In the MDU’s experience, most doctors and dentists will face a complaint or claim at least once in their career. It is never pleasant, but it can help to know that others have gone through something similar, and that you have the MDU or DDU on your side to guide, support and defend you.

The case studies that follow offer an insight into the challenges doctors, dentists and other healthcare professionals have faced in their working lives, and how we assisted the individual member in each case.
Delay in diagnosis
A 43-year old patient reported calf pain which was diagnosed as a sports injury by her GP, an MDU member. At the same time she was referred for a chest x-ray for her ongoing cough. The x-ray showed a shadow which needed further investigation and the patient was referred for a CT scan. The CT appointment was arranged for a date two months after her initial complaint of calf pain.

In the interim, over a bank holiday weekend, the patient experienced an episode of chest pain and haemoptysis. This had settled but she rang her GP a week afterwards to tell him about it. She reported continuing mild shortness of breath on exertion.

The GP was reassured by the fact that the patient had not sought medical attention for a week before contacting him and that her symptoms had largely resolved by the time of the telephone consultation. Being concerned about a possible diagnosis of lung cancer, as a cause for her reported shortness of breath on exertion, the doctor expedited the patient’s CT scan under the two-week rule.

The CT scan took place 13 days later and showed a massive bilateral pulmonary embolism involving both pulmonary arteries. The discharge summary referred to chest pain and calf swelling over the previous three months.

The claimant subsequently instructed solicitors who alleged that the GP had been negligent in failing to consider and rule out a pulmonary embolism. It was alleged that the claimant should have been referred to A&E immediately.

The MDU obtained independent expert evidence from a GP who advised that a combination of haemoptysis and shortness of breath, with a recent episode of chest pain lasting several days — as reported by the claimant during the telephone consultation — merited at least an urgent, detailed GP assessment.

The MDU’s haematology expert advised that at the time of that telephone consultation the claimant would probably not have had elevated jugular venous pressure, a gallop rhythm or systemic hypotension, as, in the presence of such signs, she would have presented as an acute emergency rather than telephone her GP. However, he believed the claimant would have reported ongoing chest pain if asked in more detail. He could not be certain as to whether the claimant would have had tachycardia, tachypnoea, pyrexia or a pleural rub, as all those symptoms could have been transient. Similarly, the haematologist was unsure what the claimant’s Well’s score for pulmonary embolism would have been on the day of the phone call.

The GP accepted that his notes of the consultation were brief and that he should have asked the claimant further questions, either on the telephone or during a face-to-face consultation, to rule out a differential diagnosis. He also accepted the MDU’s advice that there was a significant litigation risk that a judge trying the case would be likely to find that the claimant would have reported ongoing chest pain and calf swelling had she been assessed in more detail. This would have led to a referral to A&E where an elevated d-dimer would have been measured which, together with additional investigations, would have led to an immediate clinical diagnosis of pulmonary embolism.

The claimant accepted £1,500 for the pain and suffering she experienced as a result of the 13-day delay in diagnosis. The claimant’s solicitors accepted that the claimant would have had the same management and medical outcome, including the need for indefinite anticoagulation, had she been diagnosed 13 days earlier.

Joe Schmid
Senior Claims Handler
A 23-year old female presented to a GP, an MDU member, with several complaints including folliculitis, recurrent ear infections and change of OCP. The doctor decided to treat her recurrent folliculitis with a course of erythromycin, which due to a prescription error was mistakenly given in a dose of 500mg four times daily for two months, instead of correct dose of 500mg twice a day.
The patient took the medication for the better part of a month before re-presenting complaining of feeling very unwell, with stomach pain, sickness and dizziness. She also complained that she had suffered hair loss and as a result of the anxiety this caused had not been able to go into work for most of the preceding month.

The following week, the patient’s mother complained to the practice about her daughter’s treatment. The GP apologised for his error in the dosage of antibiotic prescribed and for the gastrointestinal effects this had caused.

While the GP was awaiting a response from the mother to his letter, the patient saw a private dermatologist who had advised erythromycin was a reasonable choice of antibiotic in the usual doses, although acknowledged that it can cause gastrointestinal upset. The dermatologist also advised that the patient’s hair loss was likely to be due to autoimmune alopecia, as opposed to a side effect of the erythromycin. The dermatologist changed antibiotics and advised using chlorhexadine solution as a preventative measure.

A month later, the GP received a further letter from the patient’s mother saying she did not accept his apology. The letter set out a demand for financial compensation in relation to the private dermatologist consultation, for private prescriptions and for the cost of the over-the-counter medication to encourage hair growth that her daughter had used before seeing the dermatologist.

The MDU wrote to the patient asking for confirmation that his mother was authorised to deal with the matter on her behalf and advising her that the MDU was representing the GP.

The doctor prepared a written factual statement explaining how the script error had occurred. He also supplied a full copy set of records to the MDU.

It transpired that the patient had in fact called the practice and spoken to a different doctor following his appointment with our member. They discussed the dose of antibiotic, which the patient thought was too high based on the dose her friend had once been given. Unfortunately, the GP who took the telephone call had advised that the antibiotic was in the correct dose so the patient continued to take it. Our member also advised that actually he had intended to prescribe the antibiotic at 500mg twice a day, rather than four times a day, and had not noticed the error.

In light of these admissions, the MDU sought permission from him to settle this matter. We wrote to the patient's mother, passing on a further apology from the GP and advising that we would negotiate a settlement relating to the gastrointestinal side effects, although not to the hair loss, as this was not a recognised side effect listed by the BNF and this had been confirmed by the patient’s private dermatologist.

The patient’s mother continued to threaten further action, demanding £5,000 in compensation. We explained that a legal claim had to prove negligence in that the clinician breached their duty to the patient and that harm had resulted from the breach. As liability was only admitted for the gastrointestinal side effects, we refused the claim for £5,000 compensation. An offer of £500 was rejected outright. After some negotiation, the patient’s mother finally agreed and accepted a compromise offer of £1,000 compensation.

Dr Shabbir Choudhury
MBBS DRCOG MA
Senior medical claims handler
A mother brought her 18-month old son to see their GP. The child had a history of congenital heart defect. The mother reported that he had been suffering with a cough and runny nose for one week, and now also had a fever.

The doctor carried out a full examination, including removing all the child’s clothes to check for rashes. The GP noted that he was alert and did not have a rash, and that his temperature was 38°C.

The GP identified a systolic murmur, which was in accordance with the paediatric cardiologist’s recent letter. He recorded a pulse of 118bpm and noted that the child was not in respiratory distress, nor was he dehydrated. He prescribed amoxicillin and advised the mother to return immediately if her son’s condition deteriorated, or within 48 hours if he did not improve.

Later that day, the mother took the child to the park. He was initially babbling and moving but then he suddenly became quiet and stopped moving. An ambulance was called and the child was taken straight to hospital. Sadly, despite cardiopulmonary resuscitation, he died.

The boy’s mother brought a claim for clinical negligence against the GP. It was alleged that he failed to carry out an adequate assessment of the child and failed to diagnose pneumonia. It was also alleged that in light of the child’s known cardiac history, the doctor should have had a low threshold for arranging an emergency hospital admission. Had the child been admitted, he would have received IV fluids, IV antibiotics and ventilation if necessary. On the balance of probabilities, it was alleged, the child would then have survived.

The MDU obtained expert evidence from a GP and a paediatric cardiologist.

The GP expert was supportive of the doctor’s management in keeping a full and accurate contemporaneous note of the child’s assessment. The expert also considered that it was reasonable for the doctor to treat the child with oral antibiotics and that he had provided good safety-netting advice.

The paediatric cardiology expert noted that the child had a complex congenital heart abnormality, for which corrective surgery would not have been possible. He was at high risk of dying from an acute pulmonary hypertensive crisis. On the balance of probabilities, even if the GP had arranged for an emergency admission, the child’s death could not have been prevented.

A Letter of Response was drafted denying liability in full. The claim was discontinued.

Dr Grace Cheung
Senior medical claims handler
“On the balance of probabilities, even if the GP had arranged for an emergency admission, the child’s death could not have been prevented.”
The 35-year-old patient alleged she presented to her GP, an MDU member, with classic cardiac symptoms, including chest pain radiating to the jaw and face. She stated that she had experienced an episode of such pain at rest while in the waiting room just before the consultation. The GP's account of the consultation differed substantially from the claimant's version of events. He denied that the claimant complained of breathlessness or other exertional symptoms. Rather, she reported fleeting aches and pains bilaterally which were worse at the end of the day. He considered that the patient's symptoms were likely to be attributable to stress. In addition to being left to cope with small children whilst her partner worked abroad, her younger sister, to whom she was close, had recently been badly injured in a road accident.

The doctor asserted that if he had been confronted with a classic presentation of ischaemic heart disease, including rest pain of apparent cardiac origin while in the waiting room, as alleged by the claimant, he would have arranged for urgent hospital admission.

The GP expert instructed by the claimant's solicitors was critical of the fact that the MDU member had conducted no physical examination and had inappropriately diagnosed the claimant's symptoms as stress-related. It was alleged that the claimant should have been referred to A&E immediately. The claimant sought to recover £550,000 in damages plus several hundred thousand pounds in legal costs. The MDU obtained expert evidence from a GP who noted that the doctor's version of events was supported by the consultation notes, which made it clear that the claimant had been significantly stressed. He also noted that the claimant did not have a high absolute risk of cardiovascular disease. However, the amount of information...
recorded in the available medical records was insufficient for him to form an adequate view of whether the claimant did or did not merit emergency hospital admission.

It was the claimant’s case that if she had been referred to A&E, troponins would have been positive and she would have undergone coronary angiography soon after admission. Had this taken place, an angiogram would have shown multi-vessel coronary artery disease for which she would have had an angioplasty and stent insertion.

By contrast, the independent cardiology expert commissioned by the MDU advised that if the claimant had been admitted to hospital on the day of the consultation, she would have been sent home again, since the history was atypical and because both ECG and blood troponin would have been normal. Her myocardial infarction nine days after the consultation therefore could not have been avoided.

After consultation between the member, the experts and a barrister, it was decided that the defence case was strong enough to take it to trial. We therefore rejected the claimant’s solicitors’ offer of settlement in the sum of £50,000 plus legal costs, made three months before trial. Just a month before the trial date, we offered to the claimant’s solicitors that they would not have to pay the MDU’s costs should they discontinue the claim prior to trial. This offer was accepted, and the case was discontinued.

Joe Schmid
Senior Claims Handler
A consultant plastic surgeon, an MDU member, saw a 40-year old female patient who requested cheek augmentation surgery. The patient had already undergone several plastic surgery procedures, including the insertion of malar implants, but she remained dissatisfied with her appearance.
The plastic surgeon agreed that it would be possible to undertake surgery to augment the cheeks and mandible using a different type of implant than had been used previously. The operation was carried out using new malar prostheses and angle of mandible implants.

Upon review, the right angle of the mandible was slightly more prominent than the left but it was thought that this would settle with time. Several months later the patient attended a different plastic surgeon for a second opinion as she was still unhappy with her appearance. The second plastic surgeon thought the implants might have been slightly rotated.

The patient then attended our member again complaining of ongoing asymmetry. The prostheses were palpated and it did not appear that there was any displacement. It was thought that the asymmetry was probably due to scar tissue. The consultant gave the patient several options as to the next steps and she opted for further surgery.

During surgery, the consultant found that the implants were in the correct position but there was a mass of scar tissue around the right implant which was causing the asymmetry. A small ridge was shaved off the implant before it was replaced. Later, the patient was still complaining of swelling and the member thought it may be appropriate to inject a steroid into the scar to try and settle it.

The patient subsequently suffered an infection and it was agreed that both implants should be removed to allow the infection to clear.

Over the next few months the patient continued to suffer from an infection and three months after the procedure to remove the prostheses it was noted that a fragment of the implant had been left in situ and was extruding from the lower molar region. This was easily removed with forceps.

The consultant subsequently received a letter from a solicitor alleging that the implant had been malpositioned, resulting in asymmetry, and that the infection had not been diagnosed or treated quickly enough. It was also alleged that the injection of the steroid was contra-indicated in the presence of infection and that there was a failure to remove all of the implant.

The MDU obtained a report from an independent plastic surgeon who noted that the implant had been found not to be malpositioned during the revision surgery, and any asymmetry was in fact a result of scar tissue surrounding the implant. He was of the opinion that as soon as the infection had been recognised, appropriate treatment had been implemented and surgery to remove the implants had been carried out.

While it was agreed that had an infection been present this would have been a contra-indication to a steroid injection, at the time of the injection there had been no indication that an infection had been present. On the basis of the expert opinion, these allegations were denied.

It was accepted that a fragment of the implant had been left in situ, and it was likely that this fragment had delayed successful treatment of the infection by several months and a procedure had been required to remove it. On the basis of this allegation alone the patient’s claim was settled for £4,000 in damages.

Charlotte Taylor
Lead claims handler
An obese patient with a BMI of 44.7 was referred for a bariatric procedure to a consultant vascular surgeon with an interest in bariatric and laparoscopic surgery.

Following surgery, the patient, a 32-year-old man, initially lost nearly four stones over a period of nine months but this stopped and he regained the lost weight. It transpired that the band had become unclipped.

The private healthcare company through which the procedure was arranged only offered free revision surgery within the first three months post-procedure. The surgeon, an MDU member, offered to perform revision surgery free of charge, either privately provided the patient could make arrangements with the private hospital, or to treat the patient on the NHS, for which he would require a GP referral. However, the patient's local NHS trust did not fund revision surgeries where the initial procedure was undertaken on a private basis.

The patient's claim against the surgeon alleged that he had been negligent in fitting the band and that it had become unclipped because it was not secured properly.

The MDU asked an independent consultant general surgeon to give an opinion in relation to the performance of the surgery. The expert found that:

- The operation note written by the surgeon was of a good quality.
- The fact that the patient recorded good progress with a weight loss of at least three stones suggests that the band was correctly placed and properly clipped together.
- The unclipping was a recognised complication of the procedure.
- The original surgery performed by the MDU member was not in any way substandard and any allegations against him were unfounded.

On the member’s behalf, we denied liability in relation to the claim, and to prevent the costs escalating if the claim was prolonged, we made a ‘drop hands’ offer to the claimant's solicitors. This means that the claim is discontinued, with both parties paying their own costs.

The claimant's solicitors made a counter offer to settle the claim for damages of £10,000. We restated our ‘drop hands’ offer with a caveat that discontinuance would not be an option after the expiry date of the offer, and we would then seek repayment of our costs.

The claimant's solicitors agreed to discontinue the claim against the surgeon and no compensation was paid to the claimant.

Funke Oduwole
Claims handler
Allegation of non-accidental injury

The scene
A consultant paediatrician had been asked to provide a report regarding a five-year old child he had seen on the ward. The child had sustained an injury which could not easily be explained by the parents, and the consultant was concerned that it might be non-accidental. The consultant recorded the history and his examination findings carefully in the records.

The consultant was later contacted by a solicitor acting for the child’s father in family court proceedings. The letter explained that the court was being asked to decide what had happened to the child and in particular to decide upon the nature and causation of the injuries. The court were also to determine whether the injuries were non-accidental, and if so, to identify the perpetrator(s).

The consultant rang the MDU medico-legal helpline.

MDU advice
The advisor explained that the consultant was right to be concerned and to have contacted the MDU. They went on to say that because the consultant had been asked if he wished to intervene with respect to the Finding of Fact hearing, it could suggest that the parents had made allegations against him, such as alleging that he had caused injury to the child when examining her on the ward. The advisor explained that the consultant was obliged to write a statement, as this had been requested by the court. However, as it now appeared that criminal allegations had been made against him, it was important that he was assisted by a solicitor and represented at the hearing, if he was in fact asked to attend.

The advisor instructed a solicitor to assist the consultant. After further investigation the solicitor found that the child re-presented to the hospital with a fracture the day after the consultant had reviewed her. The father was alleging that this fracture had occurred during the examination and was caused by the consultant. The solicitor helped the consultant in the wording of his statement, having sought disclosure of the relevant documentary evidence from the court. The solicitor attended court with the consultant and the allegations were easily defended.

Dr Kathryn Leask
MDU medico-legal adviser
The patient was referred to the surgeon, an independent practitioner, by her GP with severe back pain and sciatica with radiculopathy. She saw him on a total of six occasions and also periodically wrote to him to update him on her progress.

By the time of the sixth consultation, the patient had reached the level of her private medical insurance cover. The surgeon suggested that she return to see him as an NHS patient and, in particular, investigate newer symptoms she had recently complained of that potentially related to her hips.

The patient thereafter attended her GP who, due to PCT constraints, could not refer the patient back to the same orthopaedic surgeon who had been treating her. She was eventually seen six months later by an NHS orthopaedic surgeon. By this time the patient’s right hip had collapsed as a result of avascular necrosis and she underwent a right hip replacement the following month.

In her claim for clinical negligence, the claimant alleged that the private orthopaedic surgeon had failed to properly diagnose and treat her hip condition.

At trial, it became clear that although the claimant argued in evidence that her symptoms had deteriorated, the contemporaneous medical notes and the correspondence sent to the surgeon by the claimant (all kept in her clinical file) described a marked improvement in her symptoms following epidural treatment.

It was only at the sixth and final consultation with the surgeon that the claimant complained of hip pain and difficulties with walking. As she had by then exhausted her private medical insurance cover, the surgeon recommended that she should be referred via the NHS for further investigations.

Liability was denied throughout the history of the claim and the case was brought to trial. In his judgment, the judge commented that the claimant showed a tendency to view events subjectively, and with the benefit of hindsight. He concluded that her opinions on the merits of the case had coloured the evidence she gave.

He considered it likely that the claimant did have some symptoms, although not to the extent that she claimed. The judge concluded that there could be no finding of lack of care in the surgeon’s treatment during the period alleged by the claimant.

The claim was therefore dismissed and the member successfully defended.

Lee Lewis
Senior Claims Handler

The MDU successfully defended at trial a claim against a consultant orthopaedic surgeon in respect of alleged failure to diagnose avascular necrosis.
Member's perspective

'This claim against me and my professional conduct came out of the blue. The patient had presented with a severe back situation and radiculopathy and had responded very well; she even wrote and thanked me.

‘In the end, when her back and leg pain had settled, she complained of hip joint symptoms, but had run out of insurance cover and I suggested she saw me on the NHS. That never happened.

‘The action against me started two years after I last saw her, and the final Judgement came in almost four years later. It was a gruelling and unpleasant experience. It couldn’t have been defended without diligent record keeping (including all of the claimant’s letters to me).

‘I would have found the process unsustainable without the support of the MDU and the legal team they instructed. All of them were totally honest with me and diligently warned me at the start how long and hard it would all be.'
A GP visited an 81-year old patient who had stumbled in the street and injured his right ankle. The doctor noticed that although the patient was able to fully weight bear, there was mild pitting oedema of both ankles.
The patient reported that he had had gout in his right ankle in the past and that the injury was around 10 days old. He was already taking ibuprofen with no side effects and the doctor prescribed a further supply to help reduce swelling and pain.

The GP questioned whether the pain might be attributable to pre-existing gout or a sprain as a result of the fall. He recommended an x-ray but the patient refused.

A month later, the patient went to see the doctor again. The GP considered osteoarthritis and requested an x-ray. In the meantime, the patient suffered a heart attack and was admitted to hospital where it was noticed that his ankle was swollen. An x-ray was undertaken and the patient was referred to an orthopaedic surgeon.

The x-ray showed that he had an undisplaced fracture of the lateral malleolus. He continued to experience pain in his ankle and a further x-ray confirmed opening of the joint space medially. He was treated with a local anaesthetic injection into his ankle to combat the pain.

Some months later, the GP received notice of a claim alleging that he had failed to provide reasonable care and treatment. It was the claimant’s case that the doctor had breached his duty of care by not following the Ottawa Ankle Rules. It was also alleged that there was a five-week delay in diagnosing the fracture, and that earlier diagnosis would have reduced the pain and suffering in the six to eight weeks after the injury.

The MDU obtained a report on breach of duty from an independent GP expert. The expert noted that while there was a failure to diagnose the fractured lateral malleolus, they did not consider that the GP’s care of the patient was negligent. The MDU expert was of the opinion that the claimant was a candidate for low trauma fracture, in light of pre-existing factors including his age and that he regularly smoked and consumed alcohol. However, as the injury was over one week old, the patient was fully weight bearing and the nature of the injury was the result of only a stumble, the expert found it reasonable that the doctor should have diagnosed a sprain or gout, and that the likelihood of fracture was low.

The expert also pointed out that the GP had offered to arrange an x-ray, which the patient had declined.

Regarding the second consultation, when the GP reconsidered the diagnosis from gout to include underlying osteoarthritis, the independent expert stated that this was reasonable. In his opinion, it would be most unusual for an attack of gout to last four weeks, whereas osteoarthritis classically causes chronic pain.

Based on these findings, the MDU denied liability on behalf of the MDU member. The claim was subsequently discontinued.

Patricia Cassidy
Claims handler
A patient with a long history of depression, which had been treated over the years with various medications including anti-depressants, was referred to an NHS psychiatrist because he was experiencing severe mood fluctuations. He had also recently shown violent tendencies towards other people.

The psychiatrist considered treatment with lithium at a dose of 100mg. At the time of the test, the patient's urea and creatinine levels were marginally high at 8.1 mmol/L and 104 umol/L. Repeat tests were ordered and the psychiatrist advised the addition of lithium to the claimant's current anti-depressant regime if the second readings were normal.

Two weeks later, the patient saw his GP, a member of the MDU. The GP had previous training in psychiatry and was responsible within the practice for the management of patients requiring psychiatric medication.

Before starting the patient on lithium, the GP rechecked the patient's urea level and noted that it had improved since a reading taken six months earlier – it was now 9.4 mmol/L compared to 11.1 mmol/L. The GP felt it would be in the patient's best interests to commence lithium medication despite being aware of the pre-existing mild renal impairment.

The patient was prescribed lithium on four occasions over a four-month period, and during that time his urea and creatinine levels increased but remained within the range for mild renal impairment. The GP carried out several renal function tests over the period to monitor any effect of the lithium treatment, as well as seeing the patient in his clinic.

Shortly afterwards, the patient was diagnosed with chronic kidney disease stage 3 and over the next two years continued to suffer a decline in renal function. He was assessed for renal transplant.

The patient brought a claim against both the Trust and the GP member in which it was alleged that he was an unsuitable candidate for lithium and the GP member was negligent in starting lithium treatment due to pre-existing concerns over renal function. It was also alleged that the GP breached his duty of care by continuing with lithium despite increasing urea and creatinine levels.

Further, it was alleged that the lithium caused the patient to suffer acute kidney failure, and permanent kidney damage with
progressive deterioration in renal function over a number of years so that he required haemodialysis and his life expectancy was reduced.

The MDU obtained evidence from independent GP and psychiatric experts that was supportive of the GP’s management. The psychiatric expert noted that the doctor was well qualified to assess the patient’s psychiatric condition and treatment thanks to his experience and pre-existing training. In the event, the monitoring took place more frequently than was recommended at the time, and it was therefore perfectly reasonable for the doctor to start lithium and to monitor the patient in the way he did.

Expert evidence was also obtained on causation from a consultant nephrologist who opined that significant renal damage would only be caused by decades of lithium use and even in the early years of taking the drug, the expert would have expected any renal damage due to lithium toxicity to have been entirely reversible. There were other significant co-morbidities that contributed to a gradual decline in the patient’s renal function, which had improved on cessation of the lithium, and it was noted that the patient did not start the haemodialysis it had been alleged he now required.

In response to the MDU expert evidence, the claimant made a small offer of settlement based on their own expert’s revised view that the lithium caused additional tiredness and fatigue only. The MDU rejected this and the claim was subsequently dropped.

Andrew Norman
Claims handler
An 18-year old student consulted her general practitioner to discuss contraception. In the past, she had not found it easy to take the pill regularly and felt that condoms were not sufficiently reliable. She had also tried a depot injection but found the side effects of mood changes unacceptable.
The patient and the GP discussed her contraception options and agreed that she would proceed to have an intrauterine coil device (IUCD) fitted. The GP described in detail what the procedure would involve and the risks - namely an internal examination, some pain on insertion similar to a period, a small risk of infection or the coil falling out, the chance of intermittent bleeding over ensuing days/weeks and a chance that the coil might pierce or perforate the uterus. The doctor prescribed analgesia to be taken on the morning of the coil fitting and also afterwards in case of any post-procedure discomfort.

The patient attended the practice a week later for the insertion of the IUCD. The practice nurse was present as a chaperone. The doctor was careful to explain what she was doing at each stage. The patient did experience discomfort during the coil insertion, at which point the GP paused and used GTN spray to relax the cervical os. This eased the patient's pain and with her ongoing consent the procedure was completed without further problems. She agreed to come back to the surgery after her next period so that the GP could check that the thread positions were satisfactory.

However, the patient returned three days later complaining of lower abdominal pain with vaginal bleeding. Examination of the right iliac fossa indicated tenderness but there was no guarding or rebound. On vaginal examination the GP could not identify the coil threads. She referred the patient for urgent gynaecological assessment, querying a perforation of the uterus. An ultrasound scan identified that the IUCD lay outside the uterine cavity. It was retrieved by way of laparoscopy.

Three years later the patient submitted a claim for compensation. In their Letter of Claim, the claimant's solicitors alleged that the GP had fitted the IUCD in such a way as to cause it to lie outside the endometrial cavity and had failed to adequately assess the positioning of the device.

On the member's behalf, the MDU investigated the claim and obtained an expert opinion from a general practitioner with experience in family planning. The expert advised that the GP member's records were of a good standard and that her practice could be supported.

Our Letter of Response highlighted the GP's postgraduate training, experience as a general practitioner and as a family planning doctor. It was pointed out that the claimant's contention that perforation of the uterus following insertion of IUCD always indicates negligent treatment was untenable. One of the rare but recognised complications of IUCD insertion is perforation of the uterus, which nearly always occurs at the time of insertion. It is often a 'silent' phenomenon and clinicians cannot rely on a signal of pain from the patient to indicate that perforation has occurred. Patients often experience discomfort during uncomplicated IUCD insertions.

It was pointed out that the GP had proceeded cautiously and with the claimant's ongoing consent. The assertion that she had failed to adequately check the positioning of the device was challenged. The notes documented each step of the procedure and the claimant's solicitors failed to outline the additional steps they considered the doctor should have taken.

Some months later the claimant's solicitors advised that they were no longer instructed to pursue a claim.

Dr Sharmala Moodley
Deputy head of claims handling

Learning points

- **Just because something has gone wrong, this is not prima facie evidence of negligence.** Investigation may show that the doctor performed to an appropriate standard.

- **Full, contemporaneous notes are essential – they can provide evidence of a good standard of care in cases where negligence is alleged.**
A male patient was diagnosed with type 2 diabetes mellitus and began insulin treatment. He had many other co-morbidities, including chronic kidney disease, hypertension, previous MI and non-proliferative diabetic nephropathy.

He developed a blister on the ball of his big toe, for which his GP prescribed erythromycin as the patient was allergic to penicillin. The patient attended the practice nurse for dressing changes and was seen by GPs at the practice for review. He continued to suffer blisters on his foot, which became infected. He was prescribed more erythromycin and the infection largely cleared. However, it returned shortly after completion of the course of antibiotics. When the patient was seen again by the practice nurse and the GP, the wound was indurated, weepy and red. He was prescribed clindamycin.

Some 10 days later, the patient attended the GP again. No infection was identified and a non-urgent referral was made. A few days afterwards, the patient attended another GP who sent a second referral letter.

A week later the patient attended the practice nurse for a dressing change and another a few days later. The nurse noted that the infection had cleared with antibiotics but the wound was leaking fluid and the foot was swollen and inflamed. Another course of erythromycin was prescribed.

Soon afterwards, the patient was seen in the podiatry clinic and was sent to A&E and admitted to hospital. He was discharged eight days later.

Over the months that followed, the patient's condition did not improve, despite undergoing debridement of the foot. Subsequently, he underwent a transmetatarsal amputation of the left foot and a skin graft.

The claim which followed alleged failure to refer the patient urgently to secondary care. It was alleged that on a balance of probabilities, the transmetatarsal amputation would have been avoided if an earlier referral had been made.

The MDU commissioned several expert reports which highlighted vulnerabilities in the clinical management of the patient. It was agreed by the experts that an earlier referral should have been made, in which case the left metatarsal amputation might have been avoided. All healthcare practitioners involved were vulnerable to criticism.

With the member's consent, the claim was settled on behalf of all involved for a six-figure sum, including the claimant's costs.

Lauren Shan
Claims handler
"It was alleged that on a balance of probabilities, the transmetatarsal amputation would have been avoided if an earlier referral had been made."
Faulty equipment
A 35-year-old female patient attended her dental practice for a routine restoration on the LL7. When preparing the cavity for filling, limited space within the mouth meant that the GDP needed to angle the head of the handpiece towards the patient’s tongue. The dentist noticed a large white patch 2cm x 1cm on the side of the patient’s tongue, although there was no bleeding. The handpiece appeared to be working normally.

On discovering the white patch on the patient’s tongue the dentist asked her to check if this was something she had had prior to the appointment. The patient confirmed it was not there previously. The GDP apologised that this had happened at the practice. The GDP completed the cavity preparation without a need to angle the handpiece towards the patient’s tongue, and the white patch did not get any larger.

After the patient had left the consultation room, the GDP checked the handpiece and noticed that the head was overheating when it was running, while the rest remained cool. At this point the GDP spoke to the patient and explained the handpiece was faulty and this had caused a burn to her tongue. The GDP gave advice on how to treat the burn when the local anaesthetic wore off and gave her some Gengigel to apply.

The patient saw her GP the following day and was prescribed antibiotics as she was finding it difficult to sleep, eat or talk.

The handpiece was sent for repair, and it was returned with no fault. The GDP continued to use and monitor it. Several weeks later, the ultrasonic scaler failed and an engineer was called. A fault was identified in the unit that would have caused overheating in the bearings of the handpiece, producing heat in one small area on the head. Until this time, the piece appeared to be functioning normally to the GDP and the other dentists working in the surgery.

The claimant brought a claim for compensation for the trauma. The DDU obtained independent expert advice from a general dental practitioner who was unable to support the dentist’s actions, as such trauma can only be reasonably viewed as a breach of duty of care. The dentist agreed that he was responsible for the burn.

The principle of res ipsa loquitur (the thing speaks for itself) applies, which states that without the direct involvement of the dentist the injury would not have occurred. Initially, this could appear to be a product fault, but as the dentist was in control of the handpiece the overheating should have become apparent to him.

The claimant’s solicitors initially requested settlement at £13,700 and the DDU counter-offered £2,000. Meanwhile, the claimant’s solicitors obtained expert advice that suggested the claimant had sustained some loss of sensation in her tongue. On the basis of this additional information, the DDU offered £5,000, with no admission of liability. This was accepted and the claim was settled.

Emma Gilroy
Claims handler
A patient attended his dentist in 2009 for the first time in five years for a routine check-up. The dentist, a DDU member, noted that the patient had a fractured carious UR8.

After taking bitewing radiographs, the dentist recommended that the tooth be extracted. At the extraction appointment, a periapical radiograph was taken, and the dentist noted that the tooth was badly fractured with no coronal tooth remaining. He administered local anaesthetic and attempted to extract the UR8.

Unfortunately, the tooth fractured further during the extraction. The dentist concluded that the retained root was not retrievable and would require surgical extraction, should the tooth develop symptoms. He noted in the contemporaneous clinical records that he had informed the patient that part of the root remained in the socket.

Some six months later, the patient attended but did not complain of pain at UR8. He told the receptionist that he no longer wanted the hospital referral and asked her to remove the request, which was noted in his records.

In early 2010, just before the DDU member was due to move on to another practice, the patient was seen for his last appointment with the DDU member, who noted ‘pain in the UR8. Refer to OMFS for extraction’. This was done but the patient’s notes state that he subsequently cancelled the referral, for a second time.

A further two months passed and by now the site had completely healed, with an examination by a different dentist at the practice finding no root palpable and no symptoms. It was only after a further four months that the patient attended with pain and swelling. He was referred and underwent surgical extraction of the UR8.

The patient brought a claim alleging that the DDU member had failed to undertake adequate radiographic assessment of the UR8 to confirm whether a conventional extraction was appropriate. It was also alleged that the dentist had failed to inform the patient of the position, and failed to take post-operative radiographs to review the size and position of the retained root. The patient maintained he had no recollection of cancelling hospital appointments.

The DDU instructed an expert to review the case. He commented that the dentist had indicated that the patient should be referred to an oral surgeon, who would have been in a position to take post-operative radiographs. Breach of duty was denied on the member’s behalf. In response, the claimant’s expert commented that whether to leave a retained root in situ or refer the patient for its removal depends, among other things,
on the size of the root and whether any pathology is present. The only way this can be ascertained is by post-operative radiograph, which is usually sent with the referral. The pre-operative radiograph did not, he asserted, show the entire root complex of UR8 that is necessary to determine whether a conventional extraction was appropriate, or whether the patient should be referred for its surgical removal.

The claimant's solicitors further maintained that failure to have a pre-operative radiograph of a third molar that showed the entire root complex and its relationship to other anatomical features, such as the maxillary antrum, was also a breach of duty. On causation, they claimed that if the dentist had fully informed that claimant of the clinical need for removal of the root and the risks of leaving it in situ, a timely referral could have been made and on the balance of probabilities, the claimant would have avoided the ensuing pain and infection leading up to the eventual surgical extraction.

In the member's defence, the DDU argued that the contemporaneous notes clearly show that dentist advised the claimant of the potential need for surgical extraction in hospital, and of the presence of the retained root at the time of the attempted extraction. The fact that this was noted in the clinical record enabled the DDU to mount a robust and ultimately successful defence of the case.

Throughout the course of the claim, the dentist's notes were crucial in rebutting the claimant's arguments that treatment had been negligent.

It was accepted that extraction of a wisdom tooth can be complex, depending on the position of the tooth. However, if the dentist considers conventional extraction is possible, the patient is fully informed of any potential difficulties and, should a root fracture during treatment, the dentist explains the situation and further treatment options, the DDU will be in a better position to defend the claim.

The claimant's solicitors threatened to take the claim to court, but because of the strength of the records, the DDU continued to deny liability. The claimant's solicitors finally confirmed that the claim had been discontinued some two years after it was first brought.

Amelia Lunning
Claims handler
A patient in her 60s attended her dentist, a DDU member, complaining of pain in the upper right quadrant of her mouth. Following examination, the dentist prescribed antibiotics for the pain but the patient returned three days later, complaining that the pain had intensified. The dentist examined the teeth in the upper right quadrant again and diagnosed that the pain was emanating from the UR6. The dentist offered a choice of root canal treatment or extraction of the tooth. The patient opted for extraction, which was carried out straight away.

The patient returned to the practice the next day. She complained that she was still in pain and that the pain was coming from the UR5 and not the UR6 which had been extracted.

The dentist explained that, in his view, the UR6 had been the cause of the patient's symptoms, and that pain from one tooth can be referred to another.

It later transpired that the UR5 required root canal treatment. Subsequently, the patient had the UR5 extracted, though by a different treating dentist.

The patient made a claim for compensation and for remedial treatment for UR5 and UR6, which were both to be replaced with implants. The patient requested the sum of £12,000.

The dentist, a DDU member, requested the DDU’s assistance with the claim.

The DDU instructed an independent expert who was of the view that the DDU member extracted the UR6 erroneously and would therefore be responsible for its loss and replacement. The expert however, did not agree that our member should be responsible for the loss and replacement of the UR5.

Our member placed a satisfactory root filling to the UR5 and although it was still symptomatic when the patient attended a different dentist, she was not offered the option of specialist re-root treatment prior to it being extracted. The records indicated that the UR5 had sufficient tooth substance remaining for it to be restored. The DDU settled this matter, with our member's agreement, for a total of £4,500.

Lauren Shan
Claims handler
A 50-year old male patient attended his dentist for extraction of his UL6 retained root, and replacement with an implant retained crown. Unfortunately, during the course of the treatment, the implant penetrated the sinus lining, causing blood loss from the nose. It was alleged that to retrieve the implant, further drilling was required to the bone in the upper jaw. A second implant was then placed.

Three months later, the dentist fitted an abutment to the implant and a crown was also cemented. The crown subsequently fractured, and the patient returned to the practice when attempts were made to remove the implant by a different dentist, who found that the implant had integrated and could not be removed. Following a CT scan it was possible to ascertain that the implant was not completely surrounded by bone, and there was insufficient space to restore it. The implant was subsequently removed.

The patient instructed solicitors to pursue a claim against the first dentist for incorrect placement of the implant at UL6 towards the UL7, and for piercing the sinus floor during either the implant placement, or during removal of the misplaced implant.

The independent expert instructed by the DDU was of the opinion that based on the available radiography, there had been a high risk of perforating the maxillary antrum at the time of implant placement, as the pre-extraction radiographs indicated the roots of UL6 were in close proximity or through the floor of the antrum.

Whilst the loss of the first implant fixture into the antrum appears to have been an unfortunate incident, the dentist may have been vulnerable to criticism in that more care should have been taken thereafter.

The expert also found the outcome would have been more predictable if, at the time of the loss of the first implant, the socket had been packed with a substance to promote healing and bone growth, such as a demineralised bone matrix, and the second implant then placed after the appropriate healing period.

Finally, due to the proximity of the implant fixture to the UL7, it would have been very difficult to place an all-ceramic crown on a standard abutment, because the crown would have been too thin at its distal aspect. An alternative solution might have been a screw retained porcelain fused to metal crown fitted directly to the implant.

On receipt of evidence from an independent expert instructed by the DDU a letter of response was served, with the DDU member’s consent, offering £3,500 compensation to cover the cost of an implant retained crown and its removal plus £1,000 for any discomfort and inconvenience caused.

This offer was rejected. The claimant’s solicitors counter-offered with a detailed schedule of loss totalling over £30,000, which included sums for lost earnings and future treatment costs. On further negotiation, however, the claim was finally settled for £7,000 plus £19,000 legal costs.

Samuel Hedges BSc (Hons)
Lead Claims Handler
A patient attended her dentist to enquire about having veneers fitted to cosmetically straighten her teeth. The dentist discussed with her options for Invisalign orthodontic treatment, but the patient seemed keen to achieve immediate results.

When the patient attended to have the veneers fitted a month later, the dentist prepared nine upper and lower anterior teeth for crowns, in an apparent change of the treatment plan. The crowns were fitted in stages; four upper teeth first followed by the five lower teeth.

Over the following six months, all five lower teeth developed symptoms indicating loss of vitality. The dentist completed root canal treatment on four of these, and extirpated the pulp on the fifth. The patient also complained that some of the crowns did not fit.

After more than six months’ treatment, the patient was unhappy with the outcome and sought a second opinion. The patient was in pain and was not happy with the appearance of some of the crowns provided. Further root canal treatment was carried out on the patient and she sought legal advice.

Her complaint was that she had pain in the lower anterior teeth, and pain associated with sensitivity to hot and cold at UR2/1. She was unhappy with the appearance of her lower teeth and found eating difficult as she felt the lower anterior teeth were bulky.

The DDU instructed an independent general dental practitioner to provide an expert opinion on the dentist’s treatment. The expert was critical of the treatment provided, saying that there had been a failure to obtain a history of past orthodontic treatment or trauma to the lower teeth, or to undertake preoperative radiographs or vitality tests of the teeth to be crowned. Most importantly, there was criticism of a failure to obtain appropriate consent from the patient.

The most important issue was the discussion that the dentist had with the patient at the initial consultation.
Their evidence differed as to what was allegedly discussed, as did their view of the treatment plan. The dentist asserted that the patient was insistent that he proceeded with treatment as soon as possible and suggested that the patient would have proceeded with the treatment in any event.

The claimant's solicitors intimated that the patient would need replacement of the crowns immediately and also made a claim for future crowns for her lifetime.

As the expert opinion obtained was not supportive of the dentist, we asked the member for consent to settle the claim.

An initial offer from the claimant's solicitors of £45,000 was rejected and the claim was subsequently settled for £38,000. The claimant's costs were £60,000.

Taiye Omo-Ikerodah
Dental claims manager

This case highlights the importance of recording the discussions regarding options for treatment, in order to demonstrate that valid consent has been obtained, and of confirming the agreed treatment with a formal treatment plan.
As an MDU or DDU member you can ask for the following types of assistance.

- Professional indemnity for claims of negligence made against you.
- Support and representation at GMC or GDC fitness to practise hearings.
- Criminal investigations arising out of your clinical practice.
- Personal and confidential medico- and dento-legal advice.
- Help at inquests, inquiries and disciplinary proceedings.
- Support from our press office when faced with media attention.

We also provide guidance and support in the following areas.

- Risk management advice and guidance.
- Advisory publications, podcasts and videos.
- CPD-accredited education courses.
- Government relations – representing our members to the Government and regulators.
- Generous savings on books from leading publishers.
- Online support at themdu.com and theddude.com

Not just for one year, but lifelong and beyond.
† The Dental Defence Union (the DDU) is the specialist dental division of the Medical Defence Union Limited (the MDU) and references to the DDU and DDU membership mean the MDU and membership of the MDU.

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Conduct Authority for insurance mediation and consumer credit activities only. MDUSL is an agent for The Medical Defence Union Limited (MDU). MDU is not an insurance company. The benefits of MDU membership are all discretionary and are subject to the Memorandum and Articles of Association.