Volume 1 | Issue 1 | **July 2022**

Medical Protection

Case in Point

A medicolegal journal, featuring topical news, thought-provoking articles, and a selection of case studies written specifically for consultants working in private practice.

Medical Protection

Private Practice: making the move with confidence

Advice and protection from the experts

Thinking about the next steps in your career? Before you make the move into private practice there are lots of things you need to consider, but don't let that put you off.

You've got the medical experience you need, but the business side of things may be new to you.

We understand the challenges you face and want you to feel confident moving into a new field. We have partnered with Sandisson Easson to bring you a set of online guides that will help support you through your career.

Content covered includes:

- starting private practice
- running a business
- the tax system explained.

Find them at
medicalprotection.org/starting-private-practice

Welcome

Dr Rob **Hendry**
Editor-in-Chief

Welcome to *Case in Point*,

Here at Medical Protection, we know just how important it is to have protection that's tailored to the work you do as a consultant in private practice.

It's not just about supporting you when things go wrong, it's about protecting your career, finances, and reputation from the get-go.

Our team of experts are here to support you at every stage of your career, and they are here to help with any legal and ethical problems you may face, while also helping to provide assistance when it comes to claims, complaints, and much more.

Benefits of membership don't just stop at your career. We offer a full wellbeing service, including confidential counselling to help you through any stressful times. And unlike some other providers, you, your family, and your estate have the right to request indemnity for future claims arising from any year during which you were a Medical Protection member.

This edition of *Case in Point* includes a range of articles on topics that are relevant to your work in private practice and shares some real-life case studies based on the experiences of members.

I hope you enjoy reading it and seeing for yourself how we can help members, and support and protect them in a range of different circumstances and stages of their career.

Yours sincerely

Rob Hendry
Medical Director
Medical Protection

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A look at how we're doing

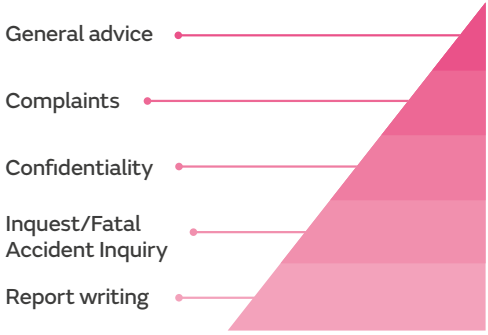
The stats speak for themselves

When it comes to the benefits of membership and how we protect members from day one, the statistics and numbers speak for themselves.

Members are at the heart of everything we do, and the data does the talking when it comes to the way Medical Protection supports members through claims, cases, investigations, and more.

The NHS offers indemnity - but this doesn't protect you in every circumstance and not for work carried out in private practice. We'll always be there for our members when they need us.

Top five reasons members contacted us in 2021



We successfully defended

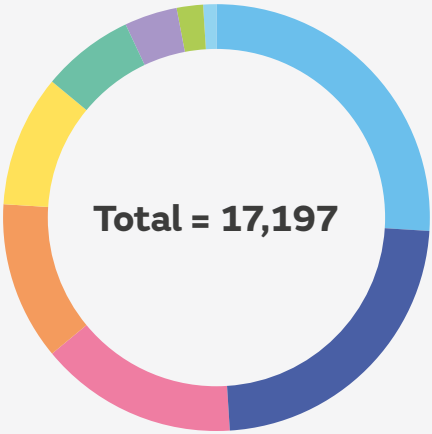
88%

of medical claims and pre-claims matters in 2021[2,3]

With the world's largest medicolegal team and the greatest reserves of any defence organisation, we protect the finances and reputations of over 300,000 members worldwide.

New cases we opened on behalf of medical members across the world in 2021[1].

Medical case types	%
General medicolegal advice	27%
Complaints	23%
Reports of adverse incidents	15%
Inquests	12%
Claims and related matters	10%
Regulatory	7%
Other	4%
Disciplinary	2%
Criminal	<1%



1. New cases opened in 2021 breakdown by case type; figures as at 31 December 2021
2. Includes claims determined in 2021 with no indemnity paid, plus pre-claims and incident likely cases closed in the year (ie that did not progress to a claim)
3. An improvement on 2020 figure: 84.8%
4. MPS in-house legal services survey results UK and Ireland

Here's what members think

We've been supporting doctors for over 130 years and we're proud of the protection we provide, but don't just take our word for it.

> **Excellent support & communication wrapped up in human kindness**

> **Thank you for always being there when I have needed you**

We routinely survey members to see how they feel about their Medical Protection membership and to gather feedback about the services and support we offer. We use this feedback to consider how we can continue to improve our services. Here's a snapshot of what members have to say.

Our Brand Score

Statement	2020	2021	YoY
Medical Protection...			
Is a provider I trust	95%	97%	↑ 2%
Is financially secure	90%	95%	↑ 5%
Has legal and support teams on hand that have an extensive medical/dental background	93%	95%	↑ 2%
Offers a high level of expertise that will protect and reassure me	93%	96%	↑ 3%

One of the things that sets Medical Protection apart is the quality of the advice we provide to members. Satisfaction from members in relation to our in-house legal team looks like this[4]:

2021 Feedback

100%	100%	100%	100%	100%	99%	96%
2020: 95%	2020: 95%	2020: 94%	2020: 95%	2020: 96%	2020: 94%	2020: 88%
Overall satisfaction with professional support and advice	Ability to listen and understand the issues	Quality of advice given	Clarity of advice	Tone/politeness and empathy when dealing with your issue	Keeping you informed and updated	Ease of communication

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Reducing the risks that come with remote handovers

Communication between clinicians during a patient handover is a known point of medicolegal risk. ***Dr Sarah Coope****, Senior Medical Educator at Medical Protection, looks at how gaps in information, misunderstandings, and assumptions can increase the risk of errors, conflict, and complaints.*

While we can't have complete control over our patients' illness and disease progression, or the way they respond to interventions, we can take active steps to ensure there is safe continuity of care for the patient at the point of handover, and reduce unnecessary adverse events and medicolegal risk.

Imagine you are between appointments on a Friday afternoon. Your colleague calls and he asks if you mind covering for him this weekend as he needs to tend to his elderly parent who has had a fall. He has performed a routine operation on a private inpatient earlier that day and says everything is fine.

How do you respond? Most of us would agree to do this, knowing that these arrangements often need to be reciprocated. However, how do you ensure safe continuity of care as the patient moves across to your care and responsibility, albeit temporarily?

No doubt you would usually ask more questions before ending the call. You would seek to find out more about the patient's background, to assess if there is any likely risk of complication and establish what the plan is for his discharge. You'd likely check that your colleague has documented this conversation with you in the patient's records, for medicolegal reasons but also so that ward staff know that you've agreed to be contacted if necessary, instead of your colleague.

However, would you make a note yourself of the patient's details, history, and current status so that you have this information available to remind you, now that you've taken over responsibility?

Communication gaps

For much of the time, despite any weakness in the handover communication and process, these situations pass uneventfully. The patient recovers with no complications and your colleague takes over their uneventful care again on Monday morning.

However, there are inevitably occasions when this is not the case. You accept a handover from a colleague, either a cover arrangement such as this or agree to give a second opinion, arrange an admission or transfer of your patient, and then things go wrong as they move between care providers.

Sometimes this is due to complications arising that you couldn't have foreseen, but other times analysis of adverse outcomes indicates that communication failure between colleagues around the time of the handover is frequently the root cause[1,2]. For example, a significant underlying condition isn't mentioned, a drug is missed off their transfer sheet, or a key abnormal observation or result isn't alluded to. And not having this information may lead to poor decision-making or suboptimal management.

If there is a communication gap, safe and effective care of the patient can easily fall through, leading to possible adverse events and increased risk of claims or complaints.

Often several health professionals are involved in a typical patient's care journey, eg from the GP to consultant specialist, radiologist, theatre and ward staff, pharmacist, physiotherapist, and back to the GP. With more people involved, there is a greater chance of there being miscommunication and errors at some point along the way.

Many conversations about patient care with our colleagues take place over the phone, rather than in-person. Remote communication can exacerbate the existing risks further, primarily due to a lack of visual and non-verbal information in the interaction. The oft-stated phrase "words make up only 7% of your message" resonates here. Aside from the content of your spoken words, the other 93% of the communication comes from the style of delivery. This includes the speaker's body language, tone of voice, and attitude, which all convey crucial meaning, however, much of this is missing on the telephone. What is said is therefore more open to misinterpretation. So particularly for complex cases, discussing the patient over a video call might be a less risky option to consider if face to face isn't possible.

Common causes of weak links and gaps

What stops us from transmitting key information when referring a patient or ensuring that we've received all the facts we need to know when accepting a handover remotely?

There are in fact a range of factors affecting either the quality of the interaction or the information.

Those affecting the **quality of the interaction** include:

- barriers in access, availability, and approachability of colleagues
- unstable connection and signal if using a mobile device
- high level of external interruptions, distractions, and time pressure
- existing dysfunctional relationships and lack of trust
- reluctance to take responsibility.

These are not always easy to eliminate or resolve, but it is helpful to be aware of them and compensate where possible by consciously strengthening the factors that you can address.

Factors affecting the **quality of the information obtained** include:

- inadequate preparation before the call
- lack of relevant facts about the patient's situation, current status, or background
- missing details about the care received so far
- unclear message, agenda, or request
- lack of confidentiality or privacy when taking the call
- not building a positive connection or rapport
- ignoring verbal cues
- abrupt or dismissive manner
- interrupting or talking over
- assumptions about a colleague's level of knowledge and skill
- not clarifying areas that are ambiguous
- not speaking up or challenging potentially suboptimal decisions.

Strengthening the communication of the transition conversation

All of these potential weak links are important, however, the key thing to focus on is ensuring that adequate, relevant information is included in a handover, so that it is as complete and safe as possible.

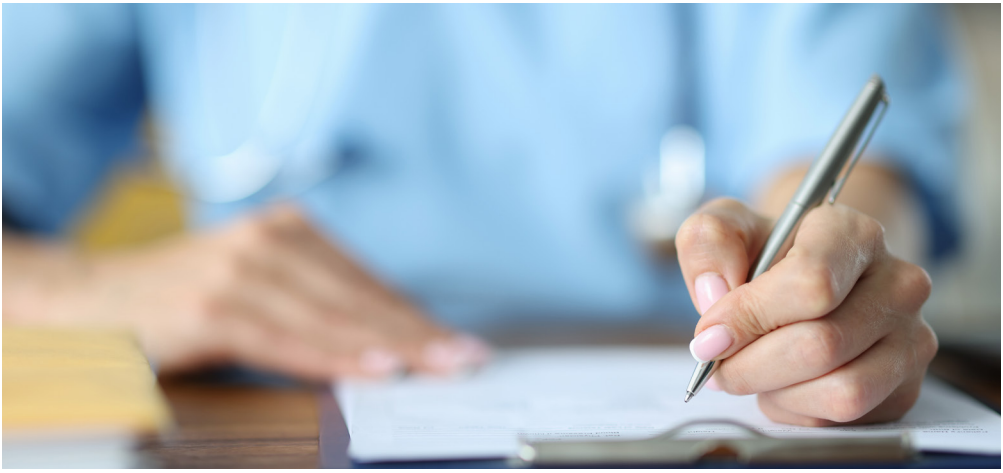
A framework can be helpful to have in the forefront of your mind, to aid preparation before making a call, or while accepting a patient. You may already be familiar with the ISBAR3 model[3], widely used in clinical settings, although initially developed by Dr Michael Leonard for the US Military to assist with safe communication on nuclear submarines. At Medical Protection, we have also developed another model for safe transfer of patient care, which we teach in our Mastering Professional Interactions workshop.

I – identify

- Identify yourself and the site/unit you are calling from.
- Identify the recipient's name and role.
- Identify the patient by name.

S – situation

- State the location of the patient as appropriate.
- Give a brief summary of the patient's current status.
- Describe your concern and reason for the call.



B – background

- Give the patient's reason for admission.
- Explain significant medical history.
- Inform the receiver of the patient's background: admitting diagnosis, date of admission, prior procedures, current medications, allergies, pertinent laboratory results, and other relevant diagnostic results.

A – assessment

- Vital signs.
- Trajectory of the patient's condition.
- Clinical impressions, concerns.

You need to think critically when informing the receiver of your assessment of the situation. This means you have considered the possible underlying reason for your patient's condition. Not only have you reviewed your findings from your assessment, but you have also consolidated these with other objective indicators, such as laboratory results.

R3 – recommendation, risk, and read-back

What you would like to happen by the end of the conversation. Any advice that is given on the phone needs to be repeated back to ensure accuracy.

- Explain what you need – be specific about your request and time frame.
- Make suggestions.
- Clarify expectations. Have clear agenda/request/purpose – include concerns/fear about what's likely to happen. State any additional relevant risks that the recipient may need to be aware of, eg falls risk, visual impairment, similar name to another patient on the unit.
- Check that the message you have sent has been accurately received by asking the recipient to 'read-back' the information.

So, how strong are your remote interactions with colleagues in these situations? Next time you pick up the phone to accept or make a patient handover, put yourself in the shoes of the patient's journey and aim to build a safe, solid structure into your communication.

By reflecting on this, and making changes to the way that you present or receive vital information about a patient, you can fill in the gaps, strengthen the connection, increase the chance of a smooth transition of care, and mitigate the associated medicolegal risk.

"Overcoming risky interactions with colleagues remotely" forms part of Medical Protection's recently launched series of webinars on telemedicine. Medical Protection members can find out more about these webinars at:

medicalprotection.org/uk/hub/telemedicine

Further learning

Want to know more? We run virtual workshops on reducing medicolegal risk through clear communication and better management of patient expectations. They are available to all members at no extra cost, and you can find them on our online learning hub. **Click to find out more**

REFERENCES

1. Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission guide to improving staff communication. Oakbrook Terrace, IL: Joint Commission Resources; 2005
2. Beckman HB, Markakis et al. "The doctor-patient relationship and malpractice: Lessons from plaintiff depositions". Archives of Internal Medicine 1994; 154: 1365-1370
3. Improvement.nhs.uk SBAR communication tool

High-profile patients

Treating high-profile patients can often present a unique set of medicolegal challenges, so it is important that doctors protect themselves, as well as the patient. ***Dr Emma Green****, Medicolegal Consultant at Medical Protection, discusses the common issues and sets out some advice.*

When a high-profile patient dies, the circumstances around their death, and sometimes their relationship with their doctor, can be thrown into the media spotlight. This is a daunting prospect for doctors. Although very few doctors will face such an extreme situation, it is useful to be aware of some of the potential medicolegal challenges that can arise when treating someone in the public eye.

Imagine you have a patient presenting with a viral sore throat and insisting on a course of antibiotics. In the case of the 'everyday patient', we know that the right thing to do usually is to advise on symptomatic treatment, not antibiotics. But what would you do in a situation involving a high-profile patient – perhaps a well-known politician or celebrity? Would you feel it safer to prescribe the antibiotics when your patient is in a position of power and used to getting what they want?

From a medicolegal point of view, your medical judgement should not be swayed by the social status, wealth, or other influence of the patient you are treating. As a doctor, you have a duty of care to all your patients, regardless of who they are. Your prime consideration should be regarding their medical condition and what you can do in your capacity as a doctor to help.

Confidentiality

Open up any gossip magazine and you will find examples of celebrities' physical and mental health battles. For doctors who treat these patients, dealing with issues around confidentiality can be problematic. As a result, celebrities may request details of their medical condition to be omitted from their records, or for no records to be made, in fear of it being leaked into the public domain.

The first step is to instil trust between yourself and the patient. Everyone has a right to confidentiality and high-profile patients may need extra reassurance that this right will be respected. However, it is never appropriate to intentionally leave relevant clinical information out of a medical record, and this must be explained to the patient. Your duty to the patient includes ensuring that there is continuity of care – omitting information from the record could mean other healthcare professionals are misinformed about their condition.

The GMC's guidance on this matter is clear. In its publication, *Decision Making and Consent*, it states: "Keeping patients' medical records up to date with key information is important for continuity of care. Keeping an accurate record of the exchange of information leading to a decision in a patient's record will inform their future care and help you to explain and justify your decisions and actions."

However, under GDPR, patients have the right to ensure their information is accurate and are able to request that factual inaccuracies within their record are rectified. They do not, however, have the right for a medical opinion made by you as a professional to be changed. The Information Commissioner's Office has further details in relation to complying with these requests, situations where requests may be refused, and timescales. If you need to make a correction, make sure you enter the date of the amendment and include your name. You should only comply with a request if you are satisfied that the entry is indeed factually inaccurate, but if you decide that a correction is not warranted, you should annotate the disputed entry with the patient's view.

Even the most demanding of patients should understand that it is your professional obligation to keep a record of their care, for their wellbeing and yours. Reassure them that they can take comfort in the fact that there are laws to protect against disclosure against their wishes, and ensure their need for confidentiality is respected.

Pressure

Sometimes, despite building up a trusting doctor-patient relationship, outside influences such as celebrities' managers or other individuals involved in their day-to-day lives may take it upon themselves to make decisions on behalf of their client. This can pose problems when the decisions they make are in conflict with what you believe to be in the patient's best medical interests.

If you feel you are being pressured into a decision by a patient or third party, take time to consider your position. Ultimately, the right thing to do is to outline your concerns, and the options, and tell them what the worse-case scenario would be if the patient was to refuse the advice. You cannot enforce any treatment without the patient's consent, apart from in emergency situations. Equally, you shouldn't proceed with treatment that you think is wrong merely because the patient has requested it. As with any patient, ensure you include details of all these discussions, including any refusal to treatment, in the medical notes.

You may wish to obtain the patient's consent to discuss potential treatment options with other clinical colleagues, as you might do with other patients. You can reassure the patient of confidentiality and explain that this would be considered to be good practice.

It is important to remember that you have been tasked with providing medical advice and treatment. No amount of pressure should deter you from maintaining the professional boundaries of the doctor-patient relationship to the best of your ability.

When treating high profile patients, we also need to take particular care in discussing and considering the patient's individual needs and circumstances. For example, would a possible treatment impact on their career or talent?

A cautious approach is also required if the patient is presenting with problems relating to their particular talent. For example, if a well-known singer presents with increasing hoarseness, and an ear, nose, and throat specialist confirms polyps on the vocal chords, failure to warn them about the possible complications, or discuss the options available, could leave you open to criticism if something goes wrong during the procedure. Although adverse complications would be distressing for any patient, the potential loss of earnings of a famous singer could mean that a claim brought against you would be of a much higher value than a patient who doesn't rely on their voice to make a living. Such a claim may also be high profile with the risk of reputational damage.

Starstruck

When faced with treating a high-profile patient, many doctors react in different ways. Some will be nervous, worried the patient could ask them to go outside the boundaries of what they consider to be best practice, and some may feel intimidated or even flattered that they have been chosen to consult for medical treatment or advice.

Despite these feelings, as a professional, you must maintain the same high professional standards as with any other patient. Remember that the usual rules apply: communicate openly, keep detailed medical records, manage professional boundaries, seek informed consent, and maintain their confidentiality.

You may feel extra pressure when dealing with those in the public eye, but as long as you act in their best interests and can justify any decisions you make, your integrity and professionalism should remain intact.

If in doubt, or if you require advice, always contact your medical defence organisation.

Media scrutiny

Dealing with high-profile patients can lead to enquiries from the media. Breaking confidentiality, whether inadvertently or not, could lead to a complaint, disciplinary action, or regulatory sanction. However, saying "no comment" to a journalist can come across as defensive, and there are ways in which you can respond to media enquiries without breaching patient confidentiality.

Media scrutiny could put your personal and professional reputation at risk, but early advice from the Medical Protection Press Office can help to mitigate this. Media advice is available to our members 24 hours a day, 7 days a week.

Managing timetable conflicts

When carrying out NHS and private practice work, it's important to ensure that the needs of both your private patients and your NHS patients are met. ***Dr Heidi Mounsey****, Medicolegal Consultant at Medical Protection, looks at one potential scenario and offers some guidance.*

Imagine you are a consultant general surgeon with both an NHS contract and practising privileges at the local private hospital. You are contacted by the private hospital to inform you that a patient you operated on yesterday has become very unwell. The Resident Medical Officer has reviewed the patient and considers that an emergency return to theatre may be needed. They are asking that you attend urgently.

You are, however, contracted for NHS duties today and are just about to start your ward round. You are aware you have several complex patients who require consultant review.

It is important to be aware of your obligations in a timetable clash like this.

The GMC's *Good Medical Practice* states that you must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must promptly provide or arrange suitable advice, investigations, or treatment where necessary, and refer a patient to another practitioner when this serves the patient's needs.[1]

In managing this scenario, you must ensure that the needs of both your private patient and your NHS patients are met. The document *Terms and Conditions – Consultants (England) 2003* states that the consultant is responsible for ensuring that the provision of private professional services or fee-paying services for other organisations does not result in detriment of NHS patients or services, or diminish the public resources that are available for the NHS.[2]

This should be read in conjunction with *A Code of Conduct for Private Practice*, which sets out that the provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services. Previously-agreed NHS commitments should take precedence over private work, except for when emergency care is required.[3]

In this situation, you have been requested to attend to your private patient urgently, but you should also ensure that your NHS patients are reviewed.

The options available to you may include:

- Discussing the matter with your clinical lead to request that you are granted time to review your private patient and to seek cover for your NHS ward round

- Request that a colleague with practising privileges in the private hospital reviews your patient while you conduct your NHS ward round.

It would, however, be prudent to consider, before committing to both private and NHS work, how to prevent or mitigate this scenario by pre-emptively arranging for cover if and when such a situation was to arise.

This could, for example, include reaching an agreement with another colleague who holds privileges in the same private hospital, so that you cover each other's private patients should an emergency arise. You could also arrange for your NHS colleagues to cover your NHS duties were you to be urgently called away to the private hospital. You should ensure that your NHS lead approves any cross-cover arrangement and that you keep proof of the agreement.

It would also be prudent to ensure your contract or terms of engagement with your private patients makes clear that in the event of an urgent problem or emergency, another clinician would need to be involved if you are not available.

Furthermore, you may to wish to consider whether it would be appropriate to request changes to your NHS job plan, or to your scheduled times at the private hospital, to minimise any disruption that may be caused to your NHS work should there be a complication arising from a procedure you have performed privately. This might, for example, mean adjusting your timetable so that you do not have NHS clinical commitments at a time when it may be more likely that complications would occur in your private patients.

Failure to ensure that all your patients, both NHS and private, receive the appropriate care may result in an adverse outcome for the patient, which may lead to a complaint or claim against you, or disciplinary and/or regulatory action. It is worthwhile giving consideration in advance as to how you would tackle the above dilemma if it arose.

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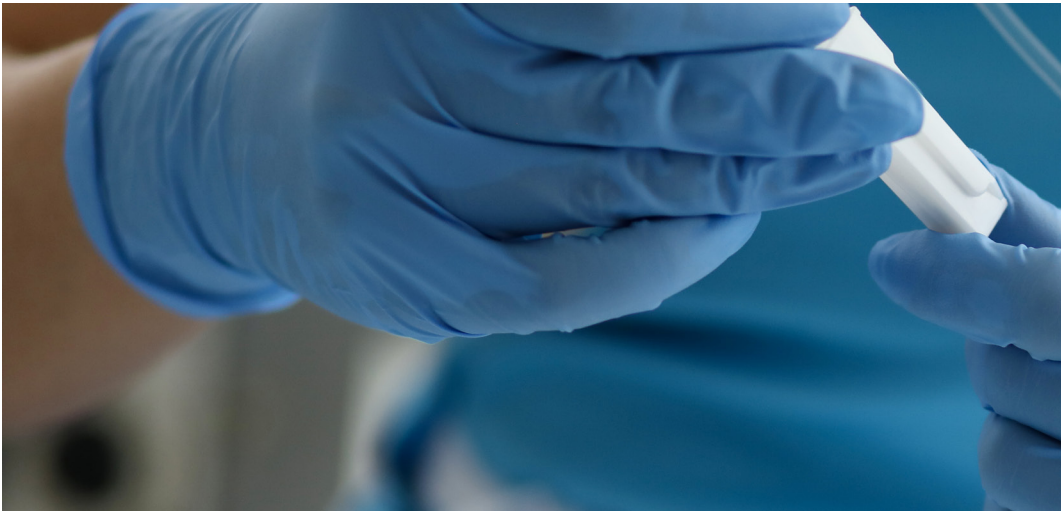
1. Good Medical Practice. General Medical Council. April 2019
2. Terms and Conditions - Consultants (England) 2003 (Version 11, April 2018). NHS Employers. April 2018
3. A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants. DoH. January 2004



Case study

A cannula complication

Mrs H, a 28-year-old massage therapist, was admitted to hospital for laparoscopic tubal ligation. Dr T was the anaesthetist for this surgery.

Before the surgery, Dr T placed a cannula in Mrs H's right wrist and, after surgery, a patient-controlled analgesia (PCA) was commenced through this cannula. According to the cannula chart, a cannula was also placed in Mrs H's left hand, although this was not in place following surgery. Mrs H also recalled a cannula site in the left forearm and a further cannula site in the right forearm following surgery, although these were not recorded on the cannula chart.

Records show that a day later, slight bloodstaining was present at the cannula site in Mrs H's right wrist. The following day, Mrs H reported the site of the cannula being painful so it was removed. No further problems were recorded and Mrs H left hospital a day later.

A month later, Mrs H attended the hospital in relation to umbilical wound oozing; she also complained of altered sensation in her left thumb and for this was referred back to Dr T. He noted that Mrs H had had two cannula sites over her left arm where she had developed a haematoma and now had paraesthesia over her distal thumb. Dr T referred Mrs H to Dr Q, a consultant orthopaedic surgeon.

Dr Q noted neurapraxic damage to the dorsal branch of the radial nerve, and advised desensitisation exercises. A month later, improvement was noted and Dr Q recorded that the hyperaesthesia had settled. He further noted that there was 40% function in the dorsal branch of the radial nerve and that there was a reasonable chance that this would recover, at least to a degree.

Mrs H made a claim against Dr T for alleged substandard technique during cannulation, also alleging poor record-keeping in his failure to record

two cannula insertions on the cannula chart. Mrs H claimed that when the needle was inserted into her vein, poor technique was employed, resulting in the bevel of the needle cutting through nerves and creating neuromas, causing neurological damage. Mrs H also claimed that the sensory injury had left her disabled, in that she found it extremely difficult to carry out her job.

Expert opinion

Medical Protection obtained an expert report on breach a short time after the letter of claim was received. Professor I, a consultant in anaesthesia and intensive care, produced the report and was robust in his defence of Dr T. Professor I stated that he considered Dr T's technique to be entirely appropriate and that he could not see any evidence of substandard care. He considered it likely that the nerve damage did arise from the unsuccessful cannulation but did not in any way reflect bad technique. Professor I also found Dr T's record-keeping to be appropriate, as he would not expect failed cannulations to be documented.

The Medical Protection legal team was aware that Mrs H's own legal advisers were still to obtain their report on breach of duty, and considered that issuing them with a quick response that was supportive of Dr T would dissuade them from pursuing the matter. Medical Protection served its expert evidence along with the letter of response a short time after the letter of claim was received.

Mrs H withdrew her allegations and the claim was discontinued.

Learning points

- **Good record-keeping is essential for continuity of care – therefore, the medical records you keep should provide a window on the clinical judgment being exercised at the time.**
- **When inserting a cannula, consider using the patient's non-dominant hand if possible.**
- **It is helpful to write a report soon after an adverse event, because of the lengthy time that can sometimes pass before a related complaint or claim arises.**
- **This case is a reminder that not every adverse outcome is negligent. Medical Protection's robust approach meant the case was dropped and the allegation withdrawn very quickly.**

Further learning

Want to know more? Our e-learning resources cover subjects like understanding and applying the principles of good record keeping. They are available to all members at no extra cost, and you can find them on our online learning hub.

Click to find out more

Case study

Corneal graft surgery leads to claim

Mr M, a 45-year-old lawyer with a substantial income, consulted Dr L, an ophthalmologist, for the management of deteriorating keratoconus. He had become intolerant of contact lenses and was experiencing visual difficulties. His right eye had a corneal scar secondary to severe keratoconus, and he had keratoconus forme fruste in his left eye. Visual acuity was 6/20 in the right eye and 6/12 in the left eye.

Dr L offered Mr M corneal graft surgery in order to improve his symptom of deteriorating vision. He was counselled regarding complications, specifically that eye infections were a possibility, but he was not told about the rare risk of loss of the eye. Dr L performed uncomplicated corneal graft surgery on the right eye, and before discharging Mr M, provided him with his mobile phone number and a postoperative information leaflet that informed patients that they should contact him immediately if they experienced any pain or poor vision.

Written records show that Dr L reviewed Mr M on the first day post-surgery. He was satisfied with the eye and prescribed a topical corticosteroid and a topical antibiotic. On the morning of the second day following the surgery, written and telephonic records show that Dr L gave Mr M a courtesy call and that Mr M did not inform Dr L of any pain during this conversation. Twenty-four hours later, Mr M called Dr L and complained of severe, worsening pain in the right eye, that started shortly after Dr L's phone call the previous day. Dr L saw Mr M immediately and observed a fulminant endophthalmitis.

Mr M was referred to Dr G, a vitreo-retinal surgeon, who arranged immediate treatment with intra-vitreal and systemic antibiotics. A posterior vitrectomy and lensectomy were performed, but B-scan ultrasonography later showed a retinal detachment. Bacterial culture of the vitreous revealed a serratia marcescens infection, sensitive to the antibiotics being used. As a result of the retinal detachment Mr M lost all vision in the right eye. His corrected visual acuity in the left eye was 6/36.

Mr M made a claim against Dr L, alleging that he had failed to inform him of the risks of corneal graft surgery or of the significance of pain postoperatively. He further alleged inadequate postoperative care, which led to Mr M developing an uncontrolled infection and subsequent blindness in that eye.

Expert opinion

Medical Protection sought expert opinion from an ophthalmologist. She was supportive of the care provided by Dr L and concluded that the postoperative patient information leaflet had sufficient information about warning signs. She also noted that Dr L did warn that eye infections were a possible complication and opined that loss of vision due to an infection was such a rare complication that the patient did not need to be warned specifically about the risk.

The expert made the additional point that, in Mr M's case, there was a real risk that the natural course of the disease may have led to blindness through the complications of keratoconus itself, in the long term.

The case was considered to be defensible and was taken to trial. The court was satisfied that Dr L's management was appropriate and that there was no evidence of a failure to provide adequate informed consent or negligent aftercare. Judgment was made in favour of Dr L.

Learning points

- **Doctors must now ensure that patients are aware of any 'material risks' involved in a proposed treatment, and of reasonable alternatives, following the judgment in the Montgomery case in 2015. GMC guidance also recommends that serious adverse events (such as irreversible loss of sight) must be discussed even if they are rare.**
- **When providing important information in a written format, the patient must be made aware of its importance. Consider providing verbal information as well as written information for important matters. When giving written information to sight-impaired patients, the format and font should be suitable for their visual ability. When applicable, consider adjunctive methods to deliver information, such as audio or video formats.**
- **Although the primary purpose of medical records is to ensure continuity of patient care, medical records are used as evidence of care when dealing with complaints and medicolegal claims. Therefore, clear and detailed medical records are in both the patient's and the doctor's best interest.**

Further learning

Want to know more? We run virtual workshops on navigating adverse outcomes. They are available to all members at no extra cost, and you can find them on our online learning hub.

Click to find out more

Case study

Abnormal blood results – alleged failure to follow up

Ms D, a 60-year-old woman, underwent a total hip replacement under the care of consultant orthopaedic surgeon Dr R.

She recovered well from the surgery, however her routine postoperative blood tests were slightly abnormal. She was discharged on day three post-procedure and was advised by the resident medical officer, Dr B, to see her GP for follow-up blood tests. The abnormal results were not communicated to the consultant in charge, nor was it documented on Ms D's discharge summary.

Four days after her discharge, Ms D attended her GP requesting an appointment, as she was advised that she needed blood tests. This was booked in for two weeks later, as there had been no indication of how urgently these needed to be done.

Twelve days after she had been discharged, Ms D felt unwell and attended the Emergency Department. She was admitted to intensive care and sadly died three days later.

An inquest took place. Witness statements were obtained from the staff involved. Dr B recalled verbally advising Ms D that she should see her GP for follow-up blood tests. He requested that this instruction be entered into Ms D's discharge letter. However, he did not prepare the letter, nor did he review it prior to it being sent to Ms D's GP. The hospital process at the time was for the nursing staff to complete all discharge documentation with no clinician sign-off required.

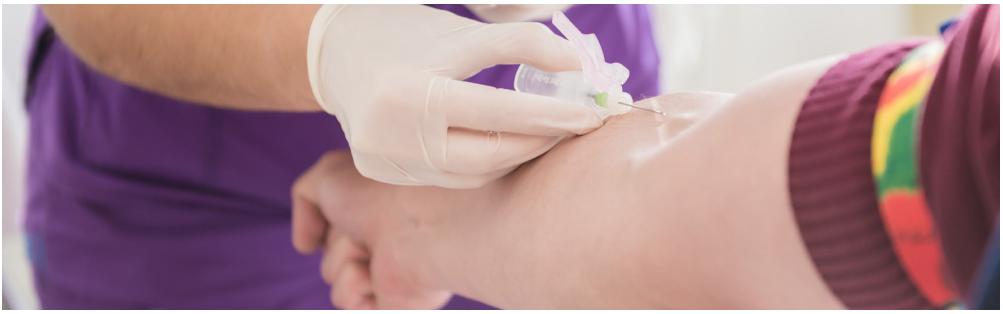
The nurse advised that she had printed the recent blood tests and attached them to Ms D's discharge summary. She verbally confirmed with Ms D that she was aware of the need to follow-up with her GP. This conversation was not documented.

Dr R, the consultant in charge, had not been made aware of the abnormal results prior to Ms D's discharge. He confirmed that had he been aware, he would also have advised GP follow-up and repeat blood tests within a few days.

How Medical Protection assisted

An inquest took place 18 months after Ms D's death. Medical Protection's legal advisers and counsel were instructed to assist our member, Dr B.

The legal team managed to avoid any direct criticism of the member at the inquest. Although Dr B's instructions to Ms D had not been documented, her attendance at her GP practice provided evidence that the verbal instruction had been given and understood.



Dr R, the consultant in charge, had not been made aware of the abnormal results

One year after the inquest, a letter of claim was received by Dr B. It was alleged that the failure to ensure that Ms D had a follow-up blood test within a week, or to ensure the GP was able to do so, was a breach of duty of care. It was also alleged that the failure to notify Dr R was a breach of duty.

Medical Protection obtained an expert report to comment on the allegations of causation. This was supportive of our member and indicated that even if Ms D had been followed up sooner, it was unlikely that earlier treatment would have altered her outcome or prevented her death.

However, the risk remained that we would be unable to defend breach of duty due to the lack of documentation by any of the parties involved, and in particular by Dr B. The GP practice documented Ms D's attendance to book herself in for blood tests. Had this not been done, Dr B would have no evidence that Ms D had been informed of her need to follow up.

Outcome

Following the inquest, the coroner concluded that the failure to ensure that a follow-up blood test did not cause or contribute to the death. He identified concerns with the discharge policy of the hospital. In particular, there was a lack of guidance on how post-discharge investigations should be arranged or communicated, by whom, and when. The hospital took steps to ensure their discharge policy was rewritten, with clearer identification of roles and responsibilities.

As our member Dr B was not directly criticised, he avoided the need to self-refer to the Medical Council.

A letter of response was served to the claimant's solicitors denying causation and the claim was withdrawn.

Learning points

- This case highlighted the importance of ensuring that recommendations for follow-ups are robustly documented in the notes and communicated effectively to the patient, along with expected timescales.
- Clear and timely documentation to the GP would have indicated the reason for Ms D's attendance and may have altered the timing of the appointment that was offered.
- Had Ms D misunderstood the instructions in any way, there would have been no way of ensuring an adequate follow-up took place.
- Junior doctors working in rotation at various hospitals need to ensure they are familiar with local processes and clear on their responsibilities.
- It is vital to ensure that supervising consultants are made aware of any problems with their patients prior to discharge. These conversations must always be documented. Consultants and juniors should establish expectations from each other on which matters should be escalated.
- Although Dr R was not criticised in the claim, it is important for consultants to be satisfied that a clear follow-up plan is in place for their patients.
- Ultimately, the overall responsibility for care does lie with the consultant in charge and therefore they must be content that appropriate care has been given. It is often difficult to document telephone conversations when covering multiple sites, but this must be done at the earliest opportunity.
- As local discharge policies vary between hospitals, consultants must be aware of any nuances and be content that plans on discharge will be carried out. They should ensure that all letters are checked for accuracy as close to the point of discharge as possible.

Case study

Sympathectomy claim centred around consent

Thirty-year-old Mr P had suffered from facial and palmar hyperhidrosis and blushing since he was fourteen. Over the years, he had tried various over-the-counter remedies and a period of psychotherapy with no success. Although he had learned to live with his condition to some extent, he found it socially inhibiting and believed that it was preventing him from progressing in his career as an accountant.

Having researched hyperhidrosis on the internet, Mr P was attracted to the potentially permanent solution offered by a sympathectomy and asked his GP to refer him to a suitably trained surgeon.

Three weeks later he saw Mr R, a consultant surgeon, at his clinic and requested an endoscopic transthoracic sympathectomy, telling Mr R that he had conducted detailed research on the internet and therefore had a good understanding of what the surgery entailed. Although Mr P had clearly done his research and had already concluded that surgery was his best option, Mr R nevertheless explained the operation and its risks and benefits to him in detail, emphasising the well-known side effect of compensatory sweating.

After discussing the implications, Mr P was still intent on undergoing the surgery, indicating that he considered compensatory sweating an acceptable risk outweighed by the benefits of the operation. Mr R therefore agreed to perform the surgery, but gave Mr P a patient information leaflet to take home with him, asking him to read it and telephone him if he had any further questions.

Mr P was admitted as a day patient a month later for the surgery. Mr R performed endoscopic transthoracic sympathectomies on both sides at T2. The operation was uneventful and Mr P was discharged home later the same day.

The operation had the desired effect of eliminating Mr P's problems with blushing, and his facial and palmar hyperhidrosis, but it did result in compensatory sweating on his trunk and thighs. Unfortunately, this failed to resolve itself and increased in severity over the next 18 months, to the point where Mr P had to change his clothes several times a day. This was extremely distressing to Mr P. He deeply regretted having the operation and became profoundly depressed, unable to work and socially withdrawn.

Two years later, Mr R received a letter from Mr P's solicitors requesting a copy of Mr P's medical records. He alerted Medical Protection to the possibility that a claim would be made against him and sent copies of the records to the solicitors and Medical Protection. Fortunately, Mr R had documented the substance of Mr P's preoperative consultation in the medical records and, furthermore, had followed up the consultation with a letter to Mr P (with a copy to his GP), in which he reiterated the risks and benefits of the operation.

In our opinion, Mr R was in a strong position to defend an allegation of negligence on the basis of failure to secure adequate consent for the operation. Mr P's solicitors evidently agreed with our assessment as no further action was taken.

Learning points

- **The 'well-informed patient' is a common phenomenon in countries with widespread access to the internet. Although these patients may claim that they've thoroughly researched their treatment options and thought it all through, their doctors should still ensure that patients are given all the necessary information to make a properly informed choice.**
- **Doctors might also consider familiarising themselves with sources that are available.**
- **Patients requesting specific surgical procedures often have unreasonably high expectations about outcomes. They may be so focused on the perceived benefits of the surgery that they don't give due regard to the risks.**

Further learning

Want to know more? Our e-learning resources cover subjects like consent, including the ethical and legal principles involved, and strategies for obtaining it. They are available to all members at no extra cost, and you can find them on our online learning hub.
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