Doctor in defence
Unique member's account

Setting subscriptions - Chaperones - Health Service Ombudsman's role
Only **ONE** UK doctors’ owned mutual defence organisation provides insurance for clinical negligence claims against you

Unparalleled experience. Unsurpassed security. Unrivalled defence

Who would protect their home or car on a solely discretionary basis - only knowing after a loss had occurred whether they would be able to receive compensation?

No informed person would, and in the case of motor insurance the Government does not allow us to. Yet some UK doctors are not aware that only one of the doctors’ owned mutual defence organisations provides insured indemnity to its members in the event of a clinical negligence claim.

With the MDU you have the security of insurance* along with access to discretionary indemnity for matters which may not be covered by the policy.

Is it any surprise that more of the UK’s doctors choose the MDU than both of the other defence organisations put together?

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* subject to the terms and conditions of the policy provided by Converium

For more information visit [www.the-mdu.com](http://www.the-mdu.com)
Making amends the CMO’s paper containing 19 recommendations for NHS clinical negligence reform was published in June 2003. The MDU has commented on these comprehensive and innovative proposals and our detailed response is on our website at www.the-mdu.com The key recommendations that may affect members are set out below. Members will be aware of the MDU’s campaign for repeal of section 2 (4) of the Law Reform (Personal Injuries) Act 1948. We have long believed it anomalous that damages awarded for successful personal injury claims must provide for private medical care only. The suggestion, therefore, in recommendation 17, that the costs of future care in any award for clinical negligence should no longer reflect the cost of private treatment, is a very welcome starting point as it will retain vital funds in the NHS. The recommendation is limited to NHS hospital care initially, but we believe that repeal of section 2(4) should be extended to primary care and the independent sector. We also suggest that it should extend to all personal injury awards, so that the NHS could benefit from the additional funds it could potentially secure. The MDU has long suggested that NHS money saved by repeal of section 2(4) should be used to improve NHS rehabilitation services for all patients. Recommendation 10 proposes that effective rehabilitation services be developed for all personal injury, including medical accidents, and is again welcome. There is evidence to suggest that early rehabilitation can substantially improve a damaged patient’s final outcome and better NHS rehabilitation facilities would be a good thing for patients and defendant doctors.

Recommendations 1 & 2, the setting up of an NHS Redress Scheme and extending it to severely neurologically impaired babies born under NHS care would introduce the most profound changes. The schemes are intended for NHS hospitals and will provide a combination of remedial treatment, rehabilitation and care when needed; explanations and apologies, and financial compensation if appropriate, which in the case of babies also includes up to £50,000 in damages for pain, suffering and loss of amenity, and lump sum payments to make home adaptations and buy equipment throughout the child’s life. Patients will retain the right to sue, but the redress available is intended to provide sufficient remedy to spare patients, their families and defendant doctors the distress and uncertainty of a negligence claim. How these schemes will operate remains to be seen. Instead of being more effective, they may prove prohibitively expensive and create delays. There is again welcome. There is evidence to suggest that early rehabilitation can substantially improve a damaged patient’s final outcome and better NHS rehabilitation facilities would be a good thing for patients and defendant doctors.

Other key recommendations are 12, proposing a duty of candour and exemption from disciplinary action when reporting incidents and 13, proposing that documents and information identifying adverse events should be protected from disclosure in court. The GMC already requires doctors to explain fully and promptly to patients and to offer an apology if something has gone wrong, and we do not believe that a legal duty of candour would add anything nor is it clear how this would work in practice. Clinicians may be reassured by the proposal for exemption from disciplinary action, but, again, it is difficult to see how this would work in practice. Doctors who have concerns about patient safety have an ethical duty to take appropriate steps to protect patients and, depending on the situation, this can include the need to report a colleague to the GMC. As for protecting reports of adverse events from disclosure, the facts are the facts and would have to come out in court anyway. It is more important to ensure that incident reports are not misused in the litigation process and any finding that a system or practice could be improved should not be misrepresented as an indefensible error.

Making amends has some great ideas and reasons for optimism. But, as always, the devil is in the detail.

Dr Christine Tomkins Professional Services Director

*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. All images used in this issue of The Journal unless otherwise stated, are posed by models.
New look Coroners’ Service - what it will mean for you

A major shake-up of death certification services in England, Wales and Northern Ireland was recently proposed by the Coroners Review Group, which presented its findings to the Home Office in June. The Group spent 18 months taking evidence from hundreds of organisations and individuals including the MDU. Its report A Fundamental Review of Death Certification and Coroner Services makes 123 recommendations which its says will help prevent abuse of the death certification system.

A month later, in July, Dame Janet Smith, who is conducting the Shipman Inquiry, published her report on Death Certification and the Investigation of Deaths by Coroners. This report also identifies the need for radical review of both the coronial system and death certification and makes several proposals for change.

The MDU assisted 290 members last year with inquests and fatal accident inquiries. We agree that the current system is out of date and welcome many of the key recommendations, which, if implemented, will have wide radical and far-reaching changes for members. The recommendations of the Fundamental Review include:

- Virtually all deaths while under medical care, unless certifiable as due to natural causes or old age, would have to be notified to the coroner
- The formation of a new professional service replacing the current 136 coroners districts in England and Wales with around 60 area coroners’ services geographically corresponding with police authority areas.
- Only solicitors and barristers of five years standing will be eligible to become coroners.
- A new role of statutory medical assessor will be responsible for overseeing and auditing the certification process and advising the coroner in cases of natural death. It is hoped this will lead to a reduction in the number of post mortem examinations and routine inquests.
- All deaths would be certified by two medical practitioners, regardless of the method of disposal of the body. The first certifier should usually be the doctor looking after the person who has died. The second should be from a panel chosen and supported by the statutory medical assessor.
- All deaths should be subject to professional verification that the life has ended. This verification should be made after the body has been viewed. The report says that verifying a death has occurred should be statutorily defined as a step distinct from certifying the cause of death. Verification of death may be performed by a doctor (whether or not the doctor also certifies the cause of death), or by other suitably qualified personnel.
- The remit of the inquest would be much wider with a stronger bias towards learning lessons and preventing repeat occurrences rather than apportioning blame. The MDU was pleased to see that the idea, suggested in an earlier consultation paper, that inquests should be extended to consider the need for disciplinary action, civil claims or award damages was rejected by the Coroners Review Group. The MDU was concerned that this proposal was outside the remit of the inquest and could lead to doctors being pilloried in the press before the facts were proven.
- A new statutory Family Charter will set out standards of support for bereaved families for all coroners to meet. It should include new rights to challenge decisions by coroners, for example to order an autopsy in the face of religious or other objections from the family, or not to order an autopsy where the family thinks there should be one.
- All coroner investigations will have clearer, more accessible and suitable outcomes for families. The review group suggests that public inquests should be used more selectively so that fewer families would be subject to delay and publicity. Routine and public inquests, for example into all suicides, would cease and be replaced with “objective and professional investigations conducted out of the glare of publicity”.
- Autopsies in England and Wales would be used more selectively, to clearer purpose and only where the essential facts could not be established in other ways.

Copies of the A Fundamental Review of Death Certification and Coroner Services can be found at: www.official-documents.co.uk/document/cm58/5831/5831.pdf
Copies of Death Certification and the Investigation of Deaths by Coroners can be found at: www.the-shipman-inquiry.org.uk
Copies of the MDU’s response to Certifying and investigating deaths in England, Wales and Northern Ireland, November 2002, can be found at www.the-mdu.com
We reported the setting up of the National Patient Safety Agency (NPSA) in the May 2002 issue of the Journal. The primary purpose of the Agency is to introduce and oversee a national reporting system for learning from adverse events and near misses in all sectors of the NHS.

In the last year, the Agency has undertaken a pilot study of the reporting system and is now ready to roll out the national programme from November. The process will take about a year and involve both the primary and secondary sectors simultaneously so that by December 2004, the whole NHS will be in a position to report.

Many different words have been used to describe “events” in healthcare – “critical”, “untoward”, “adverse”, etc.. In response to confusion around terms and removing connotations of blame, the terminology has changed to a standard all-encompassing term and what were previously referred to as adverse events will now be known as “patient safety incidents”. Those where no harm was caused (near misses) will be termed “prevented patient safety incidents”.

The pilot study emphasised the need for simplicity in the method of reporting and the new system will either continue with the established local risk management systems or use an electronic report form - the eForm - adapted for use in all healthcare settings. All NHS staff will be encouraged to report, though the process is not to be mandatory. All actual and prevented incidents should be reported and the NPSA has developed a simple system for grading the incident to rate the harm (or potential harm) caused. The system will be confidential and anonymous at the NPSA level. The Agency will not store any data that identifies either the reporter or patients/staff involved in a patient safety incident.

Reporting can be undertaken in three ways, for example, in primary care:

- Attributable i.e. identifiable reporting to the PCT by sending the eForm to the risk manager at the PCT who will then collate the information and arrange appropriate action locally. On receipt of the information, the NPSA will remove any identifying data.
- Anonymous reporting to the PCT and data can be forwarded to the NPSA.
- Direct to the NPSA using the eForm via their website www.npsa.nhs.uk

The NPSA will use the information it receives to identify patterns of incidents and key underlying factors. It intends to use the data to develop practical solutions to problems identified and to feed this information back to all members of healthcare teams nationally so that changes can be implemented locally.

The MDU supports incident reporting as a useful risk management tool and we published our own advice to GP members in a booklet entitled The MDU’s Guide to Adverse Incident Reporting last autumn. As members will be aware, we have shared our claims data with you over many years for risk management purposes. Once the NPSA’s system is implemented it will be the first national system to process patient safety incident data in the world on such a scale. The NPSA will measure success by the ability to identify and to act upon patient safety issues and the development of practical solutions to prevent repetition of harm and distress to patients and staff.

Dr Stephen Green  Head of Risk Management

Members can either order or download a copy of The MDU’s Guide to Adverse Incident Reporting by visiting www.the-mdu.com
GPs’ obligations under the Freedom of Information Act 2000

Under the Freedom of Information Act 2000, which applies to England, Wales and Northern Ireland NHS GPs (and other NHS bodies) are obliged to adopt and maintain a scheme relating to the publication of information by the end of October this year.

The Act, passed on 30 November 2000, will give a general right of access to all types of “recorded” information held by “public authorities” (which include NHS bodies such as hospitals, as well as GPs, dentists, pharmacists and opticians) and sets out exemptions from that right.

The Act also places a number of obligations on such authorities, chief among which are the duty to (1) produce a “publication scheme” (by 31 October 2003) and (2) respond to individual requests for information (from 1 January 2005).

Publication schemes

Section 19 of the Act deals with the duty of public authorities to adopt and maintain a scheme for publication of information, which must set out (1) the classes of information the authority publishes or intends to publish, (2) the manner in which it is published and (3) whether the information is available to the public free of charge or on payment.

Once a publication scheme has been approved, it is up to the public authority to decide how to publish the scheme and to review it periodically. Schemes may be designed for particular bodies or may be generic. The Information Commissioner can approve model schemes for groups of similar bodies.

The NHS Freedom of Information Project Board has submitted model schemes for (among other health service public authorities) dentists, GPs, community pharmacists, opticians and optometrists in England. These model schemes, which have been approved by the Information Commissioner, together with guidance for completing them, are available on the NHS Freedom of Information website at www.foi.nhs.uk. Independent practitioners wishing to adopt the model scheme need send nothing to the Information Commissioner, who will assume that the model scheme has been adopted. Members wishing to suggest an alternative scheme should have submitted their proposed scheme to the Commissioner for approval by 31 August 2003. Similar model schemes have been approved for Wales and Northern Ireland and can be found on the Information Commissioner’s website www.dataprotection.gov.uk.

New powers to oversee GMC, GDC and other regulators’ decisions

The Council for the Regulation of Healthcare Professionals (CRHP) was created under the National Health Service Reform and Health Care Professions Act 2002. The Council’s role is to ‘oversee the activities of the various regulatory bodies of the health care professions’. Under section 29, CRHP was given power to refer a fitness to practise decision by a regulatory body to the High Court where it seems to be desirable for the protection of the public, either because the decision was too lenient, or CRHP judges it should not have been made.

The explanatory notes to the Act make it clear that CRHP would do this only in extreme cases, where the public interest in having a clearly perverse decision reviewed by a Court outweighs the public interest in the independent operation of self regulation.

CRHP expects that it will refer very few cases each year, though it may consider rather more in some detail in order to decide whether to refer them.

If a case is referred, the High Court has the power to substitute its own decision for the one referred to it, or to refer the case back to the regulatory body for a re-hearing. The rights of the doctor or dentist whose case is being heard are protected and he or she will have a right to be represented at the appeal hearing.

The powers under section 29 came into operation on 1 April 2003 and CRHP is currently developing a procedure to be used to investigate and refer regulatory body decisions.

The MDU is representing members’ medico-legal interests in this process in discussions with CRHP about its proposals. CRHP hopes to publish a consultation paper in September.

It is expected that the final procedure will be in place by the end of 2003, but in the meantime, members need to be aware that CRHP already has the power to refer decisions by regulatory bodies and is able to use it.

Mary-Lou Nesbitt Head of External Relations
Membership News

From the Medical Editor

When I was approached, towards the end of last year, and asked if I would take over the reins as Medical Editor of the Journal, I was somewhat in the dark as to quite what the role would entail.

Fortunately, this has turned out to be an enjoyable opportunity to work with a dedicated team who not only know the ropes, but also know exactly what they want me to do.

My early memories of the Journal date back to my house officer days, when I recall flicking through it while relaxing in the bath after a busy night on call, rather morbidly reading about the difficulties some poor unfortunate "colleague" had got into (and thanking my lucky stars that it wasn’t me). I’m sure many members have similar memories.

The Journal has been in existence now for over 18 years and we are always looking for ways to improve it to ensure that it will continue to be read and enjoyed by as many of our members as possible.

The first issue was published in Spring 1985 and had articles on the “new” Mental Health Act 1983, several dental articles (the Journal of the DDU is now a publication in its own right) and an article heralding the opening of the MDU’s Manchester office (which closed in 2000).

That first issue also contained several medico-legal “case histories”. We know that these case histories are popular and are currently working on several ideas to diversify their subject matter and increase the number we publish.

Case histories apart, we are always keen to hear about any ideas you may have that could be incorporated into future issues.

While we can never hope to please all MDU members with every article published, all comments and ideas submitted will be considered to ensure that the Journal will remain as relevant and interesting as it has always been.

Dr Matthew Lee
medico-legal adviser

Telephoning the MDU

We have freephone numbers so members can contact us easily and cheaply if they need medico-legal advice or if they have a query about their membership. We have different freephone numbers for Ireland and the United Kingdom (England, Wales, Scotland and Northern Ireland).

Calling from Ireland
Freephone 24-hour advisory helpline: 1800 535 935
Call this number when you need medico-legal advice. This number only works in the Republic of Ireland. Unfortunately, it is not always possible to call this number from a mobile phone so you may need to try again from a landline.
Freephone membership helpline: 1800 509 132
Call this number when you have a question about your membership, your subscription or to simply get a copy of one of our publications. Again, this number only works from the Republic of Ireland and only from a landline.

Calling from the UK
Freephone 24-hour advisory helpline: 0800 716 646
Call this number when in need of medico-legal advice. This phone number only works from the United Kingdom. If you call this number from a mobile phone you may be charged for this call.
Freephone membership helpline: 0800 716 376
Call this number when you have a question about your membership, your subscription or to simply get a copy of one of our publications. Again, this number only works from the UK and if you call from a mobile you may be charged for this call.

Calling from outside the UK or Ireland
The freephone numbers for each country only work if you are in Ireland or the UK. If you need to contact the MDU, for whatever reason, from abroad please call +44 (0)20 7202 1500. This will put you through to our switchboard and they will make sure you are quickly transferred to the correct department.

Only an email or website away
Members can also use our website www.the-mdu.com to: order publications; download application forms; order elective letters; notify the MDU of a change of address and; forward queries to membership and advisory (& receive electronic confirmation of this).

You can contact the MDU by emailing or faxing:
Membership queries: membership@the-mdu.com
UK Fax: 020 7202 1696
Ireland Freephone Fax: 1800 509 143
Advisory queries: advisory@the-mdu.com
UK fax: +44 (0)20 7202 1662
Membership news

New insurance company for MDU members

Since 2000, through its joint venture company MDU Services Ltd, members of the MDU have been provided with fully underwritten contractual indemnity insurance against claims from third parties – a major difference between the MDU and other medical defence organisations that provide only discretionary cover.

Until July this year, the issuer of the policy for UK members has been the Zurich Insurance Company. From July, as UK members have renewed their membership, they will have noticed that their policy is issued by Converium Insurance Company Ltd. While the name of the policy issuer may have changed, that is all that has changed; the major carrier of the financial risk involved has not changed and there is only one minor addition to one of the clauses in the terms and benefits of members’ cover. The new Converium policy is gradually replacing the Zurich policy for all renewals and new joiners from 1 July 2003.

The name change: Zurich Re becomes Converium

Since the introduction of the contractual insurance cover, Zurich Reinsurance, a Swiss-based reinsurer, has held most of the underwriting risk of members’ insurance policies issued by the Zurich Group. It was not, however, able to write the insurance policies needed in the UK, so these were provided by the Zurich Insurance Company and reinsured by Zurich Reinsurance.

As members will know from the Report & Accounts 2001, in late 2001, Zurich Reinsurance, with $1.6 billion in shareholder equity and over $6 billion in invested assets, specialising in clinical indemnity among other areas, was floated off from the Zurich Group and became Converium Ltd. In the past 18 months, the MDU has re-established its existing MDU Services joint-venture partnership to be with Converium. The Converium Group has since established Converium Insurance Company Ltd, a wholly-owned UK-based subsidiary, through which the Swiss-based reinsurer can underwrite insurance in the UK.

Converium’s willingness to set up the new insurance subsidiary, allowing it to underwrite members’ policies directly, and to re-establish the joint venture with the MDU is testimony to the company’s long-term commitment to the UK medical indemnity market.

There is no change at this time to the insurance provided to the MDU’s Irish members, who will continue to be covered by their existing Eagle Star policy.

Keeping out of court

In association with the MDU, the Royal Society of Medicine is hosting a series of three evening lecture meetings for healthcare professionals on the major medical risks in current practice in a number of specialty fields, with discounts on registration for MDU and RSM members and further reductions for attending all three meetings.

Focusing on orthopaedics, gynaecology and general surgery, each evening in the series, aimed at SHOs, SPRs, consultants, nurses and clinical risk managers, will comprise three 30-minute lectures, from two experienced practitioners in the field and from Dr Stephen Green (pictured), Head of Risk Management at the MDU, followed by discussion.

The RSM CPD-accredited meetings, which will take place on Thursday evenings this autumn at the Royal Society of Medicine’s premises

1 Wimpole Street London between 6.00pm and 8.00pm, are scheduled as:

- 2 October
  (Orthopaedics)
- 13 November
  (Gynaecology)
- 4 December
  (General Surgery)

The charge for registration, which includes all refreshments and conference materials, is £35 each evening (£100 for all three) for RSM/MDU dual members; £40 (£100) for RSM or MDU members; and £50 (£140) for non-members, representing a full 20 per cent discount for MDU members, and 30 per cent for those with dual membership.

Members interested in attending one, or all, of the meetings should contact

Caroline Evans
at the
RSM’s Academic Conference Department on
tel: 020 7290 3920
or
e-mail: events@rsm.ac.uk
MDU Report & Accounts 2002: Representation and contractual indemnity

The MDU’s key role at the forefront of medico-legal debate and its provision of contractually insured professional indemnity are among the topics covered by the Chairman and the Chief Executive in their reports to members in the MDU Report & Accounts for the financial year 2002.

The Chairman of the MDU Board of Management, orthopaedic surgeon Mr David Markham, pays tribute to the dedication of MDU staff in representing members’ medico-legal interests to governmental bodies, policy-makers and a range of clinical and other organisations.

**Leading debate**

Mr Markham explains that it is the MDU’s role to lead the debate in areas that are of particular importance to members – for clinical, legal, ethical and financial reasons. Such involvement ensures that the MDU is aware of plans for change or developments and that policy-makers are fully acquainted with the potential medico-legal impact on members.

Mr Markham sets out the MDU’s policy in key areas. Since the report went to press, the CMO has published his consultation document Making Amends. This document outlines proposed clinical negligence reforms and changes that the MDU has promoted for a number of years.

One of the key proposals for which the MDU has campaigned is the repeal of section 2(4) of the Law Reform (Personal Injuries) Act 1948, which requires that damages paid to a patient compensated for negligence must allow for all future medical treatment to be received privately.

This means that NHS funds used to compensate patients are being paid to the private sector and depriving the NHS of money that could otherwise be used to improve long-term care for all severely injured patients.

**Contractual indemnity**

The MDU’s Chief Executive, Dr Michael Saunders, reports that membership numbers are stronger than ever and market share continues to rise.

Regular market research indicates that members are consistently pleased with the quality of the services, especially the medico-legal and risk management advice.

Dr Saunders reports that UK paying members of the MDU have, since July 2000, been progressively protected by an insurance policy, giving them certainty of assistance, subject only to the terms of the policy, so that they know that they will be helped if they have a clinical negligence claim – up to £10 million per claim and in total per member for the year.

While some detractors might say that a contractual right to assistance, over and above traditional discretionary benefits, only costs our members more and boosts shareholder profits, Dr Saunders explains that the MDU’s board believes that the additional cost is a fair exchange for the certainty that only regulated insurance (available from the MDU alone among UK mutual defence organisations) brings.

Dr Saunders describes the upheaval in other territories in the provision of professional indemnity by discretionary medical defence organisations (MDOs).

He cites the professional liquidation of Australia’s largest MDO and changes to medical liability in France that forced one MDO to cease independent trading, both causing major anxiety and uncertainty for their members.

No informed person, he suggests, would protect their home or car in such a way that only after a fire or a crash would they know if they would recover their loss – and no government would allow it. And yet this is exactly what is being allowed to happen in the case of medical indemnity.

The way ahead for all has to lie with insurance-based indemnity products. He calls for regulation of medical indemnity insurance providers in the UK.

Members can now have their statutory communications (Report & Accounts, AGM notification and proxy papers) delivered by email, enhancing speed and convenience and helping reduce costs and paper use. To register, visit the MDU website at [www.the-mdu.com/agm](http://www.the-mdu.com/agm) and complete the short registration form. Then, before the AGM, we will send you an email containing: a link to the Report & Accounts; a link to the online proxy form; and notification of the MDU AGM. If we are advised that the email notification has failed, we will send your notification by post. You can revert to paper format at any time by re-visiting the registration form and following the instructions.
New Membership Services Manager

Eleanor Price has recently assumed responsibility for the Membership Services team, taking over from Sara Barnard, who has returned to Australia to pursue a career in education.

Eleanor moves to her new post from heading up the MDU’s Advisory Support function, where she was responsible for streamlining operations by introducing both homeworking and the electronic work process to the MDU.

Eleanor brings to Membership her three years of experience within the MDU, on which she plans to build in order to strengthen the Membership team and further enhance the service they provide to members.

Future plans include further developing and refining the department’s operations and working more closely with other departments to provide a multimedia contact centre that delivers a seamless service responding to the needs of members in their busy professional lives.

Head of Advisory Services retires

Dr Patrick Dando, Head of Advisory Services at the MDU, retired at the end of May 2003 after a long and distinguished medico-legal career.

Patrick qualified from UCL in 1969 and was a principal in general practice for many years before joining the MDU as a full-time medico-legal adviser in 1989 in the Manchester office. Many grateful members will remember him as a very supportive and meticulous adviser.

In 1994, he became Head of Advisory Services. At that time the staff comprised 15 advisers, half based in London and half in Manchester. With his customary care and diligence, Patrick set about welding the two teams into a highly effective unit. In his nine years at the helm, Patrick has led widespread change. In 1999, a start was made on computerising the work of Advisory Services, which entailed an entirely new way of working with files. As might be expected, there were minor teething problems, Patrick’s tenacity and leadership helped overcome these problems, and today Advisory Services is almost entirely paperless. When the Manchester office closed in 2000, advisers became home-based. Gradually, home working spread to include advisers in the London office and today all medico-legal advisers are home-based.

Patrick spent much of his time in recent years ensuring that management of the service was at the cutting edge, introducing protocols and a comprehensive and multi-faceted system of audit. Patrick has left Advisory Services with a professional staff of 18, plus six part-time telephone advisers and 20 clinical complaints advisers.

His wise leadership counsel will be greatly missed by all, but we are pleased that he is continuing in retirement as a part-time telephone adviser and a clinical complaints adviser for the MDU.

Dr Peter Schutte
Acting Head of Advisory Services

Member discount for online revision service

Members preparing for the new-style MRCP part 1 and part 2 written examinations can practise their technique on an established revision website at a 50 per cent discount, negotiated by the MDU as part of our ongoing programme to support doctors in their career development.

Onexamination.com is a leading provider of online medical education. The site’s revision database includes over 4,000 “best of five”, “n of many” and multiple-choice style questions based on topics from recent M RCP part 1, part 2 written, M RCPCH, PLAB and medical finals exams.

Members can qualify for the 50 per cent discount and register for 2 or 4 months’ access to the service when they sign up for the M RCP parts 1 and 2 or M RCPCH exams at www.onexamination.com. The offer is also available to Irish members and, while there are as yet no questions tailored specifically to the Irish exams, most questions in the database will be equally applicable in the UK and Ireland.

Registration for M RCP parts 1 and 2 is £25 (£50 full price) for 2 months and £35 (£70) for 4 months.

For M RCPCH, the fee is £20 (£40) for 2 months and £25 (£50) for 4 months.

The discount offer will run initially until 1 July 2004, and may be extended. Site users can check their answers, monitor progress and compare their performance with that of their contemporaries. Members can practise trial questions, which will be marked, before deciding to register, by going to www.onexamination.com/freetrial and quoting the reference MD39.
On-line risk assessment. How do you compare?

Have you completed a risk assessment of your practice yet? The MDU’s new interactive service, launched earlier this year, is proving popular with members. Based on the GMC’s guidance Good Medical Practice, it allows you to identify areas of risk in your practice and create a personalised action plan to deal with them.

Using the anonymised online benchmarking facility, you can also see how your practice compares against the overall average. This first module of the service covers four categories of the GMC’s guidance: Good clinical care; Maintaining good medical practice; Good relations with patients; and Working with colleagues. A second assessment module is due to be launched soon covering the remaining categories: Teaching and training; Probity; and The performance of other doctors. It is hoped that the two assessment modules together will help contribute towards the evidence you need to collect for the appraisal and revalidation process. To start your assessment, go to: www.the-mdu.com/gp

AIR in hospitals and specialist care

A new freely accessible electronic guide to adverse incident reporting (AIR) in hospitals and specialist care is now available to members on the MDU website. This guide, written specifically for the hospital and specialist care teams, will help members in these areas to gear up for AIR, which is being implemented throughout the NHS to help improve patient care by learning from mistakes. To access the new AIR guide, go to www.the-mdu.com/hospital

Our GP guide to AIR is also available, both as a published booklet and as an online document on the website at www.the-mdu.com/gp

Home improvements

In response to feedback from members, we have recently redesigned our homepages. We’ve made the content more relevant to your area of interest and also made it easier for you to access the services you use most often.

Our Advice Centre is regularly updated with the latest medico-legal hot topics and the improved “at a glance” design allows you to easily spot news most relevant to you.

MDU teams up with AnaesthesiaUK

AnaesthesiaUK is a free educational website for Anaesthetists. It is endorsed by The Royal College of Anaesthetists, The Irish College of Anaesthetists and The Intensive Care Society for its role in education.

The site covers every aspect of training with a special focus on the post-graduate examinations. AnaesthesiaUK provides a wide variety of educational resources, covering all topics relevant to Anaesthesia and Intensive Care. There are large banks of MCQs/OSCEs and Viva questions as well as updated content for handheld computers.

The site has recently launched an online examination centre, which provides access to interactive multiple-choice questions, set out in the FRCA format. Upon completion of the questions, guided answers are provided. At the end of the exam, feedback includes comparison of your mark with the average mark for that exam taken by other trainees in the UK.

The MDU has teamed up with AnaesthesiaUK to provide medico-legal input into their site. The fictional scenarios are based on typical medico-legal or ethical dilemmas that an anaesthetist might face.

These questions, together with the medico-legal content of the site, are designed to increase anaesthetists’ awareness and knowledge of the medico-legal aspects of anaesthesia.

To visit the site go to www.anaesthesiakuk.com

Web watch

Recent hot topics from the MDU’s website that you may have missed:

- Court of Appeal child abuse decision
- Epilepsy driving bans
- Change in law on controlled drugs
- GP certificates
- New guidance on child protection
- Freedom of Information Act
- New look coroner’s service – what it means to you
- Same sex partners count as relatives

Check them out in the News section at www.the-mdu.com

Jason Ellis E-business Manager, ellisj@the-mdu.com
How subscriptions are set:
Providing value for members

The M DU provides its members with a level and quality of service and support that is second to none. Here, Gerard Cooper, Head of Management Information & Statistics, reviews all the various elements that are taken into account when setting members’ yearly subscriptions.

Less than 20 years ago, all M DU members paid the same mutual subscription rate regardless of the nature or extent of their practice. Today, there are a wide variety of rates, but few members will be aware of the process the M DU undertakes to ensure subscriptions are appropriate for each category of member.

What the subscription pays for

The M DU’s accumulated subscription rates must be sufficient to meet the costs of supplying the M DU’s wide range of services. These services include the Advisory Helpline, which provides an accessible, friendly and knowledgeable ear at any time of day or night throughout the year. Last year we received over 24,000 calls covering a wide range of subjects.

Our professionally qualified medico-legal advisers can also provide support to members who face complaints or disciplinary procedures including before the GMC/Medical Council. Over the past few years we have seen demand for our assistance in these areas increase rapidly. For instance, the number of GMC complaints involving M DU members has increased over 15-fold since 1990 and in the past couple of years has risen by 33% per annum.

The Governmental and External Affairs department and our press department represents members’ interests in medico-legal forums and can assist members in their personal dealings with the media. The M DU has long been a pioneer of risk management and its team of risk managers provide members with a range of publications and on-line tools to help them avoid common pitfalls.

A major benefit of M DU membership is access to indemnity in the event of a claim for clinical negligence. Uniquely among UK mutual defence organisations, the indemnity for paying members is provided by a Converium Insurance contract of up to £10m in the membership year.

This provides a level of certainty which members of other traditional defence organisations simply do not have, as their memberships give them only the right to ask for assistance, not the right to receive it. M DU paying members have the right to ask and the right to receive. In addition, all members still retain the right to request assistance on a discretionary basis in the event of a claim not being covered by the policy.

As many members will be aware, there have been medical indemnity crises in Australia and France in recent months. As a result, in Australia, it is now a requirement that all medical indemnity is provided on an insured basis such as that offered by the M DU to its UK and Irish members.

Setting the overall budget

So how is the overall budget for the total level of subscriptions determined?

Every year, the M DU supplies its independent actuaries, Bacon & Woodrow Deloitte, with long and short-term data about
past years’ claims experience. From this, they project the expected notifications and likely cost of claims for the coming year. As claims may not arise for many years after the membership year has ended, funds need to be available to provide for all settlements that may eventually be made on behalf of members.

The actuaries’ work concentrates on two factors – the **claims frequency** (the number of claims per 1,000 members in a given year) and the **claims severity** (the average size of payout on each claim). Over the past 25 years, combined upward trends in the frequency and severity of claims have led to increases in claims costs of 12 to 15 per cent per year. This has inevitably led to similar changes in the subscription rates.

**What has driven this level of claims inflation to be so much higher than the level of retail price inflation indices over the same period?**

The rise in **claims frequency** in recent years has resulted from an increased propensity among patients to claim compensation against the medical profession. In the 1970s relatively few compensation claims were made, but through the 1980s and particularly the 1990s, more patients began to make claims. The advent of legal firms advertising their services in this regard has only increased this trend.

The increasing **claims severity** has been driven by the level of damages awarded by the courts. While many negligence claims are settled for between £10,000 and £30,000, each year there are some large cases, which are settled for much larger sums, of the order of £500,000 and above.

In these large cases, the main elements of the award relate to damages for providing long-term care and/or for lost earnings. When calculating the extent of damages to award by means of a lump sum, the courts use a notional interest rate to discount future costs and convert them into today’s money.

Unfortunately, as base interest rates have fallen in recent years, the courts were directed by the Lord Chancellor in June 2001, to reduce the discount rate to 2.5%, adding over £1 million per year to the money the MDU pays out to compensate patients on behalf of a member.

It should be noted here that analysis of past large claims indicates that their incidence is unpredictable. A doctor with no previous claims is as likely to have a very large claim as a doctor with several previous small claims. A large claim does not denote the degree of negligence, but the degree of damage.

This is one reason why the concept of a no claims discount is less relevant to medical indemnity claims than motor insurance. The other main reason is that claims can be notified many years after the end of a membership year and so a discount could have been given for a particular year without justification.

Our actuaries calculate the costs of all these effects to which are added the estimated legal costs both for defending cases and for successful claimant actions.

Once this has been done, the MDU factors in the costs of providing the MDU’s other activities such as the 24-Hour Advisory Helpline, risk management activities and the membership department and of the business's overheads, in order to determine the overall sum required for the forthcoming year.

It is at this stage that the MDU’s various departments come together to review the actuaries’ findings and agree the individual membership subscription rates for the coming year.

**Factors that determine different rates**

The MDU’s members undertake a wide variety of work and some of this activity is more likely to generate claims or complaints than other specialties. In order to set subscriptions appropriate to the relative risk, the MDU assesses a number of factors which have been shown to be useful measures. These include:

**Type of work:** Some medical activities are inherently more inclined to give rise to more costly claims because of the potentially severe and long term damage to patients for example obstetrics. Other specialties give rise to claims more frequently even though not necessarily of high value, for example plastic surgery. Non-invasive radiology and dermatology are two specialties less likely to give rise to such claims.

**Amount of work:** Subscriptions also reflect the amount of work that doctors undertake which is not otherwise indemnified – for example by NHS indemnity. Junior Hospital doctors undertake relatively little work that is not covered by NHS indemnity/medical indemnity and so their subscriptions tend to be significantly lower than those of their more senior colleagues. For consultant members who engage in little if any private practice work, the subscriptions will usually be lower than for their colleagues in the same specialty who have a substantial private practice.

Among General Practitioners there is a wide diversity in the amount of work undertaken and so the MDU has rates for full, three-quarters, half and less than half-time working, based on the number of sessions – or half days - worked.

**Looking to the future**

The MDU is continually reviewing changes that affect risk, for all of its practitioners – whether this be the impact of new procedures, changing NHS regulations or increased litigation. For example this year, the MDU became aware of an increase in claims as a result of laser refractive surgery undertaken by ophthalmologists and introduced new subscriptions for this activity.

Some of the likely drivers of change over the next few years are the new GP contract and the changes in NHS secondary care provision. The MDU will examine these areas carefully to ensure its subscriptions continue to be appropriate to provide the highest level of service to members at the lowest price consistent with financial prudence.
When three’s not a crowd:

The importance of chaperones

Every year the M DU assists doctors who are accused of assaulting a patient during the course of an examination. There are few cases but some of them might have been avoided had the consultation been conducted in the presence of a chaperone. Louise Wilson, an M DU medico-legal adviser, looks at when – and how – to involve an independent witness.

“Mummy, a strange man asked me to take my top off today.” These words are enough to fill any parent with dread. But what if that “strange man” were a community paediatrician and his request was a totally professional one made as he attempted to carry out a perfectly routine chest examination on a timid child?

Children and vulnerable adults

It is unusual for intimate examinations to take place in a school setting. Yet, even in a routine physical examination, a professional request such as asking a child to remove her blouse for her chest to be sounded can easily be misconstrued. And the same potential for misinterpretation could arise from a consultation with a person with learning difficulties. It is just such events that have been known to precipitate a GMC investigation or even police involvement.

Examining young children and vulnerable adults can be a sensitive job at the best of times. So, to avoid the potential for misunderstandings that could result in complaints about improper conduct, it is advisable to have a chaperone present. However, arranging for a chaperone, particularly at short notice, is not always easy; last year alone the M DU’s 24-Hour Advisory Helpline took over 100 calls from members wanting advice about the use of chaperones.

Of course, the chaperone doesn’t necessarily have to be a medically qualified person. The child’s parent, guardian or a teacher are just as suitable as a school nurse. Having a nurse or parent present during an examination can be doubly helpful. As well as acting as a chaperone, they have on hand someone who will often be familiar with the patient’s medical history.

It is important that the person with parental responsibility for the child gives authority before a consultation at school takes place. If a parent has given authority, but neither the parent nor a school nurse are available to act as chaperone, the doctor could consider asking the health visitor or a teacher to stand in. Failing that, it may be felt more appropriate to rearrange the consultation for a time when a chaperone can be present.

The broader context

Of course, young children and vulnerable adults are not the only kinds of patient capable of misconstruing the actions of a doctor wishing to carry out a perfectly defensible examination. Indeed, many routine procedures and examinations that seem perfectly innocuous to the practitioner concerned may seem quite otherwise to the patient being examined.

Consider, for instance, a perfectly normal ophthalmological examination, carried out for good practical reasons in a darkened room. Here the practitioner, who could be an ophthalmological consultant or a GP looking for ophthalmic pathology, or papilloedema in the case of suspected meningitis, will need to get very close to the patient with the ophthalmoscope in order to be able to visualise the inner eye from every direction. As a result, their face will inevitably come very close to the patient’s and their breathing will be clearly audible (and amplified) just beside the patient’s ear. A patient unfamiliar with this kind of fairly routine examination could react by thinking that the doctor is trying to become intimate.

Communication is key

The importance of communication and providing full information to the patient of what any examination entails and keeping comprehensive contemporaneous notes in the patient record cannot be overemphasized. If the reasons for an examination are not fully explained, then an internal examination on a female patient or a rectal examination on a male patient can be perceived by the patient as improper conduct, giving rise to a complaint of indecent assault.

First, it is vital to explain what is involved in an examination in order for the patient to make a fully informed decision about consenting to the proposed procedure. This explanation...
should be noted in the patient's record. It is then equally important, if there could be the least possibility of the doctor's actions being misconstrued even after the examination has been fully explained and apparently understood, to offer the patient the opportunity of having a chaperone present during the examination.

Of course, the patient may well consider the presence of a third party at the time of such an examination to be an unwanted intrusion on their privacy and may decide not to take up the offer. This decision, too, should be noted in the patient's record. If the offer of a chaperone is taken up and a chaperone is available, then this too should be noted in the patient's record, along with the identity of the chaperone for future reference.

Offering a chaperone provides protection for both the patient and the doctor. For the patient, it means that there is someone else on the scene to ensure that the doctor's actions don't go beyond those explained beforehand and are necessary for the examination concerned. For the doctor too, it is an independent witness to the fact that they have done no more than is necessary for the examination and helps to reduce the risk of allegations being made that could lead on to a charge of assault and battery or trespass upon the person.

A high-tech alternative

Technology could be coming to the aid of some doctors without access to a chaperone in the shape of a tiny computerised video recorder that makes an encrypted audio and visual record of the consultation or examination. One benefit, to both the patient and doctor, maybe having that record should an allegation be made that could lead on to a charge of assault and battery or trespass upon the person.

The MDU suggests that it is advisable to have a chaperone present in certain circumstances, for example, during intimate examinations or when examining children or vulnerable people.

Explain to the patient why an examination is necessary and give them an opportunity to ask questions.

Explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any potential pain or discomfort (paragraph 13 of the GMC booklet Seeking patients’ consent gives further guidance on presenting information to patients).

Obtain the patient’s permission before the examination, record that permission has been obtained and be prepared to discontinue the examination if the patient asks you to.

Keep the discussion relevant and avoid unnecessary personal comments.

Offer a chaperone or invite the patient (in advance if possible) to have a relative or friend present. If the patient does not want a chaperone, you should record that the offer was made and declined.

If a chaperone is present, you should record that fact and make a note of the chaperone's identity. If for justifiable practical reasons you cannot offer a chaperone, you should explain that to the patient and, if possible, offer to delay the examination to a later date. You should record the discussion and its outcome.

Give the patient privacy to undress and dress. Drapes should be used to maintain the patient’s dignity. Do not assist the patient in removing clothing unless you have clarified with them that your assistance is required.

The GMC advises that, when conducting intimate examinations, a doctor should:

• Obtain the patient’s permission before the examination, record that permission has been obtained and be prepared to discontinue the examination if the patient asks you to.

• Keep the discussion relevant and avoid unnecessary personal comments.

• Offer a chaperone or invite the patient (in advance if possible) to have a relative or friend present. If the patient does not want a chaperone, you should record that the offer was made and declined.

• If a chaperone is present, you should record that fact and make a note of the chaperone’s identity. If for justifiable practical reasons you cannot offer a chaperone, you should explain that to the patient and, if possible, offer to delay the examination to a later date. You should record the discussion and its outcome.

• Give the patient privacy to undress and dress. Drapes should be used to maintain the patient’s dignity. Do not assist the patient in removing clothing unless you have clarified with them that your assistance is required.
A new Charter of Understanding: Bringing doctors and patients together

Peter Walsh, Chief Executive of Action for Victims of Medical Accidents, outlines a new initiative in the campaign to create an open and fair culture, to encourage healthcare professionals to report – and learn from – adverse incidents and to foster a better understanding between patients and doctors over medical accidents and disputes.

On 16 June this year, at a joint “Safety First” conference with the Royal Society of Medicine, I had the pleasure of launching a new initiative, one that I hope will help to develop a change in culture and the way in which doctors and the rest of society react to medical accidents and disputes over clinical treatment.

Charters have acquired somewhat of a bad name both with patients and doctors. I have no illusions about how much a few words on a piece of paper on their own can achieve. However, the launch of the new Charter of Understanding between Doctors and People affected by Medical Accidents marks, I hope, the start of a real partnership approach between doctors and patients and their representatives that has the potential to change culture.

Changing a culture

In recent years, a desire to move away from a so-called “blame culture”, where individual health professionals take the blame for what are often system failures without really getting to the root causes of problems, has become evident. Action for Victims of Medical Accidents (AVMA), a charity that supports people seeking investigation of clinical complaints and even helps them find legal remedies and compensation where appropriate, readily aligns itself with that desire.

However, we are glad that even NHS bodies such as the National Patient Safety Agency have stopped talking about a “no-blame culture”, which smacks of removing the concept of accountability.

The term “open and fair” culture is more in tune with what we want to see. We firmly believe that it is possible to retain accountability while encouraging “openness”. It should not be necessary to protect anonymity in order to enable reporting of medical errors or risks, for example.

“Fairness” is vital on all sides, especially when there has been a medical accident or there is a clinical dispute. The damage and stress that can be caused on both sides of a dispute is well documented. The emphasis should be on learning how to avoid future mistakes and providing the injured patient the information and, where appropriate, the apologies and possibly compensation they deserve – not punishing the doctor.

A groundswell for change

But culture cannot be changed by government quangos – it takes people. And in this area it takes those people most affected – doctors and patients. That is why we hope as many of you as possible will join us in signing up to the Charter to show your individual support for the principles it contains. The Charter was drawn up by AVMA staff and by doctors who are already supportive of AVMA’s aims. It already has the support of a wide spectrum of doctors’ and patients’ groups. See what you think. You can sign up by sending an email to admin@avma.org.uk. You can also read the Charter and sign up on our website: www.avma.org.uk.

Action for Victims of Medical Accidents

Action for Victims of Medical Accidents (AVMA) is an independent charity and the only organisation working exclusively for the victims of medical accidents. A “medical accident” is one where avoidable injury has been caused as a result of medical treatment or failure to diagnose.

Since its formation over 20 years ago, AVMA has helped over 100,000 patients and relatives to obtain an explanation when something has gone wrong, to obtain reasonable compensation where appropriate, and to achieve a just outcome to complaints.

In addition to providing free independent advice and support to individuals, AVMA works with others to reduce the number of avoidable medical accidents and campaigns for fairer, more effective systems for complaints and claims arising from such accidents.
A Charter of Understanding between Doctors and People Affected by Medical Accidents

- The practice of medicine and undergoing medical treatment carry with them risks. These risks should be explained by doctors in a way the patient can understand. Patients’ physical and mental health must remain the paramount concern of any treating doctor, whether or not there is a dispute over treatment or a medical error is alleged to have been made.

- There will be occasions when an adverse outcome is unavoidable. Avoidable injury may also be caused by human error on the part of doctors, or others assisting doctors in the care of a patient. When it appears this has occurred, the patient or the patient’s partner, close relative or friend should be informed and have the circumstances fully explained.

- Committing an error is not in itself an indication of incompetence or negligence. A doctor should be supported in (indeed applauded for) reporting errors honestly and openly without fear of unreasonable consequences. The safety of patients must always be paramount in assessing what should happen next.

- Doctors should receive help and support in coming to terms with having caused unintentional harm to their patients and helped with learning lessons from any errors in order to prevent further accidents. It is also the responsibility of healthcare organisations to identify and learn from system failures which may be the root cause of accidents, including individual errors.

- Medical accidents have a real and deep impact on people’s lives. Patients (or their partners or relatives) who have been affected by a medical accident have a perfectly reasonable right to explanations and to seek apologies, assurances and/or financial compensation for injuries caused where appropriate.

The MDU welcomes the AVMA Charter of Understanding initiative

As the largest indemnifier of UK doctors, the Medical Defence Union welcomes AVMA’s launch of the Charter of Understanding between Doctors and People affected by Medical Accidents.

The MDU supports the Charter, which formalises the advice we have been giving to members for the past 50 years, that, if something goes wrong, patients deserve a full explanation. In our experience, giving an explanation, an assurance that steps have been taken to avoid the same thing happening again and, where appropriate, an apology helps resolve patient complaints at an early stage.

It is helpful to see this advice being formalised in a Charter of Understanding from a patients’ organisation. A more open and accountable culture is becoming a natural part of the NHS, but to make these changes, doctors need the support of patients’ organisations like AVMA. We are pleased to see that AVMA recognises that doctors involved in adverse incidents need advice and support at what can be a difficult time, something which the MDU provides for its members.

The launch of the charter will help send a signal to doctors that reporting and learning from mistakes and near misses is part and parcel of good medical practice. It is extremely encouraging to see that, in return, AVMA is calling on all of us, as patients, to accept that all medical treatment carries an element of risk.

**Dr Stephen Green** Head of Risk Management
In the last issue of the Journal, we announced the three finalists - and the winner - of the MDU's risk management competition held in 2002 in association with GP Magazine. Here we give detailed profiles of the top three risk management initiatives.

**competition winner**

**Kelty Medical Practice, Fife**

**Tracking GP patient referrals**

Lost referral letters and laboratory results can delay diagnosis and lead to complaints and claims. The potential for errors in the referral process was brought home to the Kelty practice, when a patient complained that a request for referral by their GP had been lost. With no real system in place, it was hard to identify where the process had failed.

The practice's procedure for referrals was to attach a note to a patient's record. In the case in question, the note had come off and the referral was not made. The practice decided it needed a system to prevent similar errors and developed a protocol for letter tracking. Introducing well-thought-out, robust protocols has made all the difference.

Dr Alan Melville, one of the practice's five GPs, explains: “In the past, each consultation room had a box for letters that needed typing. However, the request could get lost if the GP removed the letter from the room.” The practice now uses specially-designed duplicate tracking documents to record when referrals are requested, typed and posted. Once a letter is typed, the tracking document ensures that a signed copy is returned to the secretary and posted to the hospital.

The procedure was developed by the entire staff. Every two weeks, the practice secretary checks that all requested letters have been processed. Since the system's introduction, no discrepancies have been found between hard copies of the document and duplicate copies kept by GPs and there have been no lost referrals and no complaints. The practice hopes to add patients’ receipt of a hospital appointment to the procedure. “We now know who has been referred but not whether if they have been given an appointment”, Dr Melville says. “We can document that the referral has been ordered. But once the referral request leaves the building it could get lost in the post. Ideally, the patient would notify us when they receive an appointment, or the hospital would send us a copy of the appointment electronically.”

In addition to referrals, the practice also has an in-house form for tracking specimens sent for analysis. In the past, requests for tests leaving the practice were recorded simply to track costs. Staff can now ensure that results come back to the practice. There is a similar procedure and form for blood tests, to ensure that the correct tests have been carried out, check progress and ensure that non-attendees are recalled. This final step was added following the 2001 Ombudsman's report on complaints, which said that GPs could be held responsible for incidents if a GP-recommended blood test did not take place - even if it was the patient who had failed to attend their blood test appointment.

The new system means that staff can inform inquiring patients immediately about the stage in the process that their test has reached. Each month, several results are not received from the laboratory and these can be chased. Patients who fail to attend blood-test appointments are contacted and their GP notified if they do not respond to reminders. Phased in over several years, the protocols have succeeded because they are jointly owned by all members of the practice staff. The cost to the practice has been £400 a year for printing the tracking form duplicate books, plus the cost of group meetings, other paperwork and in-house training, which was partly funded by the pharmaceutical industry.

The judges said: This entry impressed the judges, as it was a very positive response to an event - a lost referral letter. Recognising that human error is inevitable, the practice
introduced a system to prevent the problem arising again, involving the entire practice team in designing the procedure using risk management techniques. The system was gradually expanded to incorporate tracking results of blood and other tests. It was clear that the initial investment had led to an improvement in patient safety and that the system was under continuous review.

Overall, it was the practice’s ability to cope with an apparently complex problem in a practical and efficient way that identified this entry as the winner.

**competition runners-up**

**Groves Medical Centre, New Malden**

**Helping patients help themselves**

Having patients take responsibility for their own lifestyle and existing conditions can reduce the risk of health problems. The Groves Medical Centre initiated a programme of six patient education evenings annually that raise awareness, encourage self-management and enable the practice to reach out to patients with undiagnosed conditions.

GP Jeremy Harris, who devised the programme, explains: “We try to benefit as many patients in the practice as possible, with at least one topic each for the elderly, women, men and children, as well as a general clinical topic such as hypertension or asthma.” Several of last year’s sessions addressed health promotion issues such as reducing obesity and smoking and a party was held for children with asthma to test their inhaler technique.

Each computerised patient record is coded with their particular condition[s]; to generate a mailing list, a code is entered and the system throws up the relevant names and addresses.

For an obesity session, the practice targeted patients with a BMI greater than 30, identifying and inviting 290 patients, of whom over 200 attended. Meetings are held in the church hall opposite the surgery; postage and hall-hire costs are met by pharmaceutical companies.

The sessions, led by hospital consultants, dietitians and GPs, who discuss disease management in the context of lifestyle issues, have helped improve patient care. Patients are more interested in their own health, understand their conditions, comply with treatment and attend for check-ups. Patient awareness and compliance are rising too.

Following an asthma evening, patients record their peak flow before a consultation, saving time; a diabetes evening identified new diabetics; an evening on breast care helped reduce patients’ fears about cancer and led several women to identify breast lumps, some of them cancerous and treatable.

The judges said: This entry portrayed risk management in the broadest sense, concentrating on patient education and screening and recruiting patients in some recognised “difficult to reach” areas such as men’s health.

The judges were impressed by the enthusiastic approach to the problem and their linking of topics to the National Service Frameworks, local health needs and other risk management processes such as critical events. Patient feedback was very positive and the programme was effective in identifying new diagnoses at an earlier stage.

**Errol Surgery, Errol, Tayside**

**One-stop warfarin shop**

Prescribing warfarin is open to communication errors between hospital lab and primary care practice. Limited resources in the secondary sector and difficult access to hospitals mean that, in rural Scotland, warfarin testing is increasingly performed in primary care.

The Errol Surgery devised a one-stop-shop testing and prescribing system. Practice manager, Marion Easton, saw the potential for error in misreading handwritten notes and the possible benefits of a computerised system: computerised dosing, using the patient’s history (not just the latest reading) is known to stabilise patients better than more traditional methods.

Practice GP Dr Lyndsay Easton, supported the idea. An ageing population had increased demand for warfarin testing dramatically, from four patients in 1990 to 34 in 2002. The new system reduces the practice’s workload, lessens the risk and improves the service for patients.

Nurses take blood by finger prick and place it in a coagulometer, which calculates the INR reading. This is then downloaded to a computer decision-support system, which determines the warfarin dose, suggests a date for the next check and provides the patient with a print-out.

Finally, the INR value and warfarin dose are downloaded to the patient’s electronic health record, eliminating paper records and the risk of transcription or oral communication errors.

The new system has increased patient compliance and satisfaction. The test is non-invasive, patients no longer have to telephone for results or appointments and the system notifies practice staff of non-attenders who can be contacted. The coagulometer can even be taken to housebound patients’ homes and the data subsequently downloaded at the surgery.

The practice uses rigorous quality controls to guarantee the accuracy and reliability of its equipment and results. After the initial £3,000 outlay for computer hardware and software, funded by a pharmaceutical company, the system costs the same as other methods.

The judges said: Warfarin monitoring is an area of general practice that, in the MDU’s experience, has the potential for communication errors and causing serious harm to patients.

The judges were impressed by the evidence-based nature of the project and the use of a computerised decision-support system. The automatic transfer of information to the patient’s record was an important risk management issue, as was the identification of non-attenders.
The concept of an ombudsman for the United Kingdom (from the Swedish word meaning “representative of the people”) originated after the Second World War. The Parliamentary Commissioner, or Ombudsman, came into being in 1967, followed by the Health Service Ombudsman in 1973, the two offices always held by the same person. Appointed by the Queen and answerable to Parliament, the Ombudsman is independent of Government and the NHS and not a member of the medical profession.

The Health Service Ombudsman’s powers and duties are set out in the Health Service Commissioners Act 1993. Jurisdiction was initially confined to the classic Ombudsman territory of maladministration (in the NHS), but was extended in 1996 to include clinical complaints and complaints about Family Health Service practitioners.

As a result, the Ombudsman has become the last resort for a complainant who remains dissatisfied after exhausting the initial two stages of the NHS Complaints Procedure. Following the second, independent review, stage of the procedure, the review panel convener should always inform the complainant of their right to approach the Ombudsman.

Impartial investigator

The present Ombudsman, Ann Abraham, was appointed in November 2002. Her role is to look into complaints made by or on behalf of people who feel they have suffered because of unsatisfactory treatment or service from the NHS. She is neither the complainant’s advocate nor an apologist for the actions of healthcare professionals. Aware of the stress, for complainant and healthcare professional alike, to which an investigation can give rise, she attempts to keep investigative delay to a minimum and has no disciplinary function. Her role is that of an impartial, objective fact-finding investigator and her services are free.

In 2002, some 140,000 complaints were made to the NHS, of which only a small proportion were not satisfactorily resolved in the first and second stages of the Complaints Procedure. In the same year, 3,994 complaints were received by the Ombudsman’s Office, only 30 per cent of which were accepted as eligible for investigation.

Many complaints were referred prematurely, as the complainant had not invoked and exhausted the NHS Complaints Procedure (as required by law). Others were out of jurisdiction for other reasons. For example, the intention on the complainant’s part to take legal action against the Health Service body concerned would put the case beyond the Ombudsman’s remit. After screening, between 20 and 25 per cent of eligible cases were subsequently investigated, the remainder being answered with a full explanation of why no investigation was to be pursued.

Screening and investigation

The Ombudsman has discretion as to whether or not to investigate a complaint and considers each case on its merits. She will not consider a complaint about a decision by an NHS body or practitioner simply because a complainant disagrees with it, but will require some evidence that the decision was wrongly taken – for example, that a relevant fact was not taken into account. The Ombudsman always considers whether her intervention would be likely to achieve anything further for the complainant; if the body concerned has...
done all that could reasonably be expected to put things right, she will not usually take any action.

The decision not to investigate is communicated to the complainant (now copied, with the complainant's permission, to the trust) in a letter explaining in detail why the Ombudsman will not be undertaking an investigation. Depending on the circumstances of the case, the letter might explain how each aspect of the complaint has already been answered by the trust and, if necessary, expand on the explanations already given.

Sometimes a comeback letter is received from the complainant and, if any new information is provided, the decision not to investigate may be reversed. However, complainants are often relieved just to know that their complaint has been analysed in detail again, even if an investigation is not considered warranted; sometimes they are not, and do not hesitate to say so.

Investigating a complaint

If a case is taken on for investigation, an Investigating Officer (IO) will send the NHS body complained against a statement of complaint, summarising the issues that are to be investigated and requesting the body's complaints file and, with the patient's permission, his or her clinical notes.

Once the IO has all the relevant papers, s/he makes a detailed analysis and chronology of the case. If the case involves clinical issues, the IO seeks advice from one of the Ombudsman's Internal Professional Advisers (IPAs). There are 15 IPAs including hospital consultants, GPs, two senior nurses, a midwife, a psychiatric nursing specialist and a dentist. The IPAs advise the IO whether the clinical issues demand investigation. Sometimes a trust can be seen to have been defensive and economical with the facts. Sometimes it is clear that a convener (the individual who considers complainants' requests for independent review) has received inadequate professional advice, possibly from an inappropriate source. Sometimes the clinical service has clearly been inadequate, or even non-existent.

The IO, sometimes accompanied by an IPA or an external professional adviser with expertise in the particular area involved, will usually start gathering evidence by interviewing first the complainant and then the NHS staff concerned. A complainant may be accompanied by a family member or friend and NHS staff are entitled to have a friend or professional representative present if they so wish. Everybody who is interviewed is sent a copy of the interview notes afterwards and asked to agree that they are correct. At the same time, the professional advisers produce reports on the clinical aspects of the case.

Having gathered all the evidence, the IO drafts a results report, which will usually start with the statutory and administrative background to the complaint. The complainant's version of events is then rehearsed, followed by the NHS staff's evidence. The outcome of an investigation will be to uphold, partially uphold, or not to uphold the complaint. This decision is made by the IOs, their senior managers, or ultimately the Ombudsman herself. The report ends with the findings and, if the Ombudsman upholds the complaint, recommendations for redress. The findings take account of standard practice and do not demand the standards of a centre of excellence.

The draft report is sent to the body complained about for comment on the accuracy of the facts as presented. The respondent body is also asked to agree the recommendations for redress, which could take the form of more training for staff, tightening up procedures, introducing audit programmes, protocols and policies and re-organising clinics and/or an apology and, where appropriate, a refund of the complainant's out-of-pocket expenses.

Investigation reports are published, in anonymised form, in the Ombudsman's regular reports to Parliament, which are available from The Stationery Office and are also posted on the Office's website: www.ombudsman.org.uk

Case characteristics

The Ombudsman's case mix includes complaints about NHS hospitals, Family Health Services and NHS Dental Services, issues concerning NHS funding (such as for continuing care for the chronically ill), and issues concerning complaint handling by NHS bodies. Not all complainants need be patients; the Ombudsman has, in the past, upheld complaints from GPs about the way in which independent reviews into their work were carried out.

Communication – or the lack of it – is often a major issue in any complaint. When public services fail to live up to expectations, we all demand the communication of information and explanation, whether about a 30-minute rail delay or a death following a non-resuscitation order. When such communication is inadequate or lacking, people complain. In the medical context, the fundamentals of communication are information that can be understood, a clear explanation, reassurance and seeking consent where necessary.

Nearly all complaints that the Ombudsman sees involve poor communication. It is well recognised that what a doctor believes they have said may be very different from a patient's or relative's perception of the same discussion. The importance of documenting such a discussion cannot be over-emphasised; an investigation can rarely resolve two contrasting memories of the content of a discussion in contention.

“Making things right”

The proposals for reform of the NHS Complaints Procedure, Making things right, involving CHAI in the second stage and published in March this year, may, if adopted, alter the Ombudsman's role. In the meantime, however, although relatively few patients complain about their management and most complaints are resolved locally, the Ombudsman, independent of the NHS, is a valuable check on the healthcare system and the only part of the overall complaints system that complainants perceive as wholly independent.

Peter Clein MD FRCP is an Internal Professional Adviser to the Health Service Ombudsman.
A little something for the weekend?

The MDU’s advisory team are on call round the clock, 365 days a year, manning the 24-Hour Advisory Helpline. Dr Matthew Lee, medico-legal adviser, looks back at a typical weekend on call earlier this year. The calls mentioned in this article reflect the broad nature of the advice sought but certain details have been altered to maintain confidentiality.

It’s 5.00pm on a Friday afternoon and, as the MDU’s Blackfriars office gradually winds down in preparation for the weekend break, I’m busy checking that my mobile phone is charged and working in preparation for the next 64 hours “on-call”.

Routine calls

The first few calls of an evening are usually not too urgent. The MDU switchboard is open until 6.00pm and members will often leave making a call about a less urgent matter until they have finished their afternoon commitments. At 5.10pm the first call comes through from a doctor seeking advice about the need to warn patients about certain side-effects of medication. We discuss the need for patients to be fully informed in order to be able to consent to receiving any particular treatment and talk about what might constitute negligence in this area.

This call is quickly followed by another from a consultant wishing to stop treating one of her private patients, who, she feels, is becoming unreasonable and over-demanding. We discuss the difficulties she is experiencing and I outline to her the current GMC guidance pertaining to ending professional relationships with patients and informing patients’ GPs about the care they are – or are not – receiving.

With the time approaching 6.00pm, I speak briefly to the MDU switchboard operator, who is about to hand over to the weekend answering service, and bid her a good weekend. With no calls waiting, I take the opportunity to grab a bite to eat.

Over the next couple of hours I take two more calls, both from members who have encountered problems earlier in the day. The first is from a psychiatrist concerned about a conversation she has had with the police who, she felt, were keen to use her assessment of a patient as evidence against him. The second, barely 10 minutes later, is from a doctor working in Obstetrics & Gynaecology who found out earlier in the day that several midwives have raised concerns about his clinical performance. I encourage both callers to write in for ongoing assistance.

Withholding treatment

By now it is getting on for 9.30pm, and I am hopeful that things have quietened down. However, I am soon notified of another call. This time the call is from a consultant physician looking after an elderly patient who has suffered severe anoxic brain damage after a cardiac arrest. The patient is extremely unwell and, in the view of the medical team, would not benefit from intensive care or active resuscitation should she deteriorate. The patient’s family, however, have taken a very different view and are insisting that the patient should be actively resuscitated if she were to arrest again.

I explain that the ultimate decision lies with the doctor treating the patient and that, should he feel that escalating treatment...
would not be in the patient's best interests (having taken into account the views of the family), he is not obliged to do so. He has already obtained a second opinion from a colleague who concurs with his view but, despite several doctors and nurses having spent several hours with relatives, the family remain steadfast in demanding that the patient must be treated.

I advise the member that he might consider formally notifying his trust of his concerns by informing the medical director of the situation. I also stress the importance of keeping detailed notes. I then refer the member to the new GMC guidance on Withholding and withdrawing life-prolonging treatment (published August 2002). The guidance accepts that resuscitation may not always be in a patient's best interests and stresses the need for good communication between those involved in making decisions about whether to resuscitate a patient. It also covers situations where there are disagreements about best interests and suggests that a multidisciplinary medical or ethical review, independent of the healthcare team, might be helpful. However, where informal review fails to resolve any dispute, the GMC suggests seeking a legal opinion and informing those close to the patient so that they can be represented should they wish.

In this case, the member felt that he would make one last attempt at explaining to the relatives why escalating treatment would not be in the patient's best interests and, should that fail, would speak to the trust's legal department for further guidance on how to proceed.

As I finish speaking to this member, my mobile rings again with what proves to be the penultimate call of the evening, from a trainee in surgery who is calling as a result of being "informally suspended" on health grounds earlier in the day. We discuss the problems that she has experienced and I urge her to spend some time over the weekend writing an account of the difficulties she has encountered at work, which I suggest she fax in so we can offer assistance early next week. By the time this call is completed it is almost 10.45pm so I head off to bed, just a little too soon!

**Drink driving patient?**

The last call of the evening comes at 11.30pm from an A&E consultant. He has a patient in his department awaiting transfer to intensive care. The patient is anaesthetised and ventilated having sustained head injuries in a road traffic accident. Apparently the driver of the other car involved was fatally injured and the police feel the patient in A&E may have been drunk and caused the incident. The police have asked our member to take a blood sample for alcohol levels and the member is contacting us to ask whether he can agree to the request without the consent of the patient concerned.

I explain that, under the Police Reform Act 2002, the police can request a blood sample be taken from a patient who lacks the capacity to consent. However, the doctor in charge of the care of the patient has the right to refuse such a request on clinical grounds (but should be prepared to justify those clinical grounds, in court if necessary). Any such blood sample should not be taken by a doctor involved in the clinical management
of the patient and preferably would be taken by a Forensic Medical Examiner or police surgeon. The blood sample cannot be tested for alcohol levels until the patient regains consciousness and gives consent for it to be tested, so it should be stored in the lab until that time.

**Self-prescription**

I sleep through until morning. The next call arrives at just before 9.30am on Saturday morning. This call is from a retired GP, wondering whether he is entitled to prescribe himself a repeat prescription for his usual medications, as he has forgotten to take certain things away with him on holiday.

I explain that, so long as he remains on the GMC register, then he is legally entitled to do so, but caution him about the GMC’s views on self-prescribing, which are that doctors should avoid treating themselves or close family members wherever possible.

Two more calls come in before lunch. One concerns a complaint about a failure to diagnose a fractured hip and the other involves disclosing information to the police following the theft of controlled drugs from a practice. In the course of the afternoon I take a further seven calls: one a new claim arising from a patient who fell over while being examined and fractured her hip; one a doctor currently undergoing a GMC performance assessment; one a member wanting to complain about the care his GP had provided to him; one an obstetric registrar who had a patient demanding to go home despite a significant risk of miscarriage; one a doctor who had some concerns about a medical research paper due to be published by a colleague; one a doctor about to give a statement to a solicitor; and one a doctor who had been notified of a fraud investigation into her practice. The last call is over by 8.00pm, after which the evening is quiet.

**Disclosure to prevent crime**

1.37am Sunday morning... a call from another A&E consultant. He is treating a patient with stab wounds to his legs, although he wonders whether they might be self-inflicted. What is worrying the consultant, however, are the threats the patient is making to "kill" his friend who, it is alleged, caused the injuries.

I outline the GMC guidance with regard to disclosing information without consent in order to prevent a serious crime, risk of death or serious harm to the patient or others. I explain that consideration needs to be given to the practicalities of seeking consent to disclose information and that, if a disclosure is to be made, it should consist of the minimum information necessary and the patient should be informed afterwards as to what has been disclosed.

It is left that the consultant will try to contact the patient’s next of kin to find out more background information and that, unless he is able to satisfy himself that there is no risk to a third party, he will disclose information about the threats to the police, whether or not the patient concerned gives consent.

Back to bed... Sleep until morning.

I take a further five calls later that day: another doctor facing a fraud investigation; a prison doctor concerned about a prisoner on hunger strike whose condition is deteriorating; a GP who has discovered that his partner is self-prescribing diazepam; and a GP who is feeling pressured by a patient into providing a prescription for the patient’s usual medications, to cover a whole year, while the patient takes an extended foreign holiday.

**Reuniting member and wallet**

The fifth call – and the final call of the weekend – comes early on Sunday evening. The caller is the manager of a video shop in Edinburgh. He has found a wallet in the street outside his shop and has phoned the number on the MDU membership card that he has found in it, to see if we can help locate the owner.

I take some details and search our database, but unfortunately we have no current phone number for the member, just an address. An internet search of directory enquiries reveals that the member is ex-directory, but as a last-ditch attempt I try the electoral role, which produces the name and address of the member’s next-door neighbour! He, as it turns out, is not ex-directory and very helpfully calls next door with details of where the missing wallet is being kept. I later get a call from the member, letting me know that he has got his wallet back and offering thanks.

So, after 64 hours on duty and 23 calls (of which, thankfully, only one in the middle of the night), I reach the end of my working weekend. But now it’s Monday morning, so it’s back to work....
There, but for the grace of God...

When it comes to medical negligence claims, MDU members can relax, safe in the knowledge that they have the professional indemnity policy and can also approach the MDU for discretionary assistance with other matters. But what happens if they fall on hard times? Dr Ian Kelsey Fry, past President of the MDU and Trustee of the Royal Medical Benevolent Fund, describes the work of this charitable trust.

Members of the MDU are well aware of the medico-legal minefield with which they are confronted. On that score, the MDU provides peace of mind. However, for doctors who fall into severe financial difficulties there is no MDU but there are charities that exist specifically to help doctors in need of financial support. The largest and most comprehensive of these, in terms both of the range of doctors helped and the type of help provided, is the Royal Medical Benevolent Fund (RMBF).

Doctors and their families are not immune to disasters such as accidents that cause permanent disability or illnesses that are incurable. These can strike at any time of life and will inevitably affect the whole family. Moreover, doctors are now working under unprecedented pressure in both hospitals and general practice. Long hours of work, continuing changes in the NHS and escalating rates of change in technology and medical practice all increase the risk of stress and its consequences. Younger doctors seem especially vulnerable, at a time when they are financially insecure, with student loans to repay.

A vital practical lifeline

The Fund provides a lifeline of practical help and understanding for members of the medical profession and their families who, through illness or misfortune, find themselves in genuine financial need. Help may take the form of either one-off financial assistance in response to an emergency or continuing support as long as the need exists.

Whenever possible, we provide our beneficiaries with the help they need to get back on their feet and resume their careers or retrain for new ones. The Fund assists hundreds of doctors every year with charitable expenditure in excess of £700,000. Recent cases include doctors who have suffered strokes, multiple sclerosis, paralysis after a road accident, blindness, schizophrenia, manic depression and dependency.

Regular Case Committee meetings and a team of caseworkers ensure that the Fund can make a rapid response to requests from across the UK. Importantly, financial support is supplemented by a network of volunteer Area Visitors, who themselves have connections with the profession and who provide local support for beneficiaries. As one doctor put it, “regardless of what I get from the Fund, the fact that someone listens means more to me”.

Funding and income

Stringent criteria have to be satisfied before financial aid is provided. Indeed, the majority of applicants are already receiving state benefits. The Fund’s investment income, together with contributions from members of the profession and other supporters, go a long way to cover costs. Yet, more income is required if the Fund is to continue to assist those who need our help, all the more so, as the number of calls for help is increasing, particularly among the younger age group.

Many members of the profession are not aware of the Fund’s existence, so doctors and their families may not know that help is available when they need it. While all doctors stand to gain from the Fund’s activities, this lack of awareness also limits the numbers of doctors who contribute to the Fund. Only a small proportion of the profession currently make regular annual contributions, although many more support the Fund through donations and local Guild activities.

There are a number of ways in which MDU members can help. First, you can spread the word, to ensure that others in the profession and their families know about us, so that when they or one of their colleagues need help they know where to turn. Second, you can support us financially and encourage your colleagues to support us, so that we can continue to help those in need. Whatever you are able to do, we would appreciate your help.

To find out more about the RMBF, or to make a donation, you can call 020 8540 9194 or visit our website at www.rmbf.org
Behind the scenes at the MDU:
Putting the “legal” into medico-legal

As a medical defence organisation and provider of medico-legal advice, the MDU relies on a team of in-house legal specialists. Here, Joanne Brundrett, an MDU solicitor, describes the work of the MDU’s Legal Department on behalf of members.

The MDU’s in-house legal department was established 10 years ago by our current head of department, Charles Dewhurst, a solicitor with 25 years’ experience in medical law. Based at the MDU’s Blackfriars offices, the team currently comprises 12 solicitors, with secretarial support staff.

All MDU solicitors specialise in clinical negligence and other branches of medical law. At present, the team handle almost half of all medico-legal matters that require the involvement of a lawyer, the rest being dealt with by external medico-legal specialist solicitors. Between them, they deal with negligence claims, GMC and hospital disciplinary hearings and inquests, as well as criminal cases.

Negligence claims

Every claim is assigned to a claims handler in the Claims Handling Unit, who instructs a solicitor, when appropriate, to safeguard our member’s interests.

One point at which this may occur is when a letter has been received outlining a proposed claim prior to court action; a solicitor may be instructed to draft a response on behalf of the member. In the minority of claims that go so far as formal proceedings, a solicitor is needed to accept service of the papers on the member’s behalf.

Typically, the solicitor invites the member to the MDU’s offices to discuss in detail the circumstances surrounding the claim and draft a detailed witness statement on behalf of the member.

The solicitor subsequently handles all correspondence with the claimant’s solicitor and the court, working closely with the claims handler throughout the claim process.

Medical experts in specialties relevant to the facts of the particular claim are instructed to review and provide their opinions, in the light of the allegations made by the claimant. The expert opinions help the solicitor to assess whether the claim is one where the member is vulnerable to an adverse finding and negotiating a sum of money in settlement should be considered, or whether it should be defended in full.

The solicitor keeps the member advised of developments in the case and of the prospects of success in seeking to defend the claim. The member is consulted before any major steps are taken, such as: providing a formal defence document answering the various allegations raised; before any admissions are made (if necessary); and before negotiations begin (if the claim is one that should be settled).

Where appropriate, the solicitor may instruct a specialist clinical negligence barrister to provide further advice and represent the member in court should the claim proceed to trial – a very rare occurrence. As the claim progresses, the solicitor may arrange a round-table meeting with the barrister, attended by the member and the experts providing opinions in the case, at which the claim can be discussed in detail and the barrister provide an opinion as to the best way to proceed.

The in-house solicitor deals with all aspects of the claim as it progresses. These include: liaising with solicitors for any co-defendants in the claim; collating the relevant documentation and medical records; contacting witnesses such as practice staff; and supporting the member at court hearings.

In-house solicitors may also become involved in cases in a more peripheral way; for example, providing a claims handler with advice on technical legal aspects or a view on the valuation of a claim. They may also be instructed to assist in the final stages of cases that have been settled without court proceedings but, which require a hearing, either because the settlement must be approved by the court as the claimant is a child, or because the court will assess the claimant’s costs.

GMC complaints

When a member contacts us concerning a complaint made to the General Medical Council, the case is initially assigned to a medico-legal adviser, who may in turn instruct a solicitor if the case progresses, the two working together on the member’s behalf throughout the proceedings.

Once instructed, the solicitor typically meets the member (often along with the adviser) to discuss the matter fully, prepare a witness statement and draft a letter of response to the Preliminary Proceedings Committee. If the matter progresses to the Professional Conduct Committee (PCC), the solicitor liaises with factual witnesses, such as practice
staff and fellow professionals, and contacts colleagues and patients to request testimonial letters on behalf of the member to provide to the Committee if necessary. The solicitor also handles the bulk of the correspondence with the GMC and their solicitors on behalf of the member.

The solicitor will instruct a barrister to represent the member at the PCC hearing, arranging a conference with the barrister before that hearing, to be attended by the member and any experts instructed, depending on the circumstances of the particular case. The solicitor will also attend the PCC hearing with the member and coordinate the attendance of witnesses of fact and of character.

Disciplinary hearings and coroners’ inquests

Solicitors may also be instructed for certain hospital disciplinary proceedings, meeting the member to take detailed instructions, liaising with the various parties involved and, where possible, attending the disciplinary hearing with the member.

In some cases, solicitors may be instructed to assist members who are summoned to attend inquests. They will typically meet the member to advise on the inquest procedure and to prepare a witness statement regarding the events in question. The solicitor may also liaise with the Coroner’s officer and the family’s solicitors and may also attend the inquest to represent the member or instruct a barrister to do so.

Criminal allegations

One solicitor member of the in-house team specialises primarily in cases arising from medical “criminal” allegations, while some of the others undertake such work as part of a mixed caseload. Such proceedings commonly involve allegations that could lead to charges of murder, manslaughter, indecent assault and assault arising out of clinical procedures and investigations. As with disciplinary matters, each case is assigned to a medico-legal adviser, who instructs a solicitor, the two liaising throughout the course of the case.

The solicitor meets the member to advise and take detailed instructions, accompanies the member at police interviews and court hearings, and liaises with the police and the Crown Prosecution Service. The solicitor also obtains statements from factual witnesses and supportive letters from colleagues and patients by way of character evidence; collates all the documentation; instructs a barrister to represent the member should the case progress to trial and experts to give evidence as to the care provided and its causative effects, such as pathology evidence as to the cause of death.

Furthermore...

All these various areas of work outlined above often overlap. For example, a member may be the subject both of GMC proceedings and a claim, in which case the same solicitor will often represent the member in respect of both matters.

In addition to these more formal “set-piece” activities, the legal team carry out a number of other responsibilities. They assist with manning the Advisory Helpline, provide “ad hoc” advice to the Claims and Advisory teams on legal queries, and review important documentation such as proposed changes to statute or GMC procedure.

They also assist with obtaining injunctions in certain cases and, in cases where there is media interest, liaise with the MDU’s press department and, where necessary and appropriate, provide an “on the steps of the court” statement on behalf of a member.

All in all, the legal team perform a varied and challenging role supporting the service provided to MDU members in many areas of their professional lives.
Clinic background

A male patient complained of a non-exercise-related localised pain in his left calf. I took a history, examined him, and thought that he had probably sustained a minor muscle tear. Some time later, the man was admitted to hospital through A&E, with an acutely ischaemic left lower leg, and a popliteal aneurysm diagnosed. Vascular reconstruction failed and a below-knee amputation had to be performed. The patient felt that I had been negligent and sued me for failing to investigate and refer him to a vascular surgeon, who might have saved the leg.

Following a number of interlocutory hearings giving directions for the conduct of the trial, the case is to be heard by a so-called “Red” High Court Judge, sitting alone. Am told court will sit at 10.30am, the morning session usually lasting until about 1.00pm, with a 75-minute break for lunch, resuming for the afternoon at 2.15pm and typically ending at 4.15pm.

Have met my barrister only once before, at conference in London. She has a substantial background in medical negligence cases, is well thought of by the MDU and has a reputation as a formidable cross-examiner.

Day 1:

Monday – The curtain rises

Preliminary conference called for 9.30am. In a small room just outside the court itself, my barrister outlines the running order for the first day. Claimant’s barrister will first make his opening remarks. Then my barrister will apply to the Judge for an order to obtain a witness statement from the surgeon who operated on the claimant. (This has been requested before by our side but repeatedly blocked by theirs on confidentiality grounds).

Court is arranged as most people would imagine: Judge’s seat centre front, up high. In the front row, immediately facing the judge, the two barristers; close behind them, in the next row, their respective solicitors, with the expert witnesses and me; and finally, in the row behind, the claimant and his family and other witnesses, staring at the back of my neck.
Proceedings, which I was told would be surprisingly informal, turn out to be very formal. We are told very firmly to rise before the Judge is ushered in – all red robes, ermine cuffs and wig – and to sit once he is comfortably seated. He is very much in absolute and undisputed charge, directing the barristers as he wishes, and they are careful to comply with his directions, calling him “My Lord” or “Your Lordship”. No one can speak apart from the Judge, the barristers and the witness in the stand. If I wish to communicate with my barrister, I pull the back of her gown and hand her a note.

The claimant’s case

The first two hours of the claimant’s “statement of case” are harrowing in the extreme. Claimant’s counsel enumerates all the ways in which they feel I have been negligent, all the symptoms and signs I have missed, by my carelessness and general lack of regard for their client, and the consequences that have flowed from this. All told, of course, from their point of view and, as far as I am concerned, entirely biased, indeed most – if not all – of it entirely wrong. Extremely hard to sit silently and listen to all this. Have not really been warned how hard this is going to be.

At about 12.30, the statement of case is complete and the application [for the witness statement order] is made. Quite a battle ensues, as the claimant’s side oppose our application. The Judge appears to be surprisingly unsympathetic to our request. To my simple mind it seems that, if the treating surgeon has something useful to say, it would be worth hearing it. Eventually, the Judge allows the request, with some limitations on what may be asked.

After lunch, the claimant is the first witness. He is taken through his story by his barrister, and then cross-examined by ours. Tempers become frayed, as apparent inconsistencies in his evidence are highlighted. Cross-examination is still under way when the Judge brings the first day’s proceedings to a close.

Days 2 and 3:

Tuesday and Wednesday – Witnesses for the claimant

My wife comes with me on the second day. First 30 minutes is a continuation of the claimant’s cross-examination.

Next comes the claimant’s wife, who attempts and maintains a far more reasonable façade than her husband, although there are inconsistencies both within her story, and between hers and her husband’s. Over a whole day, from Tuesday into Wednesday, their side calls three further witnesses (family and friends) to corroborate their stories, but these again highlight inconsistencies. It is now getting on in the [Wednesday] afternoon, and our practice nurse gives her evidence out of turn, so that she doesn’t have to come up again tomorrow.

Incommunicado

Have been led to believe I will not be called until Thursday morning, but in the event take the stand this afternoon with 30 minutes to go, allowing my barrister to put some questions to me about the patient’s notes by way of explanation for the Judge. Unfortunately, it also means all further discussion with my lawyers is blocked, as there is a strict rule that they are literally not allowed to talk to me once I have begun my evidence.

Day 4:

Thursday – Cross-examination

My cross-examination starts promptly at 10.30. Although feeling all right about it by now, have to admit it is not pleasant. Claimant’s counsel starts by going in great detail through my two consultations with his client. He then sets about trying to tie me in knots with strings of hypotheticals, not directly about my consultations with his client, but about situations having some bearing on them, concerning the circumstances in which I would consider referral and, if so, whether it would be urgent. It is difficult to decide how much to qualify my answers and any point I concede in a hypothetical case is quickly extrapolated to the actual case in hand.

The Judge also interjects supplementary questions at times to elucidate a point in his own mind. I am cross-examined all morning, finishing soon after 1.00pm for lunch. After lunch, there is a further half hour of re-examination by my own barrister to clarify some points, after which, it is the turn of the expert witnesses.
Expert witnesses

First up is one of the claimant’s expert witnesses. He is asked in great detail, by both sides in turn, about the concepts behind the causes of the claimant’s symptoms and says that he can remember one similar case. Although our expert vascular surgeon and the treating surgeon have both said that what the claimant claims he experienced does not actually happen, the Judge appears to accept that it does on the evidence of this one expert witness alone.

Return home in rather a low mood, convinced that I am going to lose, but not really ready to face that outcome. Don’t sleep at all well; the roller-coaster effect on the emotions in this game is greater than anything else I have experienced. I feel ready to quit practice.

Day 5:

Friday – The GP experts

Usual conference today, but at 9.00am for an early 9.30am start to get through all the experts’ evidence in one day. Our barrister is looking more cheerful. Says they have spoken overnight to the treating surgeon, who has evidence that should help our case significantly if the Judge will admit it, which he may not, as the surgeon will be acting as an expert, not a witness to fact.

In court, the two GP experts are taken first. First is GP expert for the claimant, who appears benign, makes all the right points against us under direct examination, but then under cross-examination seems almost to be on our side, admitting that my diagnosis was perfectly reasonable. Then our GP expert takes the stand, is fine under direct examination, but then has the same rough ride on cross-examination as I did – great strings of convoluted hypotheticals – and accepts many of the same propositions that I did.

Admissible evidence?

At the end of the morning there is a legal argument about whether the treating surgeon’s new statement is to be admitted. The claimant’s barrister is just beginning his objections when the Judge adjourns for lunch. After lunch, the argument becomes quite heated, with our counsel fighting long and hard to have the treating surgeon seen. However, the Judge rules it out on the grounds that it was too late for the other side to have any notice of what he is going to say and prepare an answer.

Our second expert arrives at 2.30pm, takes the stand and makes all the points well. However, the general feeling on our side is that the Judge has not really paid much regard to his testimony, since he appears to have taken no notes of what he has said.

Feeling of powerlessness

Have reconciled myself by this stage to the prospect of losing the case, even though I have done nothing wrong, and really feel all right about it. I can see now that the whole thing is a game. It’s not about rights and wrongs on the ground, as there were only two people there.

It is very hard to defend an adequate examination at a distance of almost five years with the sort of positive-only notes that we often keep, particularly in apparently straightforward cases. It is also very hard to educate a lay judge in just one week to a point where he can appreciate the sort of pressure that we work under. How do you prove that you gave a patient an adequate chance to give the right history and asked the right questions to help him?

Weekend respite

Have a phone call over the weekend from the MDU solicitor who handled everything up to court. He is still very hopeful that we will win, saying that if we can’t win this he may as well give up. For my part, I am reconciled to a negative outcome, since it won’t change what actually happened or the way I practise. It is good to write this without knowing the judgement, as that is bound to colour my perception of this whole process.
Day 6:
Monday – The last lap

Didn’t sleep well again. Accessed my e-mails at 3.00am, including our counsel’s closing “skeleton” argument (completed and sent at 2.00am). I may be biased, but it seems to me like a masterpiece. Far from being literally a skeleton outline of what she wants to say in court, it runs to 33 pages covering 83 separate points she wants to make and is, as far as I can see, unanswerable. She has also faxed it to the Judge’s lodgings, so he can read it before court, and the opposition barrister will have done the same with his.

Pre-court meeting with our barrister, who, having gone through it all again, feels that we have an excellent case. She gives me a reprint of a judgement by Lord Bingham in an appealed case from 1988 concerning some engineers sued after a methane gas explosion killed several people. His judgement sets out the parameters by which a professional should be judged and is a fine exposition of the Bolam principle.

In court, our barrister goes first; in this situation, the claimant’s team have first say and last say, which seems a bit unfair. The Judge says that, as he has read the outlines, there is no need to go through them word for word. Nevertheless, my barrister insists on taking him through hers paragraph by paragraph, as she has re-read it on the train from London and wants to change a few emphases, and the Judge has very few questions for her. We then get on to the other side’s submission.

Sense of frustration

Lunchtime conference, and our counsel seems upbeat. Tell her I am now struggling with hearing myself criticised unfairly and she says that I do not need to stay for the further hour there will be after lunch or to come tomorrow [Tuesday] for the judgement, as there may be press asking for statements and, whichever way it goes, it will be rather awkward with the claimant and his wife. She says it can be nail-biting, waiting for the Judge to take an hour or so going through his judgement, which may run to 30-40 pages. He may say who has won at the outset, or keep it to the end of his judgement.

Had intended to go for the judgement, but am now happy to take my barrister’s advice. Really feel as if I am on quite a short fuse. The weekend break was good, although I realised on Sunday that I was emotionally frayed, and could not really think about anything else. But the thought of coming back again tomorrow for even more of the same just seems too much. In the event, have to wander around town for half an hour before coming home, as my briefcase has been locked in court over lunch.

Was able to write a few days ago that winning or losing probably wouldn’t matter too much. Now it seems to matter quite a bit again.

Day 7:
Tuesday – The judgement

Slept well to this point (3.20am) but now wide awake. Judgement expected around noon today. Really feel I need a few days’ space to recover from this, regardless of the outcome. If we lose, I shall have to see how I feel but I have to admit that, at this stage, I am not really expecting to lose. I think my barrister has done a superb job and her closing seems unanswerable.

11.30am. Waiting, waiting, waiting… And I was trying to kid myself that this wasn’t important to me.

The case was successfully defended. No finding of fault was attached to our member.

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