Conversation Piece – The Medical Defence Organisation Doctor

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DR P.D. WELSBY: Dr Mathewson, you were a well established general practitioner in Edinburgh: why the sudden change in career direction?

DR W.B. MATHEWSON: Some would say it was the male menopause! And others early dementia! It was however a carefully weighed up decision to apply for the post. I had for some time been aware that I had been meeting general practitioner colleagues in the course of work and at lectures and meetings who were perhaps 10 and 15 years older than myself and who seemed to be wishing away the years to retirement. I certainly wanted to avoid drifting into that position and was therefore keeping an eye open for a possible change of career. When this post was advertised I was immediately attracted to apply on the basis that if I didn’t I would always wonder what might have been. However, when I was shortlisted and then offered the post, I suddenly realised that a major decision had to be made. I have no regrets although I thoroughly enjoyed my time in general practice.

PDW: How is your day filled? Is it mostly a desk job?

WBM: My day is a variable mixture of the planned and unplanned. My own daily mail has to be dealt with. This is usually a rich mixture of letters to doctors, lawyers, other medical defence organisations’ secretaries and administrators dealing with such matters as medical negligence claims, fatal accident inquiries, hospital complaints, general practice terms of service complaints and requests for medico-legal advice.

In addition we offer a telephone service giving advice on medico-legal problems, ethical issues, General Medical Council matters, and that most urgent request of all – what to do on receipt of a solicitor’s letter claiming medical negligence.

The telephone advice service is certainly an important part of my job and a part which I find enjoyable. There are, of course, inevitable telephone calls to be made as well as received. Frequently it is necessary and preferable to have a discussion of a case with a solicitor or expert before giving our opinion and sometimes even after that opinion has been received.

The members of the Secretariat have a daily meeting in the Secretaries’ office at which we discuss our cases, in particular any difficult or unusual problems that may be arising.

I have the particular task in the Union of liaising with the medical students’ final year clubs and medical societies in the four Scottish medical schools. I therefore spend some of my time in contact with student presidents, and committee members regarding educational and social events which we offer to sponsor in a modest way. For example we recently sponsored a debate between Aberdeen University Medical Society and the Aberdeen University Law Society on euthanasia and we recently had a ‘medico-legal playlets evening’ in the Royal Medical Society in Edinburgh in which the students put on a series of small plays illustrating common medico-legal pitfalls, using, I should add, a fair amount of poetic licence. Occasionally members wish to come into the office to discuss a problem rather than write and we welcome this. In addition to all of this I do indulge in a fair amount of coffee drinking!

PDW: What are the satisfactions?

WBM: It is satisfying to belong to this Union with the specific aim of helping our members in situations which can cause much anxiety, frustration, or anger. This is especially so in situations where unjustified and exaggerated allegations are made. It is also very interesting to deal with a wide spectrum of specialists and general practitioners as well as other professional people such as lawyers and administrators.

PDW: And dissatisfactions?

WBM: Dealing with the minority of lawyers who refuse to admit they have no case despite protracted correspondence or who, when presented with information and opinions which clearly put an end to their allegations and claim, merely cease to correspond without comment.

PDW: As you will know the Health Boards aim to indemnify their medical staff only, I presume, whilst on Board business. What changes do you envisage in the roles of the Defence Organisations?

WBM: With the onset of Crown Indemnity, the medical defence organisations have ceased to be responsible for the indemnity of hospital and community NHS medical staff. This is now being covered by the Crown. However, private work, whether in or out of NHS Hospitals, category 2 work (e.g. insurance reports), General Medical Council and disciplinary procedure representation and medical and legal advisor services are not undertaken by the Government. General practitioners, being independent contractors, are not covered by Crown Indemnity. Our role, therefore, is unchanged towards general practitioners but considerably changed towards hospital and community staff.

We envisage our advisory role as increasing as we think it more likely that members will feel less secure if a claim is made against them under Crown Indemnity. This is hardly surprising since the employer will also be the investigator of claims, the instructor of solicitors for legal advice, the settler of damages. We may be called on increasingly to give an independent assessment and opinion for our members although ultimately the major decisions will of course remain with the Health Boards and their solicitors.

It is likely that we will be given the task of ‘running’ new claims for Health Authorities and Health Boards. We think that, by choosing to do this, the Authorities will save money in the longer term since the defence organisations have a considerable bank of expertise in teasing out these often very complicated claims, pursuing reports, and instructing appropriate and experienced experts. We think it likely that there will be more complaints made to the General Medical Council, particularly if Health Boards and Health Authorities choose to settle smaller claims out of financial expediency rather than investigate thoroughly individual claims by obtaining reports from all the doctors concerned.

There is now a distinct possibility that general practitioners will be made a third party to an increasing number of claims for medical negligence by the solicitors to the Health Boards and Health Authorities if they feel that
there is a possibility of implicating the general practitioner and thus offsetting a percentage of possible damages. For example, where there may have been a lengthy delay in making a particular diagnosis or in referring a patient to outpatients or for admission. In addition, there may be a 'new contract factor'. When this new contract comes into force patients will be able to change their general practitioner much more easily. Almost inevitably in some case there will be loss of patient loyalty, perhaps with an increased willingness to complain about services or to make claims for damages.

PDW: Will the Health Boards be able to cope? And what would I do if I were not satisfied with their response (resigning is not an option)!

WBM: We think that the Health Boards and Health Authorities will seek the expertise of the Medical Defence Organisations in the management of claims against their employees. Some may of course choose not to do this. We feel strongly that a doctor with medico-legal experience should be the first person to investigate the claim and advise the Boards/Authorities and their solicitors on appropriate further investigations and expert opinions.

Unfortunately, should an individual doctor not be satisfied with the handling of a claim against him, there is little he can do. We would strongly advise that our members consult us at the very earliest opportunity should they be notified of a complaint or claim against them. We will certainly advise on the writing of reports and will vet members' statements before they are sent to administrators and lawyers.

PDW: What are the common problems you deal with? What proportion of complaints by patients are avoidable, and how should they have been avoided?

WBM: These are: (a) Accident and emergency claims alleging, for example, missed fractures and mismanaged head injuries. (b) Orthopaedic claims, such as nerve damage occurring during operative procedures. (c) Obstetric and gynaecological claims, such as mismanagement of labour, misdiagnosis of ectopic pregnancy, failed sterilizations.

The best defence a doctor can have against allegations is adequate contemporaneous legible records. No matter how strongly a member feels, it is impossible to defend a case in the absence of records! Communication with patients is all important. Patients should be kept informed at every opportunity if problems are developing. Clearly a courteous manner is important. Patients are much less likely to complain or claim if they have a good relationship with their medical attendants. Senior doctors should avoid improper delegation and be accessible to their juniors. These factors crop up frequently in medical negligence claims.

PDW: Have there been any changes in the type of complaints over, say, the last decade or so? I seem to remember that psychiatrist's couches and dental chairs seemed to be high risk areas for practitioners (and also their patients)!

WBM: The changes which have taken place in this field in recent years have tended to mirror the changes in medicine itself. For example interventional radiology and cardiology and laparoscopic techniques (especially sterilization) have given rise to new types of claims. Informed consent is an area of great debate and is often at the centre of claims for medical negligence. There is also an increasing tendency to sue for pain and suffering caused by investigation procedures or delays in making the diagnosis even though no permanent loss is sustained by the patient. The change in types of claims is inextricably linked with the rising tide of medical litigation which in itself is part of a wider awareness of litigation procedures generally.

PDW: Is there any way in which the seemingly inevitable escalation in financially driven, but medically dubious, claims can be avoided? Or will the American system eventually cross the Atlantic?

WBM: The American system is fundamentally different and is unlikely to colonize us. In America liability and damages are decided by juries. This inevitably leads to higher awards when negligence is found and also to rogue decisions in some cases. The medical litigation scene in America is further complicated by the contingency fee system operated by lawyers. This is a 'no win no fee' system in which the legal adviser charges a percentage of the damages awarded. This has the effect of increasing the amount of litigation commenced and further bumping up the damages awarded.

Financially driven and medically dubious claims are on the increase in Britain too, and can be dealt with only by proper professional assessment of the allegations backed by expert medical and legal opinion at an early stage thus leaving no reason for the pursuer's solicitors to persist in their allegations. Certainly settling out of financial expediency without admission of liability in cases where there is no clear evidence of negligence should be avoided as this merely stokes the fire.

Clearly the wider issue of education of the legal and medical professions in medical negligence is important in preventing meritless litigation commencing in the first place but at the same time we have to allow access to the system to those people who have proper and sometimes tragic claims to be investigated.

PDW: Do you think that different premiums for different specialties should be introduced? Even if the Boards indemnify us there will still be a need for private practice doctors to be insured.

WBM: I do not think that differential subscription by specialties should be introduced. In our new system following Crown Indemnity we have differential subscriptions according to hospital grade and according to the amount of private practice undertaken. All specialties are at risk and although the frequency of claims in some specialties is higher than in others, a single claim in a low frequency specialty can often be very much more expensive in total than a large number from a high frequency specialty.

PDW: It seems that managers are becoming more powerful. Do you envisage a scenario whereby managers are sued because the clinicians did not have the capability to treat certain conditions. I know that Health Board files must be full of letters from clinicians eschewing responsibility for the consequences if the Board concerned failed to comply with their wishes.

WBM: This could become an area of conflict under Crown Indemnity. In the past there has been a financial contribution to the settlement from the Health Board and Health Authorities in claims that have been settled where there has been a defect in the provision of equipment or services provided by Health Boards or Health Authorities. Under Crown Indemnity the total liability falls on the Health Board and Health Authority and thus there is
unlikely to be the same stimulus to remedy any such defects with the same degree of urgency. It would clearly be important in the event of any settlement out of court that recognition be given to any system failure attributed to Health Boards and Health Authorities.

PDW: Who will defend doctors against threatened action by the General Medical Council? – especially if the Boards indemnify us and, for any reason, are unwilling to undertake such defence actions.

WBM: Your medical defence organisation will provide medico-legal advice and representation in the event of a doctor’s actions being brought to the attention of the General Medical Council. Similarly medical defence organisations offer medico-legal advice and representation at hospital disciplinary procedures, tribunals, fatal accident inquiries and Coroner’s inquests.

PDW: A question I ask everyone. As I intend to live forever (if doctors cannot achieve this who can?) and wish to practice medicine most of the time what advice would you give me? (with regard to ‘keeping my nose clean’).

WBM: The best advice on how to avoid a ‘dirty nose’ is perhaps the simplest to state but not the easiest to carry out. Failure to communicate with the patient and with one’s colleagues is frequently a central factor in medical negligence claims. When things are not going to plan patients should be kept informed. They are then much less likely to complain or make a claim. Adequate contemporaneous and legible records are vital. Documented consultation with one’s peers in difficult situations can be most useful in preparing a defence against allegations of negligence. So briefly my advice would be to communicate, record, and consult.