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125
YEARS
LEADING
THE WAY

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Journal

125th Anniversary Issue



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CONTENTS

News

Civil litigation reforms welcomed
 Concerns over CPS assisted suicide policy
 Tougher data protection sanctions
 Good records
 Patient feedback on NHS Choices
 MDU appointments
 Tax rules and disclosure of information
 Can high jinks jeopardise a budding medical career?
 New GMC guidance on research

Membership

Tax advice helpline for doctors
 My MDU - a new way to manage your membership
 Sending patient data to the MDU
 The true cost of defence

Cover story – Celebrating our 125th anniversary

Assisting members for 125 years
 Landmark cases – MDU cases that changed the law
 The MDU's rich and colourful history

Features

A guide to setting up in independent practice
 In the hot seat – Jill Harding, MDU head of claims
 Mandatory insurance will protect patients
 Shared care – ensuring patients don't lose out

Claims analysis

Bariatric surgery claims
 Treatment behind bars

Advice line dilemmas

Case histories

Delay in referral nearly proved fatal
 Delayed diagnosis but no damage
 Conflicting opinion
 Miscarriage following laparoscopy
 Failure to diagnose heart disease

03

03

03

03

03

04

04

04

05

05

06

06

06

06

12

08

08

09

10

07

07

13

14

15

17

17

20

23

25

25

26

27

28

29

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MDUJournal

Medical editor
 Dr Karen Roberts



Editor
 Sarah Mougier



Comments and queries from members are welcomed.

Please write to: The Editor, MDUSL, 230 Blackfriars Road, London SE1 8PJ.

The case for mandatory insurance

MDU members, and many other doctors and dentists, will know of the MDU's commitment to indemnity insurance for clinical negligence claims. Members have many reasons for joining the MDU, we know one of them is that MDU membership means you are insured if a clinical negligence claim is made against you, and you don't have to rely only on discretionary indemnity. Discretion provides only a right to ask for indemnity and no right to receive it. Our members value the additional security that insurance brings, because of the protections they receive from a regulated insurance policy which are not available with discretionary indemnity. Insurance also has legal protections for patients who claim compensation that you just don't get with discretion.

So, you might ask yourself, given the undoubted superiority of insurance, why are some doctors and dentists still happy to rely only on discretionary indemnity? And, perhaps more important, given that this is about ensuring that patients are properly compensated, why are doctors and dentists still allowed to rely only on discretionary indemnity?

The MDU thinks this is wrong. We believe it is in our members' and the public interest that all healthcare professionals are insured. We have been using our best efforts to highlight the problems with discretionary indemnity for well over 10 years and find it hard to believe it is still allowed in the UK. In Australia, for example, it was outlawed in 2003. Other professionals whose negligence may harm or damage members of the public such as architects, engineers and solicitors have to be insured, as do many healthcare professionals, other than doctors and dentists.

MDU membership has risen markedly since we first introduced an insurance policy for UK members in 2000. Our members are well over 50% of the UK's doctors, and 30% of dentists. One reason our membership is so strong is because members value the security of an insurance policy; we are still the only mutual medical defence organisation to provide medical and dental members with insurance.

We do so because we believe it is the right thing to do. We believe there should be security for all healthcare professionals who make 'buying decisions' about indemnity, and for patients who need to know they will be properly compensated if they are negligently harmed. We would welcome a medico-legal climate in which all healthcare professionals were insured.

We have made the case to the Department of Health that, in the public interest, insurance should be mandatory for doctors and dentists, and discretionary indemnity should no longer be acceptable. However, it is the Department's stated policy that indemnity (insurance, discretionary, or from NHS bodies) should be mandatory for doctors and dentists as a requirement of registration. To that end, the GDC and GMC were given powers in 2005 and 2006, respectively, to require registrants to have indemnity as a condition of registration, and to make rules defining 'adequate and appropriate indemnity'.

Defining 'adequate and appropriate indemnity' is complex. It covers what is essentially a financial service, so it is perhaps surprising that making the decision was left to healthcare regulators who are the first to admit that, while they are specialists in a number of areas, funding and delivery of financial services are not among them. The MDU, which has over 125 years' experience in this area, has provided information to members of staff and Council of the GMC and GDC and shared legal advice with them, as well as sitting on working groups and making presentations to various committees. However, neither body has made the relevant rules, and any deliberations are now halted as the Department of Health started a policy review of this area in late 2009.

It seems unlikely there will be changes in the near future and this is very unsatisfactory. We believe that in the 21st century doctors, dentists and patients should know there is a contractual guarantee of indemnity for clinical negligence claims, and not just a right to ask for help. There should, surely, be no doubt that compensation, when due, will be forthcoming.



Dr Christine Tomkins
MDU chief executive

Read more about how insurance benefits MDU members on pages 11 and 12.

NEWS

Civil litigation reforms welcomed

The MDU welcomed Lord Justice Jackson's review of costs in civil litigation, published in December 2009, as a positive first step towards reform of the current system.

The recommendations, many of which were proposed by the MDU in its submission paper, will create a system that is fairer to doctors and dentists who face claims for clinical negligence. The present system means they may find themselves funding claims payments which have disproportionately high legal costs.

Jackson criticised the current system of conditional fee arrangements (CFAs) and after the event (ATE) insurance and proposed 'a coherent package of interlocking reforms, designed to control costs and promote access to justice'. In particular, the outcome of civil cases should be to leave successful claimants no worse off than they are at present, while defendants should pay only 'normal and proportionate' costs to successful claimants.

'The recommendations will restore balance and fairness to civil litigation procedures,' commented Jill Harding, MDU Head of Claims.



Concerns over CPS assisted suicide policy

The MDU has grave concerns about how the new Crown Prosecution Service guidance¹ for prosecutors in cases of assisted suicide will be applied to doctors.

The CPS policy is designed to clarify the public interest factors that prosecutors may take into account when deciding whether to bring charges of assisting suicide. Although the policy has not changed the law on assisted suicide, it has shifted the focus of the decision to prosecute on to the motivation of the suspect.

Section 43(14) states that a prosecution is more likely to be required if 'the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional...'. The MDU believes this may result in an increased likelihood of a doctor being investigated for assisted suicide.

Doctors who must usually provide reports and/or medical records when requested to do so by patients may find themselves in some difficulty when the patient who is requesting them is contemplating assisted suicide. A doctor who provides a report or records motivated by compassion may not realise that this may be a criminal offence; others may be unaware of the patient's reason for requesting his or her records.

The MDU's advice remains the same – if a patient approaches you for advice about suicide you should not engage in discussion which assists the patient. Please contact the MDU for advice if you receive a request of this kind.

1. *Policy for prosecutors in respect of cases of encouraging or assisting suicide, CPS, 25th February 2010.*

Tougher data protection sanctions

MDU members who are data controllers should ensure they understand their legal duty under the Data Protection Act 1998 (DPA) to ensure personal information is held secure and protected from unauthorised or unlawful processing.

A data controller is a person who, alone or jointly in common with others, determines the purpose for which and the manner in which any personal data is or is to be processed.

The MDU is reinforcing this advice following new legislation enabling the Information Commissioner's Office (ICO) to order organisations to pay up to £500,000 penalty for serious breaches of the DPA. *The Data Protection (Monetary Penalties) Order 2010*, which came into force on

6 April 2010, is designed to act as a serious deterrent to those who recklessly flout data protection principles.

While it seems unlikely that the Information Commissioner would have to resort to such a sanction in primary care, his office can impose fines where there has been a serious contravention of the DPA which is likely to cause substantial damage or distress and which was either deliberate or the data controller knew or should have known of the risk but failed to take reasonable steps to prevent the contravention. The regulations contain safeguards to ensure that penalties are administered fairly.

For further information on protecting patient information for data controllers, see Membership News page 8.

Good records

Good medical records are essential for safe and effective patient care and successful defence in clinical negligence claims may not be possible if records are incomplete or inadequate. The Royal College of Physicians has defined 12

standards for record-keeping that aim to standardise hospital record-keeping and prevent mis-communication. These can be found at: rcplondon.ac.uk/clinical-standards on the Health Informatics Unit page.

Patient feedback on NHS Choices

Constructive criticism may be helpful, but members concerned by offensive or unsuitable comments on the Department of Health's NHS Choices website can report them to the site's moderators. NHS Choices says it will investigate such complaints as soon as possible and remove comments that do not comply with its terms and conditions.

NHS Choices was established in August 2009 to provide an online forum for patients and others to rate their NHS hospitals and GP practices and post comments.

Site users are encouraged to share their experiences, whether as a patient or family member. However, all patient feedback is moderated and should be 'constructive, truthful and not abusive' and not name individual doctors.



The website is not a forum for complaints about the NHS or individual doctors. It states that 'specific accusations of clinical negligence in which an individual is identified will not be published'.

If you are concerned about personal criticism on the site, contact NHS Direct or talk to one of the MDU's medico-legal advisers.

MDU appointments

Dr Peter Schütte is retiring as head of advisory services after seven years leading the development of the MDU's medical advisory services. Dr Schütte was instrumental in creating a team whose expertise, and commitment to providing the highest standards of care for members, are second to none.

Born and raised in South Africa, Dr Schütte qualified as a doctor at the University of Cape Town. In 1976, he emigrated to the UK, working as a GP, police surgeon and hospital practitioner in anaesthesia before joining the MDU in 1985. He has worked tirelessly to promote the interests of the medical profession, both at the MDU and, recently, on the board of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians (as treasurer). He is also a prolific writer and lecturer.

Dr Schütte will continue as a consultant adviser to the MDU.

Dr Michael Devlin takes over as head of advisory services in June. Dr Devlin joined the MDU in 1997 as a medico-legal adviser. He trained as a GP through the Army and served around the world for six years following full registration. A former Major

in the Royal Army Medical Corps, Dr Devlin also holds an MA in law.

He said: 'I am looking forward to leading an excellent advisory team. The medico-legal landscape is as challenging as it has ever been; the MDU is well-equipped to assist and advise members in a changing regulatory environment.'

Dr Hugh Stewart, has been appointed head of Scottish affairs at the MDU in recognition of the increasing need for doctors in Scotland to be able to access medico-legal advice tailored to Scots law. Dr Stewart, who is also head of case decisions at the MDU and a deputy chief examiner for the Faculty of Forensic and Legal Medicine, will head up the MDU's Scottish team.

With seven medico-legal advisers based in Scotland, the MDU is well equipped to provide expert advice to members north of the border.



Dr Peter Schütte



Dr Michael Devlin



Dr Hugh Stewart

in brief... NEWS

Tax rules and disclosure of information

New rules under the Finance Act 2008 (Schedule 36, part 1) give tax inspectors legal powers to obtain documents relating to private income, to help them check a tax payer's position. This may involve information such as names and addresses from patient invoices, but may occasionally include information about treatment.

The onus is on the tax inspector to prove it is necessary to have confidential patient information. If the request is reasonable, patient consent may not be necessary. However, in the interests of maintaining a professional relationship with the patient, the MDU advises doctors contact the patient first, if practicable and it does not undermine the purpose of the tax inspector's request, and keep a careful record of all discussions. We recommend members seek advice from the MDU.



NEWS

Can high jinks jeopardise a budding medical career?



Medical students who misbehave may find themselves being investigated under their medical schools' fitness to practise (FTP) procedures, which may affect their careers as doctors.

The GMC published revised guidance¹ on student fitness to practise at the end of last year. Students are expected, among other things, to demonstrate that they are honest and trustworthy. A criminal offence committed by a student would be viewed extremely seriously.

The GMC has the power to refuse to grant registration to a graduate whose fitness to practise has been questioned while he or she was a student. But the GMC has said that, while it needs to know everything relating to disciplinary action against a student, a one-off misdemeanour may not necessarily be a cause for concern. Press articles last year suggesting that students are facing disciplinary hearings for such misdemeanours as parking violations on campus and having dirty kitchens were unfounded. There are, in fact, three main

reasons for a referral to a student fitness to practise committee – criminal activity, unprofessional behaviour and illness, particularly mental ill-health.

Professor Timothy David, academic lead for student fitness to practise at the University of Manchester, commented: 'Last year's press reports were misleading. I am not aware of any sudden change in policy at medical schools, or that they are getting tough on students for any misbehaviour. A sense of proportion remains when dealing with students, and it is inconceivable that a student would have to attend a fitness to practise committee purely because of a minor misdemeanour.'

'Nonetheless, medical students should be aware that the highest standards of professional behaviour are expected of them and that the consequences of serious or repeated irresponsible behaviour can be severe.'

1. gmcuk.org/education/undergraduate/professional

New GMC guidance on research

New GMC guidance on conducting clinical research, *Good Practice in Research and Consent for Research*¹, stresses that the safety, dignity and well-being of participants, whether patients or health volunteers, should take precedence over the development of treatments or furthering knowledge.

The MDU receives many calls each year from members asking questions about research. The most common queries are: how much information to give to patients taking part, with whom information may be shared, whether data should be included in the patient's records and indemnity arrangements.

It is vital that patients are given sufficient information about what is involved in the research, including any potential risks, in a way they can understand, together with information leaflets and, if appropriate, a copy of the protocol approved by the ethics committee.

Dr Udvitha Nandasoma, MDU medico-legal adviser, said: 'Clinical research is vitally important for improving healthcare. However, the outcome of each trial may be uncertain and it is important that participants are fully aware of the risks they may be undertaking and give their informed consent.'

1. *Good Practice in Research and Consent for Research*, GMC, 13 April 2010.



NEW tax advice helpline for MDU members

Lines open until 30 June 2010

Now that HM Revenue & Customs (HMRC) has put the spotlight on medical professionals, you may be in need of sound tax advice from an expert you can trust. The MDU has joined forces with Taxwise, one of the UK's leading providers of advice on tax and VAT, to give members the opportunity to consult a team of professionals with many years of experience within both HM Revenue and Customs and accountancy practice.

If you have any tax questions, you can call the new tax advice helpline for members on **01455 852 589**. For free advice, remember to quote the reference number **TXMDU1** and have your membership number to hand. Lines are open from Monday to Friday, 9am-5.30pm until 30 June 2010.

Tax Health Plan

Medical professionals who notified their intention to disclose undeclared tax liabilities under HMRC's Tax Health Plan (THP) now face another deadline. By 30 June 2010 they must disclose and make full payment of all outstanding taxes and duties, interest and penalties.

The THP was launched in January 2010 to provide a simple, straightforward opportunity for medical professionals to get their tax affairs in order. Medical professionals with undeclared tax liabilities could face penalties up to 100 per cent of the tax due and in some exceptional circumstances criminal investigation may be considered.

For further information visit:
hmrc.gov.uk/tax-health-plan/index.htm and
the-mdu.com/tax



A new way to manage your MDU membership

It's now even easier to manage your membership online. Visit the new **My MDU** section of the website to:

- Change your contact details.
- Order a replacement card or policy document.
- Manage your mailing preferences.

When you register for this new service you have the opportunity to enter our on-line prize draw for the chance to win a Dell laptop. Go to the-mdu.com to find out more.

Sending patient data to the MDU

Many members, including general practitioners and consultants working in private practice, will be considered data controllers under the Data Protection Act 1998 and are bound to inform patients about how they will use the data they hold about them.

We suggest that you may wish to inform patients – in practice leaflets and complaints procedures etc – that, in order to assist the practice to respond fully and appropriately to any complaints, you may need to provide information about the patient, and treatment they have received, to insurers or legal advisers.

Help us to help you

The MDU has strict procedures to protect confidentiality and we need to remove patient details from incoming correspondence before passing it on to our advisory team. Therefore, we ask members who are seeking medico-legal advice from the MDU to please remove or blank out information that would identify the patient/s concerned, unless we specifically need the information or we have requested original or copies of patient records. Providing us with documents that contain unnecessary patient information may delay our ability to respond quickly.



For membership advice, please contact
the MDU's 24-hour freephone
membership helpline
0800 716 376



FEATURE

Setting up in independent practice

The Care Quality Commission's new system of regulation for health and adult social care has wide medico-legal implications. If you plan to provide clinical services in the independent sector in England – or if you are already doing so – the regulations will affect you. By Emma Doherty, MDU medico-legal adviser.

The new system of regulation for independent healthcare providers aims to ensure essential standards of quality and safety for patients.

As a practitioner providing clinical services in the independent sector, you may be classified as an independent healthcare provider. If you already perform 'regulated activities' in independent practice, or are thinking of setting up an independent practice, you will need to be registered with the CQC by 1 October 2010. This applies even if you are already registered under the Care Standards Act 2000; there is no automatic transfer to the CQC.

An 'independent healthcare provider' is an individual, partnership or organisation and it is the legal entity providing the service which must register. Where clinicians are in partnership, every partner is required to register.

Regulated activities requiring registration include surgical, diagnostic and screening procedures as well as treatment of disease, disorder or injury. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 gives full details.

However, there are exemptions and currently doctors who also have some NHS practice need not register unless they are providing certain specified services including:

- treatment under anaesthesia
- obstetric services
- cosmetic surgery
- endoscopy
- termination of pregnancy.

In a partnership or organisation, exemption from registration will only apply if all doctors have some NHS practice. If any one doctor does no NHS work, then the whole partnership or organisation must register.

Clinicians using consulting rooms in an NHS or independent hospital, and who provide a service carried out wholly under the management and policies of the hospital will be covered by the hospital's registration. However, if the practitioner rents consulting premises and is acting independently of the hospital, he or she is required to register as the healthcare provider even though the hospital will also be registered.

Statement of Purpose

A Statement of Purpose is a requirement of registration. It tells the CQC what services are offered, the aims and objectives of carrying out regulated activities, the legal status of the provider and details of where the services are provided. Updates must be notified to the CQC within 28 days.

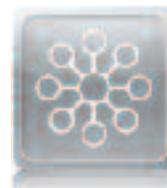
Twenty-eight essential standards of quality and safety, including complaints processes, are also set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. Providers will need to show the CQC that they meet specified outcomes. Sanctions exist for failure to do so.

Registered independent providers are legally required to inform the CQC of certain events, such as alleged misconduct, serious injuries, death of a patient or changes that affect their registration.

Full details of the registration process and requirements are available at: cqc.org.uk/guidanceforprofessionals

From April 2010 the CQC will be writing to independent healthcare providers with notification of a four week period in which to submit an application. It is your responsibility to comply with this timescale, and to allow ample time to meet the 1 October 2010 deadline.

Corporate indemnity from the MDU



As the shape of healthcare provision in the UK continues to change, many doctors are restructuring the provision of their clinical services into new corporate entities. Incorporating a business brings with it additional risks including the potential for the company itself being sued for clinical mistakes. The MDU recognises how companies need to protect themselves and their employees to cover the new operational and vicarious liability risks they face.

The MDU, through its unique Corporate Indemnity Solution, is able to offer a comprehensive medical indemnity tailored to your company's activities.

Details can be found on:
the-mdu.com/cis

Assisting members for 125 years

In celebration of our landmark anniversary, the *Journal* reviews the MDU's rich and colourful history.

In 1885, while Pasteur was developing a vaccine for rabies in France and Dr W W Grant performing the world's first appendicectomy in the USA, doctors in England were rallying to a cause - the defence of qualified members of the medical profession facing allegations of clinical negligence.

Their movement was fuelled by outrage at the case of Chesterfield GP Dr David Bradley. Dr Bradley had been wrongly accused of sexually assaulting a female patient, Mrs Eliza Swetmore, in his surgery. Though innocent, he had been unable to afford legal defence. He was convicted and sentenced to two years' imprisonment with hard labour.

Doctors across the country were indignant that an innocent doctor could be prosecuted without proper legal representation, expert evidence or financial support. In this and other cases, the doctor on trial risked losing not only his freedom but also his livelihood, whether or not he was successful in court. Only the philanthropy of their peers (notably Sir William Jenner) rescued some doctors from penury following their trials.

Two 'defence' organisations existed at the time – the Medical Defence Association and the Medical Alliance Association – though they did not defend doctors as their function was largely to protect the reputation of the profession as a whole by prosecuting unqualified 'quack' practitioners who used questionable practices and dubious remedies.

The qualification for the 'safe doctor' had been introduced in the Medical Act 1858. Once achieved, this standard of education allowed a doctor to practise anywhere in the UK and perform any medical or surgical treatment, without further training.

Despite greater professionalism and improving medical science, patients were becoming more inclined to question the authority of doctors. Vexatious or malicious legal actions brought by patients were growing in number. The status quo was clearly untenable.

Two solicitors and five gentlemen

Perhaps surprisingly, the MDU's founders were not doctors.

In 1885, Messrs Daune and Cridland, solicitors, and Messrs Rideal, Clements, Leggatt, Sinyanki and Fitzgerald, who described themselves as gentlemen - signed a Memorandum that established the aims and objectives of the newly registered company, The Medical Defence Union, to promote and support the character and interests of its members.

The annual subscription was set at 10 shillings, although this



Mr Robert Lawson Tait - chief architect of the MDU.

covered only advice and legal fees, but not claimants' costs or damages.

The response among the profession was mixed initially, though 400 members joined in the first four months. The organisation's reputation grew rapidly and in 1900, eminent surgeon Marmaduke Shield remarked: 'Never attend a case of fracture unless you have joined the Medical Defence Union first'.

Mr Robert Lawson Tait

The chief architect of the MDU was Mr Robert Lawson Tait, who had been vociferous in calls for an organised medical defence organisation following the Bradley case. He was elected the first President in 1887 and his strong leadership guided the MDU through its first years.

Brilliant, unconventional, pioneering – Lawson Tait was one of the key figures in late 19th century medicine. Under his leadership, MDU membership and funds grew and it took just a decade for the organisation to establish its reputation as a powerful voice for the medical profession, and a formidable opponent in court. Over a nine-year period to 1906, of 267 malpractice cases defended, only two were lost.

125TH ANNIVERSARY

Breaking new ground

Throughout its history, the MDU has responded to the changing requirements of members with ground-breaking innovations. The case of Hartnett v Bond and Adams in 1924 rocked the profession when the plaintiff was awarded damages of £25,000 for conspiracy, assault and false imprisonment by the two defendants. The MDU responded by introducing discretionary indemnity for compensation payments, in addition to legal and advice costs.

Members' interests were paramount when the MDU responded to the introduction of key legislation that redefined the provision of health services in the UK. Most notable were the National Insurance Act 1911 and the National Health Service Act 1948. The MDU was active in guiding doctors in the interpretation and observation of regulations for both Acts.

Introduction of insurance

As a mutual organisation owned by its members, the MDU has offered the traditional benefits of support and defence for members on a discretionary basis since 1924. Members have a right to ask for assistance and their requests must be reasonably considered but assistance is at the discretion of the Board of Management.

During the 1990s, the MDU, wanting to provide the best possible assistance for members, took the ground-breaking decision to introduce contractual insured indemnity for clinical negligence claims. This was introduced as a benefit of membership in 2000, although discretionary assistance remains a fundamental member benefit alongside contractual insurance, giving members the best of both worlds.

Continuous innovation

Over the years, the MDU has consistently been the first medical defence organisation to introduce innovations designed to give improved and more relevant service to members. It was the first medical defence organisation to introduce a 24-hour freephone helpline to provide medico-legal and dento-legal advice to members when they need it most.

The introduction of an indemnity scheme for NHS healthcare staff in 1990 meant that the MDU relinquished responsibility for clinical negligence claims arising from NHS hospitals. Overnight, the scheme took over all claims involving hospital doctors working in the NHS.

The MDU remained relatively unaffected in terms of membership and continues to provide members indemnified by their NHS employers with access to the full range of advice and assistance on medico-legal issues, including for disciplinary matters and complaints, in addition to indemnifying medical and dental practitioners for general practice and private work. Recognising that it was operating in a changing world, the MDU responded by restructuring and introduced a Board of Management to ensure members' interests would be best served into the future.

With a 125 year history of service and innovation, the MDU continues to provide support, assistance and advice on medico- and dento-legal matters to members. Our ethos remains what it was in 1885 – to protect our members' interests and support them in providing patients with the best possible care.

Five legal landmarks

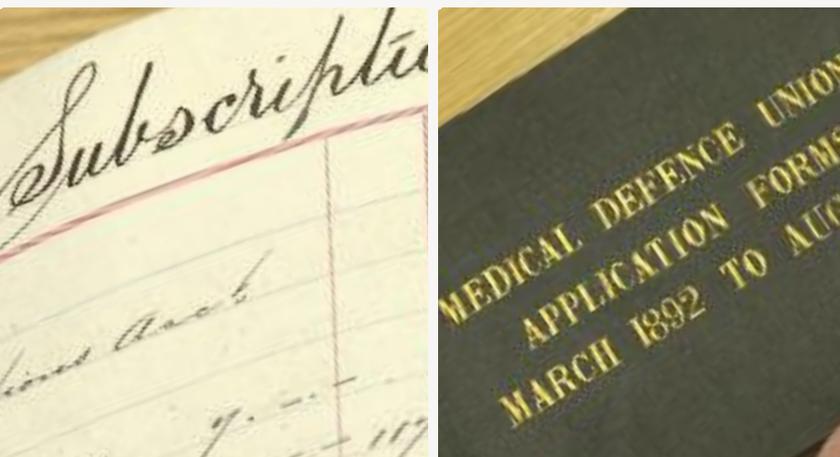
As a mutual medical defence organisation, it's important the MDU goes the extra mile to defend our members where matters of professional principle are at stake. In the last 125 years we have a successful record of doing just that.

These cases from the MDU archives show how our determination and expertise has helped us win landmark legal judgments and bring about positive changes for members.

1. 'Due inquiry' by the GMC

In 1939, Dr Eric Spackman was cited as co-respondent in divorce proceedings, an accusation the judge found proven. Dr Spackman was ordered to appear before the GMC which decided the adultery took place while he was in a professional relationship with the woman and he was guilty of infamous conduct. It resolutely refused to hear fresh evidence from Dr Spackman and summarily ordered that his name be removed from the medical register, a decision which the MDU believed went against natural justice.

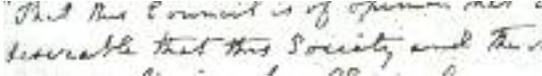
Despite an unsuccessful appeal to the Kings Bench Divisional Court, the MDU persisted with an appeal to the House of Lords¹ on the grounds that the GMC was obliged to hold a 'due inquiry' into all cases within its jurisdiction, other than those arising out of a criminal offence. The Lords unanimously found against the GMC in 1943 and after a fresh hearing in which the new evidence was finally admitted, Dr Spackman was restored to the register. The case meant the GMC was



The MDU subscription and application book 1892.

125TH ANNIVERSARY

The MDU's rich and colourful history

Date	MDU Event	Medico-Legal Event	1885
1885	The Medical Defence Union is established as the world's first medical defence organisation.		
1890	Number of members reaches 1000.	First x-ray taken for clinical purposes.	
1896			
1899	MDU accepts first female member – Dr Elizabeth Ramsey.	National Health Insurance Act.	
1908	Insurance introduced through the Yorkshire Insurance Company – up to £2,500 cover for damages and costs.		
1911		Penicillin discovered by Alexander Fleming.	
1920	Annual subscription raised to £1.00.		
1921	Number of members passes 10,000.	Introduction of the National Health Service.	
1924	<i>Hartnett v Bond and Adams</i> - £25,000 damages awarded. 1924-2000 MDU introduced discretionary indemnity for members, initially funded partly by self-financing and partly through Lloyds' brokers, and eventually through MDU fund with reinsurance arrangements.		
1928		Bolam test established. The test, of a responsible body of relevant professional opinion, remains a key medico-legal principle.	
1947	Membership extended to allow doctors working 'elsewhere in the British Empire' to join.		
1948		Government introduces NHS indemnity.	
1948	MDU accepts dentists into membership.		
1951	Membership extended to doctors working anywhere overseas (ex. USA) if they held GMC qualification.	Woolf reforms introduced revolutionising clinical negligence claims procedure.	
1957			
1961	MDU total payments since 1885 pass £1 million.		
1981	Membership passes 100,000.		
1983	MDU first defence organisation to introduce a 24-hour medico-legal helpline.		
1988	MDU pays out its first claim that exceeds £1 million.		
1990			
1993	MDU first defence organisation to establish an in-house legal team.		
1994	The Dental Defence Union is established, providing specialist support for dentists.		
1998	MDU exits from overseas territories to focus on UK and Ireland.		
1998	First medical defence organisation to introduce worldwide Good Samaritan cover.		
1999			
2000	MDU introduces the extra security of a professional indemnity policy (the first and only defence organisation to do so).		
2000	MDU moves to new head office. (Blackfriars Road, London).		
2009	MDU pays out a claim in excess of £6 million.		
2010	The MDU celebrates 125 years with nearly 200,000 members.		

125TH ANNIVERSARY

obliged to end its custom of simply accepting the findings of a civil court without allowing doctors to defend themselves and present further evidence.

2. The principle of double effect

When Eastbourne GP, Dr John Bodkin Adams was put on trial for murder at the Old Bailey in 1957², it caused a sensation.

For many years, Dr Adams had been subject of local gossip about the money he had inherited from patients. Matters came to a head in 1956 when he was charged with the murder of Edith Morrell, who had died following a stroke leaving her doctor a large sum of money, some furniture and her Rolls Royce. Dr Adams had treated Mrs Morrell with morphine and heroin during her illness.

During the 17-day trial, the medical experts disagreed about whether the dosages of opiates Dr Adams prescribed were justified. In the end, the jury took less than an hour to acquit him. While murder trials involving a doctor are rare and often attract a high profile, the case is also significant because it established the principle of 'double effect'. In summing up, the judge said: 'The doctor is entitled to relieve pain and suffering even if the measures he takes may incidentally shorten life'.

3. Confidentiality and the public interest

A patient in a secure psychiatric unit, W, had been convicted of killing five people and had a diagnosis of paranoid schizophrenia. After ten years, W's lawyers asked Dr Henry Egdell, a consultant psychiatrist, to prepare a report to support an application for his release or transfer to a less secure unit. However, after examining W, Dr Egdell concluded that, although the psychosis was in control, W's life-long preoccupation with guns and homemade bombs had not been addressed and he remained a serious danger to the public. The solicitors withdrew the application after receiving the report but Dr Egdell discussed this with the treating psychiatrist and sent a copy to the Medical Superintendent of the secure hospital.

W applied for an injunction against the disclosure, accusing Dr Egdell of a breach of patient confidentiality. However, the High Court held that because of the grave concern for public safety, Dr Egdell was justified in making the disclosure in the public interest, and in 1990 the Court of Appeal upheld this decision³.

The judgment, reflected in the GMC's confidentiality guidance, is important as it means that in certain circumstances, such as the prevention of a serious crime, doctors may legitimately conclude the public interest overrides their duty of patient confidentiality.

4. Unfair manslaughter conviction quashed

In May 1993, the MDU successfully appealed the manslaughter conviction of Dr Michael Prentice⁴ who had been convicted alongside colleague Dr Barry Sullman two years before. As a pre-registration house officer at Peterborough District Hospital, Dr Prentice had mistakenly administered the chemotherapy drug vincristine intrathecally, rather than intravenously. The 16-year-old patient, Malcolm Savage, died two weeks later.

During the original trial, the judge directed the jury to apply a test of 'recklessness' to determine manslaughter which meant

they could not consider any explanations or excuses for what had happened. However, a number of mitigating factors were highlighted during the proceedings. For example, while Dr Prentice thought he was being supervised by his co-defendant, Dr Sullman believed he was only there to supervise a lumbar puncture and neither had any special knowledge of cytotoxics. In quashing the convictions, the Court of Appeal determined the jury may well have come to a different conclusion had it been left open to them to take these factors into account.

This case was significant because it re-established that the proper test for manslaughter was 'gross negligence', enabling all the circumstances of an individual case to be taken into account in assessing criminal liability. This was later confirmed by the House of Lords in a separate judgment and the test is still in use today.

5. Defending the principle of causation

In the case of *Gregg v Scott* (2005)⁵, the MDU successfully resisted a patient's appeal to the House of Lords on the issue of causation.

The patient had presented to his GP and reported a lump in his left axilla which the GP diagnosed as a lipoma. Nine months later, the lump was diagnosed as a non-Hodgkin's lymphoma. The patient brought a claim and the trial judge found a breach of duty by the GP and that this failure caused a nine month delay in treatment.

'Had the appeal succeeded, there would have been a flood of claims.'

The patient claimed damages for the loss of a chance of cure – defined in terms of 10 years' survival. However, statistical evidence presented to the court suggested that, even with earlier treatment, his chance of surviving more than 10 years would have been only 42%, reduced to 25% by reason of the delay. Therefore, applying the traditional balance of probabilities test, the judge held that the delay had not deprived the claimant of a cure, because he would probably not have been cured anyway. The Court of Appeal upheld that decision.

By a 3:2 majority, the House of Lords dismissed the patient's appeal and rejected the argument that the patient was entitled to be compensated for the 'loss of a chance' of a better outcome. Had the appeal succeeded, there would have been a flood of claims by patients claiming loss of a chance notwithstanding that delay in diagnosis or treatment probably made no difference to the outcome. The House of Lords decision to uphold the traditional 'balance of probabilities' approach to causation was a landmark decision in this area.

References

1. *GMC v Spackman* [1943] AC 627 (HL).
2. *R v Adams* [1957] Crim LR 365.
3. *W v Egdell* [1990] 1 All ER 835.
4. *R v Dr M C Prentice and Dr B Sullman* [1993] 4 All E.R. 935.
5. *Gregg v Scott* [2005] UKHL 2.



The true cost of defence

It may surprise members to know just how much the cost of defending clinical members' interests has risen in the last few decades. Dr Peter Schütte, MDU head of advisory services, reports.

The case concerns a consultant surgeon at a district general hospital. A patient's husband expressed concern that the surgeon had, during an NHS out-patient clinic, brought undue pressure on his wife to have an operation done privately. The surgeon denied he had put improper pressure on the patient, but admitted that he told her, in response to a direct question, that the post-operative infection rate was significantly lower at the private hospital. This information was factually correct.

The nature of the allegation was deemed to be serious. The surgeon was excluded from the district general hospital by the medical director and had his admitting privileges withdrawn by the independent hospital where he also worked, pending the outcome of NHS investigations.

The patient herself eventually withdrew the complaint, but not before a full investigation had been undertaken. The inquiry raised a number of concerns about the surgeon's note keeping, his attitude to nursing and junior medical staff and his alleged bullying approach to seeking consent from patients. There was also evidence to suggest that he might have tampered with a set of clinical records.

The hospital trust passed the allegations on to the General Medical Council (GMC). After many months, a Fitness to Practise Panel hearing was held in public. The facts were not proven, and the surgeon was exonerated. However, the costs of legal fees and expert fees for the defence exceeded £50,000, to say nothing of the surgeon's loss of private income and the considerable personal cost to him and his family during these proceedings, even though he was fully supported by the MDU.

'In CFA cases where damages awarded were £5000, claimants' legal costs were £22,000.'

Inexorable rise

The MDU is very careful to contain legal costs and at the same time provide an excellent service. Nevertheless, the MDU's legal costs for GMC and disciplinary cases have doubled in the last five years, and now exceed legal costs for defending clinical negligence claims.

The number of GMC investigations continues to rise, but more than that, the complexity of the process is increasing. The MDU's advisory services department now handles

double the volume of correspondence that it did in 2004 and, to meet the needs of our members, the number of medico-legal advisers has increased from 20 to 30 over the same period.

On the other hand, the number of clinical negligence cases the MDU sees is relatively stable, but the cost of settling claims is rising by more than the rate of inflation. Legal costs awarded to claimants' solicitors in conditional fee arrangements (CFA) are a key reason for the increase. In the last three years, in CFA cases where the average damages awarded were £5,000, the average claimants' solicitors' costs were four times higher at £22,000.

Rising costs of defence mean it has never been more important for doctors to have adequate indemnity. This is not only an ethical obligation¹ in respect of clinical negligence claims, to make sure that patients will be properly compensated if they can prove negligence, but it is also a sensible practical decision. Doctors need access to specialist advice and support with GMC and other investigations that may threaten their licence to practise medicine and/or their livelihood.

Indemnity provided by NHS employers does not provide any of this.



Reference

1. See the GMC's booklet *Good Medical Practice*, paragraph 34.

Note: The case history described is fictional, but based on several factually accurate cases.



IN THE HOT SEAT

Mutual strength

It is 10 years since the MDU introduced a contractual professional indemnity policy¹. Today, the MDU's unique combination of insurance and discretionary benefits continues to provide members with the best possible protection.

The *Journal* quizzed Jill Harding, MDU head of claims, about what insurance means for members.

Q: What does insurance offer that discretionary assistance doesn't?

A: The insurance policy is a binding contract, entitling the member to contractual benefits if a claim for clinical negligence is made against them. A member knows exactly what cover they are receiving because it is set out in the insurance policy. If a claim for clinical negligence is brought against the member, the insurance policy indemnifies him or her against compensation, claimants' costs and defence costs up to £10 million for any one claim and the total of all claims during one year of insurance². This provides the member with a high degree of certainty.

Alongside the insurance policy, the MDU continues to offer traditional discretionary benefits which means that members of the MDU can request assistance, which is at the discretion of the Board of Management.

Q: Why did the MDU introduce an insurance policy?

A: The late 1990s was a time of increasing litigation and tighter regulation in the medical profession. We believed it was increasingly important for healthcare professionals to have adequate insurance in respect of their professional indemnity requirements, so they will get the best possible support at a time when they need it.

Even a successful defence against clinical negligence can incur substantial costs and members need to know that they will be supported.

Q: Does that mean the MDU is now an insurance company?

A: No, absolutely not. The MDU was the first medical mutual organisation of our kind and this year is our 125th anniversary. We were owned by our members in 1885 and we are still owned by our members in 2010. Members' policies are



Jill Harding
Head of claims

underwritten by SCOR UK Company Limited and International Insurance Company of Hannover Limited. These companies are regulated by the FSA and members have the security of knowing that financial resources are in place to cover claims notified while they are an MDU member and have an insurance policy.

Q: What happens if a claim is made against an MDU member?

A: The first indication a member will have that a patient is seeking some form of compensation is normally a letter from the patient – or, more usually, a solicitor acting on the patient's behalf. Occasionally, court papers may be served without any notice. It is important that the member contacts the MDU immediately. A medico-legal adviser will arrange for the member to receive a checklist of the documents which the member needs to send to the MDU. Alternatively, this list can be downloaded from the MDU website. The case will be allocated to an individual case handler who will send a letter detailing exactly what is required from the member.

The case handler will take up correspondence with the claimant or claimant's solicitor on the member's behalf and will liaise at every stage of the process and take the member's views into account.

Q: Is it likely that the member will have to attend court?

A: It is very unlikely. Fewer than 2% of cases reported to the MDU run to trial. We do ask members to co-operate fully with us in working up their defence and this may involve meeting with the case handler and/or the legal team.

References

1. The professional indemnity insurance policy provided to members of the MDU is co-underwritten by SCOR UK Company Limited and International Insurance Company of Hannover Limited.
2. Subject to the terms and conditions of the policy.



Mandatory insurance will protect patients



The recent case of an uninsured independent midwife highlights the need to address compulsory indemnity for healthcare professionals.

In January, the Nursing & Midwifery Council (NMC) found that the fitness to practise of independent midwife Susan Angela Rose was impaired and the sanction was a 'Striking Off Order'. The majority of findings against Ms Rose related to the care she provided to a patient, Ms A. However, the NMC also found that she: *'Failed to explain to Ms A that as an independent midwife (she) did not have and/or would not be able to obtain professional indemnity insurance'*.

There is no legal requirement for nurses or midwives to have professional indemnity insurance, though the NMC recommends it in the Code which states that indemnity insurance 'is in the interests of clients, patients and registrants in the event of claims of professional negligence'.

The Code recognises that some nurses and midwives who are not indemnified by their employer may not be able to secure indemnity for themselves. This is the case with independent midwives who may not have indemnity insurance because the cost is simply too high for them. In such circumstances the Code says: *'If unable to secure professional indemnity insurance, a registrant will need to demonstrate that all their clients/patients are fully informed of this fact and the implications this might have in the event of a claim for professional negligence.'*

In the case of Ms Rose, the section of the booking form stating that the client understood that the midwife did not have insurance had not been signed or dated by Ms A.

Risk

It is interesting in the current medico-legal climate, where compensation awards to babies with neurological damage can reach more than £5 million, that some parents must be agreeing to have a baby delivered by an independent midwife who has no indemnity cover, in the knowledge that if the baby or the mother is damaged and they sue, the midwife cannot pay. But even if individual patients may sign such forms because they believe there is no other option, it is astounding that patients' organisations are not clamouring for mandatory indemnity for midwives.

Currently there is also no legal requirement that doctors and dentists hold clinical negligence indemnity, even though the legal framework for implementing this has been in place for more than four years. We believe, in the interests of clinicians and patients, that this must be addressed. It is astonishing that the Department of Health, which has policy responsibility for this area, has not yet made indemnity compulsory for all healthcare professionals.

Mary-Lou Nesbitt Head of government and external relations

'It is astonishing that indemnity has not yet been made compulsory for all health care professionals.'

RISK MANAGEMENT

Shared care – ensuring patients don't lose out



Good medical records and efficient communication are essential to effective patient care. In the MDU's experience, breakdowns in these systems are regularly a factor in complaints and claims. This is particularly crucial at the interface between primary and secondary care. Karen Roberts, MDU medico-legal adviser, reports.

The recent headline¹ that each year there may be more than 500,000 emergency readmissions to hospital within a month of discharge should alert doctors and other healthcare professionals to the potential risk involved in the shared care of patients between primary and secondary sectors.

There may be many reasons for readmission and not all will be due to lapses in clinical care. Nevertheless, the Department of Health is quoted in the same article as saying the 'high rate of emergency readmission after elective surgery is a matter of concern'.

The key medico-legal point arising from the article is the need to ensure that shared care is properly and clearly managed. It is essential that systems are in place to maintain continuity of care between hospital and home, and that any risk is managed effectively, particularly in respect of communication and clinical records.

One area where problems are particularly common is with regard to delays or failures in diagnosis, despite in many instances patients being referred between primary and secondary care. These types of allegations give rise to the majority of claims reported to the MDU by GP members. A delay or missed diagnosis may not necessarily be negligent provided that appropriate steps have been taken to investigate a patient's symptoms or follow up and review a patient where symptoms fail to improve as expected.

Prescribing responsibilities

One area where mis-communication can occur is in prescribing responsibilities. MDU members frequently seek advice regarding this - for example, where medication is initiated in secondary care and prescribing is handed over to the patient's GP. Prescribing off-label or unlicensed drugs, and prescribing a drug with which the doctor is unfamiliar are also frequent topics.

Medication errors are a recurrent theme in adverse incidents reported to the MDU's medico-legal advice line and in analysis of claims settled on behalf of GP MDU members. Problems include:

- Failure to monitor long term medication.
- Prescribing the wrong drug, the wrong dose or to the wrong patient.
- Prescribing to patients with a known allergy to the drug.
- Vaccine errors.

The following fictitious case studies are examples of the problems that may arise.

Case examples

Continuity of care

A 46-year old male patient attended A&E complaining of abdominal pain and vomiting a small amount of blood. The doctor advised the patient that he would ask the patient's GP to arrange further follow-up, but information was not sent to the practice. The patient attended an out-of-hours centre three days later complaining of abdominal pain and an episode of passing a black stool. The doctor advised the patient to see his GP and details of the attendance were sent to the practice the next day.

Two weeks later the patient attended his own GP practice complaining of abdominal pain and dyspepsia. The patient did not mention the initial A&E attendance and there was no information about it in the medical records. The GP examined

RISK MANAGEMENT

the patient, but failed to spot the previous attendance with the out-of-hours doctor and the history of melaena. The GP arranged for H Pylori testing and prescribed an alginate. The patient called the practice five days later requesting a home visit complaining of more severe abdominal pain and vomiting.

The practice nurse called the patient to triage him, and advised him to come in the next day for an appointment. The patient was admitted later that night with a haematemesis. A diagnosis of duodenal ulcer was made.

The patient brought a complaint that the practice had delayed in diagnosing his duodenal ulcer.

'Mis-communication can occur in prescribing responsibilities.'

Medication mix up

During a hospital stay, a 75-year old patient's diabetic medication was adjusted and information about this was sent to the practice on discharge. A receptionist entered the new medication on the patient's repeat prescription computer record and asked the GP to check this was correct. However, the GP failed to do this and the patient's original medication was not discontinued. A prescription was issued for the original and the new medication but fortunately the error was picked up by the pharmacist who called the practice to query the prescription.

The patient was unhappy about the mix up with her medication and complained to the practice.

Delay in diagnosing a scaphoid fracture

A 30-year old patient attended his local A&E department complaining of pain and swelling in his left wrist following a fall onto his outstretched hand whilst playing squash. The casualty officer requested 'x-ray of the wrist' which was reported as showing no fracture. The patient was reassured; a sprain was diagnosed, tubigrip applied and advice given regarding analgesia. After two weeks there was no improvement and the patient consulted his GP. The GP was aware of the A&E attendance and negative x-ray and she advised the patient that a sprain could take a long time to resolve. The patient returned to his GP on two subsequent occasions, complaining of continuing pain and restricted movement. On the last occasion the GP undertook a more thorough examination which revealed tenderness in the anatomical snuff box whereupon the patient was re-referred for x-ray with a specific request for scaphoid views to be performed. An un-united fracture of the scaphoid was diagnosed. Surgical pinning was required which would otherwise have been unnecessary with timely diagnosis.

Reference

1. *Daily Telegraph*, 18th February 2010.



Risk management recommendations

In secondary care you should ensure that:

- When patients, particularly those with complex health needs, are discharged from hospital, information is passed to the patient's GP in a timely manner.
- Letters about out patient visits, A&E attendance or other reviews are sent to the GP promptly.
- Medication information is clear and unambiguous.
- Patients understand their medication and arrangements for follow-up. Back this up with written information as necessary.
- Responsibilities for follow-up are clear.
- If special monitoring is required then it is clear who will carry this out and where it will take place.
- Doctors in training undertake tasks appropriate to their level of training and clear lines of communication are established for queries or if evaluation by a more senior team member is required.
- You take a careful note of the history before deciding on the most appropriate investigations.

In primary care you should ensure that:

- Patients' long-term medication is reviewed and monitored appropriately and updated by an appropriately experienced member of staff when a patient is discharged from hospital.
- You seek further information from the specialist if follow-up and/or prescribing arrangements are unclear.
- There is a robust system for dealing with messages from patients and for giving and documenting telephone advice.
- You take care to note if a patient is receiving further input from other services after discharge from hospital and ensure there are proper communication links with these services.
- You review a diagnosis if symptoms fail to improve as expected and do not rely much on negative results in the light of continuing symptoms or signs.
- That medical records are organised in such a way that information about admission, discharge, out patient or other (for example, out-of-hours) care, is easily accessible and that patients' notes are summarised.
- If tasks are delegated, the person to whom it is delegated is appropriately qualified and experienced, and that it is appropriate to delegate that particular task.

CLAIMS ANALYSIS

Bariatric surgery claims



The apparent increase in the incidence of claims for clinical negligence relating to bariatric surgery has accompanied a rise in the popularity of this type of surgery. Dr Karen Roberts, MDU medico-legal adviser, analyses the potential risks.

This study looks at clinical negligence claims for compensation notified to the MDU since 2000 by consultants undertaking surgical weight loss procedures in the independent sector. These relate to gastric banding and gastric bypass procedures, which are undertaken to produce weight loss in obese patients.

There are a variety of procedures and the mode of action can be purely restrictive (making the stomach smaller by banding), malabsorptive (bypassing or removing part of the stomach), or a combination of both. The weight loss that can result from bariatric surgery can have health benefits for the patients involved, including the reduction in related health problems such as diabetes.

The first claims were notified in 2003. This is not that surprising given that this type of surgery is fairly new and, in the MDU's experience, there is usually a time lag of a few years between an incident occurring and the notification of a claim. There have been 35 notified claims in total since 2003 and the

majority remain active, which means they have not yet been concluded. The rest were discontinued or fell outside legal time limits (that is, they were not made within three years of the incident or the date the claimant became aware of the problem) or have been settled.

Not all the active claims will lead to compensation being paid to patients. In the MDU's experience, we need to settle around 30 per cent of claims on behalf of our members. However, even claims that do not result in a compensation payment can cause considerable concern for the doctor involved and for patients who perceive that there has been a problem in their care. The following analysis of the common trends in notified cases, in terms of types of treatment leading to claims and the allegations brought, may help members to identify where things may go wrong and to avoid similar problems.

It is noteworthy that, of the relatively small number of cases, more than half have been notified in the past two years. This appears to represent an upward trend as there has been a rapid rise in the numbers of procedures undertaken in the NHS and independent sectors. When the NICE commission guide was published in 2007, NICE estimated that 10 out of 100,000 people in England would undergo bariatric surgery on the NHS over the following five years, which it said was a threefold increase in the estimated rate of bariatric surgery commissioned by the NHS at that time¹.

Reasons for claims

Several claims have resulted from consent issues and post-operative infection. Other reasons include:

- Cases where it is alleged that gastric bands slipped. In one case it is claimed there was a delay in diagnosing that the band had slipped.
- Allegations of perforation of the gut - for example, one case in which the stomach was perforated during a laparoscopic banding procedure and the patient suffered a serious infection.
- Allegations that bands leaked, requiring further surgery.
- Allegations that an item such as a suture or swab was left inside the patient and had to be removed during further surgery.
- Other cases include an alleged failure to diagnose a pulmonary embolism, an allegation that the wrong procedure was performed and technical problems in the inflation of a gastric band.

While most of the problems were not life-threatening, in a handful of cases the outcomes were severe for the patients concerned. In at least one case the patient died following an infection (peritonitis), which it is alleged was caused by perforation of the gut. In another a patient had to be placed on a ventilator after a leak following gastric bypass surgery led to sepsis and aspiration.

CLAIMS ANALYSIS



'Bariatric claims may arise from consent issues and post-operative infection or complications, such as a gastric band slipping or perforation of the gut.'

CLAIMS ANALYSIS

A significant proportion of claims follow post-operative complications, such as infections and band slips or leakages, and/or delays in diagnosing these complications. In addition, there were a number related to allegations of poor technique and intra-operative complications, particularly perforation of the gut.

Risk management advice

Appropriate selection of patients is set out in nationally recognised clinical guidelines (see box opposite), as is selection of the appropriate procedure (the MDU knows of at least one allegation that the wrong procedure was carried out).

It is important for surgeons to ensure they are fully trained and experienced to undertake the procedures, and that training grade doctors are adequately trained and supervised. As with any surgical procedure but particularly where the procedures are in a developing field, it is important that good records are kept and procedures audited for outcomes and complications. Incident reporting is now mandatory in the NHS and will also be so in the independent sector from October 2010.

Surgeons, even in the independent sector, need to be familiar with nationally recognised clinical guidelines, for example the NICE clinical guidance 2006², and if they decide not to follow the guidance, be prepared to justify this if called upon to do so. The team will need to have protocols to define appropriate standards of care and roles and responsibilities within the team. The team itself should have an appropriate composition of staff with relevant experience and expertise.

Some complications may be recognised risks of the procedure. Before patients are asked to consent to the operation you must give them full information about the procedure and its risks, answering their questions, exploring their expectations for weight loss and discussing alternatives in a way they can understand. It may be necessary to supplement the discussion with written information and leaflets.

Information about after-care and follow-up must also be given, such as providing the patient with details of the post-operative diet required and an explanation of why it is vital that the patient adheres to the diet including problems to look out for, and what to do if something goes wrong. This is all part of the process of getting the patient's consent for the procedure³.

It is also important to consider who seeks consent from the patient, as although responsibility for obtaining consent may be delegated, the staff member should be qualified and experienced enough to understand the procedure, its risks and complications so that he or she can fully answer any questions the patient has. If there has been a time lag between the initial discussion and the subsequent date set for surgery, then it is important to ensure that the patient still gives consent and the procedure remains appropriate. Consent must be fully documented, including written records of discussions about potential risks, alternative procedures and information given.

NICE guidance

The NICE guidelines recommend bariatric surgery as an NHS treatment option for adults over 18 years with obesity if all of the following criteria are fulfilled:

- They have a BMI of 40 kg/m or more, or between 35 kg/m and 40 kg/m and other significant disease (for example, type II diabetes or high blood pressure) that could be improved if they lost weight.
- All appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least six months.
- The person has been receiving or will receive intensive management within a specialist obesity service.
- The person is generally fit for anaesthesia and surgery.
- The person commits to the need for long-term follow-up.

It is important to provide the patient with information following the procedure, not just to explain about the importance of follow-up, such as keeping to post-operative diet, but also to tell patients what to expect in terms of the recovery process, likely time course, what problems may occur and symptoms to look out for that may indicate a problem. Clear communication is also essential within the multi-disciplinary team so that its members know what their responsibilities are in respect of follow-up. The patient's GP will also need timely discharge information.

Appropriate follow-up must be given to ensure that should complications occur, the patient recognises them promptly and knows what steps to take to deal with them.

References

1. Determining local service levels for a bariatric surgical service for the treatment of people with severe obesity nice.org.uk/using-guidance/commissioningguides/bariatric
2. 'Obesity – guidance on the prevention, identification, assessment and management of overweight and obesity and in adults and children', NICE clinical guideline 43 (December 2006). nice.org.uk/nicemedia/pdf/CG43NICEGuideline.pdf
3. Detailed guidance may be found in the GMC publication *Consent: patients and doctors making decisions together*, 2008, gmc-uk.org

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



Treatment behind bars



Clinical negligence claims involving prisoners as patients are relatively uncommon compared to claims in other specialties, yet they share a number of distinct features. Senior medical claims handler, Dr Pierre Campbell, reviews clinical negligence claims involving prisoners as patients which have arisen from MDU members' practice.

At the inception of the NHS in 1948, prisoners were excluded from receiving free healthcare. It took nearly 50 years for them to be fully integrated into the NHS.

Today, prisoners present a vulnerable population in respect of their health. They may be drug users; they are more likely than the average population to have a history of mental illness¹; they may sustain injuries while in prison (which they might not be willing to explain).

During their time in prison, inmates can be seen by a variety of clinicians, including GPs, police surgeons, forensic medical examiners and psychiatrists. They may also be examined and treated in situations that are far from the norm for the rest of the population. For example, consultations may take place without access to GP or hospital records, or may be held in an environment that could compromise safety for both patient and doctor.

Analysis of claims from prisoners shows that some or all of these may be factors in the complaint. Despite this, these types of claim are rare.

Successful defence

Between 2000 and 2008 inclusive, MDU members notified us of just 61 clinical negligence claims involving prisoners as patients. Of these, 47 were claims against GP members; the remainder were against others involved in treating prisoners.

Typically, the allegations arose from treatment that took place in a prison setting, although some were made after treatment received in the member's private rooms, or after the member had produced a report relating to the prisoner's care.

Half of the 61 cases are now closed. The majority have been successfully defended, discontinued by the claimant or are now statute (time) barred. Just seven cases have been settled so far, for which the MDU has paid out a total of £270,000 including damages and legal costs on behalf of our members. The MDU continues to successfully defend those cases which remain open at the time of publication.

'Prisoners present a vulnerable population in terms of their health.'

CLAIMS ANALYSIS

The basis of allegations in the 61 cases includes, among others:

- Opiate analgesia and detoxification programmes (14 claims).
- Failed/missed/inaccurate diagnosis (22 claims).
- Prescribing or drug error (6 claims).
- Allegations involving psychiatric assessment/reports (6 claims).
- Allegations of defamation or breach of confidence (3 claims).

There are additional factors shown in the analysis of these cases:

- Allegations may include third parties (such as allegations of mismanagement by the police or prison service).
- The claimant is a litigant in person (ie represents him/herself) in a fifth of cases.

Missed diagnosis

The majority of claims were notified to the MDU by GP members providing primary care medical services to prisoners in the prison setting and these fell into categories broadly similar to claims notified by GP members overall. Some 22 claims, including almost half of the non-opiate type claims, alleged missed, failed, inaccurate or delayed diagnosis of a variety of conditions (see Fig. 1 below). For example, three cases involved allegations of delayed diagnosis in recognising and treating infection, and four alleged missed diagnosis of cancer.

Some claimants also alleged inappropriate clinical management, or mismanagement. For example, mismanagement of back pain featured in four cases – instances include allegations of several months’ delay

in diagnosing, respectively, disc prolapse and spinal osteomyelitis.

Opiate claims

Allegations involving opiates fall into two categories – failure to prescribe an appropriate detoxification regime, such as refusal to give methadone to heroin addicts, and insufficient prescribing to control the patient’s acute pain. No such case has yet been settled on a member’s behalf.

Third party involvement

Medical care of prisoners may not be solely under the management of the doctor. Members treating prisoners cannot always influence the delivery of the care or treatment they believe the patient requires. When investigating clinical negligence claims, the MDU often has to examine the involvement of the prison’s staff and management. In some cases, our experts have advised that liability should fall to the institution, rather than the MDU member.

Litigants in person

Claimants opted to represent themselves in around one fifth of the cases analysed – a significantly higher proportion than any other type of claim reported to the MDU. It is typical with litigants in person that because of their unfamiliarity with the procedure, the time taken to deal with the claim, as well as the costs of defending it, can increase dramatically.

Conclusion

The unique nature of the prison setting warrants special consideration for claims of this type. There are particular aspects of clinical care and the environment that give rise to key risk management learning points.

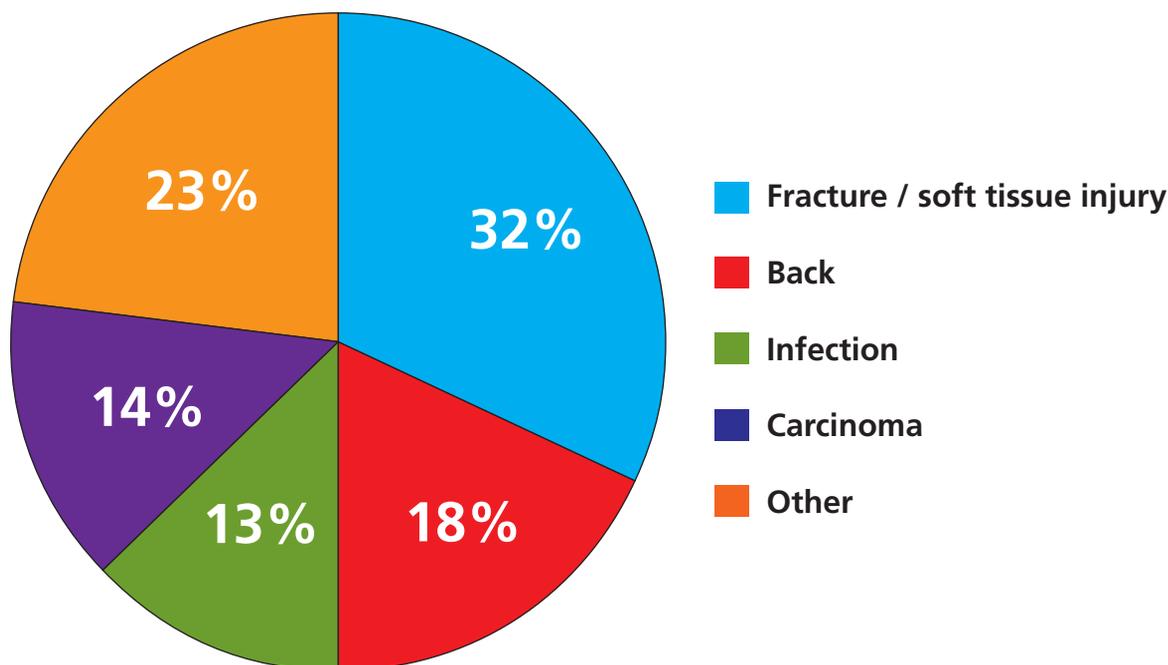


Fig. 1 - Claims for failed/missed/delayed/inaccurate diagnosis, by category.

CLAIMS ANALYSIS

Case study

Missed finger fracture

A prisoner was brought to the healthcare centre in the prison to be seen by the doctor, an MDU member, for examination of a finger injury. After having taken a history from the patient and performed an examination the doctor formed the impression that the patient had suffered a soft tissue injury. He applied neighbour strapping and advised the patient to return for review if not improving.

Five days later, the prisoner returned for further examination, complaining of a persistent painful finger. The doctor advised gradual mobilisation and asked him to come back in a week for review. At that point, the member referred the prisoner to hospital for an x-ray.

Three weeks later, the patient was taken to hospital, where a fracture was diagnosed and treated with joint manipulation of the PIP joint and K-wire stabilisation. Later, the patient was admitted for Volar Plating Arthroplasty.

Two years later, the MDU member received a letter of claim from the prisoner's solicitors outlining allegations of negligence against him. It was alleged that the member had failed to organise a referral to A&E at the first examination, had failed to undertake an urgent x-ray and had not chased up the results of the x-ray investigation.

The member responded that there had been no signs of fracture at the time of examination and that when he did refer the claimant for an x-ray, there was a delay of three weeks before this took place. It was contended that prison authorities are often under considerable pressure to discourage short-notice transfers out of prison and this appeared to have been the case on this occasion.

The MDU claims handler investigated the case by obtaining expert evidence. Unfortunately this was unhelpful of the member's actions. Accordingly the claims handler felt that the case would be difficult to defend successfully in its entirety, given the failure to diagnose the initial injury. With the agreement of the member, the case was settled. Given the apparent delay by the prison authorities, a contribution was sought by the MDU on behalf of the MDU member. They agreed to pay a sum towards settlement of the claim.

Learning points

Medical records

Access to a patient's GP or hospital records is often not possible in a prison. In some cases the history given by the patient may be vague and incomplete, and/or information from a person or authority previously involved in the patient's care may not be available. You may need to take even more steps to ensure you seek as full a history as possible from patients or those already involved in the patient's care and take care to document this, as well as documenting the diagnosis, treatment and management plan.

Communication

As many prison doctors are not involved in monitoring and

follow-up and it may fall to others to do so, you will need to take great care to ensure that you give information to patients in a way they can understand and that there are appropriate handover procedures in place with those also involved in the patient's care. If particular monitoring or follow-up is required, write down your instructions and check that whoever will be responsible has understood them.

Protocols

These can be useful to define the standard of care to be provided, and roles and responsibilities in the team. If you are in a position where you cannot influence the way in which care or treatment is delivered then it would be advisable to ensure there are protocols in place in order to ensure that the patient gets an appropriate standard of care. If it is alleged that care was deficient, the existence of protocols may also prove useful to a defence.

Diagnosis

If you consider a possible diagnosis, make sure you make a full note in the medical records of the steps you take to confirm or exclude this. It can be difficult to make a diagnosis in the early stages of some conditions, and so it is essential that you give the patient information about what to do if the condition does not improve as expected, arrange necessary follow-up and document your management plan in the records and in handovers. Again, because you may not be in a position to follow up the patient, you need to ensure that whoever has that responsibility understands, as well as the patient.

Medication errors

Drug errors are relatively common as a cause of claim. An accurate drug history is crucial to identify known allergies and interactions. Accurate documentation is also crucial in continuing the patient's care, particularly where others may be involved in administering and dispensing medication.

Patient safety

If you have concerns regarding the systems or environment in which you are asked to work then you should take steps to rectify this if possible, or notify those who are in a position to do so. The GMC gives advice in its guidance *Good Medical Practice* (para. 6): 'If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them.'

Reference

1. *The Bradley Report* on people with mental health, problems or learning disabilities in the criminal justice system, April 2009. More than 70% of the prison population has two or more mental health disorders and the suicide rate among prisoners is almost 15 times higher than in the general population. Source: *Psychiatric Morbidity among Prisoners in England and Wales*, Dept of Health, June 1998. dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4007132

Dr Pierre Campbell MDU senior medical claims handler



ADVICE LINE DILEMMAS

Recent dilemmas



The MDU's medico-legal advisers assist members with a wide range of medico-legal queries. Here we share some recent dilemmas from our 24-hour advice line case files.

In-patient detention under the Mental Health Act 1983

The scene

A patient attended A&E at 2am after taking a non-accidental overdose. The patient did not require further physical treatment but the junior hospital doctor treating him was concerned that the patient still posed a significant risk to himself, but was refusing admission to hospital.

The doctor thought it was in the patient's best interests to admit him under section 2 of the Mental Health Act 1983, and called the MDU Advisory Helpline for advice. Section 2 allows the admission of a patient with a mental disorder where the nature of the disorder warrants it, and for his or her own health and safety or to protect others. In addition, section 5(2) allows detention of an in-patient for assessment. Would it be possible, he asked, as it was out-of-hours, to detain the patient under section 5(2) and then assess him for detention under section 2 in the morning?

The advice

The adviser discussed the Mental Health Act 1983 and the Department of Health Code of Practice on the Act with the member and confirmed that the holding power of section 5(2) cannot be used for an out patient attending a hospital's accident and emergency department, or any other out patient.

It also goes on to say that patients should not be admitted informally with the sole intention of then using the holding power of section 5(2). Furthermore, if the patient required no further physical treatment and was not thought to meet the criteria for detention under section 2 of the Mental Health Act then it would not be possible to admit the patient. An alternative course might have been to detain the patient under an emergency application for assessment. Section 4 of

the Act allows emergency detention of patients with a mental disorder for up to 72 hours.

However, the determining factor in this case was whether the patient had a 'mental disorder', defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind'. If the patient has capacity and no mental disorder, then there are no grounds for detaining him in hospital.

The outcome

Following this advice the doctor decided to discuss the case further with the on-call psychiatrists, with a view to requesting an assessment of the patient.

An inspector calls

The scene

A hospital consultant received correspondence from a local tax inspector, in which invoices containing the names and addresses of patients whom she had treated in the independent sector were requested in order to investigate her annual tax return.

The consultant worked primarily in the NHS, but also treated a number of patients in the independent sector each year. Several patients seen in the preceding tax year had not paid their bills in full and this had come to light during the preparation of the consultant's tax return by her accountant.

In order to investigate the tax return fully, the tax inspector asked for copies of the invoices that had not been paid in full, stating that these should include the patients' names and addresses as this information did not form part of the medical records and could therefore be disclosed.

The consultant was concerned that providing this information without patient consent would be a breach of confidentiality. The member was already receiving advice about the enquiry from her accountant but was unsure whether medical invoices could be disclosed in this way. She rang the MDU for advice on this point.

The advice

The MDU adviser said that tax inspectors have legal powers to obtain documents (under Schedule 36, Part 1 of the Finance Act 2008). However, it may be possible to disclose the necessary information without actually giving patient names and addresses – that is, by anonymising the invoices – and doctors should do this wherever possible.

However, if the inspector required anything more – if he asked for patients' names and addresses, for example – he must give notice in writing of the information required and the doctor would need to be satisfied that it was reasonable to provide that information. If so, the doctor

ADVICE LINE DILEMMAS

should provide relevant information only, and not the whole record.

While there are safeguards that apply to medical records, the tax inspector's powers extend to personal health information, whether or not patient consent has been obtained. The overall advice was that whatever information the tax inspector required, onus would be on the him to prove that it was necessary to have confidential patient information in order to check the doctor's tax. In addition, while patient consent may not be necessary, ethically doctors should consider whether they can let patients know beforehand, if it is practicable to do so and does not undermine the purpose of the tax inspectors seeking the information. The consultant was advised to keep careful records of all discussions relating to the matter, and to keep copies of all correspondence exchanged with the tax inspector for future reference.

The outcome

When the consultant explained her concerns about her duty of confidentiality to the tax inspector, he agreed that it would be sufficient for her to just put a number on the invoices, retaining the originals for inspection if necessary.

See page 7 for news of the new tax advice helpline for MDU members.

Public display of images

The following article has been revised since it was originally published in the June 2010 edition of the MDU Journal to correct an error in the original version that was introduced during the process of preparing the article for publication.

The scene

A hospital consultant contacted the MDU for advice on the consent required to display histological and radiological images. He was involved in planning a major medical exhibition that would be open to members of the public.

The member was aware that he would need consent from patients to display any images from which the patient could be identified, but thought that if the patient was not identifiable from the images that consent would not be required.

The Trust management suggested that there may be legal implications to consider, which prompted the member to seek advice.

The adviser asked the consultant if he already had the images that he was planning to exhibit. He did, but added that at the time the x-rays and the samples were taken he had not thought about an exhibition and had not discussed any such use with the patients. Some of the images were quite old but some were more recent.

The Human Tissue Act 2004 Act governs the use of human tissue but only applies to material taken on or after 1st September 2006, when the Act came into force. If the

consultant obtained the material on or after that date he should have obtained patients' consent to remove their tissue for the production of histological slides. As to whether specific consent was required to display images of the material, the Human Tissue Authority, which was created by the Act, says in its Code of Practice that while the display of photographic or electronic images falls outside the Act, it does consider it to be good practice for the practitioner to follow the relevant GMC guidance¹ on the use of recordings and photographic material.

This guidance sets out a number of general principles:

- When making recordings you must take particular care to respect patients' autonomy and privacy.
- Seek permission to make the recording and get consent for any use or disclosure.
- Give patients adequate information about the purpose of the recording when seeking their permission.
- Do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent.

However, the GMC guidance specifically states that no additional consent is required to make recordings (including photographs) of images taken from pathology slides, x-rays, laparoscopic images, ultrasound images or images of internal organs, or to use such recordings for any purpose, provided that the recordings are effectively anonymised by the removal of any identifying marks.

The adviser explained that this was likely to apply to the images that were to be used in the exhibition but added a warning. While it is unlikely that patients could be identified from most x-rays and images, there may be patients with an unusual condition or presentation which would render the patient identifiable from an x-ray. An example might be an x-ray of a very unusual penetrating injury. The consultant would have to consider each of these images carefully and satisfy himself that no single patient could be identified when deciding whether to approach any patients for consent.

Reference

1. GMC Guidance: *Making and using visual and audio recordings of patients*, section 1, May 2002.



For further advice, please contact
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0800 716 646



CASE HISTORIES

Delay in referral nearly proved fatal



A patient claimed £80,000 against two GPs whom she alleged had failed to diagnose tubo-ovarian abscesses.

A patient saw her GP complaining of pain in her left loin and suprapubic pain. She had a history of nausea and urinary frequency. A presumptive diagnosis of pyelonephritis was made and a urine sample sent to the lab. The patient was started on antibiotics.

The following day the patient had a telephone consultation with another GP in the practice, saying there was no improvement in her symptoms. The GP changed the antibiotics.

Three days later the patient saw the second GP and reported continued pain in the left loin. The GP performed an examination, but no abnormalities were detected. The patient's mid-stream urine was negative and a diagnosis of urinary tract infection made. The patient was advised to finish the course of antibiotics, and if there was no improvement she would be referred for an ultrasound scan.

A month later the patient was seen by the second GP again as her condition had not improved. A further urine sample was sent to the lab and a different antibiotic started, with analgesia.

'A gynaecologist would not necessarily have diagnosed pelvic inflammatory disease.'

The patient was next seen by the out-of-hours service with a two-week history of abdominal pain. No dysuria or frequency was noted. The patient was afebrile, and her vital signs normal. On examination, there was no evidence of abdominal tenderness. The urine sample revealed blood protein and white cells and a presumptive diagnosis of possible renal colic/urinary tract infection was made. The patient was advised to continue the antibiotics and to see her GP in the morning for further investigation.

She was seen that morning by the first GP and was referred for an x-ray of her kidneys and an intravenous pyelogram. Her condition deteriorated later that day and she was advised to go to hospital where she was found to have abdominal tenderness, especially in the suprapubic area and right iliac fossa.

A CT scan showed bilateral tubo-ovarian abscesses associated with pelvic inflammatory disease. The patient was very unwell and was taken to theatre where peritonitis was found and a

bilateral salpingo oophorectomy was performed. The patient did not recover quickly and had post-operative complications.

Both GPs received a letter of claim from the patient's solicitors alleging that the delay in referring the patient to hospital had proved nearly fatal, that the patient had suffered permanent injury in that she was unable to have children, and that she was suffering from psychological problems.

The MDU's response

The MDU consulted a GP expert who agreed that the 'watch and review' approach taken by the GP initially was reasonable as the claimant's condition was not worsening. However, at the patient's final GP consultation before being admitted to hospital, the expert was concerned that there was no documented clinical examination and no urgent investigation. The expert felt the latter should have been instituted at this stage although he noted that the GP had advised the patient to go to hospital later on the same day, which was appropriate.

The MDU received an opinion from a gynaecological expert who was asked whether the delay had made any difference to the eventual outcome for the patient. He advised that he did not think a gynaecologist seeing the patient between her initial consultation and the time when she was seen by the out-of-hours service would necessarily have made a diagnosis of pelvic inflammatory disease.

He also pointed out that the doctors had prescribed antibiotics which are commonly used when treating pelvic inflammatory disease and therefore it was his opinion that the natural history of this infection would not have been altered had the patient been referred earlier.

The MDU wrote to the claimant's solicitors to point out that they had incorrectly interpreted the medical record and that the chronology in their letter of claim was inaccurate. Nearly a year later, the claim was discontinued.

Learning points

- If a potential diagnosis is considered, appropriate steps should be taken to exclude that diagnosis within a reasonable timescale.
- The management and follow-up plan should be formulated from an appropriate history and examination and documented in the records.
- Ensure you make appropriate, timely referrals for further assessment, treatment or procedures, particularly if there is no improvement in the patient's condition.

Dr Sharmala Moodley Deputy head of claims

Delayed diagnosis but no damage



A lump in the breast diagnosed as a benign sebaceous cyst turned out to be an invasive ductal carcinoma. The MDU successfully defended the GP member, proving that any delay in diagnosis did not affect the outcome.

A 53-year old patient with a history of a benign breast lump complained to her GP of a new lump. On examination, the GP made a working diagnosis of a benign sebaceous cyst on the chest wall. He informed the patient she could have the lump removed if she wished but reassured her it was not necessary. The patient chose not to have surgery and she was not referred.

At a routine mammogram nine months later a lump was revealed and the patient explained it had been present for a year. A biopsy confirmed it was a tumour.

The patient underwent a wide local excision of what was found to be a Grade 3 invasive ductal carcinoma. On hearing this, the GP immediately rang the patient to apologise for missing the diagnosis. He added a note about the dimensions of the tumour to the patient's records.

The patient elected to be treated with radiotherapy and tamoxifen. On review a year later, there was no evidence of recurrence of the disease.

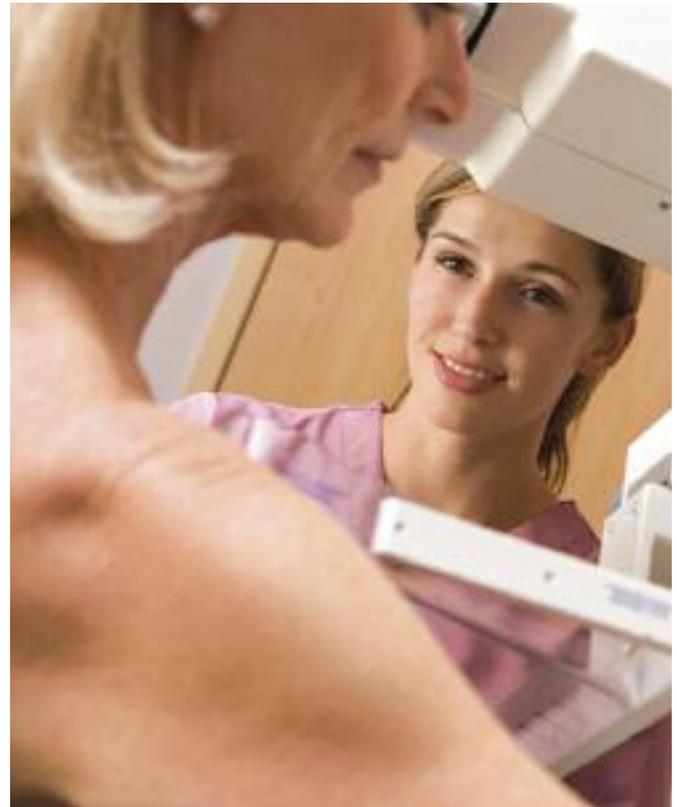
The claim

The following year, the GP received notice of an intended claim alleging that the delayed diagnosis had resulted in the patient requiring a more extensive operation and radiotherapy thereafter, and that she had suffered psychological symptoms as a consequence.

The GP immediately rang the MDU.

The key medico-legal issue in the case was causation. Had the failure to diagnose the lump at the first consultation resulted in harm to the patient? As part of its investigations, the MDU obtained expert opinion from an oncologist. The expert agreed that had the diagnosis of cancer been made when the patient first presented to the GP, it would have made no difference to the treatment given or the patient's survival prospects. In other words, no damage had resulted to the patient from the delay in diagnosis.

There was also the matter of addition to the records. The MDU's advice is always that any additions should be separately dated, timed and signed. In this case, the claimant's solicitor accepted that the GP had not intended to mislead, but altering the records could have seriously weakened the defendant's case. The patient's solicitor issued proceedings, naming the MDU



The patient underwent a routine mammogram nine months after her initial diagnosis of a benign cyst.

member as defendant. The MDU maintained a defence of causation which showed no damage. The expert oncologist reviewed the claimant's arguments and maintained his original assertion about the irrelevance of the delay in diagnosis to the patient's outcome. The following day, the claim was dropped.

Learning points

- To succeed in a claim of clinical negligence, the claimant must prove on the balance of probabilities that:
 - The doctor owed a duty of care.
 - There has been a breach of that duty.
 - Harm followed as a result (causation).

The claimant must establish whether there is a causal link between the alleged negligent act or omission and the harm that the patient claims has resulted. If there is no causal link the claim cannot succeed.

- Records – any addition to records may weaken your defence against a claim of clinical negligence.

Dr Sharmala Moodley Deputy head of claims

CASE HISTORIES

Conflicting opinion



A patient who suffered a detached retina claimed he had not been warned that this was a risk of cataract surgery, an allegation denied by the MDU member.

A consultant ophthalmologist, an MDU member, examined a patient who had reduced vision. The patient had a history of myopia. A cataract was found on examination and the member recommended cataract surgery with a lens implant, to be carried out under local anaesthetic.

According to the records, the patient was given an information leaflet pre-operatively. The complications listed in the leaflet included infection, haemorrhage, clouding of the cornea, glaucoma and retinal detachment.

The patient underwent the procedure which itself was uneventful.

Post-operatively, the patient suffered a retinal detachment and his care was transferred to another ophthalmologist. The patient later made a claim against our member, claiming

he had specifically asked whether or not there was a risk of retinal detachment and was told there was not. He also complained that he had experienced considerable pain during the course of the cataract surgery.

The MDU's response

The MDU obtained a detailed factual account from the member. He stressed that it was his usual practice to discuss with the patient, among other things, the possibility of complications arising from surgery. An expert opinion was obtained from a consultant ophthalmologist. The expert report indicated that the member's position was weakened by the lack of documentation of any discussion about retinal detachment, including the lack of detail on the consent form for the cataract surgery. The expert did, however, note what the member had said in relation to his normal practice and he also noted that the patient had been given a detailed information leaflet.

The expert found it difficult to accept the allegation that the doctor had denied any risk of retinal detachment, particularly since he documented the patient's history of myopia.

The second allegation put forward was that of pain during the course of the surgery. There was no evidence of this among the papers provided to support the claimant, and it was also documented by the anaesthetist that the patient 'appeared comfortable throughout' the procedure.

The expert concluded that there was no evidence of any deficiency in the care provided by the member, and this included the cataract surgery itself.

No formal letter of claim was ever served. The MDU wrote to the claimant's solicitors to let them know that we had obtained a supportive expert opinion in this matter. In the event, the claim was discontinued.

Learning point

- While information leaflets can be a useful way of summarising information about a procedure, they should be used to support full discussion with the patient about the risks and benefits of a procedure and any alternatives. GMC *Guidance on Consent* (2008), para 51, says: You must use the patient's medical records or a consent form to record the key elements of your discussion with the patient. This should include the information you discussed, any specific requests by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made.



The patient suffered a retinal detachment following uneventful cataract surgery.

Dr Sharmala Moodley Deputy head of claims

Miscarriage following laparoscopy



An MDU member was accused of failing to establish whether the patient was pregnant before proceeding with diagnostic laparoscopy.

A patient saw her GP requesting referral to a gynaecologist following recurrent lower abdominal pain and sub-fertility. The GP's referral letter mentioned a history of recurrent intermittent lower abdominal pain for more than 12 months, with irregular periods.

The patient saw the gynaecologist, who was an MDU member. He noted '*LMP just finished*' and an irregular menstrual cycle of 45-50 days. Examination was unremarkable and the uterus found to be normal in size. Laparoscopy and a dye test were arranged, partly to assess whether the pain could be due to adhesions around the left fallopian tube and partly to assess tubal patency.

The member noted that the patient had not been using any contraception for the last two years.

A month after seeing the gynaecologist, the patient was admitted for laparoscopy under general anaesthesia. The first day of the patient's last period was not recorded in the admission record, although it was recorded that the patient considered she was not pregnant. The laparoscopy showed that the uterus was enlarged to the size equivalent to a six week pregnancy. No cause of pain was identified and there was no spill of dye via the fallopian tubes. The member considered the likeliest diagnosis was tubal occlusion together with adenomyosis.

Some time later the patient attended hospital complaining of a three day history of lower abdominal pain, described as sharp and dull. A six week history of '*staining and bleeding, passing clots, increasingly severe over past 2-3 days*' was recorded. A pregnancy test proved positive and an ultrasound scan showed an empty uterus with some retained tissue. Incomplete miscarriage was diagnosed. The patient underwent evacuation of retained products of conception (ERPC).

'The patient alleged that laparoscopy caused her to suffer a miscarriage'

The gynaecologist member later received notification of a claim. The patient alleged that the member negligently failed to establish whether or not she was pregnant before proceeding with the laparoscopy. The patient alleged that the laparoscopy caused her to suffer a miscarriage and that she now suffered psychological problems.

The MDU's response

The MDU instructed an obstetrician/gynaecologist to give expert opinion on the case. The expert advised that, although it was reasonable for the member to have advised the patient to undergo laparoscopy, failure to establish whether the claimant was pregnant was unfortunate. He advised that a potentially fertile woman having unprotected intercourse and undergoing surgery must be asked: '*When was the first day of your last period?*'.

The expert explained that while it was not routine practice to perform a pregnancy test prior to laparoscopy without an indication of pregnancy, in this case there was a clear indication.

When it came to the causative link between laparoscopy and the subsequent miscarriage, the MDU's expert advised that had there really been a significant amount of pain and heavy bleeding following the laparoscopy, then the miscarriage would have occurred within a matter of days, not several weeks later.

The outcome

Given the expert's view that a pregnancy test should have been carried out, the member agreed to the claim being settled. The key issue in determining the value of the claim was whether or not the patient was likely to have had a miscarriage as a result of laparoscopy, and whether she suffered psychological problems as a consequence.

Learning points

- In these circumstances asking a patient whether she thinks she is pregnant is not enough. The question should be asked: '*When was the first day of your last period?*'
- Following this case, the member drafted a protocol stating that the possibility of pregnancy must be excluded in all potentially fertile women before laparoscopy. A urinary pregnancy test is now performed pre-operatively on all women from 'menarch to menopause' regardless of LMP or use of contraception.

David Franklin Senior claims handler

For further advice, please contact
the MDU's 24-hour freephone
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0800 716 646



CASE HISTORIES

Failure to diagnose heart disease



A patient with a history of indigestion and hypertension alleged that her GP had negligently failed to diagnose heart disease. She later had a heart attack.

A female patient in her mid-50s visited her GP complaining of spasms in her arms and pain radiating from chest to upper abdomen. The pain was worse on moving and seemed to be related to eating. The GP did not consider a cardiac cause was likely. However, noting the patient's blood pressure was high, the GP asked the patient to return for a blood pressure review in two weeks. The patient did not return.

The patient was a smoker with a history of hypertension and problems with reflux oesophagitis. The notes recorded that the patient had not complied with advice from several GPs concerning hypertension medication and smoking cessation. She also had a family history of heart problems.

Eight months later, the patient saw another GP at the local community hospital, complaining of chest pain and nausea. She was diagnosed with indigestion and prescribed medication. However, on returning home her condition worsened and an ambulance was called. At that stage, it was established that the patient had had a myocardial infarction.

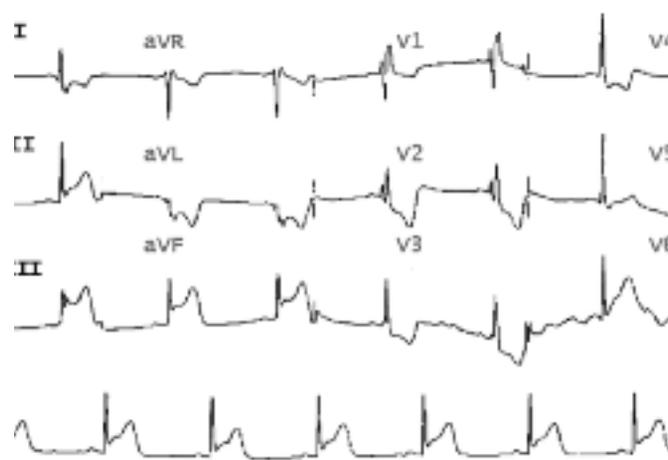
The following year, the first GP, an MDU member, received a letter of claim from the patient's solicitor alleging that at a consultation several years earlier the GP had failed to prescribe a statin to lower the patient's cholesterol or to provide appropriate follow-up. Had this been done, it was claimed, the patient would have been unlikely to have developed angina or suffered a heart attack.

The solicitors also claimed that the GP had been negligent in failing to consider a cardiac cause for the patient's symptoms during the original consultation, particularly given her family history, and that she should have been referred to a rapid access chest pain clinic.

The MDU's response

The MDU asked a GP expert to report on the standard of the GP's care. The expert's view was that the patient's cholesterol level had not been high enough to prescribe statins. Any criticism by the patient of her treatment over the previous few years would have to be considered in the context of the entries in her records about her continued cigarette smoking and poor compliance with medical treatment. He concluded that the GP had provided appropriate GP care at the original consultation and had considered, but reasonably discounted, a cardiac cause for the patient's pain.

The MDU also obtained an expert report from a consultant cardiologist on causation; that is, whether the alleged



The patient had a family history of heart problems.

negligence caused the alleged injuries to the patient. The expert advised that it was impossible to say, on the balance of probabilities, if the patient had been prescribed a statin several years before and received appropriate follow-up she would not have developed angina or suffered a heart attack. Even if the patient had been referred to a rapid access chest clinic and seen by a cardiac registrar, the expert considered that no intervention would have prevented her heart attack eight months later.

On the basis of this evidence the MDU sent a letter of response denying liability, saying that the MDU GP member's care of the claimant was entirely appropriate throughout. After some months, the claimant decided to drop her case.

Learning points

- Delay in diagnosis is not necessarily negligent – it is possible to refute claims if the clinical management is shown to be appropriate and reasonable.
- Keep a record of any advice you offer patients in relation to lifestyle changes and of their compliance with this advice.
- Have a practice system in place for following up patients who do not attend for review appointments.
- As in this case, ensure you keep a contemporaneous record of any examination, including negative findings.

Dr Sharmala Moodley Deputy head of claims



MDU 2010

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website

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