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 dilemmas doctors, dentists and other healthcare professionals have faced in their working lives, and how we assisted the individual member in each case.
Bile leak

The MDU successfully defended a general surgeon who received a claim from a patient following post-operative complications of a laparoscopic cholecystectomy. It was alleged by the patient’s solicitors that the operation should have been converted to an open procedure.

The patient was referred with a history of numerous episodes of right upper quadrant pain. Investigations showed thickening of the gall bladder with inflammatory changes. Multiple stones in the gall bladder were also noted. The patient consented to have her gall bladder removed laparoscopically. As part of the consent discussion, she was advised that the operation would be converted to an open procedure if required.

During the operation, the surgeon found that the gall bladder was inflamed. He recorded this and also noted that he had identified the cystic duct, cystic artery and common bile duct, and that the artery and duct were clipped and the gall bladder removed.

The cystic artery was difficult to identify, but two structures were identified that were probably a double cystic artery and these were divided in a similar manner. Post-operatively, there was bile in the drains.

Subsequently, the patient required three ERCP procedures and a laparotomy before the leak could be stopped. Further investigation indicated that the leaking duct was a branch of the posterior sectoral bile duct.

The claimant alleged that damage caused during the original laparoscopic cholecystectomy had led to a post-operative bile leak. It was alleged that the bile duct injury should have been identified during the original procedure and that the surgeon should have converted to an open procedure. It was suggested that an open exploration would have allowed more precise localisation and ligation or re-implantation of the damaged duct, depending on its size, into the bowel. If this had occurred, the claimant alleged, she would have avoided the subsequent post-operative complications and the additional surgery required.

The MDU instructed an independent professor of surgery to review the papers and comment on the allegations made against the member. The expert was supportive of the member’s management and commented that it was not uncommon for an accessory duct draining small areas of the liver to be divided during cholecystectomy and that the bile leakage usually dries up within a few days. In this case, the expert noted that the duct appeared to be somewhat larger than normal, but it was probable that this duct would have been divided by many surgeons undertaking laparoscopic cholecystectomy in the same circumstances as this case, and there was no evidence that the member failed in his duty of care.

The claim was rebutted on the member’s behalf and the claimant’s solicitors subsequently confirmed that they would not be pursuing the matter further.

Lee Lewis
Senior claims handler
In 2009 a consultant gynaecologist, an MDU member, undertook laparoscopic surgery for deep infiltrating endometriosis in a young woman. He video-recorded the 25-minute procedure, which was a block dissection of the utero-sacral ligaments using monopolar diathermy as the operative modality. The surgery appeared to go well.

The patient was discharged the following day but five days later became seriously unwell and returned. She was diagnosed with faecal peritonitis and rectal perforation. A defunctioning colostomy and repair of the perforation led to a good recovery after a period of convalescence.

The patient sued, alleging negligent perforation of the rectum and initially claimed £140,000 damages. She alleged that the rectal probe had been used negligently when identifying the rectum and that the bowel had been perforated through direct diathermy contact. The case proceeded to trial.

On viewing the video, the claimant’s expert, a retired consultant gynaecologist with a special interest in diabetes in pregnancy, believed he could identify two occasions when the perforation could have occurred. The defendant’s expert, an acknowledged and practising expert in this specialist field, disputed this and considered the damage was probably caused by unpredictable heat spread from the diathermy, not by direct contact. Thermal heat spread is a recognised risk of diathermy. This view was accepted by the claimant’s expert.

The video was played to the court, and there was a great deal of discussion about technique with the rectal probe as well as the use of monopolar diathermy and heat spread.

The judge found that:

- the claimant had not established, on a balance of probabilities, that there had been a direct application of the diathermy instrument to the rectal wall
- the damage had inadvertently been caused by heat spread from the use of the instrument and, although the defendant might have expected to see the damage, this is not always visible
- there had been many uncertainties and very different opinions but the evidence of the defendant’s expert was to be preferred, based on his particular experience and expertise
- the claimant had suffered inadvertent heat damage, which was a recognised complication of the procedure.

No blame was attributed to the surgeon. While expressing his sympathy for the claimant for the complication she had suffered, he felt that having a complete recording of the procedure allowed for an objective, rather than an opinion-based, assessment.

Hilary Halfpenny
Senior claims handler
No warning of ectropion

A 54-year old woman consulted a plastic surgeon, an MDU member, seeking surgical intervention to improve the appearance of wrinkles beneath her eyes. The surgeon discussed possible alternatives, including minimally invasive methods of improving the appearance, and the patient left to consider her options further.

She arranged to see the plastic surgeon again a few months later and following further discussion opted to undergo bilateral blepharoplasty. She was warned of the risks of surgery, including anaesthetic risk, bleeding, infection, and that there would be some scars. The surgeon also advised of the risk of developing post-operative chemosis and asymmetry.

No asymmetry was evident following surgery, and everything appeared satisfactory. When the patient attended for removal of sutures a week later, it was noted that there was bilateral ectropion and chemosis. She was advised on how to manage this with conservative measures, including massage and moisturising. Arrangements were made to review her progress.

There was significant improvement at review two weeks later, but only on the left side. Unfortunately the right-sided ectropion and chemosis persisted. She was given steroid eye drops and asked to return for review in three weeks.

The appearance of the patient’s eyes did not improve, however, and therefore arrangements were made to carry out a lower eyelid release. Unfortunately, the desired improvement was not achieved. The patient sought a second opinion, and underwent corrective surgery with a different surgeon, involving a skin graft.

A claim was then brought against our member. The allegations included that the consultant had breached his duty of care by excising excessive skin, leading to tension below the right eye which caused an ectropion to develop. It was also alleged that this would have been evident immediately at the end of surgery and on post-operative review. When corrected surgically, a skin graft should have been undertaken.

Solicitors and an expert plastic surgeon were instructed, and it was noted that in the pre-operative discussions there had been no specific mention of the possibility of developing an ectropion, and that further corrective surgery had been required. It was felt that, on balance, too much tissue had been excised at the initial operation, leading to complications. While it is recognised that such complications can occur with non-negligent surgery, in this case the specific risk of developing an ectropion was not something the patient had been explicitly warned of.

Unfortunately, it was felt likely that our member would be found to be in breach of duty, and therefore a decision was made to settle this case.

Following negotiations, the claim was settled for £20,000 damages, and costs at £80,000. The costs were claimed under a conditional fee agreement, which included a 100% success fee. The MDU successfully challenged the initial costs bill of well over £100,000, reducing it by over 25%.

Dr Catherine Thompson
Senior medical claims handler
**No-scalpel vasectomy**

A 48-year old man was referred for a vasectomy to a GP, an MDU member, who was experienced in performing no-scalpel vasectomies. At the initial consultation, and with the aid of diagrams, the GP explained how he would perform the procedure, and talked through the possible complications including the risk of bleeding which, if severe, might require hospital admission. The MDU member also gave the patient an information leaflet that listed the possible complications of a vasectomy.

Two weeks later, the patient attended for the procedure, which seemed to be uncomplicated, and the patient went home, having been given advice regarding post-operative care, and an information leaflet with post-operative instructions.

Two days after the procedure, the patient was admitted to hospital with a scrotal haematoma that required drainage. The patient made a complaint to the primary care trust, who carried out a root cause analysis, with which the GP cooperated fully. The analysis raised some concerns about the standard of the doctor’s note keeping and audit, but none about his operative technique.

Eighteen months later, the GP received a letter of claim from solicitors instructed by the patient, alleging that the patient had not been properly advised about the procedure and complications. It was also alleged that the performance of the vasectomy was below an acceptable standard and that as a result the claimant had suffered a scrotal haematoma.

The GP was unable to recall the operation itself, but on the basis of his usual practice he was able to describe in detail the consent process that he would have undertaken, and how he would have carried out the vasectomy. He was also able to provide copies of the leaflets which the claimant had been given, both before the vasectomy and on discharge. Although the consent form itself did not list haematoma as a possible complication, it referred to the leaflet, which did clearly state that this was a potential complication.

The MDU obtained independent advice from a GP expert with experience in performing no-scalpel vasectomies. The expert was entirely supportive of the care afforded to the claimant and felt that he had been provided with adequate information peri-operatively. The technique used by the GP is well-recognised, and there was nothing to suggest that the vasectomy had
been performed in a substandard way. Unfortunately, the claimant had suffered a recognised complication of the operation, about which he had been warned.

The letter of claim raised concerns about the doctor’s record keeping, as had the PCT investigation, but this was of no causative consequence, since it had not contributed to the occurrence of the haematoma.

The MDU served a detailed letter of response, setting out the doctor’s standard practice in relation to the consent process and the operation itself, providing copies of the leaflets, and responding to the allegations made on the basis of the independent expert advice. It was also emphasised that the doctor had cooperated fully with the root cause analysis, and had taken steps to address the issues raised by this.

The fact that a root cause analysis had taken place did not indicate that the procedure had been performed in a substandard way. Liability was denied, and the claim was subsequently discontinued.

This case emphasises the need to keep accurate and contemporaneous records. Doctors should clearly explain the potential complications of a procedure, document these on the consent form, and if possible provide the patient with a leaflet, giving them sufficient time to read and consider this before the operation takes place.

It is also important to cooperate with investigations into complications that arise, and take steps to address issues that may be identified. This is part of efforts to improve clinical care for patients, and reflective practice, and is not necessarily indicative that care has fallen below an acceptable standard.

Dr Claire Wratten
Senior medical claims handler
Medical claim

Distal phalanx amputation

A 51-year old patient came to a walk-in centre with a history of having knocked his finger while playing cricket. He was seen by a nurse practitioner who noted a pus-filled blister on his right index distal interphalangeal joint. She noted that the patient was a diabetic. She cleaned and dressed the finger and treated him with flucloxacillin. She advised him to see his GP if the finger did not improve.

Four days later the patient saw his GP, an MDU member, who noted that he still had discharge from the lesion. The doctor advised him to continue with the antibiotic and asked his practice nurse to change the dressing on the finger, which she did. The patient returned for a further re-dressing the next day.

The day after this visit, the patient returned to the walk-in centre and was seen by the same nurse practitioner he had seen originally. It was noted that the finger was much worse, very swollen and with widespread redness and blistering.

He was referred to hospital where he was found to have osteomyelitis of the finger. Several attempts at debridement were made. However, it was found necessary to amputate the distal phalanx. The patient had a long period of recovery to regain movement in the finger.

The GP received a letter from a solicitor alleging that the care given was inadequate. It alleged that the patient should have been referred to hospital and that the practice nurse was not sufficiently trained to assess and care for such a lesion. It was further alleged that if treatment had been instituted earlier, the patient would not have needed an amputation and would have better hand function.

The MDU obtained a report from an independent GP expert who noted that the records were not very full, the GP had not referred to the fact that the patient’s diabetic control was poor and the management plan was unclear. The expert commented that there was no indication that the GP had considered that the patient may have osteomyelitis.

The MDU obtained a report from an independent nursing expert. This expert felt that the nurse had made an excellent record of a thorough and thoughtful assessment. She had recorded a full range of painless movement and made a reasonable management plan.

The MDU then asked an independent orthopaedic surgeon to give an opinion as to when the osteomyelitis started and at what stage treatment could have resulted in a better outcome. The expert advised that it is likely that the infection progressed very rapidly as a result of the patient’s poorly controlled diabetes. If the GP had referred him to hospital when he first presented, he would have avoided amputation and been left with better function in his dominant hand.

The patient’s claim was settled for £10,000 in damages.

Dr Alison Cooper  
Senior medical claims handler
Bilateral vocal cord paralysis

A 52-year old patient developed a swelling in the left side of his neck and after several months attended his GP who arranged an urgent referral. Initial fine needle aspiration and an ultrasound scan confirmed a papillary thyroid neoplasia. The patient was referred to an independent ENT consultant, an MDU member, who recommended surgery and discussed with the patient a number of serious or frequently-occurring risks.

Following the consultation he wrote to the referring doctor, recording: “I explained to [the patient] that he will require a total thyroidectomy with a central neck dissection and he was anxious for this to be done. I explained to him the risks of injury to the recurrent nerve of hoarseness and post-operative hypocalcaemia, bleeding and infection. He was happy for us to proceed to surgery.”

The operation, a central neck dissection, was performed six days later.

Post-operatively, it was noticed that the patient was hoarse and had occasional difficulty in swallowing. He had sustained a rare complication – permanent bilateral vocal cord paralysis, full on one side and partial on the other, due to recurrent laryngeal nerve injury. He subsequently brought a claim against the ENT consultant.

The claimant accepted that the operation had been carried out competently and that he had been warned about the risk of unilateral laryngeal nerve damage. However, he alleged that he should have been warned about risk of such damage occurring to both nerves, and that damage to either or both nerves could be permanent. He further alleged that he should have been advised that the procedure was not urgent.

It was the claimant’s case that if he had been properly consented he would not have gone ahead with the surgery on the date it took place but would have taken more time to gather information and seek a second opinion. He claimed that he relied heavily on his voice in his professional life and was no longer able to participate in meetings effectively due to a lack of confidence and inability to project his authority. He claimed that this affected all areas of his working life.

The claimant sought damages of almost £400,000, comprising £40,000 in general damages for pain and suffering on the grounds that the injury would have been avoided had the operation been postponed, and £338,000 compensation for the increased risk of losing his job as a result of ongoing problems with his voice and and disadvantage in the labour market if he had to look for a new one.
The MDU obtained expert evidence from an ENT surgeon. After consultation between the member, the expert and a barrister it was accepted that the patient had not been warned about bilateral laryngeal nerve damage, a risk in the region of approximately one to five cases in 10,000. The MDU argued that there was no need to consent patients in relation to such vanishingly small risks. The patient's expert did not agree and the case proceeded to trial.

Under cross examination the MDU's ENT expert argued that there was a responsible body of ENT opinion and practice which would not have warned the patient of the risk of bilateral laryngeal nerve damage or the possibility that such damage could be permanent.

By contrast, the claimant's ENT expert believed that the consultant should have explained the risk of bilateral cord palsy given that the risk, albeit rare, has significant consequences for patients. He also argued that the patient should have been advised that surgery could be delayed for at least two months without adverse consequences on his long-term prognosis, even though there was no viable alternative to the patient undergoing the surgery.

The judge accepted the MDU's case that there was no need to warn about bilateral laryngeal nerve damage since the risk of it occurring was too low. However, he also held that the claimant should have been advised that damage to the laryngeal nerves could be permanent and that not advising the patient accordingly constituted a breach of duty. The patient's case was nonetheless dismissed on the grounds that he would have proceeded with the surgery on the same date even if he had been advised about additional risks.

The judge noted that the claimant had wanted the operation to be performed as soon as possible and that there was no alternative treatment available to him. He therefore also dismissed the allegation that the consultant ENT surgeon had breached his duty of care to the patient by proceeding to surgery six days after the initial consultation or by not explicitly advising that the surgery did not need to be performed urgently. The judge remarked that it would be an unusual patient who would postpone life-saving surgery and that most patients would be eager to get on with such treatment without delay. Therefore, even if the patient had been advised about additional risks or the possibility of postponing the operation, he would still not have delayed it or sought a second opinion.

The MDU recovered over £28,000 in costs for defending the claim successfully at trial.

Joe Schmid
Claims handler
‘Sporadic’ rectal carcinoma

A 32-year old journalist brought a claim against his GP for an alleged delay in the diagnosis of rectal carcinoma.

Solicitors acting for the patient served a letter of claim, alleging that his GP, an MDU member, had failed to heed his rectal bleeding and altered bowel habit. They said there had been an 18-month delay before the correct diagnosis was made, leading to anterior resection, radio- and chemo-therapy – treatment that would have been unnecessary if the cancer had been diagnosed on first presentation. Eighteen months earlier, it was alleged, the cancer would have been a simple polyp and snare endoscopy could have excised it completely.

The MDU investigated the claim for the member, obtaining expert opinion from both a GP expert and a colorectal surgery expert.

The MDU’s GP expert was supportive of the doctor’s management. A year earlier, the claimant had experienced similar symptoms and piles had been noted on proctoscopy. Subsequently the GP had obtained a history of isolated rectal bleeding alone, no other red flag symptoms, and had reasonably considered the claimant was suffering from a recurrence of piles. The doctor disputed the fact that the claimant described altered bowel habit during the consultation. He would have specifically enquired about this, recorded it in the contemporaneous records and managed matters differently if there had been a reported alteration.

The GP expert considered that, given the patient’s young age and apparent lack of red flag symptoms, the doctor’s diagnosis was reasonable. Furthermore, the doctor had adequately safety-netted in asking the patient to return if his symptoms persisted. In the year following the consultation, the claimant had attended the surgery on a number of occasions about other health issues, but had not mentioned any persistence of rectal bleeding or other bowel symptoms. Breach of duty and liability were formally denied.

The colorectal surgery expert was asked to give an opinion on whether the claimant would have avoided complex treatment with an earlier diagnosis. The expert noted that the clinical features of the case included histology demonstrating no evidence of polyposis or features associated with microsatellite instability. The expert advised that it was most likely that the claimant’s cancer fell into the ‘sporadic’ group of colorectal tumours and would have been slow-growing in nature, developing over many years. This meant that, on the balance of probability, 18 months earlier there would still have been an established carcinoma, requiring an anterior resection. However, at this stage the patient would not have needed post-operative radiotherapy and chemotherapy.

Adult claimants have three years following the date of the alleged negligent act or knowledge thereof in which to bring a formal medical negligence claim. This deadline fell shortly after the MDU served a denial of liability and there was speculation regarding whether the claimant would go forward with the case, despite our robust denial. Ultimately, we were advised that the claim had been discontinued and the doctor was very relieved with this outcome.

Dr Lucy Baird
Senior medical claims handler
Concerns about a senior colleague

The scene
A newly qualified consultant physician started work in her new role at a trust she had not worked in before. Within a few months, she became concerned about the clinical practice of one of her senior colleagues in the department. In particular, she was worried about the standard of care that he was providing to patients and that he was using management plans now considered outdated.

The doctor called the MDU for advice. She was unsure how to tackle this problem as, despite being seriously concerned, she felt awkward in raising an issue about a senior colleague, especially when she had only just started working in the trust.

MDU advice
The MDU adviser asked the doctor if she was concerned about patient safety as a result of her colleague’s clinical practice. The doctor confirmed that she was and that in fact a patient had been admitted the previous week which, in the doctor’s opinion, was as a result of a sub-optimal treatment plan instituted by her colleague.

The safety of patients must come first at all times and in its guidance Raising and acting on concerns about patient safety (2012) the GMC states that all doctors have a duty to act when they believe that patient safety is at risk or that patient care or dignity is being compromised. This duty overrides any personal or professional loyalties.

The guidance goes on to explain that if the doctor is unable to put the matter right, then they should raise the concern with an appropriate person in their employing organisation. The doctor does not need to wait for proof and can justify raising a concern if it is done honestly, on the basis of reasonable belief and via the appropriate channels, even if the doctor is mistaken.

The adviser suggested that the doctor may wish to report her concerns to her clinical or medical director without delay and that she should be clear, open and honest about her concerns, keeping the focus on patient safety. She was advised to keep a record of the steps she had taken.

Outcome
The doctor discussed the matter with her medical director. He took the concerns seriously and thanked the doctor for raising them with him. The trust dealt with the concerns appropriately through their local procedures.

Doctors who have concerns that the clinical practice of another healthcare professional might be putting patients at risk are obliged to act upon those concerns but should be careful to do so through the proper channels and in a factual, unbiased way. As this is an area that can be fraught with difficulties, MDU members with such concerns who are unsure how to proceed are encouraged to contact us for advice to ensure that their actions in raising the concerns are not subsequently subject to criticism.

Dr Judith Clark
Medico-legal adviser
**Ethical dilemma**

**Information governance breach**

**The scene**

A GP practice sent out a survey to 500 patients by email. Very soon afterwards, a number of patients complained that the email had been sent in such a way that everyone who received it could see the email addresses of all other recipients.

The practice manager contacted the MDU for advice, having already established that the cause of the problem was a human error: the staff member concerned had forgotten to check that the email would be ‘blind copied’ to recipients. The practice had already designed a check-list, including a new requirement that future mass emails would be double-checked by a second staff member.

**MDU advice**

The adviser recommended that the practice write to all recipients of the email to apologise and explain what had gone wrong, set out what was being done to prevent similar incidents in future and provide an opportunity for people to complain. The adviser assisted with the letter and recommended further, individual responses to all who had already complained or did complain, addressing their particular concerns.

The adviser also recommended that the practice hold a significant event review to discuss and disseminate the learning from this incident and inform the Local Area Team of NHS England about what had happened.

Serious information governance breaches must also be reported to the Information Commissioner (ICO). The Health and Social Care Information Centre provides guidance, available on the ICO website, which includes a checklist for determining the seriousness of incidents according to the scale of the breach and the sensitivity of the information. All organisations processing health and adult social care personal data are required to use the Information Governance (IG) Toolkit Incident Reporting Tool to report serious incidents to the ICO, Department of Health and other regulators.

**Outcome**

The practice reported the incident and the ICO noted that a significant number of people were involved but sensitive medical information had not been disclosed. In addition, the ICO noted that the incident had resulted from human error and steps had been taken by the practice to inform and apologise to those affected, and measures put in place to try and prevent recurrence. No further action was taken by the ICO.

**Dr Catherine Wills**  
**Medico-legal adviser**
Chaperone dilemma

The scene

A male GP was carrying out morning surgery when he called in the next patient. She was a 15-year old girl attending alone. She explained she was very worried because in the shower a few days ago she thought she’d felt a breast lump. She was tearful and anxious. She had not told anybody else about this and was very worried because her maternal grandmother had died in her 60s of breast cancer.

The patient was clearly very upset but was keen to be examined there and then. The GP explained he would like to discuss the matter further with her and that if he were to proceed with a breast examination he would like to have a chaperone present.

The patient became very distressed and said she did not wish anyone else to be present and wanted the examination to take place as soon as possible. The GP asked the patient to take a seat in the nurse’s room while he took advice. He felt that as she was so upset he could not send her back into the waiting room. The GP called the MDU advice line seeking guidance on how to proceed.

MDU advice

The MDU adviser explained that GMC guidance highlights that before conducting an intimate examination a doctor should explain to the patient why the examination is necessary, and give the patient a chance to ask questions, explain what the examination will involve in a way the patient can understand so they have a clear idea of what to expect. The doctor should get the patient’s permission before the examination and record it. The guidance also states the patient should be offered a chaperone.

If dealing with a child or young person, the doctor should assess their capacity to consent to the examination and if they lack the capacity to consent the doctor should seek their parent’s authority.

The GP felt in the circumstances the patient was so distressed that she did lack capacity to consent to the examination, notwithstanding his own reluctance to carry out an unchaperoned breast examination on such a distressed young patient. In discussion with the MDU adviser, the GP concluded that the examination was not immediately necessary and could be deferred to a more appropriate time.

The MDU adviser suggested the doctor speak to the patient again and try to offer her as much reassurance as possible and explore with her whether there was an older friend or family member she could confide in and who might attend with her for a detailed consultation and examination.

Outcome

The GP contacted the MDU after the consultation to feed back that when he had spoken to the patient again he had explored with her the reasons for her anxiety. She remained upset but had settled down a little. He talked to her about the possibility of involving an adult relative or friend in a future consultation so that they could provide her with emotional support. At that point, the doctor offered to contact the patient’s mother himself to explain the patient’s concern and to ask if she would attend with the patient for a consultation and examination. This is what transpired and the patient was seen the following day with her mother when the GP was able to reassure them both that there were no suspicious findings from the history or examination.

Dr Catriona James
Medico-legal adviser
Unwise decision to self-prescribe

The scene

An F2 working in a busy surgical job at a local hospital called the MDU advice line one afternoon after she had received “a worrying letter from the GMC” that morning. She told the MDU adviser that a local pharmacist had written to the GMC expressing concerns about a prescription she had written for herself for diclofenac 25mg tds and diazepam 2mg.

The doctor explained that she had been prescribed diclofenac a few weeks before by her GP when she had had severe back pain. The pain continued but she was too busy to make a follow-up appointment. She said that she had written a private prescription on a blank piece of paper, and added the low dose benzodiazepine for short-term use as a muscle relaxant to help her cope with a long flight to Australia.

She was surprised that the pharmacist had dispensed her prescription without expressing any concern to her, but had then written to the GMC.

She sent a copy of the GMC's letter to the MDU, along with a draft of her initial thoughts on how to respond. Her medico-legal adviser explained that it is the GMC's normal practice to write to doctors’ employers to ask if they have any other concerns about the employee’s performance or conduct. Fortunately, it seemed unlikely that her employer would have other concerns.

MDU advice

The medico-legal adviser suggested that the doctor review the GMC’s prescribing guidance and discussed with her the reasons behind it. These include the difficulties of making objective decisions about one’s own health (especially with mental health problems). He also pointed out that diazepam is a Class C controlled drug under the Misuse of Drugs Act 1971, which the doctor had not appreciated. She was encouraged to do some background reading and an online course so that she could demonstrate, if necessary, that she had taken pro-active steps to update her knowledge of safe prescribing.

The GMC's core ethical guidance states that doctors should not, in general, treat themselves or people to whom they are close. Specifically, Good medical practice (2013), paragraph 16g says you must: ‘wherever possible, avoid providing medical care for yourself or anyone with whom you have a close personal relationship.’

The GMC also publishes more detailed guidance in Good Practice in Prescribing and Managing Medicines and Devices (2013).

Outcome

With the MDU's advice, the doctor reflected on what she had done and drafted a letter to the GMC. In this, she explained her reasons for self-prescribing, indicated that she now understood that it had been unwise and detailed her reflections on the matter.

The GMC closed the case with advice to follow GMC guidance in future.

Dr Philip Zack
Medico-legal adviser
NAD on cystoscopy

A consultant gynaecologist saw a 49-year old patient who had been referred with a history of dysfunctional uterine bleeding and abdominal pain thought to be due to a complex ovarian cyst. Following assessment and further investigation, the patient underwent hysterectomy and bilateral salpingo-oophorectomy. The consultant planned to perform the operation laparoscopically.

The surgery initially proceeded as expected, but the gynaecologist encountered complications when the patient started bleeding from the uterine pedicle. Further steps were taken and haemostasis was achieved. Due to the treatment required to stop the bleeding the consultant had some concerns that damage may have occurred to the patient’s ureter and therefore performed a cystoscopy. She found nothing abnormal.

The patient appeared to progress well and was discharged from hospital three days later. However, she was subsequently readmitted with abdominal pain and vomiting. On assessment she was found to have right hydronephrosis and damage to the ureter on that side. The patient was subsequently treated with a stent and then re-implantation surgery.

The patient brought a claim against the consultant alleging that it was negligent not to have detected the ureteric injury at the time of surgery.

The MDU instructed an independent gynaecology expert who advised that although it may not in itself be negligent to cause damage to the ureter during the surgery, it would be difficult to defend the claim, in view of the delay in detecting the damage and the interpretation of the cystoscopy as normal.

The MDU therefore offered to settle the claim but with no admission of liability. The claimant accepted £8,000 damages, while her costs amounted to four times that figure.

Dr Louise Smy
Senior medical claims handler

Medical claim
**Decision to refuse treatment**

**The scene**

An elderly patient with multiple co-morbidities was reluctant to engage with medical services and on two occasions had stopped taking all her medication. She had also stopped eating and drinking and refused admission to hospital, although on both occasions she resumed her medication and normal eating patterns within a few days. However, she had drafted an advance decision to refuse treatment when she first stopped taking her medication.

Her GP was concerned as the patient had now developed diabetes and was once again omitting her medication. He did not believe that she lacked capacity at present, although he had not had the opportunity to formally assess her. His concern was that she was at risk of losing consciousness and, therefore, capacity. He was aware that at that point her advance decision may apply and rang the MDU for advice as to whether he would be vulnerable to criticism if he did, or did not, treat the patient.

**MDU advice**

The medico-legal adviser discussed the situation with the doctor and explained that an adult patient with capacity has the right to consent to or refuse treatment and patients are assumed to have capacity unless it is established otherwise. However, the issue of capacity relates to the specific decision in question at the time that the decision needs to be made. Capacity can vary according to the complexity of the question and a person's capacity can vary over time. Therefore capacity should be assessed on each occasion. It would be prudent to make, and fully document, a thorough assessment of the patient's capacity relating to this specific decision. If necessary, it can also be reassuring to obtain a second opinion from a suitably-qualified colleague.

An advance decision can allow an adult patient who wishes to refuse treatment to ensure that their wishes will be respected in future when they lack capacity. An advance decision can take many forms and does not always have to be in writing. However, if the patient loses capacity, a healthcare professional is expected to ensure that not only does the advance decision exist but that it is valid and applies in the current circumstances.

If the decision is refusal of life-sustaining treatment, it must be in writing, signed and witnessed. It must state clearly that the decision applies even if life is at risk. It must also state what treatment the patient wishes to refuse. A general statement that they do not wish to be treated is insufficient. In this case, the directive did not contain these details.

Healthcare professionals are also expected to try to find out if the person has done anything that clearly goes against their advance decision, has withdrawn the decision, has subsequently created a power of attorney or would have changed their decision if they had further information about the current circumstances. It was noted that the patient had previously acted inconsistently with the directive and that it would be important to ascertain her intentions on this occasion and document them in detail.

**Outcome**

In the event, the patient resumed normal diet and medication and the advance decision was not required. However, the doctor took the opportunity to discuss with the patient that in order to ensure that her direction was valid, thus ensuring that her wishes were clear and would be followed, she may like to seek advice to ensure that it was properly drafted.

**Dr Lynne Burgess**

Medico-legal adviser
No endodontic referral

During almost 20 years' attendance at his dental practice, a 60-year old patient had received a number of treatments, including fillings and crowns. He had also received consultations for periodontal care and root canal treatment.

On one occasion, the patient attended for a crown to be fitted at UR5. The dentist did not take a radiograph, but noted a deep periodontal pocket associated with UR5, and that the tooth should have root canal treatment if problems developed.

Over the course of several further consultations, the patient continued to complain about pain in the upper right quadrant and the member planned to monitor this but no treatment was provided. A radiograph showed the UR5 had a large periapical area. However, the dentist did not record the results of the radiograph, or provide any advice or treatment at UR5.

The patient moved to another practice where the UR5 was extracted. He later rejoined the dentist’s practice.

When the patient re-attended the dentist’s practice as an emergency, a periapical radiograph was taken of the UR6 but no detail recorded. A month later the UR6 was root treated without any recording of working length or the root canal procedure and no report of the radiographs taken. The patient was referred for a crown for the UR6.

For several months afterwards, the patient complained of a permanent bad taste in his mouth and viscous saliva. It was noted that there was periapical pathology associated with the UR6 and apicectomy was advised. A radiograph showed interdental bone loss between the UR6 and UR7.

The patient sought a second opinion from another practice, complaining of swelling and pain in the upper right quadrant of his mouth. Examination revealed a discharging sinus visible between the UR6 and UR7.

The patient brought a claim against the dentist, alleging negligence in that he:

• failed to perform root canal treatment to UR5 at any stage before extraction
• failed to establish adequate contact between UR6 and UR7 when placing the crown at UR6
• took no steps to address the gap at UR5 such that UR6 was able to drift mesially, exacerbating the gap between UR6 and UR7
• failed to record adequate details of examinations and treatment.

The patient contended that but for the alleged breaches of negligence he would not have suffered the avoidable loss of the UR5. With the UR5 in place, the crown at UR6 would have maintained contact with UR7, and would not have drifted mesially. A gap would therefore not have opened up, allowing food-packing causing a continuous bad taste and leading to interdental bone loss at UR6-UR7.

The DDU expert was critical of the dentist’s management, including failure to provide appropriate and timely endodontic intervention for the UR5, which could have avoided loss of the tooth. He also criticised the dentist’s poorly documented or missing records.

The expert stated that if the UR5 had been in situ then the UR6 would have remained in position. He noted the presence of a perio-endo lesion on the UR6, possibly contributed to by a periodontal pocket on the tooth and poor plaque control, and the UL6 defective crown margins.

With the member’s agreement the claim was settled for £9,500 and costs of £19,900.

Taiye Omo-Ikerodah
Dental claims manager
A 50-year old male patient attended as an emergency complaining of pain at the LR7. The tooth had fractured. The dentist, who had been treating the patient for over five years, restored it with a mesio-occlusal amalgam filling. The tooth remained sensitive and at a routine examination a month later, a fluoride varnish was applied. A periapical radiograph of the LR7 revealed that the filling was deep and that the periodontal ligament was intact. The use of interdental brushes was recommended.

Over the course of the next year the patient returned for a replacement crown at LR6. Once this treatment had been completed he attended complaining of discomfort at LR7. On examination a buccal sinus was noted to be present. Following a course of antibiotics, root canal treatment was started at LR7.

Unfortunately, access to the LR7 was difficult and compounded by a fracture to the lingual cusp of the tooth shortly after the first stage of RCT had been completed. By the time successful working length measurements of the mesial and distal canals had been taken almost four months had passed with nine visits to the dentist.

The patient became unhappy with the length of time the treatment was taking and sought treatment elsewhere. His new dentist referred him to an oral surgeon for extraction of the LR7.

The patient instructed solicitors to pursue a claim against the first dentist for failing to perform root canal treatment of the LR7 when it had first fractured. Based on radiographic evidence, it was alleged the dentist had placed the mesio-occlusal amalgam filling into the pulp chamber. It was also alleged that once he had started RCT, he had then failed to use reasonable care and skill or consider a referral to an endodontist. It was claimed the dentist was responsible for the loss of the LR7 and its replacement by way of an implant-retained crown.

The independent expert instructed by the DDU examined the tooth together with photographs and radiographs and found that the LR7 would in fact have been amenable to root canal treatment at the time of extraction. However, given the difficulties the claimant had experienced, it may have been that he had decided to opt for extraction by then.

The expert found that while on the initial radiograph it did appear the amalgam restoration was in contact with the pulp chamber, it could not be inferred from a two-dimensional image that the filling actually contacted the nerve. He confirmed that the dentist did not cause any damage to the tooth during the initial root canal treatment, did not give up on the patient and may well have succeeded in saving the tooth in time.

The DDU expert did find, however, that the dentist had not referred or offered to refer the claimant to an endodontist at an appropriate time.

Liability for loss of the tooth was therefore formally denied, but a compromise of £1,500 compensation was offered in view of the failure to refer. Legal costs amounted to £7,000.

Samuel Hedges
Lead claims handler
After treating a female patient for 16 years, a dentist faced a claim that he had not provided the standard of treatment expected of a general dental practitioner.

The patient had been treated on the NHS since the age of 10. At 13, the dentist noted that the upper right permanent canine was only partially erupted, although by the following six-monthly consultation it had fully erupted. At that appointment, the dentist took a periapical radiograph of the upper left deciduous canine. He noted that the tooth was in place and the permanent canine was also present, just slow to erupt but requiring no treatment. The patient was by now 14 years old. The dentist asserted that he continued to monitor the situation and provided a restoration when the deciduous tooth became discoloured.

As an adult, the patient consulted an orthodontist and was told that the upper left permanent canine was ectopically positioned and extensive treatment was required. She wrote to the dentist stating that he should have recognised this when she was a teenager, when she could have received NHS orthodontic treatment.

The patient requested £8,000 for private remedial orthodontic treatment. In response, the DDU instructed an expert dentist to provide an opinion on the case. Unfortunately, the expert was not supportive of the dentist’s clinical management, specifying that the dentist should have followed up the periapical radiograph taken at age 14 with a further radiograph 6-9 months later and if a permanent tooth has not shown signs of erupting approximately six months after the contralateral tooth had erupted, then it should be investigated.

If there had been no change at the subsequent appointment it would have then been appropriate to extract the upper left deciduous canine, as research has shown the likely benefit of an interceptive extraction. If this did not result in an improvement in the position of the permanent canine, the dentist should have referred the patient for specialist advice and treatment, ideally by the age of 14½ years.

The expert further indicated that if the deciduous canine had been extracted at the appropriate time, then the upper left permanent canine might have erupted uneventfully and no further treatment would have been required.

The patient may then have had an occlusion that was normal, albeit with mild crowding, that could have been accepted or treated with fixed appliances under the NHS at that time.

The expert advised that the patient’s private orthodontic estimate was reasonable and that the treatment would now take longer than it would have taken but for the breach of duty.

After considering this report and with the member’s consent, the DDU offered the claimant £8,000, which she accepted.

Rubia Sultana-Kabiri
Claims handler
Permanent molar extraction

A dentist found himself facing a claim for compensation as a consequence of the erroneous extraction of a 6-year old patient’s tooth.

The child had been referred to the dentist’s clinic for the extraction of several deciduous teeth, some grossly carious, under general anaesthetic. Unfortunately, the dentist mistook a small permanent lower molar for the appropriate deciduous tooth. The permanent molar was reimplanted immediately and splinted to the adjacent sound deciduous teeth.

Subsequent reviews by the hospital consultant found that the molar tooth was not painful or sensitive and the gingival tissues around it all appeared healthy. The indication was that the tooth was responding well to treatment and there was no cause for concern.

In the meantime the dentist apologised to the patient and the parents, who went on to make a formal complaint to the clinic. As a DDU member, the dentist sought our assistance and the DDU dento-legal adviser helped the member to respond to the complaint.

Hospital reviews in the following months confirmed that the molar tooth remained healthy and no further active treatment was envisaged.

The child's parents nonetheless instructed solicitors to bring a claim for compensation, alleging that the error could lead to serious complications and long-term dental health problems for the patient.

The DDU instructed an independent dental expert witness to examine the child and provide an opinion on the case. The examination took place over a year after the date of the incident and found that the permanent molar did not exhibit signs of periodontal attachment loss. It was not tender to percussion or mobile. It appeared that root formation was continuing normally and, on balance, the expert agreed with the hospital consultants that the prognosis was good. However, the expert advised caution as there was little research evidence on which to base the opinion.

Eventually, they accepted that there was no immediate indication of further problems with the permanent molar, but during further negotiations it was acknowledged that, but for the error, the child and the parents would not have had the anxiety and inconvenience of multiple hospital appointments. Also, there remained some concern for the future of the permanent molar. An amicable settlement of £2,000 plus legal costs was finally reached.

Ian McLaren
Claims handler
Child in pain

The scene
A 12-year old child attended a practice in Scotland as an emergency, in pain from a lower molar. The family was new to the area and had only just registered with the dental practice. As the child’s mother had to go into hospital, a neighbour kindly offered to accompany him to the emergency appointment. She didn’t know the boy well and so couldn’t confirm his medical history. The dentist called the DDU for advice about treating the patient without a medical history.

DDU advice
The DDU adviser explained that there were several issues involved in this case:

- What is the child’s medical history?
- Is it safe to treat the child?
- Is the child fit and well enough to treat?
- Is he competent to consent to treatment?

The neighbour would not have authority to act on behalf of the parent in hospital unless the parent had formally delegated that authority, and therefore it is necessary to assess whether the child’s dental pain can be safely treated with valid consent.

Except in life-threatening circumstances, a current medical history is necessary before any medical or dental treatment can take place. The dentist could call the child’s GP and ask them to confirm if the child is taking any medication or has any condition that might preclude dental treatment in general dental practice. Ideally, the information should be confirmed by fax or email.

If the dentist cannot access the child’s GP, they could consider trying to contact one of the parents by telephone. While not ideal, a valid medical history and authority to treat a minor can be obtained by telephone from a parent who has parental responsibility, following appropriate explanations.
Once the medical history has been assessed and if the child is considered fit and well enough to undergo dental treatment, but parental authority cannot be obtained, the next question is whether the child himself can consent.

A child under 16 years of age may be able to make decisions about their own treatment and care if they are what is termed ‘Gillick competent’ – that is, they are mature enough to understand what is involved in their treatment and make a balanced judgement. In Scotland, the rights of people under the age of 16 to consent to treatment are governed by the Age of Legal Capacity (Scotland) Act 1991, section 2(4). This states that a competent person under the age of 16 can consent on their own behalf to medical treatment, providing they are capable of understanding the nature and consequences of the treatment.

If he is considered competent, then the dentist may rely on his consent and go ahead with treatment, but it may be wise to restrict the treatment to that which is immediately necessary, pending involvement of the child’s parent.

If parental consent cannot be obtained and the child is not Gillick competent then treatment immediately necessary to protect the child’s health and well-being can be provided in the patient’s best interest, although the dentist must be prepared to justify their clinical decision to treat the child if called upon to do so by the parents, the courts or the GDC.

The DDU adviser explained that as the child is in pain, the General Dental Council would expect them to act at all times in the best interests of the patient, which could include emergency dental care to relieve a child’s dental pain, if that was clinically necessary and appropriate.

The child’s condition may require a number of visits to the dentist. Should the mother’s hospital stay be prolonged and should there be nobody else with parental responsibility available, then a detailed treatment plan could be provided to the mother and the dentist could request a letter of authority from the mother to allow a responsible adult to act on her behalf when bringing the child to future appointments. This would allow definitive treatment to be offered to the child as required.

Angela Harkins
Dento-legal adviser
Missed perforation

A man in his 30s visited his dentist complaining of severe toothache and sensitivity. After examining the patient, the dentist recommended root canal treatment at UL6. An appointment was booked and when the patient attended one month later he reported that the tooth was hypersensitive. The dentist dressed the tooth and a few weeks later carried out the root canal treatment using Protaper rotary files and an apex locator. He noted that there was a mesial hook on the mesio-buccal root, and advised the patient of the poor prognosis and referred him to a specialist.

The patient attended the specialist but did not return to see the dentist again. Some years later he brought a claim against the dentist, a DDU member. He alleged the dentist had failed to use reasonable skill and care in the technical execution of root canal treatment at UL6. In particular, he alleged that the dentist had:

- failed to ensure that the rotary endodontic instruments and material were contained solely within the lumen of the root canal system
- over-excavated the floor of the pulp chamber and created a perforation in the furcation area
- failed to identify the shortcomings of the root canal treatment or to advise the patient of the perforation which was visible on the radiograph
- failed to locate the mesio-buccal and disto-buccal canals and to clean, shape and obturate the canals to a satisfactory clinical standard.

The DDU appointed a dental expert who examined the records and a report from the dentist. The expert thought it likely that a perforation had been created during treatment. He added that once it became clear that the root canals were not easily detectable, the dentist should have been alert to the heightened risk of perforation. The expert further noted that the dentist should have been aware when the perforation had taken place and should not have instrumented the perforation to avoid making it larger than necessary.

The expert was further critical that our member used an apex locator during the root canal treatment. It was our expert's opinion, based on experience, that the device will not give an accurate reading and will give an obviously erroneous reading when there is some form of perforation present. Our member should have been aware, therefore, that he had created a perforation but there was no evidence to show this.

The expert also found that the perforation in the floor of the pulp chamber in the patient's UL6 was large and beyond repair. He further found that there was an area of radiolucency indicative of infection present in the furcation area between the roots. It was the expert's opinion that the area of radiolucency related directly to the presence of the perforation and that, if the root canal treatment had been completed satisfactorily, the area of radiolucency would not have been present. The expert opined that the prognosis for the UL6 was very poor as a consequence of the perforation and that extraction was indicated.

With our member's agreement, we settled the claim for £4,400 plus legal costs.

Richard Grimmett
Lead claims handler
What’s in a name?

The scene

An unusual complaint from a patient led a general dental practice to review its computerised records system.

The patient had recently divorced and had reverted to her maiden name. She complained after she received a fee note by post, made out in her married name. The patient wrote an angry letter to say that she had already told the receptionist at her last visit about her name change. She threatened to report the practice to the Information Commissioners Office for failing to keep accurate and up to date information.

The practice principal rang the DDU advice line for assistance.

DDU advice

The DDU adviser discussed with the dentist both how to manage the patient's complaint and how the error might have arisen. As a first step, he advised that the practice should amend all the patient's records immediately and ensure the changes made to computerised records had been saved.

Addressing the patient's complaint, he advised that the practice consider offering the patient a sincere apology for the error and reassurance that the computer records had been amended to reflect her desired salutation and name.

The error may have stemmed initially from human error. As a precaution against a repeat of the mistake in future, the practice could also consider providing further staff training. The principal could then let the patient know that following receipt of her complaint, training had been provided to everyone in the practice to reinforce the importance of keeping patient information up to date.

Outcome

The practice followed the DDU advice and the patient responded to say that she was reassured that the error would not happen again to her or to other patients.

Leo Briggs
Dento-legal adviser
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-legal advice – 24 hours a day, 365 days a year.
- 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

Not just for one year, but lifelong and beyond.

*This is on an ‘occurrence basis’. This means you can ask for our assistance as long as you are (or were) our member at the time the incident happened. This applies even if you are no longer a member, have retired or stopped practising. Your estate can even ask for our help after your death.