[Francis:

So thank you, Matthew and EIDO for inviting us to present. So as Matthew said, I'm a consultant spinal surgeon working in Cardiff and I'm also assistant clinical director for the South Wales spinal network. So we're trying to implement or improve some of the access to spinal surgery in South Wales. So in terms of conflicts, as Matthew said, I'm a content board member for EIDO Healthcare, also got a medical legal practice, which, we sort of used some of the cases from this.

The medical legal environment in the UK, quite often people are surprised to see that we're second behind Israel for the number of litigations that are instituted around medical care in the UK. That's ahead of the USA. It cost the NHS 2.7 billion in 2022, 2023 and that cost, as we heard from the Welsh risk pool, is likely to be increasing. And specific to consent, the information's a bit harder to come by, but before 2015 it averaged about 28 million, specific for claims where consent was an issue, and that's now gone up to around 78 million, so a significant increase. A lot of that, people feel, may be related to the Montgomery issues.

So, we've already had far more intelligent nuance around the legal aspect of the Montgomery case. So we know that we have to make a decision around what is a reasonable care for that patient and be aware of any material risks. Now, one of the things that the GMC talk about is trying to establish what material risks are for that patient and in the simple act of asking that patient what they want to know. It's not often seen as sufficient enough to make sure that you've established what they really want to know. So it's really important that that consent process isn't just a one moment in time where you have that discussion around them okay. And I think that's one of the things that I've taken, is that

consent isn't an appointment, come and consent. Consent starts from the moment that you meet that patient and you're trying to establish what exactly they want to know about.

Unfortunately, a lot of the medical literature or the legal cases, there does seem to be a large number of spinal cases. So Thefaut, I think that's how you say it, and Johnston was Mrs. Thefaut was presented with information which they successfully argued was understating the risks and overstating the chances of success of it. And this was in 2015. One of the big things that came out of that is that patients should be given adequate time and space to make an informed decision about whether they want to go ahead and we need to make an effort to minimalise the medical jargon. So presenting the information in a clear and understandable way that the patient can understand the risks that they're going ahead of.

Prior to this in 2004, there's the Chester v Afshar case, which again looked at the risks. And in that case, the risk of developing post-operative cauda equina for a discectomy was not discussed with Mrs. Chester, and unfortunately, she went on to develop that and successfully sued Mr. Afshar around that.

The GMC guidance states that consent has to be individualised to the patient and it'd be interesting to see what the thought process around pre-filled in consent forms, which I see from time to time in practice, is. Clearly if it's prefilled, then it's not necessarily taken in the individual risk of the individual concerns of that patient. Although the consent form only represents that a discussion has taken place. Obviously, we need to be able to give patients information in a way that they can understand, around the diagnosis, prognosis and potential

complications that they're putting themselves at, and listen to the concerns and respect the views, even when they may go against what we would accept or feel ourselves. That's something that can be quite difficult to do in clinical practice and certainly when dealing with high risk cases in terms of spinal surgery, where there's a risk of paralysis if they don't have the operation, but equally there's a risk of paralysis if they do have the operation, and trying to understand and mitigate that and understand the patient's concerns around it.

I personally find consent is quite a confusing issue in terms of understanding the case laws around it and understanding what our obligation as doctors are. What I try to do in my clinical practice is apply the guidance as best as we can and try and take that to an individual level, and I think the EIDO health care leaflets really do help with that and, but as I say, other comparison sites are available.

So the case that I thought was of interest or might be of, doesn't actually involve an operation, but it involves a patient who is a 48 year old builder and he presented with a two week history of a painless foot drop. So the significance of painless foot drop in spinal surgery is there's no evidence that spinal surgery actually improves the outcome with a painless foot drop. There's loose evidence, about sort of 60%, that you might get some improvement. So a foot drop to myself as a spinal surgeon as where the power or the MRC grade is zero, so there's no contraction, there's no flicker. There's absolutely nothing. Patient reported normal bladder and bowel and that's documented and in clinic when he attended, it was documented that he had a pre and post-void volume. So again, the significance of this from my point of view, is I'm looking at this and seeing that this patient has 250 mil so, sort of a

can of Coke. We know that from evidence that once you get to about 250 mil, you should start getting the urge to open your bladder and after it was documented, the bladder scan was zero. A PR examination was done in clinic and that revealed normal tone, so the patient could voluntarily squeeze and also reported normal sensation and actually sensation was done using sharp and dull touch so that again adds that the cauda equina nerve routes were working normally at this point.

A discussion because the MRI scan on this patient showed a canal fill at disc L4-5. So he was at risk of developing cauda equina, although clearly doesn't have Cauda equina at this time, and the medical literature doesn't help clinicians. I don't think in terms of understanding cauda equina because there's lots of different grades on it. The patient's big concern was whether surgery would paralyze him and the surgeon involved explained that you couldn't give a guarantee that the patient wouldn't be paralyzed by the surgery, which I think I tried to defend this case, and I think that was a fair assessment. Whilst the risk of paralysis about 0.01%, the patient was told that the surgeon couldn't give him the guarantee that that wouldn't be a sort of outcome from the surgery, but understood that the surgery was aimed to get rid of the disc and prevent them losing bladder or bowel. A few weeks later there's documented evidence from a physio consultation that the patient underwent, that he had soiled the bed but he didn't seek medical attention. So this case ended up being litigated around the episode that this was a missed cauda equina. And that the patient wasn't appropriately advised around the risks of him developing cauda equina and that actually surgery should have been done and that the patient, if he had known the risks, would have undergone surgery.

Now, unfortunately, this case, the documentation of the clinic wasn't very good. The patient was red flagged in terms of, but wasn't actually told the risk of cauda equina and this was settled out of court. Initially, I think they were aiming for much higher, so we were able to reduce it with the medical legal, with the arguments around it, but settled out of court for around £40,000.

So I think this highlights that actually consent isn't just about operations or interventions. It's about actually establishing that understanding of what the options are for the patient. I think this goes on to show that we have to make sure that patients are understanding the situation and understanding it. And what, I'm sure the lawyers will agree is the biggest thing around these cases, of around documentation, and if it's not documented, it's very difficult to prove that that was said or that was done.

So that that's my case. I think Joe's got some other cases so I'll pass over to Jo now.

{Jo:
Yeah, thanks Frankie.

Yeah, it's interesting actually. So in a previous role that I had, still an underwriting role but previous, our largest claim which paid over something like, over a million quid, maybe 1.6 or something, that was also a failure to diagnose cauda equina. And really, that was with a chiropractor actually, so the issue that we had on that wasn't that the chiropractor had done anything clinically wrong, but she'd failed to red flag. But the reason the claim was so expensive was because it was to do

with patient profile, which I'll go and talk about that a bit in a minute.

But yeah, this case too, this is quite interesting. This is actually in Australia, it's an Australian case. It's interesting because it's a regulatory matter. So this was not any sort of civil litigation and it was about a GP. I think the other interesting aspect of it was to do with, the kind of the thrust of it really, was that the GP was sort of overstretching himself in in the treatment he provided and, really wouldn't like to say he wasn't clinically competent, but perhaps he should have involved other people. He should have referred on and that kind of thing.

So that was an issue on this, but there were 11 patient complaints and they found all kinds of failings in his practice. He hadn't really discussed any alternatives. He'd just sort of gone gung-ho with all these patients and done these skin surgeries which, clearly as a GP, probably not difficult to imagine that he wasn't perhaps the best clinician to be doing the procedures in the first place. You know, he didn't give the patients any time to reflect. He didn't refer anyone on, didn't get any second opinions. He didn't detail his notes properly and then he also admitted, as part of the investigation. that he didn't he didn't even make contemporaneous notes. Which is obviously a bit of a disaster, because if you're seeing multiple patients, I think he said he sometimes made them later in the day, or maybe the following day. Which probably meant to my cynical mind, probably means the following week (laughs).

So he's seeing, you know, a number of patients in that time and, you know, you're not going to remember the specifics of every case,

especially if you're seeing people for similar problems, providing similar, you know, options to them. Or lack of options in this case. He was using, I think we've touched on already, but using a very basic consent template for the surgery, so it was more like a tick box exercise and it didn't contain any notes and it also meant that it wasn't individualised to the patient, which, of course, is key. Although this was Australia, but that is a key aspect of Montgomery, that it needs to be personal for the patient. And then, of course, he wasn't really clinically competent, it does say actually 'a lack of clinical competence'.

And yeah, he also was a lone wolf. He was a solo practitioner, so he wasn't seeking any kind of peer support or anything like that, particularly for these cases that might have been out of his area of expertise. So the upshot was that actually he was suspended for five months, which actually I thought was for such a load of issues in his practice, I thought that was quite a modest suspension. But there was conditions on that, which also included, you know, he had to seek treatment from his GP and a psychologist. So there was obviously a little bit more to the whole thing, which when I was reading the case report, it didn't go into details of that obviously. But then when he returned to practice, there were quite a lot of restrictions, I think probably around supervision and that kind of thing. So I thought it was quite interesting just because of its regulatory nature, if nothing else. That's my source there at the bottom. I actually got that from Avant, who are one of the MDAs in Australia, got that off their website. They have quite a lot of interesting material if you want some extra reading. (Coughs)

So I don't know, a lot of people don't really know what underwriters do. So I'm not a lawyer. I don't work on the claim side of insurance, I assess risk and so this is something that I always say to clinicians, and it plays so crucially into Montgomery, I think, is that you really need to get to know your patients. Because patients, you know, really in the interest of not being sued. I mean, nobody really wants to be sued, I don't think. But patients are, they can be quite tricky. I guess like, you know, 90% of your patients will be fine and not cause you any problems, you'd like to think. But we call this, I call this, red flagging for patient profile.

So, you know, we're providing insurance for people in the private sector. So this is often something, you know, if you get these kind of red flags crop up, then maybe think about consulting a colleague, referring on to a colleague, declining to operate, you know, if that's an option as well so. But yeah, all these kind of characteristics. So serial patients. Ones that have had numerous treatments elsewhere, particularly we see this a lot in the complementary arena as well, where patients are really desperate for solutions if they've had like ongoing chronic issues. And so that is definitely something to watch for because ultimately, if you can't solve their problems, that's probably going to come back to bite you.

Secretive patients. This is always a massive red flag for me. The patients that aren't happy to consent for you to share information with GP or vice versa and that that kind of thing. That should definitely always ring alarm bells. They’re usually hiding something. Unrealistic patients. That's, you know, obviously a classic. We obviously we cover a lot of cosmetic surgeons and so patients are often unrealistic about

cosmetic outcomes. I think my favourite example of this was, quite a long time ago, where we had a claim and it turned out when we investigated it, that the patient who was, I think in his early 70s or something. I think that he'd been treated, I think at least half a dozen times for, I think it was Botox treatments and fillers. So it wasn't really surgery, but it turned out that the very first consultation he'd had with the clinician, that he had pulled a photo out of his bag and said, 'oh this is what I want the result to look like'. Bearing in mind this guy was in his early 70s, and it was a photo of Elvis. Probably not going to happen. (Laughs) So, you know, that sort of thing, you really need to manage their expectations, you know, and impatient patients, same thing. You know, if people are in a hurry, they're not going to give due consideration to anything like the consent process, the risks involved, cooling off, that kind of thing.

Your bedside manner is so important with this stuff. So patients don't sue people they like, or they try not to. But if you have a sympathetic, empathetic bedside manner with a patient, they will tell you more about themselves probably. You'll find out more about them, which means you can more effectively consent them because you'll be better informed, which means you can, you know, that their consent process will be more informed because you can tailor it appropriately. And yeah, emotional intelligence is something. Always try and be emotionally intelligent around your patients, I think. And, you know that will basically have better outcomes for consent, which will, you know, avoid having, you know, avoid any litigation, hopefully.

And I think, probably people have talked about this already, but I cannot stress it enough. You might have the best consent process in the world,

like top notch, ticking every single box you possibly could, but if you don't write it down, it doesn't matter. So record keeping is just so important. Contemporaneous notes is so important. The consent form, I think Frankie mentioned, it's only a small part, really, of the whole consent process. So you really need to evidence all the discussions. You need to say, you know, 'the patient asked me if she would be able to go, you know, when she would be able to go back to swimming or running' or something like that. Those kind of conversations should really be reflected in your notes. Cooling off period, again, you know, there's a lot of information to take in for patients, so you never underestimate that. And always provide them with relevant literature, make sure that it's reflected in your notes or in your standard practice that you can provide evidence that you always send patients this, you always write to the GP, and that kind of thing. Because basically if it's not recorded, then it might, you know, it doesn't really matter. You might as well not bother doing any of it in the first place. We just say, no notes, no defence. Poor notes, poor defence. Is what we say to people.

But, it's not all bad news. (Laughs) I mean we kind of wanted to put something positive in here, because it's all a bit doom and gloom sometimes when you're talking about consent, but this is a case we had, was fairly recent, a couple of years ago. It was a rhinoplasty procedure and the allegations were specifically around a failure to consent, so that it was a 100% consent allegations, and specifically about the risk of scarring and it was the particular scar as a result of the particular procedure. And the patient, again, slight alarm bells here. She's quite young, had an online profile as well. So you know, she was I think she did a bit of, she did a bit of modelling. I think mostly for friends and that kind of thing, and it was all online, but that's the sort of thing

that rings alarm bell with me. When the claim came in, we initially assessed it was probably worth around £140,000, which would have been the damages to the claimant, the claimants lawyers' costs, wouldn't have included any defence costs. But when we investigated, the surgeon concerned had had two, hour-long consultations with her prior to the procedure being done and then further discussion immediately before the procedure was done. So there was quite detailed discussions and it was all reflected nicely in the notes. He also had good evidence that he'd shown her examples of the you know, the same procedure being done and what the result would potentially look like. And it mentioned, I think his notes specifically mentioned scarring several times. so that was already good and it was also all there in the notes. So there was no real way it could be contested, which was great. He was also able to say, you know, this is what I do with every patient and here, you know, I provide them with these leaflets and that all that kind of thing. Surgical outcome was good, which helped. And the expert evidence. we got an expert on it. Expert evidence were supportive of the surgeon because of all of those things, really. And then there was also, there was nothing really to call into question his expertise. He had published papers on his techniques and that sort of thing which all supported it but without the stuff, you know, in the notes, then that wouldn't really have been worth a lot, but it did help the case. And so we were able to just really robustly defend the claim from the outset.

We issued a letter of response and then we never heard anything more basically, after a few months or after a bit of chasing, the claimants lister said they hadn't heard from the patient and they were gonna close the file. So the claim was discontinued and we actually only spent around 10,000 pounds on it, which is a massive difference, really, if you think

about the £140,000. And I think clinicians, it's kind of like the clinical notes, you know, we get a lot of claims in where clinicians say, 'oh, but I didn't do anything wrong. This this claim is complete bullshit'. And it's like, yeah, but we need your notes to support that. Like it's not that we don't believe you. (Laughs) It's just we need the hard evidence. And so it's really satisfying when we can actually just say, 'no, this claim is complete bullshit'. And I think it was in this case. I think, probably fair to say that it was a bit of a try on. But that wouldn't have mattered if we hadn't been able to rely on what was in the notes. It wouldn't have made any difference. We would have paid out on it and she would have walked off with a nice little damages payout. And I mean, there was some photos on the file when I read through it and like, I couldn't see the scar. I mean, the scar was, you know, pretty non-existent, if you ask me, but I am quite cynical (laughs).

So yeah, so there's just some top tips on how to avoid getting sued. But a of these are around, you know, around consent. So you got your patient, you know, your patient profiling, watch that. Keep good notes. But your patient specific consent, it's just so important. Learning from mistakes is something they regulate I don't know if anyone has really ever had the misfortune to be investigated by the GMC, but that's something that the regulators are always really keen for, is that level of insight. They really want to see that you know, you are learning from your mistakes, you've changed your practice because of something that might have happened. You know, stick to knitting, don't go outside your area of expertise, or if you do make sure you're consulting with peers and that kind of thing, and yeah, just be emotionally intelligent, is always a good thing.

And I think that's us done. But yeah, now you know.

[Matthew:

Do you want to take a seat.

Thank you, Frankie and Joe. We've got a couple of minutes left, one minute 37 seconds for questions. So if you pop your hand up.

[Unnamed attendee:

Thanks, Jo and Frankie.

Quick question on the cooling off period. How long is a reasonable amount?

[Jo:

14 days. Yeah. Sorry, 14 days for anyone who didn't catch that. I mean you know I guess that depends, maybe on the type of procedure you know, how complex it is and that kind of thing. But I would say, this is what we usually say to the cosmetics surgeons, we usually say a minimum 14 days. Yeah.

[A different unnamed attendee:

Thank you for that excellent talk. In the cancer world, we often have targets where, within 31 days, patients need to have a diagnosis which includes a biopsy in the operating theatre. So if we were to allow 14 days cooling off period, including the 14 days where the patient has already been referred from the GP, we're already at 28 days, plus time to get the histology back from the lab and then discuss in our cancer meeting. we'll be looking at more like 42 days or something like that. Where do we stand on this?

[Jo:

Yeah, I mean the 14 days is not hard and fast. I think if you're under time pressures for clinical reasons, then again that would be a much easier position to explain, I'm talking about elective I suppose. I don't know what kind of cooling off you would think would be appropriate in those circumstances Frankie?

[Frankie:

I think, obviously when you're dealing with cancer, you're dealing with a time dependent condition and you have to factor that in and obviously in an emergency situation. so when we get patients who have fractured necks and such like, we don't have the luxury, like you're saying, of a 14 day period, you know. Your cord's at risk, you need your surgery now. So I think, and I defer to the legal experts, I think there is a degree that, there is a an allowance for that.

Obviously on an elective procedure, like a discectomy, we want the consent to be within three months so that they haven't completely forgotten all the pros and cons, but equally we don't want to be doing it on the day. And there was a case from a RDNE which actually kind of covered that process where the patient was consented by the fellow who was going to be doing the spinal operation on the day and the patient felt that they had waited for the consultant to do the surgery so felt pressured to have the operation and therefore they agreed and then unfortunately they had a complication.

Now, some of the expert evidence on that case was that the complication wouldn't have happened if the consultant had done it. Now, I think that was a leap of faith, but an expert had said that based on his experience

when he was a junior consultant, his risks or his complications were higher than now as a senior consultant. So that case was successful in the litigation because they argued that there had been pressure applied to that patient, that they had waited so long they were in the bay for the anaesthetic. and therefore they felt that there should have been more of that cooling off period applied to that. Now, I think for elective cases, you can definitely do that and obviously when you’re dealing with, you know, time dependent conditions you've got a slight leeway in my opinion.

[End of transcript]