When NHS indemnity is not enough

Highlighting the risks for hospital doctors
It is not that long ago that risk management in general practice was the preserve of the enthusiast or researcher….now the techniques for controlling the risk of inadvertent harm to patients are well-known and being embraced by the profession.

Although many in the media seem happy to run only stories that are critical of doctors, our experience of the enthusiasm and competence of GPs sheds a more realistic light on the state of general practice in the UK. We have been involved in training primary care staff in risk management for over three years and have amassed a large amount of data from the results of risk assessments. Many examples of good practice arise from discussions during workshops. A survey recently published by the MDU reviewed the results of a self-assessment questionnaire completed by 330 practices from 20 PCTs who had undertaken workshops introducing the concept of risk management in primary care. These results can be seen as an assessment of the current state, in clinical governance terms, of existing systems for limiting risk in general practice. Over 90% of practices reported satisfactory procedures in the important areas of repeat prescribing, arranging adequate emergency appointments, monitoring incoming results and following up patients who need review.

Members are clearly keen to improve the quality of their services to patients and the feedback that we receive about our risk management workshops and publications confirms this. Introduction of effective systems does not have to be complex or bureaucratic and practices have been keen to exchange ideas about practical improvements to patient safety in our group discussions. We recently launched a risk management competition, with GP newspaper, to publicise and to recognise the contribution many GPs have made in implementing change within their practice. The prize is £3000 worth of equipment for the surgery. We hope this will help to share good practice throughout …one of the principal aims of clinical governance.

As risk management becomes a part of everyday practice we shall continue to support members with advice and the tools to undertake risk assessments. Our risk assessment pack has been revised to conform to the GMC’s guidance in “Good Medical Practice”, the document that sets the core standards expected of all doctors. GPs who complete the forms in the pack will at the same time be assembling evidence which can be used in both appraisal and revalidation and we encourage members to order a copy. Members will also find in this Journal a form to order the new Adverse Incident Reporting booklet for General Practice, which will be published shortly. This will help you to prepare for the introduction of mandatory adverse incident reporting to the National Patient Safety Agency (NPSA) in 2003.

We are all probably sceptical of what we read in the press, and on our evidence, that is the right approach. Reporting isolated instances of “bad” practice does not give the true picture of the depth of quality improvement that is taking place in general practice today. It is time to tell it how it is.

Dr Stephen Green
Head of Risk Management

*Opinions expressed by authors of articles published in the Journal are their own and do not necessarily reflect the policies of The Medical Defence Union Ltd.
Justice for All?

The Lord Chancellor’s Department published ‘Justice for All’, their White Paper on reforming the criminal justice system, in August 2002. One area of concern for our members is a proposal that would prevent doctors being exempt from jury service. On behalf of members, the MDU is commenting on this and other proposals of medico-legal significance.

The Lord Chancellor’s Department’s White Paper, Justice for All, sets out wide-ranging proposals to reform the criminal justice system. The White Paper follows Lord Justice Auld’s review of the system (the ‘Auld Review’). We reported on our response to the Auld review in the last edition of the journal. We supported some of the proposals, but cautioned against others. ‘Justice for All’ takes up a number of the Auld Review proposals, some of which may have a significant medico-legal impact on members.

Jury Service

One issue of particular concern was a proposal that would abolish the automatic right of members of certain professions, including doctors, to be exempt from jury service. The MDU had concerns about this proposal when it was mooted in the ‘Auld Review’ and we are disappointed to see that the proposal has been taken up in the White Paper.

We believe that to abolish doctors’ automatic right to be excused would not be in the public interest since it could threaten continuity of patient care in some areas where it may not be possible to find a replacement doctor, or someone with the same specialist skills. In addition, it could also place additional pressures on colleagues and affect patient care.

Charges

The Auld Review recommended requiring the Crown Prosecution Service (CPS) rather than the police to be responsible for pressing charges, except for minor offences. This was taken up by the White Paper and the MDU welcomes it. We believe that such a proposal should help reduce the problem of inappropriate charging that we have seen in some cases involving our members.

Rules of evidence

Members may find themselves involved in a criminal investigation or trial in many ways: to provide medical records, give evidence or, even, as a defendant.

The Auld Review suggested various changes to court procedures and rules of evidence which would widen the scope of evidence admissible in court. The MDU was disappointed to see that this proposal was taken up in the White Paper. We are concerned that undue weight could be attached to evidence which in reality may be of limited or no real value. We consider that the safest and most consistent approach is the one which exists at present.

Cases heard by judge alone

The Auld Review suggested allowing the defendant to opt from trial by a judge alone. The MDU is pleased to see that this proposal has been included in the White Paper. On rare occasions a doctor may be accused of a crime arising out of his care of patients. Some of these cases involve complex causation issues that, we believe, may on occasion be more effectively heard by a judge alone who was well versed in the legal intricacies. Justice for All does not include certain ‘Auld’ proposals. For example, restricting the right of defendants to choose trial by jury in the Crown Court. The MDU had grave concerns about this proposal and is pleased to see that it is not being taken forward.


Jessica Watkin Governmental Relations Officer

Stop Press…

The Home Office is planning a separate consultation to look at whether certain professionals, including doctors, should be exempt from jury service in certain circumstances. Given the comments we have already made on behalf of our members, the MDU has been approached and has agreed to take part in this consultation.

The National Clinical Assessment Authority (NCAA) rolls into action

The NCAA has recently celebrated its first birthday and has now begun its primary role, assessing doctors. With a remit to assist NHS employers where there are concerns about a doctor’s performance, the NCAA had by August received around 279 approaches from trusts, health authorities and PCOs. Two-thirds of these related to hospital doctors and the remaining third were GPs.

Often the role of the NCAA is no more than to provide advice to the referring body, but in some cases they embark on a thorough assessment of the referred doctor using prototype procedures that are available to view on their internet site. So far the NCAA has completed a total of 22 assessments with over 70% of doctors assessed coming from hospital specialties. It’s very early days yet to judge how the assessment process is working from our members’ perspective. We will return to look further at the NCAA’s procedures in a future issue. MDU members wanting to know more about the current format of the assessment process can find a summary of the procedures for GPs and hospital doctors on the MDU’s website at www.the-mdu.com. The NCAA website is at www.ncaa.nhs.uk/
New legislation on confidentiality: to disclose or not to disclose?

A new law but no change in a doctor's duty of confidentiality. The MDU has received numerous calls from members, concerned about new regulations which came into force on 1 June on the disclosure of patient-identifiable information to bodies such as cancer registries.

The legislation has given rise to a great deal of debate and some confusion. Some members were concerned that they may fall foul of the Act if they respected patients' refusal to disclose such information.

We would like to reassure members that the legislation does not change a clinician's duty of confidentiality – and that clinicians should continue to seek patient consent for disclosure.

Regulations
The Health Service (Control of Patient Information) Regulations 2002 were introduced under section 60 of the Health and Social Care Act 2001 and provide a new legal framework for processing and disclosure of certain confidential patient information.

They permit doctors to disclose information to cancer registries and other approved research bodies that want access to patient-identifiable information and whose applications have been approved by the Secretary of State.

However, the present legislation does not change a doctor's duty of confidentiality to patients since doctors are still expected to seek patient consent for disclosure to an approved body.

In deciding which research applications to approve, the Secretary of State will be advised by a new body called the Patient Information Advisory Group (PIAG), an independent panel composed of clinicians and lay people.

Future changes
The Secretary of State is empowered, under section 60 of the Health and Social Care Act 2001, to issue future regulations which would require disclosure of confidential data to approved bodies, in the absence of or even in spite of a patient's refusal of consent.

If such a requirement were to be introduced, a doctor who did not comply with it could, potentially, face a £5,000 fine or referral to the GMC.

However, at present there is no such requirement and doctors are expected to seek patient's permission to release their confidential information. Should the position change, we will inform members.

The NHS Executive has produced detailed guidelines on the legislation, which are available for you at www.doh.gov.uk/ipu/confiden/genguide.doc

Dr Matthew Lee Medico-Legal Adviser

New guidance from the GMC on end of life decisions

The GMC has published new guidance for doctors on withholding and withdrawing life-prolonging treatment (August 2002). The MDU's medico-legal advisers have offered advice to members about this important subject for very many years and we currently take about 20 calls a week on the subject. But, until now, there has not been one source of clear and considered guidance to which we can refer members.

The GMC guidance on this important aspect of treatment includes advice about withdrawing treatments including artificial hydration and nutrition. It also covers 'DNR' decisions, patients who lack capacity to make decisions and recommends the procedure in emergencies. It should help doctors faced with difficult management problems as it suggests the course of action to be followed in a number of commonly-faced situations where clinicians have to reconcile the needs of their patients, and the wishes of their relatives, with their legal and ethical duties towards these patients. The new guidance also places an onus on doctors to consult colleagues, specialists and sometimes to put the matter before the courts, rather than taking certain decisions alone.

The guidance is available from the GMC website at: www.gmc-uk.org/global_sections/search_frameset.htm. Members who find they face difficult decisions in this area are advised to contact the MDU on our 24-Hour Advisory Helpline on 0800 716 646 to discuss the issues with an adviser.

Dr John Gilberthorpe Medico-Legal Adviser
The Department of Health proposes to implement a policy of allowing patients to automatically receive copies of clinical letters about themselves. The MDU welcomes the move, but warns that it must not jeopardise patient consent and confidentiality.

The NHS Plan contained a proposal requiring letters between clinicians about a patient’s care to be copied to the patient as of right.

A working group was set up in July 2001 to advise the Department of Health and they produced draft guidelines in February (these can be found at: www.doh.gov.uk/patientletters/issues.htm).

The Department is planning to launch a series of pilot projects in 2002/2003. The aim is to implement the policy in full by April 2004.

The MDU has extensive experience of advising and assisting members with issues surrounding disclosure of records, consent and confidentiality. We offered detailed comments to the working party on medico-legal aspects of the policy.

We welcome the initiative which may assist with communication and could provide an important means of improving patients’ ability to understand and make choices about their own health care and treatment.

Exemptions

The working party recognised that for clinical reasons there could be instances where letters should not be copied to patients.

These include:

● Where the patient does not want a copy
The MDU emphasised that a patient is entitled to refuse a copy and this wish should be respected.

● Where the clinician feels that it may cause harm to the patient
We explained that “There may be a number of clinical reasons why a doctor judges it not in the patient’s best interests for him to see some or all of a letter. It will be up to the individual doctor to make such a judgement and he or she will need to show good reason if this decision is later challenged.”

We suggested that the term ‘harm to the patient’ was ambiguous as it is our experience that the concept of ‘harm’ is perceived in different ways by different groups of people.

We recommended that the guidance should more clearly define the concept of ‘harm’ and referred to GMC guidance which advises that:

“You should not withhold information necessary for decision making unless you judge that disclosure of some relevant information would cause the patient serious harm. In this context serious harm does not mean the patient would become upset, or decide to refuse treatment.”

Assessing the likelihood of harm resulting from disclosure is necessarily a subjective test. Clinicians are not obliged to tell the patient that sensitive or confidential material has been withheld, but they can do so if they wish.

● Where the letter includes information about a third party
The Data Protection Act 1998 affords protection to third parties and prohibits disclosure without their consent. In addition, where the third party is also a patient, clinicians may be in breach of their duty of confidentiality if they pass on information about them without their consent.

In addition, we also pointed out areas where there is a risk that breaches to confidentiality or consent could occur and provided detailed suggestions of how these could be averted.

Our key concerns include:

Children and young people

Young people aged 16 or 17 and mature children (Gillick competent) are able to consent to treatment. However, a refusal will not necessarily override any authorisation given by the court or someone who has parental responsibility for them – as long as the treatment is judged to be in their best interests. This will need to be borne in mind when considering whether, on occasions, letters should be sent to those with parental responsibility.

Protecting confidentiality

Measures will need to be put in place to minimise the risk of accidental breaches of confidentiality. We suggest that as well as giving patients the option of receiving copies of letters by post or email; they should also have the opportunity of collecting them in person.

Our comments are available on the MDU website at www.the-mdu.com

Dr John Gilberthorpe Medico-Legal Adviser
Suspensions

In the MDU’s experience, the NHS hospital suspension processes are often used inappropriately. The Department of Health is currently reviewing the hospital disciplinary procedures and the National Clinical Assessment Authority (NCAA) and the National Audit Office (NAO) are also conducting research into how the suspensions are working. The MDU has considerable experience of assisting doctors with the procedures and, on behalf of members, contributed our comments and recommendations for reform.

The cost to the NHS of poorly managed suspensions is high – and not just in financial terms. The procedures are supposed to be a neutral act to allow allegations to be properly investigated. However, most of our members find that they are anything but. In some cases patient care can suffer and the personal and professional implications for clinicians can be devastating.

The MDU has considerable expertise in this area and we estimate that we are currently assisting in the region of 40–60 members with both formal and informal suspensions.

We believe that the procedure is in need of urgent reform.

How are suspensions working?

The National Audit Office (NAO) is conducting a study into NHS management of suspensions. It is looking at whether suspensions are efficient in terms of their effect on the clinicians who are suspended and their patients and their financial impact, given that highly qualified and competent clinicians have been unable to work for prolonged periods of time. The National Clinical Assessment Authority (NCAA) is carrying out a confidential survey among doctors who are or have been suspended, either formally or informally and is asking hospital doctors about their experience of the procedures. The MDU is contributing to these projects by outlining our experience of assisting members with the procedures and suggesting reforms. Some of our members who have been suspended have filled in a confidential questionnaire for the NCAA.

At the time of publication, these studies are ongoing and we will inform members of their findings which are not expected until 2003.

Reviewing the procedures

The Department of Health is currently reviewing the NHS hospital disciplinary procedures as part of the negotiations on the consultants’ contract. The MDU has commented on the draft guidance on behalf of members. Our key recommendations include:

- **Abolition of informal suspensions**
  Some trust managers continue to resort to informal suspensions (sometimes euphemistically known as ‘gardening leave’ or ‘special leave’) even though they are not recognised in the existing disciplinary procedures. There are no safeguards for doctors involved, as they do not have recourse to legal advice because the allegations are not fully disclosed. There should be no place in the existing, or in any new procedures for anything resembling informal suspensions.

- **The terms ‘personal misconduct’, ‘professional misconduct’ and ‘professional performance’ need to be clearly defined**
  On a number of occasions, the MDU has assisted members when inappropriate disciplinary procedures have been followed. Clear definitions should help avoid such cases. Any new procedure should recognise the need to have a separate disciplinary procedure for clinicians which can consider allegations of professional misconduct against doctors.

- **Effective alternatives to formal suspensions**
  Suspensions should only be used as a last resort and, generally, only when alternatives have been explored. For example, mediation may be successful in some cases. In our experience, partial suspensions can sometimes be effective, with no danger to patients. For example, if there are concerns about a clinician’s laparoscopic technique, that surgeon could be prevented from performing laparoscopic surgery while the concerns are investigated, but be allowed to perform other surgery. There may be circumstances where a manager has good grounds to believe that a clinician may be a danger to patients and it may be appropriate to suspend that clinician in the public interest, but this should be exceptional.

- **Overcoming lack of experience of disciplinary procedures**
  Some trusts are inexperienced at using the procedures, given that they resort to them relatively rarely. Managers should be given the opportunity to consult others who have considerable experience of conducting disciplinary procedures, either on a regional or national basis.

- **Right of appeal**
  Some suspensions are unnecessarily lengthy. We suggest that if matters are not resolved within a specified time (say 3 months) doctors should be given a right of appeal.

- **National Guidance**
  There should be national guidance setting out factual criteria upon which performance would be judged.

We will keep members informed about this important matter and shall continue to represent your medico-legal interests.

Jessica Watkin  Governmental Relations Officer
Membership news

Individual Assistance: Enhanced cover for assault victims

It is now a year since we introduced Individual Assistance for MDU members. The policy provides personal cover, primarily for doctors, following a malicious attack sustained during the course of their work and cover for the theft of professional equipment when outside their normal workplace. Individual Assistance also covers members for legal assistance and representation costs in respect of health and safety, data protection and tax investigations, and provides access to a specialist 24-hour legal and tax helpline.

Perceived vulnerability

The positive response from members to Individual Assistance would appear to indicate that there is a widely shared feeling of vulnerability among medical professionals in the workplace. This year, we have extended the policy’s malicious attack section to include cover of £500 per night (up to a maximum of £5,000) for working time lost during an in-patient stay in hospital or recuperation period at home following a personal assault. In addition, cover of up to £250 is now provided for working time lost while receiving treatment as an out-patient in A&E. The existing cover under the policy remains unchanged and we are pleased to be able to hold the current purchase price of £195.

Members should note that Individual Assistance can only be purchased when they renew their annual membership subscription. The extended cover is available immediately on all new and renewed policies. Full details can be obtained by calling the MDU Membership Department on Freephone 0800 716 376 between 8.00am and 6.00pm, Monday to Friday.

New Head of MDU Claims

In June, the MDU appointed Stephen Fash to the post of Head of Claims Handling, heading up its 40-strong team of doctors and insurance professionals. Stephen, whose background has been in senior NHS management, succeeds Dr Julia Neild, who very successfully built up the Claims Department over the past eight years, and has been helping MDU members for over 15 years and will continue as an expert consultant to the MDU.

Stephen brings a wealth of experience to the MDU, having worked for over 30 years as an NHS manager, most recently as Chief Executive of Ashford and St Peter’s Hospitals NHS trust. He has also served as a manager reviewer for the Commission for Health Improvement (CHI) and has undertaken three CHI reviews.

Announcing Mr Fash’s appointment, Dr Christine Tomkins, MDU Professional Services Director, said: “Stephen is able to hit the ground running at the MDU because of his NHS experience. He has an excellent working knowledge of the legal process relating to medical negligence claims, as well as a thorough understanding of the professional interests and concerns of medical staff involved in claims and complaints.”

Stephen Fash said: “Litigation against MDU members is rising. It is a daunting and stressful prospect for doctors and patients alike. As Head of Claims, I’ll be in charge of a team of dedicated professionals whose aim is to support our members by managing claims with efficiency, understanding and expertise. My priorities will be to maintain and build on the excellent claims handling service the MDU provides for doctors and to assist in developing further service opportunities for our members.

It is good to be joining at a time when many potential improvements in the clinical negligence system are under scrutiny. The MDU is helping to shape these through its membership of the Chief Medical Officer’s working party into clinical negligence reform.

I am looking forward to the White Paper on this subject which is due out in the autumn and to playing my part in implementing whatever new arrangements emerge from this process.”
Membership news

Introducing… The revitalised Membership team

The Membership Department has undergone a number of significant changes in recent months, all aimed at enabling us to continue to provide excellent service levels to members.

The department has been reorganised to enable three complementary teams to focus primarily on their own special areas and to improve efficiency. Membership Services Manager Sara Barnard heads up the Membership team. Sara joined the MDU 18 months ago from Aon (UK) Ltd where she worked for 16 years, and has a wealth of customer service experience in the insurance industry. Sara held several senior management roles whilst working for Aon including responsibility for administration and customer service. She is assisted by Membership Operations Manager, Louise Lilley, who has been with the MDU for six years and has long experience in meeting the needs of our members, and Lucy Kendall, Membership Customer Services Manager, who has recently joined the MDU and comes from a customer service management background.

Membership Operations incorporates a New Business team responsible for enrolling new members and reinstating returning members (former members who are joining us from the St Paul) and an Administration team that answers members’ written and emailed membership queries. The Membership Customer Services team is dedicated to assisting members with telephone queries regarding subscriptions and levels of membership cover. A Membership Trainer, within the Membership Customer Services team, is responsible for ensuring that all new Membership staff are fully trained to deal with all possible aspects of member enquiries. The third area within Membership is the Finance team who are responsible for processing all subscription payments. Together the teams organise their work in shift patterns to ensure there are people available from each area to answer all your enquiries when the Membership phone lines are open – 8.00am–6.00pm, Monday to Friday.

Aiming high

The teams are constantly striving to achieve the highest possible standards of service, to respond to members’ enquiries as quickly and efficiently as possible. To ensure that we provide you with the best level of service, we set targets for customer service levels, such as the minimum time in which members’ calls must be answered and when members should receive replies to letters.

Call volumes tend to peak and trough according to the number of members due to renew in any given month and other related factors. In recent years the volume of enquiries has increased vastly in relation to the number of members. July is our busiest month, when calls fielded by the customer service teams can reach 1,000 a day. The most common calls are about levels of subscription required for particular work, requests for written confirmation of subscriptions paid for tax or reimbursement purposes and calls which will eventually be passed through to one of our advisers. The team also receive many more unusual queries on a daily basis, ranging from being a ship’s doctor, to working at high profile sporting events such as the recently held Commonwealth Games, or members facilitating medical cover on the set of action movies.

Some of our members now prefer to contact us via email and we currently receive an average of 30 emails every day from existing or prospective members.

Don’t hesitate to call

Membership staff are available from 8.00am to 6.00pm, Monday to Friday to take your calls.

You should be sure to let us know of any changes in your circumstances, such as: the hours you work; the level of your private income; your specialty and; the country you work in. These may affect the subscription you pay or your access to cover and other benefits of membership.

The number to call is Freephone 0800 716 376 or email them on membership@the-mdu.com

Lucy Kendall, Sara Barnard & Louise Lilley.
Frequently asked questions

In addition to facilitating subscription payments, the Membership team also regularly answers general questions from members. Some of the more common queries are:

Q: As a GP registrar, I am entitled to a total/partial refund of my subscription from my health authority. How do I go about doing this?
A: Contact Membership and we will send you a written breakdown of your subscription amounts, which you then forward to your health authority.

Q: How long does the MDU consider a “session” to be?
A: A session would be a morning, afternoon or evening surgery and would generally last from 3 to 4 hours.

Q: Will I still enjoy the benefits of membership if I work at sporting events?
A: In many cases, providing you have the appropriate training and equipment, your membership would allow for this type of work. However, you must always contact us beforehand to check so that we can record the details.

Q: Does the MDU offer short-term membership?
A: We only offer membership for a minimum of 12 months. However, if you have been ill for an extended period, are taking a career break for 3 months or more, are retiring or going abroad, please contact us and we may be able to adjust your subscription.

Q: Do you offer membership for work outside the UK and Ireland?
A: Overseas membership is provided at no additional cost for training grades for up to 12 months in most countries, but you must contact us before you go. The MDU does not offer permanent membership to non-training grades outside the UK and Ireland. If you are not in a training grade and are planning to work abroad, please contact Membership to confirm details.

New guidance on consent in Scotland

A recently enacted consent law will have a major effect on doctors working in Scotland. The MDU has issued new advice to all our members working in Scotland, relating to Part V of the Adults with Incapacity (Scotland) Act 2000. For the first time, it will be possible for relatives or carers of incompetent adults to give consent to – or refuse – treatment on their behalf. Under the new legislation an adult, when competent, may nominate a person, known as a welfare attorney or proxy, to take decisions on their behalf if, and when, they lose the capacity to make those decisions. The Act, which applies only in Scotland, also puts in place a number of stringent safeguards to ensure that patients’ rights are respected.

Dr Catriona McColl, an MDU Medico-Legal Adviser based in Scotland, said: “This legislation will have a significant impact on members working in Scotland and caring for incapacitated patients. At some stage, most doctors will encounter patients who are unable to provide the necessary consent for treatment. Hospital doctors and GPs alike will need to familiarise themselves with this new legislation, as it could fundamentally change the way in which situations like this should be handled.” The Act provides a comprehensive framework for dealing with the medical affairs of incapacitated adults, as well as with their financial and property affairs. The Act imposes a duty on doctors to formally assess the capacity of adult patients to consent to treatment. Where capacity is lacking, the proxy should then be consulted. On a more practical note, the legislation introduces the need for a “certificate of incapacity” to be issued before doctors provide any treatment to patients who lack capacity to consent (except in an emergency). These certificates will be issued by the “medical practitioner primarily responsible for treatment”.

Dr McColl continued: “Doctors need to ensure they complete a certificate of incapacity before providing non-urgent treatment to patients unable to give consent. Once a certificate is issued, the doctor is legally able to treat these patients, within the general principles laid out in the Act.” The general principles stated in the Act outline that any intervention should benefit the patient, be the minimum intervention necessary, take into account the past/present wishes of the adult (including encouraging the adult to exercise any residual capacity) and be discussed with the patient’s relatives and carers.
Over the past year, the MDU has been actively involved in representing the interests of its members from all specialties and grades in Ireland. We have also witnessed the introduction of new legislation which will affect the professional conduct of members.

Mental health

The Mental Treatment Acts of 1945 and 1961 are consolidated in a new Act, the Mental Health Act 2001, with part of the 1945 Act being repealed. At the time of writing, the Act has yet to come into force, although, when it does, there will be significant changes to Irish mental health law.

The 2001 Act will provide for involuntary admission to approved centres of persons suffering from mental disorders. It will also provide for independent review of the involuntary admission of such persons with the establishment of a mental health commission and the appointment of mental health commission tribunals and an inspector of mental health services. As soon as the Act comes into force, the MDU will be in a position to provide definitive advice to our members.

Coroner service

In March this year, the MDU submitted comments to the Department of Justice, Equality and Law, which is currently carrying out a review of the Coronial System. The legal basis for enquiries into unexpected and other prescribed deaths is currently provided by the Coroners Act 1962. Among other reforms, the MDU supports the need for a statutory basis for the removal, retention and deposition of tissues and organs in Coroner directed post-mortem examinations. The MDU has also stated that, in respect of section 30 of the 1962 Act (which provides that questions of civil or criminal liability shall not be considered or investigated at inquest), we would not wish to see any additional legislative enactment that would widen the scope of an inquest.

Ombudsman for children

The Ombudsman for Children Act 2002 introduces a new office whose primary function is to promote the rights and welfare of children. The Ombudsman’s role embraces a variety of responsibilities, including:

- Advising government ministers on developing and coordinating policy relating to children.
- Encouraging public sector bodies and voluntary hospitals to develop policies, practices and procedures designed to promote the welfare of children.
- Liaising with Children’s Ombudsmen in other jurisdictions.

The Ombudsman will also have the ability to investigate complaints against public bodies, voluntary hospitals and other prescribed bodies in respect of children. This will be done by way of a preliminary examination of the matter, which may then proceed to a more detailed and exhaustive investigation. A system of formal reporting of such investigations will be established.

Medical council: revalidation proposals

The regulation of doctors in Ireland is currently provided for in the Medical Practitioners’ Act 1978 (as amended). While Part V, Section 45(1)(b) of the Act allows the Medical Council to consider a doctor’s “fitness to engage in the practice of medicine by reason of physical or mental disability”, there is currently no statutory provision in Ireland for dealing with deficiencies in professional performance or for demonstrating continuing professional competence (revalidation).

In March 2002, however, the Medical Council published a document entitled Competence Assurance Structures – An Agenda for Implementation, whose proposals seek to establish performance procedures and processes to revalidate doctors.

The primary aim of competence assurance structures is to protect patients; a secondary aim will be to enhance the performance of doctors. The continuous revalidation of doctors will be achieved through continuing medical education and continuous professional development frameworks together with peer review and audit on a proposed five-yearly cycle.

Deficiencies in professional performance will be dealt with under proposed performance assessment procedures. These procedures, the Medical Council accepts, will have to be fair, transparent and defensible.

Medical practitioners’ (Amendment) Act 2002

This Act addresses, as a matter of urgency, doctors’ registration requirements in order to avoid problems with service delivery and deal with inequalities in access to registration among applicants.

The main change from the current position is that the Medical Council may now take professional experience into account when accepting an applicant to the permanent register.

Interns from the EU may now apply for registration even if they have not obtained a primary medical qualification from an Irish university. A further change is that intern and temporarily registered doctors may now work in healthcare settings outside the hospital environment.
Services for sick doctors: A changing but ongoing need

Self-diagnosis and self-prescription still occur when a doctor falls ill. Here, Dr Jolyon Oxley, Secretary of the NCSSD, looks at the extent of the problem, suggests some possible remedies and lists some of the services doctors can turn to when they are sick.

The National Counselling Service for Sick Doctors (NCSSD) was established in 1985 as the first national, independent, confidential advisory service for sick doctors and their colleagues. Since then, many other local and national “sick doctor” services have been established (see opposite). At the same time, there has also been a profound change in both the way and the extent to which doctors’ performance at work is monitored. Taken together, these developments should make it much less likely that ill health in doctors remains unrecognised, thereby enhancing the prospects of early recovery and the prevention of any harm to patients.

The person or the job?
But while such developments are encouraging, there has perhaps been less progress in other ways. The national services by their very nature are reactive to problems that have already arisen and their need to maintain confidentiality makes it difficult to get an overview of the national picture.

Government and regulatory organisations that monitor doctors’ performance all recognise the role that ill health can play in poor performance. And yet the view still appears to prevail that it is sufficient to just “fix the person” rather than attempt to “fix the job”. Fixing the job entails finding and remedying the root causes of ill health that arise from the workplace and through the heavy demands placed on those who pursue the calling of being a doctor.

The factors that cause doctors to fall ill and yet fail to take appropriate steps to achieve recovery have not been adequately addressed in a proactive, preventative way. There are quite simply too few doctors nationally and workloads are often unmanageably onerous. High standards are demanded without the time and resources always being available to achieve and maintain them. Locums are difficult to recruit to cover sickness absence and the prolonged illness of a doctor within a small primary or secondary care team can create major tensions for colleagues, managers and patients.

A duty of self-care
Some doctors are reluctant to concede that they are ill and need time off work, often feeling they would be letting patients and colleagues down. Perhaps they do not want to admit to themselves that they too are vulnerable to stress and illness like everyone else.

Not that this change of role is at all easy. Doctors who treat doctors need special skills and insights into what being a doctor is all about. Doctors who become patients need to step back and allow themselves the time to be properly assessed and treated. Self-diagnosis, self-prescription and “corridor consultations” with colleagues continue to occur, risking neglect of thorough clinical assessment, treatment and management.

So there is still much work to be done to promote and protect the health of doctors, who are such an invaluable part of the NHS workforce. Addressing their health needs should play a far more prominent part in their own education and professional development, and in planning and implementing developments in patient care.

Jolyon Oxley FRCP is Hon. Secretary of the National Counselling Service for Sick Doctors.

Members are regularly prompted to phone the MDU’s 24-hour Medico-Legal Advice Line because of health issues. Not uncommonly the caller is a doctor suffering with stress problems and wondering what help is available. We are of course happy to pass on contact numbers for the agencies that can help, as set out in this article.

When health problems appear to be affecting the ability to work effectively, we may also need to discuss the question of what action, if any, needs to be taken to protect patients. By soldiering on in these circumstances, members are likely to become vulnerable to criticism from the GMC. The GMC booklet ‘Good Medical Practice’ makes it clear that all registered doctors have an obligation in this regard:

“If you know that you have a serious condition which you may pass on to patients, or that your judgement or performance could be significantly affected by a condition or illness, or its treatment, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practice”.

The booklet also deals with concerns a doctor may have about a colleague:

“You must protect patients from risk of harm posed by another doctor or other health professional’s conduct, performance or health, including alcohol problems or substance abuse. The safety of patients must come first at all times.”

Members should, as usual, contact the MDU’s Advisory Service in the first instance to discuss any medico-legal matters on Freephone 0800 716 646.
Witnessing a crime

From the surgery or hospital window, a doctor sees a patient stealing his car. By the time he has run out of the building, the patient has driven the car out of the car park and disappeared.

Clearly, the doctor must report the theft to the police, as his insurance policy requires him to do. However, when reporting the theft, is the doctor entitled to breach patient confidentiality and identify the thief by disclosing his name and address, when the only reason he knows the thief’s identity is because he is a patient on his list whom he has recently treated?

It is the MDU’s view that the doctor whose car is stolen may be justified – just like any other member of the public - in reporting the theft and identifying the person he has seen stealing it. However, if the doctor decides to disclose information he will have to decide how much information it is necessary to provide, given the nature of the crime which would not appear to put anyone at risk of serious harm or death. In this case it is unlikely that it will be more than the patient’s name and address and a factual statement of the events that he has witnessed.

In the same way, if the doctor has seen a patient stealing another patient’s car, the aggrieved patient has reported the theft and the police approach the doctor as a witness, the doctor may be justified in confirming the thief’s name and make a factual statement of what he has seen.

The same would be true of any other criminal act committed by a patient that the doctor might observe in the course of his work, such as the theft of a purse by one patient from another – or from a member of staff.

However, if the theft were minor – for example the theft of a stapler or hole punch from the reception desk – the GP might consider options short of reporting the crime.

By the same token, if a crime has been witnessed by a nurse, practice manager or receptionist, they are likely to be bound by a duty of confidentiality, either ethically or because they have signed a confidentiality clause in their contract and can – like the doctor – confirm only limited information if questioned by the police.
The GMC view

“The issue raised is can a doctor disclose information about the identity of a person when he has been a witness to a crime, in which the person committing the crime is known to the doctor solely because he is the doctor’s patient?”

“In disclosing the patient’s identity, the doctor would be disclosing information learned in his professional capacity. Such information would therefore fall within the definition of “personal information” contained in the GMC’s booklet Confidentiality: Protecting and Providing Information.

“We agree with your conclusion that the doctor may be justified in disclosing information to the police. The usual approach is to balance the competing interests, between the harm to the patient and the trust between doctors and patients, and the benefits arising from the release of information.

“We believe that this approach remains valid but that in this particular case, there are additional issues to take into account. In particular, the evidence of witnesses is central to the effective operation of the criminal justice system, and that there is a significant benefit to disclosure if it contributes to maintaining that system.

“In the specific case of thefts from surgeries or hospitals, an absolute prohibition on disclosure could lead to the ridiculous situation of patients being able to steal with impunity, safe in the knowledge that staff who witness the crime cannot provide evidence to the police. There is therefore also a wider benefit to disclosure in preventing property crime against medical premises.”

Assisting the police

What should a doctor do if a theft has been committed in or around the medical premises to which the doctor has not been a witness, but which is reported to the police who ask the doctor to provide the names and addresses of all patients who have visited the premises on the day in question?

The MDU’s view is that in this case the doctor would be advised not to provide the information, as it would be difficult to justify breaching the confidentiality of a large number of patients.

Patient confessions

The situation is rather more clear cut where a doctor hears a patient confess to a theft in the course of a consultation. In this case, there would be no reason for breaching confidentiality, not least because the doctor would have no proof that a crime had indeed taken place in the manner described by the patient.

In most circumstances, where a patient confesses to a criminal act during a consultation, assuming the doctor thought there was no risk to anyone of death or serious harm, he would be expected to keep this information confidential. However, there will be circumstances, such as where a patient tells a doctor they have a weapon that they intend to use for terrorist purposes, where the doctor is required by law (Terrorism Act 2000) to inform the police as soon as possible.

The GMC view

“The disclosure involved is relatively minor, involving only the identity of the patient. It is of a fundamentally less serious nature to the disclosure involved, say, in the case of a confession made during a consultation. In that case, any disclosure would involve details of the conversation that took place during the consultation, on which there is a high expectation of confidentiality, far beyond that attached to the identity of the patient. The likely damage to the overall trust between doctors and patients arising from disclosure of a patient’s identity in relation to a crime seems to us rather lower than the damage that may arise from disclosure of details of the proceedings of a consultation.

“In considering the direct harm to the patient which might arise from the disclosure, the fact that the patient may face legal consequences does not seem to us to carry much weight. Those consequences arise directly from their involvement in an illegal act, not from the disclosure itself, and it does not seem to us reasonable that the doctor should be expected to protect someone from those consequences. However, doctors should bear in mind their duty of care to the patient. A patient may have a clinical condition, such as depression, which could underlie their behaviour. Disclosure may have a significant effect on the health of such patients, which would certainly be a relevant consideration in deciding whether or not to disclose.

“On the whole, we think that the balance of competing interests is more likely to lie on the side of disclosure in cases where a doctor has witnessed a crime than it does in most other situations. It will, however, still be relevant to consider the seriousness of the crime as part of the exercise of weighing the balance of interest, and to consider other options short of reporting the crime to the police. For example, a very minor theft from a GP surgery may warrant no more than a warning to the patient that future thefts may be reported. If another member of the practice team witnessed the crime, they would need to make much the same assessment in deciding whether to disclose information to the police.”

MDU conclusion

It is the doctor who holds ultimate responsibility for protecting the confidentiality of patients’ information. We would urge any members facing the possibility of having to provide – or of any of their ancillary staff practice team having to provide – a witness statement to the police over incidents occurring on the medical premises to call our 24-Hour Advisory Helpline on Freephone 0800 716 646, for advice about the consequences of a decision to breach confidentiality and to disclose patient information of any kind.
Black-box recorders are not the only new piece of medical equipment on offer for the operating theatre. The latest anaesthetic machines come complete with built-in stereo sound systems. MDU Medico-Legal Adviser Dr Sally Barnard selects appropriate music.

A consultant anaesthetist member called the MDU’s 24-Hour Advisory Helpline for advice about the purchase of anaesthetic machines for his hospital’s newly refurbished operating theatres. As well as the machines being available in a range of colours, there was also the option of an integral CD player, complete with speakers. A surgeon colleague in the hospital’s consultant body had considered that music in theatres was “medico-legally indefensible” and the anaesthetist member had called to ask the MDU for an opinion. The anaesthetist was reminded of the Bolam principle. If the decision to play music in theatres was supported by “a responsible body of medical opinion” then, if a claim arose as a result of having music playing in theatres, it could be defensible.

Musical divertissement
The grounds for any potential claim could be that the music was a distraction for either the surgeon or the anaesthetist. However this might be somewhat difficult to prove. The claimant would invariably be the patient, who, in all normal circumstances, is blissfully unaware of anything that goes on during their time in the theatre.

The member had heard of plans to introduce into operating theatres something equivalent to the black-box voice and data recorders installed in aircraft. He asked for our view on a system that would provide real-time video of procedures and also enable analysts to make post-operative examination of both verbal and non-verbal communication, as well as the attention of the operating team. It may also provide surgeons and anaesthetists with evidence for their defence, should the need ever arise. As far as the MDU is aware, the plans are still only at the very earliest of development stages and many issues remain to be discussed. Given that such black-box equipment is unlikely to be introduced widely in theatres for some time, we will have to wait until we know what role the system will play before forming a medico-legal view.

Mind sharpening benefits
On the other hand, there are studies which show that playing music can have a beneficial effect on those who hear it. Some research has suggested that playing music – and in particular, the music of Mozart – can enhance hand-eye co-ordination. It would appear that the music activates those areas of the brain involved in fine motor co-ordination, vision and other higher thought processes.* All of these areas might be expected to come into play for the kind of spatial reasoning required of a surgeon. However, most studies of the so-called “Mozart Effect” have used a single work from the composer’s opus – his Sonata for Two Pianos in D major (K448). The argument for allowing any old piece of music to be played in an operating theatre may not be as well grounded and further research may be needed to assemble a watertight defence.

The MDU playlist
After the member had been provided with advice, a discussion ensued within the MDU’s Advisory Department about the choice of music for the operating environment. Clearly, the net would need to be cast further than Mozart and his Sonata for Two Pianos in D major, which would doubtless have lost much of its appeal – let alone its efficacy – by the end of an all-day list. At the end of a lengthy meeting of the MDU’s Theatre Music Advisory Group, the following was drawn up as a therapeutic “Top 10” broadly representative of a wide spectrum of musical tastes and medical specialties for playing in operating theatres:

<table>
<thead>
<tr>
<th>Music</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Wake me up before you go-go</td>
<td>Anaesthetists</td>
</tr>
<tr>
<td>2 In the wee small hours of the morning</td>
<td>Renal physicians</td>
</tr>
<tr>
<td>3 Always on my mind</td>
<td>Psychiatrists</td>
</tr>
<tr>
<td>4 Can we fix it?</td>
<td>Trauma surgeons</td>
</tr>
<tr>
<td>5 I’llychocoo Park</td>
<td>Paediatric dermatologists</td>
</tr>
<tr>
<td>6 All I need is the air that I breathe</td>
<td>ITU personnel</td>
</tr>
<tr>
<td>7 The shoop, shoop song (It’s in his kiss)</td>
<td>GU physicians</td>
</tr>
<tr>
<td>8 What becomes of the broken-hearted?</td>
<td>Cardiologists</td>
</tr>
<tr>
<td>9 You make me feel brand new</td>
<td>Plastic surgeons</td>
</tr>
<tr>
<td>10 If I gave my heart to you</td>
<td>Transplant surgeons</td>
</tr>
</tbody>
</table>

Do you have any better musical suggestions of your own?
The MDU is giving you the opportunity to win a CD walkman by entering a free prize draw. For your chance to win or to find out more, simply visit our website www.the-mdu.com

The winning entry and selection of some of the other entries will be published in the next issue of the Journal.

Refreshed MDU website:
A big hit with members

With over 1.5 million hits in its first six months, the new MDU website is proving popular with members. More than 4,000 members have registered to date and the site is receiving an average of 12,000 visits every month. So why are members visiting the site? Analysis of the web statistics so far highlights some of the site’s most popular features:

**Book discounts**

**Our services >Training & Education >Book discounts**

With generous discounts of up to 30% for MDU members, it’s no surprise that there have been over 2,000 visits to this part of the site.

From here members can browse through the publishers’ online catalogues and take advantage of the reduced MDU prices available.

**Hot topics**

**News**

The subject of medical ethics is never out of the headlines for long and the web provides the perfect way to keep members up-to-date with the things they need to know. The MDU’s site is constantly updated with the latest medico-legal news and advice as it breaks.

**Hot topics you may have missed:**

The following are important topics that have recently featured on the site. To access the full article, go to the News section at [www.the-mdu.com](http://www.the-mdu.com)

**Recording telephone consultations**

Following new guidance from the GMC on telephone and video consultations, this article covers some of the important consent issues that members need to be aware of.

**National Clinical Assessment Authority**

This article looks at the role of this organisation set up to provide a support service to health authorities and hospital and community trusts faced with concerns over the performance of an individual doctor.

**Withholding and withdrawing life-prolonging treatment**

This new guidance from the GMC emphasises that the decision to withdraw or withhold treatment from a terminally ill patient is such a serious one that doctors need to consult widely before acting.

**Email**

More and more people find email invaluable in their day-to-day lives and MDU members are clearly no exception, with over 2500 emails received from the site so far.

To make it easy for members to get in touch, we have included a number of key contact forms on the site, including the facility to:

**Securely email an adviser**

[Our services >Advisory >Email an adviser](http://www.the-mdu.com)

**Contact a local representative**

[Contact us >Find your local contact](http://www.the-mdu.com)

**Advise of a change of address**

[Membership >General membership enquiries](http://www.the-mdu.com)
In the future, as part of our ongoing commitment to keep you informed of important medico-legal news as it breaks, we are planning to introduce regular email updates to members. If you would like to subscribe to this new free service and haven’t yet registered on our site please go to www.the-mdu.com/registration or complete the cutout slip below.

MDU publications

Our services > Training & Education > MDU publications

The MDU’s advisory and risk management publications are an invaluable source of expertise and we have now made them even more accessible.

Besides being able to order publications through the website, members will find that we have also started producing electronic versions which can be downloaded. So far the following are available as electronic versions and more will follow:

- Can I see the records?
- Clinical Negligence – the legal process explained
- Confidentiality

Have you registered yet?

Registration on the site is free and gives you full access to our online case histories, articles and electronic publications, as well as the range of new interactive services which we will be introducing. Registration will also make sure you are kept up-to-date with all the latest news. Make sure you experience the full benefit of MDU membership and register now at www.the-mdu.com/registration

Coming soon

Online risk assessment for revalidation

Risk management is the process of identifying, assessing and reducing risk. When applied to general practice it can help to prevent errors, reduce harm to patients and improve the quality of care.

This new free interactive tool, due to be launched soon, will allow GPs to carry out an assessment of their practice in key areas such as clinical care, good medical practice and relations with patients and colleagues. They will be able to receive detailed feedback and create a personalised action plan. There will also be the facility to benchmark results against other practices in the UK.

Interactive risk assessment will use the GMC’s booklet Good Medical Practice as a framework and it is hoped that it can be used to provide evidence for appraisal and the revalidation process.

Don’t miss out - to make sure you’re the first to hear when the new service is launched, all you need to do is register on the site.

Jason Ellis E-business Manager

Prize draw winners

Members who registered on the site before 31 July 2002 were entered into a free prize draw. Congratulations to the following lucky winners:

- Palmtop computer
  Dr Ahmed El Houssieny
- APS camera
  Sheena Sodha
- DVD player
  Dr Alan Budd
- £20 HMV voucher

Details of the winners of the 10 HMV vouchers can be found on www.the-mdu.com

If you haven’t yet registered on our site and would like to be kept up to date on the latest medico-legal issues and other important developments by email, please complete your details and return to:

The Marketing Department, MDU Services Limited, FREEPOST WC438, London, SE1 8YX.

Membership number □ □ □ □ □ □ □

Name ____________________________________________

Email address ______________________________________

Alternatively, register your details at: www.the-mdu.com/registration
So you’d better call the MDU

Every week, the MDU’s 24-Hour Advisory Helpline receives several hundred calls from members seeking advice and reassurance. Here, Dr Paul Colbrook, an MDU Medico-Legal Adviser, sifts through the files and highlights just a few of the real life cases.

Police access to patient records

A GP rang to say that a child known to him had just died in the local hospital from non-accidental injuries. The police child-protection team wanted access to the records of both the child and the mother. He was calling to find out whether he could disclose them.

The GP was advised that he should, whenever possible, seek consent before disclosure. However, given that a police investigation had begun into the child’s death, it would be possible to justify releasing the entirety of the child’s notes without consent. The GMC’s guidance says disclosure without consent may be justified where:

- third parties are exposed to a risk of death or serious harm that outweighs the patient’s privacy interests; and
- it may assist in the prevention, detection or prosecution of a serious crime – defined as a crime that would put somebody at risk of death or serious harm and would usually be crimes against the person, such as abuse of children.

Although in most circumstances it is necessary to seek a parent’s authority to disclose information about their child, in this circumstance the GP did not need to do so.

Disclosure of the mother’s notes is a different matter, however. First, the GP would need to seek the mother’s consent. If she refuses, he will need to consider whether failure to disclose an item of information might put another child at risk, or whether disclosure might help in the prevention, detection or prosecution of a serious crime, as defined by the GMC.

In this case, the GP confirmed that the police were investigating the mother’s role in her child’s death. If he decided he could justify disclosing the notes on these grounds, he was reminded that he should disclose the information on a “need to know” basis only, so that he disclosed only information relevant to the enquiries. He was also advised to let the mother know what he was doing.

Consent from third parties

Another GP received a call from an insurance company to say that one of her patients had become unwell while on holiday abroad. The insurance company was requesting information from the patient’s medical records in order to ascertain whether the patient had informed them appropriately about past medical problems, hoping to avoid the cost of repatriating the patient. Because the patient was unable to get to the fax machine, they had submitted a consent form signed by the patient’s husband.
The GP was advised that, in England and Wales, no one else can consent on behalf of a mentally competent adult. In this particular case, disclosure of this information might not be in the patient’s best interest. She was therefore advised that she should decline to give information to the insurance company in this instance without the specific direct consent of the patient. She could seek verbal consent by telephone and would need to ensure that the patient understood what was being disclosed, to whom and what the consequences might be (in this instance, withdrawal of insurance cover).

However, should a doctor from the overseas hospital contact her regarding the patient’s past history to help with the patient’s ongoing management, it would be reasonable to disclose information without written consent on a “need-to-know” basis, but only if the GP believed that the call was genuine and that she would be acting in her patient’s best interests.

Recovering a patient’s unpaid debts

A call was taken from a private surgeon, explaining that a woman who had undergone a nose reconstruction had paid using a cheque that was found to be fraudulent when presented to the bank. The surgeon wanted to know if it would be a breach of patient confidentiality to approach the patient’s husband for payment, or whether he could set about recovering the money through the courts.

He was advised that speaking to the husband without the patient’s consent would be a breach of patient confidentiality. However, he could take court action to recover the unpaid debt, but should disclose only the minimum amount of information necessary for the purposes of the court. He would be able to disclose his patient’s name and address, but should avoid giving any personal medical details, unless specifically ordered to do so by the court.

Non-specific police access to records

A GP called the Advisory Helpline to say that he had been contacted by the police in connection with an allegation that a patient had forged a doctor’s signature on an insurance claim form following a holiday cancellation. The police asked the GP to disclose the patient’s notes and the surgery appointment list to ascertain whether the patient or any of his family had attended the surgery.

The adviser reflected the GMC’s advice that disclosure may be justified if it assists in the investigation of a serious crime that might put someone at risk of death or serious harm. The GP felt that the current investigation did not meet the GMC’s criteria. If, on the other hand, the police showed him the form, he could confirm whether it was his signature or not without being in breach of confidentiality. He was advised, however, that if the police got a court order requiring disclosure, he should comply or would risk being in contempt of court.
Fresh AIR guidance

In the May issue of the Journal, we ran an article about the importance of learning from adverse incidents and about the new National Patient Safety Agency, set up in July 2001 to “implement, operate and oversee all aspects of the new national system for learning from adverse events and near misses in all sectors of the NHS”.

A new booklet

It is expected that collection of data for Adverse Incident Reports (AIR) will form part of the portfolio of information and evidence that all GPs will need to assemble in order to meet the GMC’s revalidation requirements and comply with the mandatory national reporting system. The MDU has so far published three booklets to help members with revalidation. The third in the series is The MDU’s Guide to Adverse Incident Reporting, which will be available in Autumn 2002.

The new booklet, available free of charge to all members, is a practical guide aimed at helping GPs to establish a mechanism for reporting and analysing adverse incidents and near misses within their practice. It also aims to assist GPs to collect evidence for appraisal and revalidation and set up a process that encourages reflective practice and can form part of a personal and practice development plan.

Using practical case examples, graphical illustrations of procedures and processes and samples of reporting forms throughout, the booklet gives advice on setting up an Adverse Incident Reporting system, analysing adverse incidents and near misses to discover their root causes and classifying incidents with a risk rating.

Members interested in receiving a copy of the new MDU Guide to Adverse Incident Reporting can do so by visiting our website www.the-mdu.com or alternatively please complete and return the order coupon opposite.

An interactive workshop

The NPSA has set a target for all NHS trusts and a significant proportion of Primary Care Organisations (PCOs) to provide information to the NPSA’s national reporting system during 2003. A recent NPSA study found that almost 60 per cent of incidents reported by pilot trusts were inadequately risk rated by staff and this has enabled the NPSA to amend its proposed risk rating system which should allow practice team members to identify risks and to prioritise them more accurately in future.

To assist PCOs to prepare for the new system, train staff and overcome barriers to admission of error, the MDU has developed an interactive Learning from Events workshop structured around the NPSA’s guidelines. This can be taken as a standalone workshop or as the second of two ‘Introduction to Risk Management’ workshops, part of the MDU’s Primary Care Development Programme.

If you feel this workshop would be of interest to your PCT or practice or if there are any other training needs you may have, please contact the MDU’s Risk Management Department direct on 020 7202 1550.
Caution when involving patients in SEA

Significant Event Audit (SEA) and complaints handling are, strictly speaking, separate processes. Nevertheless, sharing the findings of SEA with a complainant can provide reassurance and help to resolve the complaint at an early stage. But caution needs to be exercised in how information is shared, as MDU Medico-Legal Adviser Dr Louise Wilson explains.

“We just want to make sure the same thing doesn’t happen to anyone else...” is a commonly stated reason for a patient or relative to make a complaint. And in the MDU’s experience, appreciating this is the key to handling complaints. We advise members that it is a good idea to apologise when they feel it is appropriate, and we also suggest that any changes made as a result of the incident are communicated to the complainant. This demonstrates that the wish to prevent it happening again is shared by the practice, and shows in general terms that the complaint is being taken seriously.

Significant Event Audit has been described as:

“A systematic and detailed way to ascertain what can be learned about the overall quality of care of an individual case and indicate changes that might lead to future improvements.” (Prof Mike Pringle)

So when the case in question has also prompted a complaint, identifying the ‘changes that might lead to future improvements’ will help to ensure the highest possible quality of care in the future, and will also help the practice resolve the complaint ‘in house’.

An SEA Case

A GP practice which had been using their SEA process to help resolve a complaint contacted the MDU for advice. They outlined the case as follows:

A patient’s wife had contacted the practice for a repeat prescription for her husband who had been registered with the practice for many years. The patient’s wife collected the prescription and noticed that the dose of the medicine appeared to be different. She was reassured by the receptionist and she took the prescription to be made up at the local pharmacy.

When the patient became increasingly breathless he called out a GP who checked the prescription and noticed that the medication dose was half what it should have been, according to the patient’s medical records.

When the patient learned of the clinical error, he submitted a letter of complaint to the surgery, which was considered under the practice complaints procedure. During the complaint investigation the practice realised that the error had been made because there were two patients with similar names registered with the practice. They were both prescribed the same long-term medication, but in different doses.

In response to this incident, the practice decided to undertake a Significant Event Audit, to determine what could be learned from it. In responding to the complaint letter, the practice told the patient that they were looking into the incident and that, following the audit, he would be sent a copy of the draft SEA report and invited to submit his comments.

The audit was conducted as an open and frank exchange of views among professional colleagues in the spirit of learning from experience. The practice concluded that there had been “clinical negligence” and this phrase was included in the copy of the draft report that was sent to the patient.

In submitting comments on the draft SEA report, the patient requested an explanation of the reference to clinical negligence. In an attempt to clarify the matter fully, the practice decided to invite the patient to attend the follow-up SEA meeting and asked him to submit in writing any further comments or questions he might have in advance. At the meeting, the patient asked whether any disciplinary action would be taken against the members of staff involved in the incident.

Following the meeting, the practice prepared the final SEA report, which was also to be forwarded to the patient.

This was the point at which they contacted the MDU asking us to look over the report before they sent it.

We advised the practice that, while there is no problem with disclosing a SEA report to a patient, they needed first to ensure the report was anonymised and did not attribute blame to individual staff, nor mention any disciplinary action. It should concentrate on the changes that were to be made to the way the practice works.

If they did not wish the patient to see the full report, they could simply include a summary of the outcomes and action plans resulting from the SEA in their letter responding to the complaint.
Although the patient had seen it in the draft report already, we advised the practice to remove the phrase about ‘negligence’. SEA meetings are not about reaching such conclusions, which is a matter for the courts to decide should a claim be made. Any legal-sounding phrases may also trigger a patient to consult a solicitor, thinking they have a good case for compensation.

We suggested that in future they might prefer not to invite patients to an SEA meeting. The SEA meeting is designed to encourage open and frank discussion of an incident’s root causes and this may be compromised if a patient is invited to attend. Of course the practice could offer the patient a meeting to discuss the complaint as part of their complaints procedure, but such a meeting has a very different purpose to an SEA meeting, which we suggest should be just for practice staff in order to achieve maximum openness and change as a result.

We also pointed out that an SEA report (and indeed any adverse incident report, whether it has led to a meeting or not) is disclosable if a claim arises and the patient’s solicitor requests a copy. So any report needs to be objectively written, covering the facts of the case rather than subjective opinion, should be anonymised and should not include any disciplinary details, whether they are intending to show a copy to the patient or not.

We also pointed out that it was important for the practice to consider disciplinary matters quite separately to the complaints and SEA report. Disciplinary procedures are strictly between employer and employee and should not be discussed with a patient. This should be made clear to patients.

Although practices may consider complaints as a significant event and wish to analyse them, and the SEA findings can help to resolve a complaint, remember that they are essentially separate processes.

If you are unsure how best to respond to a complaint please contact an MDU Adviser and we will be happy to discuss this with you.

Our Freephone 24-Hour Advisory Helpline number is 0800 716 646
Unprotected hospital doctors: When NHS indemnity is not enough

Hospital doctors relying on NHS indemnity will discover that it is just that: indemnity for negligence claims arising from their work in NHS hospitals and in the community as part of their NHS hospital employment. As MDU Senior Medical Claims Handler Dr Tom Leigh explains, those who fail to take out their own membership of a medical defence organisation will find themselves unindemnified for events that are not picked up by the NHS arrangement.

Hospital doctors working in NHS trusts may well feel that they are fully indemnified should anything untoward happen in the course of their clinical practice. After all, they reckon, the NHS has its own indemnity arrangements and they don’t really need to take out membership of a medical defence organisation for cover they already have.

However, if they care to look at the small print, they will discover that there are a number of areas where, adequate as it may be for the purpose of indemnifying their work in hospital and the community, compensating patients for negligent errors that may occur, NHS indemnity is limited and will not support them in all the areas they need medico-legal assistance.

Legal limitations

Hospital doctors may be surprised to learn that NHS indemnity only extends to medical negligence claims arising from work in an NHS hospital or the community – excluding primary care. The indemnity does not extend to claims arising in connection with any voluntary, Category 2 or private work they undertake, or Good Samaritan acts outside the UK. The MDU can provide members with indemnity for all of these.

Doctors need to make their own arrangements for support with a whole range of medico-legal problems. These include assistance with GMC complaints, inquests, criminal investigations, employers’ disciplinary proceedings, assessments by the National Clinical Assessment Authority and, in some instances, investigations by CHI. While doctors can expect to receive assistance from their trust should they face a complaint or be called to give evidence at a coroner’s inquest, they may, where their own interests conflict with those of the trust, need to seek separate advice and support from the MDU to protect their own position.

The GMC requires doctors to ensure they have adequate professional cover for all areas in which they work. Paragraph 33 of Good Medical Practice states:

“In your own interests, and those of your patients, you must obtain adequate insurance or professional indemnity cover for any part of your practice not covered by your employer’s indemnity scheme.”

Inquest evidence and statements

The very nature of many hospital doctors’ work means they are often called to give evidence at an inquest. Such proceedings can be highly stressful and many doctors prefer to have their own professional advice and support.

On average, some 500 members a year are concerned enough about their medico-legal position to seek assistance from the MDU because they have to attend an inquest. We can help to draft a statement, and advise on whether certain elements of care are likely to be criticised. We can also provide legal representation if necessary, and advise members on how to deal with any media attention that may arise.

GMC complaints procedures

Doctors can face investigations by the GMC when their professional conduct or performance is called into question. The GMC advises doctors to contact their medical defence organisation as soon as they receive written notification of a complaint against them.

Our assistance with GMC investigations ranges from helping members to respond to the initial letter from the GMC, to providing legal advice and representation at Professional
Once bitten…

…treat with caution

Animal, reptile and insect bites can have catastrophic effects and need careful and timely treatment. Dr Matthew Robson reviews some MDU case files and finds that a bite from a domestic cat’s incisors can cause far-reaching repercussions. He highlights Veterinary Defence Society advice about the need for prophylactic treatment.

Every year, thousands of patients are bitten by animals of one sort and another. Of the total animal bites that gave rise to claims received (or settled) by the MDU over a recent period of analysis, 42% were canine in origin (caused – ironically – by man’s best friend), 23% were caused by insects, including scabies and mosquitoes, 16% were inflicted by fellow human beings and 11% were feline. Bites from the most feared animal source, snakes, came in at a mere 3% of cases. In five of the cases the bite resulted in the patient's death. Three of these cases related to insect bites – one in which anaphylaxis led to death, another in which the reaction to the bite led to a deep venous thrombosis followed by fatal pulmonary embolism, and another in which a depressed patient overdosed on paracetamol and dextropropoxyphene while on anti-histamines for a reaction to insect bites. A fourth case involved an elderly patient who was bitten a number of times and died later in hospital; and the fifth involved a snake bite where the anti-venom was administered too late to save the victim.

The veterinary view

Among our domestic pets, although dog bites are by far the most common, cat bites are generally considered more dangerous. The Veterinary Defence Society (VDS) recently

Conduct Committee (PCC) hearings. The PCC may make a finding of serious professional misconduct and the sanctions that may be imposed include suspension or removal from the register, conditions on registration or admonishment.

NHS disciplinary proceedings, including suspensions

Doctors can also face disciplinary investigations by their employing trust. In such cases, where a doctor’s future career may be at stake, the MDU can assist throughout the procedure, providing legal advice and assistance as and when it is appropriate. We strongly advise members who may be subject to disciplinary procedures to contact us as early as possible.

Comprehensive advice and support

Membership of the MDU provides an insurance contract for any negligence claims relating to care of individual patients. This policy is underwritten by Zurich Insurance Company and gives a contractual right to assistance, subject only to the terms of the policy. Membership also gives access to the MDU’s highly experienced team of medico-legal advisers, who provide permanent round-the-clock medico-legal and ethical advice on any clinical situation a doctor may face.

The MDU’s advice is tailored to each member’s personal situation and provided by advisers who are themselves fully qualified doctors and nurses. They have between them assisted members with hundreds of similar cases and can provide immediate, expert and detailed advice on ethical and medico-legal problems. Their role is to offer clarification, advice and – essential in times of difficulty – reassurance.

The MDU also places great emphasis on helping members to prevent problems in the first place. A dedicated Risk Management Department aims to help members avoid complaints and claims, by highlighting the common medico-legal pitfalls relating to their specialty through regular research of the MDU’s database, undertakes training, produces a variety of educational material, and deals with any related questions members may have.

Professional peace of mind

Any doctor working for an NHS trust should consider carefully the protection provided by their employer and ask whether it provides the full peace of mind they should have in their daily professional life.

The MDU, a mutual organisation run by doctors for doctors, provides access to benefits of membership that are much broader than NHS indemnity, giving members the highest level of career security and the support of an advisory service that is second to none.

Readers wishing to explore further the levels of cover and the range of additional services the MDU provides should call the Membership Department on Freephone 0800 716 376, or visit the MDU website at: www.the-mdu.com
re-issued to its membership its guideline document *The Handling of Cats*. While the guidelines are primarily aimed at ensuring that no unnecessary injury is sustained by veterinary staff and owners during consultations, they also point out what potential problems can arise if anyone is bitten or scratched by a cat.

Since our members are likely to encounter patients at surgeries or A&E departments who have been bitten by cats, we feel it is important that we pass this information on so that members are aware of the VDS’s suggested prophylactic measures. The following is an extract from the VDS’s guideline leaflet:

Most normal cats carry a variety of aerobic and anaerobic pathogenic bacteria in their oral cavities, including *Pasteurella multocida*, *Streptococcus* species and *Fusobacterial* organisms. Pathogenic bacteria can also be harboured in the nails and introduced through cat scratches. *Bartonella* species, now considered to be the cause of *Cat Scratch Syndrome*, can be found in a significant percentage of cats.

A bite or severe scratch can result in the deep implantation of infection. Particularly when a joint is involved, inadequate treatment can result in permanent disability. *Cat Scratch Disease* can affect a variety of organ systems with potentially very serious consequences, especially in immunocompromised patients…. If someone does suffer an injury, … superficial cleansing of a wound is not sufficient and the injured person should be advised to obtain prompt medical attention. … This is sometimes misdirected solely towards prevention of tetanus, which is an unlikely infection following a cat bite or scratch.

**Appropriate prophylaxis**

Fingers are often the target of cat bites. Their long narrow incisors typically inflict small but deeply penetrating puncture-type wounds, often straight into a finger joint, which can easily become infected, resulting in nerve damage or even gangrene, necessitating amputation. The effects of cat scratches can be similarly far-reaching. Cat scratches are often inflicted to the face: eyes are particularly vulnerable and long-term scarring of facial skin may also cause serious problems, especially in young or female victims. Yet few when bitten or badly scratched feel the need to seek medical treatment from a doctor or a nurse.

Cat bites can have far-reaching consequences not only for the bitten, but also for the medical professional brought in to treat the bite. The MDU has a number of cat-bite cases on our files, half of which concern the alleged mismanagement of bites. Some of these were serious enough to lead to the amputation of a digit; one resulted in the amputation of a limb.

**A cat-bite case**

A wild cat bit a man’s finger. The same day he attended his GP, who prescribed *erythromycin* and administered *tetanus toxoid*. After five days of pain and swelling, the man returned to his doctor, who prescribed *flucloxacillin*. The finger continued to cause great pain and 12 days after sustaining the injury the patient was admitted to hospital.

A swab grew *Pasteurella multocida* – the common organism in cats’ mouths – and at operation teeth marks were seen on the articular cartilage. Necrotic tendon and cartilage was excised. Left with impaired function and reduced dexterity, the patient sued the GP for negligence.

The MDU’s expert adviser opined that the risk of infection with cat bites is high, as they are puncture wounds and not easy to clean, and that the consequences of infection in this case could have been prevented by earlier referral. The patient accepted a moderate *ex gratia* payment without an admission of liability. His solicitors’ costs (paid by the MDU) were nearly three times as much.

**Risk management advice**

Dr Peter Williams, an Oxford GP who sits on the MDU’s Board and Council, advises members on the importance of prescribing appropriate prophylactic antibiotics in the case of cat bites.

“It is sound practice, after washing the wound, to prescribe an antibiotic; thinking only of *Clostridium tetani* is not enough. *Pasteurella multocida* is a common pathogen and is fortunately sensitive to penicillin. Moreover, the patient should be warned that if there is not a quick improvement, they should waste no time in seeking further medical help.”
Orthopaedic Risk in Private Hospitals

For some time the rise in obstetric litigation has been the focus of press attention as the cost of claims has soared. However, over the past few years, the MDU has settled more claims relating to orthopaedic surgery than obstetrics in the private sector. In this article Dr Matthew Robson, an MDU Claims Handler and Clinical Risk Manager examines recent orthopaedic claims settled by the MDU to determine what were the common mistakes and how they can best be avoided.

This analysis of private orthopaedic claims settled by the MDU in a recent 10 year period focuses on 192 claims and looks at where problems occurred, what went wrong and how such problems might be avoided in the future. The claims led to £16.6 million being paid out in compensation and legal costs, making orthopaedics the most costly private surgical specialty after obstetrics.

The above chart shows the anatomical location involved in each of the settled claims. Claims relating to lower limb surgery were the most prevalent with 16 of the 59 claims (27%) resulting from knee arthroscopy and 10 (17%) from knee replacements. The rest of this group was composed of a diverse range of problems ranging from scarring, deformity, nerve damage and delayed diagnosis of ligamental tears.

The management of spinal problems accounted for one quarter of the settled claims.

In 19 of these 48 claims (40%) neurological damage was a major factor. A number of other claims arose as a result of disagreement over whether the procedure chosen was appropriate. Seven of the claims (15%) resulted from spinal fusion procedures.

While less frequent than claims relating to the management of lower limb conditions, spinal claims were far and away the most expensive, costing over £8.6 million in legal costs and damages. This is because the severe damage that occurred as a result of things going wrong when operating close to the spinal cord meant that the patients needed extensive medical care for the rest of their lives, which had to be provided privately.

The largest settlement – £1.3 million – was awarded to a 34-year-old man who suffered neurological deficit resulting in permanent disability after laminectomy was delayed. A dural tear during hemi-laminectomy and discectomy for sciatica led to a payout of £1.1 million for a 42-year-old woman who was left with significant mobility problems and needed further surgery for worsening sciatica. Another patient was left quadriplegic when a routine cervical discogram at C4-7 was complicated by abscess formation and spinal cord damage that occurred during emergency laminectomy. In this case, the MDU paid out £900,000 in damages.

Hip surgery led to 20 claims, almost all of which resulted from total hip replacements. Most common problems encountered were persistently dislocating prostheses and sciatic nerve damage.

A substantial proportion of settlements related to errors of site and side, such as procedures performed on the wrong limb or at the wrong spinal level. Some of these problems are examined below.

Wrong site/side surgery

The most common procedure to be performed on the wrong side was arthroscopy. Cases commonly arose through incorrect marking of the operative site, either because the patient was not involved in identifying the site or because members of the surgical team did not communicate clearly with one another. One woman was compensated after a total knee replacement to her left knee when she clearly had severe osteoarthritis in her right knee. Allegations of surgery performed at the wrong spinal level are relatively common (almost 10% of settled spinal claims). Risk factors include involvement of more than one surgeon in a patient’s care, where the surgeon operating may not have been looking after the patient preoperatively, and miscalculating the level of the lesion when interpreting X-rays or scans.

Risk management and avoiding errors

Wrong site/wrong side

The MDU’s experience shows that, despite it now being usual practice to mark the site before surgery, there has been no significant reduction in the incidence of wrong site/side
surgery. For the avoidance of wrong side claims, it is imperative that hospitals adhere to rigorous procedures at each stage of a patient’s route to theatre. Checks include:

- review of referral letter, clinical record, consent form and operation list to check that they are in agreement
- confirmation that the correct side is marked with the patient
  - on admission
  - on leaving the ward en route to theatre
  - on entering the theatre suite
  - in the anaesthetic room
- checking the marking once the patient is on the operating table, and if necessary, re-checking against the patient’s notes.

The most common site error in spinal surgery was performing the procedure one level above that intended. (The American Academy of Orthopaedic Surgeons has introduced a useful and comprehensive “checklist for safety” for use in the case of such procedures which can be found at www.spine.org/smax.cfm)

Pre-operative X-rays should always include the whole bone and the joint above and below if appropriate. Cervical spine X-rays must always show the whole cervical spine down to the upper border of T1; similarly, a clear view is needed of one vertebra either side of the lumbosacral junction. Radiological identification at the time of operation helps to avoid errors: a fixed marker is introduced to the appropriate segment and the level is checked with the image intensifier.

Informed consent
It is vital that consent is obtained by an appropriate member of the surgical team. This should preferably be the operating surgeon, especially if a complex procedure is to be undertaken. Consent must be clearly documented in the clinical record, and should show that the indications for surgery, as well as for alternative treatments or non treatment, have been mentioned.

The potential complications of the procedure must be discussed; the fact that a complication is extremely rare should not preclude its discussion. The severity of potential adverse outcomes should be taken into account when talking to patients about surgery. For example, failure to warn of the possibility of sciatic nerve injury prior to total hip replacement, or of the possibility of new or worsening neurological impairment prior to spinal surgery, could greatly prejudice the ability of the MDU to mount a successful defence to a case centred around failure to adequately warn.

The likely outcome must be clearly explained to the patient, as doctors’ and patients’ expectations – in the case of, for example, total hip replacement – can vary considerably. Again, this discussion should be clearly recorded, the entry being dated, timed and signed legibly. A common allegation made by patients is that they did not receive sufficient information about the side effects associated with a particular operation. Should they convince the court that, if warned, they would not have undergone surgery, or that they would have undergone a different procedure, then they are likely to succeed in a damages claim even if the surgery was not negligent. For example, if a patient has to leave his job because of permanent mobility problems arising as a result of a known complication of minor knee surgery, he may be in a position to claim damages for pain and suffering and possibly loss of earnings, unless he was warned of the risks of this potentially serious complication when giving consent to undergo the procedure.

Retained items
Overall, 7.5% of MDU surgical claims involve an allegation of a retained item. Although this figure is lower in orthopaedics than in specialties where the abdomen is opened, claims involving retained drains, swabs and pins following orthopaedic procedures have all been settled. Problems can be minimised by ensuring that all equipment is maintained and serviced regularly, that disposable items are checked before use, and that swab, instrument and needle-counting policies are strictly adhered to.

Post-operative monitoring and infection
A recent National Audit Office report* highlighted the significance of hospital-acquired infection. While recognising that this type of infection cannot be completely avoided, the report stresses the importance of early recognition and treatment. Careful post-operative monitoring is imperative to prevent delays in diagnosis and treatment of infection that can lead to unnecessary harm to patients. The MDU has had to settle a number of cases relating to post-operative infection in which it was not possible to demonstrate from the clinical record that the patient was satisfactorily monitored after surgery. Monitoring is particularly vital in orthopaedics, given the emergence of multiple antibiotic-resistant bacteria and the difficulty in eradicating deep-seated bone and joint infection.

As Alexander Pope said: ‘to err is human’, and even the most cautious of medical staff can make mistakes. Analysis of MDU claims files will inevitably highlight those areas where mistakes are most common, or most costly. However, it is important to remember that there were a relatively small number of settled claims in relation to the total number of operations undertaken privately by our orthopaedic members and our data does not indicate any increase in the incidence of such unfortunate occurrences.

Learning from the experiences of others, adhering to risk management guidelines and taking an even more diligent approach to basic procedural matters can help reduce the likelihood of an error that leads to human suffering – and a claim – to a minimum. And remember, if in doubt, call the MDU for advice.