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THE MDU

MDU Journal

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Adequate, appropriate, ethical

The secrets of good communication

IN THIS ISSUE

NEWS

COMMUNICATION

FEATURES

IN FOCUS

FROM OUR FILES

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FEEDBACK

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MDU Journal

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EDITORIAL

Upward spiral

Advisory services are an essential part of our work for members, but the legal costs incurred in defending members have spiralled in the last five years.

There has been a quiet revolution in the work the MDU advisory department carries out on members' behalf. Today, more doctors than ever before seek help from our advisory team – with everything from queries about data protection or confidentiality, to those heart-stopping moments when a notification of a GMC investigation drops on the doormat.

Members turn to us for help not only with clinical negligence claims but also for advice and assistance by phone, through correspondence or in person with advisory matters. These are the wide range of medico-legal problems arising from everyday professional practice such as NHS complaints, inquests, disciplinary and criminal investigations and, increasingly, GMC enquiries.

Members have a right to seek help from the MDU when they encounter difficulties in their professional life. The MDU exists solely for our members and you can turn to us for help safe in the knowledge that the advice and assistance available from our advisory team is unsurpassed.

Often, because of early MDU intervention, we are able to help members resolve the matter so it does not progress, but in some cases we need to instruct specialist lawyers to help members present their case robustly. We have an expert legal department in-house and can also instruct external lawyers who comply with our rigorous standards. It is about having support from those who are the best in their field but who also understand how difficult the experience is for a doctor who is held to account by one or more tribunal.

We are mindful not only of the personal cost to our members, but also the financial cost. The MDU is your company and these are your funds. It might surprise members to know how much advisory legal costs have increased in recent years. The facts are stark – against an increase of 24% in the number of cases which had legal support between 2006 and 2009, legal costs rose by 54%. Advisory legal costs have far outstripped inflation in the last five years.

One of the underlying reasons is that since 2005 we have seen an exponential increase in the number of members referred to the GMC, many of whom are represented by barristers if the case comes before a fitness to practise (FTP) panel. In the last three years alone, the GMC reports a 35% increase in complaints about doctors, while referrals from employers and the police have risen by 117%. There are up to 17 concurrent FTP panels taking place each day whereas back in 2000 there were just two.

There are many reasons behind this dramatic rise, the most important being changes to the FTP procedure itself and the fact that the GMC regularly considers cases that involve clinical care. These cases accounted for 35% of those before FTP panels during 2009 and are invariably complex and lengthy because of the additional expert evidence required.

It is also interesting to note how many cases now being investigated by the GMC started life as something else entirely, such as an inquest, complaint or a disciplinary matter.

Examples of the high level of legal costs in the past few years include a case of a doctor who was subject to trust disciplinary and GMC investigations for alleged bullying and lack of co-operation with colleagues, to the detriment of patient safety. The costs of defending the member came to £233,000.

In a complaint to the GMC in which the doctor was alleged to have performed a procedure on the wrong side, legal defence costs were £185,000. In another, the doctor was facing questions about professional performance. No findings were made but the legal costs reached £200,000. Such costs are not at all exceptional and can sometimes be much higher. In response, we have taken a number of steps including the expansion of our in-house legal department which now comprises 16 solicitors dedicated to assisting our members. We have also introduced an early review of GMC cases by our in-house legal team to assess the merits of responding early to optimise the chances of swift resolution without a hearing.

We are in regular contact with the GMC, feeding back our views and suggestions for improvement of case management throughout the FTP process. Some changes can be and are made swiftly and easily, whereas others need amendments to the GMC's powers. For example, the MDU has recently submitted comments on the GMC proposals to reform the investigation stage of its FTP procedures with the aim of reducing the need for formal FTP panels.

All of this work on your behalf is aimed at ameliorating an often painful and costly experience. Members will readily understand the personal costs involved, but may not appreciate just how high the financial costs can be too.

Dr Christine Tomkins
Chief executive

NEWS

Welcome news on legal costs

The Justice Secretary Ken Clarke's announcement in March that he intends to reform the civil justice system, and in particular conditional fee agreements (CFAs), is welcome news.

CFAs have helped fuel the excessive rise in legal costs in clinical negligence cases, to the point where they are disproportionate to the compensation awarded to the damaged patient. For example, the MDU has settled a claim where the patient was awarded £8,000 damages, but their lawyer's costs totalled £62,000, which included a 90% success fee and an 'after the event' (ATE) insurance premium.

Dr Sharmala Moodley, deputy head of claims at the MDU, commented: 'Such spiralling costs are not only shouldered by our doctor and dentist members through their subscriptions, but also by taxpayers who are funding NHS cases. The reforms will address the issue of costs under CFAs while ensuring patients can still seek compensation if they have been negligently harmed.'

The reforms propose that claimants will fund their solicitor's success fee from any damages awarded, and that defendants will not recover costs from losing claimants – in return, claimants won't need to take out ATE insurance against these costs.

'With plans to increase damages awards by 10%, we think the proposals strike the right balance,' adds Dr Moodley.

For medico-legal advice, please contact the MDU's 24-hour freephone advisory helpline 0800 716 646

Welsh redress – independent providers exempt

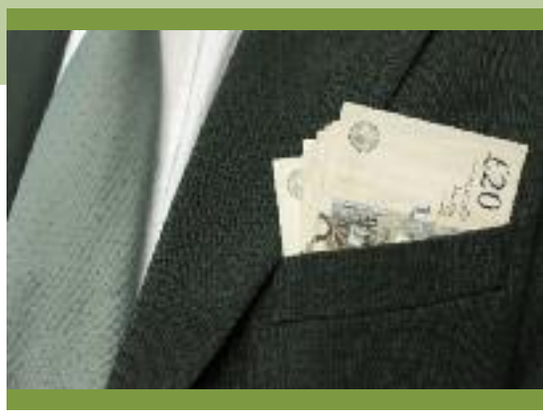
Independent providers of care to NHS patients and primary care providers in Wales are exempt from the redress requirement of the new Welsh NHS complaints regulations, which came into force on 1 April 2011.

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 introduced significant changes to complaints handling in Wales, including a new requirement for NHS hospitals and local health boards to consider whether it is appropriate to offer patients financial redress of up to £25,000 where there has been negligence.

Independent providers of treatment to NHS patients are covered by these regulations but they are excluded from the redress requirements. The MDU advises that if NHS patients are referred by a Welsh NHS body to an independent provider for NHS treatment it is important to ask the contractor to make clear what indemnity arrangements will apply if something goes wrong.

For more information, visit the-mdu.com

Bribery Act 2010



The Bribery Act 2010 comes into force on 1st July 2011, and brings with it a new corporate offence of 'failure of commercial organisations to prevent bribery'.

Corporations can be guilty of the general bribery offences under the Act, but Section 7 is aimed specifically at commercial organisations, which includes partnerships.

A commercial organisation will be liable to prosecution if a person associated with it bribes another, intending to obtain or retain business or an advantage in the conduct of business for the organisation. Employees and suppliers of services to the organisation are capable of being 'an associated person' for these purposes.

However, the organisation will have a complete defence if it can show it had adequate procedures in place designed to prevent such bribery.

The penalty for the failure to prevent a bribery offence is an unlimited fine. For an explanation and guidance on the Bribery Act 2010, please see www.justice.gov.uk/guidance

IN BRIEF

GMC recordings guidance

Updated GMC guidance, published in April 2011, clarifies the ethical principles of making and using visual and audio recordings, including secondary uses for which the patient may not initially have given consent. MDU members are advised to think ahead to potential future uses of a recording when gaining patient consent. **www.gmc-uk.org/ethical_guidance/making_audiovisual.asp**

No ageism

The new Equality Act outlaws age discrimination in the provision of health and social care services. Elderly patients who believe they have been the subject of ageism in healthcare decisions about them could sue under the Act.

Although GMC ethical guidance requires doctors not to discriminate on any grounds, age may be a factor in considering an elderly patient's best interests. Members are advised to discuss healthcare decisions carefully with patients and make a comprehensive note of the reasons for a decision in the records.

Public interest disclosures

Decisions on whether to breach patient confidentiality are rarely black and white. The recently-published Department of Health *Confidentiality: NHS Code of Practice* supplementary guidance on public interest disclosures provides clear, helpful support for doctors faced with a confidentiality dilemma. The DH guidance should be read in conjunction with GMC guidance *Confidentiality* (2009). See ***www.dh.gov.uk*** and ***www.gmc-uk.org***

Twitter in court

The lord chief justice has opened the way for the use of social media (Twitter, text and email) by journalists in court reporting in England and Wales. He issued interim guidance in December 2010 pending a public consultation. If the proposal goes ahead, journalists will be able to apply for permission to use social media on a case-by-case basis.

By mutual agreement

The MDU responds to GMC proposals for concluding fitness to practise cases by 'mutual agreement'.

The MDU has responded on behalf of members to the GMC's proposals for concluding FTP cases by 'mutual agreement' before they get to a fitness to practise (FTP) panel. In principle, we believe it could benefit our members personally and professionally if it were possible to conclude cases the GMC would otherwise refer to an FTP panel at an earlier stage.

The GMC has seen a dramatic rise in complaints – up 35% in the last three years. This translates into greater numbers of cases proceeding to an FTP panel. In 2000 there were 333 FTP panel hearing days; by 2010 there were 3,493.

All of this is at great cost to doctors. First, they are under scrutiny and the considerable strain associated with appearing before an FTP panel; second, because of the financial burden. Doctors are bearing the costs of FTP procedures twice. A proportion of your registration fee funds FTP cases, which cost the GMC just under £44 million in 2010. And as members of a medical defence organisation (MDO) you also contribute to defence fees, as part of a mutual organisation owned by you.

Doctors who are not MDO members may be in a worse position as they may have no option but to defend themselves without expert representation, or to fund that defence personally.

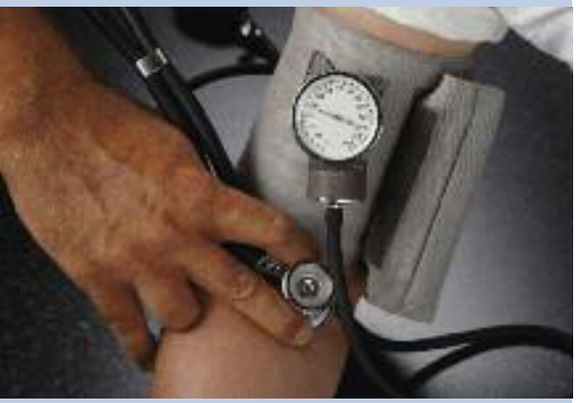
Against this background, the MDU cautiously welcomes GMC proposals to explore ways of disposing of cases short of an FTP hearing. Our response to the consultation suggested how such a procedure might operate in order to inspire confidence among doctors and the public.

There is, however, still much work to be done. In particular, it must be very clear that doctors will not be penalised should they not agree to disposal of their case by mutual agreement and choose to exercise their right to a hearing before an FTP panel. There will probably need to be pilots before it will be possible for all parties to agree a way forward, and there will also need to be legislation to enable the GMC to change its procedure. The MDU will be involved at all stages, representing members' interests robustly. It is a hopeful start but there is a long way still to go.

Mary-Lou Nesbitt
Head of governmental and external relations

IN FOCUS

Training for **FME work**



Specific qualifications are not a statutory requirement for working as an FME, but doctors may wish to consider obtaining them.

The advice follows a referral to the GMC of several FMEs by the Society of Forensic Physicians (SoFP). The SoFP alleged that, in working as FMEs without appropriate qualification or training, the doctors were in breach of paragraph 3(a) of Good Medical Practice which states that doctors "must recognise and work within the limits of [their] competence".

In representations to the GMC on behalf of FME members, the MDU highlighted that there are currently no qualifications required to hold an FME post apart from GMC registration. We were able to demonstrate that our members did have relevant and appropriate qualifications and experience and refuted that they were working outside the limits of their competence.

The GMC noted that the allegation, if proven, could give rise to concerns over a doctor's fitness to practise. However, they accepted our submissions and concluded the case with no further action.

The Faculty of Forensic and Legal Medicine[1] offers advice on training and qualifications in forensic, sexual offences and medico-legal medicine. Members who undertake FME work should contact the MDU regarding indemnity.

[1] The Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London, www.fflm.ac.uk

Laparoscopic surgery warning

Complications from laparoscopic surgery may be rare, but hospital doctors have been warned to be alert to post-operative problems.

Between 2003 and 2010, 48 serious incidents relating to laparoscopic surgery were reported to the National Patient Safety Agency (NPSA), including 11 post-operative deaths. In 2008 an MDU study of 73 settled claims found that in more than half of cases (42) the claim arose from damage to an intra-abdominal structure during the procedure. Examples included bowel perforation, and damage to the bile duct, bladder/ureter, blood vessels, cervix/uterus and oesophagus. The cases mainly arose in gynaecology and general surgery.

In a report[1] last year, the NPSA warned NHS and independent sector hospitals to monitor patients closely during the post-operative period. Although injuries are often recognised and treated during surgery, some remain undiagnosed until life-threatening complications arise, such as circulatory collapse and septic shock.

The NPSA advocates careful post-operative monitoring and the use of early warning scores (MEWS and PEWS) during the recovery period, and recommends local protocols for post-operative observation and discharge criteria. The MDU also advises members to ensure patients are aware of the signs of potential complications that might arise after they are discharged from hospital, and what to do about them. It is also advisable to ensure thorough and prompt completion of hospital discharge paperwork for the patient's GP.

[1] Laparoscopic surgery: failure to recognise post-operative deterioration, NPSA, Sept 2010.

3D/4D pre-natal scans

New ultrasound scanning technology could give rise to claims for clinical negligence if foetal abnormalities are missed.

With improving ultrasound technology, 3D/4D antenatal 'bonding' scans are increasingly popular with prospective parents.

The scans are usually carried out in the independent sector by experienced sonographers or doctors at 26-32 weeks gestation.

Because these scans are not normally medically necessary it is important that prospective parents commissioning these scans for non-medical reasons are aware that the scans are non-diagnostic and certainly not a substitute for routine antenatal anomaly screening. Given the potential for subsequent allegations of a missed diagnosis of some form of congenital malformation, it would be prudent to keep a contemporaneous record of the advice provided about the scope of the service and the need for routine antenatal care to identify potential problems in the pregnancy.

Missed diagnosis of congenital abnormalities can lead to potentially huge negligence claims following the birth of the child and even the above steps may not absolve a trained practitioner from a duty to identify overt anomalies evident on scanning. For this reason, members who undertake 3D/4D antenatal scans should contact our membership department to confirm the nature and extent of their involvement in any such work and discuss their indemnity needs.

Know your indemnity

MDU members have the best all-round support throughout their careers. Why? Because the MDU provides the strongest combination of occurrence-based indemnity and claims-made insurance. Here we debunk the jargon to explain why the difference is crucial.

Recent feedback from MDU members shows there may be confusion about the two ways in which professional indemnity is provided to doctors for matters arising from their clinical practice.

Indemnity can be provided on an **occurrence basis** or a **claims-made basis**. There are some significant differences between the two, which we aim to clarify below.

Membership of the MDU is **occurrence-based**, and is supported by a **claims-made policy of insurance**. The strength of this combination gives our members the best continual support and assistance during their career and into retirement[1].

definition

Occurrence-based

If an incident occurs while you are a current member and the patient later sues you for clinical negligence, you can rest assured that you will be able to seek assistance with the claim, no matter how long after the incident date the claim is brought. This is so even if you are no longer a member, are taking a temporary break or have retired.

Claims-made

You will be indemnified for claims that are brought during the time you have a policy in force (the 'policy period'). As soon as you leave and/or the policy period ends, the benefits of the claims-made policy cease.

If you leave the MDU, for a short time or permanently, our occurrence-based assistance means you will still be entitled to seek assistance with claims that arise later – sometimes, many years later – from the work you did during your period of membership.

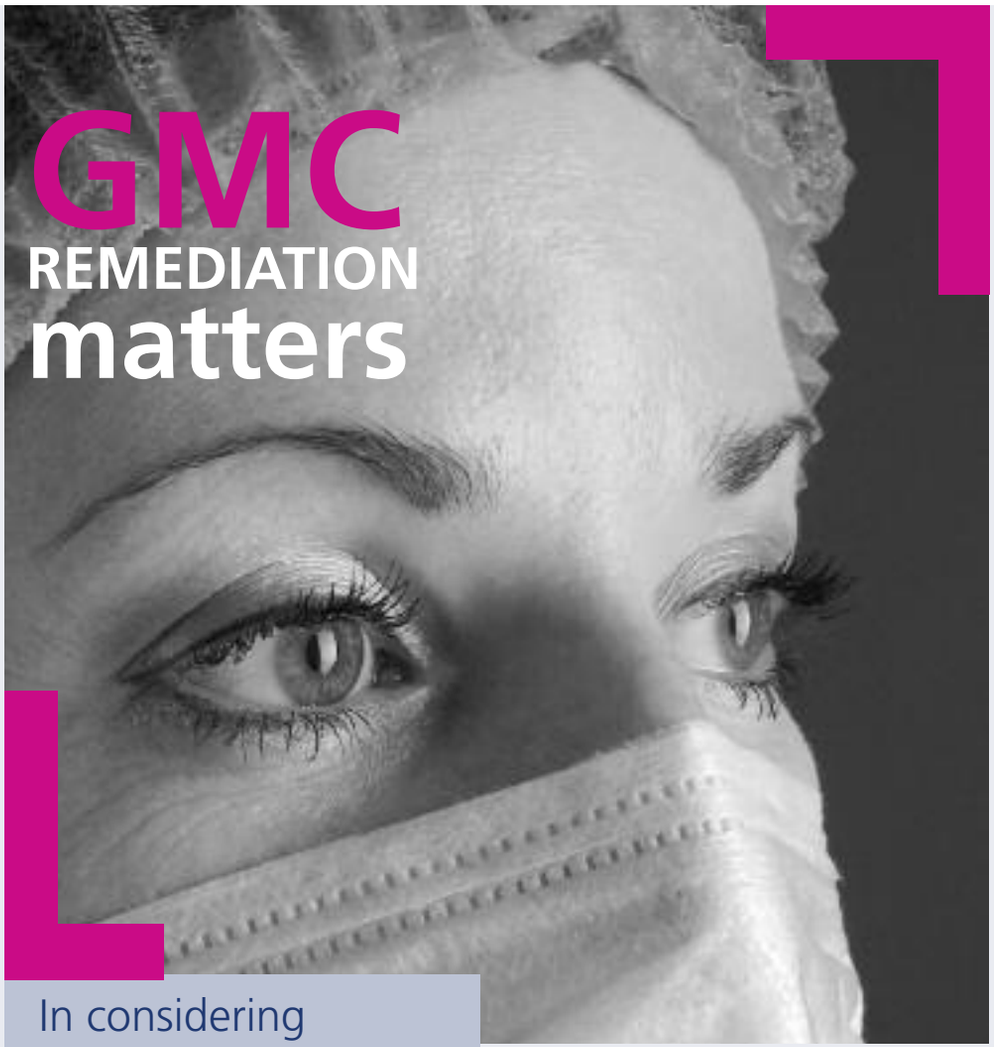
However, if you belonged to a medical defence organisation whose membership benefits are all claims-made and you decided to leave, you will have no entitlement to cover for incidents that happened during your period of membership. In order to extend the period during which you can continue to report claims after you have left, you will need to purchase additional "run off" cover. This can be expensive and may only provide a limited extended reporting period, not an indefinite one. If you do not take additional cover for future claims from that period, you may leave yourself exposed.

Medical claims can take many years to come to light. The longest delay the MDU has seen from the incident occurring to a claim being made is 38 years, in relation to independent practice. In general practice, the record time lapse between incident and claim is 49 years.

[1] Subject to the terms and conditions of the policy.

FEATURE

GMC REMEDIATION matters



In considering whether a doctor's fitness to practise is impaired by reason of misconduct, a GMC panel must take account of evidence of remediation. Charles Dewhurst, head of MDU legal services, discusses the development of this principle and its significance.

The principal issue that a GMC fitness to practise (FTP) panel has to address is whether the doctor's FTP is impaired by reason of one or more factors, including health, performance or misconduct. Of these, misconduct is the most common reason for an investigation.

This is a two-stage test, and it is now clearly established law that a finding of misconduct does not necessarily lead to a finding of impairment. The test of impairment is a current test – taking account of any past misconduct but also of conduct both before and after the events in question. In considering whether FTP is impaired, the panel should ask itself in particular:

- is the conduct remediable?
- has it been remedied?
- is it likely to recur?

Having initially opposed this principle, the GMC has now espoused it. Indeed, the GMC's standard notification letter to the doctor, which advises that a complaint has been made and offers an early opportunity for comment, includes a specific invitation to explain any steps taken to remedy deficiencies in areas identified in the complaint.

Any practitioner preparing for a hearing before an FTP panel should therefore be reviewing not merely the facts of the case giving rise to the allegations but also wider aspects of their practice. This should include steps taken, or that should be taken, to address deficiencies.

It is becoming commonplace to put before an FTP panel a 'remediation portfolio', which may take many forms, including CPD course certificates, evidence of re-training or mentoring, literature studied and/or advice sought from the postgraduate deanery.

But remediation may take a much more subtle form. Mere reflection on an adverse incident or outcome may not just represent good practice but can also provide the GMC with the necessary reassurance that the doctor is prepared to learn from experience and has insight – an important ingredient in any assessment of impairment. Reflection does not necessarily imply culpable conduct; it may simply be a review of events and perhaps an adjustment of practice or protocols to avoid recurrence of a particular complication.

It is clear that the GMC wants evidence of insight and remediation at the earliest possible stage of an investigation. These are barely charted medico-legal waters, and the GMC has the opportunity to show its commitment to the principle by giving due weight to such evidence and avoiding unnecessary referrals to FTP panels in future when the remediation evidence they seek is duly provided.

It has been a hard battle to establish the principles that misconduct does not of itself mean impairment, that the test is of current (not past) fitness to practise, and that a practitioner can remedy deficiencies demonstrated by the misconduct so that his FTP is not impaired. Practitioners facing a misconduct complaint should be aware of the importance of these principles and strive to address remediation at an early stage.

FEATURE

Mistaken identity

Some events should never happen in secondary care. Mixing up a patient's identity is one of them. Sally Old, MDU medico-legal adviser, reports on the development of this 'never event'.

The 2008 Department of Health report *High Quality Care for All*[1] highlighted the designation of 'never events' – events that are serious and largely preventable – in some hospitals in the United States. It asked the National Patient Safety Agency (NPSA) to work with stakeholders to draw up its own 'never event' list and the first list of eight designated never events was introduced in April 2009.

Never events are considered to be incidents that can cause death or result in serious impairment, but which might have been prevented. NHS organisations have a statutory requirement to report all serious patient safety incidents to the National Reporting and Learning Service[2] and to the Care Quality Commission (CQC). This plays a key role in ensuring that lessons are learned from past errors.

The list of never events was revised in February 2011[3]. The original list of eight never events has been extended to 25 and now includes 'severe harm/death due to misidentifying patients by failing to use standard wristband identification processes'. Where never events do occur in the NHS, the Department of Health will give local commissioners discretion to withhold funds from treatment providers.

When a never event occurs, there should be a root cause analysis to identify steps that can be taken to prevent a repetition. It is also expected that the patient will be informed, and this is in keeping with GMC guidance.[4]

Never events are by no means confined to secondary care and the MDU attended an NPSA workshop in December 2010 following on from a patient identification error in primary care. In this case, a patient was mistaken for another with a similar sounding name and prescribed medication to which he was allergic. As a result, a call was made for safe patient identification procedures to be established nationally.

Wristband id

For hospital in-patients, the use of the wristband can be helpful in ensuring correct patient identification. In 2007 the NPSA published guidance about the standardisation of wristbands to improve safety.[5] This followed more than 24,000 reports of wrong care given to patients, nearly 3,000 of which were due to wristband use.

However, in the out-patient setting wristbands are not available and other methods of checking a patient's identity are needed to ensure safe provision of care and avoid breaches of confidentiality.

Simple strategies

Perhaps one of the simplest and yet effective means of checking that you have the right patient in front of you is to ask them to confirm their name. This is preferable to asking a question such as "Are you Mrs Smith?" to which a nervous or confused patient might mistakenly answer "yes".

Furthermore, by checking more than one identifier you can limit the risk that you will mistake one patient for another – such as asking the patient for their date of birth and/or address as well in situations where it is especially important to be sure of the patient's identity.

The most reliable patient identifier is their unique NHS number, but in day-to-day practice few patients would be able to recall it when asked.

We all strive to provide the best care we can to our patients in sometimes busy settings, but we must not forget the importance of ensuring that we are giving the right treatment to the right patient. Without such basic checks the necessary treatment that we have recommended for one individual can have devastatingly harmful effects if provided to someone else.

References

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

[2] A division of the National Patient Safety Agency

[3] http://www.dh.gov.uk/en/MediaCentre/DH_124579

[4] Good Medical Practice (2006) paragraph 30

[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824

COMMUNICATION

Good communicators listen. They ask questions. They 'mirror' patients, manage their expectations and gain their compliance.

Is this important? Emphatically yes, from both a medico-legal and an ethical point of view. The MDU Journal examines the issues of good communications.

What makes a good communicator?

How difficult can it be to communicate with patients and staff? Not as easy as it might seem. Around 30% of complaints notified to the MDU involve poor communication. Dr Emma Sedgwick, with a background in psychiatry and now a trainer in communications in a medical environment, discusses what makes a good communicator.

COMMUNICATION

"Communication is no longer a 'nice to have' – it is essential"

What is all this fuss about communication skills? After all, you may not have received any specific training in communication skills either at medical school or during your specialist training and think it hasn't caused you any difficulties. Surely your Trust and your patients are most concerned with your clinical competence?

Yet communication skills training is now widely included within the undergraduate curriculum, assessed in many postgraduate exams and recognised by all in the profession as one of the cornerstones of being a good doctor. It is no longer a 'nice to have'; it is essential.

COMMUNICATION

Being a good doctor involves a number of skills – professional, technical and social (figure 1). Communication is an inherent part of social skills and enhances the other two.

Different specialties might need these skills in varying amounts. Situations and patients may test different aspects of each skill. But doctors in any specialty require skills in each circle, not just one or two. You could be the most proficient technical doctor but unable to discuss the patient's condition with him or her.

Communication is a significant factor in many complaints, claims and disciplinary matters. In the MDU's experience, up to 30% of complaints involve some aspect of poor communication. The attitude and perceived rudeness of the doctor was cited as the reason in 13% of the complaints in one survey of complaints notified to the MDU (MDU, 2003). Similarly, in the Healthcare Commission's review of complaints (the body that used to be responsible for the second tier of the NHS complaints procedure) 20% were due to a combination of communication, information provided to the patient and staff attitudes (Healthcare Commission, 2008).

Research from the USA and Canada echoes these findings. Doctors whose communication skills scores were in the bottom quartile at qualification had a significantly increased risk of subsequent complaints from patients to the medical regulatory body (Tamblyn et al, 2007). In the case of obstetricians and gynaecologists who already had a history of previous claims, patients reported that they felt rushed, ignored and received inadequate explanations from their doctor (Hickson et al, 1994).

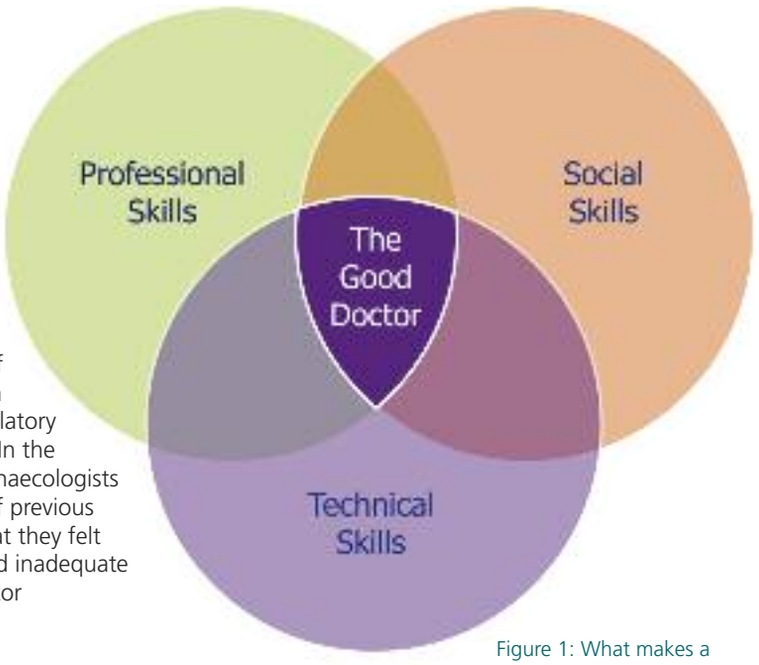


Figure 1: What makes a good doctor?

Is there a correlation between good communication and fewer complaints from patients? In a study of 103 orthopaedic surgeons, those who had better rapport with their patients, took more time to explain and made themselves available to their patients had fewer malpractice suits (Adamson et al, 2000). Similarly, fewer malpractice suits were also seen in physicians who pointed out to their patients what was happening when and why, asked for patients' opinions, checked for understanding, encouraged patients to talk, laughed and used humour (Levinson et al, 1997).

Of course, it is useful to remember that complaints and claims arise for a number of reasons and just because you may have been subject to one, doesn't necessarily indicate you are a poor communicator.

Positive impact

While good communication may help you avoid some medico-legal pitfalls, it can achieve a number of other significant benefits for you, your patients, their relatives and your colleagues.

Research has shown good communication skills can positively impact on patients' symptoms and even help resolve them. In patients with chronic headache, for example, symptoms were more likely to resolve if they felt they had been able to discuss their headache and the problems associated with it at the first consultation, rather than at any other stage in their diagnosis and treatment (Headache Study Group of the University of Western Ontario, 1986). If patients are involved in the choices available for their breast cancer they are less likely to suffer anxiety and depression (Fallowfield et al, 1990). A reduced need for analgesia after myocardial infarction is related to the discussion with the patient and information provided (Mumford et al, 1982).

Essential communication skills

What skills do good communicators demonstrate? First and foremost, they listen. Many doctors interrupt within the first 20 seconds of the patient explaining their symptoms (Groopman, 2007). Doctors are trained to home in on symptoms and ask significant questions to confirm or refute a diagnosis. But when focusing on this alone, doctors may find their patient 'hanging on the door frame' – that is, when the patient is leaving the consultation room they hang on the door frame and say, 'Oh doctor, what I really wanted to tell you about was….the pain in my chest, ….the blood in my urine.' And then you have to begin again and that takes much longer than if you had listened without interruption at the very beginning. And it doesn't take as long as you may think – on average the patient takes around 90 seconds to describe their concerns (Rabinowitz et al, 2004).

While you listen, you need to focus on the patient. In Western cultures we know someone is interested in us if they are looking at us and not at the computer screen, looking through results or thinking about the next patient. Eye contact is how we know someone is listening to us and interested in what we are saying. Do not underestimate the power of non-verbal communication. The human limbic system is geared towards reading subtle signs and we instinctively know whether what people are saying or doing is congruent with what they mean.

Good communicators show they have been actively listening by using the patient's own words. For example, if the patient describes a pain as 'a hot prickle' it is advisable to repeat these words exactly in the conversation, without changing or interpreting what the patient says. This helps build rapport and trust and patients will be much more likely to then listen to what you have to say in response.

'Matching' patients is a powerful way to put them at ease and build rapport. People live in their own world, creating a map of what they believe the world to be like, and try to make

sense of other people's worlds. To build rapport by 'matching' someone, you reflect their own world back to them. Matching involves reflecting the patient's body language, breathing, tone and volume of voice, and their values. This is not copying; it is a respectful matching of some aspects of how people communicate, in order to put them at their ease.

Traditionally paternalistic, medicine has increasingly moved to patient-centred care, where patients are involved in decisions about their own treatment. Involvement significantly increases compliance. You can begin this process by asking the patient about their thoughts, beliefs and concerns about their illness. What do they think is causing it? What have they tried so far that has helped? What has been the effect of the symptoms on their life? Asking these types of questions significantly raises patients' satisfaction (Stewart, 1984; Arborelius & Bromberg, 1992).

Meeting patient expectations of a consultation is a significant factor in reducing complaints. What are they anticipating is going to happen today? What questions would they particularly like to ask? Once you have established what the patient expects, you can then be realistic about what you can and can't achieve that day and ensure at the end of the interview you have addressed these particular issues. This can also help with time management.

Patients remember only a small proportion of what their doctor said. There are a number of ways you can significantly increase the amount of information a patient remembers. Begin by making it clear to the patient where you are in the process of the interview and what is going to happen next. The longer you are a doctor the less likely you are to remember what it is like to be a lay person. A female patient presenting with stomach problems won't normally understand why you want to listen to her heart and so have to move her left breast out of the way. Explaining what you are doing and why, before you do it, can avoid misinterpretation by patients.

Many doctors draw diagrams for patients to take away and use patient information leaflets for patients to refer to later. Asking the patient to repeat in their own words what they have understood of the consultation can increase recall by up to 30% (Bertakis, 1977). Dictating a follow-up letter while the patient is there also helps patient recall.

Feedback

Talking and reading about communication skills is all very well and can help inform ideas but ultimately you need feedback from others. The increased requirements of appraisal and revalidation have stressed the use of 360° feedback from colleagues and patients. It can sometimes be a shock to find others think your communication skills could be improved. One-to-one personal coaching can help.

Good communication is all about being able to see things from the other person's perspective. If you can imagine how it may be for them and treat them with the respect you would hope to be shown towards you or a member of your family, then you will go a long way to becoming a good communicator.

Dr Emma Sedgwick
Director, Healthcare Performance
www.healthcareperformance.co.uk

Dr Emma Sedgwick and Dr Mike Roddis of Healthcare Performance facilitate the MDU's 'Effective communication with patients' and 'Effective communication with colleagues' workshops. Courses are held at the MDU offices in London.

See page 27 for details of courses in 2011 and how to book.

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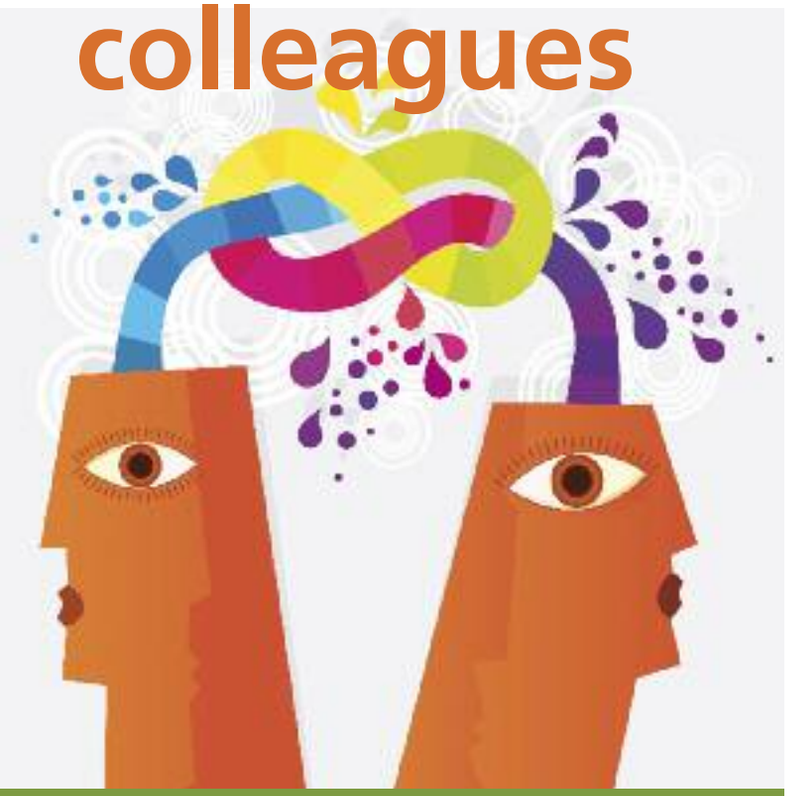
COMMUNICATION

Good communication with colleagues



Patients' lives depend on open and honest communication between doctors. Complaints, claims for medical negligence, dismissal and criminal convictions can also arise as a result of poor communication. Dr Louise Dale, MDU medico-legal adviser, reports.

To practise good medical care is to practise ethically. Doctors have a moral responsibility that dictates the highest standards in all aspects of their work and having sublime surgical skills or being a world renowned expert are not enough in themselves to fulfil this ethical obligation. Doctors should also remain vigilant in ensuring that their communication with colleagues is promoting best practice and excellence in patient care.

The GMC advises that effective communication with colleagues is essential for good healthcare[1], and places an ethical duty on all doctors to ensure their senior managers, peers and junior staff have the information they need, when they need it.

Fitness to practise may be called into question when communication between doctors is lacking or inappropriate. One of the fundamental ethical principles underpinning the modern practice of medicine is nonmaleficence, ie doctors should not harm their patients[2]. In cases notified to the MDU, poor communication has been shown to cause delays and wrong treatment, which may consequently harm patients. The GMC can therefore investigate a doctor's fitness to practise if they have harmed patients by failing to communicate appropriately or adequately with colleagues.

Communication styles

Doctors will no doubt recognise that communication is unethical when it is absent, delayed or when misleading information is intentionally given to the patient. However, some doctors may not fully appreciate that some styles and methods of communication may also be harmful and unethical. In a working environment where doctors and other staff feel they must never question management and procedure, or feel unable to ask for help, situations may arise that do not benefit patients. It may even lead to mistakes that harm patients.

Accusations of bullying and intimidation can be a feature of some disciplinary and GMC cases. Sometimes, when communication breaks down between colleagues, the "dysfunctional department" can become the focus of the investigation, rather than any sub-optimal clinical performance on the part of the doctors involved. GMC guidance[3] requires doctors to treat colleagues 'fairly and with respect', and not to make 'malicious or unfounded criticisms of colleagues that could undermine patients' trust in the care they receive or the judgment of those treating them'. In the worst cases, doctors' health can suffer as a result of hostility towards them.

In *Good Medical Practice*, the GMC says that doctors must respect the skills and contributions of colleagues[4]. The GMC also says that doctors should act as a positive role model and try to motivate and inspire colleagues[5]. Senior doctors therefore have an ethical obligation to promote a climate of openness in their departments, where doctors of all grades respect one another. All doctors have an ethical duty to give and accept constructive criticism to improve practice to the benefit of patients. GMC guidance requires doctors to 'participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies'[6].

In an ideal secondary care setting, clinical leaders will have open discussions within their teams and across specialties, whenever good clinical care dictates this. Written and verbal communication methods will be clear and appropriate. Such a climate would reduce the occurrence of unforeseen harm to patients that might follow.

Consequences

Although failures in communication at the primary-secondary care interface can be a cause of problems, the MDU often assists members with the consequences of poor communication between colleagues within the secondary care setting, perhaps reflecting the greater number of clinicians involved in patients' care, as the following indicative scenarios demonstrate.

Disciplinary action

A consultant specialist in mental healthcare of the elderly admitted a 70-year old male psychotic patient from her outpatient clinic without any clear oral or written instructions to the juniors on her team. Three weeks after admission, without the correct steroid medication, the patient suffered a loss of vision from temporal arteritis, from which he never recovered. The trust responded to this critical incident by suspending the consultant while it undertook a lengthy investigation. This revealed poor communication between the consultant and her juniors and also between the juniors within the team which had meant that the patient's medication had been overlooked. MDU assistance enabled the consultant to be reinstated without sanction but extensive changes were made to the admitting procedures and communication methods within the department.

Gross negligence manslaughter

A 15-year old girl with a history of nausea was seen in a casualty department by a consultant paediatrician who gave oral instructions to an ST1 that the patient could be discharged after the x-rays were checked. The ST1 went off shift shortly afterwards. The ST2 who came on duty next discharged the patient. The girl collapsed and died two days later from a subdural haematoma. The skull x-ray was subsequently found to show a parietal fracture.

In a statement the ST2 later said he had felt unable to query with the consultant, who was always aloof and irritable, the meaning of the message he had been given by the ST1. He alleged that the ST1 told him that the consultant had said to discharge the patient straight away. The consultant and both juniors were interviewed under caution at a police station, in relation to allegations of gross negligence manslaughter.

The consultant, an MDU member, was assisted in the interview under caution and after some time the police told him that they were taking no further action. The MDU assisted subsequently at an inquest, because of the potential conflict between the consultant and junior doctors.

Complaints and claims

When patients overhear disputes between doctors, complaints may easily ensue. In one case, an elderly patient presented to casualty with necrotising fasciitis of his leg. His daughter brought a complaint that she had overheard doctors from several specialties arguing over who would take responsibility. There was a considerable delay in admitting the man who, despite surgery, went on to die from his condition. His daughter also brought a claim for medical negligence, citing the disputes and consequent delays as contributing factors in her father's death.

Emails and social networks

The MDU is now starting to see cases of exclusion, dismissal and GMC investigation for inappropriate use of emails and social networking sites to criticise colleagues.

Hospital teams and departments that encourage an atmosphere of honest dialogue and respect for all team members demonstrate ethical medical practice that benefits patients and doctors alike. Doctors should endeavour to foster a culture of constructive communication that enables safe and effective clinical care.

The MDU advises:

- Honestly assess your communication style for approachability and openness; 360° appraisal may be helpful in this regard.
- Have difficult or sensitive discussions with colleagues in private, away from patients or their relatives.
- Document instructions to colleagues and other members of the healthcare team clearly in the clinical records. If oral instructions have been given, consider carefully how you ensure these have been carried out.
- Consultants should check that instructions have been understood correctly by juniors, perhaps by summarising key action points at the end of a discussion and encouraging questions. If possible review any notes made to ensure that there is no misunderstanding of instructions given.
- Have robust protocols for junior doctors at shift changeovers and when patients are admitted or discharged. Consider the use of audit to assess whether such arrangements are effective.
- Do not use emails or social networking sites to raise criticisms about colleagues. Where it is necessary to raise such concerns you should follow your trust's procedures and ensure any comments made are factual, accurate and verifiable. Contact the MDU for advice if you are unsure of your professional, ethical responsibilities.

References

[1] GMC Management for Doctors (2006), para 51

[2] Principles of Biomedical Ethics, Beauchamp and Childress (Oxford University Press)

[3] GMC Good Medical Practice (2006), paras 46, 47

[4] GMC Good Medical Practice (2006), para 41a

[5] GMC Good Medical Practice (2006), para 41

[6] GMC Good Medical Practice (2006), para 41d

These are fictional cases compiled from actual cases in the MDU files.

CLAIMS ANALYSIS

Bones of **contention**

An analysis of MDU claims for orthopaedic and trauma procedures

Awards for damages in orthopaedic surgery are increasing. Settlements of over £1 million in individual cases, while still the exception, are no longer unheard of. The MDU Journal looks at trends in orthopaedic and trauma claims.

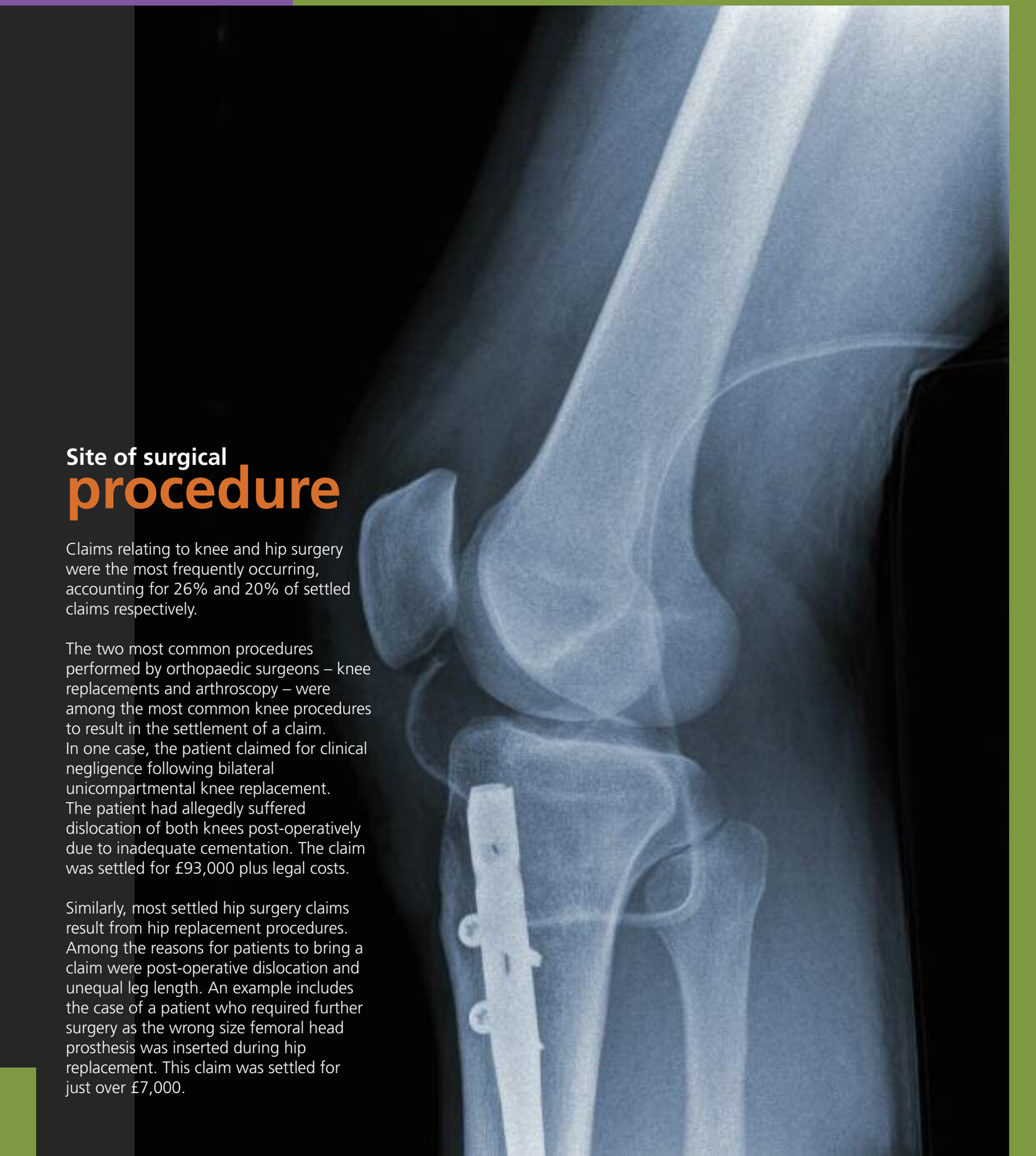
In comparison with the number of successful orthopaedic procedures undertaken every day, the percentage that go wrong or where the patient is unhappy with the outcome is still relatively small.

An analysis of 248 orthopaedic claims settled by the MDU shows that damages awarded to patients who have been negligently harmed are rising steadily. The average settlement of claims in this study was in excess of £60,000 and it seems likely this figure will increase in line with the general trend of rising settlement values.

Payments for the ten highest value claims averaged almost £800,000, for incidents including deep vein thrombosis and AV malformation following left total knee replacement and subsequent manipulation and arthroscopic division, and damage to the popliteal artery during orthopaedic correction of bilateral leg deformities.

Awards for damages, excluding legal costs, ranged from £1,000 for scarring of the lower leg during removal of a plaster cast, to almost £1.1 million for a patient who suffered an incomplete cervical cord lesion following administration of an interscalene brachial plexus block.

The level of compensation is not related to the perceived gravity of any alleged negligence but is calculated according to how much it would cost to restore the patient to the position they would be in had the negligence not occurred.



Site of surgical procedure

Claims relating to knee and hip surgery were the most frequently occurring, accounting for 26% and 20% of settled claims respectively.

The two most common procedures performed by orthopaedic surgeons – knee replacements and arthroscopy – were among the most common knee procedures to result in the settlement of a claim. In one case, the patient claimed for clinical negligence following bilateral unicompartmental knee replacement. The patient had allegedly suffered dislocation of both knees post-operatively due to inadequate cementation. The claim was settled for £93,000 plus legal costs.

Similarly, most settled hip surgery claims result from hip replacement procedures. Among the reasons for patients to bring a claim were post-operative dislocation and unequal leg length. An example includes the case of a patient who required further surgery as the wrong size femoral head prosthesis was inserted during hip replacement. This claim was settled for just over £7,000.

CLAIMS ANALYSIS

Reason for claims

The primary reason patients brought a claim for clinical negligence was that they had experienced an unsatisfactory outcome, ranging from ongoing pain and loss of mobility to nerve damage, infection and tissue damage. In a number of cases, patients required corrective surgery as a result of technical problems during a procedure that orthopaedic experts considered amounted to negligence.

Several cases highlighted the need for improved pre-operative counselling to ensure patients have realistic expectations of what surgery can achieve and the likelihood of complications. There were nine claims in which failure to obtain fully informed consent was cited as the primary factor.

Diagnosis

There were 22 cases in the review period where diagnosis was alleged to have been missed or delayed, or the wrong diagnosis made, including fractures, dislocation, deep vein thrombosis and cancer.

It can sometimes be difficult to make a diagnosis on clinical grounds alone and expert advice in these cases found some recurring themes, including:

- Inadequate patient examination and delays in arranging further investigation.
- Inadequate recording of clinical history, particularly following trauma.
- Diagnoses considered but not excluded.

In an ideal secondary care setting, clinical leaders will have open discussions within their teams and across specialties, whenever good clinical care dictates this. Written and verbal communication methods will be clear and appropriate. Such a climate would reduce the occurrence of unforeseen harm to patients that might follow.

Wrong site surgery

Although rare, the MDU settled six claims where an operation was carried out on the wrong site or side, and where the wrong operation was performed. In one case, the procedure was performed on the wrong patient. Such cases are difficult to defend successfully.

The MDU advises members to perform simple checks, in addition to any automated patient identification systems which are used. These include asking the patient to state (not simply confirm) their name, date of birth and anatomical location of the intended procedure and confirming with the patient that all details are correct at all stages: on admission, en route to theatre, on entering the theatre suite, and so on.

Retained items

A very small number of the claims in the analysis involved a retained item following an orthopaedic procedure. Problems can be minimised by ensuring all equipment is maintained and serviced regularly and that swab, instrument and needle-counting policies are adhered to. All disposable items should also be checked before use.

Manage the risk –

CONSENT

The MDU offers this advice for obtaining consent:

- Ensure consent is obtained by an appropriate member of the surgical team, ideally the surgeon who performs the operation.
- Advise the patient of the risks and benefits of surgery, other treatment alternatives, the option of no treatment and the complication rates – and document this.
- Diagrams and other written information may help patient understanding and copies should be retained in the notes.
- Check the patient understands, and assess for unrealistic expectations.
- Ensure the patient is aware of the possible post-operative complications and knows what steps to take if problems arise after discharge from hospital.

DIAGNOSTIC ERRORS

It is not necessarily negligent to fail to make or delay in making a diagnosis. However, the MDU offers this advice for orthopaedic surgeons:

- Take a thorough clinical history.
- Conduct a thorough examination of all areas that could be injured and make a note of this.
- Make a note of the initial diagnosis and management plan in the record and be prepared to review and reassess the diagnosis if symptoms fail to improve as expected.
- Ensure that appropriate investigations, x-rays and other tests are carried out, the results reviewed and action taken where necessary, and that you document all this in the records.

Case scenarios

Scenario 1

Missing screw

A consultant orthopaedic surgeon who misplaced a screw in a patient's knee was not negligent.

The surgeon operated on a 47-year old patient to reconstruct the anterior cruciate ligament in his left knee. During surgery, a 10mm bio-absorbable screw, intended to fix the tibial side of the graft, was lost in the wound and could not be found. An arthroscopic search within the joint was in vain.

Several days later, the patient underwent an MRI scan which showed the screw behind the ligamentum patellae. It was removed surgically and the patient recovered well.

The patient brought a claim for negligence alleging that the surgeon should never have lost the screw, and that he should have found and removed it as soon as he realised it was lost, saving the patient from a second operation and continued pain and stiffness in the knee.

The MDU sought advice from an expert orthopaedic surgeon who advised that to lose a 10mm screw during an ACL reconstruction was not necessarily negligent. The expert thought the surgeon had searched diligently to locate it and that he had dealt with the problem promptly and correctly and within an acceptable period of time.

The MDU denied liability, maintaining the care the claimant received was consistent with that of a responsible body of orthopaedic surgeons. The claim was discontinued.

Scenario 2

Shouldering the blame

A dispute over whether consent was properly obtained highlights the importance of effective record-keeping.

A young female patient was referred to a consultant orthopaedic surgeon. Following a dislocation injury of her left shoulder, she experienced a continual 'catching' sensation and an MRI scan revealed a Bankart lesion. During the consultation, the surgeon assessed the patient and discussed with her the available management options, including conservative management.

The patient opted for surgery and underwent arthroscopic assessment of her shoulder and anterior stabilisation in the form of Bankart repair with soluble tacks. The surgery was uneventful and the patient returned to her job as a sports coach.

Subsequently, the patient underwent further arthroscopy on the left shoulder which identified loose tacks. These were removed.

The surgeon who carried out the first operation, an MDU member, received a letter of claim from the patient alleging that he had given her inadequate information pre-operatively about the risks and benefits of arthroscopic as opposed to open surgery. She also maintained that the operation was performed negligently and the tacks should not have become loose. She claimed that she was unable to work as a result of her shoulder problems.

Expert opinion agreed that the surgery was not carried out negligently and that the patient's prognosis would have been no different whichever operation was carried out. However, there remained a dispute over consent. The surgeon could not recall exactly what risks he had warned the patient about. As he was anxious not to go to trial over a factual dispute, it was decided to settle. The claimant's solicitors said the claim would be worth over £500,000.

Eventually, a settlement offer of £15,000 was accepted by the claimant. The legal costs amounted to £42,000.

Learning point

In seeking patient consent to a procedure, members are advised to note comprehensively in the records all information given to the patient. This should cover all treatment options as well as the option of no treatment.

ADVICE LINE DILEMMAS

Following publication of new Department of Health guidance on disclosure of patient information, the MDU Journal shares some recent advice line cases regarding this difficult ethical area.

Crime threat

The scene

A young psychiatric patient openly admitted to his consultant during a routine consultation that he wanted to go back to prison and would commit a crime in order to do so. Although the patient's psychiatric symptoms were well-controlled at the time, the psychiatrist believed the threat was real. He told the patient that he might have to disclose this information to the police. The patient was clearly unhappy about this and refused consent.

The psychiatrist called the MDU for advice and on the basis of that advice (see below), rang the police to inform them about the patient's threat. It turned out that a crime had already been committed. The police suspected this patient and wanted more information about him, mostly relating to his appearance and mental health condition, to help them trace him. Before saying more to the police, the psychiatrist contacted the MDU again.

The advice

On first calling the MDU advisory helpline, the member's dilemma concerned disclosure of information without consent on the grounds of the public interest – ie the prevention of a serious crime. When considering a public interest disclosure of confidential patient information, the doctor has to weigh up the benefits of a disclosure to the patient and to society against the public's and patient's interests in keeping the information confidential. To make this decision, the doctor needs to consider the risks of not disclosing and weigh this against the harm which might result from making the disclosure.

The second call to the advice line concerned disclosure of additional information to the police after the crime had been committed. The GMC advises that information may be disclosed without consent to assist with the detection or prosecution of a serious crime. 'Serious crime' is not defined but the MDU advises that this should usually be interpreted as including violent crimes against a person. The adviser suggested the member should seek more information from the police about the crime (such as, had anyone been harmed?) so that he could weigh up the harms and benefits in relation to further disclosure without consent. If disclosure could be justified, it would be important just to disclose the minimum necessary information, and document carefully any reasons for disclosure. At this stage, there did not appear to be any justification for disclosing medical information but disclosure of information about the patient's appearance and what he had been wearing might have been justified.

When considering a disclosure in the public interest a doctor should usually tell the patient they intend to do this, and then confirm to the patient after they have made the disclosure. The member had already told the patient that he intended to disclose the information but he was concerned about telling the patient that he had made this disclosure. GMC guidance *Confidentiality* paragraph 39 does not require a doctor to inform a patient about a disclosure if to do so would put anyone at risk, but the reasons for such a decision must be carefully documented.

In an evolving situation, members may call the advice line for further advice at each step.

ADVICE LINE DILEMMAS

Emails and recorded calls

The scene

A patient applied to her GP practice for copies of all emails sent between doctors about her – including between her GP and her consultant gynaecologist – dating back seven years to before the birth of her first child. As the practice routinely recorded all calls made to and from the practice, she also asked for release of telephone calls between her GP and gynaecologist.

Having been advised by the local primary care body that the information held in this form need not be disclosed, the practice manager rang the MDU advice line for clarification of the medico-legal position.

The advice

This is an unusual case, but such requests are likely to become more frequent. The MDU adviser observed that, generally, patients ask for disclosure of their records, as they are entitled to under the Data Protection Act 1998 (DPA). However, it is advisable to be aware of what might need to be disclosed to the patient relating to communications between doctors, and between doctors and other healthcare professionals, if the patient requests it.

Emails are increasingly used by clinicians in primary and secondary care to communicate about patients. To some extent they replace informal (and non-recorded) chats that might formerly have taken place by phone. As they are effectively 'information that is held electronically', the emails fall under the requirements of the DPA and must be disclosed on the patient's request.

Call recordings can also be the subject of disclosure requests from patients. All recorded calls must be disclosed under the DPA (subject to the usual exclusions where disclosure of the data would identify a third party without their consent or if disclosure of the information is likely to cause serious harm to the physical or mental health or condition of the applicant or someone else). When calls are recorded, all parties, both within the practice and those calling in, should be made aware that the recordings are being made and if patients refuse consent, their calls may not be recorded.

The adviser added that with recorded calls, doctors should bear in mind that what they say about the patient could be disclosed to him or her in the future.

New GMC guidance

New GMC guidance on making and using visual and audio recordings of patients, published in April 2011, reiterates the principle that patients' privacy and dignity must be respected, and their consent or valid authority obtained before recordings are made. It states that telephone calls may be recorded for legitimate reasons (such as medico-legal purposes, staff training and audit), providing that 'all reasonable steps' have been taken to inform the caller that the conversation may be recorded. Doctors must not make secret recordings of telephone conversations with patients.

These are fictional cases compiled from actual cases in the MDU files.

FEATURE

Expert Witness Immunity

Expert witnesses are no longer immune from actions for breach of duty following the judgment in Jones v Kaney (2011).

The immunity of expert witnesses dates back over 400 years. Immunity ensured that an expert, medical or other professional discipline, could not be sued by his client if he acted negligently in his role as an expert witness when preparing for trial. This included the preparation of reports for service on the opposition, conferences and oral evidence.

At that time, there were public policy reasons for granting such immunity. It was considered to be in the public interest that experts should feel free to give their honest professional advice in litigation cases, for the benefit of the court, without the threat of being sued by disgruntled clients. In the past, it was also felt advisable to encourage professionals to act as experts. The position has now changed following the supreme court decision in *Jones v Kaney*[1].

In the majority decision, the supreme court ruled that experts are no longer immune from actions for breach of duty. There is no question of the judgment creating a new duty owed by the expert to the party who engages his services, or that previously the duty was only owed to the court. The duty has always been owed to the engaging party. It was simply that there was previously a public policy to give immunity in relation to that breach of duty and since the ruling there is not.

The judgment is clear that experts continue to enjoy absolute privilege in respect of claims in defamation, so immunity persists in that respect. Immunity will also continue as before for witnesses of fact, who owe no duty to a claimant and are not motivated by contractual or other reasons to give evidence; in fact, they have no option but to do so.

The position for MDU members

For MDU members who act as experts, their duty to the court is as before. If those who instruct an expert believe he or she has been negligent in their advice, or has breached a contractual duty to exercise reasonable skill and judgment, then they are entitled to issue proceedings to recover damages.

However, claimants will still need to show breach of duty under the *Bolam* test. An expert accused of negligence will be entitled to be judged by the standards of other experts in his discipline. Even if breach of duty were to be established, the claimant will have to show he has suffered a loss.

FEATURE

Dr Michael Devlin, head of MDU advisory services, observes that the judgment may cause some concern among members who act as experts, but offers this reassurance: 'Experts who carry out their duties with diligence, skill and care should not be troubled by the loss of immunity.'

Guidance for experts

Despite the judgment, expert witnesses are still expected to meet the responsibilities previously set out in Civil Procedure Rule 35.3 which states:

- It is the duty of experts to help the court on matters within their expertise.
- This duty overrides any obligation to the person from whom experts have received instructions or by whom they are paid.

Experts have always been, and continue to be, expected to be impartial and so even when instructed by one party, they must provide evidence that is a true representation to the courts and is not misleading in anyway. As stated in the *Protocol for the Instruction of Experts to give evidence in Civil Claims 2005*, paragraph 4.1:

"Experts always owe a duty to exercise reasonable skill and care to those instructing them, and to comply with any relevant professional code of ethics. However, when they are instructed to give or prepare evidence...they have an overriding duty to help the court on matters within their expertise. This duty overrides an obligation to the person instructing or paying them."

Similarly, the 2008 GMC guidance, *Acting as an Expert Witness – a Guide to Doctors* states: "...you have a duty to act independently and not be influenced by the party that retains you."

If you act as an expert witness, you may be concerned about the removal of immunity, but it is important to remember that fundamentally the role has not changed and that your overriding responsibility is to the court and to act in a manner that allows the court to reach balanced decisions based on impartial expert evidence.

Remember, the MDU provides indemnity for medico-legal work under the Professional Indemnity Insurance policy. Members undertaking expert witness work will need to be sure the MDU is aware of the full extent of their work.

Jones v Kaney – the facts

The case arose out of a road traffic accident in which J had been knocked off his motorbike. Liability was admitted and the only issue was the amount of damages. J alleged physical and psychiatric injuries.

J's solicitors instructed K, a consultant psychologist to examine J and report for the purpose of his claim. K examined J and diagnosed that he was suffering from PTSD; subsequently, on re-examination, it was her view that he did not have all the signs for a diagnosis of PTSD but was still suffering from depression.

The matter proceeded and K was required by the district judge to participate in a joint discussion with the psychiatrist appointed by the insurers against whom the claim was brought to provide a joint statement. A draft joint statement was prepared by the insurer's expert, which K signed without amendment or comment. The statement noted that J's reaction to the accident was no more than an adjustment reaction; it also stated that K had found J to be deceptive and deceitful in his reporting of his symptoms and agreed his behaviour cast doubt on the genuineness of his subjective reporting.

Following this, K told her instructing solicitors that she had not seen her opponent's reports before the discussion and that the joint statement did not reflect what she had agreed but she felt pressured to sign it. In truth she had found J evasive rather than deceptive and that he had suffered from PTSD which was now resolved. She said she was happy for the joint statement to be amended.

As a result, the claim was settled for less than J otherwise would have anticipated.

J sued K as it was his case that he was constrained to settle the claim for significantly less than would have been achieved had she not signed the joint statement in the terms that she did. K claimed immunity as an expert. At the first trial, the judge found against J but granted him permission to appeal the matter directly to the supreme court.

The supreme court decided the immunity could no longer be allowed to stand for a number of reasons, including:

- All experts have a duty to the court to give an honest and professional opinion. There is no conflict between the duty owed by the expert to the court and that owed to the client. It is an implied term of the contract that the expert will exercise reasonable skill and care in undertaking his duties on behalf of his client.
- There is no evidence that experts will be reluctant to testify or to accept instructions.
- The immunity only applies to acts in contemplation of or preparation for trial, whereas the vast majority of cases settle pre-trial and most expert advice relates to pre-action settlements so would not benefit from the immunity.

Reference
[1] Jones v Kaney [2011] UKSC 13

CASE HISTORY

BLOODGATE

Charles Dewhurst, head of MDU legal services, explains the story of 'Bloodgate'

Photo: Karina Hoskyns

A case well known but not well understood, 'Bloodgate' first came to the media's attention when the European Rugby Cup (ERC) investigated an incident in the Heineken Cup game between Harlequins and Leinster in April 2009.

The game was a crucial quarter-final, tantalisingly poised with Leinster leading 6 – 5 as the match approached the last five minutes. But Harlequins' fly-half Nick Evans had been replaced by Chris Malone who then suffered a torn hamstring, leaving them with no recognised goal-kicker on the field. Evans couldn't come back on – except as a replacement for a blood injury. When winger Tom Williams went down and was led off by physio Steph Brennan with blood apparently pouring from his mouth, Evans was on but officials had smelled a rat.

The ERC brought charges against Harlequins, and individually against Williams, Brennan, and director of rugby Dean Richards, alleging involvement in the fabrication of a blood injury to allow Evans' return to the field of play. There was also a charge against the MDU's member Dr Wendy Chapman, a match-day doctor

CASE HISTORY

at the game. Based mainly on the evidence of the Sky video footage, Williams was found guilty and suspended from rugby for 12 months; but the cases against Richards and Brennan were not proved.

Williams, feeling he had been made the scapegoat, appealed. He wished to give fresh evidence: that Richards had directed he would come off for a blood injury; Brennan had provided him with a blood capsule which he had used to fabricate injury; after he had left the field he had asked Chapman to cut his lip which she did; and Richards had told him to lie about the true facts.

At the appeal hearing in August 2009, Williams' suspension was reduced to four months; Richards was found guilty and banned for three years; and Brennan found guilty and banned from rugby for two years.

The ERC case against Chapman had been that she had known of or assisted in the fabrication to allow Evans to return. But she had had no involvement to that point, and the case against her had been dismissed accordingly on a submission of no case to answer. Therefore there was no jurisdiction for the appeal committee to entertain an appeal, and they could make no determination on the 'cut lip' allegation, but observed: '... there is no evidence of any premeditated conduct on the part of Dr Chapman... It is apparent the atmosphere in the physio's room and changing room was fraught, heated and intense. It is not surprising that persons inexperienced in such circumstances should have become swept up in events... The situation ... which Mr Richards acknowledges he had instigated ... resulted in intense pressure on all those involved. They had no time to reflect. They were reacting to a set of circumstances ... (for) which they were wholly unprepared.'

The GMC initiated its own investigation of the allegation against Dr Chapman, and also referred it to the Interim Orders Panel (IOP). In October, the IOP received evidence that the doctor had been suffering with a major depressive disorder for a year at least (she had in fact been referred to occupational health before the rugby incident), and the interim suspension of her registration took that into account.

The ERC had progressed from appeal to hearing in a mere nine days. By contrast, the GMC process took a long 12 months, during which time Dr Chapman was struggling to recover from her depression, facing continuing and intrusive press interest, subject to questions from her trust, and preparing for the GMC fitness to practise (FTP) hearing listed for August 2010.

By April, she was considered fit for a phased return to work, invited by the Trust to consider non-clinical work options (within the constraint of the ongoing IOP suspension), then in May suddenly told she was being 'excluded', then that she was 'suspended', without pay.

As the hearing approached, Dr Chapman was diagnosed in July with breast cancer, requiring major surgery. But the thought of putting the hearing off was worse than the prospect of attending in discomfort, and no application for an adjournment was made.

At the hearing, the FTP panel heard evidence about Dr Chapman's examination of the player in the physio room, of two officials coming into the room shouting, of the doctor's suspicions being aroused by the colour and texture of the 'blood', and then of the player demanding to be cut – 'I've got to have a real injury'. Horrified to realise that they had cheated, she refused, and refused several times, before eventually giving in to the 'extreme pressure' from the player, attested to by an independent witness who was present.

Having waited 12 months from Williams' appeal to give her account, Chapman did not seek to defend her actions. She said she felt ashamed that she had done the wrong thing. She didn't understand how she had acted the way she had, and why she didn't just walk out. In the aftermath, she discovered everyone else involved was saying it was real blood, she didn't know what to do, and there was no-one she felt she could confide in. 'As I've got better, it's become harder and harder to understand how I did it'.

The panel heard from two psychiatrists and also read the report of Dr Chapman's treating psychiatrist. The psychiatric evidence, uncontested by the GMC, was that she had been suffering from depression for two years, was severely depressed at the time, her judgment was impaired, and that she acted in the way she did at the match and later because of her depressive disorder.
Dr Adrianne Reveley, consultant psychiatrist, and Dr Clare Gerada, director of the Practitioner Health Programme[1], were agreed that the incidents would not have occurred if she had not been depressed.

The panel accepted all this evidence. They said that Dr Chapman's ill-health was particularly relevant to the context of the misconduct. She was placed in a 'difficult and unique situation'. Her judgment had been impaired and, as they told her, 'the circumstances of this case are wholly exceptional in that the expert evidence suggests that in the absence of depression, you would not have acted in this way'. She had insight, had admitted her errors and publicly acknowledged that her behaviour was wrong, had an unblemished career, and was a 'good and useful doctor'. Her fitness to practise, they found, was not impaired.

Dr Chapman received much support in the preparation for and at the time of the hearing. Noteworthy was the evidence of Professor Arthur Tanner, the club doctor for Harlequins' opponents Leinster. He expressed sympathy for her, said that in all his years in rugby he had never himself been placed in the situation in which she found herself, and described it as 'unique' and a 'nightmare'. He wanted to convey to the panel the abnormal environment in which events had occurred.

It was vital that, unlike the other parties who initially were jointly represented with Harlequins, Wendy Chapman sought the MDU's assistance and was separately represented from the outset. This case was an extreme example of how incidents can escalate, and it was possible to manage these developments as they arose.

Viewed by some without knowledge of all the circumstances as a surprising outcome, the no impairment determination was the right decision – or, as Clare Gerada put it on being informed, 'a testament to common sense'.

This article is published with the permission of Dr Wendy Chapman.

Reference

[1] The Practitioner Health Programme is a confidential service for doctors and dentists who have mental or physical health concerns and/or addiction problems. www.php.nhs.uk

END PIECE

Licence TO PRACTISE

If you are registered with the GMC but no longer in direct clinical contact with patients, you may have considered relinquishing your licence to practise. Think carefully before you do so, advises Dr Matthew Lee, MDU professional services director.

Medicine offers a huge range of career opportunities, from the sharp end of clinical practice through to cutting-edge laboratory research. Many roles undertaken by doctors do not involve any contact with patients and we have received a number of enquiries from members uncertain whether they need to retain a licence to practise when no component of their current work involves direct contact with patients.

There are certain activities that can only be performed by registered and licensed medical practitioners and these are outlined in detail on the GMC website. Even when working in roles that do not legally require doctors to hold a licence, a number of employers and other bodies have also specified that doctors undertaking certain roles for them must retain a licence alongside their registration.

But what if your current work neither legally nor contractually requires you to retain a licence? Revalidation to maintain a licence will, in time, require registrants to associate with a responsible officer, undertake regular CPD, participate in multi-source feedback and, of course, pay a higher annual retention fee to the GMC. Easier and cheaper, surely, to relinquish your licence to practise and renew it when and if you return to clinical work?

It is a tempting thought, but carries a rather large caveat. Think carefully about your long-term ambitions before making any move to hand in your licence. Reapplying for a licence at a later date may not be altogether straightforward, particularly once revalidation comes into force. You might not currently be planning to undertake functions requiring a licence but is there a chance that you may want to at some point in the future?

Currently, a registered doctor wanting to reapply for a licence has to provide evidence of identity (and possibly undergo an identity check) and a medical services statement from their most recent employer. If you are registered in any other country or countries you will also need a certificate of good standing from each registration body.

At the time of writing it is unclear quite how the reapplication process will work once revalidation and relicensing are rolled out but it is likely that restoring a relinquished licence will become increasingly difficult and may require applicants to find a responsible officer and demonstrate their fitness to practise in some way.

Furthermore, applicants may find themselves restricted to working in 'approved' settings which may limit the scope of any planned return to clinical work.

Until the position is clearer post-revalidation, the MDU's advice is to resist the apparent attractions of working without a licence.

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