The ethical maze
in this issue

The ethical maze
04 Maintaining boundaries
08 The dark world of the resurrection men
18 Quiz: Can you navigate the ethical maze?

Features
12 Judgement seat
   Interview with David Pearl, chair of the MPTS
14 Giant cell arteritis

Claims
20 Aortic aneurysm
23 Burning eyes
24 No attachment of the bowel
25 Raised expectations

News
17 New prescribing guidance

End piece
26 Encouraging medical innovation

Contact the MDU

UK
Advisory
Membership
0800 716 646
0800 716 376
+44 (0)20 7022 2210
membership@themdu.com
themdu.com

Ireland
Advisory
Membership
1800 535 935
1800 509 132

Write to us at
The Editor, MDUSL,
230 Blackfriars Road,
London SE1 8PJ

Or online
themdu.com/feedback

Medical editor
Dr Udvitha Nandasoma
Editor
Sarah Mouger

Have you got our app?

Corporate member of
Plain English Campaign
Committed to clearer communication

The MDU Journal is published for members of the MDU in the UK and Republic of Ireland. First published 1985.

The medico-legal advice in the MDU Journal is for general information only. Appropriate professional advice should be taken before acting or refraining from action based on it.

Opinions expressed by authors of articles published in the MDU Journal are their own and do not necessarily reflect the policies of the Medical Defence Union Limited.

The photographs used in this publication are selected from stock images, posed by models or have been specially commissioned by the MDU, unless otherwise stated.

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Services Authority in respect of insurance mediation activities only. MDUSL is an agent for the Medical Defence Union Limited (the MDU). The MDU is not an insurance company.

The benefits of membership of the MDU are all discretionary and are subject to the Memorandum and Articles of Association. All MDU professional indemnity insurance policies are issued by SCOR UK Company Limited and by International Insurance Company of Hannover Limited.

MDU Services Limited (MDUSL) is registered in England 3957086. Registered office: 230 Blackfriars Road, London SE1 8PJ © MDU Services Limited 2013 JNL201-1304
Reform is needed now

When claims severity and frequency threaten to compromise our members’ practice and patients’ access to healthcare, it is time to act. That time is now.

England and Wales have amongst the highest level of personal injury damages awards in the world. Damages inflation far exceeds other inflation measures and now runs at about 10% a year. In each of the last three years, the MDU settled several claims at over £5m and higher. Claims frequency is also rising steeply: we opened 15% more medical claims files in 2012 than 2011.

The effect on subscriptions is self-evident, but there are less obvious implications. Ultimately, we are all paying for a system which awards damages at a level that outstrips society’s ability to pay for it. Large sums of money are leaving the NHS to pay for clinical negligence claims – in 2011, £1.2bn was paid out and NHSLA total liabilities stood at £16.7bn, all funded by the tax payer. Ever-rising medical defence subscriptions, needed to meet unrealistic claims payments, are already a significant factor in the economics of private and general practice and will eventually deter doctors from entering or staying in the specialties most affected.

It is not as if we have never seen this problem before. Australia faced a medical professional indemnity crisis in 2002 which resulted in wholesale reform of the way clinical negligence claims were dealt with. In Ireland, the government introduced caps on claims against private practitioners to ensure that private practice did not become unaffordable, thus placing an excessive burden on publicly-funded healthcare. In many US states, tort reforms have been introduced, differing from state to state, in response to a claims environment which was driving doctors out of practice and preventing patients from receiving the care they needed.

What can we in the UK do? Some answers lie in the way the law requires us to compensate for the cost of long-term future care and loss of earnings. Loss of earnings awards are based on an estimate of what the patient could have expected to earn, had the negligence not prevented them from doing so. These can be very large sums. Some jurisdictions have capped loss of earnings to, for example, three times the national average salary, which might seem reasonable to most people. One way or another, everyone is paying for these awards.

Awards for long-term care costs are based on Section 2(4) of the Law Reform (Personal Injuries) Act 1948, which requires that ‘there shall be disregarded, in determining the reasonableness of any expenses, the possibility of avoiding those expenses or part of them by taking advantage of the facilities available under the National Health Service....’. This might have made sense in 1948 when the NHS was new and untested, but makes no sense now.

The practical effect of the Act is that defendants who must pay for the future healthcare and treatment of negligently damaged patients must do so on the presumption that care will be provided by the independent sector, and ignore the fact that good NHS treatment may be available. This creates a classic vicious circle. Compensation is paid for out of NHS funds, diverting resources from NHS care. For every patient whose injuries are the result of negligent care there are many more with similar injuries, not caused by negligence, and the same requirements for future care.

The current system means millions of pounds are diverted from the NHS to set up care arrangements for a tiny number of individuals at public expense. This in turn may encourage a perception that privately-funded care is superior, and also the incentive to seek access to privately-funded care through litigation. If the money currently being diverted out of the NHS was used to set up specialised NHS care units and facilities, the resources could be retained in the NHS to allow an equal or better standard of care to be delivered than through private arrangements. This does not mean that defendants should escape paying care costs in personal injury cases. Defendants should continue to meet the reasonable costs of negligently injured claimants. However, if legislation were introduced to ensure that the NHS and other public bodies could recover costs from defendants to fund public sector care packages as part of personal injury compensation awards, the money could be used by the NHS and local authorities to extend the provision of these services generally. Over time, there would be greater choice of public services available to claimants, as well as those many others who also need these services.

Changes to Section 2(4) and other tort reform measures will not be easy. Nor is it realistic to expect the NHS and other public authorities to be able to provide the necessary care immediately and consistently throughout the country. But those are not good reasons for allowing the current destructive system to continue unchecked. We need reform now.

Dr Christine Tomkins
Chief executive
Maintaining boundaries
Of all the ethical dilemmas doctors face, maintaining professional boundaries is among the most sensitive, for both patient and doctor. Medico-legal adviser, Dr Louise Dale, examines some of the issues in this area.

Instances of doctors allegedly breaching professional boundaries can be headline news and the painful consequences of an investigation can be extremely serious for a doctor, even when the allegations are proved to be unfounded.

In a recent 10-year period, the MDU opened over 700 advice files relating to medico-legal issues involving professional boundaries. Of these, 30% triggered a GMC investigation. While general practice represented just over half of the files, psychiatry, obstetrics and gynaecology, emergency medicine and general surgery also featured strongly. However, most specialties attracted at least one file relating to boundary issues in that period.

The doctor-patient relationship is almost always an intimate association where the normal boundaries of human social interaction are stretched, in terms of personal information given, with consent, and during examinations. The balance of power is more often tipped towards the doctor. Some patients are more emotionally or physically vulnerable to breaches of professional boundaries than others and, although this can be an obvious risk in some specialties, such as psychiatry, an imbalance of power can arise in any relationship between a doctor and patient.

Medical professionalism demands high standards of practice and the assiduous building of trust in the doctor-patient relationship. This dictates that the boundaries of professionalism must be respected at all times.

**Boundaries**

Although most often associated with improper emotional relationships or allegations of sexual impropriety, breaching professional boundaries can also encompass expressions of personal beliefs, financial conflicts of interest, and physical harm.

The GMC provides clear guidance on the diversity of boundary situations when a doctor might inadvertently, or deliberately, act unethically.

*Maintaining Boundaries* is specifically relevant to improper emotional relationships and sexual impropriety. In paragraph 4, the GMC says that: ‘...you must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them’.

Relationships with former patients may also be inappropriate and can lead to a GMC investigation. Such relationships may be considered inappropriate regardless of the time elapsed since the therapeutic relationship. The GMC does acknowledge that doctors may sometimes consider a sexual relationship with a former patient. In such circumstances it says that doctors must: ‘...use their professional judgement and give careful consideration to the nature and circumstances of the relationship’.

**Chaperones**

Some 40% of the files opened involved issues around the appropriate use of chaperones.

In *Maintaining Boundaries*, the GMC gives advice on intimate examinations and chaperones. It says that chaperones do not have to be medically qualified although, ideally, they should be familiar with the examination being performed and should be able to reassure the patient. If you are unsure about whether to use a chaperone, the GMC advises discussing your concerns confidentially with an impartial colleague, your medical defence organisation or the GMC itself.
Most doctors understand that there can be few, if any, situations where it can be appropriate to combine a professional and sexual relationship with a patient, and when the patient’s feelings are not reciprocated great care must be taken to respond appropriately and not to inflame the situation.

Amorous advances
Care should be taken if you become the subject of an amorous advance from a patient. Over a recent three-year period the MDU opened an average of one file every month from members who were worried about a patient's amorous attentions. Most doctors understand that there can be few, if any, situations where it can be appropriate to combine a professional and sexual relationship with a patient, and when the patient's feelings are not reciprocated great care must be taken to respond appropriately and not to inflame the situation.

The MDU generally advises the doctor to gently but unambiguously ask the patient to stop, explaining that because of the professional relationship between doctor and patient, any other type of relationship is not possible. However, if the patient persists, we advise members to keep records of the contacts and get in touch with the MDU for assistance as soon as possible.

Social media and mobile telephones
The MDU is beginning to see more complaints and disciplinary matters arising from the use of social media. Doctors are expected to behave professionally in all aspects of their lives. One of the GMC’s roles is to protect the public’s trust in the medical profession and they may investigate a doctor’s fitness to practise if a complaint is received about, for example, inappropriate language used on a social networking site, even if the comments are made in connection with a matter unrelated to their professional life.

Doctors may wish to exercise care when contacting patients using mobile phones and restrict calls to appropriate clinical matters, making a clear note of the discussion. Inappropriate use of mobile phones can lead to both disciplinary and regulatory investigation.

Allegations, suspension and the police
If a patient alleges that a doctor has behaved improperly, the doctor’s employing trust will often act swiftly, possibly to suspend the doctor immediately, while it carries out an investigation. Sometimes, the trust will inform the police who may ask to interview the doctor under caution. The GMC may also be made aware, and a full investigation into the doctor’s fitness to practise may follow. The investigations may take many months and are extremely stressful, with serious consequences for the doctor’s professional and private life. One recent study has shown that trusts are inclined to punish doctors more strictly for misconduct than for underperformance. One reason may be that it is much more difficult to demonstrate remediation in a doctor’s conduct than in underperformance. There are some specialised courses on boundary issues, such as those provided by The Clinic for Boundary Studies.

Raising and acting on concerns
All doctors have a duty to raise concerns if they believe patients’ safety or care is being compromised by the practice of colleagues, including where professional boundaries are being breached. The GMC may investigate doctors who do not act on their concerns in this regard.

Where possible, you should first raise a concern with the consultant in charge of a team, the clinical or medical director, or a post graduate dean if you are a doctor in training. If this is not possible, or you feel the responsible person or body has not taken adequate action, you may wish to report your concerns to the GMC. If you are not sure whether, or how, to raise a concern, you can ask the MDU for advice. The charity Public Concern at Work also provides free, confidential legal advice on raising concerns.
Inappropriate touch

A 40-year old female patient attended casualty complaining of shortness of breath. The A&E consultant carried out a routine chest examination before admitting the patient to a medical ward for further investigation and treatment. The following day, the consultant was suspended. He was told it was a neutral act while the trust investigated the patient’s complaint that he had inappropriately touched her breasts. The trust manager warned the doctor that the police might be informed.

The doctor vigorously denied the allegation and immediately contacted the MDU for advice. He explained to the medico-legal adviser that he had been very busy and had seen the patient alone, not having had time to find a suitable chaperone.

Within the next week, the doctor was called to a police interview under caution. An MDU-instructed solicitor accompanied him. A few weeks later, he attended a trust investigatory meeting, again supported by an MDU representative. He then received a letter from the GMC indicating that he was now under a full investigation into his fitness to practise.

The Crown Prosecution Service subsequently decided not to charge the doctor, as a family member came forward and gave evidence that the patient had in fact made similar allegations against a family friend and a dentist in the past. However, the doctor had now become unwell as a result of the stress of the suspension and the allegations, and the effect this was also having on his family.

The trust eventually closed their disciplinary investigation. The MDU continued to support the doctor through a long GMC investigation, that by now required him to undergo GMC medical examinations.

Eighteen months later, the doctor returned to work, with undertakings imposed by the GMC that included reports from his own treating GP for a further 18 months.

This is a fictional case compiled from actual cases in the MDU files.

Key points

- Keep strict boundaries with your patients.
- You must not pursue a sexual or improper relationship with a patient.
- Always offer a chaperone when carrying out an intimate examination. Be aware that some patients may consider routine touching or even being close to them (such as performing ophthalmoscopy in a darkened room) as intimate and requiring a chaperone.
- Be aware that acting unprofessionally in any aspect of your professional or personal life, such as when using social media, could result in an investigation into your fitness to practise.
- Raise concerns if you believe a patient’s safety or care is being compromised by a colleague.

This is a fictional case compiled from actual cases in the MDU files.

Reference

1. GMC, Maintaining Boundaries (2006)
2. GMC, Good Medical Practice (2009) paras 32, 33
3. GMC, Personal Beliefs and Medical Practice (2008)
4. GMC, Conflicts of Interest (2008)
5. Disciplining doctors for misconduct: character matters, but so does competence (2012)
7. www.professionalboundaries.org.uk
8. www.pcaw.co.uk
9. Doctors still top the poll as most trusted profession, RCP, 5 March 2008

Further reading

In 1820s London the dead could not always rest in peace. The growing demand from the anatomy schools for human bodies for dissection drove a shadowy but lucrative trade in illicitly exhumed corpses.

Here, the MDU Journal delves into anatomy’s murky history and examines doctors’ duties today under the Human Tissue Act.
The ‘resurrection men’ who prowled the capital’s graveyards, undertakers’ premises and even hospitals, were feared and loathed by ordinary Londoners. Only the bodies of executed murderers could be legally passed to the anatomists for dissection and the prospect of a family member meeting such a fate was horrifying.

Grieving relatives made strenuous efforts to thwart the body snatchers, employing iron coffins, locks, man-traps and even armed security guards. But the financial rewards on offer were enough to outweigh these deterrents. The price of a corpse – up to 20 guineas when demand was at its highest – could provide a handsome living for a working man and special rates could be negotiated for bodies of special interest to the anatomists.

Grave robbing required a good deal of planning. Professional resurrection men would monitor the phases of the moon for the most suitable conditions and haggle over prices with the anatomy schools before setting out for the night. A common technique, to minimise disturbance to the burial plot, was to dig down at the head-end of the coffin. The coffin lid would then be snapped open with a crowbar and the body – assuming it had not putrefied – would be pulled from the hole by rope. The corpse’s clothes and possessions were often abandoned because being caught with stolen property carried harsher penalties than taking a body.

By the 1820s, there were an estimated 50 resurrectionists working in gangs to supply the capital’s four major hospitals and 17 private anatomy schools. Many of the foremost surgeons of the day, such as Sir William Blizard and Sir Astley Cooper, were forced into uncomfortable alliances with these disreputable characters to ensure a steady supply of specimens during the ‘dissection season’ (October to April).

When, in 1823, medical students were legally obliged to obtain a certificate from one of the London schools of anatomy recognised by the Royal College of Surgeons before they could qualify, demand for bodies soared. By 1831 there were estimated to be over 900 students studying anatomy in London but only 11 bodies legally available for dissection. Respectable surgeons reviled the resurrection men but they also desperately needed their services.

It was perhaps inevitable that some would go too far to meet the demand. In 1820s Edinburgh, the murderous Burke and Hare made a criminal career out of supplying Dr Knox, a respected local surgeon, with fresh corpses for his dissection table, no questions asked. Burke’s conviction and execution in 1828 (on the evidence of his partner-in-crime) led to widespread panic about ‘burking’, which intensified after the ‘Italian boy’ case in London two years later. On this occasion, anatomists from Kings College raised the alarm when three resurrectionists attempted to sell them the body of a street urchin although it was still bleeding.

The trial, execution and dissection of two of the culprits in the Italian Boy case generated extensive press coverage and public outcry about the dissection trade but it also gave renewed impetus to efforts to regulate the work of the anatomists and address the shortage of bodies available for dissection.

The result was the 1832 Anatomy Act which made it lawful for certain parties to be in possession of corpses (for ultimate disposal to the medical schools) and established an inspectorate to visit the anatomy schools and examine paperwork. The Act was controversial for religious reasons but also, critics argued, because the poor would pay the price of medical advancements since most of the bodies would come from workhouses and hospitals, whose residents were less able to object. Others questioned whether the legislation reinforced the value attached to dissection subjects.

While it did not have an immediate impact, the Anatomy Act 1832 did eventually drive the resurrection men out of business, as well as the private anatomy schools. In their place was a system which effectively guaranteed that medical schools had access to the specimens needed for teaching and research, arguably helping to bring about significant improvements in surgical technique over the next 150 years.

Susan Field

We would like to thank the Museum of London for its excellent exhibition, Doctors, Dissection and Resurrection Men which inspired this article.

Reference

Volume 29 • Issue 1 • April 2013 • MDU Journal
Anatomy today - ruled and regulated

Consent is considered the underpinning principle of the legislation. Appropriate consent must be obtained to undertake regulated activities. Appropriate consent is defined by reference to who may give it, such as a ‘nominated representative’, who becomes a decision-maker after a person’s death. There are penalties for carrying out regulated activities without appropriate consent.

It is also unlawful to obtain any bodily material with the intention of analysing its DNA without qualifying consent, subject to certain exceptions. This offence applies to the whole of the UK.

The Human Tissue Authority (HTA)

The HTA is the regulatory body which licenses organisations that store and use human tissue for purposes such as research, patient treatment, post-mortem examination, teaching and public exhibitions. The HTA codes of practice set out expected standards for each of the sectors regulated. The codes of practice, which are available online, provide guidance to support professionals.

Scotland

Scotland has its own legislation in the form of the Human Tissue (Scotland) Act 2006, which introduced the concept of ‘authorisation’. The Act was designed to embody the principle that people can expect the wishes they express during life about what should happen to their bodies after death to be fulfilled.

Advice

- Members are advised to follow guidelines published by the relevant Health Departments as well as the codes of practice produced by the Human Tissue Authority.
- The GMC has published guidance Consent to Research which includes advice on research involving human tissue.
- Members with specific queries, for example in relation to consent and the Human Tissue Act, should contact the MDU’s telephone helpline for further advice.
The Medical Practitioners Tribunal Service (MPTS) took over the adjudication of GMC fitness to practise cases in mid-2012. His Honour Judge David Pearl, chairman of the MPTS, spoke to the MDU Journal about his vision for the new service.

Only a very small proportion of complaints and enquiries to the GMC end up at a fitness to practise (FTP) hearing. In 2011, there were just over 200 FTP cases resulting from 8781 complaints. That’s little comfort for the individual doctor facing a stressful process that often takes many months to conclude and, in the most serious cases, may result in erasure from the professional register.

David Pearl understands the distress that an FTP hearing can cause. Having overseen the establishment of the MPTS in June 2012, he is now in the process of refining its procedures, ironing out any impediments that have emerged since the service started. One of his main concerns is to reduce the length of time a doctor’s fate hangs in the balance while waiting for a decision. This is among several changes he has proposed which, at the time of writing, are being considered by the Department of Health.

The MPTS (www.mpts-uk.org) exists to manage Interim Orders Panels (IOP) and FTP hearings and its stated aim is to ensure high standards of decision-making. It is part of the GMC but operationally separate – a crucial distinction, Mr Pearl explains, especially in relation to the confidence the profession has in the service. ‘GMC FTP panels were always independent but the external perception was that the GMC was investigator, prosecutor and decision-maker. It is of immense importance that the medical profession feels that decisions taken in relation to a small number of fitness to practise cases are made by an independent body.’

A separate adjudication function was recommended following the Shipman enquiry, so that the GMC would handle only the investigation/prosecution of cases. As Mr Pearl points out, ‘The MPTS now makes the decisions about whether a doctor should continue to work without conditions when his or her fitness to practise has been called into question. We are not here to punish doctors but to make findings of fact and determine if there are risks involved in allowing a doctor to continue to work. We have a duty to protect the public, but also to uphold the reputation of the medical profession.’
Distinguished career
After a distinguished career as a barrister and teacher of law at both Cambridge and the University of East Anglia, Mr Pearl was for seven years president of the Care Standards Tribunal where he heard appeals from decisions by regulators, including the Care Quality Commission and OFSTED. The MPTS represented a new and exciting challenge, he says. ‘I was attracted by setting up the tribunal and defining how it should operate, and also by the selection and appraisal of panel members. Ultimately, I am responsible for the quality of the MPTS’s decision-making at a strategic level.

Although he doesn’t himself sit on the panels (though he often observes) Mr Pearl is involved in hands-on case management and has seen at first hand where procedures might be improved. A robust case management system is a top priority. ‘A lot of time is lost on procedural issues at the start of a hearing which delays the decision-making part of the process, to the detriment of the doctor. I believe these should be ironed out before the hearing, and any decisions taken be binding on the panel. It is one of the changes I have proposed to the GMC and the government. I hope it will be in place later this year.’

Other changes include developing the quality assurance function of the MPTS by providing better explanations for decisions and monitoring why cases are adjourned – for example, if IOP panels are being required to hear more cases than they can fit in a day.

More far-reaching improvements are on the distant horizon. They include introducing a costs regime, removing the need to appoint legal assessors in all cases, and giving the GMC a statutory right to appeal MPTS decisions it believes are wrong. ‘If this passes into legislation, I believe it will underline once and for all that the decisions on fitness to practise are made completely independently of the GMC,’ concludes Mr Pearl.

His Honour Judge
David Pearl

Born
11 August 1944

Educated
University of Birmingham (LLB)
Queens’ College, Cambridge (LLM, MA, PhD)

Called to the Bar
Gray’s Inn, 1968

Employment
Lecturer in Law, Fitzwilliam College, Cambridge
Professor and Dean of Law, University of East Anglia
Circuit judge 1994-2012

Senior judicial appointments include:
President, Immigration Appeal Tribunal
President, Care Standards Tribunal

MPTS Panels
MPTS panels hear GMC cases in which, after the investigation stage, the doctor’s fitness to practise is thought may be impaired for reasons of conduct, performance or health. After hearing evidence, the panel decides on the facts of the case whether or not fitness to practise is impaired.

Panels are made up of three members, both lay and medical. All medical panel members are licensed practitioners. A legal assessor advises the panel on the law.

Where the case involves performance issues, the judicial decision will be based on whether the doctor’s actions were reasonable in the specific circumstances of the case. The panel must give its reasons for deciding one way or the other.

If the panel imposes sanctions on a doctor’s practice, it expects the doctor to demonstrate that he or she is determined to address and put right any deficiencies that led to impaired fitness to practise. This is known as remediation.

If you have been notified of a GMC complaint against you, please contact the MDU as soon as possible.
Giant cell arteritis (GCA) can cause rapid severe visual impairment in both eyes. Permanent visual loss occurs in 20-50% of cases. Among patients who have developed visual loss in one eye, without treatment almost 90% will develop visual loss in the other eye and 25-50% will develop bilateral blindness. The period from involvement of one eye to involvement of both eyes is usually less than five days.

Incidence
GCA almost always presents after age 50 and predominantly in caucasians, particularly those of Scandinavian descent. In the UK, there are approximately 7,000 newly diagnosed cases each year.

Presentation
Patients with GCA may present not only to GPs, rheumatologists, ophthalmologists and neurologists, but to many hospital departments including A&E, general medicine, healthcare for the elderly, cardiology, vascular surgery, general surgery, gastroenterology, ENT, oral medicine and maxillofacial surgery, as well as to dentists.

Symptoms and signs
Typical non-visual symptoms of GCA include headache, which characteristically localises to the temporal region but may localise to the occipital region or to the face (leading to misdiagnosis of sinusitis), scalp tenderness, systemic malaise and weight loss. Jaw claudication is highly specific but often overlooked. About 15% of patients have a history of polymyalgia rheumatica (PMR).

Less common non-visual manifestations include fever, altered mental state, stroke, angina, myocardial infarction, pericarditis, limb claudication, abdominal pain, facial pain and/or swelling, tongue pain and/or swelling or necrosis, ear pain, cough and hoarseness.

GCA may cause transient visual loss that is usually unilateral but may affect both eyes simultaneously or, more commonly, at different times. There may also be transient or persisting double vision. Any transient visual symptoms are harbingers of permanent visual loss. About 20% of patients with visual loss due to GCA have no non-visual symptoms (‘occult GCA’).

The superficial temporal arteries may be tender, thickened, or pulseless. (GCA is associated with potentially fatal aortic aneurysm, especially affecting the thoracic aorta.)

Diagnosis
Clinical diagnosis is confirmed initially in most cases by markedly elevated erythrocyte sedimentation rate (ESR) and/or C-reactive protein (CRP), which together have greater sensitivity than either test alone. Individually they are normal in up to 15% of cases, whereas they are both normal in less than 5% of cases but both may be suppressed by steroid treatment. Anaemia, thrombocytosis, leucocytosis and elevated serum alkaline phosphatase are common in untreated GCA.

The gold standard for diagnosis of GCA remains temporal artery biopsy, which should be performed without undue delay but not necessarily within a few days of
starting systemic steroid treatment. It is important that a specimen of at least 2cm and preferably 3cm is obtained. In some cases a negative biopsy warrants a second (contralateral) biopsy.

**Treatment**

It is crucial to start systemic steroid treatment as soon as a clinical diagnosis of GCA has been made, especially when permanent or transient visual loss has already occurred. It should result in rapid resolution of headache, scalp tenderness, jaw claudication, general malaise, PMR and transient visual symptoms, followed by normalisation of ESR and CRP. Intravenous treatment should be considered, especially in patients presenting with bilateral visual symptoms or progressive visual loss despite oral treatment.

Paul Riordan-Eva, MB BChir, is a consultant ophthalmologist at King’s College Hospital, London and an MDU Council member.

### Learning points

1. The mean age at diagnosis of GCA is over 70 years, but GCA needs to be considered in any patient over 50 with new onset headache or symptoms potentially due to arterial insufficiency including sudden visual loss.
2. GCA especially needs to be considered in patients with a history of PMR and older Caucasians of Scandinavian descent.
3. Jaw pain in older patients may be a manifestation of GCA.
4. ESR and CRP are usually elevated but may be normal in GCA.
5. The most definitive diagnostic test for GCA is temporal artery biopsy.
6. Once GCA is suspected, systemic steroid treatment needs to be started urgently, or as an emergency if there are visual symptoms.
7. In the early period following initiation of steroid treatment, patients with GCA need to be regularly reviewed to ensure that treatment is adequate.

### Case studies

The following fictionalised cases, based on actual cases, highlight the pitfalls of diagnosing GCA.

1. A 62-year-old woman consulted her dentist about jaw pain on chewing that was ascribed to temporomandibular joint dysfunction. She had also consulted her GP about recent onset occipital headaches. GCA was not diagnosed until she presented to hospital with sudden loss of vision in her left eye.

2. An 85-year-old man on oral steroid treatment for PMR presented to A&E with sudden loss of vision in his right eye. He was assessed by an ophthalmologist and a neurologist who agreed a diagnosis of ischaemic optic neuropathy. There was no history of headache and ESR and CRP were normal so GCA was thought to be unlikely. Three days later on waking he was completely blind (no perception of light) in both eyes. Temporal artery biopsy was positive for GCA.

3. A 71-year-old woman with fever, general malaise and weight loss was found to have markedly elevated ESR and CRP. She denied any headache or scalp tenderness. Before temporal artery biopsy could be performed, she developed sudden loss of vision in her left eye due to central retinal artery occlusion. Once started on systemic steroids she reported rapid resolution of neck and shoulder pain that she had ascribed to her age.

### References

The MDU has introduced two new topics to its range of medico-legal seminars for hospital doctors.

**End of Life Care** examines the difficult ethical issues that can arise from caring for patients who are approaching the end of their life.

**Patient Complaints** looks at how to deal with complaints and ensure appropriate lessons are learnt.

The MDU seminars are designed to meet the medico-legal training needs of all hospital doctors, including consultants and specialty training grades. Our full menu of seminars spans a wide range of topics, from GMC Fitness to Practise to Good Record Keeping.

The presentations are delivered at your hospital or practice, at a date and time that's convenient for you. They are entirely free of charge.

To book a seminar or to find out more about what the MDU offers, please visit themdu.com/learnanddevelop or contact your local MDU liaison manager.

---

Dr Matthew Lee, director of professional services at the MDU explains a recent change to the MDU's indemnity for members treating patients with dermal fillers

From 1 April 2013, we are asking members performing treatments with dermal fillers to ensure the filler is one which has been approved for use by the US Food and Drug Administration (FDA). We expect that practitioners will use fillers which also have a CE mark (which relates to production standards, not efficacy). After that date, it is unlikely that we will provide support or representation for any matter arising from a treatment or procedure carried out involving a dermal filler which is not on the FDA list.

We have taken this step in response to reports from indemnity providers in other European countries of increasing litigation in respect of the use of filler products. The FDA approved list of fillers was selected in the absence of any UK or European regulation of the efficacy of such products.

We have written to the members affected to advise them of this change. The list of FDA approved fillers can be found on their website: http://bit.ly/approvedfillerslist. We appreciate that some of the fillers on the FDA list have slightly different brand names in the UK and confirm that we are happy for members to use the equivalent UK product where the name differs but the manufacturer and product are the same. We are happy to provide clarification on this point to any member with queries.

If members wish to continue to administer fillers which have not been approved by the FDA they are of course free to do so but they would need to review their indemnity arrangements for such work.

---

**GMC prescribing guidance**

The GMC has updated its guidance on prescribing in *Good Practice in Prescribing and Managing Medicines and Devices* (2013). The new guidance has helpful sections on shared care and recommending medicines to colleagues or prescribing those recommended by colleagues. These are common reasons for questions to the MDU advisory helpline.

You can read the full guidance at http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

---

The new, improved MDU website (themdu.com) has been designed to make it easy for you to get the most from your membership.

The website includes a number of new sections:

- **Guidance and advice** contains all our medico-legal guidance, including the MDU guides, podcasts, videos and the latest hot topics.
- **Get MDU support** is new. It offers quick, no-nonsense advice to members who need our help.
- **Learn and develop** is where you can sign up for our CPD courses. It also contains advice on revalidation and case histories from our files.
- **My membership** allows you to update your details and download membership documents. You can also take advantage of members-only discounts on books from leading medical publishers.

When you visit the site you can choose to see only information relevant to you. If you log in, we’ll automatically take care of this for you.

Please take a look at themdu.com. We’d like to hear what you think about our new website. Send your comments to feedback@themdu.com.
The following dilemmas are typical of the scenarios that confront doctors in their working lives. In each case there are two responses but only one demonstrates that the doctor has considered their legal and ethical obligations. What would you do? asks Dr Mike Roddis.

**Q** A 13-year-old patient has an aggressive brain tumour. The majority of doctors in the multi-disciplinary team treating him believe that further aggressive treatment is futile and would cause unnecessary distress and they want to begin palliative care. His parents, who have no other children, are distraught and have questioned whether the hospital is giving up on their son. What should the doctors do?

**A** The doctors know they are not obliged to provide any treatment which is not to the patient’s overall benefit. However, they recognise the distress felt by the parents and hold a further meeting with them and their son to explore their concerns. When this does not result in consensus, they consult the trust’s legal team about seeking a court order.

**B** The team reluctantly agree to the parents’ demands for a further round of chemotherapy treatment. Sadly the patient does not respond well and dies a few months later. His parents say they are grateful to the hospital for everything they have done.
A 17-year-old girl is brought to A&E after being found slumped in the street. She has been drinking heavily and has cuts and bruises but refuses to be treated or give her name and address. She is later seen to leave hospital with an older man but forgets her purse which contains an ID card. Should her details be reported to social services without her knowledge or consent?

A. The doctor in charge consults the trust’s named doctor for child protection who agrees the local authority should be told. When the patient refuses consent, the doctor explains that he is so concerned about her safety that he has to pass on the information. He tells her what is likely to happen next and gives her the details of an independent advice organisation for teenagers.

B. The doctor in charge determines the patient is at risk and contacts the local authority straight away without seeking the patient’s consent. He passes on the patient’s contact details, the reason she was admitted and the treatment she received. He does not tell the patient what he has done.

An elderly patient who has had a second stroke has been deteriorating in hospital and is now unconscious. Her husband wants everything possible to be done to keep her alive until their daughter arrives back from Australia the next day. He says mother and daughter were close and his wife had been determined not to cause her pain and has no realistic chances of success. However, they do not tell her husband that a DNACPR decision has been made because they do not want to cause him further distress.

A. Having been told of the patient’s previously expressed wishes the team agree not to record a DNACPR decision in her notes at this stage. However, they tell the patient’s husband that they need to keep the situation under review and this may change when their daughter returns. They explain that in some circumstances, it may not be clinically appropriate or to her overall benefit to attempt CPR and the doctor in charge of her care will need to make an appropriate decision if this happens.

B. The care team decides CPR would cause the patient pain and has no realistic chances of success. However, they do not tell her husband that a DNACPR decision has been made because they do not want to cause him further distress.

A 15-year-old girl is brought to A&E after being found slumped in the street. She says that her small breasts make her self-conscious and she has been teased about them by her friends and family. Her parents have offered to pay for the surgery for her 18th birthday and she wants him to increase her cup size from a B to a DD. Should the surgeon agree?

A. The surgeon is deeply reluctant to operate on such a young patient. He is also concerned she is being pressured to have treatment by others and that her expectations are unrealistic. He explains his concerns to the patient and refers her to a counsellor.

B. The surgeon decides that the patient would only go elsewhere if he refused to carry out the procedure and goes ahead after explaining the risks of damage to her breasts and other possible complications.

Dr Mike Roddis is a joint director of Healthcare Performance. With his colleague Dr Emma Sedgwick he runs the MDU’s practical workshops including sessions on medical ethics and law. For more information on courses, visit the Learn and Develop section of the MDU website, themdu.com
Over a recent 10-year period, 328 cases featuring aortic aneurysm were reported to the MDU. These included both complaints and claims.

An analysis of the main reasons for notification to the MDU shows the diversity of difficulties that a doctor may encounter when a patient becomes very ill, or dies, as a result of aneurysmal disease. In many cases, disciplinary and legal processes arose from one incident. (This is known as ‘multiple jeopardy’. An example may be a complaint, serious untoward incident and clinical negligence claim occurring concurrently.)

In most cases, the doctor contacted the MDU when they received a complaint or notification of a claim. Members also requested assistance with serious untoward incidents and the coroner’s process. Complaints from relatives, and in particular those made by relatives on behalf of a deceased patient, featured heavily in the notifications received.

![Aortic aneurysm](image-url)

**Fig 1a**

**Fig 1b**

Failure to diagnose/delay in diagnosis
- Failure to refer
- Iatrogenic
- Failure to follow up
- Unknown
- Failure to treat
- Other
- Not related to aneurysmal pathology

**Table:**

<table>
<thead>
<tr>
<th>Failure to diagnose/delay in diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to refer</td>
</tr>
<tr>
<td>Iatrogenic</td>
</tr>
<tr>
<td>Failure to follow up</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>Failure to treat</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Not related to aneurysmal pathology</td>
</tr>
</tbody>
</table>
The consequences of aneurysmal disease can be devastating for patients. A case can present to any clinician regardless of specialty or grade, as Dr Pierre Campbell, head of underwriting, found in an analysis of MDU claims and advisory files.

Specialty
The analysis of members involved in these types of cases revealed that whilst general practitioners were involved in the majority of the cases (54%) the remainder were spread across many different specialties. As can be seen in table 1, almost any clinician could be expected to report this type of case.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medical practice</td>
<td>177</td>
</tr>
<tr>
<td>Accident &amp; emergency</td>
<td>30</td>
</tr>
<tr>
<td>General medicine</td>
<td>20</td>
</tr>
<tr>
<td>General surgery</td>
<td>18</td>
</tr>
<tr>
<td>Cardiology</td>
<td>15</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>11</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>10</td>
</tr>
<tr>
<td>Radiology &amp; imaging</td>
<td>8</td>
</tr>
<tr>
<td>Orthopaedic/traumatic surgery</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>5</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>3</td>
</tr>
<tr>
<td>Neurology</td>
<td>3</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>3</td>
</tr>
<tr>
<td>Urology</td>
<td>3</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>2</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2</td>
</tr>
<tr>
<td>Cardiology (proc)</td>
<td>1</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>1</td>
</tr>
<tr>
<td>Intensive care</td>
<td>1</td>
</tr>
<tr>
<td>Maxillo-facial surgery</td>
<td>1</td>
</tr>
<tr>
<td>Nephrology</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>328</strong></td>
</tr>
</tbody>
</table>

Table 1

Reason for claim
Analysis of 85 claims arising from general and independent practice revealed a number of different reasons why they were pursued (See Fig 1b). In the majority of cases (54%) it was alleged that the clinician failed to diagnose aneurysmal disease (at all or in a timely manner). In 15% of claims, incidents relating to the iatrogenic formation of an aneurysm were reported. These usually followed vascular intervention such as angiography or angioplasty, or orthopaedic surgery.

As can be seen from table 2, the site of the aneurysm in the notified claims varied considerably and broadly reflected the anatomical sites commonly seen in practice. The majority of claims related to intracerebral aneurysms and in particular the failure to diagnose them.

<table>
<thead>
<tr>
<th>Site of Aneurysm</th>
<th>Number of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral</td>
<td>42</td>
</tr>
<tr>
<td>Abdominal Aortic</td>
<td>18</td>
</tr>
<tr>
<td>Popliteal</td>
<td>6</td>
</tr>
<tr>
<td>Thoracic Aortic</td>
<td>6</td>
</tr>
<tr>
<td>Femoral</td>
<td>5</td>
</tr>
<tr>
<td>Other Site</td>
<td>4</td>
</tr>
<tr>
<td>Site unknown</td>
<td>2</td>
</tr>
<tr>
<td>Carotid</td>
<td>1</td>
</tr>
<tr>
<td>Subclavian</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
</tr>
</tbody>
</table>

Table 2

Cost of claims
Claims involving aneurysmal disease can result in high damages awards and costs. In the 10-year period under review, the highest payment made to a claimant was in excess of £415,000 in respect of both damages and costs. It should be remembered that the level of damages paid reflects the level of injury to the patient. In cases in which there is a catastrophic injury, the damages payment may run into many millions of pounds.
Just after midnight the ST3 was asked to review a patient on the surgical ward who had developed a raised temperature. The ST3 took a history from the nurse over the phone and was satisfied with the patient’s observations. She said she would ask the F1 doctor to review the patient after theatre.

The F1 noted that the patient’s pyrexia had resolved with paracetamol. As the patient’s recorded observations were normal, he chose not to wake her.

The F1 doctor returned to the surgical assessment unit and began to assist the ST3 who was still seeing the new admissions from the previous evening. Some 15 minutes later the F1 was notified that the patient had suddenly deteriorated and suffered a cardiac arrest.

The surgical doctors rushed to the ward and attempted to revive the patient with other members of the resuscitation team. Despite their best efforts, the patient could not be resuscitated.

The death was reported to the coroner who requested statements from everyone involved. The ST3 contacted the MDU for assistance in drafting the statement.

The statement was sent to the coroner in good time and the MDU member was relieved not to be summoned to the inquest. It was subsequently reported that the patient’s cause of death was a ruptured aortic aneurysm.

This is a fictionalised account based on actual cases from the MDU files.

Manage the risk

1. As clinicians in any specialty can come across this type of case, consider re-familiarising yourself with vascular conditions if you are not up-to-date.

2. Consider aneurysmal disease in your differential diagnosis, including as a potential complication of surgery or vascular intervention.

3. If a complication does occur, advise the patient as soon as possible, in accordance with GMC guidelines.

4. Consider if an apology is appropriate. This is not an admission of liability.

5. As always, record a thorough history and clinical examination, noting both positive and negative findings. Record your discussion with the patient including the pre-intervention discussion. You should check that the patient understands the nature of any condition and procedure, and the possible complications.

6. Consider your review of patients with diagnosed vascular disease. Have safe processes in place to ensure that they are followed up or reviewed.

Normal obs, sudden death

The surgical assessment unit was exceptionally busy when the ST3, an MDU member, arrived to start her shift at 10pm. With 11 patients waiting to be seen, it was agreed that the F1 doctor would assist the senior registrar with the first of three emergency cases in theatre. The ST3 started seeing patients in the unit, at the same time as receiving calls from the wards as she was covering house officer duties as well.

Just after midnight the ST3 was asked to review a patient on the surgical ward who had developed a raised temperature. The ST3 took a history from the nurse over the phone and was satisfied with the patient’s observations. She said she would ask the F1 doctor to review the patient after theatre.

The F1 noted that the patient’s pyrexia had resolved with paracetamol. As the patient’s recorded observations were normal, he chose not to wake her.

The F1 doctor returned to the surgical assessment unit and began to assist the ST3 who was still seeing the new admissions from the previous evening. Some 15 minutes later the F1 was notified that the patient had suddenly deteriorated and suffered a cardiac arrest.

The surgical doctors rushed to the ward and attempted to revive the patient with other members of the resuscitation team. Despite their best efforts, the patient could not be resuscitated.

The death was reported to the coroner who requested statements from everyone involved. The ST3 contacted the MDU for assistance in drafting the statement.

The statement was sent to the coroner in good time and the MDU member was relieved not to be summoned to the inquest. It was subsequently reported that the patient’s cause of death was a ruptured aortic aneurysm.

This is a fictionalised account based on actual cases from the MDU files.
The hospital note sent to the GP's practice indicated a diagnosis of blepharitis. The management plan, including prescriptions, was outlined in the note.

Six months later, the GP referred the patient again because of continuing irritation in both eyes. The consultant ophthalmologist noted a history of chronic ocular irritation, which had not improved with treatment. He prescribed supportive measures, including warm compresses, along with steroid ointment to be applied twice a day to the lid margins, to be repeated 'PRN'. The prescription for the ointment was issued by the hospital.

Thereafter, the same steroid ointment was prescribed by the patient's GP practice on six occasions over a one-year period, until the patient re-presented complaining of difficulty with her vision. Her condition was confirmed by a consultant ophthalmologist as steroid-induced glaucoma. Her visual field tests showed very marked glaucomatous damage and she had lost all peripheral vision.

The patient brought a claim against the GP and, subsequently, against the hospital. The MDU asked a GP expert to advise on the GP's standard of care in addressing the patient's ophthalmic symptoms, providing appropriate referral and note-keeping. The expert found all to be of a high standard. He also advised that, in his opinion, the GP was entitled to rely on the hospital consultant's advice to prescribe the steroid ointment on a 'PRN' basis and that there was no requirement for the GP to monitor visual acuity. He noted that the prescription history suggested intermittent rather than continuous use.

The hospital's GP expert disagreed. He thought the steroid ointment was prescribed over an excessively long period and the GP should have been aware of the dangers of this. He was also critical of the instructions given to the patient as it should have been made clear that the ointment was to be used for a limited period of time.

The hospital expert did, however, state that, in his opinion, the primary cause and subsequent development of steroid-induced glaucoma was the consultant's unqualified recommendation to use the steroid ointment on a PRN basis, which may have misled the GP and allayed his reservations about issuing repeat prescriptions. Nevertheless, it was the expert's opinion that the GP had to share responsibility in the prescribing of the ointment.

A causation opinion from an ophthalmic surgeon advised that, had the claimant been reviewed at an eye clinic, raised ocular pressures would have been detected at an early stage before any damage was present. If the glaucoma had been diagnosed at that stage, the condition would have resolved by simply stopping the steroid ointment.

The member agreed that he was aware of the risks of prolonged use of steroid ointment and that he should have reviewed the patient and discontinued the medication. The case was eventually settled without an admission of liability for £125,000, of which the MDU contribution was 25%, the balance being contributed by the hospital trust.

Dr Sharmala Moodley MB BCh BAO MFFLM LRCP&SI
Deputy head of claims handling
The principal allegation was that during the repair the consultant had either stitched or attached a section of bowel and had not closed off an internal orifice in the midline from which the bowel had emerged.

The consultant’s evidence was that he had found the hernial orifice beneath the swelling at the right end of the incision, away from the midline. At operation he had noted a loop of bowel in the fat at the lateral end of the incision. The hernia could be pushed back into the abdominal cavity. He had then opened the rectus sheath toward the midline incision and made sure that the bowel was not in the way when he sutured the rectus sheath. He checked to see if there was any other hernia and did not see one. It had been relatively straightforward to close the defect.

When the consultant reviewed the patient post-operatively, the repair appeared to have been successful, with no signs of remaining hernia or infection. The patient’s bowel sounds were consistent with her long-standing constipation.

In the year following the surgery, the patient had gained weight and had to undergo lumbar disc surgery via an abdominal approach. A few months later, she suspected she might have another hernia and this was diagnosed by the consultant gynaecologist and confirmed on ultrasound. The patient asked another surgeon to undertake the hernia repair. He found bowel protruding at the midline and then turning to the right in a pocket above the right rectus muscle in the rectus sheath and adherent to a stitch previously inserted by the consultant gynaecologist.

The case went to court. The issue for the judge was whether, in suturing the rectus sheath, the consultant had stitched through a section of bowel or in some way attached the suture to the exterior surface of the bowel, or whether the bowel had later become attached to the suture.

On hearing evidence for both parties the judge found, first, that the consultant was entitled to regard the operation as being uncomplicated and one which did not need to involve a general surgeon specialising in hernia surgery. Second, the consultant’s account was credible and reliable and that he had made a transverse incision towards the midline and he did not observe a hernia near the midline. Had the midline hernia existed, he would have seen it.

The judge accepted the opinion of the expert for the consultant that it was either impossible or most unlikely that the bowel was transfixed or caught by a stitch, and therefore on the balance of probability the hernia was repaired at the initial surgery and a new hernia had developed the following year.

The claim was dismissed and the MDU recovered £96,000 in costs and disbursements.

Lynne McNamara LLB
Senior claims handler
At the initial consultation the consultant surgeon, an MDU member, outlined the surgical options available. The patient was keen to undergo liposuction of the area and the risks of the procedure were discussed including scarring, bruises, infection, bleeding, numbness, loose skin, lumpiness, pain and expectations of the results that could reasonably be achieved. In addition to the warnings given by the surgeon, the private clinic issued a leaflet detailing the risks and complications of liposuction and the patient signed a consent form, also detailing the risks.

The liposuction procedure went ahead using a tumescent technique - 1.5 litres of fluid were injected and 1.5 litres aspirated. It was estimated that 500mls of fat was removed from each thigh. Post operative recovery was uneventful and the patient was discharged.

Three months later, the patient returned to clinic and expressed her unhappiness with the outcome of the surgery. The consultant advised waiting for the area to settle and documented in the patient's notes a plan to review in one year. After two further visits to the clinic, during which the patient complained about asymmetry of her thighs and a contour defect of the right outer thigh, the surgeon agreed to carry out further liposuction, again using the tumescent technique. On this occasion 50mls of fluid was injected and 40mls aspirated with approximately 20mls of fat. The procedure and post-operative recovery were once again uneventful.

However, the patient remained unhappy with her appearance. The surgeon recommended a fat transfer using fat from the abdomen to try to correct the contour defect. He discussed the risks, including fat re-absorption, bruising, swelling, surface irregularity, bleeding and infection.

After the procedure, the fat re-absorbed and the contour defect remained. Two months later, a further fat transfer procedure was carried out, using fat from the abdomen and right buttock.

The surgeon later received notification of a claim from the patient's solicitors. Her allegations included that the surgeon had removed too much fat from the area of the right thigh and had failed to appreciate that a large volume of fat would be required for transplant.

Following exchange of expert opinion it became evident that there had been an over-correction of the fatty deposits on the right thigh and that the appearance had been accentuated by the secondary liposuction and attempts at correction using fat transfer. This was considered a sub-optimal outcome about which the experts were critical.

In light of the expert opinion, the surgeon accepted that on balance the patient should be compensated. The MDU’s legal team negotiated settlement of the claim without a formal admission of liability being made on behalf of the surgeon. Damages for pain, suffering and loss of amenity (PSLA) and associated losses were agreed at £22,000, while the claimant’s costs amounted to £19,500.

Christopher Craig LLB PGDipLit PGDipLPC DipCII
Claims team manager
On 3 December 2012 the Medical Innovation Bill was introduced into the House of Lords by Lord (Maurice) Saatchi and had its first reading. The broad intention of the Bill is to set out accepted ‘best practice in the use of medical innovation, enhancing certainty and clarity, encouraging responsible innovation and deterring unacceptable behaviour’. Lord Saatchi spoke in the media at the time the Bill was published and explained he was introducing it because he believed that fear of litigation is preventing doctors from offering innovative treatment. His Bill seeks to distinguish innovation from ‘reckless experimentation’.

The Bill raises an important point on which the MDU regularly receives requests for advice from members in all specialties, namely about the risks and medico-legal implications of using an innovative treatment or experimental drug regime. We also regularly receive queries about members’ indemnity should they wish to use cutting edge over more conventional treatment options.

Our general advice is that there should be no reason to fear the consequences providing the following apply:
- appropriate safeguards are in place
- the patient fully understands what is proposed and why the clinician considers it in the patient’s best interests, and
- the patient consents.

Doctors will, of course, need to have evidence to demonstrate that they have good reasons for departing from accepted practice in the patient’s best interests and that they have the patient’s fully informed consent. But that should not prevent doctors from pushing the boundaries.

In terms of indemnity, much of this type of work will be carried out in an NHS setting. Where this is the case, it is essential that local procedures for obtaining appropriate ethical and organisational approval are followed.

For innovation in independent practice, we are able to indemnify most types of clinical treatment within our standard subscription framework but would encourage members to notify us in advance and to confirm the indemnity position if they plan to trial or adopt new treatments in their clinical portfolio.

Although members now practise in a climate where there are increasing numbers of guidelines and expositions of ‘good practice’ by authoritative bodies, it is also recognised that there must be departure from accepted practice in order for medicine to evolve and develop. The law and ethical requirements do not present any bar to evolution. It has long been accepted that doctors can successfully defend themselves against claims or complaints if they are able to demonstrate they acted with care and had good reasons to depart from standard practice.

Lord Saatchi’s Bill suggests there are doctors who are concerned that innovation presents particular medico-legal concerns that don’t exist with standard treatments, and that this prevents them from suggesting something new to their patients. We are grateful for the opportunity to clear this up and to reassure members that is not the case. Whether doctors are proposing a conventional course of treatment or something new and experimental, the principles are the same: patients need to understand fully what is proposed, to be fully informed about the options open to them (including doing nothing) and agree to what the doctor proposes.

Encouraging medical innovation

A new Bill intended to encourage medical innovation draws attention to the need to consider the legal and ethical consequences. Dr Matthew Lee, MDU director of professional services, reassures members that this need not leave them exposed to the threat of litigation.
You can’t buy a great reputation.

But you can defend it.

Expert business support
Specialist risk assessment
Personal account management
Tailored solutions

Visit themdu.com/corporate
Email corporate@themdu.com
Call freephone 0800 716 376