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The battle for life

Medicine on the frontline

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Challenging claims costs on behalf of members

The MDU has long worked on behalf of members to ensure claims costs are fair and proportionate. Over the years, we have encouraged governments to make changes where we believed they were needed. Most recently we have supported the changes proposed by Lord Justice Jackson that the government plans to introduce next year. These will restore fairness to the civil justice procedure by ensuring claimants and their solicitors bear appropriate responsibility for their costs.

But our work on your behalf does not stop there, and we are now moving ahead to challenge the cost of damages awards themselves.

At a time when the government proposes radical changes to the NHS, the MDU is asking it to look at another law whose repeal is long overdue. The Law Reform (Personal Injuries) Act 1948 section 2(4) requires compensation awards to be funded so that patients who are negligently damaged can buy all necessary medical treatment and care from the independent sector. This law is anachronistic and anomalous – it was made in order to protect patients at a time when the new NHS was untried and there were no guarantees about the quality or availability of treatment and care provided by the state.

MDU members, and the general public, may be surprised to learn of the Law Reform Act's requirement to disregard NHS care when funding compensation awards – and equally surprised at the rate at which this inflates claims costs. Two-thirds of the total liability for clinical negligence claims that the MDU pays on behalf of members reside in a small number of large claims, in which as much as 75% of the damages may be awarded for future care.

These sorts of claims can happen to any member at any time, irrespective of the doctor's specialty and do not necessarily represent the 'severity' of the negligence.

If you consider this in the context of money going out of the NHS, these high value claims could account for as much as £600 million of the £863 million paid to settle NHS clinical negligence claims during 2010/11, or over £10bn of the NHS's £16.8bn total claims liabilities going to the independent sector. We question whether it is realistic, in the

current economic climate, to expect taxpayers' and MDU members' funds to be used to pay for these inflated damages payments.

Of course patients who are negligently damaged by healthcare, whether NHS or private, should receive compensation that covers their future care costs. But the assumption that it must be provided privately must now be challenged. Over the last 70 years the NHS has demonstrated it can provide appropriate levels of treatment and care. We believe defendants should be free to put together care and treatment packages that meet claimants' needs fully, irrespective of who provides the care.

The MDU calls on the government to repeal this anachronistic law. At the same time we are also proposing a wider package of changes to bring down the costs of damages awards, including a cap on loss of earnings payments and other aspects of damages awards to restore proportionality. It is now possible for successful claimants to receive awards of well over £5million just for loss of earnings.

This year we are having to ask our members, who are themselves financially squeezed, to pay increased subscriptions in order to fund claims costs that are increasing dramatically in number and in the cost of each claim. Claimants must be compensated, true, but that compensation must be fair – to all parties. The economic downturn that society is experiencing must be reflected in damages awards. They cannot keep rising at a rate that far exceeds wage and general inflation.

Dr Christine Tomkins
Chief executive

NEWS

NICE end of life care standards



NICE has issued a quality standard¹ for end of life care for adults which, it says, provides a benchmark for 'high quality care for adults aged 18 years and older with advanced, progressive, incurable conditions; adults who may die within 12 months; and those with life-threatening acute conditions. It also covers support for families and carers of people in these groups'.

The guidance emphasises 'accessible and sensitive' communication with patients and their families; meeting patient's physical and psychological needs at all times, such as access to pain relief; offering personalised support to ensure patients can remain as independent as possible; and training for those providing end of life care to ensure they have the necessary skills, knowledge and attitude.

The MDU receives many calls from members seeking advice about end of life care. In addition to following GMC² and NICE guidance, members may wish to consider the following points when broaching difficult conversations about condition or prognosis with patients:

- The patient may appreciate the opportunity to have a friend or relative present during the discussion.
- Establish what information the patient wants you to share with the family and carers and in what circumstances.
- Use lay terms and avoid medical terminology; give the patient time to reflect and ask questions.
- If the patient doesn't want to know details about their condition or treatment, the GMC says you should find out why. If they still do not want to know, you should normally respect their wishes. Where this will make ongoing care impracticable or impossible, MDU members are encouraged to contact the advisory helpline on 0800 716 646.
- DNAR decisions need to take into account the benefits, risk and burdens of resuscitation and consider the patient's wishes and preferences, the views of the healthcare team and, when appropriate, those close to the patient. The aim is to arrive at a consensus.

¹ End of life care for adults quality standard, NICE (November 2011)

² GMC, Treatment and care towards the end of life (2010)

Doctors as patients

The MDU assists doctors experiencing a range of mental and physical health problems who face procedures such as GMC investigations. With this in mind, we attended the first meeting of the UK Association for Physician Health (UKAPH) in October 2011. This important initiative will, we believe, promote the health and well-being of doctors through consistently high quality healthcare.

The Royal Colleges of General Practitioners and of Psychiatrists and the Faculty of Occupational Health Medicine have received funding to train their members specifically in addressing the needs of doctors as patients. There is also a range of other specialist providers of health support for healthcare professionals, including the Practitioner Health Programme in London.

With our individual members' consent, the MDU is pleased to work in collaboration with these other agencies to support and advise doctors with health concerns.

GMC web health resource

The GMC has recently launched a new website, Your Health Matters (www.gmc-uk.org/doctorshealth), to provide information, resources and advice for doctors going through fitness to practise procedures.

DH drops 'gossips' charter



The Department of Health (DH) has announced it will not proceed with proposals to impose a duty of co-operation to share information about healthcare workers. The MDU strenuously opposed the draft regulations and responded robustly to the DH's consultation in 2010.

Had the proposal gone ahead, it would have allowed unsubstantiated allegations

regarding a doctor's conduct or performance to be communicated from one organisation to another, without the doctor having been given the opportunity to challenge them first or, in some circumstances, without the doctor even being aware the allegations existed. It would have created, in effect, a 'gossips' charter'.

The MDU did not believe the regulations were the most effective way to enhance patient protection, and spent four years working on members' behalf to oppose them. Dr Hugh Stewart, the MDU's head of case decisions, commented: 'We were not persuaded that passing on so-called soft information about doctors in the way proposed by the DH would have added anything to existing measures in place to protect patient safety.'

In fact, the MDU was so concerned that we instructed an opinion from leading counsel on behalf of MDU members. Counsel advised that the regulations as drafted provided the potential for legal challenge, and may have infringed doctors' rights under the European Convention on Human Rights.

Dr Stewart added: 'We made the point consistently that we believed this policy could considerably undermine confidence of and in doctors for no good reason. We welcome the DH's decision not to proceed with the regulations.'

Senior doctors' role in implementing new GMC guidance

Two new pieces of guidance from the General Medical Council, which came into effect in March, aim to encourage doctors at all levels to come forward with concerns in the workplace, and to remind all doctors that being a good doctor is about more than being a good clinician.

Raising and acting on concerns about patients (March 2012), sets out a doctor's duty to act when they believe patient safety is at risk or when a patient's care or dignity is being compromised, while *Leadership And*

Management For All Doctors (March 2012) details a doctor's responsibility in relation to employment issues, teaching and training, managing resources and helping to develop and improve services.

Dr Catherine Wills, deputy head of advisory services at the MDU, says: 'Consultants are likely to be familiar with many of the issues raised in the new guidance but the MDU encourages every doctor to become familiar with, and follow, the guidance as it applies to their own situation.'

For more information on the guidance please visit the-mdu.com

Doctors love apps

Nearly 70% of hospital doctors recommend health apps or websites to patients, an MDU survey has found.



The online survey, carried out in late 2011, polled the practice and opinions of doctors regarding the use of modern communications technology in their work. Of the 273 hospital doctors who responded, 99% use some form of communications technology in their day-to-day work.

Email is the most popular; 92% use it to communicate with staff. Around 64% use communications technology to track test results and 63% to research patient symptoms. Some 50% of consultants who responded use a smart phone for work, but only 37% of non-consultant hospital doctors (NCHD). For use of a laptop, the figures were 64% and 40% respectively.

While the majority (52%) of hospital doctors agree that modern communications technology allows patients to be kept more informed and involved with their care, 41% expressed concerns about potential threats to patient confidentiality.

Dr Mike Devlin, head of MDU advisory services, commented: 'Communications technology brings many advantages to a hospital doctor's work, and it's positive to see that MDU members recognise and embrace the benefits it can bring.'

'However, new technology also brings new risks. It is important that using technology does not threaten a hospital doctor's ethical and legal obligations.'

The MDU offers general advice for the use of communications technology on its website the-mdu.com.

Organ donation

As debate about the state of organ donation in England and Scotland rumbles on, the Welsh government has said it plans to introduce presumed consent for donation by 2015. The proposal is for 'soft' presumed consent – families would still be consulted after a person's death.

Lost chance in the US

The Washington State Supreme Court has ruled that a patient may recover damages for medical liability even if they cannot prove, on the balance of probability, that the negligence caused injury¹. The patient merely had to show that, but for the negligence, they would have stood a better chance of recovery. The court said that 'the injury is the lost chance of a better outcome'. In the UK, in *Gregg v Scott* [2005] the MDU successfully defended a case where the patient claimed damages for the loss of a chance of a cure. The Law Lords upheld the traditional view that it must be demonstrable on the 'balance of probabilities' that the patient's injuries arose from the negligence alleged. This remains the law.

¹*Mohr v Grantham*, reported in PIAA, November 2011

Tribunal chair appointed

The Medical Practitioners Tribunal Service (MPTS), the new independent service set up to adjudicate GMC fitness to practise hearings and create 'even greater separation' between the GMC's investigations and FTP hearings, will begin management of cases in summer 2012. Its new chair His Honour Judge David Pearl, who was appointed in February, will be responsible for appointing and training panel members and will report directly to Parliament annually.

Online records

Proposals to enable patients to download their medical history from the internet, as well as view prescriptions, appointments, test results and discharge notes, within the next three years have been put forward by the NHS Future Forum. The plans received government support, but give rise to concerns such as the issue of patient confidentiality.

IN FOCUS

Contractual duty of candour

Although aware that doctors already have an explicit duty to be open and honest with patients if something goes wrong, the Department of Health is going to impose a contractual duty of openness on 'all relevant providers of NHS care'.

The consultation seeking views on how this might best be achieved closed in January and the MDU responded on behalf of all members. We raised two main areas of concern.

The first is that any admissions made in order to comply with the duty must be agreed with the doctors responsible for the patient's care and must not compromise their rights in any action arising from the incident. If a patient believes he or she was not told that something went wrong, it is most likely that either the doctors did not think anything had gone wrong; or that something unexpected arose later which was not apparent at the time. Either way, treating doctors must be involved in any response.

Our second concern is the proposal to extend the contractual duty to primary care providers through the GP contract. We responded robustly because GPs already have an explicit duty in respect of all patients for whom they are responsible, even if they did not treat the patient themselves. Any additional contractual duty would be unnecessary and cause considerable confusion.

The DH is expected to respond later this year and to publish more detailed plans. We will continue to represent members' medico-legal interests and will let members know how they will be affected by any proposals in due course.

Mary-Lou Nesbitt
Head of governmental and external relations



Dr Matt Lee, MDU professional services director, explains why accepting a GMC warning may not always be advisable.

The GMC

introduced warnings in 2004 as part of its wider fitness to practise reforms to deal with complaints that do not reach the threshold for impaired fitness to practise. Warnings may be offered at the end of the investigation stage, when no facts have been proven. They are meant to warn doctors that a repeat of the alleged behaviour would, if proven, be likely to lead to a finding of impairment.

Warnings are generally offered when there are allegations about matters including inappropriate prescribing, poor record-keeping, offensive behaviour to colleagues and drink-driving convictions. The record of a warning is available to anyone (including members of the public) who chooses to check the doctor's registration via the GMC website for five years, and indefinitely if requested by employers.

The fact that warnings are public for so long is, we believe, one of the factors that has contributed to their being treated by some, including employers, contracting bodies and independent healthcare providers, as a far more serious sanction than was ever intended. For example, some individual private providers have withdrawn practising privileges from doctors who have received a warning, for the full five years.

This means that a warning can have more significant consequences for a doctor than a sanction that was intended to be more

GMC warnings – unintended consequences

serious. For example, a six-month suspension from practice after a finding of impairment would allow a doctor to return to work after the period of suspension, whereas a warning issued without a finding of impairment and no finding of fact against the doctor may have ongoing consequences for a considerable time after the matter that caused the GMC to issue it.

When the GMC considers that it is appropriate to conclude a case with a warning, a doctor can either accept the warning or exercise the right to a public hearing before the Investigation Committee. The committee can:

- confirm the warning should be issued
- conclude the case with no further action
- refer the case to an FTP panel – though only if new evidence arises during the hearing indicating this is appropriate.

Given the potential impact of a warning, some members prefer to refuse it and allow the matter to be considered by the Investigation Committee. This is contrary to the spirit of the current changes which are intended to resolve matters appropriately at an earlier stage.

The MDU believes it is in our members' interests, and the public interest, that the GMC should have at its disposal a proportionate way of indicating to doctors that if there was a repeat complaint of certain alleged behaviour it might need to take action in order to protect patients.

However, we do not believe that warnings as they currently exist are proportionate. Our experience suggests warnings are often treated by third parties more seriously than FTP sanctions that have been put in place to protect patients. This can be detrimental to doctors, out of all proportion to the allegations that give rise to a warning.

Under the influence

Patients with alcohol-related problems present a range of medico-legal challenges for doctors.



Figures from the NHS Information Centre¹ for 2009/10 show more than one million alcohol-related hospital admissions, an increase of 12% on the previous year. Prescriptions for the treatment of alcohol dependency increased by 56% between 2003 and 2010.

Patients affected by alcohol present their fair share of ethical challenges for doctors who treat them. In 2010, the MDU received over 300 calls to the advisory helpline from hospital doctors and GPs who had concerns about treating alcohol dependent or intoxicated patients. Perhaps not surprisingly, the majority of calls from hospital doctors came from those working in A&E departments and psychiatrists.

More than 10% of the calls concerned complaints from the patient or their family.

The most common allegation was that the doctor's care had been inadequate, followed by poor communication, usually that the doctor had been dismissive or rude.

Interestingly, more than 50% of complaints in the alcohol study were made by a third party, usually the patient's partner or family. By contrast, an MDU study of all patient complaints received in the year to April

2010 showed that 84% of complaints were made by patients themselves, and only around 10% by a relative. This could simply reflect the fact that patients with alcohol problems may be unwilling or unable to complain themselves.

In 16% of calls the patient had died and the doctor needed help with a coroner's inquest or report. Often the inquest followed a suspected suicide or overdose, and in several cases death was due to undiagnosed subdural haemorrhage, a condition for which alcohol is a risk factor but where many of the symptoms are also associated with both the acute and chronic effects of alcohol excess.

Around 90 members sought advice on whether they could disclose confidential information about the patient to the family or another third party, usually the police or social services.

The final category concerned capacity and consent, such as requests for advice about taking blood from a patient to determine alcohol levels, usually at the request of the police after a car accident.

Members also sought advice when they had been asked to give an opinion on the capacity of patients with alcohol related problems. Such assessments can be difficult as these patients may have fluctuating levels of capacity. The Mental Capacity Act 2005 sets out the criteria for assessing capacity.

Manage the risk

- Be aware of and consider the latest guidance on treating alcohol dependence, such as the NICE guidelines published in July 2011².
- When responding to complaints from a third party, it is important to ensure that the person has the authority to bring the complaint. Respect the patient's wishes about disclosure of information – eg if they do not want their family to know they have attempted suicide.
- You may only disclose confidential information without patient consent if required to do so by law or in exceptional circumstances when the public interest outweighs the patient's right to confidentiality³. You should inform the patient that you intend to disclose information, unless it is not practicable to do so. Carefully document any decision to disclose without consent.
- Record in the patient's notes your differential diagnosis, management plan and relevant findings following examination, negative as well as positive.
- Guidance from the Faculty of Forensic and Legal Medicine⁴ and the BMA makes clear that the treating doctor should not take blood samples for forensic purposes. This will almost always be taken by the forensic medical examiner although the treating doctor must be informed.

References

- 1 Statistics on Alcohol: England, 2011, The NHS Information Centre, 26 May 2011,
- 2 Alcohol-use disorders: The NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence, NICE, 29 July 2011
- 3 GMC, Confidentiality (2009)
- 4 Taking blood specimens from incapacitated drivers, FFLM and BMA, July 2010.



PUTTING THINGS RIGHT

Putting things right

Time was when reflection and insight following clinical incidents was just an ethical duty. Today, a doctor's response could make or break their career. Dr Kathryn Leask, MDU medico-legal adviser, looks at the practical aspects of 'putting things right'.

Situations inevitably arise in clinical practice that result in scrutiny of a doctor's actions, often following a clinical incident, a patient complaint or at a coroner's inquest. The investigation that ensues may prove uncomfortable and stressful for the doctor concerned, but may also offer an opportunity for learning both from the perspective of the individual practitioner and also for the organisation.

This type of reflection and insight is not simply an ethical requirement; it can make or break a career.

For example, 'lessons learnt' play an increasingly important part of job appraisals, and remain on an employment record, providing reassurance (or otherwise) to current and future employers.

PUTTING THINGS RIGHT

When revalidation is introduced as planned at the end of 2012, evidence of learning from events and taking steps to 'put things right' will become an essential part of the revalidation process. The purpose of revalidation is to reassure the public and patients that doctors are fit to practise. Doctors will be required to identify for themselves areas of their practice where there may be deficiencies – not always an easy thing – and provide evidence of remedial action they have taken to improve their performance.

At the GMC, demonstration of remediation has become integral to a doctor's defence in fitness to practise hearings. The GMC takes a more positive view of doctors, brought to their attention due to a complaint, who have taken positive steps to learn from any clinical incidents, show insight and have evidence to prove this.

Ethical guidance

The ethical imperative for reflection and remediation is contained in the GMC's guidance in *Good Medical Practice*¹ which requires doctors to continually maintain and improve their performance and regularly reflect on the standard of the medical care they provide. Doctors should take regular part in audits to allow the services they provide to improve and respond constructively to the outcomes of such audits and other reviews of their performance, taking part in further training if necessary.

Doctors will need to maintain a portfolio of supporting evidence relating to the work they do and show that they continually reflect on their practice. How others perceive the quality of their work is also important and this should include feedback from colleagues and patients, if appropriate².

When an incident has occurred, it is normal practice for an employing trust to carry out a critical incident or serious untoward incident investigation to establish how the incident arose and what can be done to stop it happening again. The MDU regularly assists members who have been asked to provide a report for the trust explaining their involvement in the incident. Often, the trust produces an action plan following the investigation which may include action that the trust as a whole has to take but can also refer to specific individuals – for example, recommending a doctor undertakes further

training in specific areas or attends particular courses.

Remediation can take a number of forms. Deficiencies in clinical knowledge, for example, may be rectified by attending specialist clinics, as an observer or under the supervision of a consultant colleague. In addition to this, specialist courses run by Royal Colleges or other organisations are an appropriate way of improving knowledge and fulfilling Continuing Professional Development (CPD) requirements. It is important for the doctor to maintain a record stating specifically what learning has taken place and reflecting on how this will help to inform their practice in the future.

Where concerns are raised about a doctor's personal interaction with patients and colleagues, rather than their clinical performance, this, too, could become the subject of a trust or GMC investigation. Again, it is important to show that any concerns have been taken on board and action taken to address this. A number of courses are now available, including from the MDU, focusing on professionalism and communication skills of healthcare professionals. Courses on medical ethics and law may also be relevant.*

A doctor's health may be impacting their ability to treat patients. Again, the GMC tends to look more favourably on doctors with health issues, including those with illnesses relating to alcohol and drug misuse, who take positive action to get advice and treatment for their condition.

Case

A consultant was referred to the GMC by his employing trust following a disciplinary investigation into his personal conduct and clinical care of patients. Colleagues had raised concerns about his behaviour towards them and reported that he often smelt of alcohol at work. He had also received complaints from patients relating to his clinical care and attitude toward them. A local GP reported that the consultant had not been informing her of decisions made at out patient appointments. On investigating the matter it became evident that the consultant had not been documenting many of his clinical encounters with patients and had not been dictating letters following clinics.

The GMC investigators were impressed by the fact that the consultant had co-operated fully with the trust's investigation and had sought advice from his own GP and an occupational health physician. He had been to a psychiatrist who diagnosed depression following a number of life events and addressed the issue of the doctor's misuse of alcohol, for which treatment and monitoring was arranged. The consultant was voluntarily undergoing follow-up, including monitoring of his blood alcohol level.

The consultant had also attended CPD courses on professionalism and communication skills and another on documentation in order to address deficiencies in these areas. The GMC placed conditions on the consultant's registration that reflected the action he had already taken and did not feel it was necessary to suspend the doctor or place on him any more onerous restrictions in view of the fact that he had shown insight into his situation and had acted accordingly at his own volition.

References

- 1 GMC, *Good Medical Practice* (2006), para 14
- 2 GMC, *Supporting Information for Appraisal and Revalidation*, updated March 2011

*The MDU Education programme offers a wide range of CPD and personal development courses. See the-mdu.com/education for more information.

PUTTING THINGS RIGHT

GMC 'consensual disposal' pilot

Consensual disposal of cases before the GMC will be piloted this Spring. Charles Dewhurst, head of the MDU legal department, explains how it is likely to work.



The GMC consulted last year on proposals to change the way it deals with cases at the end of its investigation. The consultation paper recognised that 'public hearings often result in a great deal of stress and anxiety for both the doctors involved and the witnesses' and that there were concerns that its approach was 'overly punitive'. Therefore it intends to seek co-operation from doctors in all cases where the doctor is prepared to agree to the GMC's proposed sanction.

It will also introduce an additional stage of investigation by arranging a meeting with the doctor and doctor's representative to explain the GMC view, invite comments, and explore the possibility of agreement of the appropriate outcome. In that way, it is suggested, only cases in which there remains a substantial dispute on the facts or the doctor will not accept the GMC's sanction will go to a public hearing.

A pilot, due to start in Spring 2012, will test these proposals in practice. This will operate within the constraints of the current GMC fitness to practise (FTP) rules, which require the registrar to notify the doctor of any complaint or information that is considered to raise an allegation of impaired FTP and to offer the opportunity to comment.

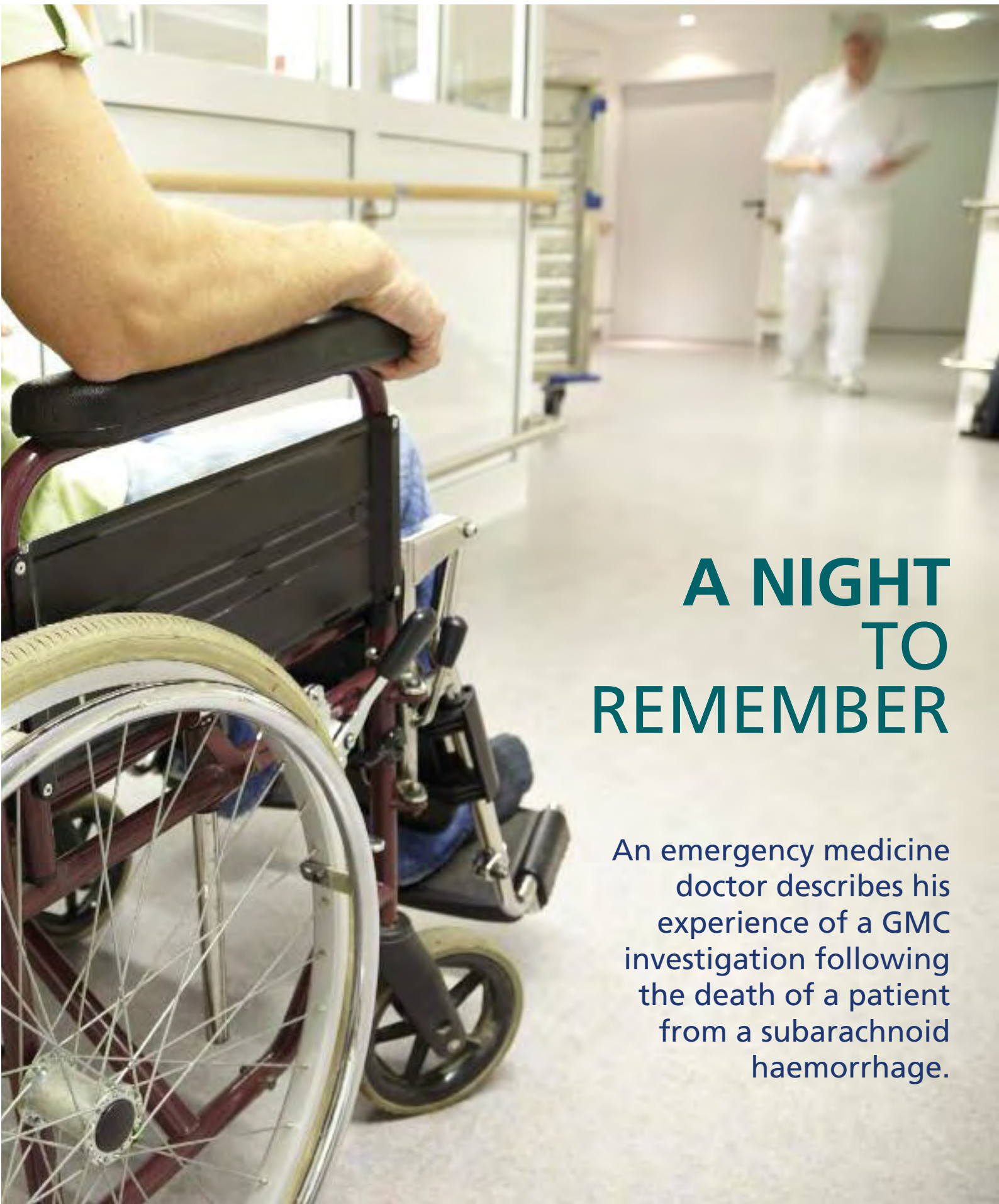
Currently, if, having investigated the matter, the GMC case examiners determine that there is a case to answer, the doctor will then be invited to respond to formal allegations, before the case examiners decide whether to refer the case to an FTP panel hearing. Under the pilot, a meeting with the doctor and doctor's representative will take place before the case examiners make their final decision.

At this meeting, the GMC and doctor will have the opportunity of putting across their views. The GMC will explain its tentative view on sanction. Any further relevant information – and this may include evidence of remediation undertaken by the doctor – will be identified, and the case examiners will review this evidence after the meeting, before they reach a final view. The GMC will then write to the doctor to advise of the case examiners' decision and, unless they decide to close the case with no action, will invite the doctor to indicate whether he or she will agree the GMC's proposed outcome.

In due course, the GMC intends that any sanction may be agreed, but the pilot will not permit agreement to suspension or erasure from the register. In practice therefore, the pilot will concentrate on cases that might be resolved by a warning, by the doctor agreeing undertakings – such as medical supervision in relation to health, retraining, or restriction of areas of practice – and borderline cases of potential suspension which might be avoided by the provision of relevant further evidence, such as of remediation.

The MDU cautiously welcomes these developments whilst emphasising to the GMC the importance of ensuring a fair process, encouraging flexibility in the timing of the meeting, and seeking clarity about what information from such meetings might later be available to FTP panel hearings in the event of a failure to resolve a case.

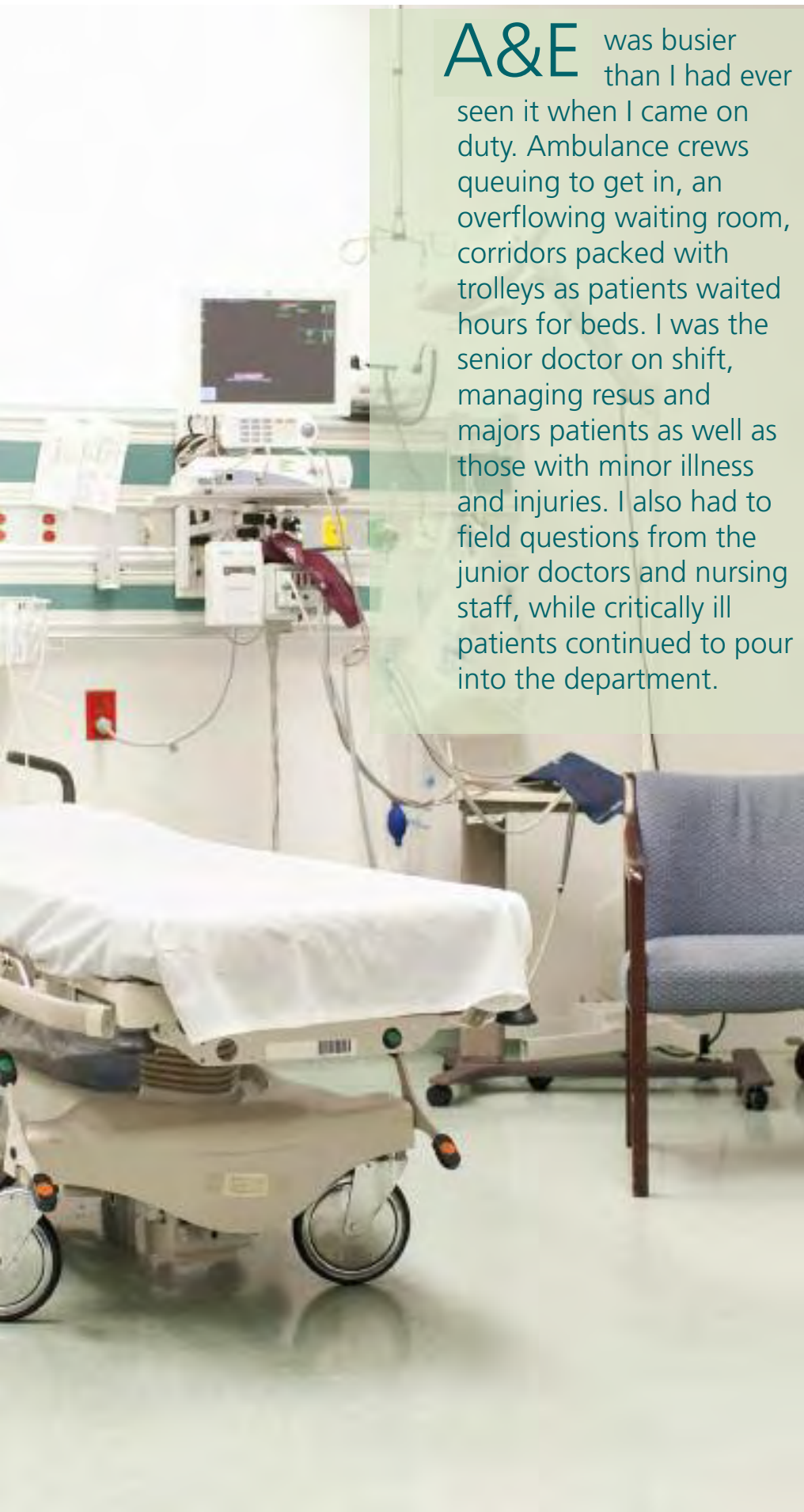
We will report on the outcome of the pilot in the next issue of the MDU Journal.



A NIGHT TO REMEMBER

An emergency medicine doctor describes his experience of a GMC investigation following the death of a patient from a subarachnoid haemorrhage.

FIRST PERSON



A&E was busier than I had ever seen it when I came on duty. Ambulance crews queuing to get in, an overflowing waiting room, corridors packed with trolleys as patients waited hours for beds. I was the senior doctor on shift, managing resus and majors patients as well as those with minor illness and injuries. I also had to field questions from the junior doctors and nursing staff, while critically ill patients continued to pour into the department.

I was attending to three very sick patients in resus when a colleague asked to discuss a patient brought in by the police. He told me that the patient was unable to speak and had an elevated white cell count and raised pulse. He had referred the patient to psychiatry, who suggested admitting her under medicine for further investigations. My colleague wanted me to confirm that this was appropriate.

What I did next – or rather didn't do – turned out to have consequences unimaginable at the time.

When my colleague told me there was no other abnormal neurology, I did not ask if a full neurological examination had been carried out, nor did I carry out one myself. I saw the patient only briefly. She did not look unwell or in any distress or pain and had not vomited. I urgently needed to get back to my patients in resus, so I just asked the doctor if he had found any other abnormal signs and when he replied no, I confirmed the patient's admission to the medical ward.

The pace was relentless for the rest of the shift. Large numbers of major medical, surgical and traumatic emergencies persisted. Preoccupied with treating other patients, I was completely unaware of what happened to the woman I had been asked about, of the delays in her transfer to the medical ward or that regular observations had not been performed. When I finally left the department after a punishing 19 hours on duty, I thought to myself: 'I will certainly remember that shift.' As it turned out, I was right but not for the reasons I had imagined.

Atypical presentation

A couple of weeks later, a friend asked me if I had heard about a patient who had presented with atypical symptoms to A&E and was later found to have had a subarachnoid haemorrhage. The patient had died. I realised that it must be the same patient but I assumed she must have deteriorated significantly after admission. I was shocked and saddened, but I still didn't realise that vital clues had been missed from the outset.

Several months after the incident, a trust investigation began. I was asked to provide a report as a matter of urgency. Without really thinking about what might be required, I hastily cobbled together an account from the medical notes regarding

the clinical management of the patient in general terms, rather than my own involvement in the patient's care.

Some months later, the trust's head of legal services rang and advised me to contact my medical defence organisation. Another investigation had found evidence to suggest that the patient may have

'What I did next – or rather didn't do – turned out to have consequences unimaginable at the time.'

presented to A&E with clinical signs that would have warranted an urgent CT head scan. It was also clear that she had not been examined thoroughly enough by a senior clinician when she first came in. Expert reports suggested that the patient would likely have died whatever treatment she had received, but she had been brought in on my watch and I had failed her. I hadn't fully assessed the patient and an early opportunity to diagnose and start treatment had been missed. I had also submitted a statement that was shoddy and misleading. I felt ashamed, guilty and that I had not lived up to my usually high standards. I also felt scared – I realised that I might be facing the potential loss of my career and possibly a charge of manslaughter.

My MDU adviser instructed a solicitor to act on my behalf. He explained things very clearly, and then put me through the mill with some very challenging questions. At the time I found his questioning very tough, but it served me well for what was to come later.

I was referred to the GMC who wrote to me explaining they were investigating my fitness to practise and summoning me to appear before an Interim Orders Panel (IOP) the following month. It was a very strange and emotive experience, seeing my last patient the day before the hearing. I considered the possibility that this gentleman might be my last patient and contemplated the fact that my career could end the very next day.

The IOP hearing was daunting. The panel consisted of lay people and doctors from other specialties; I wondered whether they would understand the pressures of working in an exceptionally busy A&E department. I really wanted to speak for myself and give my side of the case, but at the IOP hearing, it is the legal representatives who present the evidence. The panel listened to all the evidence and took into account nine glowing testimonials they had received

from consultants whom I had worked closely with. They also noted I had an unblemished record up until then. In the end, the panel did not place any

restrictions on my practice, but made it clear that this was pending further proceedings.

The coroner's inquest was held two years later. My barrister

stressed the importance of being open and honest about what happened, admitting any failures and expressing regret when I gave evidence in court. This was what I wanted to do anyway.

My cross-examination in the coroner's court lasted for hours. I gave my evidence then was questioned extensively by barristers acting for the patient and other healthcare workers involved in the case. I welcomed the chance to apologise to the patient's family for my mistakes – I didn't expect it to lessen their feelings towards me; after all, I had failed their loved one. The inquest lasted over a week and the coroner returned a narrative verdict. This was scathing about the organisations and systems of care in place at the time and the poor care that the patient had received.

Following the inquest, the trust conducted a root cause analysis of what had happened that night. The report identified underlying contributory factors including understaffing, deficiencies in management and a shortfall in support for the A&E department. By now, I was in a position within the department to make significant changes to systems that would protect patients and staff from similar events in the future. For me, this was not only a professional goal but an ethical and a personal one. Making changes to my own practice and improving processes within the department and trust helped me cope constructively during the years that I was under investigation.

Another two years passed before I heard from the GMC again. They sent me a list of allegations and invited me to respond. With guidance from the MDU and my solicitor, I wrote back accepting the failures I had made in not thoroughly reviewing the patient and submitting a substandard report, and set out what I felt I had learnt from the incident. I also described the educational and clinical governance work I had undertaken in the years since and described the processes I had put in place

in my own department and trust to prevent a similar incident. I gathered testimonials from professional colleagues who knew my work. All of these testimonials were submitted to the GMC.

A month later, I received notification that the GMC was concluding the case with no further action. Their advice was fair, sensible and reflected what had become my practice in the years since the incident. After such a long period under investigation, it was a huge relief that a conclusion had been reached and that the tremendous stresses on my family and me were over. It was not something to celebrate but to feel grateful to have come through.

The case has had a tremendous influence on me professionally and motivates much of what I now do. It has made me a better doctor, professional colleague and patient advocate. But I still feel the stigma of being involved in a GMC case. The experience has certainly made me more aware of how much doctors are scrutinised now compared to when I qualified – and perhaps rightly so. It was rare then to hear of a GMC investigation but I have since been approached for advice by several colleagues in a similar position.

Looking back, I think it really helped to think of myself as part of a process. I tried to remind myself that this wasn't a personal vendetta; it was about trying to find out what went wrong. It was up to me to show the GMC what kind of doctor I am and for me to regain my feeling of professionalism after making such fundamental mistakes. I do have some lasting scars: whenever someone says to me 'remember the patient you saw yesterday?' I automatically think 'what have I missed?'. Not surprising, I guess.

I was very fortunate in having phenomenal support from my family, friends, professional colleagues as well as the MDU and an extraordinarily able solicitor and barrister who helped me through the roughest of journeys. It is so very important to have support if the worst happens, rare though it is.

FEATURE



The battle for life

Some of the most brutal conflicts of the last 100 years have inspired medical innovations in a number of specialties which have saved or transformed many civilian lives.

The effect of war on civilians is always catastrophic: civilians accounted for 20% of the total UK death toll during the second world war¹. Yet the exigencies of war also drive doctors to invent, adapt and hone their techniques in extreme circumstances. Haematology, plastic and reconstructive surgery and psychiatry are just some of the areas which have advanced for civilians because of the types of traumatic injuries – physical and mental – seen in wartime, and the urgent need to treat them.

Survival

The first biggest killer in war is traumatic blood loss. Blood transfusions had been successfully carried out following the discovery of blood types by Karl Landsteiner in 1901 and the use of sodium citrate as an anticoagulant meant blood could be refrigerated and stored for a short time. But the technology was relatively untested. At the outbreak of the first world war, person-to-person transfusions were still common.

However, the large number of haemorrhage cases spurred army doctors to consider alternatives. One was US Captain Oswald Robertson who in 1918 described in the *BMJ*² how he had managed to store blood for up to 26 days to treat wounded soldiers on the western front. Meanwhile, Lieutenant Geoffrey Keynes, who served with the British Expeditionary Force (BEF), published an authoritative book on transfusion³ based on what he had learned during the war and worked with the Red Cross to establish the first blood donor service in London in 1921.

Following the civilian loss of life caused by bombing raids in the Spanish Civil War, particularly the savage aerial attack on Guernica in 1937, it was predicted, as the prospect of another war with Germany loomed, that the Luftwaffe would wreak havoc on British cities. In 1939, four large civilian blood centres were opened in London to deal with the expected demand. One

pioneering young doctor, Patrick Mollison, who was posted with the South London Blood Supply Depot, used the opportunity to develop a formula for storing blood for 21 days without the risk of bacterial contamination which was later used worldwide. As air raid casualties started to come in from 1940 onwards, he also studied the effects of different transfusion rates in resuscitation and sought to make the process safer for patients by testing and matching rhesus blood groups. Like Keynes, Mollison drew on his wartime experiences to write a definitive book in 1951, *Blood Transfusion in Clinical Medicine*, now in its 11th edition. Meanwhile, the success of Britain's wartime blood transfusion services led to the establishment of the National Blood Service in 1946.

Today, war continues to drive advances in haematology. In order to tackle the extensive blood loss caused by the improvised explosive devices (IEDs), US and British army field hospitals in Afghanistan have experimented with new transfusion procedures, employing plasma at an early stage to encourage clotting. These wartime discoveries are already being trialled in UK hospitals and could eventually transform the way civilian trauma patients are treated.



Reconstruction

Advances in battlefield medicine meant badly injured soldiers might survive the initial trauma but then had to face a life with terrible disfiguring injuries.

Early reconstructive treatment must have been excruciatingly painful and most would have been left with some remaining disfigurement, but the first world war army surgeon Harold Gillies represented the best hope of a normal life for many patients. He established a hospital in Aldershot to provide specialist care to those with severe facial wounds. One of the first to benefit was Walter Yeo, a sailor whose face was badly burned during the Battle of Jutland. Gillies used a technique called a tubed pedicle to transplant a flap of skin across Yeo's face and eyes, keeping the original blood supply intact to help prevent infection. By the end of the war, Gillies had treated around 11,000 patients⁴ using various materials including metal and bone to reconstruct shattered jaws and teeth.

The next period of rapid progress in reconstructive surgery came during the second world war. Moved by the plight of bomber aircrews and fighter pilots who were severely burned on the face and hands in crash landings, civilian surgeon Archibald McIndoe established a specialist centre in East Grinstead to treat and rehabilitate them. The name of the society formed by McIndoe's patients – the Guinea Pig Club – reflects the pioneering nature of the treatment he provided but innovations such as soaking wounds in saline solution to help the healing process, and his developing expertise and precision in techniques such as skin grafts meant some patients were even able to fly again.



Archibald McIndoe, pioneer of reconstructive plastic techniques. Inset left – one of his patients after several operations.

FEATURE

The contribution of Gillies and McIndoe and its recognition established a new kind of medical specialty but without the opportunities provided by war to develop their skills and test them on patients, it is doubtful such rapid advances would have been possible.

Regeneration

Today, the emotional and psychological effect of war on fighting men and women is widely understood but this was not the case during much of the Great War when soldiers who were apparently unable to cope were condemned for cowardice. Some 306 were executed by the British and Commonwealth military command.

One who did appreciate the trauma caused by the war was W H R Rivers, a medical officer at Craiglockhart Hospital near Edinburgh which successfully treated shell-shocked officers, most famously poets Siegfried Sassoon and Wilfred Owen. In a paper delivered to the Royal Society of Medicine on 4 December 1917⁵, Rivers argued the repression of traumatic wartime experiences was responsible for a range of physical symptoms, including insomnia, nightmares and facial tics. His theory that talking therapies could help soldiers acknowledge what had happened and find a way of addressing their fears remains central to the treatment of post-traumatic stress disorder today.

The first world war revolutionised the specialty of psychiatry which had previously been looked on with suspicion. In his 1919 book, *Psychiatry and the War*⁶, Rivers himself wrote of the difference he believed the conflict had made to his specialty: "Psychiatry will emerge from the war in a state very different from that it occupied in 1914. Above all it will be surrounded by an atmosphere of hope and promise for the future treatment of the greatest of human ills". It is equally true of other specialties.

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Spitfires and cataracts

As a surgeon at Moorfields eye hospital during world war two, Harold Ridley treated spitfire pilots who had plastic embedded in their eyes from the shattered canopies of their planes.

Ridley had been searching for an inert material which could be permanently implanted into the eyes of cataract patients to improve outcome of surgery. Noting that the plastic – polymethylmethacrylate (PMMA) – had not caused any inflammation in the pilots' eyes, he decided to use it to develop an intraocular lens (IOL).

After the war, Ridley became a consultant at St Thomas' hospital and it was there that he carried out the first IOL implant in November 1949. The surgery was initially controversial and Ridley was the target of criticism.

However, the technique and design of IOLs was perfected and the procedure is commonly used today. In later life Ridley became one of a few medical pioneers to benefit from their own discovery as he underwent successful cataract surgery.

Medico-legal issues in war zones

Many MDU members are military doctors. Their role in attending to the medical needs of the servicemen and women in their company can give rise to many of the same ethical dilemmas that affect civilian doctors, but in ways that will be totally unfamiliar.

Confidentiality

A serviceman or woman's physical and mental fitness will determine whether they can be deployed or carry weapons. As a uniformed officer, a military doctor may be torn between their duty of confidentiality to service personnel as patients and their duty to advise a unit's commanding officer of a soldier, airman or sailor's medical problems that impinge on the operational effectiveness or safety of the unit.

Consent

In war, stressful decisions have to be made instantly and in the heat of battle, consent to treatment may be an issue. But a military doctor's biggest challenge may come when treating enemy combatants, particularly if the patient can't provide informed consent to treatment – perhaps because of language problems, or if they feel under pressure to consent by the presence of an armed guard.

The MDU advises doctors in all medico-legal situations, including uniformed medical officers on operational tour overseas. The scenarios reported by military doctors are some of the most extreme we encounter.



Back issues

In recent years there has been a dramatic increase in the cost of claims arising from spinal surgery. In fact, claims notified by spinal surgeons have resulted in some of the largest awards for damages ever paid by the MDU. Dr James Armstrong, head of underwriting at the MDU, analyses MDU spinal claims arising in independent practice.

In the 10-year period of analysis, 180 claims were notified to the MDU relating directly to the management of spinal pathology by consultant neurosurgeons and orthopaedic surgeons.

The number of spinal surgery claims presently valued at close to, or exceeding, one million pounds is in double figures and, in several cases, the value exceeds this by a considerable margin.

However, this analysis relates only to known liabilities associated with clinical negligence claims. We have not included in the analysis files opened by the MDU during the same 10-year period that relate, for example, to patient complaints or adverse event notifications where no claim has been intimated. Our experience shows that a proportion of these are likely to evolve into claims in due course and so the eventual costs associated with the period of analysis may rise further.

The majority of the 180 claim files opened during this time have concluded, either successfully defended (47%) or settled in the claimant's favour (18%)

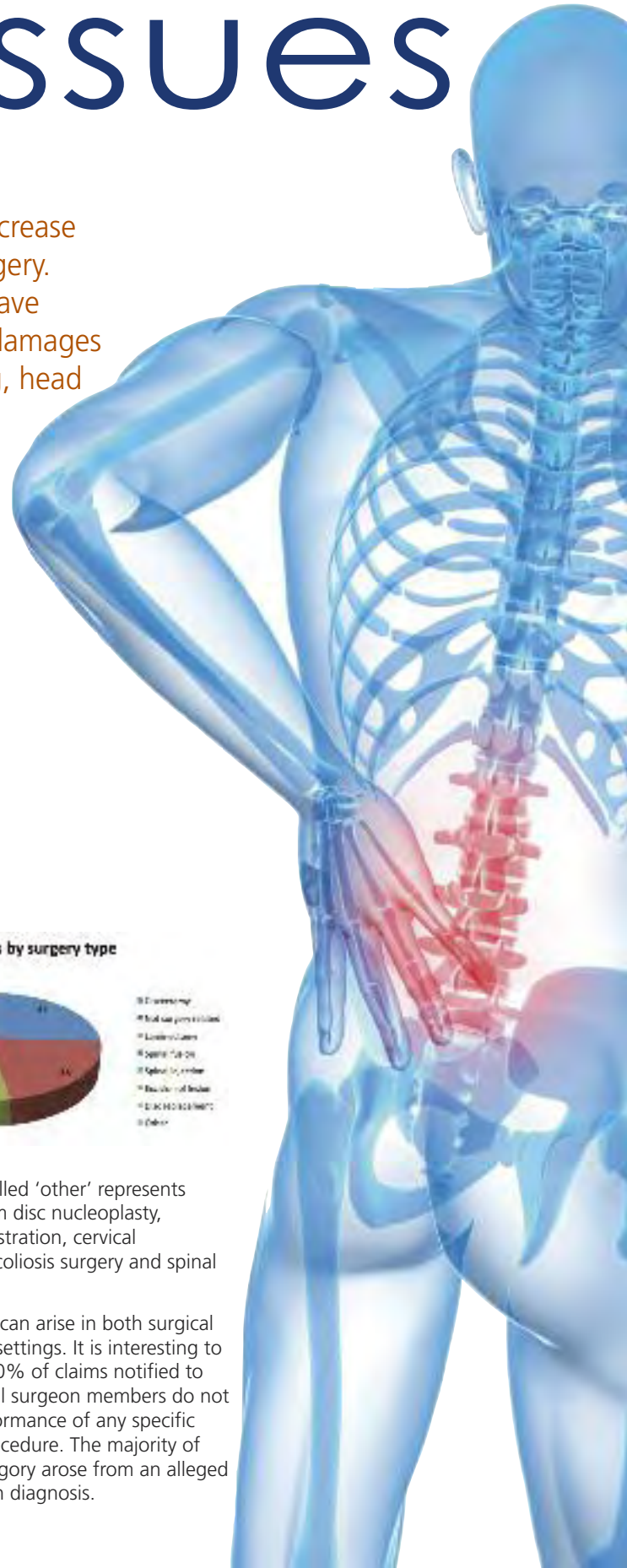
Surgical procedure

The distribution of the particular surgical procedures giving rise to the claims broadly corresponds with the frequency with which the various procedures are undertaken. For example, the relatively commonly performed discectomy and laminectomy feature prominently.



The category labelled 'other' represents claims arising from disc nucleoplasty, discography, fenestration, cervical decompression, scoliosis surgery and spinal implants.

The risk of claims can arise in both surgical and non-surgical settings. It is interesting to note that some 20% of claims notified to the MDU by spinal surgeon members do not relate to the performance of any specific spinal surgical procedure. The majority of claims in this category arose from an alleged failure, or delay, in diagnosis.



CLAIMS ANALYSIS

On what basis were claims pursued?

The majority of medical negligence claims will involve more than one alleged breach in the standard of care provided by the defendant. However, the primary allegation in each claim in this analysis has been identified.



In just under half of all cases, the primary allegation was that the surgery was not performed competently or with appropriate technique. The next most common allegation was delay or failure in diagnosis (discussed below), arising in 23% of all cases.

Around 10% of claims arose from an alleged failure to obtain consent. This often occurs where a known risk has materialised with the claimant later alleging that he or she would not have agreed to surgery had they been properly informed of that risk.

There was a higher than expected proportion of claims relating to alleged 'wrong site/wrong side' surgery. Nearly all of these cases related to a discectomy or laminectomy said to have been performed at the wrong level.

A small number of cases related to the discovery, some months or even years post-operatively, that an instrument had been retained in the patient following surgery (for example, a needle or scalpel blade). These claims are often pursued on the basis of *res ipsa loquitur* where, in simple terms, the claimant contends that the circumstances could only have arisen through a negligently performed procedure. In effect, the claimant hopes to establish a presumption of negligence which must be rebutted if the claim is to be defeated.

Delay in diagnosis

In cases where the alleged negligence related to a failure to diagnose, around 20% concerned an alleged delay in diagnosis and treatment of an infective process such as spinal TB or discitis, in some cases post-operatively. A similar proportion related to delay in diagnosis and treatment of cauda equina syndrome, while over 25% related to an alleged failure to diagnose another cause of nerve compression, with a particular preponderance towards a failure to diagnose disc prolapse.



Claims frequency and costs

It is notable that both the frequency (number) and severity (cost) of claims notified to the MDU by spinal surgeon members is increasing.

The number of claims notified during the second five years of the analysis period was some 22% greater than in the first five years while the number of members indemnified to undertake this work remained relatively static.

The cases settled in this period ranged in value from £10,000 to over £5million and there was a three-fold increase in average settled claim costs over the previous 10-year period.

Some of the very largest claims were notified by long-standing MDU members whose record was otherwise unblemished. This reflects the difficulty posed in setting subscriptions for specialties such as spinal surgery, where very large claims relating to procedures that took place many years before can materialise without warning.

Conclusion

This analysis demonstrates the substantial and increasing indemnity risk that spinal surgery presents, a situation that in all likelihood will continue into the future.

It is important to stress that the level of compensation awarded to a claimant is not related to the 'gravity' of alleged negligence, as punitive damages are not awarded in the UK for medical negligence claims. The lion's share of large settlements invariably relates to the cost of care for a severely damaged patient and/or the claimant's projected loss of earnings. Damage to the spinal cord may leave a patient severely disabled, unable to work and requiring long-term care yet with a near normal life expectancy.

'Missed' spinal fusion

A 40-year old solicitor with a 10-year history of back pain was referred by her GP to a spinal surgeon, an MDU member. The surgeon's notes of the consultation indicated that the patient had left-sided back pain radiating into her left leg. It was noted that she had undergone a spinal fusion at L5/S1 eight years previously.

CT and MRI scans showed that the patient had degenerative disc disease and, after undergoing discography, the patient was consented for a two level fusion at L3/4 and L4/5. The operation was uneventful and the patient discharged home.

Post-operatively, the patient experienced pain in her back and her leg symptoms persisted. She continued to see the surgeon over the following nine months and took time off work as the pain was difficult to manage. A number of conservative measures were undertaken before the patient underwent a further MRI scan. The MRI recorded a fusion at L4/5 and L5/S1. The surgeon immediately realised that there had been some confusion of labelling of the levels because of a variation of anatomy between the lumbar spine and the sacrum. The surgeon indicated the error and apologised to the patient.

However, the patient instructed solicitors to pursue a claim against the surgeon alleging that there was a negligent failure to extend the fusion to L3/4, as a result of which she suffered continuous pain in her back and leg. It was further alleged that she developed chronic pain syndrome and depression and that her physical symptoms were permanent.

The MDU obtained an expert opinion from a spinal surgeon. The expert advice confirmed that the initial decision to offer a spinal fusion at the level of the two abnormal discs above the previous fusion was appropriate, given the amount of pain that the patient was suffering. The expert went on to conclude that had the surgery been undertaken appropriately at the two levels, the patient's chances of improvement in her condition were 60%-75% and that the disability would be 50% of her current condition.

The surgeon, after meeting with the expert and a barrister, conceded that he had not appreciated that he had not fused up to the correct level, ie to L3/L4. He agreed with the expert that the patient would have done substantially better had the fusion been carried out appropriately. This was also the view of the claimant's expert.

The patient alleged that she was no longer able to work as a result of her problems and began a claim for compensation in excess of £1 million, the major part of which was claimed in respect of loss of earnings. The barrister instructed by the MDU advised that the patient would receive a substantial amount of compensation on the basis of premature retirement, albeit that allowance would have to be made for the likely impact of her degenerative disease in any event. After negotiation, the case was eventually settled for £300,000.

Manage the risk

Consent

The MDU offers the following advice for obtaining consent:

- Employ a two-stage consent procedure – at the time of the consultation and just before surgery.
- Advise the patient of the risks and benefits of the proposed procedure, including all major and commonly occurring minor adverse outcomes.
- Provide written information about the risk, wherever possible.
- Check the patient understands the risk, and assess for unrealistic expectations of the outcome.
- Document your discussions clearly.

Diagnosis errors

A failure or delay in diagnosis is a relatively common allegation in negligence claims but such claims are defended successfully more often than not. However, the MDU offers this advice to spinal surgeons:

- Read all referral documentation carefully.
- Record a thorough clinical history and examination, including relevant negative findings.
- Ensure that appropriate investigations, imaging and other tests are carried out, the results reviewed and action taken where necessary.
- Where a conservative approach to management is indicated ensure appropriate safety netting measures are put in place, including a follow up appointment where appropriate.
- Where a patient is unhappy with your suggested management plan consider offering and arranging a second opinion.

Wrong site, wrong side

- When referring to side, site or level on consent forms and operating lists, write in full, avoiding abbreviations wherever possible.
- Check the patient's referral letter against the clinical record, consent form and operation list to ensure they are consistent.
- The operating surgeon must be satisfied of the intended site, side or level of surgery before the patient is anaesthetised.
- Before surgery starts, take a moment to re-check the patient records and x-rays and images to satisfy yourself that no errors have crept in.

RISK MANAGEMENT



Between the cracks

The introduction of new shift patterns has created the potential for patients to 'fall between the cracks' at handover. Dr Udvitha Nandasoma, MDU medico-legal adviser, looks at the implications for doctors.

Over the past decade, changes to medical training, coupled with the impact of the European Working Time directive on working patterns, have had a fundamental effect on how acute medical and surgical care services are structured. Doctors in training working on the frontline will now more commonly work a night shift than a night on call and may be accessing patient records, checking test results or prescribing for patients when some distance away from the patient in question.

One thing that has not changed is the importance of an effective handover. This may be between individual doctors in different teams or on different shifts, or when transferring patients to another ward or sub-specialty.

Effective handover not only assures seamless care for patients but also provides a clear break in the line of responsibility for those handing over the patients. The implications of failed handovers are not, therefore, purely clinical but have important medico-legal considerations, too.

The handover process

A locum ST3 started work on a busy ENT ward. No one was available to provide an induction. At the end of the shift, she spoke to the nurses who confirmed there

RISK MANAGEMENT

was nothing else to do for the patients, so she went home. However, three patients had been admitted during the night to outlying wards as the ENT ward was full. As there were no handover notes, they were not reviewed by anyone from the ENT team the following day. One of the patients had been admitted with a nose bleed that had settled during the night but recurred the following day leading to the patient needing urgent assessment and a blood transfusion. The results of a clotting screen taken during the night had not been reviewed and were later found to be abnormal. The trust instigated a serious untoward incident investigation into the care provided both by the locum and the ENT team on duty the following day.

Clear guidelines for staff, including locums, on what is expected from the handover process and who should participate are essential. Although it is often junior medical staff who undertake the clinical handover, consultants and hospital management may be very important in ensuring the handover process is effective. They can create a culture where the importance of attending handover meetings is understood and ensures that, unless attending to an emergency, staff involved in handover are not disturbed.

Does your induction process cover the importance of handover to new staff and the policies and procedures in place in your trust?

Who is responsible?

A patient with abdominal pain and jaundice was admitted to the ward from A&E. Initially, the patient was reviewed by both the medical and surgical teams but a lack of communication resulted in each team thinking the other was responsible for his care. There was no clinical handover of the patient and it was another 24 hours before he was reviewed, at the request of nursing staff. The patient complained to the trust.

In times past, where a district hospital may have had a handful of consultant staff, there would usually have been no scope for confusion as to who was ultimately responsible for the patients' care. In larger hospitals, it is likely that the consultant on call will change during a single 24-hour period and it is very important that records are kept of who is on call and who is actively admitting patients.

In the main, this will be straightforward and coincide with the on-call rota but does your trust take care to record swaps and cover periods arranged between colleagues?

Appropriate documentation

Problems such as claims or complaints to the GMC often occur many years after the incident. Entries in the records such as 'consultant informed' can make it very difficult to establish what discussions took place and between whom.

While it would be impracticable to document the handover of each hospital patient, most handovers will require doctors to pass on information about patients who are yet to be assessed, or who require review, are particularly unwell or have the potential to deteriorate. Standard handover documentation has been suggested by the Royal College of Physicians in their Acute Care Toolkit¹.

The principles of such documents are to ensure that it is clear:

- which ward or unit the handover relates to
- who the outgoing and incoming medical staff were and who else was in attendance
- when the meeting started
- whether there were interruptions
- whether documentation was available that might allow subsequent audit of handover proceedings, should the handover process be challenged later.

The MDU is aware of cases where there has been confusion as to what was specifically required at handover – for example, that a patient be reviewed or merely that the incoming doctor should be aware of their potential to deteriorate. It may aid communication and clarity for the clinical team if patients specifically requiring clinical review by the incoming team are listed, with a brief note as to the reasons for the review and aims and limitations of therapy.

Additionally, specifying what outstanding results need to be chased up or investigations organised can avoid things being forgotten and allow clear allocation of tasks between team members and also provide a mechanism by which to ensure that the desired tasks have been completed.

Handing over complex cases

Handover of critically ill patients may just involve the exchange of clinical information, laboratory or imaging investigations and details of therapy. However, circumstances where the patient is at end of life, or where there has been a dispute or complaint by the patient or their family, can pose particular difficulties. Such issues may be exacerbated if there appears to have been any inconsistency between information provided to the family by different members of the medical team.

The risk of this is particularly high if doctors who have not previously been involved in the patient's care have limited knowledge of discussions between the normal clinical team and the family. It is therefore important to include such information in the handover process and it may be helpful to nominate a person of appropriate seniority from the incoming team to speak with the family if required to. Equally, communication of Do Not Resuscitate decisions, or similar limits to therapy, are important in avoiding unnecessary intervention and potential distress to a patient or their family.

Summary

Regular clinical handover is a reality of modern acute care and managing handover effectively is essential to the safe care of patients. There are many challenges to ensuring effective handover, not least the fact that where handover is most critical, for example on a very busy acute admissions unit, there will be many pressures on the participants. It is important in these situations not to allow clinical duties to vie for time with the handover process. Determining a culture of safe handover, where the process is a routine part of the on-call system, with appropriate documentation of discussions, can help if matters arise at a later date.

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FEATURE

The politics of defensive medicine in the United States



Defensive medicine has reached the political agenda in the United States. Susan Field reflects on the contentious arguments that tangle medical practice, finance and the law.

In June 2011, Republican Congressman Tom Price, introduced a Bill to 'end the practice of defensive medicine' which he said 'adds billions of dollars of unnecessary costs to our healthcare system and diverts doctors' focus away from delivering quality care'.

The Health Care OverUse Reform Today Act¹, which at the time of writing had been referred to the House Committee on Energy and Commerce's Sub-committee on Health for consideration, addresses what the Georgia Congressman sees as the 'distortion of the healthcare system caused by lawsuit abuse'. It proposes a new system of healthcare tribunals to hear cases before a claim could be filed with a State court.

As a qualified orthopaedic surgeon, Congressman Price might be expected to be uneasy about clinical negligence litigation but his is not a voice in the wilderness. In recent years, critics of the civil justice system have become louder and many advocates of tort reform in the United States claim doctors now carry out unnecessary and expensive tests and treatment to try to eliminate the risk of a frivolous negligence suit, inflating the cost of healthcare.

Are US doctors practising more defensively?

Those who claim tort reform will deny patients access to justice doubt the existence of defensive medicine, arguing that healthcare reform is desperately needed to address inefficiencies within the system.

Actual and perceived risk

One of the most recent studies into malpractice claims against US doctors showed that while there was a high risk of a malpractice claim, the majority of claims were discontinued or successfully defended. Published in the *New England Journal of Medicine* in August 2011², the authors examined claims data from a mutual professional insurance provider which had indemnified over 40,000 doctors between 1991 and 2005. They reported that across all specialties, 7.4% of doctors annually had a claim although only 1.6% resulted in settlement.

In high risk specialties such as neurosurgery and thoracic-cardiovascular surgery, 99% of doctors had received a claim by the age of 65, while in low-risk specialties such as psychiatry and paediatrics, the figure was 75%. In contrast, the risk of doctors actually having to settle a claim by this time was 71% and 19% respectively.

The authors contended: 'Although these annual rates of paid claims are low, the annual and career risks of any malpractice claim are high, suggesting that the risk of being sued alone may create a tangible fear among physicians'. This, they said, may explain why US doctors 'consistently report concern over malpractice and the intense pressure to practise defensive medicine'. They stressed however that the evidence is that 'the scope of defensive medicine is modest'.

But advocates of tort reform are in no doubt that defensive practice is widespread. Jackson Healthcare is a US company which provides healthcare staff, technology and services and runs the website defensivemedicine.org. In July 2010, the company published the results of a series of surveys of the medical profession in 'A Costly Defense: Physicians sound off on the high price of defensive medicine in the US'³. Its stated aim was to encourage 'physicians, patients, attorneys and legislators to work together to find a solution that eliminates defensive medicine practices, protects physicians from frivolous lawsuits, penalizes true malpractice and fairly compensates patients for negligent care.'

According to the study, 73% of those participating in a Gallup telephone poll (of

462 doctors) and 92% in the Jackson Healthcare survey (to which around 3000 doctors responded) said they had practised some form of defensive medicine in the previous year. In a separate survey of 8669 obstetricians (of whom around 700 responded), the respondents estimated that 38% of caesarean sections were carried out to avoid litigation. The company estimated the annual cost of unnecessary caesareans to be over \$5billion.

Others are unconvinced, suggesting that surveys of doctors about defensive practice have an inbuilt response bias. A 2011 report⁴ by the not-for-profit consumer organisation Public Citizen called *Defensive medicine: The Doctored Crisis* analysed 12 studies published since 1989 and found the evidence for defensive medicine was 'weak'. In one passage, the authors assert: 'Some defensive medicine exists. But even in high-risk scenarios involving specialties that are at the highest risk for litigation, defensive medicine appears to be responsible for only a very small percentage of medical decisions, most of which involve diagnostic testing. Moreover, many practices that some would call defensive may be sound exercises of medical caution and therefore should not be categorized as waste.'

But the believers' camp now has a powerful ally. In a speech about healthcare reform to a joint session of Congress on healthcare in September 2009⁵, President Obama remarked: 'I don't believe malpractice reform is a silver bullet, but I've talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs.' And in his State of the Union address of January 2011⁶ the President went further, promising: 'I'm willing to look at other ideas to bring down [healthcare] costs, including...medical malpractice reform to rein in frivolous lawsuits.' Unsurprisingly this pledge was greeted with scepticism by Republicans, for whom tort reform is a high priority and with dismay by consumer organisations and trial lawyers, many of whom are aligned with the Democrats. Both sides continue to dispute the need for change and its potential to reduce the country's healthcare budget.

A political issue

In the United States at least, it seems the issue of defensive medicine has become entangled in a wider party political debate about tort reform and the cost of healthcare. Of course, the MDU cannot comment on the rights and wrongs of the US health or legal systems but we are

regularly asked about whether defensive practice exists in the UK, often in response to reports about 'compensation culture'.

Clearly, doctors will always be concerned about the possibility of a claim or a GMC investigation but in our view the label defensive medicine is perhaps a red herring. Medicine is not an exact science: one doctor may make a clinical decision to refer a patient while another may decide to watch and wait in circumstances where either course is reasonable. Even treatment provided by doctors who say they knowingly practise defensively may not be seen as out-of-the-ordinary by their colleagues.

If there is no benchmark for what is defensive practice, how can it be measured? So much depends on the individual clinician's examination, the patient's history and even the patient and the doctor's view of the balance between risks and benefits. In the US, as much as in the UK, it's tempting to conclude that defensiveness is in the eye of the beholder.

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ADVICE LINE DILEMMA



Assessing a patient's testamentary capacity

The scene

A consultant physician received a letter from solicitors asking her to comment on the testamentary capacity of a former patient.

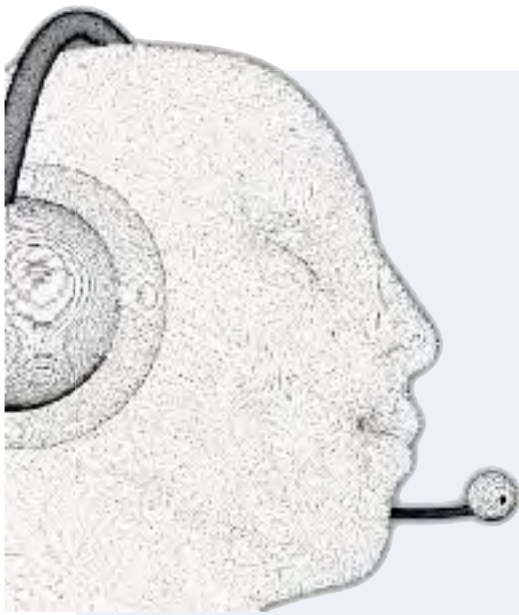
The patient had recently died and her son was disputing the will. The solicitor's letter explained that the patient was a wealthy woman with considerable assets. She had made a will 20 years ago, after her husband had died, in which she left her entire estate to her son. She met a new partner only two years before her death. Subsequently, she made a new will naming her new partner as her sole beneficiary. Her son was challenging the validity of the new will, alleging that his mother lacked capacity when she made it.

The patient's clinical records showed that she suffered with Alzheimer's dementia and asthma and that she had been discharged from hospital following an asthma exacerbation approximately five days before changing her will. The consultant had also seen her several times

in the out patient department subsequently. The solicitors asked the consultant specifically whether she believed the patient had testamentary capacity at the time she changed her will.

The consultant saw that during the patient's admission the notes referred to discussions about 'Do Not Attempt CPR' and that she had documented the patient had capacity to make this decision. She recalled that the patient had been generally well-orientated when seen in out patients and also how happy the patient had been about her new relationship. She was therefore keen to reply to the solicitors and confirm that she believed the patient did have testamentary capacity but, before she did so, sought advice from the MDU medico-legal helpline.

ADVICE LINE DILEMMA



The advice

The MDU medico-legal adviser (MLA) explained a doctor's legal and ethical duties when commenting on a patient's testamentary capacity. First, the doctor must have an understanding of the legal meaning of 'testamentary capacity' as well as knowledge of their role in assessing a patient's capacity. Second, they should bear in mind the GMC's ethical guidance that they must recognise and work within the limits of their training and competence¹ and that any reports they produce should not be misleading².

The case of *Banks v Goodfellow* sets out what a person must understand in order to make a will. That case concerned a patient with delusions who passed his sizeable property estate to his teenage niece. The case established that the testator should:

- understand the nature and effect of making the will
- understand the extent of the property of which he is disposing
- appreciate the claims (i.e. the potential beneficiaries) to which he ought to give effect.

The test for whether a patient has capacity with regard to the above decisions has effectively been restated in the Mental Capacity Act 2005. Under the Act, a person lacks capacity if they fail one of the following criteria:

- (a) Understanding the information relevant to the decision.
- (b) Retaining the information (even if only for a short period).
- (c) Using or weighing that information.
- (d) Communicating the decision (by any means).

The test is slightly different in Scotland, where the Adults with Incapacity (Scotland) Act 2000 specifies that people

over the age of 16 lack capacity to make a specific decision if they are incapable of:

- acting
- making decisions
- communicating decisions
- understanding decisions
- remembering a decision.

In this particular case, the MLA advised, as the consultant did not make a specific assessment of testamentary capacity at the time she saw the patient, she would only be able to provide general observations based on the clinical records. She could include her recollection of the patient at the time. The doctor may be able to provide a factual report that could assist the solicitor in assessing whether the patient had the requisite capacity but may not be in a position to confirm testamentary capacity to the solicitors.

She was also referred to other resources regarding assessment of testamentary capacity, including The British Geriatric Society guidance entitled The British Geriatric Society Guidelines on Capacity and Testamentary Capacity⁴ and the BMA and Law Society's joint booklet entitled Assessment of Mental Capacity, Guidance for Doctors and Lawyers⁵.

Manage the risk

When considering testamentary capacity, the MDU advises doctors to:

- Only assess testamentary capacity in relation to a particular will.
- Consider whether you feel competent to assess testamentary capacity. If not, then you should not do so, as the GMC requires doctors to recognise and work within the limits of their competence.
- Clearly document all assessments and opinions, including the identities of any other people present at the time.
- Be careful not to equate the presence of psychiatric illness with an absence of testamentary capacity.
- Ensure patients understand the implications of making a will, including that it can be revoked.
- Ensure both you and the patient have a broad knowledge of the extent of the property in the will, although not necessarily the precise value. This is required for the patient to have made the will and for you to assess their capacity.
- Consider whether the patient has the ability to recognise the number and nature of likely claims on his/her estate.
- Consider seeking a second opinion (or advise the patient or his/her solicitor to do so) if you are unable to form a view as to the patient's testamentary capacity.
- Remember that if you witness a will, it may be inferred that you have made a formal assessment of the patient's testamentary capacity.

If you haven't assessed a patient's testamentary capacity and are then asked to provide an opinion

retrospectively, you will probably only be able to provide factual information from the patient's clinical records. You could include any recollection regarding the patient's capabilities at that time.

Finally, you are under no obligation to speculate on the patient's testamentary capacity at a particular point in the past.

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FEATURE

Olympic heights



On racing form: Dr Roger Hackney

In the build-up to the greatest sporting show on earth, one consultant orthopaedic surgeon and MDU member recounts how he competed for Team GB in three Olympic Games, while pursuing a successful career in medicine.

It was only chance which made Roger Hackney take up the steeplechase. 'I had entered the 1500m at the County Championships when I was 16,' he explains, 'but then it turned out there were only two competitors in the steeplechase so I thought I might as well give it a go as I would get a medal. And I won.'

By chance, he had chosen one of track and field's most challenging events – a 3000m course in which runners must clear 28 fixed barriers of nearly a metre high and seven 3.5m-wide water jumps. Mr Hackney himself describes the race as 'gruelling'.

However, his desire to become a doctor was equal to his love of running. Determined to pursue both, he elected to study medicine in Birmingham which had an excellent reputation for sport. He regularly clocked up 80-100 miles a week in between his morning attachment and afternoon lectures. He then joined the RAF which also had a strong record of supporting athletics, spending all his annual leave training and competing.

1980 was a golden era for British athletics. Still a medical student, Mr Hackney qualified for the Moscow Games, and reached the semi-final. He vividly recalls watching Alan Wells win gold in the 100m and fierce rivals Steve Ovett and Sebastian Coe compete in the 800m and 1,500m final.

In 1984, he reached the final himself although he remembers being more relieved than elated. Eventually, he found the heat and humidity in Los Angeles too much. He again reached the semis at the 1988 Seoul Games but was struck down by a

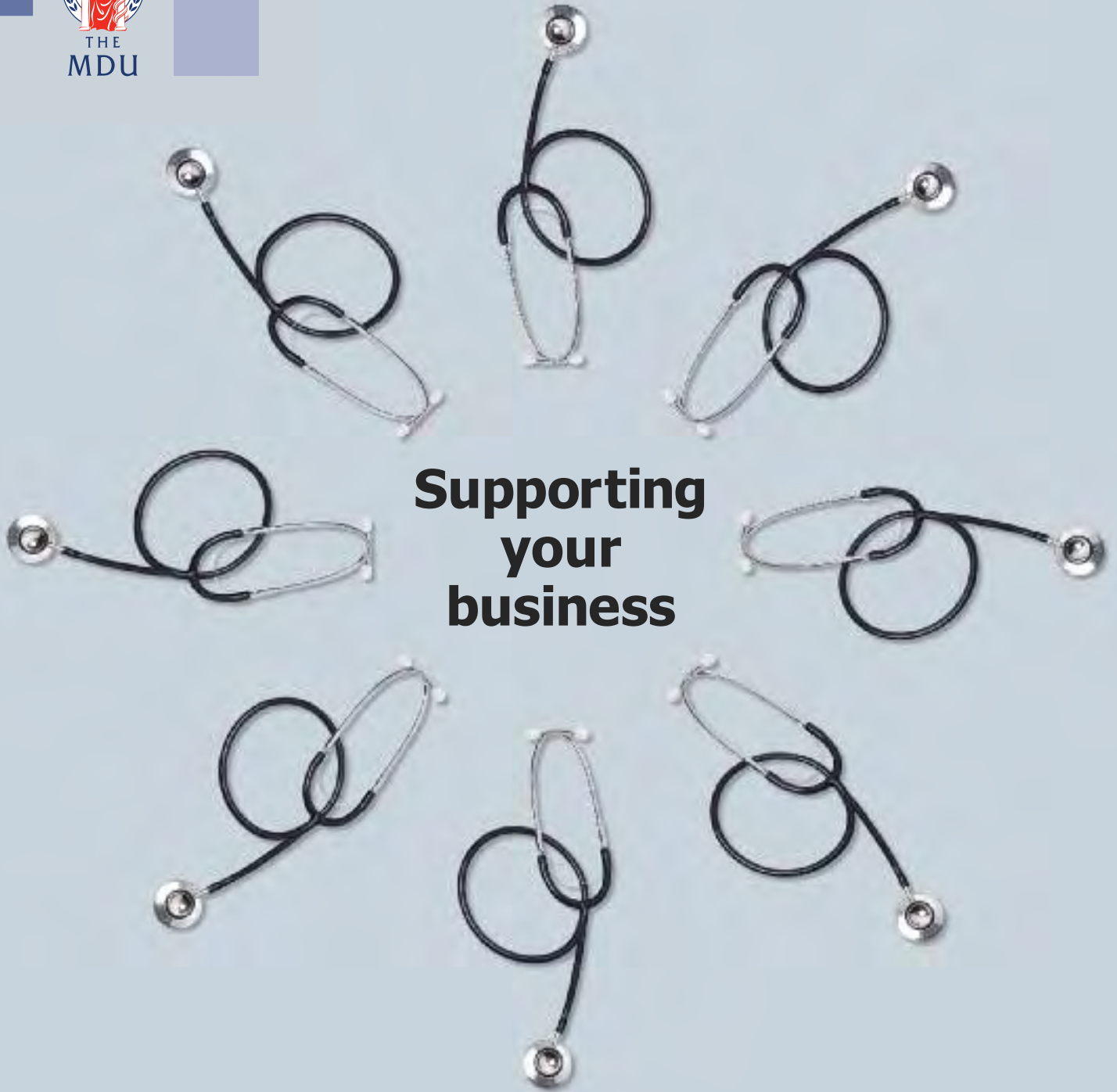
debilitating virus which meant he was unable to finish the race.

Despite achieving his best ever time in 1988 (which places him sixth in the UK all-time greats list for his event), by this time the demands of medicine and athletics were starting to conflict. 'By my early 30s, I was running well but many of the people winning medals in British athletics had given up work to train full-time. In contrast, I saw my future as an orthopaedic surgeon and I needed to pass my exams to stay in surgery.'

While he no longer competes, Mr Hackney retains a special interest in sports trauma and is President of the British Orthopaedic Sports Trauma and Arthroscopy Association which hosts the World Sports Trauma Congress later this year.

Sadly, he believes it would be virtually impossible for today's medical students to follow in his Olympian footsteps because there are few jobs which don't involve shift work. He recalls doing one house job and then running home from the hospital late that night: 'I felt so tired that I could easily have lain down in the road and fallen asleep. I couldn't have done that for long – you really need the training and recovery time to do well.'

Looking ahead to the London Games, he has tickets for table tennis and is relishing the prospect because it is the first time he will see another sport live at the Games, so focused was he on his own event. 'Of course, I'm looking forward to the athletics too,' he adds, 'but I'm sure part of me will really miss being out there.'

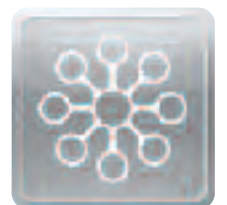


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