Someone to watch over me
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In 2013, the stream of recommendations, regulations and quality measures that emerged appeared unstoppable – increased rigour in health and social care inspection, an extended list of ‘never events’, a duty of candour on organisations, and far more. The year closed with news of proposals to introduce a criminal sanction when an individual or organisation is found to be ‘unequivocally guilty of wilful or reckless neglect or mistreatment of patients’.

The Berwick Report, alongside recommending criminal culpability for wilful neglect, called for a low-blame culture. The government has responded by saying that it wants to foster a learning culture where mistakes are analysed and put right. Jeremy Hunt is looking towards a future ‘which learns the lessons of Mid Staffordshire so that NHS patients can confidently expect all the care they receive to be safe, effective and compassionate.’ No doctor would argue against that, but is the excessive regulation that now overwhelms the medical profession the best way to achieve those aims?

Why would yet more regulation and creation of new sanctions facilitate a culture of greater protection for patients? The inference is that these measures are necessary because many doctors are incompetent, or worse. Take for example, the suggestion that doctors seek to cover up errors. There is no evidence to support the notion of a lack of candour when things go wrong. Yet there is now a contractual, and will soon be a statutory, duty of candour. Why are they necessary? It is envisaged the doctor will usually be the first to talk to the patient: but doctors already have such a duty. The MDU is very often the first port of call when something goes wrong. Doctors contacting us know they need to talk to patients and provide a clear explanation and apology, and that is what they do.

It is time to stop and question just how useful regulation upon regulation actually is to patient safety. If something goes wrong, a doctor may spend time trying to work out if the incident is serious enough to qualify for reporting under the contractual and statutory duty. Better surely, no matter how serious the incident, to tell the patient as soon as possible, to explain and to apologise. Whatever the incident, it will matter to the patient and doctor, and that is the crux of it.

The same applies to ‘never events’. Anything that goes wrong will be serious to the patient. Isn’t time better spent learning from all adverse incidents than concentrating on those that are categorised as never events?

At the heart of this lie the basic ethics of patient care. Every doctor is in practice to protect patients. That is, acting in the patient’s best interests at all times, providing excellent clinical care within the limits of your ability, and communicating appropriately and well.

It is also about professional and personal accountability. If an error is your responsibility, then you will rightly be held accountable. Multiple channels exist to ensure accountability and any doctor who has experienced a claim for clinical negligence or a complaint to the GMC, for example, will attest to just how painful that is.

Between the operational complexities of the NHS, the tendency to try and legislate for every perceived gap in care, the encouragement of complaints or claims if something goes wrong, not to mention the power of the press to ignite the public’s antipathy towards doctors, something has been overshadowed. That medicine is about treating patients and ensuring their best interests are protected.

Regulations and recommendations seem designed to exacerbate the detrimental culture of fear and blame. It would be better to focus on doctors’ vocational imperatives. To protect patients we would be better to let professionals do what they have been trained to do, and give them the right resources to do it.

Dr Christine Tomkins
Chief executive
Technology now makes it possible to record nearly every aspect of our daily lives. But what about situations when we traditionally expect privacy? MDU adviser Dr Udvitha Nandasoma examines the law and ethics of recording in a medical setting.

A life on camera used to be the glamorous preserve of celebrities. No longer. There are now up to 5.9 million CCTV cameras recording public life in Britain, including 750,000 in “sensitive locations” such as hospitals and care homes.

For anyone who wants to capture the world around them, from ‘life loggers’ to citizen journalists, the technology is increasingly accessible, portable and convenient. The latest innovation is Google Glass, a wearable hands-free computer that has been trialled in medical applications, including live-streaming operations as a teaching aid for medical students.

There has been growing debate about the value of using cameras to capture interactions between members of the public and those in positions of power or authority, including the police and healthcare workers. In October 2013 for example, the Care Quality Commission’s Chief Inspector of Adult Social Care, Andrea Sutcliffe, called for a debate on the deployment of...
For doctors, the overriding need to maintain confidentiality and preserve a relationship of trust with patients means you cannot afford to ignore the legal and ethical obligations of introducing cameras.

Crime watch
The most common reason for hospitals and private clinics to install cameras in public areas is to help prevent or detect crime. But even here you need to be confident that CCTV is a necessary and proportionate response, record your reasons and regularly review this decision.

CCTV images of patients are considered sensitive personal data which means you must abide by the Data Protection Act 1998 and follow the relevant national guidance. In June 2013, the government published a Surveillance camera code of practice under the Protection of Freedoms Act 2012. The Code currently applies to local authorities and the police in England and Wales, but other users of surveillance camera systems are encouraged to adopt it voluntarily.

It is intended to be used alongside the detailed CCTV Code of Practice published by the Information Commissioner’s Office (ICO) in 2008. This says that CCTV should only be installed for a specific purpose such as crime prevention; signs should be prominently displayed which clearly warn visitors and staff that surveillance equipment has been installed; and recorded images should be stored securely and not be retained for longer than strictly necessary.

If you need to disclose CCTV footage to the police you must comply with the GMC’s guidance Confidentiality (2009) which states that personal information may be disclosed in the public interest without consent ‘if the benefits to an individual or to society of the disclosure outweigh both the public and the patient’s interest in keeping the information confidential’. Doctors are expected to balance the likely harm that might arise from non-disclosure of information against the possible harm to the patient from disclosing it. You should also consider the effect on your relationship with the patient of doing so.

If you are considering disclosure in the public interest, consent should be sought, unless it is not practicable to obtain, especially if that would undermine the purpose of the disclosure, such as investigation of a serious crime. We advise you to consider every disclosure decision on its own merits, and to check with one of our advisers if you are unsure.

It’s important to ensure the cameras fulfil your intended purpose so seek professional advice about the most appropriate surveillance technology, the location of cameras, facial recognition, time/date stamps etc. Ensure any contract includes guarantees about data security and patient confidentiality.

We also recommend asking your data controller to produce a CCTV policy covering the installation of cameras, the safe storage of images, retention periods, disclosure and what to do if a person requests any footage you have recorded of them by making a subject access request.

Consultation-cam
While CCTV in public areas is commonplace, actually recording consultations or treatment is still relatively rare, not least because it presents significant ethical difficulties.

In Making and using visual and audio recordings of patients (2011), the GMC distinguishes between recordings made as part of patient care and those made for secondary purposes such as teaching or research.

You are expected to obtain patients’ specific consent to make a recording that forms part of your investigation or treatment of a condition or contributes to a patient’s care. There are some exceptions to this requirement for specific consent. These include where the images are of internal organs and structures and where taking images is an integral part of the procedure, such as x-rays, ultrasound or endoscopic
images. It is important that you make sure patients understand the purpose of the recording, what form the recording will take, the arrangements for secure storage, and (where practicable) any possible secondary uses in anonymised or coded form.

Consent must always be sought, ideally in writing, before making new recordings for secondary purposes such as teaching or research. You should explain to your patient that they can withhold or withdraw consent at any time without any implications for their care. The requirement to obtain the patient’s express consent remains even if you consider that you will use the images in a manner that means that the patient will not be identifiable.

Covert recordings can only be made in exceptional circumstances with appropriate legal authorisation “where there is no other way of obtaining information which is necessary to investigate or prosecute a serious crime or to protect someone from serious harm”. There are also specific legislative requirements that can apply to the making of covert recordings and any practitioner considering taking this step is encouraged to speak with their employing body and the MDU.

Any recording you make should be considered part of the patient’s records. This means you may be ordered to disclose it in the event of a complaint, claim or some other formal investigation and that patients have a right to make a subject access request under the Data Protection Act 1998. The ICO and the Care Quality Commission (CQC) expect organisations to have a consistent approach to subject access requests from patients or their representatives, including your charges for an electronic copy (a maximum of £10). The ICO has recently published a code of practice6 on this subject but you can also contact the MDU advice line if you have specific concerns.

Not so candid camera

As we have seen, there are regulations and ethical considerations concerning the use of cameras by doctors but with the proliferation of smartphones and digital cameras, patients themselves increasingly have the means to record consultations. Some may do so surreptitiously, which can be a disquieting experience.

But while the prospect of a patient recording you may be disturbing, it may also be to your advantage. It has been estimated that patients immediately forget between 40% and 80% of the medical information provided by their doctor and almost half the information they do recall is incorrect5. Even if patients try to take notes, they might not be able to take down everything accurately. They may be too busy writing to ask questions or get the reassurance they may need.

Consultant urologist Christopher Eden had no objection to a patient recording a consultation on his smartphone.

He recalled: “I was discussing the ramifications of various surgical options. There were facts, figures and side-effects to digest. By filming me, it meant [the patient] could do this in the comfort of his own home and weigh up the effects to digest. By filming me, it meant [the patient] could do this in the comfort of his own home and weigh up the options at his own pace.”

It’s also worth bearing in mind that the GMC expects you to “give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients’ language and communication needs” (paragraph 32, Good medical practice, 2013).

Of course, you would generally expect patients to ask before unleashing their smartphone. However, it may surprise you that patients do not need their doctor’s permission to record a consultation provided that the recording is for their personal use only.

If you suspect that a patient is covertly recording, you may be upset by the intrusion but it would not normally justify refusing to treat the patient. And remember that if you refuse to continue with the consultation, this might be caught on camera too.

If you are concerned that the patient’s actions are a sign that they do not trust you, you may want to discuss this with them openly.

A more pragmatic (and disarming) response might be invite the patient to record the consultation openly and ask them whether you can have a copy of the recording which can then become part of the patient’s own medical records.

In seeking their consent to this you should reassure them that the recording will be stored securely by the practice and only used for this purpose.

Finally, be aware that recordings of consultations, even those made covertly, have been admitted as evidence of wrongdoing by the GMC and in court. However, they can also prove that the doctor has acted ethically and professionally.

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Gold standard service

The MDU’s membership team strives to provide a gold standard service to members.

To find out what members think of the service they receive, we set up an online quarterly satisfaction survey in 2012. The results have been very encouraging. Since the survey began, 92% of respondents have been either ‘satisfied’ or ‘very satisfied’ with our service, and 89% would recommend the MDU to their colleagues.

Members can contact us via email, letter, fax and website, but many prefer to call. We know how busy you are, so we make sure we answer at least 80% of calls within 20 seconds. Over 98% of respondents are ‘satisfied’ or ‘very satisfied’ with our call answering times.

They also had some very positive things to say about the service they went on to receive. Here is a selection of comments.

“Staff over the phone were very warm and helpful. I felt the MDU really cared about my membership and practice.”

“Absolutely wonderful, considerate, polite and professional service – well done!”

“Every time I have dealt with the MDU I have been very impressed with the service I have received and feel that it is money well spent.”

“Wonderful service throughout my career since 1953!”

We continue to strive to improve our service and ask for your feedback on how we’re doing.

FFLM Diploma in Legal Medicine

The Faculty of Forensic and Legal Medicine (FFLM) has introduced a new qualification for anyone with an interest in legal medicine, but who doesn’t meet the strict entry criteria for the Faculty of Forensic and Legal Medicine’s MFFLM qualification.

The Diploma in Legal Medicine is open to all. The FFLM envisages this might include medical and nursing examiners; clinical risk managers; expert witnesses; forensic nurses, paramedics and psychiatrists; coroners; responsible officers, and many others interested in legal medicine.

Successful candidates will gain the post-nominals DLM, although the qualification will not entitle them to undertake specific forensic or legal medicine work. Registered doctors who gain a distinction will be exempt from the first part of the MFFLM.

The qualification was developed by the FFLM, with input from the MDU and other medical defence organisations. Dr Caroline Fryar, MDU head of advisory services and lead examiner for the diploma, says, ‘The examination broadly reflects the first part of the MFFLM and is designed to allow candidates to demonstrate an excellent grounding in the principles of legal medicine.’

The first examination will take place in June 2014 and the closing date for applications is 2 May. For details on applying, fees and an optional online training package, visit www.fflm.ac.uk

NHSLA guidance on apologising

Fifty per cent of patients just want an apology when they have suffered harm as a result of their healthcare, according to new guidance for trusts from the NHS Litigation Authority (NHSLA).

Saying Sorry stresses the importance of openness with patients and apologising verbally as soon as possible after the incident comes to light, followed by a written apology. This should happen, the NHSLA says, regardless of whether the patient has or is planning to complain or bring a claim.

The guidance echoes advice the MDU has given to members for many years on apologising and emphasises that saying sorry is not an admission of liability.

We’d like to hear from members who turned a patient complaint into a patient compliment.

Complaints can turn out well when handled appropriately, with no lasting harm to the doctor-patient relationship. Did your patient appreciate your response and understand what happened to give rise to the complaint? Did you win their praise for your openness and sincere apology?

Perhaps you changed your practice as a result of the experience?

If this has happened to you, please let us know. We would like to publish stories about the flip side of patient complaints in future MDU Journals.

Send your anonymised story to feedback@themdu.com

We look forward to hearing from you.
Indemnity and the portfolio career

Doctors are increasingly ready to take on new challenges alongside their day-to-day practice. Dr Thom Petty explains how the MDU can support members who opt to pursue a portfolio career.

The concept of a portfolio career has been a slow-burner in medicine, perhaps because of the duration of medical training. But today’s doctors are increasingly ready to follow the advice of influential US surgeon, writer and public health campaigner Dr Atul Gawande: “It turns out you can be a doctor and be almost anything else.” Thom Petty, former anaesthetist and now deputy head of underwriting at the MDU, reflects, “The profession’s culture is changing and more doctors are breaking out of traditionally-defined specialties and pursuing varied careers. In some cases, their choice stems from existing interests, such as keen amateur athletes who diversify into sports medicine. "Training in non-surgical cosmetic procedures such as dermal fillers is now more widely accessible so non-specialists are increasingly interested in working in this area. At the same time, patients themselves have become more proactive in researching treatment options online and selecting clinicians who meet their requirements, rather than waiting for a recommendation or GP referral."

Thom understands the drive to diversify. He qualified from the University of Edinburgh and, before joining the MDU, practised as an anaesthetic registrar in Bristol for over four years. Also an enthusiastic pianist and composer, he trained at the Royal Northern College of Music Junior School and more recently
“Take non-invasive cosmetic treatments, for example. On the surface, these may appear to be relatively innocuous procedures, but there are recognised risks and complications — such as intravascular injection of dermal fillers, nerve palsies, localised bleeding and haematoma. Doctors may also find that patients’ expectations are extremely high and satisfaction with the end result can be very subjective. We have seen numerous complaints, complications and clinical negligence claims arising from these types of procedures.”

Of course, there is no reason why a doctor who is trained, competent and who has taken the necessary risk management precautions cannot branch out into new ways of working but they must ensure they are appropriately indemnified. This is where Thom and his colleagues in the MDU underwriting team come in.

Thom stresses that the underwriting team has to strike a very careful balance. “Our duty is to support individual members who want to develop the scope of their practice, while not exposing the MDU’s funds to unexpected financial risks, in the interests of the membership as a whole. The underwriting team assesses the clinical and indemnity risk presented by emerging and evolving specialties and the working arrangements of our members on an individual basis.

“These are often complex decisions but it’s essential to adopt a balanced approach and agree to take on appropriately managed risks adequately reflected in any additional subscription levied.”

Operating at the heart of the MDU, the underwriting team liaises with the advisory, claims and membership teams so that members who contact us about their indemnity requirements receive the best possible service. In many cases, Thom or one of his colleagues will speak directly to the members and they aim to give a response as quickly as possible.

Thom explains: “The job requires us all to think carefully because members’ work circumstances are considered on a case-by-case basis. Before agreeing to extend the benefits of membership for a doctor wanting to undertake cosmetic work, for instance, we ask for evidence of the courses and training they have undertaken. The MDU has to evaluate and constantly reassess the risk that we accept on behalf of all our members and that means asking the right questions.

‘As we are a mutual defence organisation owned by our members, we are careful to manage the new and existing risks to which members’ funds are exposed. For example, while the MDU may indemnify members from claims arising from patients who are elite, professional athletes, we took a view some years ago that the benefits of membership are unlikely to extend to claims from other third parties such as football clubs, agents or sponsors as this could potentially expose the mutual fund to claims for commercial losses running into tens of millions of pounds, which would not be in the interests of the generality of our members.”

Online consultation services are another developing area, he says. “There are a number of factors we look at when assessing potential risks associated with providing online clinical services, including the location of the patients (who may not be UK-based), the range of services provided and the qualifications and experience of the clinical team involved.”

Thom also points out that doctors who want to expand their scope of practice must remember their responsibilities to patients. “Even if the types of treatment they are providing are also available from non-clinicians, it’s important to ensure that doctors still fulfil their obligations as outlined by the GMC, especially when it comes to areas such as record-keeping, confidentiality, follow-up, continuing professional development and the consent process.”

In his two years at the MDU, Thom has seen the popularity of portfolio medical careers among GPs and hospital doctors gain momentum and he believes the trend will continue as doctors take advantage of the opportunities provided under commissioning, as well as the growing possibilities offered by new technology.

“In the end, it’s all about balance,” he concludes. “Doctors should be able to enjoy a rich and varied medical career, providing they continue to meet the GMC’s professional standards. It’s the MDU’s role to support our members, while safeguarding the interests of the organisation and our wider membership.”
Few consultants would consider carrying out an intimate examination without a chaperone. Dr Sally Old, MDU medico-legal adviser, explains current best practice in the use of chaperones.
Chaperone is a decorous term, reminiscent of the propriety and mores of another age. In today’s medical practice, though, the presence of an impartial chaperone during intimate examinations can provide both protection and reassurance for patient and doctor alike, and regardless of the gender of either.

The latest GMC guidance *Intimate examinations and chaperones* (2013) says that doctors should offer the patient the option of a chaperone wherever possible before conducting an intimate examination. The chaperone should usually be a trained health professional; friends or family members are not regarded as impartial. However, doctors should comply with ‘a reasonable request’ to have them present as well as a chaperone.

Guidance advocating chaperone use has also been published by other professional organisations, including the Faculty of Sexual and Reproductive Healthcare at the Royal College of Obstetricians and Gynaecologists and of course, the MDU.

**The chaperone’s role**

A chaperone’s principal responsibility is to protect patients from abuse. But they can also reassure or comfort patients during examinations that they might find embarrassing or distressing.

This is reflected in the criteria listed by the GMC which says that doctors must be satisfied that their chaperone will:

- be sensitive and respect the patient’s dignity and confidentiality
- reassure the patient if necessary
- be familiar with the procedure involved in a routine intimate examination
- stay throughout the examination and be able to see what the doctor is doing, and
- be prepared to raise concerns about a doctor’s behaviour or actions.

The presence of a chaperone during intimate examinations may also help protect doctors themselves from false allegations of abuse.

Even so, the MDU is aware of cases where doctors have been accused of unprofessional conduct or sexualised behaviour by patients despite the presence of a chaperone. For this reason, we strongly advise members to document both the presence of a chaperone and their identity (name and full job title rather than a generic phrase such as ‘duty nurse’) in the records, in line with the GMC’s guidance.

If an accusation is made several years later and there is no record of who acted as chaperone during the examination, the likelihood of the doctor remembering the name of this crucial witness is slim.
Do you need to offer a chaperone?

Doctors routinely offer patients a chaperone before conducting an intimate examination but the circumstances in which a chaperone is required may extend beyond those which might conventionally be considered ‘intimate’ examinations, such as when the needs of the specific patient require it.

For example, for particularly vulnerable patients or those who have been the victims of abuse, it might be appropriate to offer a chaperone for other examinations too. The GMC says this could go beyond an examination of the genitalia, rectum or breasts to include “any examination where it is necessary to touch or even be close to a patient”. In these circumstances, doctors will be expected to use their professional judgment about whether a chaperone should be offered, depending on the patient’s previously expressed views and level of anxiety.

There may also be a misconception among some doctors that male patients do not require a chaperone. In fact, the gender of the doctor and the patient is irrelevant to whether a chaperone should be offered. The MDU’s experience is that while most allegations of indecent assault are made by female patients against male doctors, this is not always the case and we have seen cases that involve other gender combinations.

A 2010 study canvassed the views of over 200 consultants from a range of specialties on the role of chaperones. All would request a chaperone when performing female intimate examinations, but when it came to male patients, 90% of genito-urinary doctors requested a chaperone compared with 39% of colorectal surgeons and only 28% of urologists.

The authors acknowledged previous studies which found male patients are less comfortable with the presence of a chaperone and suggested that the predominantly male consultants and male patients in urology may explain why a chaperone was considered unnecessary. However, as the report points out this is contrary to the GMC’s view that doctors should give patients the option of having a chaperone present, whether or not they are the same gender as the patient. In short, the patient should have the opportunity to decide.

Examination without a chaperone

For many patients, the offer of a chaperone is a sign that their doctor respects them. But that response is not universal. Many are adamant that they do not want another person in the room while they are being examined. However, this can leave the doctor in an uncomfortable position, especially if the patient has behaved in a sexualised way.

The MDU is regularly asked whether doctors can refuse to conduct an intimate examination without a chaperone. In these situations, doctors should follow the GMC’s guidance and explain why they would prefer a chaperone present. An alternative would be to refer the patient to a colleague who would be prepared to proceed without a chaperone but the patient’s clinical needs must take precedence and this approach would not be appropriate if the delay would adversely affect the patient’s health. If they go ahead with the examination without a chaperone, the doctor should make a note that one was offered but the patient declined.

The same option to delay non-urgent examinations applies if a patient wants a chaperone but no one is available, or they are simply unhappy with the choice, for example if they will only accept someone of the same gender. However, asking a patient to return another time could make them feel under pressure to proceed without a chaperone to avoid the inconvenience; cause an anxious patient distress; and perhaps prompt a complaint. This explains why it is preferable for trusts to publish a chaperone policy which covers these situations, helping to manage patients’ expectations and encouraging them to make their wishes known at an early stage so it is easier to meet their needs.

Maintaining boundaries

For many specialties, intimate examinations are part of day-to-day clinical practice but of course they are far from routine for patients, some of whom find them intrusive and upsetting. In spite of this, most people still trust doctors to examine them when they are at their most vulnerable. If they are to justify that faith, doctors must respect patients’ right to request a chaperone but perhaps more importantly, treat each patient as an individual and heed their concerns.
Checklist for intimate examinations

**Before the examination**
- Explain to the patient why the particular examination is necessary and what it entails so they can give fully informed consent.
- Record the consent discussion in the notes, along with the identity of the chaperone or if a chaperone was offered but declined.
- If possible, use a chaperone of the same gender as the patient.
- Allow the chaperone to hear the explanation of the examination and the patient’s consent.

**During the examination**
- Ensure patients’ privacy during the examination and when they are dressing and undressing e.g. use screens and gowns/sheets.
- Position the chaperone where they can see the patient and how the examination is being conducted.
- Explain what you are going to do before you do it and seek consent if this differs from what you have told the patient before.
- Stop the examination if the patient asks you to.
- Avoid personal remarks.

**After**
- The chaperone should leave the room following the examination so the consultation can continue in private.

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**References**


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**Case example**

**Patient demands a female doctor**

A male ST4 trainee in obstetrics and gynaecology contacted the MDU for advice when a pregnant patient insisted on being examined by a female doctor, despite the offer of a chaperone. The doctor was unsure whether he had to agree to the patient’s demands and was worried that this would mean an unacceptable delay in the patient’s treatment as there were no female doctors available to treat her.

A patient does not have an absolute right to choose the characteristics of their doctor but in most cases, it is appropriate to accommodate a request for a practitioner of the same gender as the patient when this is possible. It might, however, also be appropriate to explain how practicable this might be for future care, particularly when urgent care might be required.

No examination should proceed without the consent of the patient. If there is an urgent clinical need for the examination and the patient does not wish to proceed even with a female chaperone, the GMC in *Consent: patients and doctors making decisions together* (2008) tells doctors that they should “explain [their] concerns clearly to the patient and outline the possible consequences of their decision” without putting pressure on them to accept this advice. For example, if it was felt there was a risk to the patient or an unborn child but no female doctor was available, the doctor should explain the possible consequences of any delay and carefully document the discussion.

More generally, it would be advisable for the hospital trust to inform patients in advance that the unit is staffed by a mixture of male and female staff and that chaperones will be provided where appropriate or when they wish. The trust could request that patients who will not accept the presence of a male doctor make their requirements known in advance and warn that there may be additional delay while waiting for a female doctor or other member of staff.

The patient’s request has implications for resources and could put additional pressure on female colleagues. The doctor was therefore advised to raise the issue with the seniors in his department or his educational supervisor. The trust may already address this point in its chaperoning policy but if not, he could refer them to the MDU’s response.

This is a fictional case compiled from actual cases in the MDU files.
At the heart of things
Dr Sharmala Moodley, deputy head of claims at the MDU, examines clinical negligence claims against MDU cardiology members in their private practice and offers advice for managing risk in this specialty.

Medical negligence claims in cardiology are relatively uncommon compared with other specialties, although that is no comfort to a cardiologist who is facing a claim.

In this analysis, we examined 67 claims against MDU cardiology members that were either settled or defended successfully over a 10-year period. Some of the cases were statute barred – that is, the claimant failed to bring the claim within the three-year time limit imposed by the statute of limitations. The three years run from either the date of incident or the date that the patient became aware that harm had resulted from clinical treatment, which may be many years after the incident. There is no time limit for a claim to be brought if the claimant is considered to be mentally incompetent in the eyes of the law.

We have represented members in cases where the claimant brought their action many years after the date of the incident. In some cases, the member had been entirely unaware of any damage to the patient at the time of the incident. The oldest case in this series arose from a patient who developed a stroke following a failure to anticoagulate appropriately. The incident took place in 1992 and was not notified until eight years later. This case was settled four years after it was notified — 12 years after the incident had occurred.

Once a claim is notified it can take many years to reach a conclusion. The MDU’s experience is that this can be a significant cause of anxiety to the clinician involved, which is why we always allocate a named claims handler to support the clinician throughout the claims process. The longest-running case in this analysis took eight years from the time of notification.

Costs of claims

In total, 18% (12/67) of the claims analysed were settled. The level of compensation paid to the claimant varied between £50,000 and £2.7 million. Compensation is paid with the aim of returning the patient to the position that they would have been in had the negligence not occurred. If the injury suffered is such that the person cannot return to work and needs a significant level of care, considerable damages may be awarded. In this analysis, the highest amount was awarded to a patient who suffered a stroke following an angiogram. The level of the award reflected compensation for the patient’s large loss of earnings as it was claimed that because of his disability he could not return to his high-earning job.

Individual damages awards are rising year on year in all specialties. Compensation does not necessarily reflect the gravity of the alleged negligence, but rather the costs involved in restoring the patient to the position they would have been in had the negligence not occurred. Examples include payments made to two patients who suffered strokes, one following the insertion of a pacemaker and the second after an angiogram. In the first case £560,000 was paid to the patient because of care needs. The other case, referred to above, settled for £2.7 million because of loss of earnings although this patient was less disabled following the stroke than the first patient.

The 10 highest awards for damages in the cases examined averaged just over £500,000 each. The claims included complications post-angiography and -angioplasty, treatment of coronary...
artery disease, pacemaker problems, anticoagulation complications and a failure to diagnose hypertrophic cardiomyopathy.

The lowest payment for damages was £50,000 for a patient who suffered an oesophageal tear following a transoesophageal echocardiogram.

When a claim is settled, we also pay the claimant’s legal costs, which can be considerable. The highest costs paid by the MDU were £170,000 for the claim in which the damages of £2.7 million were paid. The level of costs paid often reflects the complexity of the claim itself, but this is not always the case, and costs can outstrip damages by as much as 10 times.

If, having been awarded compensation for clinical negligence, a claimant then complains to the GMC as well, the cost of defending a member’s reputation and career following a single incident mounts up financially. In our experience, the average legal cost incurred in defending a GMC hearing is in excess of £50,000, and can be much higher.

Categories of claim

The chart above shows the most common types of problems for which claims have been received.

The majority of claims were brought following allegations of a failure to assess, make a diagnosis and treat appropriately. This group included patients who alleged failure to assess suitability for procedures such as angiography and coronary bypass. Others claimed that there was a failure to make a diagnosis or a delayed diagnosis of conditions such as endocarditis and atherosclerosis. Claims were also notified by patients who alleged that the treatment they received for hypertension, angina and valve disease was inadequate. There were also cases where the claimant alleged that test results such as ECGs and angiograms were negligently interpreted.

It was alleged that negligence caused the patient’s death in 14 of the cases notified. In eight claims, it was alleged that the negligence resulted in the patient suffering a stroke and in
three cases that the patient suffered a myocardial infarction as a result of mistreatment.

There was also a minority of claims in which the main allegations were unrelated to clinical care, such as disputes over payment in cases where the outcome was not to the patient’s satisfaction, and delays in referrals.

Consent featured as an allegation in four of the claims. The allegation of a lack of informed consent was, however, in each case just one of several allegations. Of these claims only one was settled and this involved ill-informed consent to the insertion of a biventricular pacemaker for treatment of atrial fibrillation. The patient subsequently developed congestive cardiac failure.

Consent issues in claims often arise when a patient alleges that they were not warned of a recognised complication of the procedure. It is important to document fully, if possible, the discussions that take place between cardiologist and patient before the procedure. It can also be helpful in defending claims relating to consent issues if the patient has been given a relevant information leaflet, and that this is documented in the medical records. Depending on the type of procedure, it may be appropriate to have more than one consultation before the procedure takes place to allow the patient more time to consider the risks.

Death

The worst possible outcome for any practitioner is the death of a patient from alleged negligence. Just over 20% (14/67) of the claims were reported following a patient’s death. Not all of these claims were following a procedure. Two cases involved a failure to diagnose malignancy. One case involved the death of a patient as a result of cerebral haemorrhage due to a failure to diagnose a Berry aneurysm. In five cases it was alleged there was inadequate investigation and a failure to treat the patient either with medication or with a procedure, which directly resulted in the patient’s death.

Overall, 79% of claims involving patient deaths were successfully defended and only three out of the 14 were settled. These involved death following inadequate treatment of coronary artery disease, benign prognosis for apical hypertrophic cardiomyopathy and a patient who suffered a large pericardial effusion following angioplasty, resulting in cardiac arrest and death. The highest level of damages was £342,000 in the hypertrophic cardiomyopathy case.

Drug reactions and errors

Drug errors give rise to a relatively high proportion of medico-legal problems with which the MDU assists doctors, but are rare in cardiology. Our data revealed only five notifications, none of which resulted in a settled claim. One case involved the administration of an intravenous drug as a bolus rather than an infusion, resulting in local damage to the surrounding tissue. Two concerned adverse reactions to drugs, one of which resulted in death. One case involved a prescription of an ototoxic drug resulting in the patient suffering from a disturbance of balance.

The administration of amoxicillin to patients with a penicillin allergy is an uncommon mistake, but one that continues to result in claims and for this reason is worth highlighting.

Stroke

There were eight cases in total where the patient suffered a stroke as a result of alleged negligence. Three were settled by the MDU on behalf of cardiologist members. In one case the allegations related to failure to anticoagulate a patient following a pacemaker insertion. Two cases involved patients who had undergone angiograms. Very serious adverse outcomes do occasionally occur and patients should be offered relevant information in order to provide informed consent. GMC guidance states that a patient should be given the information they want or need about the potential risks and burdens of a procedure and that doctors should answer the patient’s questions honestly and as fully as the patient wishes.

Dr Sharmala Moodley MB BCh BAO MFFLM LRCPI&SI
Deputy head of claims

Manage the risk

- A claim may be brought following a recognised complication of a procedure. Members can minimise the risk of such claims by ensuring that they document the discussions with patients pre-operatively and complete the consent form. Giving patients written information, and documenting that this has been given, may also help reduce the risk of a claim.
- Consideration should be given as to whether a patient is at particular risk of a complication. Advise the patient of the risks and benefits of the procedure, possible alternative treatments, as well as the option of no treatment, and the complication rates – and document this.
- Ensure that the patient is aware of the possible post-operative complications and knows what steps to take if problems arise after discharge from hospital.
- If a complication does arise, the patient should be advised what has happened as soon as possible and, if appropriate, an apology should be offered in accordance with GMC guidance. An appropriate apology is not an admission of liability.
- It is not necessarily negligent to fail to make or delay in making a diagnosis.

Reference
1. GMC, Good medical practice (2013) paragraphs 31 and 32
A journalist invites you to ‘give your side of the story’. What would you do?

Doctors who have found themselves subject to unfair criticism in the press may have allowed themselves a rueful smile when the Leveson Inquiry put the ethics and behaviour of journalists under the microscope. It remains to be seen whether newspaper proprietors will eventually accept the terms of the royal charter intended to regulate the press. In the meantime, MDU has seen a small drop in the number of members contacting the press office, and in 2013, a total of 123 members called after being contacted by a reporter or faced with a patient’s threat to go to the newspapers.

Doctors in this situation are understandably upset about the potential damage to their reputation and keen to give their side of the story. As one consultant obstetrician and gynaecologist explained: “The article appeared in a national newspaper over the weekend but it wasn’t brought to our attention until Monday morning as the journalist had not contacted us. The story was very negative, implying we were responsible for something that was totally outside our control. It felt very unfair and we really wanted to make a statement.”

The problem for doctors is that any attempt to counter unfair allegations in the media generally requires you to comment on your diagnosis or treatment, thereby breaching patient confidentiality and inviting censure. Even if the patient has put their own medical information in the public domain, the GMC says this does not relieve you of your duty of confidentiality. In Confidentiality: responding to criticism in the press (2009) it says, “If you deny allegations that appear in the press, you must be careful not to reveal, directly or by omission or inference, any more personal information about the patient than a simple denial demands.”

Unfortunately this means the story is likely to be infuriatingly one-sided but another factor to bear in mind is that offering any response can simply give the story added momentum. An apparently solicitous journalist may contact you with the opportunity to “give your side of the story” but they have a professional obligation to do so and it is in their interests to maximise the story and keep their by-line in the public eye for longer.

As the GMC observes: “Disputes between patients and doctors conducted in the media often serve no practical purpose; they can prolong or intensify conflict and may undermine public confidence in the profession.” Instead, the best approach is usually to explain that you cannot comment because of your duty of patient confidentiality. Some journalists could try to provoke you into saying more but it’s worth asking yourself who really benefits: them or you?

The consultant mentioned above acknowledges she was initially extremely frustrated when advised by the MDU press office not to make any public comment on the newspaper story. With hindsight she recognised this approach made sense. “It was counterintuitive. I mean you naturally want to defend your standards of care and it felt like we were sitting on our hands — but it worked because we gave the journalist nothing to work with and the story died down.”

The member added: “Any doctor will tell you that situations like this are distressing and can really affect you, so having an organisation like the MDU on your side really helps you get through it.”

Five tips

1. A journalist is unlikely to just go away so don’t ignore their call.
2. Contact the MDU press office for advice, especially if you think you want to make a statement.
3. Don’t make off-the-cuff remarks or comments which might breach patient confidentiality.
4. If a photographer tries to take your picture, allow them to do so. Ducking or covering your face will make it look as if you have something to hide.
5. Ensure patients cannot be identified by any photography. If a film crew is present, make sure they do not obstruct patient access.
Doctors have a duty to report all adverse incidents arising from use of medical devices, as MDU medico-legal adviser Dr Nicola Lennard reports.

Medical devices have an increasing role to play in the clinical care of patients. There are more than 100,000 devices currently on the market and numbers continue to increase.

We classically think of implantable prostheses when describing a medical device, but in fact the definition of a device applies to a vast range of products, from CT scanners and laboratory equipment to complex active implantable devices such as pacemakers. Even wheelchairs and beds are classed as devices.

The regulation of medical devices has been the source of some scrutiny over the past few years. A European system of regulation exists with the affixing of a CE mark to products that have been approved for marketing. In the UK, the Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for regulating devices and investigating ‘harmful incidents’. (Please note that there are separate reporting routes in Scotland, Wales and Northern Ireland for device-related adverse incidents.)

The MHRA is aware that there has been massive under-reporting of device-related adverse incidents. When asked why they didn’t report a device, clinicians cite a number of reasons, including lack of clarity on what to report and who to report to, and question the value of reporting. Some are also concerned that they may be open to criticism when things have gone wrong.

However, the introduction of new guidance by the GMC1 has clearly placed responsibility for reporting such incidents on clinicians.

What to report

The GMC advises that all incidents that have resulted in actual harm, or have the potential to put the safety of patients, users, or the public at risk, must be reported. The type of incident that can be reported is not limited to device malfunction but should also include those that arise from poor design or, indeed, human error. Causes such as poor user instructions or training, or inadequate maintenance may not seem immediately important, but when aggregated with similar reports, may indicate that changes are needed.

The reporting of recognised complications with implantable devices may help to identify devices which are not performing as expected. For example, an increased rate of lead fracture in an implantable defibrillator has led to the introduction of a more rigorous, and regularly reviewed, surveillance protocol in patients with such leads in situ.

In all cases, the threshold for reporting should be relatively low. The MHRA requests that adverse incidents are reported via their online reporting tool2. Their website includes details about what you can expect once you have reported an incident and provides links to the reporting sites for the devolved nations.

Off-label use

Off-label use occurs when a clinician uses a device for an indication for which it was not intended, or contrary to the instructions for use.

The instructions supplied with many devices contain very specific indications. Many aortic stent prostheses, for example, give precise degrees of aortic angulation beyond which the device is not recommended for use. If a clinician uses a device beyond its recommended indication, liability for safety and performance of the device could be transferred from the manufacturer to the user. The same will apply if the user modifies a device in any way.

Clinicians need to bear this in mind when considering off-label use and should ensure, as with off-label prescribing, that patients are appropriately consented and, if necessary, inform their Medical Director.

Dr Nicola Lennard was formerly deputy medical director, Devices Division at the MHRA.

References

1 GMC, Good medical practice (2013), paragraph 23c; GMC, Good practice in prescribing and managing medical devices (2013), paragraph 47b
Behind the mask

For surgeons who make a clinical error, the emotional effects can be deep and lasting. So much so, that they have been termed the ‘second victim’. The MDU can help, as Dr Jerard Ross, medico-legal adviser, explains.

Surgical error and avoidable injury to patients are, quite correctly, a hot topic. Like all doctors, surgeons are encouraged to be open and reflective, and to constructively analyse error when it arises so that the likelihood of repetition is reduced.

In surgery, a practitioner’s identity as a ‘successful surgeon’ is inextricably linked to their clinical performance. This is judged not only by peers and trainees but also those who may be distant from the process and not aware of the complexities of a given case. It is common to strive for perfection. Against this background, openly accepting and acknowledging for perfection. Against this background, openly accepting and acknowledging failure may be very difficult.

Errors are not always the same as adverse events, although the latter may flow from the former. Sometimes a surgical error results in no external signs or problems; sometimes the outcome is ‘suboptimal’. Occasionally, one slip of the scalpel or a poorly placed screw results in great harm to the patient. The surgeon may also face consequences from the error. Complaints result, experts opine, coroners inquire, judges adjudicate and regulators may investigate any indications of impaired fitness to practise. There is an increasing appreciation of the impact of error on the clinician (the ‘second victim’) and calls for organisations involved in training surgeons to recognise it in their curricula.

The emotional reaction to adverse events can be profound. In a study of 7905 surgeons, 16% of those who reported a major error experienced suicidal ideation. In the same study, the perception alone of having made an error increased the risk of suicidal ideation three-fold.

Involvement in medical errors often provokes intense emotional distress that considerably increases the risk of burn-out and depression. Commonly this manifests as distress, self-doubt, confusion, fear, remorse, and feelings of guilt and failure.

Depression, anger, shame and inadequacy can persist for longer and all may be amplified by higher degrees of perceived personal responsibility. Worryingly, evidence suggests a continuous cycle of these symptoms is followed by increased risk of future suboptimal patient care and error.

Unsurprisingly, these can have a negative impact on the doctor’s private life. In one study of 1318 doctors, of those involved in serious adverse incidents 17% reported a negative impact at home and 6% obtained professional help for the effects.

The emotional response to error has been described as coming in four recognisable phases. The initial ‘kick’ on realisation, involving feelings of failure and significant physiological effects (tachycardia, nausea). This is followed by the fall of spiralling feelings of self-doubt casting a pall over everything. Often in this phase surgeons analyse whether there really is a link between their outcomes and the actions, resulting in significant rumination and concern about other people’s opinions.

The first two phases may last a few days before the ‘recovery’ begins when surgeons need to talk to family, friends and colleagues about events. This can be significantly improved if the patient and family are understanding and often

References
1. Institute of Medicine, To err is human: building a safer health system, published November 1999.
4. Varjavid, N, Nair, S and Gracey E. A call to address the curricular provision of emotional support in the event of medical errors and adverse events. Med Educ 2012; 46: 1141-1151
doctors hope to learn something from the event. The ‘long-term impact phase’ can be prolonged and significantly affect the doctor’s personal and professional identity (‘a piece of them being taken away with every complication’).10

Individually, doctors have coped with these issues by utilising three classic strategies, firstly denial (‘that wasn’t an error’), secondly discounting (‘if the SpR hadn’t forgotten too’ or ‘if the anaesthetist had remembered to check’) and thirdly distancing (‘we all make mistakes’).11

More constructively, talking and listening to colleagues seems to play a critical role in dealing with the experience of error and drawing constructive conclusions from it.12 Although it can be difficult to find such support (Fahrenkopf ref), some doctors suggest that they would only offer such support to a close personal friend, not just to any colleague.13

Morbidity and mortality conferences and significant event analyses are organisationally absolutely essential but seldom offer much emotional support to surgeons.14

How the MDU can help

A doctor may be judged as much on their response to the error as by the error itself. Taking an objective, rational and insightful stance and acting appropriately can be difficult when dealing with the aftermath of a bad outcome. Managing the process as an individual can be even more difficult.

This is where the MDU can be helpful, guiding you through the various medico-legal ramifications and helping you obtain the best result in what can be a challenging situation for clinicians at every grade and in every specialty.

The chance to talk to medically-qualified advisers may in itself help minimise feelings of guilt and self-doubt. We can talk you through appropriate professional responses to error and management of the daunting processes which can follow.

We can also discuss the impact it has had on you and what might be an appropriate response, such as making an appointment with your GP or with occupational health. Occupational health physicians have a key role to play in work-related illness. Many are on-site in hospitals and have significant skills in supporting colleagues in these circumstances.

The MDU is on hand to help members write appropriate SUI reports and coroner’s statements. We can advise and, if necessary, organise representation for members giving evidence at a coroner’s inquiry or Fatal Accident Inquiry. We have a huge organisational experience of responding to complaints, dealing with the coronial system and handling claims for clinical negligence against our members. Each year we rebut around 70% of all claims brought against members.

Any correspondence from the GMC indicating a desire to investigate an event is best discussed with us as soon as possible. We have long and successful experience of helping our members with the regulator.

In essence, surgeons and more generally doctors can suffer significant emotional and professional consequences of error. The MDU is here to help you manage the outcome.10
The GP discussed the situation with the prescribing lead for the Local Area Team of NHS England. They liaised with the trust to produce a protocol for cases where unusual and off-licence drugs are recommended by secondary and tertiary specialists who wish to share ongoing prescribing with GPs.

With knowledge of potential adverse effects and the rationale for treatment, and with a written agreement in place which included a clear plan for monitoring and a copy for the records, the GP felt sufficiently informed to provide further prescriptions.

The prescriber has a duty to understand any drug they prescribe, including adverse effects and appropriate monitoring, even when prescribing on the advice of a specialist. When the regimen is unusual, the specialist is best placed to provide that information and must do so.

A formalised process for shared care which makes clear what is expected in primary and secondary care and what the essential elements of the process are, will help safeguard patient safety. A written record is essential for good communication between healthcare professionals, and helps prevent one doctor mistakenly thinking that the other has addressed some aspect of the process. In all cases, the overriding priority must be patient safety.

Dr Christine Walker
MDU medico-legal adviser
Postnatal pulmonary embolism

The patient had been pregnant with her first child, and saw the consultant privately for antenatal care. She was aged 34 and generally fit and well, other than having had a DVT several years earlier following a fractured ankle. The consultant arranged thrombophilia testing, which was negative.

As part of the patient’s routine antenatal care, the obstetrician documented a thromboprophylaxis risk assessment, and decided that given her history of a previous DVT, she should have post-natal prophylactic low molecular weight heparin for six weeks.

The pregnancy was uneventful, and the baby born by spontaneous vaginal delivery. The patient was discharged home the day after delivery, but did not receive low molecular weight heparin, as had been planned. Three days after discharge, she was readmitted with shortness of breath.

The consultant immediately suspected a pulmonary embolism, and arranged a CT pulmonary angiogram which confirmed the diagnosis. The patient was treated with low molecular weight heparin, followed by warfarin for six months, and made a good recovery.

In the letter of claim, it was alleged that, contrary to her antenatal care plan, and contrary to guidelines issued by the Royal College of Obstetricians and Gynaecologists, the claimant did not receive postnatal thromboprophylaxis, as a result of which she suffered a pulmonary embolism.

The MDU obtained expert advice from an independent obstetrician, who confirmed that the failure to prescribe postnatal thromboprophylaxis was a breach of duty of care. Expert advice from a haematology expert was also obtained, which confirmed that had low molecular weight heparin been prescribed following delivery, the pulmonary embolism would have been avoided.

In the light of the expert advice, and with the consent of the MDU member, this claim was settled. The MDU paid damages to the claimant of £25,000, and her solicitor’s fees of £18,000.

Dr Claire Wratten
Senior medical claims handler
The dermatologist discussed the procedure with the patient, and then excised the mole. Histology confirmed that it was benign. The patient was reviewed 10 days later and the sutures were removed. At a further review appointment a week later, the wound was healing well and the patient was discharged. She was advised to contact the dermatologist again should any problems arise.

Six months later, the patient re-attended, saying she was concerned about the appearance of the scar. The MDU member noted that there was hypertrophic scarring of the wound, and excised the scarring, but several months later the patient sought a second opinion because of ongoing concerns about the scar’s appearance.

A year after the MDU member last saw the patient, he received a request for copies of the medical records, which the MDU disclosed on his behalf. This was followed several months later by a letter of claim. It was alleged that the dermatologist had not explained the risk of hypertrophic scar formation before removing the mole. It was also alleged that when the claimant re-attended with concerns about the scarring, she should have been offered intra-lesional steroid injections, rather than scar revision which carried a risk of further hypertrophic scarring.

The MDU obtained detailed comments from the member on the consent process. He confirmed that the claimant had been warned of the risk of scarring following removal of the mole, but not specifically of the risk of hypertrophic scar formation.

An independent dermatologist provided expert evidence on the case. He observed that the mole removal was purely for cosmetic purposes, and surgery on the chest area carries a significant risk of hypertrophic scarring. Given this, the claimant should have been specifically warned of the risk of hypertrophic scar formation. Once hypertrophic scarring had occurred, the expert agreed with the letter of claim, that the MDU member should have offered a reasonable trial of treatment with intra-lesional steroid injections, and the failure to do so was a breach of duty of care. Treatment with intra-lesional steroid injections would probably have improved the appearance of the scar, whereas scar revision was very likely to result in recurrence of the hypertrophic scarring.

Following receipt of this report, the MDU member’s comments were sought, and with his agreement the MDU settled the claim for £4,000 in damages, and also paid the claimant’s solicitor’s fees of £13,000.

Dr Claire Wratten
Senior medical claims handler
Anoxic brain injury

A 32-year old woman with a history of recurrent tonsillitis was admitted to a private hospital for tonsillectomy. She was overweight with a BMI of 35. The consultant anaesthetist, an MDU member, saw the patient before surgery, established an unremarkable past history but made no note of his visit. No pre-medication was prescribed.

Induction of anesthesia and intubation were straightforward despite the presence of large tonsils. The claimant was paralysed and ventilated throughout an uncomplicated procedure and a total of 10mgs of morphine was administered intravenously. Following extubation, the patient suffered a brief period of hypoxia which was rapidly corrected by pharyngeal suction and the administration of 100% oxygen by facemask.

In recovery, she continued to receive supplemental oxygen and intravenous fluids. In view of the patient's build, our member advised that oxygen therapy be continued overnight on the ward and recorded this instruction on the recovery care plan.

Overnight, nursing staff recorded the patient’s pulse rate at between 80 and 95 beats per minute. They did not record oxygen saturation or blood pressure. At midnight, they discontinued the oxygen and gave intramuscular analgesia.

Early the next morning, the patient was found unconscious, pale and snoring with blood pressure of 85/41, pulse 72 and oxygen saturation 87%. The patient was given naloxone, with no effect. The nursing staff rang the consultant anaesthetist who advised a further dose of naloxone. He saw the patient 30 minutes later, recording that she was unrousable, hypotensive, had a gag reflex and that her pupils reacted to light. He sought the advice of a neurologist.

Transfer to another hospital ITU department was arranged. At this stage, the patient's Glasgow Coma Scale was recorded as 3.

On arrival, the patient was intubated, ventilated and resuscitated, requiring fluids and inotropic support. The patient made a rapid recovery. Her cerebral function improved and within three weeks she was responding appropriately to verbal stimuli and commands.

Two years later, she brought a claim against the hospital and the anaesthetist stating that she had continuing cognitive problems and was depressed. Her CT imaging demonstrated damage in the region of the basal ganglia and the peri-ventricular areas. She claimed that she had suffered a brain injury during the night following surgery, as a result of inadequate oxygenation and a further, secondary injury as a result of a failure to provide adequate resuscitation the next morning.

The MDU sought the advice of experts in the fields of anaesthesia, intensive care and stroke medicine. They thought it likely that severe hypoxaemia had occurred during the night as a consequence of obstructed ventilation and discontinuation of oxygen therapy. This resulted in a primary anoxic injury to the brain. A secondary, lesser injury occurred as a result of continued hypoxia and hypotension caused by inadequate resuscitation.

Experts were critical of the failure to resuscitate the patient more actively the morning after surgery. They considered that the anaesthetist should have intubated and ventilated the patient and stabilised her condition before transfer. However, neurology advice was that the secondary injury was unlikely to have made a great deal of difference overall.

It was agreed that some liability would be likely to fall to the MDU member at trial despite these arguments. The hospital swiftly acknowledged their liability and settled the claim accepting a 15% contribution to the damages on behalf of the MDU member.

At this stage, the patient’s Glasgow Coma Scale was recorded as 3.

Dr Alison Cooper
Senior medical claims handler
Medicine is a necessarily collaborative profession. Doctors commonly discuss difficult, interesting or unusual cases with colleagues, and seek advice about how best to manage patients. But when does ‘informal’ advice become formal, and what are the implications of colleagues relying on it?

Consider the following scenarios:

- Two doctors discuss an unusual case hypothetically, in the hospital canteen.
- A cardiologist, passing through Accident and Emergency, is asked to glance at an ECG.
- A radiologist is asked to have a look at an MRI scan before a surgeon operates (as opposed to providing the formal report).
- A paediatrician is asked for an opinion about a child on the surgical ward, pre-operatively, which is then recorded in the clinical records.

With each case, there is progressively increasing ‘formal’ involvement of the doctor in the patient’s management. The doctors giving less formal opinions, however, may wish to consider to what extent their informal advice may be relied on in determining how the patient may be managed. While a hypothetical discussion over coffee, without specific patient details, may not influence how a particular patient is treated, a formal pre-operative opinion provided by a paediatrician more obviously will do so.

The advice provided by the cardiologist or the radiologist may have been given informally, in passing, without necessarily seeing the patient or having access to the full or relevant history. Nonetheless, it is likely that the doctor seeking the opinion may rely on it to inform their decision making, and may indeed document that they have discussed the ECG or MRI scan with a specialist colleague.

Where you give advice to colleagues in the clinical setting, it is important to consider the following points:

- to what extent will that advice be relied on
- how much knowledge of the patient’s history will be needed in order to form an opinion about diagnosis or treatment
- will it be necessary to personally examine the patient
- are you working within the limits of your competence and expertise, and
- will your opinion be accurately recorded by you or a colleague?

It is important, when giving advice, even where this appears informal, that you put yourself in a position to exercise sound clinical judgment. What risk is there in commenting on an ECG in passing where you have not been told the patient’s history, or have not made a point of asking?

In such circumstances, it may be hard for the doctor to defend their position, and they may indeed be vulnerable to criticism if they have not kept appropriate records. If an opinion is sought, however informally, it can reasonably be assumed that the opinion will be relied on in order to determine how a patient will be managed. This is particularly the case where a junior doctor seeks the views of a senior, or a generalist the advice of a specialist.

Before providing an opinion, doctors may wish to ensure that they have all of the relevant clinical information to hand, including any previous relevant opinions, and that they appropriately document their thinking and the reason for giving that opinion.

It is a useful maxim that there is no such thing as an informal opinion.

Dr Edward Farnan
MDU medico-legal adviser

Dr Edward Farnan discusses the medico-legal implications of giving informal advice to colleagues.
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