bad case management; however, the author is not aware of any formal investigative study carried out in this area before.

The aim of this exploratory study is to initially illuminate the 'playing field' via the route of solicitors' expectations of case managers and to gauge the extent to which these are met. Those findings will be evaluated against the Competencies and Standards set by BABICM (2013) and the CMSUK Standards and Best Practice Guidelines (2009). In this way it is hoped a picture will emerge of the current compliance and consistency of case management practice with the Standards set by its two existing professional societies.

Chapter 3

Method

3.1 Design

> *"The goal is not to replicate results, but to produce a description and a perspective based on a consistent detailed study. The aim is to understand the particular individual or situation in depth"* (Kelly, 1996: p.240).

The aim of this study was to conceptualise the expectations that personal injury solicitors have of case managers and to gauge to what extent those expectations are met in order to assess current levels of case management practice against the Competencies and Standards set by BABICM (2013) and the CMSUK Standards and Best Practice Guidelines (2009).

While such expectations of an instructed body of people to behave in a certain way within a clearly-defined adversarial litigation arena may seem fairly straight forward, the confounding demands of the varying practice contexts, judicial guidance and the ambiguous professional status of the case manager, bring substantial complexity to this area. A qualitative design was chosen to accommodate the collection of extensive and complex textual data; template analysis was selected to thematically organise and analyse the data. This approach has been presented as one of 'particular utility in real world or applied qualitative research in psychology' (Brooks and King, 2012: p.1).

Template analysis (TA) lends itself particularly well to a study of this nature where the views of different groups are examined within "an organisational context" (King, 2012: p.447). It is a 'more flexible technique, with fewer specified procedures, permitting researchers to tailor it to match their own requirements', compared to, for example, grounded theory which has been developed primarily as a 'realist' methodology, or interpretive phenomenological analysis (IPA) with its ideographic focus (King, 2012: p.428; Brooks and King, 2012). TA has been described as an 'interdisciplinary' approach to the analysis of data and can be used from varying philosophical positions. While drawing from a number of phenomenological methods it has the capacity to 'horizontalise' across all data and flexibly accommodates both descriptive and interpretative material (King, 2011).

3.2 Sampling technique

Critical case sampling was used for this study (Grbich, 1999). The sample had to be an experienced representation of both defendant and claimant solicitors, with whom the researcher had not previously worked. Solicitors with at least five years' experience in the PI arena and who regularly worked with case managers were invited to participate: (*see Table 3.1: Inclusion, Exclusion & Withdrawal Criteria*). A range of 5-30 years' experience was noted in the sample giving a mean of 21.5 years' experience amongst the ten participants: *See Table 3.1: Participants in study.*

The researcher had identified four claimant and one defendant solicitor who expressed an interest in the study. Five letters of invitation were sent out on 3 June. A sample invitation letter *(Appendix Seven*) and Consent Form *(Appendix Eight)* are attached. A funding insurer, Deputy and barrister were recruited at the suggestion of the first defendant solicitor; a subsequent defendant solicitor was introduced by one of the claimant solicitors. A highly-experienced defendant solicitor in catastrophic injury and his counterpart working on the claimant side were invited later in the study.

Table 3.1: Inclusion, Exclusion & Withdrawal Criteria

Inclusion Criteria	• Must have a minimum of five years' experience working in the personal injury or clinical negligence field in the UK • Sample to be representative of both Claimant and Defendant solicitors • Willing and able to participate in Study • English spoken as a primary language
Exclusion Criteria	• The researcher will not have previously accepted instruction from any of the participating solicitors • Under five years' experience working in personal injury
Criteria for Withdrawal	• Participants were entitled to withdraw at any point in the recruitment procedure, during interview or up to one week after interview. This was clearly stated in the invitation letter

Opportunistic sampling was used to take account of new situations that arose during the research process (Grbich, 1999) and contact was made with European personnel outwith the immediate PI arena but who shared concerns voiced by solicitors in the study around rising costs of care: *(See Appendix 17).*

3.3 Ethical Consent

The research proposal, submitted on 13 May 2013, (*See Appendix Three: Application for Ethical Review*) was scrutinised by the Science, Technology, Engineering and Mathematics Ethical Review Committee at the University of Birmingham on 29 May 2013 and given conditional ethical approval, subject to the Committee's satisfaction to the following conditions [1]: (*See Appendix Four*). The researcher

[1](i) Please ensure that consent is obtained from participants for their data to be published/used in future research, and amend the participant documentation accordingly
(ii) Please include the supervisor's contact details in the participant documentation
(iii) Please include the details regarding withdrawal from the study in the recruitment/introductory sheet, as this will be what participants keep for future reference.

amended the Invitation letter and Consent Form (*as seen in Appendices 7 & 8*) and changed the Debrief Sheet (*See Appendix 9*) to fulfil the Ethical Committee's recommendations. Full ethical approval was given to the amended Research Proposal on 3 June: (*See Appendices 5 & 6, 6.1*).

Sponsorship from the University of Birmingham was sought on 18 March, provisionally confirmed on 16 April 2013 and fully confirmed on 16 September following Researcher queries: (*See Appendices 1, 2, 13, 14, 15 and 15.1*).

The principles of informed consent and guaranteed anonymity were upheld throughout this study: signed consent was obtained before each interview and the researcher emphasised anonymity of all participants in terms of attribution, place of work and geographic location. There was no potential risk of "psychological damage, loss of respect or dignity, infringement of privacy and exploitation" identified to any of the participants (Seale and Barnard, 1999: p.375).

Permission for interviews to be audio-recorded was sought in the letter of consent and again verbally at the commencement of each session. All participants were sent copies of their full interview transcriptions for agreement before analysis. Three participants (*Def2, Def3 & Dep1*) slightly amended their transcriptions and the researcher later contacted two (*CSol4 & Def3*) for clarification of meaning in one sentence during the process of analysis. All transcriptions were agreed before analysis.

3.4 Data collection

Individual interviews were carried out with the sample of four claimant and three defendant PI solicitors, one defendant insurer, one barrister and one Deputy in order to gain as wide a range of participants' expectations of case managers, as permitted by the time constraints of this study. Unsurprisingly, all participants had very full diaries and the researcher utilised repeated email and contact via secretaries to schedule interviews. The interviews were conducted between 17 June and 11 September and digitally recorded: *See Table 3.2: Participants in study (&*

Table 3.2: Participants in Study: $N = 10$

Designation & CD Appendix Listing	**Interview Mode, Date & Duration**	**Date transcription agreed**	**Years' Experience**
DEF1 **Appendix 1**	Face to Face 17 June: 50 mins	21 June	25
DEF2 **Appendix 2**	Tel 21 June: 20 mins	24 June	30
DEF3 **Appendix 3**	Face to Face 26 June: 24 mins	3 July	10
CSOL1 **Appendix 4**	Face to Face 26 June: 26 mins	2 July	5
CSOL2 **Failed recording**[2]	Tel 30 July: 50 mins	Not Agreed	20
CSOL3 **Appendix 6**	Tel 26 July: 26 mins	30 August	20
CSOL4 **Appendix 7**	Face to Face 30 July: 67 mins	15 August	20
DEP1 **Appendix 8**	Face to Face 31 July: 55 mins	18 September	30
BARR1 **Appendix 9**	Face to Face 23 Aug: 23 mins	13 September	30
DEF4 **Appendix 10**	Tel 3 Sept: 27 mins	9 September	20
CSOL5 **Appendix 11**	Tel 11 Sept: 29 mins	17 September	25

Appendix 10: Overview of Participants).

A total of 347 minutes was logged in interviews: 5.8 hours: with a range of 67-20 minutes, giving a mean of 34.7 minutes per interview. All data are stored in the researcher's secure office, under password, until conferment of the degree, after which they will be destroyed. *(A CD of all transcriptions is stored in the back cover of Volume 2: Appendices: of this study).*

[2]Regrettably a recording failure with CSOL2 meant that data was excluded from the study; CSOL2 was unable to agree the researcher notes compiled during the interview, on account of time lapse incurred after researcher family illness during most of July delayed progress of study.

Semi-structured interviews were used as a consistent approach for gathering data on particular topics that would allow the researcher the flexibility to probe further, as required. Emerging data directed the interview flow and generated new questions as the interview progressed.

A list of topic areas using open questions and prompts was developed from accumulated reflection following a number of solicitor presentations, material generated during the Case Management Module of this MSc degree (University of Birmingham, 2012), BABICM newsletters and past conferences, and discussion with colleagues : *See Figure 3.1: Interview Schedule*

It had been hoped to offer face-to-face interviews with all participants; however, due to time constraints, four were telephone interviews and six conducted face-to-face. Telephone interviews are often depicted as a less attractive alternative to face-to-face interviewing: "the absence of visual cues via telephone is thought to result in loss of contextual and nonverbal data and to compromise rapport, probing and interpretation of responses" (Novick, 2008: p.391).

Of the four telephone interviews conducted in this study, the first was noted to be initially awkward; however, after five minutes the participant engaged well with the interview. The other three telephone interviews were all carried out seamlessly with no hesitancy or awkwardness observed by the researcher: this may be due to the highly-articulate nature of the sample in this study which was accustomed to frequently engaging in Conference Calls via the telephone.

The researcher was aware of the possible influences of the contextual features of interview-generated data, for example, its status as a conversation between two people. Willig noted the importance of reflecting on the meaning and experience of the interview, and warned the interviewer "not to assume that the interviewee's words are simple and direct reflections of their thoughts and feelings" (Willig, 2008: p.23). The researcher considered that in this context, the data collected were indeed clear representations of what these solicitors expected of case man-

Figure 3.1: Interview Schedule

- Exploring the context
  Could you tell me a little bit about your practice and the work you do?

- Setting the scene
  At this stage it is important to identify how case managers 'fit' into the ways in which PI solicitors work and prompting will encourage that picture to emerge: *And the ways you work with case managers?*
  Their role in relation to your role? Some examples?
  How do you select them?
  Do you check their professional qualifications and registration details?

- Exploring expectations
  Leading into the broad question:
  What do you expect from a Case Manager?

- Exploring consequences
  From that point prompting from the Researcher will explore further issues arising, such as: *Have your expectations been met?*
  What happened on any occasion when your expectations were not met?
  What were/Were there any repercussions of those unmet expectations?

- Future ways of working
  The interview will wind down with opportunity for the participant to suggest possible clarification of case management practice, as appropriate:
  Would you like to see case management practice change? In what particular ways? Why?

agers. Researcher notes and reflections were written throughout the study and then written up as *Researcher's Reflective Notes: See Appendix Sixteen.*

3.5 Process

The processes involved in carrying out this study are recorded chronologically overleaf at Table 3.3, together with Appendix citation for relevant documents.

See also Appendix 12 for expanded version detailing 'micro-tuning' of all stages of the interview, transcription and agreement process with each participant. Copies

of all transcriptions are found on the Transcription CD attached to the back cover of the same binding.

Table 3.3: From Research Proposal to Study Completion

Date	**Event**
Sept 2012 – Feb 2013	Development of idea
18 March 2013	Application for University of Birmingham sponsorship (Form PF1) [Appendix 1]
16 April 2013	University of Birmingham sponsorship is provisionally confirmed[Appendix 2]
7 May 2013	Title slightly amended to more open style after Supervisor advice to: *What do Personal Injury Solicitors expect of case managers?*
13 May 2013	Online Application made to Ethical Review [Appendix 3]
29 May 2013	Emailed Provisional approval given, contingent on changes to paperwork [Appendix 4]
29 May 2013	Changes made: Revised Research Proposal [Appendix 5]
3 June 2013	Full ethical approval received [Appendix 6] Researcher Response [Appendix 6A]
3 June 2013	First introductory letters (5) posted with Consent form & SAE [DEF1/CSOL1/CSOL2/CSOL3/CSOL4] Invitation Letter [Appendix 7] Consent Form [Appendix 8] Debrief Sheet [Appendix 9] Overview of Participants [Appendix 10]
17 June-18 Sept	All interviews carried out Transcriptions typed up and agreed with all participants All transcriptions present on attached CD/*Back cover Appendices: Vol 2*
Early September	Synthesis of Expectations with ref BABICM & CMSUK [Appendix 11] Expanded Table of Process from Proposal to Study [Appendix 12]
15 September	Clarification of sponsorship status [Appendix 13]

16 September	Letter of confirmation received of University of Birmingham's sponsorship and insurance cover for the research project [Appendix 14]
18 September	Clarification of Title [Appendix 15] Confirmation of Title [Appendix 15.1]
July - End September	Reading around topic – notes – reflective notes – organisation of reference material *Reflective Notes*[Appendix 16]
July-22 September	Immersion in & analysis of data & developments of template
12-17 September	Liason with Mr Werwigk, Swiss Re [Appendix 17]
23 September	Telephone Supervision with Dr Larkin and favourable feedback on Template in its present form. Final template completed [Appendix 18]
30 September	Letter completed to the University of Birmingham to confirm the data collection are completed on this study and it is now being written up for submission by 25 October 2013 [Appendix 19]
25 October	**Completion & submission of Study**

3.6 Data Analysis

All of the interviews were arranged, conducted, recorded and transcribed verbatim by the researcher. Analysis of the data followed the steps given in Table 3.4.

A priori themes were identified on the basis of their relevance implicit in the Research Proposal, the Interview Schedule, and the researcher's assumptions about this study area. Five a priori themes were identified each with a brief description: *See Table 3.5.* The themes were selected tentatively and only to provide a general overview of expected data to ensure they did not assume a directive quality in the analysis of subsequent data, to the detriment of other material. It was important to avoid having much of the initial template already defined with a 'blinkering effect' on later analysis (King, 2011). At its manifest level, a theme functions as a way to categorise a set of data into "an implicit topic that organises a group of repeating ideas" (Auerbach & Silverstein, 2003: p.38;

cited Saldaña, 2013: p.176).

The researcher found it helpful to work visually and spatially using large

Table 3.4: Processes involved in data analysis (King 2011)

Process	Description of Technique
Definition of *a priori* themes	*Define* a priori *themes derived from assumptions inherent in research project*
Transcription	*Transcribe interviews and read through several times to familiarise with content*
Themes and Codes	*Carry out initial coding of data: identify sections relevant to the research question. If encompassed by an a priori theme, 'attach' code to identified section. If no relevant theme, modify an existing one or devise a new one*
Initial Template	*This is usually developed after a subset of transcripts have been coded. Group the identified themes in the selected transcript into a smaller number of higher-order codes which relate to broader themes in your data. This process may be carried out by hand on the printed transcripts, or electronically using CAQDAS program.*
Develepment of Template	*Develop template by applying to the full data set. Whenever a relevant piece of text does not 'fit' with an existing theme, a change to the template may be required*
Final Template	*The end result of careful transcription, reading, coding and theme-ing all the data set.*
Interpretation & Writing up	*The final template is the tool used to assist with interpreting and writing up findings*
Quality Checks & Reflexivity	*At one or more of the above coding stages, it is important to carry out a 'quality check' to ensure your analysis is not being systematically distorted by your own preconceptions and assumptions.*

sheets of paper on the wall, with felt pens and post-it notes. This method accommodated a dynamic changing picture of different codes and emerging themes. Analysis of the first transcription identified an initial template comprising six themes, two not identified *a priori*, and two major integrative themes of dissatisfaction with the current system and issues with communication. 'New' material not identified by the *a priori* codes is italicised: *See Table 3.6 & Transcription CD DEF1/APPENDIX1 for Transcription, Coding and Initial Template*

Once the participants had each agreed their transcriptions, the completion of the Final Template involved many hours of close reading. The researcher endeavoured to remain with the process of template analysis and not become fixed on the content of the template. While "frequencies of themes and patterns of their distribution may suggest areas for closer examination, they cannot in and of themselves tell us anything meaningful." It is suggested that "the task is

Table 3.5: *A priori* themes identified in personal injury solicitors' expectations of case managers

***A priori* theme**	**Description**
Case manager professional status, experience & qualifications	Includes: standardisation of practice, qualifications, professional status; ability to do the job; selection of case manager; verification of CV qualifications
Ethical & moral concerns	Includes: considerations of maximising claims
Working practice interface between solicitors & case managers	Includes: ways PI solicitors work with case managers; difference between roles
Meeting solicitor expectations	Includes: expectations of PI solicitors; unmet and repercussions of unmet expectations
Changes to current case management practice	Includes: suggestions for changes in case management practice

Table 3.6: Initial template after analysis of First Transcription: *DEF1*

***A priori* theme**	**Description**
Impact of contextual factors	*Includes: recent judgements & their lasting effects; changes to system; huge increases in care costs; issues around measure of loss*
Meeting solicitor expectations	Includes: expectations of PI solicitors; unmet and repercussions of unmet expectations; *issues around document disclosure; costs incurred around documentation;*
Case manager qualifications, experience & *training needs*	Includes: *appropriateness of case management model; training needs; positive case management; experience of case manager*
Ethical & moral concerns	Includes: considerations of maximising claims; *document disclosure; case manager selection process; impact on costs*
Effect on the Claimant	*Includes: collaborative practice; poorly-planned rehabilitation*
Future case management practice	Includes: suggestions for changes in case management practice ; *maximise outcomes; standardise documentation; consistency from all case managers; collaborative practice*

to consider carefully how each theme (or cluster of themes) sheds light on the topic of interest; ... the researcher must not be so strongly guided by the initial research question that all themes that are not obviously of direct relevance are disregarded" (King, 2012: p.445).

Mindful of King's advice, that the template is not the end product of the analysis but rather a tool to assist with interpretation of the data, analysis and coding were carried out by hand with the full data set to form the key ideas, experiences and concepts from the material into a Final Template that comprehensively addressed the domain of the research question: What do PI

solicitors expect of case managers? (King, 2012). *(See Transcription CD for evolving template following each transcription: Appendices 1-11).*

The research question was deliberately framed to be as open as possible in order to elicit a wide range of views from the experienced and diverse sample regarding their expectations of case managers. Nine main themes, each with sub-themes, were identified through analysis of the interview data. These are shown at Figure 3.2: *see also expanded and detailed version at Appendix 18 (Volume 2: Appendices 1-19).*

Figure 3.2: Final Template

Theme Identified	Subdivisions of Theme
1. Solicitor's Expectations	1.1 *Qualities looked for in an effective 'Good' Case Manager (CM)* 1.2 *Ability to identify need* 1.3 *Documentation* 1.4 *Document disclosure* 1.5 *The positive CM*
2. Un-met expectations & repercussions of these	2.1 *Negative scenarios*
3. Effects on claimant	3.1 *Repercussions of failed case management* 3.2 *Poorly-planned rehabilitation* 3.3 *Positive aspects of collaborative practice* 3.4 *Need for CM?*
4. Selection of Case Manager	4.1 *Experience of CM* 4.2 *When to instruct a CM?* 4.3 *Claimant lawyer selection of CM* 4.4 *Verification of qualifications/CV*
5. CM Qualifications & Training Needs	5.1 *Appropriateness of CM model* 5.2 *Training needs* 5.3 *CM qualification*
6. Ethical & Moral Concerns	6.1 *Document disclosure* 6.2 *CM selection* 6.3 *Impact on costs* 6.4 *Meaning of rehabilitation* 6.5 *Implementation of Expert recommendations?* 6.6 *Questionable charging practices* 6.7 *Commercial pressures* 6.8 *Risk Assessment* 6.9 *When over-protection becomes abuse*
7. Future CM Practice	7.1 *Maximise outcomes* 7.2 *Documentation* 7.3 *Collaborative practice* 7.4 *Use of residential setting for extended assessment period?* 7.5 *Change term 'case manager'* 7.6 *Conflict* 7.7 *Claimant solicitor 'shop-floor' training*
8. The Court of Protection & Deputy View	8.1 *The financial protection of non-capacitous parties* 8.2 *Client-centred practice?* 8.3 *Effects of litigation system* 8.4 *Deputy relationship with CM*
9. Impact of Contextual Factors	9.1 *Wright v Sullivan judgement* 9.2 *Need to educate claimant solicitors in rehabilitation arena* 9.3 *Jackson reforms* 9.4 *400% increase in value of UK PI claims* 9.5 *Measure of loss* 9.6 *Availability of NHS Specialist Rehabilitation* 9.7 *'NHS mind-set'*

Chapter 4

Results

4.1 Participants

Ten participants were recruited to this study from locations all over England. They all had over five years' experience working in the PI arena: a range of 5-30 years' experience was noted in the sample giving a mean of 21.5 years' experience. Three defendant solicitors, one defendant insurer, four claimant solicitors, one barrister and one Deputy comprised the sample. All dealt with catastrophic injury, and with the exception of DEF3, worked with case managers. The mean duration of each interview was 34.7 minutes (range 67–20 minutes).

The themes reflect the complexity of this study area: solicitors' expectations; unmet expectations and repercussions of these; the effects on the claimant; the selection of the case manager; the case manager qualifications and training needs; ethical and moral concerns; future case management practice; the Court of Protection and Deputy view, and finally, the impact of contextual factors. In addition, the themes are all linked with three further integrative themes of dissatisfaction with the current system, issues around communication and the adversarial process.

Given the word limit constraints to this study, discussion of the results will be structured around the main themes identified and illustrative examples drawn from the transcripts, with reference to the participant's study identification term

and Appendix number as stored on the Transcription CD: *(See Transcription CD: Appendices 1-11).*

4.2 Findings by Theme

4.2.1 Solicitors' expectations

Interestingly, the Deputy and the Barrister contributed a slightly broader perspective of expectation to the data, possibly due to their roles being slightly removed from the day-to-day management of the litigation:

It is the duty and responsibility of case managers and deputies to support people to get the most out of their lives. All input should be bespoke for that client (Deputy; DEP1/App8);

and

[A case manager] is someone who will get on with the job and get their hands dirty and make things happen (Barrister; BARR1/App9).

There was acknowledgement of the Good Case Manager (CM):

When it's done well, it's really empowering for the client, I think it's a super profession and it's a profession that's adding real value to clients when they really need it when they're in a very difficult position, they need help, assistance and support. So I think it's a fantastic role when done well ... (Claimant Solicitor: CSOL5/App11).

On almost every case I've been really pleased with the case manager: real goal identification, monitoring of them, taken the initiative on things, done things I wouldn't have even considered possible and things that wouldn't have happened within a statutory regime ... it's been really, really positive (Claimant Solicitor: CSOL1/App4).

I am in agreement to pay a really good CM ... because they make a difference (Defendant Solicitor: DEF4/App10).

A good CM can make an enormous contribution to a case ... a poor CM (of which there are many) can be no more than a way of wasting money and

I deprecate that just as insurers would deprecate it . . . A good CM in place can afford proper evaluation of claimant's problems instead of working with a) what a claimant may say is wrong with them or b) what their family may incorrectly say is wrong with them: getting to the right answer to obtain a true picture is by having full records (Barrister: BARR1/App9).

One of the concrete aims of this study was to assess current levels of case management practice against the Competencies and Standards set by BABICM (2013) and the CMSUK Standards and Best Practice Guidelines (2009).

The researcher extracted all the data relating to the sample's expectations concerning specific areas of case management practice and desirable qualities in a case manager. These were checked against the two sets of Standards to ensure each expectation cited was indeed made explicit in both sets of Standards and Code of Ethics: *See Appendix 11 for full version of this with detailed BABICM & CMSUK reference citation.*

As seen in Table 4.1, every expectation cited, in terms of specific areas of case management practice and desirable qualities in a case manager, are dealt with in both the current Standards and the Code of Ethics generated by the two current professional associations (BABICM, 2013; CMSUK, 2009; BABICM & CMSUK, 2008). Expectations of solicitors are all reassuringly matched by the case management professional association standards.

Case management training needs were also reported in the data. In terms of awareness of the case management role with reference to the *Wright v Sullivan* case:

. . . really understanding the independence of their role: that was always what could be a bit of an issue. Knowing that they're not an expert in the case, understanding of that. Knowing who their client is; there are some vulnerable injured people and the instructions the CM was following was often from the family rather than listening to that injured person. But missing that; thinking 'I'm the client' [meaning the Claimant Solicitor] – that isn't particularly good(Claimant Solicitor: CSOL1/App4).

Table 4.1: Expectations from Study referred to BABICM (2013), CMSUK (2009), BABICM & CMSUK (2008)

Expectation cited in data, relating to:	**BABICM (2013)**	**CMSUK (2009)**
Case Manager (CM) professional qualification, registration, experience	Present	Present
Documentation: chronological case notes ready for disclosure on request	Present	Present
Treatment Plan	Present	Present
Recognition and appropriate use of legal privilege	Present	Present
Regular communication with instructing solicitor	Present	Present
Excellent communication & reporting skills	Present	Present
Clear understanding of the CM role, answerable to whom	Present	Present
Ability to problem-solve [thinking outside the box]	Present	Present
Ability to build therapeutic relationship with client & family	Present	Present
Ability to take initiative	Present	Present
Identify goals, set appropriately and monitor	Present	Present
Identify needs already known and those unidentified	Present	Present
Maximise outcomes	Present	Present
Manage expectations of Claimant, Claimant's family & Cl solicitor	Present	Present
Manage role conflict	Present	Present
Uphold confidentiality	Present	Present
Manage complexity	Present	Present
Provide cost-effective recommendation to meet identified needs	Present	Present
Only accept referrals commensurate with CM experience	Present	Present
Demonstrate evidence-based collaborative practice	Present	Present
Full appreciation of independence of CM role, underpinned by objective view of client, regardless of referral source	Present	Present
Retain objective recommendations for client, despite advice from Experts & Claimant solicitor	Present	Present
Recognise when CM has no further input of value	Present	Present

Concerns were raised around appropriate document disclosure:

I expect really good notes of the client and I also expect CMs to understand the difference between privileged conversations and non-privileged conversations (Claimant Solicitor: CSOL3/App6);

In contrast with:

Evidence-base your work as to what you are doing. The question of whether those records are to be disclosed in the proceedings or not is a matter that isn't your concern. End of. The concern of disclosure is for the claimant lawyer to deal with and I think that the solicitors are misinforming CMs (Defendant Solicitor: DEF1/App1).

Around appropriate risk assessment and brain injury awareness training:

You need to have people a bit more attuned to it [inappropriate, challenging behaviour] and understand that we are trying to get to the bottom of quite subtle differences which then go on to have a major impact . . . the head injury cases, I think they're the most difficult ones to manage for a CM . . . I think it's very tricky for the CM to feel the nuances of brain injury (Claimant Solicitor: CSOL3/App6);

Around awareness of boundaries:

CMs can sometimes almost become aligned to the client in almost kind of buddy fashion (Claimant Solicitor: CSOL3/App6);

Around thorough and comprehensive assessment of the claimant and those around him or her:

I went to speak to the family and friends to take statements from them, and it was absolutely apparent there were huge amounts of problems and the CM on that case hadn't actually thought about talking to the people around them [the client] (Claimant Solicitor: CSOL3/App6);

Around knowing when to stop taking further referrals:

CMs sometimes just take on too much work and become a victim of their own

success. I have more respect for those that recognise they cannot take more work on (Claimant Solicitor: CSOL5/App11);

and finally, awareness of recoverability of costs:

Eventually a case manager is going to get sued . . . it's sad but I think there's a real risk it might happen one day when damages aren't recovered because fees have been incurred that aren't then recovered (Defendant Solicitor: DEF1/App1).

The only item not addressed by the Standards or the Code of Ethics is the latter point concerning awareness of recoverability of costs; otherwise all training needs voiced in the data also have a corresponding reference point in the Standards (BABICM, 2013; CMSUK, 2009; BABICM & CMSUK, 2008): *See Appendix 11 for full version of this with detailed BABICM & CMSUK reference citation.*

Documentation

Issues around documentation were frequently raised; both in terms of maintaining a full set of accessible chronological case notes and in terms of disclosure, previously cited as a training need.

I spend most of my time chasing CMs for notes . . . these are good CMs who are doing a good job, but the admin side of it is really important to me. Not because I particularly want to sit here for hours reading notes, but because I have defendants who don't know what's going on with the case and absolutely need to see those notes and I don't want to get criticised for non-disclosure (Claimant Solicitor: CSOL3/App6).

The idea of a standardised documentation system was put forward:

The industry has somehow got to, I think, come up with a uniform reporting documentation system that is followed on every case . . . So then everyone would know in every case: these are the records that will be prepared as a matter of routine . . . a consistence with documents in itself would actually be quite a big step forwards (Defendant Solicitor: DEF1/App1).

DEF1 went on to suggest that claimant lawyers are, in his view, 'misleading' CMs about disclosure of case files; that the independence of the CM was being

compromised by claimant solicitors and that there were two sets of management notes: one for disclosure and one for the claimant solicitor. His views were shared by two other defendant participants: DEF2; DEF3.

Meanwhile an evolving area of 'shop floor training' [regarding file disclosure] was suggested by a claimant solicitor:

We like the idea of nurturing certain CMs, to bring them on board, both in terms of shop floor case management, but actually looking at experts as well in terms of care ... We think that if we're moaning enough about it why don't we try and do something about it by more detailed hands-on education (Claimant Solicitor: CSOL5/App11).

The researcher responded the independence of the CM may be compromised by being part of the claimant's 'shop floor'. CSOL5's view was

Let me give you an example of how I've seen this ... we choose two or three who we think we'd like to work with further and we have training and seminar sessions with them. I just don't see that as a problem because we want them to be more professional, and I don't think the defendants would be moaning if the defendants saw what the training areas were ... I think they would see it as being of advantage as well, in terms of content of the report, access to records and so on. Clearly we need to avoid having them on our payroll, but if you look at certain experts ... they work for us on an incredibly regular basis, so they're not payrolled, they're independent albeit they've always had a claimant bias (Claimant Solicitor: CSOL5/App11).

Two points of note are raised by this claimant solicitor: firstly, the implied liaison with the defendants and the positive aspects of that communication. Echoing points made by DEF1, DEF4 had earlier noted how levels of expertise in the litigation team impacted on the client:

Old-fashioned people [are] out there who display what I would regard as incredibly poor practice in the way they approach these things and I think it actually probably doesn't do their clients any favours (Defendant Solicitor: DEF4/App10):

compared to the claimant view of consensual practice being of benefit to the client:

Over the years there's been alot of mistrust, and actually in our world that is catastrophic injury, I think it's very different because you've only got a small number of insurers, each of those will have two or three main players doing the work, and the same with the solicitors: you've got five, maybe, defendant firms doing the work, each with two or three big players and therefore you get to know each other you get an opportunity to build trust. Actually I'm in no doubt that if you can adopt a consensual approach broadly, you're far better off for the client, in the client's best interest because, classic example, you're able to obtain early interim payments; those interim payments then filter down to the CM to utilise in enabling the client on the shop floor (Claimant Solicitor: CSOL5/App11).

Secondly, CSOL5's reference to a 'claimant bias' is redolent of an earlier Claimant Solicitor's view that

I have a feeling that there's a little bit of a development at the moment of CMs who are defendant CMs and claimant CMs . . . I don't think that is particularly healthy – I don't think it's healthy for the profession and I don't think it's healthy in terms of getting the job done . . . I'm quite clear about it, I want to be able to instruct CMs and to deal with people who look at the individual [in] a completely independent way (Claimant Solicitor: CSOL4/App7).

4.2.2 Unmet expectations and repercussions of these

A range of scenarios were described in the data from 'the sacked CM, when everything stops' (Claimant Solicitor: CSOL4/App7), to the 'horrific' experience of a CM who produced 'barely legible, minimal' documentation with 'no goals or risk assessments', resulting in loss of faith with the claimant's family and issues of costs with the defendant solicitor (Claimant Solicitor: CSOL1/App4). One CM was highlighted inappropriately dealing with issues of liability in an Initial Needs Assessment (INA) which would have been 'potentially disastrous on a joint instruction'; another CM with 'a phobia' which impacted on their performance and delayed progress on the case; of 'unacceptable' failure to deliver reports on time with impact on the client; of 'unacceptably' poor performance in terms of accommodation and equipment with a substantial spinal cord injury case where, despite the CM on board, the client's electric wheelchair had been broken for 12 months (Claimant Solicitor: CSOL5/App11).

Examples were given of a CM 'spending too much money' on supporting someone who should have been enabled to become independent; in another case, English was not the first language of the CM which led to great difficulties; and in other cases 'things just don't get done'. Another situation highlighted an inexperienced new CM who had no experience dealing with PCT's: 'huge amounts of time and money spent' and no progress made. 'Wishy-washy' case management was identified and the need to work in a far more goal-orientated way (Barrister; BARR1/App9). The client's need for support in terms of 'expert organisation and not wrapping in cotton wool': the fine line between recognising vulnerability and not over-protecting: was firmly endorsed (Defendant Solicitor: DEF4/App10; Deputy; DEP1/App8).

4.2.3 Effects on the claimant

The claimant may ask why a CM is necessary: how many CMs are working outwith the personal injury claims' area? Why not have social workers instead of CMs? (Defendant Solicitor: DEF3/App3). The sample mostly recognised the need to involve a CM when their client has a brain injury in that it allowed the claimant solicitor to 'get on with the litigation'; that the appointment of a CM while 'initially front-loaded, reduces costs overall' (Claimant Solicitor: CSOL4/App7). DEF4 and CSOL5 did not consider statutory services social workers were equipped with the appropriate levels of expertise to replace a good CM.

The positive case manager, whether in immediate terms of sound documentation practice, appropriate evaluation of the client's needs, goal identification, clear grasp of the CM role, ability to manage complexity and demonstrate evidence-based collaborative practice, has a far-reaching effect on the client. Indirectly, the importance of appropriate levels of communication between the CM and claimant solicitor is underlined in order 'for the case to be pleaded and progressed properly and the claimant's interests upheld' (Claimant Solicitor: CSOL1/App4). The value of collaborative practice was noted with 'balance' achieved among all

members of the team (Defendant Solicitor: DEF1/App1). Clear role definition of all team members was emphasised to ensure the client and their family fully understood the process of the case at all times (Claimant Solicitor: CSOL4/App7).

Conversely, the repercussions of failed case management have equally far-reaching effects on the claimant. Loss of faith and cost consequences has already been noted (Claimant Solicitor: CSOL1/App4). Poorly-planned rehabilitation was summarised as a 'waste of money, time and effort' (Defendant Solicitor: DEF1/App1). The Deputy described a bleak post-settlement view of no improvement for the client, who now had a doubly-reduced Quality of Life, impaired once by the injury and again by the 'locked-down scenario' of a 'systems driven case management style [time-tabled] by rigid routines leading to a zombie-like existence'. He noted a 'formulaic litigation system' that carries over after settlement where the client becomes 'lost in the mix'. There was no acknowledgement of the client pre-injury that he could see. He urged. 'Everybody is different so let's find different solutions' (Deputy; DEP1/App8).

4.2.4 Selection of case manager

The defendant solicitor has no input into the choice of a CM after the Wright v Sullivan judgement, unless there is a joint instruction (Defendant Solicitor: DEF1/App1; Defendant Solicitor: DEF2/App2). The claimant solicitor will select several CMs from those known to them and arrange for the client and family to meet and select the CM they wish to instruct; however, DEF4 observed that 'finding a good qualified CM is incredibly difficult' (Defendant Solicitor: DEF4/App10).

The CM must 'fit' the claimant, their family and other team members, both in terms of personality and clinical background. Geographical considerations were important as well as availability. A local appointment was essential, at least within 1.5 hour's travel distance from the client and local knowledge of statutory services, therapists and other resources (Claimant Solicitor: CSOL4/App7). It was observed that there are 'a whole variety of CMs: some much more able than

others;' this solicitor tended not to use independent practitioners, instead preferring to work with CMs with whom she had worked in the past (Claimant Solicitor: CSOL3/App6). Recommendations from colleagues were 'useful' together with an observed 'personal rapport with the family' (Claimant Solicitor: CSOL1/App4). Meanwhile CSOL5 was clear about his requirements for immediate availability and focused engagement 'straight away with the client'. He emphasised the CM must be completely independent of the medicolegal process and not be diverted into medicolegal issues (Claimant Solicitor: CSOL5/App11).

With regard to verification of qualifications, one claimant solicitor expected the companies who supplied the CMs she required to check professional qualifications (Claimant Solicitor: CSOL3/App6); another did not carry out any checks with the assumption that a colleague's recommendation was sufficient (Claimant Solicitor: CSOL1/App4); meanwhile the Barrister was clear he would 'not recommend someone whose professional qualifications [he] had not verified' (Barrister; BARR1/App9).

4.2.5 Case Manager Qualifications & Training Needs

The appropriateness of the case management model was questioned and a 'clinical disjunct' highlighted by DEF1:

the concern that I have is that I'm not convinced that CMs actually have the right qualifications to be managing some cases. I don't mean that disrespectfully, it's just that if someone's an OT or a physio or a nurse they're not a consultant of rehabilitation medicine. They don't have the same critical, clinical qualifications at the medical level and therefore I just wonder whether trying to treat them as the go-to person to manage the rehabilitation process is actually the right thing, is actually ... your role. I go back to Wright v Sullivan: your prior role is co-ordinator, is an advocate for the claimant ... I think there's a clinical disjunct between the CM's role and what we really need ... in the acute phase. I'm not sure at all that the CM is the best person to be managing the rehabilitation phase ... I actually think we could pay less in the long term by having a clinician involved (Defendant Solicitor: DEF1/App1).

Various suggestions were made regarding a case management qualification

including some sort of formal accreditation but the mechanics of this were unclear; however, the need for a professional qualification or regulatory hurdle was recognised. Meanwhile the possibility of giving references for good CMs was raised (Barrister; BARR1/App9).

DEF4 noted the need to recognise those CMs who have appropriate clinical experience in brain and spinal injury; to validate those with the appropriate levels of experience and skill set required: 'what we're trying to do is stop those that are less or inappropriately experienced from making a mess of things' (Defendant Solicitor: DEF4/App10). An argument for the introduction of 'a badge' to formalise the diversity of CM backgrounds and bring 'consistency of approach' to medicolegal issues in particular was made. CSOL5 observed

Some case management practices pushing CMs, who clearly on inspection of their CV, do not have the background skill set to do the work that they are being promoted for. And again I see that on a fairly regular basis and I think that is unfortunate. And it can lead to the organisations being hauled into disrepute. I understand the commercial, there are commercial pressures . . . particularly . . . to try and break into our world, but to do so without the right skill set, where you could have a really major impact on a client to their detriment, I think is something which should be frowned upon. Though again having a badge which . . . I can see the value of that as well (Claimant Solicitor: CSOL5/App11).

He expanded the badge accreditation to include training awareness concerning the difference in standards and working practices between the NHS and the private sector, and why this was so. He noted CMs coming from an 'NHS public sector background' with 'low expectations' of what can be achieved, 'so they have what I'd call an NHS mindset which can take years to get through actually'. Apprenticeship schemes in larger case management companies was discussed; however, the efficiency of this model was not clear, in terms of a stable of junior CMs being assigned to a senior CM who still had to manage her own workload as well as supervise the junior staff (Claimant Solicitor: CSOL5/App11).

Training needs further to those covered earlier at 4.2.1 included the need to recognise diversity and train support staff to bring imagination and creativity

to client lives. The possible impact of the CM's first qualification, for example, Occupational Therapy, on case management styles was raised (Deputy; DEP1/App8).

4.2.6 Ethical and moral concerns

In the area of selection of CMs, DEF1 was clear in his view that claimant solicitors have 'their own pets' whom they instruct and noted that defendant lawyers have 'no say' in the choice of unilaterally-instructed CMs (Defendant Solicitor: DEF1/App1). Suspicions were raised that 'some back-scratching goes on' between 'some firms of solicitors and some case management companies' (Barrister: BARR1/App9).

DEF1 deplored perceived claimant practice in 'deliberate delay' of document disclosure; in 'the use of claimant experts to influence regime costs on the ground', and the 'inappropriate' use of Risk Assessment to maximise claims by 'wrapping the client in cotton wool'. He suggested that claimant solicitors 'use' CMs to maximise damages instead of utilising their skills to maximise 'life chances for the claimant'. He stated:

I've an increasingly concerned view of clinical case managers in litigation at the moment. I think that their independence is being stretched to extremes. I don't think case managers fully appreciate or understand their role within the process. The case manager's role is as an advocate for the claimant, and that's it. I think your roles have become blurred and tarnished over the years so that case managers are now being used fairly bluntly by some claimant lawyers and I think unfortunately that's poisoning the well of the reputation of case managers across the market with a view to seeing how they can dovetail the case manager's work with the value of the claim and damages. And that, I think, is undermining your reputation and that, in its turn, is harmful to claimants who will see a slow stream of financial funding through insurers who will be increasingly concerned about money being wasted: lack of focused, targeted, goal-orientated rehabilitation (Defendant Solicitor: DEF1/App1).

CSOL4 drew attention to the 'unhealthy' picture emerging of defendant CMs and claimant CMs: 'I don't want to come across people who have a different view of

need and recommendations about how those needs are met because of who they are instructed by' (Claimant Solicitor: CSOL4/App7).

DEF3 expressed doubt about how many claimants spend their damages as per expert recommendation and her concerns around claims 'being bumped up'. She wondered how many CMs were actually used in the absence of a claim: a question also raised by the Barrister (Defendant Solicitor: DEF3/App3). Regarding the implementation of expert recommendations, CSOL1 stated the claimant lawyer will go with case management recommendation over and above expert recommendation; within that she acknowledged that possibly 'standard recommendations' exist among some experts who do not know the client anyway (Claimant Solicitor: CSOL1/App4).

In terms of risk assessment, CSOL5 observed the difference between 'risk assessment and speculation': that it is 'very difficult to include [in the damages] anything that is speculative' the way the law stands at present. He noted the claimant solicitor will be sued if 'something is missed' and described the defendants 'taking a blasé view [with] broad brush strokes'. He reported in dispute that defendants take the view 'it's never going to happen' and will not agree to indemnify: 'they want their cake and eat it'. However, risk assessment is a different matter:

it's all very well for defendants to say 'look, you're not going to need two carers in later life' or otherwise or 'you don't need two carers to carry out this particular transfer' but when the carer gets injured or when two carers are subsequently required I think it's reasonable for the claimant to say 'hang on, why have I not got the money for that?' (Claimant Solicitor: CSOL5/App11).

DEF1 observed:

. . . Rehab's about taking risks; controlled risks, but quality of life isn't about protecting people in cotton wool, it's about trying to give them quality of life and that will involve some risk, some independence and there's a large number of case managers, in my view, at least pre-settlement, who get locked into the claimant lawyer's approach which is to maximise the claim and you see a closet-care

blanket cover care approach to cases. I don't think that's healthy for the claimant. It may boost the damages but actually we see through it (Defendant Solicitor: DEF1/App1).

The Deputy posed the question as to whether claimants were being given the most opportunity to 'lead as fulfilling a life as they possibly can within their cognitive and physical limitations? Were client best interests truly upheld?' He noted questionable charging practices for a 'case management systems-driven input that actually does nothing to improve client life'. Ethical implications were implicit in 'a large provider of work ... [that somehow] ... at subconscious levels [will impact] on the approach' to the case:

'We all want to make a living, we all want to make some money ... this is a client so I need to do this and that and the other because that's how I make a living' (Deputy: DEP1/App8).

Turning to abuse, the Deputy considered that abuse takes many forms and sometimes practitioners are 'too gentlemanly' about it: that it was necessary to always act in the client's best interests and break those cycles of over protection, regardless of any consequences to instruction:

'If we all do what we think is right and in the client's best interest, even if we get sacked or something, is that the end of the world?' (Deputy: DEP1/App8).

4.2.7 Future case management practice

Emphasis was placed on case managers maximising outcomes, in terms of rehabilitation carrying over into the 'real world' and not to improvement observed only in the rehabilitative setting (Defendant Solicitor: DEF2/App2). The theme of the real world was extended into recommendations that CMs should 'lighten up a bit' and bring a recognition of diversity to their practice, underpinned by 'sensible' risk assessment which meaningfully accommodated awareness of Quality of Life issues for the client (Deputy: DEP1/App8).

The role of the CM in assisting the litigation team to settle at the appro-

priate time was identified: the CM was judged to be well-placed to gauge whether rehabilitation has reached a plateau:

PI claims is all about, in my view anyway, is you're dealing with cases, you're trying to manage the case to the plateau of maintenance, therapy and maintenance support. Once you get to that situation . . . both sides take a leap of faith taking a view because . . . the worst thing for the claimant is to claim. You need to be shot of it so that the families can get on with their lives and some level of normality. Getting the case to the pitch at which you make that jump is what our job's about. CMs should I think have the same goal: the goal is maintenance therapy (Defendant Solicitor: DEF1/App1).

The sample endorsed a uniform reporting documentation system to be used by all CMs in future practice; however, the Barrister cautioned such a system must not be reduced to 'a tick box' (Barrister: BARR1/App9). Consistency in the way all records were maintained and the way in which they were disclosed was viewed positively by all participants. Full sets of notes should be released in timely fashion by the CM to the claimant solicitor. All notes should be focused and goal-directed, both those of the CM and the support staff. The INA should be abandoned since it no longer served its original purpose following its early use with the Rehabilitation Code (Defendant Solicitor: DEF1/App1; DEF2/App2).

Collaborative, goal-orientated and evidence-based practice, led by the Rehabilitation Consultant and underpinned by inter-disciplinary team working, was urged as the optimal approach post discharge into the rehabilitation setting (Defendant Solicitor: DEF1/App1; DEF2/App2). Home, with a full support package was not considered necessarily the optimum environment in early rehabilitation (Defendant Solicitor: DEF2/App2). The Deputy noted the 'most expensive solution is not necessarily the best one' (Deputy: DEP1/App8).

Concerns were raised around conflicting interests and a 'strict set of conflict rules' were recommended to prevent CMs appointing care or support in which they have a financial interest (Defendant Solicitor: DEF4/App10).

4.2.8 The Court of Protection & Deputy View

The Deputy emphasised his view of the client as 'the number one person: to me the important person in all of this is the client' and this starting point led him into 'not conflict, but discussion with the CM'. He deplored the practice of organisations 'tailoring' clients to their services:

. . . And it bothers me that alot of these standards and disciplines are all about structure of the service, whereas isn't it about the experience from the end user's point of view? (Deputy: DEP1/App8).

Regarding his expectations of the CM:

I want to have somebody who's going to think about it, somebody who will address the individual . . . this person is a person, they've got a life. So what I'm interested in is how they're going to bring the person on. Actually CM in the early years perhaps is all about getting things going: recovery, setting up the systems and getting and doing as much as possible risk assessment. But then it sort of hits a buffer, it sort of becomes a routine: on Monday go to the gym, on Tuesday go bowling . . . and it just becomes a drudge. And what we forget, maybe, is this is their life . . . (Deputy: DEP1/App8).

While acknowledging the professional background of the CM, he identified a 'special' element to the empowering CM:

the little above, that bit that actually isn't based on any qualification, which is trying to give them their life back (Deputy: DEP1/App8).

He noted the 'watershed' effect of settlement:

a sort of natural review of things post-settlement . . . It is about people who don't see this money as compensation, they see it as a lottery win . . . And they don't get what the money is there for and sometimes the CM can be the voice of reason and say . . . but they don't want to have to hear what they're saying so naturally will say 'let's get rid' (Deputy: DEP1/App8).

He referred to clients with whom he has worked for many years who do not have a CM although according to the terms of their settlement, it was strongly recom-

mended:

but they choose not to have it and some of them are leading chaotic lives, but some of them ... one in particular ... leads the most beneficial life of all my clients, yet if you looked at the case report when this case settled, he was going to be a nightmare. ... But this is twenty years on. Twenty years on this man is a very different person. And I think that's the other thing that we perhaps don't have enough of is the long term stance because all of us haven't been in this role that long, because it did not exist (Deputy: DEP1/App8).

The Deputy spoke about risk management and the 'impoverishing' effects of inappropriate mitigation of risk:

I think the worst thing we can do is wrap all these people up in cotton wool, so that they have this sterile meaningless life – they might as well be back in an institution. ... I think it's that applying a bit of imagination and, dare I say it, taking a bit of a risk sometimes. I think that risk management has its place, don't get me wrong, and I'm not for one minute suggesting that people are put at risk, but sometimes risk trumps everything else and the idea of there being no risk is more important than having a life. And I think that's the wrong way round. ... I don't think risk of itself is bad, so to say that no risk is good, high risk is bad, okay that's fine; but somewhere in the middle is a life and the no risk environment is lockdown to a great extent (Deputy: DEP1/App8).

He criticised the 'safe' routines of structure, organisation and everything 'tickety-boo', where case management had everything 'so packaged up', the client was in a virtual 'strait jacket':

I think that the structures that you see many, many times are an impoverishment – it's no life at all. Okay, they're under control, they're safe, but it's dull, it's like a zombie existence. That's so sad on one level that these people, yes, they've been impaired once by the accident or the injury and as it were they're impaired again by being put in this very sort of locked-down scenario. And that bothers me (Deputy: DEP1/App8).

The Deputy questioned charging practices of both case managers and deputies where everything is charged 'by time' and intervention forms part of a system of 'endless review' management. He noted that if intervention had not achieved

anything with the client, then why was it being charged for? He suggested that clients should be recognised for what they could do and questioned a litigation system where a person had to be shown 'as disabled as possible' rather than 'as positively as possible':

You look at the life we should be more objective and I don't agree with this idea where you've got to try and bump up the value of the claim it's about trying to build a life for a person and if they don't need that support why is it wrong not to claim it? (Deputy: DEP1/App8).

4.2.9 Impact of contextual factors

DEF1 stated 'the clear, separate role and responsibility of the claimant lawyer' was not dealt with in the Wright v Sullivan judgement (Brooke, 2005):

It lacked clarity and that's still the case, it's unfinished business. I honestly think it's undermining, poisoning the whole well of rehabilitation in catastrophic cases at the moment. Unless it gets sorted out we're not going to see effective rehab in cases, we're going to see a very bumpy road (Defendant Solicitor: DEF1/App1).

In terms of rehabilitation, CSOL3 observed her assessment of a CM was derived from her own 'huge amount of experience in working with people and their rehabilitation' and in keeping close contact with the progress of her clients (Claimant Solicitor: CSOL3/App6). DEF2 suggested that 'a broader education around rehabilitation' for claimant solicitors and compensators would be helpful. He argued the need for re-visiting the Rehabilitation Code and the adoption of 'a more segmented approach' to rehabilitation:

So perhaps there should be a catastrophic protocol? Should there be a minor injury protocol, and should there be protocols for what falls in between? The Rehab Code is focused on the INA process and it's very much one size fits all; whereas that is not the reality of rehabilitation. So could we improve the process of instruction in that regard? (Defendant Solicitor: DEF2/App2).

Participants noted the effects of consensual practice within the litigation teams filtering through to the CM in terms of interim payments and timely rehabilitation

for the client. DEF4 observed that considerations of *Wright v Sullivan* do not intrude in his practice, such is the collaborative level with which he works with the 'other side'. Concurring with DEF1 earlier, he positively endorsed the multi-track code at 'fall-back default position' (Defendant Solicitor: DEF4/App10). The Jackson Reforms were expected to have a possible indirect effect on CM costs incurred outwith the schedule (Defendant Solicitor: DEF1/App1; Claimant Solicitor: CSOL3/App6; CSOL4/App7).

DEF1 drew attention to a 400% increase in the value of high-value personal injury claims in the UK in the past 15 years that, in his view, 'mirrored the growth in CM in PI claims'. He suggested the rehabilitation process has added 'huge costs to the value of these claims'. Unfortunately such large sums of money contributed to the view of a lottery win rather than compensation; DEF1 was mindful of the measure of loss: to put the claimant back in the position they would have been had the accident not occurred:

So you're trying to wind back the clock for someone who's seriously disabled, from point B back to point A . . . it doesn't mean Rolls Royce in every case; it means proportionate, reasonable, looking at what they would have had but for the accident . . . there will have to be some assimilation between the 'but for the accident' and the post-accident (Defendant Solicitor: DEF1/App1).

CSOL4 cogently noted:

For me . . . compensation, however much I get for someone, it will never ever give them back what they've lost and I think it's really really important when you start out on a journey through a claim . . . it's not a lottery win because they didn't buy the ticket . . . What compensation can do if it's managed and used and all those good things in the manner in which it is intended, it gives back dignity. Because one of the first things that you lose when you're involved in a claim is dignity and because everybody has the right to ask you about absolutely everything and to invade your personal space, for some clients that's horrendous. But it gives you back the right to choose, it gives you the ability to make the decision about 'do you want to do this?' or 'do you want to do that?' as opposed to being told and in many ways, . . . for me the CM has a huge role in that. By identifying need you also are identifying potential opportunity. So although both [claimant solicitor and CM] are initially dealing with what is, the [CM] actual role, [once need is

identified], is to move on from that, in terms of looking at what could be and what the future offers, and my role is to try and make sure that I have got the funds to enable what that person is able to offer to make the future happen (Claimant Solicitor: CSOL4/App7).

4.3 Summary of themes

The Results section has been structured around the nine main themes identified and illustrative examples drawn from the transcripts: *See Transcription CD: Appendices 1-11.*

In summary, there was positive acknowledgement of the Good CM. The practical expectations of CMs from the study sample are all recognised by both the Competencies and Standards set by BABICM (2013) and the CMSUK Standards and Best Practice Guidelines (2009). Training needs were raised in certain areas, and these too appear in both sets of Standards. The only area not covered by the Standards is that related to CM awareness of the recoverability of costs. The appropriateness of the case management model was questioned with suggestions for more meaningful rehabilitation to be Consultant-led.

Unmet expectations of CMs all impacted on the claimant and were largely centred around poor communication, documentation, lack of experience and working in a non-targeted way.

Regarding future case management practice, CMs were urged to maximise rehabilitation outcomes that were sustainable in the 'real world'. Strict conflict rules were recommended to prevent CMs appointing care or support in which they have a financial interest.

A key expectation concerned documentation, with recommendation for a standardised, focused, goal-orientated system to be adopted by the industry: this must not be reduced to tick-box status.

Some of the sample verified CM qualifications; others did not. Some took recommendation from colleagues; others continued with the CMs with whom they had worked in the past. To all, the 'fit' of the CM with client and family was important. The need for a professional case management qualification was recognised, possibly in terms of a 'badge of accreditation' to bring consistency of approach, particularly in the medicolegal arena.

The need for creative and imaginative case management was highlighted post-settlement when training support staff. It was noted that routines become stale, structured and dull, underpinned by review management systems which do not constitute a life for the client, described as 'impaired once by the accident or the injury and ... impaired again by being put in this very sort of locked-down scenario'.

Some clients do not have CM post settlement, despite poor prognosis at time of settlement, and 20 years on are living independent, 'beneficial' lives. A research project is identified to examine the long-term view post settlement, un-afforded before because the structures of today were not in place.

Risk assessment was considered to be a means of 'wrapping the client in cotton wool' in order to 'bump up' costs on the one hand, and seen as an 'impoverishment' of quality of life on the other.

Defendant solicitors noted the negative and corrosive effects of the *Wright v Sullivan* judgement, (Brooke, 2005) to the extent of 'undermining, poisoning the whole well of rehabilitation in catastrophic injury cases' at present. The effects of unilateral instruction clearly have far-reaching effects in an already adversarial arena, where claimants are believed to involve their 'own pets' as CMs and 'back-scratching' is suspected between some firms of claimant solicitors and case management firms. Lack of confidence emerges from poor communication which in itself causes increased delay and costs. Reduced communication increases levels of suspicion and mistrust. Considerations of future work were believed to

affect the CM approach to case management by some defendants. The emerging development of claimant CMs and defendant CMs was deplored by one claimant solicitor.

Overall, the defendants noted a lack of transparency; mistrust and suspicion was felt towards the claimant solicitors, to the extent that CMs were perceived to have lost their independence and were being manipulated by the claimant to maximise claims. In contrast, those solicitors working in high-value claims acknowledged the benefits of consensual practice between fewer personnel and high levels of expertise. It was noted that claimant solicitors run the risk of being sued if they under-settle, and CMs warned they will be sued if they claim for costs which are not recoverable.

Concerns were voiced regarding huge increases in the value of high-value PI claims during the past 15 years, believed by one defendant solicitor to be mirrored by the growth of CM in PI claims.

To establish what these findings mean for the research question: *What do PI solicitors expect of CMs?*, discussion will now turn to an examination of the findings, related to the wider context of recent UK judgements and emerging trends identified in the European context of care, with implications for the future practice of all case managers working in the PI arena.

Chapter 5

Discussion

5.1 Reasons for high levels of suspicion and mistrust

Case management is a young profession without statutory regulation; however, it is supported by two professional associations, both of which have clear Standards for practice. CMs usually have a previous clinical qualification, for example, many are occupational therapists, and provided their registration with the HCPC is maintained, statutory regulation is in place via that qualification (HCPC, 2013). Not all CMs have a previous clinical qualification and not all CMs are members of either BABICM or CMSUK.

Given that immediate professional ambiguity, it was reassuring to demonstrate from the data that solicitors' specific expectations of practical, functional case management were all present in both the Competencies and Standards set by BABICM (2013) and the CMSUK Standards and Best Practice Guidelines (2009): *see Appendix 11.* Training needs identified in the data were also recognised in both sets of Standards, with the exception of CM awareness of recoverability of costs. While there was positive acknowledgement of case management from both claimant and defendant participants in this study, there were also high levels of suspicion and mistrust expressed.

The requirement for CM education in the litigation process and the interface with case management was reported elsewhere (CMSUK, 2010; Underhill, 2011). The present study suggests this is a specific need for CMs and perhaps should be formally delivered by CMSUK and BABICM instead of the solicitor-training-day forum. The *Wright v Sullivan* judgement appears to cast a shadow of ambiguity which is possibly deepened by CMs who are not fully aware of this judgement and are indeed, albeit unwittingly, losing sight of their client and 'fundamental guiding principle' of their duty of care (CSOL4). The emergence of claimant CMs and defendant CMs reported in the study is concerning: the CM should 'view the claimant as the claimant', regardless of the source of referral or fee payer (CMSUK, 2009).

Sharp described the CM as 'an important part of the evaluation of the results of treatment, therapy and care regimes' which in turn informed 'the content and value of the claim advanced on behalf of the injured person' (Sharp, 2012: p.2). Braithwaite referred to presenting a sensible life care plan instead of theorising 'about an uncertain future' (Braithwaite, 2011: p.7). Implicit in both these statements is the CM's contribution to damages and thus the potential to maximise a claim. Without appropriate training the CM can rapidly enter muddy waters. Without an appropriate clinical evidence base from which to work, the picture rapidly darkens.

Given the professional ambiguity and possible ignorance of duty of care of some CMs, the negative views of defendant solicitors in this study and elsewhere are unsurprising (Underwood, 2010; Fisher, 2013; Hibbert, 2013). The appropriateness of the case management model was questioned: 'a clinical disjunct' was highlighted with recommendation for Consultant-led rehabilitation regimes to be used instead. The need for "credible, appropriate and professional qualifications in case management" was noted by colleagues who have been involved in brain injury case management since its inception in the UK (Brooks, 2011: p.5). It is 'essential' in a brain injury case that the CM has experience of brain injuries and the 'management of the problems to which they give rise' (Sharp, 2012: p.6).

The idea that claimant solicitors required educating about rehabilitation was expressed in this study. Such concerns have been reported elsewhere in terms of undervalued claims arising from medicolegal misconceptions around the term 'rehabilitation' and of "raising expectations that are unrealistic or overvalued" (Scheepers, Thorneycroft and Perry-Small, 2009: p.263).

Despite publications such as Best Practice Guides on Rehabilitation (APIL, 2004; 2007), the British Society of Rehabilitation Medicine Standards for Rehabilitation Services (BSRM, 2009) and the Rehabilitation Code (Stevens, 2007), Scheepers et al suggest that rehabilitation continues to be understood by the legal profession more in terms of the management of a "transient period of instability", rather than "the reality of living with a life-long condition". They suggest that while healthcare professionals "may be familiar with and more accepting of uncertainty and ambiguity, the legal system translates this grey area into black and white. The result is a hybridised medico-legal terminology that is neither consistent nor clear" (p.263).

The Court of Appeal in Wright encouraged 'a spirit of openness' (par 32) to promote the open exchange of information with both parties' representatives and avoid the suspicion and mistrust generated by 'failures in communication' (Brooke, 2005: par 31). But this provided potential conflict with litigation privilege in respect of communications between the CM and the claimant's legal advisors (Sharp, 2012: p.11). If the CM does not maintain the case files in timely fashion and release these regularly to the claimant solicitor, and if the claimant solicitor does not disclose these in timely fashion to the defendants, again it is unsurprising mistrust and suspicion are generated. CMs were described as occupying 'a unique and privileged position in the litigation process' in both the ordinary and legal sense of the word; they 'hide behind a therapeutic relationship and are accountable to the claimant alone' (Fisher, 2013).

The defendant has no confidence in unilateral CM instruction and regards joint instruction as a much more open way to work. BABICM recommends that 'joint instructions from two parties are inadvisable and may lead to conflicts

of interest' (BABICM, 2005: *Protocol for the instruction of Case Managers*). The claimant has no confidence in joint instruction and in this study viewed it exceedingly negatively, in terms of 'ulterior motives ... funding is always [the defendants'] priority ... decisions taken away from the family ... grossly inappropriate'. CSOL5 was emphatic and viewed it as an 'anathema': 'I hate joint instruction': it was something to use only when there was an issue with liability and interim payments were required. The CM should be working for the client only – 'if people get over the barrier of saying I'm working for the client, it will focus their minds more clearly'

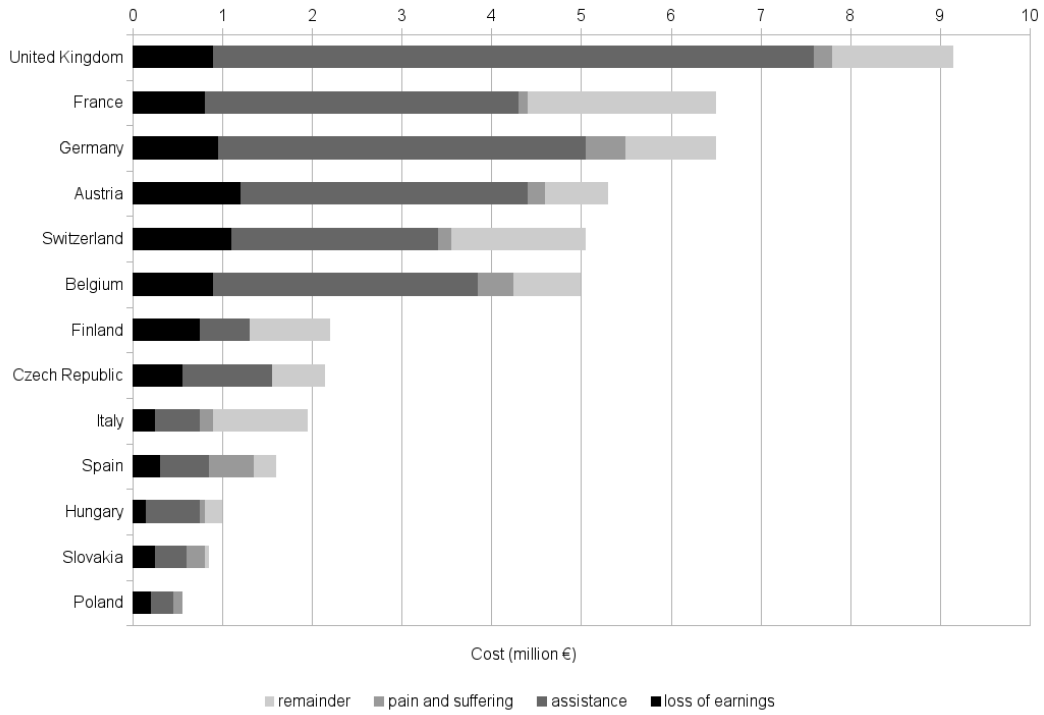
5.2 Rising costs in care

The claim is concerned with measure of loss in terms of the costs involved to put the claimant back in the position they would have been had the accident or injury not occurred: it could almost be described as a 'commodification' of disability. The drift of a market economy, regarded as a 'valuable and effective tool for organising society', to a market society, described as a way of life in which 'market values seep into every aspect of human endeavour' has been carefully noted elsewhere (Sandel, 2012: p.10). However, markets have a 'corrosive tendency', for not only do they allocate goods, 'they also express and promote certain attitudes toward the goods being exchanged ... Putting a price on the good things in life can corrupt them' (ibid: p.9).

It is suggested there are moral and ethical considerations here which must be recognised – firstly, in allocating the price for compensation. Secondly, in ensuring the arena where this is established and the parties involved in its negotiation, are transparent, clear and open. Sharp was succinct in his summing-up of 'getting the best for the claimant: this is perhaps the more appropriate aspiration, rather than simply concentrating on maximising the damages. Rehabilitation and recovery are likely to be of greater value to an injured claimant than simply large sums of cash' (Sharp, 2012: p.21)

Attention is drawn to the European context of rising costs of care (Werwigk, 2010)

Figure 5.1: Swiss Re Bodily Injury Claims – European Comparison 2010



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It is immediately clear that the UK has a disproportionately large loading of assistance in terms of bodily injury claim awards, than any of the other European countries listed: approximately €7.5mn: compared to Poland which only appears to award approximately €0.25mn towards assistance. It is important to try and identify why this is the case and some interesting points are made by the Association of British Insurers & International Underwriting Association (2007: p.62): *Timeline of Major Developments Relating to Claims 1997-2007*: and these are reproduced below with the kind permission of Richard Ticehurst, Chartered Insurer, Claims Expert, Swiss Re Services Ltd (London).

Table 5.1: Timeline of Major Developments Relating to Claims 1997 to 2007

Date	Event/Detail	Retro-spective	Financial Impact
Approx 1998	Manual Handling Regulations 1992 A few years after the Regulations came into force, they began to impact significantly on the cost of care claims as two carers were required for anyone needing assistance with transfers, where one carer had previously been used	Yes	High (relating to 1mn+ claims)
01.10.98	The Working Time Directive Implemented into UK Law as the Working Time Regulations 1998. Further increased cost of care claims due to need for more carers to avoid breaching Regulations. Impact fell quickly after Introduction.	Yes	High
17.11.98	Worrall v Powergen Plc [1999] PIQR Q103 High Court – the Ogden Tables for projected mortality (as opposed to those based on historical figures) should be used to determine multiplier. Higher multiplers – increased cost of claims	Yes	Medium
1998	Minimum Wage Act 1998 implemented The question as to whether a 'sleeping carer' was working for the purposes of the Act was answered in the affirmative, meaning that the carer was entitled to the minimum wage, thus increasing the cost of care claims	Yes	Medium (relating to £1mn+ claims)
25.06.01	Lord Chancellor makes Damages (Personal Injury) Order 2001 S1 2001/2301 Lord Chancellor sets discount rate for future losses at 2.5% (using power given under s1 Damages Act 1996	Yes	High
23.03.02	British Nursing Assoc v Inland Revenue (2002) IRLR 480 Court of Appeal further illustration of the impact of the Minimum Wage Act where the Court upheld the Employment Appeal Tribunal's conclusion that a worker was 'working' whilst awake at home waiting telephone calls, but but actually engaged in work.	Yes	Medium (relating to £1mn+ claims)
July 2002	Care Standards Act 2000 implemented Much debate ensued between 2000 and 2002 as to the likely impact on care claims of this Act, which resulted in employers of care workers having to provide induction training and carry out proper checks on prospective employees. Employers passed the increased costs to consumers resulting in an increase in the cost of claims	Yes	Medium (relating to £1mn+ claims)
09.11.04	5th Edition of Ogden Tables	Yes	High
07.02.06	Freeman v Lockett [2006] EWHC 102 (QB) First instance decision. Court refused to allow deduction from damages of money paid by local authority towards the provision of care. Court concerned that no local authority could give any guarantee as to what future policy re funding would be, and the Defendant had failed to satisfy the Court that funding would continue in the future	Yes	Medium (relating to £1mn+ claims)
03.05.07	6th Edition of Ogden Tables	Yes	High

Further to the above identified statutes and judgements, each with their impacts on increased costs of care, it is pointed out that claimants and defendants are now using the 7th Edition of the Ogden Tables which contain increased life expectancy projections which, in turn, have helped fuel increasing cost of care claims.

In addition, the following extracted from de Wilde (2013) all point to an upward pressure on care costs:

- p.287: par 31: Provision for holidays, sick pay, etc
- p.288: par 33: NEST pension contributions
- p.288: par 36: Parental contribution to the future care package
- p.290: par 47: Day centre provision
- p.290: par 48: Team leaders
- p.291: par 50: Liaison/team meetings
- p.291: par 52: Burden of proof/correct measure of damage most basic legal principles.

Appropriate evaluation of the client's needs, underpinned by evidence-based collaborative practice is now a clear expectation of CMs working in the catastrophic injury arena. Recent research identified the Rehabilitation Code as an established part of the claims process. The biggest drawback noted was cost, with many critical of the services given by rehabilitation providers and case management companies (International Underwriters Association; Association of British Insurers, 2013).

In the recent *Loughlin v Singh* judgement [2013] EWHC 1641 (QB) Parker J, the Defendant raised the issue of unreasonable provision in relation to past CM costs. Ruck's exposition at a recent Symposium (2013) examined how the Court was invited to disallow costs of past case management on the basis that *'the standard of care of such management fell significantly below that which could reasonably be expected to meet the exigencies of the claimant's condition*

and circumstances'. The clinical CM's decision-making was scrutinised as a result and it was concluded that *'the efforts made on this fundamental aspect of rehabilitation [implementation of sleep hygiene programme] were simply not adequate'*. The judge stated that *'the standard of the care and case management services did, in an important respect, fall significantly below the standard that could reasonably have been expected; in other words, the objective value of what the Claimant received was less than the amount of the charges made for the relevant services'*.

Ruck noted the many effects of this judgement (2013); however, the immediate effects for the purposes of this paper are, firstly, that there is no inevitability of recovering for past services; secondly, judicial scrutiny of the quality of past professional input is open to the defendants, and thirdly, it posits 'value for money' firmly in the litigation forum. Sharp's prescient observation that the effective CM will keep 'careful records' is timely in the light of this judgement (Sharp, 2012: p.17).

5.3 Risk assessment

Risk assessment is another considerable area for the CM, linked to costs, and also regarded with ambivalence by participants in this study. *Cui bono?* CSOL3 noted the 'nuances' in working with people with a brain injury: the subtleties that can rapidly escalate so that the client finds themselves in a predicament, that point where 'the unresolved tension between service user empowerment and professional accountability' crystallises (Colyer, 2004: p.25; Mantell, 2010).

DEP1 spoke compellingly about empowering clients, 'giving them a life back'; CSOL4 emphasised the 'choice and dignity' afforded by well-judged compensation. Similar concepts are discussed elsewhere in terms of "*binkification*: the typically counter-productive process of attempting to transform tough Dobermanns into passive and 'socially appropriate' poodles" (Ylvisaker and Feeney,

2000: p.407). The authors described their approach to social rehabilitation for young adults with disability in domains of everyday social interaction in which 'executive function, cognitive, communication and behavioural deficits interact to create potentially insurmountable barriers to achieving a satisfying life' (p.427).

The imagination and controlled risk-taking rehabilitation discussed in binkification is implicit in DEP1's observation concerning 'that bit that actually isn't based on any qualification ... trying to give them their life back' that is lacking in some CMs. Might the previous qualification of the CM influence their bearing on sensible risk management of their client? Occupational therapy has been identified as 'a discipline in a state of change, suffering somewhat of an epistemological crisis and thus may lack a common group identity' (Grant, 2013: p.410). Such change may also promote a certain role-defensiveness: when clinical competence is based on the correct prediction of risk (College of Occupational Therapists, 2006), 'the level of risk a clinician is likely to recommend is often minimised, resulting in a myriad of missed opportunities.' In trying to achieve a state of no-risk, harm may indeed be averted but 'all hope of growth, creative problem-solving and finding new ideas for solving functional problems' is lost (Gallagher, 2013: p.338).

5.4 Implications for case management

Against a background of steeply-rising costs for care and already criticised for high costs in the provision of case management services, it is essential the CM works professionally, collaboratively as part of a team and acts at all times in the best interests of their client. Independence, objectivity and clinical governance must be firmly entrenched in their practice: CMs will be challenged now that 'value for money' is firmly in the litigation forum. Appropriate training in the litigation process is strongly recommended as part of CM professional and accredited development to mitigate against the suspicion and mistrust currently experienced by defendant solicitors and to ensure their integrity is not compromised by claimant solicitors. Risk assessment must be carried out creatively by finding different solutions to problems, by focusing on 'what can be done with greater certainty, accountability and transparency' (Gallagher, 2013: p. 337).

5.5 Limitations of the study

While all participants reviewed and agreed copies of their transcripts, the time constraints of this study did not afford opportunity for respondent feedback on the Final Template.

In a future study it would be helpful to have two or more researchers to verify, define and agree the final themes. Apart from the researcher carrying out 'regular quality checks to ensure analysis was not being systematically distorted by [her] own preconceptions and assumptions' by reverting to the research question (King, 2011), the only other quality check built into this study was an independent reader checking all the transcriptions and agreeing the developing and final Template as an accurate reflection of the transcribed material.

The Results were delivered as an account structured around the main themes identified, and there is 'a danger of over-generalisation and losing sight of individual experiences' inherent in this method (King, 2012: p.446); however, the intention here was to provide a broad understanding of the issues involved.

5.6 Future study

This study has illuminated a complex arena with many possible areas highlighted for future study. The post settlement period without CM and ways in which people thrive who have had a CM pre-settlement requires investigation. An investigation of CM awareness of the terms of *Wright v Sullivan* and its impact on all parties involved would be useful.

Conclusion

> *Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth . . . In the sufferer let me see only the human being*
> (Rosner, 1977: The Prayer of Maimonides)

Through exploration of the expectations that personal injury solicitors have of case managers, this study has covered a wide ranging area of complexity in the field of catastrophic injury. The positive case manager is acknowledged and the robust system of Standards of both professional associations identified; however, an urgent training need in CM awareness of the litigation process and their function within that has crystallised out of the high levels of suspicion and mistrust found in this study and reported elsewhere. Participants recognised the lack of professional CM accreditation.

High levels of supervision are recommended from findings: not only in terms of general CM practice, but in the pursuit of 'personal and moral integrity.' Coherence between professional practice and personal sense of identity must be intact in order to retain the independence required to work with transparency, in the best interests of the client (McGrath, 2007: p.106-107; Edwards, 2009). The importance of acknowledging expertise and working as part of a team is critical to 'the integration of the person who has been fragmented by brain injury' (ibid: p.48).

Risk assessment was raised by participants and regarded with ambivalence. The practice of 'wrapping people in cotton wool' in order to maximise the claim

at the cost of maximising the claimants life chances was condemned. This, above all, is the antipathy of all therapeutic engagement: morality is lost when 'the goal of enabling human flourishing' is lost to the 'corrosive' effects of market values (Seedhouse, 1998: p.111; Sandel, 2012: p.9).

The CM is working in a context dictated entirely by market values and will be called to account following the *Loughlin v Singh* judgement (2013) if value for money is not deemed appropriate for the services provided.

The sample in this study were all agreed that a standardised, focused and goal-orientated documentation system should be adopted by the industry to start the process of consistency. CMs were urged to maximise rehabilitation outcomes sustainable in the 'real world'.

Future study is directed to examine the long-term view of claimants living post-settlement without a CM, despite poor prognosis at time of settlement.

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