Orthopaedic surgeons and medico-legal matters

David Warwick

As I take over the reins of the BOA Medico-legal Committee from Mike Foy, the first thing is to thank him on all of our orthopaedic behalves for his boundless enthusiasm and huge contribution over five years - running the Committee, advising members, writing articles and organising the medico-legal part of the Congress.

David Warwick has been a Consultant Hand Surgeon at University Hospital Southampton since 1998 as well as visiting Hand Surgeon to the States of Jersey and Bailiwick of Guernsey. He is involved daily in the clinical management of complex hand and wrist problems with a particular interest in the DRUJ, Dupuytren's, joint replacement and orthopaedic hand trauma.

So I thought I would start my term with some musings - ramblings perhaps - on orthopaedic surgeons and medico-legal matters. A topic in which we are all, one way or another, interested.

Anyone doing private practice will have seen their indemnity premiums rise inexorably to the point that some find it easier to just give up. Indeed, for spinal surgeons some indemnity organisations now turn away their business. As commercial providers enter the market, we may be tempted to change horses. But there is a minefield to negotiate, especially with regards to run off cover (will you still be insured when you retire and how much will it cost), and overlap between cover ('claims made' and 'claims occurring'). And just because the premiums are lower now, what if there is a claim against you and the premium then rises or renewal is denied? Or suppose that other policy holders indemnified by your new insurer are sued so that the insurer raises premiums for all its clients to a prohibitive level. If you flit form provider to provider each year for the cheapest premium (as if you were insuring your car or your home) who will take responsibility for a claim in which particular year? Do all commercial indemnifiers have the institutional knowledge acquired over decades to advise on other matters - employment, GMC and so on?

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We are well aware of the need to take increasingly meticulous care in our practice to make sure that our discussions with patients on all the options of treatment have been fully discussed; if we have a bad outcome, however unexpected or unavoidable, we can rest assured that the lawyers, armed with court judgements such as Hassell, Thefaut and, of course, Montgomery, will pore over every single word we have written in the notes; anything we say that have not written down was never said...so where do we find the extra time in outpatient and pre-assessment clinics which are already overloaded with waiting time and teaching pressures? By the way, we have to find the time.

Those involved in the metal-on-metal business will know how a wonderful concept with tantalisingly promising early results prompted implantation into so many younger, sportier people; despite good faith and the best of intentions, this procedure has, for some, led to a deluge of failures and potential litigation. Will this be repeated in other implants - are we sitting on another medico-legal time bomb? Perhaps some circumspection before using the next glamorous or promising gadget is wise.

To what extent will medico-legal concerns fetter new developments? Maybe the pioneers of orthopaedics (or heart transplants for that matter) would have baulked if their well - considered but unproven ideas had to be developed under the threat of legal redress. Nowadays all innovation must, quite rightly, be undertaken with the engagement of peer review, ethics committee approval, fully informed consent and meticulous follow up.

Some surgeons make a (very) decent income providing independent evidence to the court on personal injury cases. This is often straightforward work since the vexing and contentious matter of breach of duty is the lawyer's problem - we simply provide some reasonable comments to link the injury with the subsequent symptoms, consider whether the

claimant's account is proportionate and then predict the prognosis. Money for old rope...

WRULD-RSI cases are rather more of a challenge. Whilst some experts (not usually the archetypical orthopod...) take a rather left wing view along the lines of 'all work is harmful and the employer clearly harmed the patient', others (perhaps the archetypical orthopod...) take a rather more right wing view that 'hard work is good for you and if your arm is painful then you had it coming anyway regardless of your work'. If the solicitors have each picked their favourite defence or claimant gun, joint statements can be contentious with no common ground. Then an inevitable court date will block our precious clinical diary. And however much we charge for a day in court, that is annoying. Even more annoying if the case cancels the day before as each side realise it could go either way depending on the judge.

Medical negligence work is far more challenging. The issue of breach of duty is our problem not the lawyer's. Breach is often by no means straightforward and not infrequently tinged with the pangs of 'there for the grace of God go I'. Despite our reputation amongst other specialities, we orthopaedic surgeons are scientists (really) and so we are familiar with the scientific 95% burden of proof. But we get quite uncomfortable when we dither either side of the 50-50 balance of probability bar - the standard with which our legal colleagues dice every day. No one deliberately harms a patient. We all make mistakes; the retrospectoscope is a powerful thing; the gold standard is not always achievable and anyway is not expected in law. If the claimant genuinely believes they were harmed but in fact there was no negligence, then the emotionally mature independent unbiased expert should sympathetically help the claimant understand that whilst the result was not as expected, the vagaries of nature and uncertainties of treatment mean that there was no shortfall in care. On the other hand, we do sometimes see a clear error of judgement. The expert should save all parties the expense and anxiety of a fatuous defence, and advise the system to promptly confess, apologise and pay up. And very unusually, the matter is not one of an out-of-character error but frank incompetence. Our duty as a doctor, as defined by the GMC, requires us to refer these cases.

The challenging, but fascinating aspect of negligence reporting, is causation - where would the claimant be in any event despite the alleged error? Even if there were breach of duty, once the inevitable outcome from the injury is subtracted from the consequences of the negligence, there may or may not be a clinically material difference.

Sooner or later orthopaedic surgeons think of retiring. Our previous NHS employer may drag us back to comment on a case for which we remain professionally liable. The three year statute of limitation is not as protective as we might imagine, a case may crop up many years later when the claimant can reasonably deduce he was harmed. The legacy of cases which may come back and bite needs to be properly covered with indemnity, depending on the insurer, which is not always guaranteed and not always cheap.

And talking of retirement, medico-legal work can be a 'nice earner' for a few years. No stressful outpatient clinics or operating lists, no insecurity as our eyes and dexterity and resilience gradually fade. Yet there is plenty of time to deal with the avalanche of paperwork that can spoil your life when trying to manage it alongside a clinical practice. It might even be rather interesting and fulfilling. But how long can you be a 'real expert' once you are no longer a 'real surgeon'? Do you need to remain appraised and revalidated, if so how? Who will insure you and for how much?

So medico-legal matters matter to all of us. ■