Doctors at breaking point
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Medicine can never be a zero harm profession. Errors can and do happen, however careful the clinical and nursing staff. That is why the term ‘never events’ is a misnomer. But it has become an unhelpful shorthand for serious, preventable patient safety incidents that is in danger of deflecting attention from the real goal, which is continuous reduction in all patient safety incidents.

Professor Don Berwick, in his positively-received report A promise to learn, a commitment to act (August 2013), says: “While ‘zero harm’ is a bold and worthy aspiration, the scientifically correct goal is continual reduction. [...] the battle for safety is never won; rather, it is always in progress.” He goes on to say that patient needs must take priority over organisational targets and reducing costs. Otherwise, healthcare providers may ‘hit the target, but miss the point’.

Twenty five errors are classed as ‘never events’. They range from wrong site surgery to retained foreign objects. In May 2013, a BBC investigation identified 762 never events in four years, including 322 retained items, 214 incidents of wrong site surgery, 73 misplaced nasogastric feeding tubes and 58 wrong implants or prostheses.

Some incidents result in claims against the clinician responsible. In the last 10 years, the MDU has been notified of 308 claims relating to retained foreign objects alone.

While NHS trusts should investigate any incident, the penalties for an organisation when a ‘never event’ occurs can be punitive. They must report the incident following national procedures and a significant financial penalty may follow. Both the phrase, and the financial penalties, create a stigma for individuals and organisations which is not conducive to a culture that should promote reporting and learning from mistakes.

The stated intention of the never events list – to encourage greater organisational focus on specific serious safety issues – is important, but limits the scope of organisation-wide improvement in patient safety.

It is a question of focus. When all attention is on a limited number of preventable patient safety events, incidents that fall outside the categories may not receive the attention they warrant. One example is administering penicillin to a patient who is allergic to it. The consequences – anaphylactic shock and even death – of this entirely preventable error would indicate that it should be treated with the same seriousness as a never event. But it is not on the list and carries no sanctions, so may be eclipsed by those that are.

We do not dismiss the distress these errors cause to patients and their families, but the classification is meaningless to them. They do not go into hospital expecting that only a certain category of errors should never happen. They rightly anticipate that their entire experience will be safe and error-free.

When MDU members call us for advice if there has been a mistake in patient care, we advise them to ensure the patient receives a sincere apology, and an explanation of what went wrong and how it will be put right. This is every doctor’s ethical duty, and now also a contractual obligation under the duty of candour (explained in more detail on page 16).

Preventable things can and do go wrong, sometimes with severe consequences for the patient, and to the distress of the healthcare professionals involved. Professor Berwick argues for a transparent culture in the NHS where mistakes are reported and learning is shared to improve patient safety. We believe this is a far better focus, and more productive to overall patient safety, than determining whether an incident fits a never event category.

Dr Christine Tomkins
Chief executive
In hospital medicine the stakes are high, the workload demanding and the pressure unrelenting. Some doctors thrive but others burn out. Susan Field explores the causes and consequences of burnout and asks what can be done to help.
Eighty per cent of 1,000 respondents to a recent BMA survey rated the pressure they are under at work as high or very high. Their top three workplace stresses were meeting patients’ demands, lack of time and excessive bureaucracy.  

Of course, it is impossible to entirely remove the stress from medicine and many doctors flourish despite or even because of it. But surveys in the UK and the USA reveal the extent of the burnout issue. For example, in a 2012 poll of 7,288 US doctors, 45.8% reported at least one symptom, including ‘extreme emotional exhaustion’ and ‘depersonalisation’. Those in the front line of care access, such as emergency medicine, were found to be at greatest risk.  

Dr Mike Peters, head of the BMA’s support service, Doctors for Doctors, believes that it’s a growing problem in the UK too. He says: “One big factor is the fragmentation in the way care is delivered. Doctors are working different shifts so there is not the same camaraderie. At the same time, less invasive techniques and shorter hospital stays mean the turnover of beds in hospital departments is higher and there is a limited opportunity to establish a rewarding relationship with patients.”  

Then there is the sheer volume of information that doctors are expected to absorb, says Dr Sunil Raheja, a consultant psychiatrist and author of a Royal College of Psychiatrists learning module on managing stress. He observes: “It’s the nature of modern life that we are all trying to work through more tasks in the limited time available while work, family and friends compete for our attention. We rely on technology to help but it can also be a hindrance because it is difficult to focus on one thing in the huge volume of information we need to process.”  

Studies of shift workers have shown that disrupted circadian rhythms can cause health problems but it may also be true that doctors are not always the best guardians of their own health.  

In the foreword to his 2009 report into health and well-being in the NHS, Dr Steve Boorman notes a culture in which ‘highly motivated staff do not always recognise the impact of their own health needs, and where early access to care is erroneously considered to risk disadvantaging patients.’ The latest NHS sickness statistics for England show that NHS hospital doctors took an average of just 2.8 sick days in 2012-13, against a national average of 4.5 days, according to Office for National Statistics figures. Just 1.25% of hospital doctors were ill on an average day in 2012-13, the lowest rate of any staff group.
I wanted colleagues and patients to be able to depend on me so I kept up my usual routine, despite being in poor health. I thought I was heroically struggling by on one hour’s sleep and painkillers but I didn’t recognise how ill I was.

One consultant with first-hand experience of burnout recalls: “Working in a busy, under-resourced department, I wanted colleagues and patients to be able to depend on me so I kept up my usual routine, despite being in poor health. I thought I was heroically struggling by on one hour’s sleep and painkillers but I didn’t recognise how ill I was. I didn’t consult a GP because I wasn’t registered with one. I didn’t even allow myself time to recuperate following surgery so it wasn’t long before I relapsed. In short, I simply stopped thinking properly and didn’t see that I was becoming a danger to others.”

Compassion fatigue
The intense emotional engagement doctors have with their work is another important factor in susceptibility to burnout. Dr Emma Sedgwick, director of professional development at coaching specialists Healthcare Performance, estimates that burnout is a factor for 15-20% of doctors who seek her help with problems at work. She says: “Tragedies such as the death of a young patient invariably hit hard. Doctors can experience a sense of hopelessness, or even failure, when they have exhausted the treatment options for a patient. They are also often acutely conscious of the need to meet the expectations of patients, colleagues, employers and the GMC, and worry about letting others down.”

Studies have shown that burnout is particularly associated with the caring professions. The author of a 1998 US report reflected: “Medicine attracts idealists who want to help others, but as professional demands increasingly impose on their available time and energy, more is crowded into the limited work day. The support which (was) granted to physicians in the past is not at hand […] for many of the practitioners are far from their families and home towns, a great number settling in the area of their education and training. Their interactions are with patients who are in pain, sick or frightened. Rarely is a thank you proffered from a patient, practice is competitive, and the emphasis is on achievement.”

There is no doubt that admitting there is a problem can be difficult but doctors who do so can hope to recover from burnout and get back to work with appropriate practical support. For example, occupational health units can arrange phased returns to work and even make recommendations about adjustments to the working environment to support outside work, ill health, their own personality traits or a particularly traumatic adverse incident.”

End of the line
Doctors who are on the verge of burnout will, according to Dr Sedgwick, typically experience symptoms such as loss of emotional response, short-temper leading to fractured relationships at work and at home, and what she calls ‘Sunday night syndrome’, an overwhelming dread of going into work the next day. She stresses, “This is not just an off-day. Burnout is a crushing emotional and physical exhaustion which leaves you unable to cope at work and at home.”

Dr Peters reveals that those who contacted the Doctors for Doctors service experiencing burnout spoke of feeling isolated and ashamed that they are unable to cope. He adds: “It’s not uncommon for them to distance themselves from patients as a survival strategy.”

Indeed, the most disturbing consequence of burnout is that it can turn a good, caring doctor into a patient safety risk. The doctor may no longer be able to communicate effectively and sensitively with patients and may develop mental health difficulties, alcohol/substance abuse or musculo-skeletal problems, which affect their clinical judgment.

Sadly, as the consultant quoted earlier found, this can easily result in a serious untoward incident.

“A number of things went wrong simultaneously, including a bad error of judgment on my part, and a patient was harmed,” he says. “I was suspended and ultimately lost my job. Those were the worst times when everything seemed to spiral out of control. I was stressed about the way my case was being investigated, lonely because I missed the social aspects of work and felt I was failing apart.”

Surviving burnout
Burnout is a real concern because doctors with the symptoms are often unable to admit they have a problem, says Dr Sedgwick. “While some might not recognise they are ill because their judgment is impaired, others might fear letting colleagues and patients down, or that the stigma of not being able cope will follow them throughout their career.”

There is no doubt that admitting there is a problem can be difficult but doctors who do so can hope to recover from burnout and get back to work with appropriate practical support. For example, occupational health units can arrange phased returns to work and even make recommendations about adjustments to the working environment to support outside work, ill health, their own personality traits or a particularly traumatic adverse incident.”
help returning doctors. Doctors can also seek advice and support from their own GP or through services such as the Practitioners Health Programme (London and south east England) and the Doctors for Doctors 24-hour helpline. This service offers professional counselling or the opportunity to speak in confidence to a volunteer doctor adviser.

But while it is up to individuals to take the first step, it’s also incumbent on employers and colleagues to respond sympathetically and appropriately. In helping burnt-out doctors to return to safe clinical practice they can encourage others to seek help and safeguard the best interests of patients.

For Dr Mike Peters, the issue of burnout requires both an internal and external response. “It requires doctors themselves to recognise that their condition is a risk to patient safety and not be too proud to ask for help. There also needs to be a cultural change so that ‘presenteeism’ is discouraged and doctors are encouraged to seek effective support at an early stage.”

It has taken several years but the consultant has now got his career back on track at another hospital and is grateful to his new employers for giving him the opportunity and support he needed. He reflects: “Looking back, I feel I have learnt a major lesson the hard way. No one is indispensable. Taking time off when you’re not fit to work is actually the professional thing to do and means you won’t let colleagues and patients down.”

Reference

1 BMJ Careers, BMA must “act now” on stress and burnout, say doctors (25 June 2013) http://bit.ly/MDUJ01
Raising concerns is an important part of medical practice, but some doctors fear personal or professional repercussions. MDU medico-legal adviser Dr Sally Old guides members through the options for action.

Safeguarding patient safety is one of the main reasons for raising a concern in the workplace. When standards of care or behaviour fall below acceptable standards, doctors have an ethical duty to speak up. GMC guidance in Good Medical Practice (2013) emphasises that doctors ‘must take prompt action if (they) think patient safety, dignity or comfort is or may be seriously compromised’.

Niall Dickson, chief executive of the GMC, told the MDU Journal, “Doctors have a significant and wide set of responsibilities, including raising concerns. Doctors must not accept the unacceptable.”

In a recent survey of 470 MDU members, more than half of respondents thought that doctors are more willing to raise concerns nowadays than five years ago. Over 50% had raised concerns themselves, although 40% of these reported that the matter was not dealt with to their satisfaction. They were either ignored or told nothing could be done. Only 16% had encountered barriers to reporting concerns.

Raising a concern effectively, without attracting professional or personal repercussions, requires a measured approach and adherence to GMC guidance and your employer’s protocols. The MDU receives around 30 calls a week from doctors of all grades seeking help with issues of concern. We guide them through the steps towards raising their concern.

Our experience is that when doctors follow their trust policy and discuss their misgivings with colleagues, they often achieve the patient safety outcome they want. For example, an ODP confided in an anaesthetist that she believed she had seen a senior colleague acting in a sexualised manner with female patients. The anaesthetist spoke to a theatre nurse who confirmed that she had also seen the consultant behaving improperly with patients. The anaesthetist broached the subject discreetly with the consultant, who hotly denied that any such activity had ever taken place. The anaesthetist let the matter drop.

When he himself witnessed the consultant touching a female patient inappropriately, he rang the MDU for advice. The MDU adviser reminded him of his ethical duty to protect patients, explaining that the seriousness of this case required him to take action. The adviser suggested he should speak to the ODP and nurse and that they should together report their concerns to senior managers.

The team raised the concern with the trust, presenting written evidence of
specific instances, and asking the trust to investigate. The trust dealt with the matter directly with the consultant and informed the team of the outcome.

Compare this with the case of a surgical registrar who judged a colleague’s mortality rate to be too high. He reported his unfounded suspicions to the police, without involving his colleagues or employer. There was a complaint to the GMC and the registrar was judged to have brought the profession into disrepute at a fitness to practise hearing.

It’s important to distinguish between a genuine patient safety concern and a personal or professional grievance. Members often call to discuss an issue which seems to be a personal issue – for example, that they have been asked to cover an additional clinic when they are already working at capacity. On the surface, this appears to be a straightforward human resources issue. But the effect on the doctor (overwork, tiredness) could have an impact on patients, potentially compromising their safety, and therefore should be raised as a concern.

Developing an open culture
All healthcare professionals should feel able to raise concerns, but what do you do if your workplace culture discourages you from speaking up? What if your concern is ignored, or you find yourself at the heart of a bitter internal row? Niall Dickson says: “Even senior staff can feel intimidated and uncertain about raising concerns when the culture is hostile. It can be more difficult still for doctors in training, or those who have limited experience of work.”

However, he is ‘reasonably hopeful’ that openness will become the norm. “Mid Staffs was a wake-up call for the profession, and a tipping point for people leading organisations to recognise that the way things were done in the past – that is, protecting the organisation and colleagues at all costs – must be changed.”

Senior medical staff have a key role in creating a culture of openness. Not just in encouraging their teams to raise patient safety issues, but in setting an example of openness should they themselves be the subject of a concern. The GMC expects them to show insight into the concern, adds Mr Dickson.

“It is right and proper for patient safety that an investigation takes place. But being investigated locally or by the GMC is not easy. Our advice is to be straightforward, open and honest, and reflect on lessons learnt from the concern raised.”

MDU advice on raising concerns

- Before raising your concern, find out what your employer’s policy is and follow it. Most trust policies require you to raise the concern officially with them first.
- You may only speak about your concern to anyone other than your employer under specific circumstances – namely, that you have done all you can to resolve a situation but without success, patient safety is still seriously compromised and you do not breach confidentiality. Please call the MDU for advice before doing so.
- Canvassing your colleagues’ views can help verify whether your observations are justified or unfounded.
- If there really is a problem, the most powerful way of putting it right is to act as a team. It may be possible to tackle the issue in the context of a critical incident discussion within the team, in the first instance.
- If a team approach is not appropriate, or fails, the concern should be raised with the trust.
- Compile your evidence in writing and be specific, citing examples of what you have observed. Information may be anonymised if necessary.
- Focus on how patient safety is affected.
- Finally, be clear about the outcome you expect from the trust.
- The GMC advises keeping a record of the steps you have taken.

Sources of advice

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<tr>
<th>MDU advisory helpline</th>
<th>0800 716 646</th>
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<tr>
<td>GMC helpline</td>
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<td>Public Concern at Work</td>
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Further information

GMC guidance:
- Good Medical Practice (2013)
- Raising and Acting on Concerns about Patient Safety (2012)

Case studies are fictional but based on real cases from the MDU files.
The GMC closes less serious cases after initial assessment, but holds information about the doctors concerned indefinitely. The doctors involved will not usually be notified that there has been a complaint. The complaints in question are those which the GMC decides do not raise a concern about fitness to practise. The GMC does write to the doctors involved if it decides not to investigate allegations relating to something that took place more than five years ago. It must have the complainant’s consent to do so. However, it does not tell doctors about the other cases it closes after initial assessment. Looking at the GMC’s figures for 2012 alone, this would include many of the 6,240 cases that were closed at this stage.

Under current arrangements, details of these complaints are kept on file indefinitely. The GMC consulted last year on changes to its policies about how long it keeps information. Under those proposals, in future this information will be kept for four years, at which time the original record will be destroyed but the GMC will keep a summary record indefinitely.

The summary record will contain the complainant’s name, the doctor’s name, the date of the complaint, a brief description of the issue and the reason for closure. The GMC says its purpose for keeping this information is to enable it to respond to future enquiries about whether it had received specific complaints. The GMC would not normally disclose information about cases closed after initial assessment but says there may be circumstances where it would consider it appropriate, for example, in response to a public enquiry about subsequent serious concerns.

We have raised concerns with the GMC about the practice of retaining a summary record. As the complaints have not been investigated, the GMC has no way of knowing whether the allegations in the summary record are accurate. The doctor is unaware of the complaint and has not been given an opportunity to comment on the factual accuracy of the information held, or any other aspect of it.

In support of this policy, the GMC has said it is satisfied it is not breaching the data protection requirements in respect of doctors whose information it is processing in this way. Under the Data Protection Act 1998 doctors can request access to any information the GMC holds about them, including a summary record, if one exists. The GMC would also have to disclose such a complaint if it wished to use it because it was considered material to a further investigation about the same doctor. The GMC consulted on both aspects of this policy during 2012 and the majority of respondents supported it.

For the MDU’s part, we can see that seeking consent from around 6,000 complainants and then writing to around 6,000 doctors in circumstances where the complaint is not being pursued would have considerable financial and administrative implications. The GMC needs to consider the potential impact on registration fees, and the effect on individual doctors of knowing that a complaint has been made.

However, we cannot support the practice of making a summary record after four years and keeping the information indefinitely. We believe the information should be destroyed at that stage. We are bringing this to members’ attention because the information retained might be about you, and we want to make sure you know what is happening.

Dr Michael Devlin
Head of advisory services

Reference
Minor error, severe consequences

A tiny error that goes unnoticed can lead to a devastating outcome for the patient. The surprise is how expensive that error can be if a claim is made, as Dr Catherine Thompson discovered.

Former paediatrician Dr Catherine Thomson found her perceptions of clinical negligence claims turned on their head when she joined the MDU claims team. Not least, the sheer volume of claims, the large sums involved and the effect on the doctors involved. Perhaps most surprising of all was the apparent disconnect between the gravity of the clinical error and the amount of damages awarded, as the following example highlights.

A cardiologist saw a 49-year old businesswoman with suspected hypertension. He confirmed the diagnosis and before prescribing an ACE inhibitor, asked the patient if she was on any other medication. The patient said no.

What she failed to mention was that she was regularly taking over-the-counter ibuprofen to treat back pain. She had assumed the cardiologist was only asking about prescription drugs. Reassured by her negative answer, the cardiologist properly advised the patient how to take the medication and what to do if she experienced side effects. Her GP would monitor her treatment from then on, he told the patient.

A couple of weeks later, the patient fell ill with gastroenteritis but continued to take the ACE inhibitor. Forty eight hours later, she became extremely unwell and was admitted to hospital. She was found to have suffered acute renal failure from which she did not recover.

The patient sued, alleging the consultant had been negligent in not advising her to seek medical advice if she experienced severe vomiting and diarrhoea and not warning her about taking NSAIDs. A nephrologist expert confirmed that the patient had sustained irreversible kidney damage and required long-term dialysis. The claim was eventually settled for more than £600,000 compensation for pain, suffering and loss of amenity and the patient’s loss of future earnings.

Such cases typify the problems that can derail an apparently innocuous encounter with a patient and lead to a huge claim, Catherine explains. “In most cases when a doctor makes a small error of judgment, there will be no adverse outcome. But medicine is such a high stakes profession that a minor slip can have lasting consequences for both patient and doctor.”

This is something that has been brought home to Catherine since joining the MDU in 2009 after several years’ hospital practice in Kent where she was a consultant paediatrician with a special interest in epilepsy. But she was also fascinated by medico-legal work, taking a part-time master’s degree in medical law and ethics and serving on a local ethics committee. Her MDU experience has opened her eyes to the reality of claims.

She says: “Many NHS doctors have little or no involvement in the litigation process, even when the allegations are about them. Trusts usually handle it all. When I came to the MDU I had no idea of the frequency and scale of claims. Even after four years here, I am still surprised when the bills for a claim come in.”

**Damages**

Damages awards in England and Wales are some of the most expensive in the world and individual settlements of £5million or more are not unusual. General damages for pain, suffering and loss of amenity arising from the negligence can escalate when special damages, such as loss of earnings and the cost of care during the patient’s projected life span, are added. For example, in 2011 the MDU paid one of its highest ever damages of £6.5million, for a plastic surgery claim, of which just £80,000 was for the claimant’s
Dr Catherine Thompson
MDU senior medical claims handler

Injury. The remainder represented her potential loss of earnings.

The MDU has an excellent record in defending claims against members – 70% are resolved without a financial settlement. But if a claim cannot be defended and the member agrees to settle, Catherine and her colleagues negotiate with the claimant’s lawyers to determine compensation that is fair to both parties. And then there are legal costs: even for a claim that is settled for £2-3,000, the claimant’s legal fees can be as high as £50,000 or more.

The cost of settling claims goes up year by year, at a rate that far outstrips any other type of inflation. This affects the entire profession, not just the MDU. The NHS paid out more than £1bn in 2011-12, compared to £456m in 2007-8. Catherine adds: “Of course, negligently damaged patients should be compensated. But as a society we can’t go on paying ever higher compensation and legal costs. The MDU has called for a cap on future care costs and loss of earnings awards, among other changes to the civil claims system.”

**Doctors at risk**

Claims against medical members have risen sharply in the last decade. New claims notifications to the MDU increased by 20% in 2012 alone.

Catherine believes the reasons behind the increase are complex. “There is no evidence that clinical standards have slipped but maybe there is less appetite for risk than there used to be and medicine can never be a zero-risk environment. For example, in my own specialty, doctors manage complex medication that is not always licensed for use in children and this can be a particular challenge when treating neonates and very young children. Considering the numbers of patients doctors see each year, errors are actually rare and even if slight can have dreadful consequences for the patient.”

**Preventive medicine**

A vital part of the MDU’s work is to make members aware of the potential risks in everyday situations and offer preventive advice. Catherine emphasises the need for rigorous note-taking, in the interests of patient care and as evidence in the event of a claim. “Don’t rely solely on your memory,” she says. “You may have seen lots of patients in one day but the patient has only seen you, and the court usually trusts their recollection over yours. But if you make clear and contemporaneous notes it should be possible to demonstrate your management was of a reasonable standard.”

But the profession will always be vulnerable to claims, Catherine adds. “I’m sure that, like me, members experience an uncomfortable twinge of recognition when they read some of the MDU’s cautionary tales and reflect that it could easily have happened to them. The best advice I can give any doctor is to ensure they are properly indemnified. Clinical negligence is a complex area of law and certainly not something that doctors would ever want to face without the MDU’s expert support and advice.”

*This is a fictional case compiled from actual cases in the MDU files.*
Doctors have a new route for collecting patient feedback for appraisal and revalidation with the launch of iWantGreatCare.org. The free online service allows doctors and healthcare organisations to seek direct comment from patients on the care they receive. Clinicians can set up their own profile page and invite reviews from patients. Colleagues can also post feedback. iWantGreatCare provides personalised business cards, showing the doctor’s name and unique url, to hand out to patients. Each time a review is posted, the doctor receives an email alert and can respond to individual patients. Reviews can also be printed out. Malicious comments and campaigns can be detected by the site, and there is a reporting function for extreme or illegal posts.

Anaesthesia services in NHS and independent sector organisations can gain professional accreditation from the Royal College of Anaesthetists (RCoA) under a new scheme launched in June 2013. Among the benefits of the Anaesthesia Clinical Services Accreditation (ACSA) scheme, the RCoA cites support for future Commissioning for Quality and Innovation (COIN) payments, and for funding and resources bids, as well as commitment to service improvement and best practice among staff. It also says that the CQC recognises ACSA-accredited departments as low-risk.

ACSA is ‘a process of quality improvement through peer review’, says the RCoA. Initially, anaesthetic departments undertake a detailed self-assessment of their services, benchmarked against ACSA standards. This enables the department to analyse their service, define strengths and weaknesses and identify areas for improvement.

If the department not comply with the standards initially, the RCoA offers help by carrying out an on-site review and, following discussion about areas of shortfall, recommends actions for improvement. Further help is available from the RCoA’s good practice library, a collection of good practice documents and guidance gathered from organisations that are part of the scheme.

Once a department has reached full compliance with the ACSA standards, measured through on-site review, they receive the accreditation mark for four years. The cost of subscribing to the scheme is around £2,500 per year, and may be more for large or complex organisations.

The scheme has been developed by the RCoA’s Quality Management of Service Committee and the Professional Standards Directorate.

More information, including support documents and guidance for all stages of the ACSA process, is available at www.rcoa.ac.uk/acsa.

A new MDU/HMRC online tutorial explains the essentials of business tax for clinicians who are self-employed or who run their own practice. Topics covered include tax for doctors who undertake work outside their NHS responsibilities, for example medico-legal work. Separate sections explain the HMRC’s requirements when setting up, running and growing a practice. It explores personal and corporate liability, business expenses, taking on staff, PAYE and registering for VAT.

You can work through the tutorial in your own time and return to it as often as you like. There are also links to other HMRC tips and tools if you want fuller information on specific areas.

To access the tutorial visit themdu.com/learn.

Calls to the MDU membership team are answered in just 11 seconds on average, an international survey has found. Eighty-five per cent of calls receive a response within 10 seconds.

The Global Contact Centre Benchmarking study compared the MDU with call centre standards in the UK, worldwide, and in the business and financial services industries. The MDU came out well in all categories, including a member satisfaction rate of 91%.

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Members can learn from experts how to manage medico-legal risk in their everyday practice at the MDU’s CPD-accredited training courses.

Six courses have been announced for 2014 that are particularly relevant to consultants and medical training grades. All are facilitated by former medical director Dr Mike Roddis and psychiatrist Dr Emma Sedgwick of Healthcare Performance, with additional tuition from MDU medico-legal advisers.

The courses run throughout the year, but spaces usually fill very quickly so please book in good time.

**Professional challenges (5 CPD points)**
The aim of this course is to give you a fuller understanding of your professional expectations, obligations, conduct and capability. Hone your leadership skills, improve your handling of professional dilemmas, manage your time and stress levels.

**Effective patient communication skills (6 CPD points)**
Around 30% of patient complaints notified to the MDU involve poor communication. This course is designed to help you succeed in communicating effectively with your patients and building good relationships. You will experience examples of good and bad communication, and learn practical models to apply in your own practice.

**Effective colleague communication skills (6 CPD points)**
An efficient clinical team requires each member to engage and co-operate with colleagues in often challenging situations. The workshop will give you a fuller understanding of bullying in the workplace and dealing with confrontation, as well as improving your written communications in reports and complaints responses.

**Medical ethics and law (5 CPD points)**
Ethical dilemmas that arise every day – confidentiality, consent, capacity – are covered in detail. You will learn the core principles of medical ethics and law, and how to manage medico-legal risk, in this interactive workshop.

**Preparing for your first consultant role (6 CPD points)**
Designed to help doctors in training move into their first consultant post, this workshop covers essential management and clinical skills – job planning and appraisal, line management, leadership and teamwork, managing meetings and dealing with clinical incidents.

**Setting up in private practice**
For consultants planning to set up in independent practice, this covers the nuts and bolts – from accountancy, invoicing and credit control, to your medico-legal responsibilities and corporate indemnity. Practising specialists share their experience and expertise. (Please note, this is non-verifiable CPD training.)

For information and course dates, please see themdu.com/learn

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**Here’s what members say about our CPD courses**

“Challenging, interesting and informative.”

“The filming and feedback were very constructive.”

“By far the best workshop I’ve attended in years.”

“Very good experience to share worries with colleagues and gain insight on things I never thought of before.”

“Very good advice, interactive discussions.”

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**MDU clinical complaints advisers**

The MDU’s clinical complaints advisers (CCAs) provide an additional level of support for members facing investigations by their employer.

Disciplinary investigations can be stressful and it is at these times that doctors feel most vulnerable and in need of help. When MDU members are required to attend meetings with their employing or contracting body, whether this is due to a clinical incident or complaint, or a more in-depth investigation into their clinical performance, they can ask for our assistance.

MDU medico-legal advisers (MLAs) can help you respond to allegations and ensure you are being treated fairly. CCAs complement the work of medico-legal advisers by supporting and representing members at meetings. The MLA continues to maintain overall conduct of the case, and the CCA reports the outcome of the meetings to the MLA.

All CCAs are senior clinicians who have a wealth of experience in supporting and representing members. Having this facility means that representation can usually be arranged around the country, ensuring that you can rely on experienced MDU support when you need it most.

Dr Kathryn Leask
Medico-legal adviser
Doctors have an ethical duty to be open with patients and their families if something goes wrong. Now you also need to be aware of your employer’s duty of candour guidance and procedures.

Doctors are expected to play a major role in supporting their organisation’s new contractual ‘duty of candour’ to patients. Under the new NHS standard contract all NHS healthcare providers, and private providers serving NHS patients, must disclose errors in treatment that result in moderate or severe harm, or death.

Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other ‘relevant person’, within 10 days. The organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.

When services are provided under the new NHS standard contract, if a provider breaches the contractual duty of candour, the commissioning body can recover either the cost of the episode of care, or up to £10,000 if the cost is unknown, from the provider.

Dr Michael Devlin, head of advisory services at the MDU, said: “The duty of candour falls on the organisation, not on individual doctors. But doctors already have an ethical duty to comply with investigations into actual or suspected patient safety events. Doctors must be open and honest and tell patients when something has gone wrong. Their account of the incident will be crucial and they will usually be the ones who tell the patient what happened.”

Clause SC35 of the NHS contract specifies how the patient and any other relevant person should be notified of the incident. First, there is a duty to speak with the patient and this should be done by the provider’s representative/s and, if possible, the clinician responsible. The explanation must include all the known facts and an appropriate apology. The patient or relevant person should be offered a written account, and the meeting minuted for audit purposes.
The National Patient Safety Authority (NPSA) defines the three levels of harm in Seven Steps to Patient Safety as:

- **Moderate** – any patient safety incident that resulted in a moderate increase in treatment and significant but not permanent harm
- **Severe** – a patient safety incident that appears to have resulted in permanent harm
- **Death** – an incident that directly resulted in the patient’s death.

An example of a moderate incident is described as perforation of the bowel during surgery that is not picked up and results in sepsicaemia and repair surgery. A severe incident would be bowel perforation that results in a temporary colostomy and further major operations.

Service providers are expected to use these definitions to create their own guidance. The MDU advises that if your organisation does not already produce guidance on classification of patient safety incidents and investigating and reporting procedures, it will need to do so to ensure that all staff are aware when the duty of candour applies. It will also need to ensure that the guidance complies with the new duty of candour requirements.

**Ethical duty**

The GMC’s Good Medical Practice places an ethical duty on doctors to act to put matters right if a patient they are responsible for suffers harm or distress. This includes giving the patient an apology, and a full and prompt explanation, setting out what has happened and the short- and long-term effects.

“The contractual duty of candour doesn’t conflict with or restrict your ethical duty in any way,” says Dr Devlin. “The ethical duty is much wider and applies to individual doctors. In practice, this means that you will need to continue to inform patients any time something goes wrong. But you must also bear in mind your organisation’s duty of candour guidance and follow their procedures.”

**Case history**

**Uterine perforation during ablation**

A 44-year old woman was admitted to hospital for uterine endometrial ablation. Following the procedure she was transferred back to the ward but deteriorated over the next 12 hours with abdominal pain and sepsis.

Her surgeon suspected a uterine perforation and immediately spoke with the patient. He told her what he thought had happened, apologised that it had occurred, and explained that he hoped to oversew the perforation. However, he warned her that he might need to carry out an emergency hysterectomy and obtained the patient’s consent for this. The patient returned to theatre where the doctor’s diagnosis was confirmed and a hysterectomy was eventually required.

The surgeon reported the incident through the hospital’s risk management reporting procedures for patient safety incidents. As the incident had resulted in moderate harm to the patient, the hospital’s clinical governance lead and departmental manager decided that it met the threshold for the contractual duty of candour.

The hospital began a root cause analysis under its clinical governance procedures and now he had the full facts the surgeon spoke to the patient again. He described in more detail what had gone wrong, again expressing his regret at the outcome. He explained that the hospital was formally investigating the incident and would keep her updated.

The investigation found that perforation was a recognised complication of the procedure and that the patient had been informed about this before she consented to the operation. It also concluded that the surgeon had followed accepted technical practice in carrying out the ablation therapy and acted appropriately when the complication came to light. The report recommended changes to post-operative review procedures, to allow for earlier identification of perforations, and these were later put into practice by the trust. A copy of the report was sent to the patient within 10 days and she was invited to a further meeting with the trust to discuss the findings. She eventually told the trust she was happy with the way the incident had been managed and that she had no plans to make a formal complaint.

The incident was also reported to the CQC via the National Reporting and Learning System (NRLS) because it had resulted in injury to the patient.

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

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**Reference**

1. For more detail on how this arrangement works to avoid duplication of effort, see: [http://bit.ly/MDUJ07](http://bit.ly/MDUJ07)
Understanding the basis for urology claims may help surgeons manage the risk factors. Dr Vas Kavadas, MDU medico-legal adviser, analyses claims notified to the MDU in this specialty.

Urology is a broad specialty involving the management of a diverse range of pathologies affecting the organs of the urological tract. Treatment may involve a number of surgical techniques (open surgery, laparoscopic or endoscopic procedures, for example). Urological conditions may also be managed non-surgically.

During a recent 10-year period, the MDU was notified of 117 claims for compensation against urological surgeons working in the independent sector. The allegations made by claimants reveal the broad range of risk factors in this specialty, arising from both surgical and non-surgical clinical management.

Identifying those aspects of urology that may be classified as ‘high risk’ can help minimise risks in the future. It is important to note, however, that the number of clinical negligence claims received in a particular specialty does not necessarily reflect the number of complaints or patient safety incidents which may arise in that specialty.

The claims examined in this study include those that have been settled, or discontinued, and those that are still active. Some are also statute barred – that is, the claimant failed to bring the claim within the time limit imposed by the statute of limitations. The three-year period runs from either the date of the incident or the date the patient became aware that harm had resulted from clinical treatment, which may be many years after the incident.
The MDU has represented members in cases where the claimant brought their action eight, 10, 14 and even 17 years after the date of the incident. In some cases, the member had been entirely unaware of any damage to the patient at the time of the incident.

Once a claim is notified it can take many years to reach a conclusion. The MDU’s experience is that this can be a significant cause of anxiety to the clinician involved, which is why we always allocate a claims handler to each claim to support the clinician throughout the process.

Cost of claims
Analysis of the overall costs showed that individual damages awards in the specialty of urology are rising. At the same time, legal costs remain disproportionately high, sometimes outstripping the damages awarded by many thousands of pounds.

Compensation awards do not necessarily reflect the gravity of the alleged negligence, but rather the costs involved in restoring the patient to the position they would have been in had the negligence not occurred. Examples include £240,000 for a patient who experienced urinary dysfunction and retrograde ejaculation following a transurethral resection of the prostate, and £483,000 for a patient who suffered paraplegia following a lumbar laminectomy.

If, having been awarded compensation for clinical negligence, a claimant then complains to the GMC as well, the costs of defending a member’s reputation and career following a single incident mounts exponentially. In the MDU’s experience, the average legal costs incurred in defending a GMC hearing is in excess of £50,000, though this can be much higher.

Categories of claim
The majority of claims notified within the 10-year period of the study related to errors during surgery, or post-operative complications. Most operative claims arose from scrotal or groin surgery, followed by prostate surgery, then penile surgery.

A significant proportion related to alleged non-operative errors, the most common being alleged misdiagnosis of cancer. (See figure 1.) Claims arising out of surgery to the prostate related primarily to prostatectomies, both open and laparoscopic, and to endoscopic transurethral resection of the prostate. One of the cases arose out of immediately apparent damage to the rectum which occurred during the procedure, whereas the rest all concerned post-operative symptoms and complications. These invariably related to damage to surrounding structures that took place at the time of the original surgery. Many of the complications reported as part of each of these claims are recognised complications of the procedure undertaken.

Surgical procedures to the groin and scrotum which gave rise to claims include vasectomy, excision of epididymal cyst and surgery for varicocele. Settled claims arising out of these procedures again relate to post-operative complications, including haematoma leading to loss of a testicle and numbness to the scrotal skin.

Claims arising from surgery to the penis involve circumcision and penile augmentation, and occasionally dissatisfaction with cosmetic outcome. In one case there was inadvertent damage to the penile prosthesis, necessitating further surgery.

Recognised risks of particular procedures may also lead to a claim, often, though not always, as a result of poorly informed consent. In these cases, the patient alleged that they were not properly informed of the risk before consenting and would not have gone ahead with the surgery had they known the risk. Claims also arise out of allegations of misdiagnosis, although in our experience these are not settled. In the period of analysis, they ranged from a missed liver metastasis following removal of a recurrent renal tumour to an alleged delay or failure to diagnose prostatic cancer in a patient being investigated for prostatic symptoms.
Manage the risk

Consent

- The complications that give rise to claims may, in fact, be recognised risks of the procedure. Therefore, before the patient is asked to consent to the procedure the surgeon must fully explain the procedure and its risks, answering the patient’s questions and exploring their expectations, especially where the surgery may have an impact on cosmetic outcome.

- Discuss alternatives in ways that a patient can understand, avoiding medical jargon wherever possible.

- If the consent process is delegated the surgeon must ensure that the staff member seeking consent is qualified and experienced enough to understand the procedure, its risks and complications.

- If there is a time lag between consent being obtained and the procedure being carried out, it is important to ensure that the patient still consents to the procedure and it is still appropriate.

- Consent must be fully documented with a written record made of the discussions about potential risk, alternative procedures and information given.

Training and experience

- The surgeon carrying out the surgery needs to ensure that he or she is adequately trained and experienced in undertaking the procedures. This is particularly the case when circumcision surgery is carried out by doctors who are not urological consultants, or are not sufficiently skilled or experienced in laparoscopic surgery and other newer techniques.

- Ensure that good records are kept and procedures audited for both outcome and complications.

Case history

Failure to follow up

The patient, a 45-year old male, began to experience bouts of pain and swelling in his abdomen and consulted his GP complaining of colicky abdominal pain. The GP felt a urological referral was required and, at the patient's request, referred the patient privately to a consultant urologist, an MDU member.

Following examination, the patient underwent flexible cystoscopy which revealed a large, slightly congested prostate and a trabeculated bladder. The urologist diagnosed bladder outflow obstruction and started the patient on tamsulosin hydrochloride. He also carried out an ultrasound scan and advised the patient he would be contacted for review once the results were available.

The ultrasound scan showed an echogenic area in the upper pole of the right kidney which measured 3.5cm and was contained within the renal capsule. It was recommended that further diagnostic tests or discussion with the radiologists should take place.

However, the urologist failed to review the scan or to arrange for the patient to attend for review. Nor did he contact the patient's GP to advise that further action was required.

Shortly afterwards, the patient moved to a different area and registered with another GP practice.

In late 2011, five years after the initial urological consultation, the patient underwent a laparoscopic right inguinal hernia repair and returned for urological review. The examining urologist arranged an abdominal CT scan to exclude kidney stones. The scan revealed a 6cm right upper pole renal mass and 5cm mass in the right lung field. The patient underwent excision of the tumours and histology confirmed a clear cell renal cancer. Unfortunately, the patient was found to have multiple metastases and passed away as a result.

The patient's dependents brought a claim on the basis that there was a failure to act on the ultrasound scan performed in 2006. Expert urologists instructed by the MDU to investigate the claim stated that the results of the ultrasound scan should have been followed up immediately and arrangements made to ensure that the patient was seen for review. A consultant oncologist, instructed to comment on causation, was of the opinion that the mass identified on the initial ultrasound scan was the renal tumour later identified and that on further scanning this would have been diagnosed and the renal cancer treated. On the balance of probabilities, there would not have been metastatic spread and the claimant would have had a higher probability of survival.

In view of the unsupportive expert evidence, the claim was settled in the sum of £350,000 plus costs.

Lee Lewis
Senior claims handler

This is a fictional case compiled from actual cases in the MDU files.
Disclosure on social media

A photograph of an operating list posted on a social media networking site amounted to a breach of patient confidentiality.

Two surgeons who had been friends since medical school worked in trusts at opposite ends of the country. Pressures of work meant they rarely saw each other, so they kept in touch through social media networking sites.

The first doctor, an orthopaedics registrar, had been instant messaging his friend, complaining about how busy his new job was. As an example of a busy day he had had recently, he posted a photograph of his operating list on a publicly available website.

The theatre list clearly showed not only what operations he was due to perform, but also the name of the hospital, the names of the 10 patients, their dates of birth and NHS numbers, amongst other identifying details.

His friend was concerned that this confidential information was now potentially in the public domain, even though the surgeon intended the photograph to be viewed only by his friends on the website. She rang the MDU to ask whether the disclosure of these details could make the patients vulnerable to identity fraud.

MDU advice

The MDU adviser agreed with our member that it was inappropriate to post this image and that it constituted a breach of the patients’ confidentiality. It would be inappropriate even if it were intended only for the doctor’s friends. There was also the risk that it might be seen by a much wider audience.

The GMC’s guidance in Good Medical Practice (2013) states in paragraph 69: You should remember when using social media that communications intended for friends or family may become more widely available.

And its guidance on Confidentiality (2009) says in paragraph 13: Many improper disclosures are unintentional. You should not share identifiable information about patients where you can be overheard, for example, in a public place or in an internet chat forum.

Given the potential for patients to be distressed by seeing their details posted in this way, and the possibility that the disclosure could leave them vulnerable to identity theft, the other matter to be considered was whether anyone else should be notified of this breach of confidentiality.

The member was advised to contact the Caldicott Guardian of her friend’s employing hospital and notify them of the inappropriate disclosure of confidential patient details. The trust could then decide whether to take steps to contact the patients, and consider if the incident should be reported to the Information Commissioner.

Our member was reluctant to contact her friend’s employer because of the possibility that he could be disciplined for his breach of confidence. The adviser understood the member’s concern, but explained that it was her professional duty to report the matter. Paragraph 23 of Good Medical Practice (2013) advises that all doctors “must contribute to adverse incident recognition”.

Alternatively, the trust might be reassured if the doctor reported the incident himself, as this would help to demonstrate he had a degree of insight into his action.

The outcome

Our member contacted her friend and made him aware of her concerns. She asked him to take the photograph down and explained that she had been advised to notify his trust. She planned to contact the Caldicott Guardian the following day, but told him she hoped he would report the incident himself in the meantime. He did so.

Dr Sally Old
Medico-legal adviser
The patient reported increasingly troublesome heaviness and aching in both limbs. The symptoms were attributed to long-standing venous insufficiency. With a view to surgical treatment, our member advised a duplex scan to confirm the extent of the patient’s problem. They discussed likely surgical management in light of the patient’s earlier procedures and talked in-depth about general surgical risks, including potential damage to vasculature or nerves.

It was the surgeon’s routine practice to discuss scan results, her surgical recommendations and the possible complications of such surgery over the telephone with the patients. Her secretary would then follow up with a call several days later to arrange the hospital admission. The patient later suggested that he had not been telephoned in this manner but the hospital switchboard log had recorded calls to the correct number, consistent with the consultant following her usual practice.

The patient’s scan demonstrated ongoing reflux in both long saphenous veins, but no other pathology. As recommended, the patient underwent a ligation and stripping procedure on both long saphenous veins. He was formally consented earlier on the day of the surgery, when the risks and potential complications were reiterated before he signed a consent form. The surgery proceeded uneventfully and no problems were reported in the early or intermediate post-operative period.

Nine months following surgery, the patient returned to see the surgeon again, reporting electrical shock pain, preceded by numbness on the outside border of the right foot. The consultant suspected a neuropraxia (nerve bruising), which would eventually resolve. The symptoms persisted however, curtailing the patient’s recreational activities.

The patient later brought a clinical negligence claim. He alleged that he had been inadequately consented regarding the risks of the surgery, particularly nerve injury. Had he known the risks, he stated, he would have deferred surgery until his venous symptoms became more troublesome; a later procedure would not have resulted in permanent nerve injury. The patient’s treating neurologist had performed nerve conduction studies, demonstrating multiple pathology, a sural nerve abnormality and a background polyneuropathy.

The MDU obtained independent expert opinion from a surgeon and a neurologist regarding the allegations. The surgeon was supportive, stating that the member had acted throughout in accordance with a reasonable body of surgeons. The patient had understood the risk of nerve injury and proceeded on that basis. The neurologist advised that, while the claimant’s symptoms were compatible with a nerve injury, injury to the sural nerve seemed inexplicable, given the nerve’s position relative to the long saphenous vein.

The MDU subsequently served a formal letter of response, denying any breach of duty or liability and highlighting the clear inconsistency between the positioning of the operative site and the allegedly damaged nerve. The claimant withdrew his claim.

Dr Lucy Baird
Senior medical claims handler
Several months later the patient sought advice from a colorectal surgeon, an expert in this field, who agreed to try to reverse the colostomy.

The patient’s post-operative progress was satisfactory until the second day after surgery when he experienced nausea and increasing pain. The clinical staff identified that the epidural cannula had become dislodged and this was re-sited. The patient’s condition stabilised but some hours later he again complained of increasing pain; he had a cardiac arrest and following a difficult resuscitation he was returned to theatre for an exploratory procedure.

The patient was bleeding internally but despite an exhaustive search by the colorectal surgeon and his experienced specialist registrar, the source of the bleeding could not be identified. The abdomen was packed and in the early hours of the morning the patient was returned to ICU with a view to possible further surgery later that day. However, his condition did not improve sufficiently to permit further surgery and he died the following day.

The post-mortem report showed multi-organ failure, intra-abdominal haemorrhage and infarcted bowel due to band adhesions proximal to the ileostomy. The pathologist could not identify the site of the bleeding.

The patient’s widow brought a claim. The main allegation was that the surgeon had failed to divide an adhesion that was trapping the bowel at the time of decommissioning the colostomy and fashioning an ileostomy, and again when trying to identify the source of internal bleeding. Allegations were also made against the trust for failing to have sufficient experienced staff on duty. Much was made about the increasing complaint of pain and nausea on the day leading up to the cardiac arrest but it was clear from the records that the epidural catheter had come adrift, upsetting the pain control at this time.

Three medical experts agreed that to leave a loop of bowel trapped in this way would be a gross surgical error. This brought into question whether or not the ileostomy was working post-operatively. Evidence in the clinical records supported the fact that it was and, at trial, the judge concluded that the bowel could not have been trapped until and including the third post-operative day and, if at all, this would have been at the end of the second operation.

The claimant also claimed that there had been a breach of the terms of the contract with the surgeon, who treated the patient on a private basis. However, the judge considered that these allegations added nothing to the duty owed in tort. The judge said she did not doubt that the claimant gave an account of events which precisely reflected her memory of them but her recollections were at odds with those of the clinical and nursing staff and with the contemporaneous records. The claimant failed to provide sufficient evidence to support her allegations and the claim was dismissed.

Lynne McNamara
Senior claims handler
A 32-year old patient attended a consultant ophthalmologist member of the MDU regarding the possibility of undergoing laser eye surgery for myopia. His visual acuity was 6/24 unaided, improving to 6/9 in the right eye with glasses. The consultant felt that the patient would be a suitable candidate for photorefractive keratectomy (PRK). They discussed the procedure in detail and the patient decided to proceed. There were further discussions about the surgery when the patient came in for the operation three weeks later.

Post-operatively, the patient’s visual acuity deteriorated and it was noted that he had a moderate amount of haze. The consultant prescribed steroid drops. Two months later the patient indicated that his visual acuity was not acceptable. It was now 6/18 unaided improving to 6/6 with lens correction. The consultant proposed a LASIK enhancement to the right eye, which he performed a few days later. Unfortunately, the patient’s condition worsened post-operatively, resulting in his vision deteriorating to 6/24, improving to 6/7 with correction. Although this visual acuity represented an improvement on the patient’s pre-operative vision, he was unhappy with his surgical outcome.

Three years after the surgery the patient brought a claim against the ophthalmologist. He alleged that he was not adequately counselled regarding the risks of the various procedures and that he had not received sufficiently informative written material. He alleged that he had been given the impression that he would never need to wear glasses or contact lenses in the future. Had he been advised that there may be the need to wear glasses or contact lenses, he would not have undergone the first procedure.

He further alleged that the second operation was performed too soon after the first, at a time when it was not yet possible to assess the stability of the refractive outcome of the first procedure. He made a claim for the cost of the two operations, pain and suffering, loss of earnings and a modest care claim.

The MDU obtained an expert opinion from a consultant ophthalmologist. The expert pointed to the factual dispute between the MDU member and the patient about what information had been provided pre-operatively, both written materials and oral discussion. The consultant was clear that he specifically warned the patient orally that he would still need glasses at the end of the procedure.

The expert advised that the second procedure ought to have been delayed until such a time as the patient’s condition had stabilised. It was the expert’s view that the patient’s outcome may not have been materially worse as a consequence of the timing of the procedure. However, he added that a properly delayed treatment could have been more effective, improving the patient’s myopia.

The consultant, having reviewed the evidence, was concerned about the timing of the second procedure and expressed a preference that the case was settled. It was noted that the patient’s condition was now stable and unlikely to deteriorate. The MDU argued that the patient’s vision had improved as a result of the surgery. An offer was made to settle the claim in the sum of £2500 directly to the claimant, which was accepted.

Dr Sharmala Moodley
Deputy head of claims
The surgeon advised the patient of the risks associated with the procedure, including DVT, pulmonary embolism, bleeding, wound infection, acute retention of urine, bruising and a 1% risk of recurrence, and the patient signed the consent form.

At operation the patient was found to have a sliding indirect hernia. The surgeon repaired it using a mesh which was fishtailed to allow transit of the cord structures, and the sac was excised. The testicle was not mobilised from the scrotum. There was no immediate post-operative bleeding and the patient was discharged home the following morning.

By the evening the patient had developed pain in his wound. The next day he was seen by the surgeon who injected local anaesthetic into the medial part of the wound. This appeared to completely relieve the pain. The surgeon advised that if the injection failed to provide long-term relief then the wound would need to be explored to ensure that there was no nerve entrapment.

The improvement proved short-lived, the pain returned and the patient was admitted for exploration of the repair under general anaesthetic. At operation there was no evidence of nerve entrapment or haematoma. The patient was discharged home on gabapentin for the pain.

Three months later the patient returned reporting a large swelling of the scrotum. As this had subsided, he had found the testis had shrunk to half its original size. He had no further acute pain. An ultrasound scan showed an infarction of the testis due to ischaemia.

Three years later the patient instructed solicitors who issued court proceedings alleging that the surgeon had been negligent and did not exercise reasonable care in performing the surgery. It was alleged that the hernia repair had been carried out in such a way as to cause tension in the wound, which was the cause of the testicular atrophy. It was not, however, alleged that the claimant should have been warned of the less than 1% risk of testicular atrophy.

The MDU’s expert agreed that it was not a breach of duty to fail to warn of this complication when performing a primary repair as the incidence of testicular atrophy is so low. However, if the patient had had a scrotal hernia or a recurrent hernia then this would be a different matter as the incidence is higher.

The MDU expert concluded that although the cause of the post-operative pain was hard to explain, it was likely that the testicular atrophy was due to ischaemia caused either at the first operation or at the re-exploration. This is well recorded following simple hernia repairs when minimal mobilisation of the spermatic cord has been undertaken. Other causes are when a large haematoma compresses the cord or the mesh is closed too tightly around the spermatic cord as it emerges from the deep ring. This can lead to venous engorgement and strangulation of the whole cord, but it was extremely unlikely that either of these was the case here.

The expert concluded that just handling the cord, without any direct damage to the testicular artery, can lead to spasm of the artery and ischaemic atrophy. There is a very good collateral blood supply to the testis and under normal circumstances the testis should have remained viable even if the artery had gone into spasm. The expert commented that in this case the previous vasectomy may have damaged the collateral blood supply, making the testicle more prone to ischaemic damage with spasm from the testicular artery. There was no reason to believe that the member had acted in any way below the expected standard.

The MDU solicitor informed the claimant’s solicitor that the case would be fully defended and that there was no evidence of any negligence. The claimant’s solicitor was persuaded that his client’s claim would fail and proceedings were discontinued.

Dr Glynis Parker
Senior medical claims handler
A claim for clinical negligence can arise at any time, and often without warning. In our experience, around 70% of medical claims are brought within the statutory time limit from the date of the consultation or procedure which gave rise to them. But we have been notified of hundreds of claims by members in independent practice which were made more than 10 years later, and the number is even higher for GP members.

In one case, reported in the MDU Annual Report and Accounts 2012, a GP received a claim 40 years after the incident, and some 15 years after he had retired. The case concerned a mother who went into labour at 42 weeks and was admitted to her local GP-led unit. At that time, the mid-1960s, the practice was to allow labour to progress for 48 hours before transferring the mother to hospital for specialist care. The GP followed the guidelines and sent the patient to a nearby specialist obstetrics department after two days as labour had failed to progress. The specialist care unit also followed the guidelines of the time and allowed labour to continue for a further 12 hours before carrying out a caesarean section. The baby was born with severe mental impairment and poor mobility skills. In adulthood, she was unable to care for herself.

The statute of limitations requires a claim to be brought within three years of the incident or knowledge of the harm caused. In many cases, patients are themselves unaware they have a case until their condition is diagnosed or a post-operative complication becomes apparent years later. Even then, they still have three years to bring a claim. If a child is involved, the limitation period only begins when the child is 18 (16 in Scotland). But no time bar applies when the child lacks capacity. The parents in this case began their clinical negligence claim when their child was middle aged.

While the MDU has successfully defended many of these so-called ‘long-tail claims’, the shock to the doctor of receiving a solicitor’s letter after such a long time is difficult to imagine. Occasionally the MDU has been contacted by the next of kin of members who were distressed to receive a claim after the doctor had died.

The possibility of allegations being made about your practice after such a long time highlights the necessity of retaining your clinical records for as long as possible. It also shows why it is essential for doctors to check their indemnity position to ensure they will not be exposed if a belated letter of claim arrives.

If you were an MDU member at the time of an incident, even if it was many years ago and you have since retired, you have the reassurance of knowing you can seek our assistance with claims arising from incidents which occurred during your membership. This also applies to your next of kin if a claim is made against your estate.

Bear in mind that doctors who purchase claims-made insurance alone are covered only for claims notified when the policy is in force. If they want to leave the provider before retirement, they will need to buy additional ‘run off’ cover for any future claims that arise from incidents that occurred during your policy period.

Even where a claims-made provider offers extended reporting benefits post-retirement, these are likely to be limited by time and amount.

Reference
You can’t buy a great reputation.

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