

Personal risk management

Just about anything can go wrong in medical practice and when it does, a single incident lasting just a minute or two can be the subject of a long string of inquiries spanning months or years. These might include investigation under a complaint procedure, disciplinary procedures, Medical Council inquiries, a clinical negligence claim, criminal proceedings, and, in the event of a death, a coroner's inquest. Risk management is about preventing problems for the benefit of patients and your hospital or practice. Given the range of accountability procedures and their potential aftermath, there is considerable self-interest in preventing adverse incidents yourself.

Broadly, personal risk management can be broken down into a number of categories—legal responsibilities, sound clinical management, competent administration, clear communication, and comprehensive contemporaneous records. The primary purpose of medical records is continuity of care but good notes will also be of considerable evidential value, although this is merely a beneficial side-effect rather than their genuine *raison d'être*.

Legal responsibilities

Medicine is about the treatment of patients and quite naturally this is the focus of the undergraduate curriculum, but it is hardly fair to launch newly qualified doctors into their career without giving them a rundown on the rules governing medical practice.

Law is constantly evolving. New statutes and cases brought before the Courts result in continuous refinement of the law. In the United Kingdom, the Bland case¹ gave legal authority to advance refusals to medical treatments, and *W v Egddell*² confirmed that the duty of professional confidence is not absolute. Doctors must keep up-to-date with the legal framework governing medical practice, just as they must remain up-to-date with developments in their own specialty, including the law on consent, confidentiality, statutory responsibilities, accountability processes, the Medical Council's guidance on professional responsibilities, legal aspects of death, including the role of the coroner, complaint systems, and talking to patients. Perhaps surprisingly, doctors are still apprehensive about talking to patients when things go wrong. Should you come across a problem in practice, your medical protection organisation is an obvious first port of call and in terms of keeping up-to-date, journals, including *Casebook*, are probably the best source of information about current issues and developments.

Sound clinical practice

In the event of a complaint or claim, your defence is reliant upon demonstrating that you acted in accordance with

acceptable medical practice. That process starts with putting yourself in a position to make a sound clinical judgement—taking a history, conducting an appropriate examination, initiating relevant investigations, and so on. Managing patients within established protocols or guidelines is obviously helpful when defending allegations of inadequate care. But guidelines may not exist or be applicable for every instance, in which case you should be guided by established principles, by reference to experienced colleagues, and the relevant literature. Legal assessment of cases is necessarily evidence-based so evidence-based practice has a built-in advantage.

Prescribing errors are among the most common single causes of adverse incidents in clinical practice. Prior to signing a prescription, dispensing, or administering any drug, it is the doctor's duty to ensure that there is a clear indication for its use, that there are no absolute or comparative contraindications, that appropriate monitoring is in place, a review period has been set, and the patient has been warned about possible side-effects and reporting of adverse symptoms.

Other common problems include alleged delay in diagnosis, failure to arrange appropriate monitoring and follow-up, and inappropriate delegation of tasks to junior medical and non-medical staff. Part of every doctor's duty of care is to ensure that his or her practice is limited to his or her own area of expertise.

The communication net

A multitude of people may be involved in the care of any given patient, including the hospital team, the general practitioner and his/her staff, the community nursing staff, possibly including palliative care nurses, the social services department, the voluntary sector, and the patient's family. Each member of the extended team must be aware of what they should be doing, although care must be taken not to breach confidentiality without proper justification (Fig).

Communication failures include the complete absence of any communication, not checking to ensure that certain

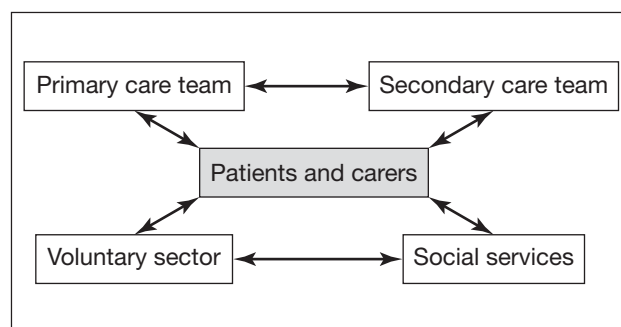


Fig. Communication network

services are available from an individual being asked to undertake them, inappropriate means of communication such as dictating a letter which will not be typed for several days when more urgency is required in transmitting the message, and using the patient as a messenger when they do not understand the information they are meant to convey.

Competent administration

Administration may be dull but efficient administration is, nevertheless, essential to any smooth-running operation. Failure to provide appointments in a timely fashion, not having a system in place to assess urgency or to check results, identify abnormalities, and take necessary action, or failing to pass a simple message from a general practitioner relevant to a patient recently arrived at hospital. A simple slip may have catastrophic results. Some administrative processes are extremely well worked out, for example, marking the correct side for operation and swab counts in theatre but, in many hospitals, systems are the result of evolution rather than design and may be over-dependant on assiduous attention to detail by one long-serving and loyal member of staff. What happens when that person goes sick or retires? Doctors are senior members of the team and must interest themselves in the mechanics of mundane processes.

Contemporaneous records

Complaints, claims of negligence, and other forms of investigation may not materialise for weeks, months, or even years after the events in question, by which time the doctor is unlikely to remember exactly what happened at a given consultation, particularly where there has been a sequence of consultations over a period of time. Even if only for corroboration, the doctor must be able to refer to contemporaneous medical records, and if they are inadequate the doctor's position will be prejudiced.

One definition of an adequate medical record is one that enables the doctor to reconstruct the consultation without reference to memory, including adequate details of the history; answers to relevant direct questions; a record of all

systems examined, noting all positive findings and important negative findings, as well as objective measurements such as blood pressure, peak flow, and so on; the clinical impression formed; any investigations ordered; treatment prescribed or referral made; and arrangements for follow-up or admission. Medical records should also be objective and worthy of independent scrutiny as, in the event of an investigation, the notes will be pored over in considerable detail.

At first this may seem a daunting task, far too onerous given the time available, and an unnecessary defensive response to the rising tide of negligence claims and complaints. This is not, however, defensive practice—the primary purpose of a medical record is to provide continuity of care and all the details referred to above are necessary to meet this end. Coincidentally, the notes will be of considerable evidential value. In addition, good medical records will create a good impression of the doctor's general standard, whereas shoddy notes will be equated with shoddy practice. Keeping comprehensive medical records is an intrinsic part of good medical practice that, by its very nature, is defensible rather than defensive practice.

Should something go wrong, the patient is entitled to a full and frank explanation of why things happened in the way that they did. However, before attempting to explain, the doctor should establish the facts and, for this, the clinician will be reliant upon adequate medical records—the paucity of which may have been the seat of the problem in the first place.

G Panting, FRCGP, DMJ
Communications and Policy Director
The Medical Protection Society
London W1G 0PS
United Kingdom

References

1. Airedale NHS Trust v Bland. 1 All ER 821. 1993.
2. W v Egdell. 2 WLR 471. 1990.