OTSIS NEWS

supported by the MPI GROUP

OTSIS is a mutual exclusively for orthopaedic surgeons, owned and governed by its members and supported by the MPI Group, a specialty specific medical defence organisation. Read on to discover exciting developments for 2019 including our inaugural training day on 16 November and a clinical overview of meniscal allograft transplantation from your Clinical Board Chairman, Ian McDermott.

Juliette Mellman Jones
Medico-Legal Director, The MPI Group

"Welcome to your first newsletter of 2019. Now we're up and running, we're planning quarterly newsletters for all Schemes supported by the MPI Group to keep you updated of all significant developments."

The medical malpractice world is certainly experiencing a number of challenges at the moment and I'm sure you're all plugged in to the latest UK Government consultation on appropriate clinical negligence cover for healthcare professionals not covered by NHS Crown Indemnity.

From 1 April 2019, Crown Indemnity will be rolled out to NHS GPs but the consultation remains very relevant to consultants practising in the private sector. Essentially, the question being asked by the Department of Health and Social Care is whether the status quo should be maintained, allowing healthcare professionals to purchase discretionary indemnity or insurance cover or whether healthcare professionals should be obliged to purchase an insurance product only (as you have done by becoming a member of OTSIS).

Predictably, the MDU has strongly advocated retaining the status quo, criticising the consultation document as flawed in a number of ways. Other responses are more measured, for example, advocating the creation of a fund to be contributed to by both discretionary providers and insurers, to which an injured patient may apply for compensation having suffered an injury following clinical negligence if, for a valid reason, the defendant doctor's discretionary indemnity or insurance policy does not respond.

The fund would operate much like the Motor Insurers' Bureau for uninsured or untraced motorists following a road traffic accident. The Department of Health and Social Care is currently reviewing all responses received and will be publishing a summary. Watch this space for updates in future newsletters!

In the meantime, do take a look at the article on the changing nature of medical indemnity which I wrote together with one of our medical indemnity advisers, James Rose, and Prof Gordon Carlson, consultant general and colorectal surgeon.

Our article was initially published in the Journal of the Association of Surgeons of Great Britain and Ireland in December 2018 and we reproduce it here with their kind permission.

Do please continue to recommend OTSIS to your consultant colleagues. Remember you can qualify for a "Refer a Friend" contribution of up to £350 towards a recognised CPD course if you successfully refer one of your colleagues who joins OTSIS as a new member and takes out Medical Malpractice insurance through the MPI Group. Full terms and conditions of how our "Refer a Friend" programme operates are available on our website **www.mpi.group**.

"The medical malpractice world is certainly experiencing a number of challenges at the moment. From 1 April 2019, Crown Indemnity will be rolled out to NHS GPs but the consultation remains very relevant to consultants practising in the private sector."

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Views from the Clinical Board Chairman, Ian McDermott

This is the third newsletter now from your new OTSIS Board, since we were elected to office last year. We hope that you find these newsletters relevant and interesting, and we would welcome any feedback that you might be willing to give. In particular, if you have any suggestions about any specific topics that you'd like to see covered, then please do get in touch.

In each newsletter we are including a clinical update section. In the last newsletter this was a short article from Joel Melton about osteotomy around the knee. In this newsletter we have an article from me about meniscal transplantation in the knee, discussing what the real meaning of 'success' might be, and how this should be defined scientifically.

Nowadays, all of us subspecialise, and it is very difficult to write content that is likely to appeal to the full breadth of OTSIS Members, particularly coming from a small OTSIS Board (with 2 knee surgeons, 1 foot & ankle surgeon, 1 limb reconstruction / trauma surgeon and 1 medicolegal specialist). So, for the benefit of variety and for all the members of OTSIS, we would greatly welcome any contributions that any OTSIS members might be willing to submit. Articles should be about 500 to 1000 words about any subject you think your peers might find interesting! Please simply e-mail them in to info@mpi.group.

In this newsletter we have an important article written by James Rose, Prof Gordon Carlson and Juliette Mellman-Jones (reprinted with permission of the JASGBI) that emphasises the differences between insurance vs discretionary indemnity, and which highlights the critical importance of each of us having a true understanding of what risks we are subject to and what precise cover we actually have. This is something that we all need to be aware of and consider carefully in advance of any potential issues rising, and not after the horse has bolted!

OTSIS is growing! Thanks to the hard work of the MPI Group team and also, we believe, because of you, the OTSIS members, spreading the word about just how good OTSIS truly is, we have retained more existing members and recruited more new members in the last few months than ever before. The bigger OTSIS is, the stronger we are, and the more leverage we, as a group, then have to ensure that we get the best support and the best possible deals for all of us, collectively. So, please get out there, spread the word and help recruit – and please simply put any interested colleagues in touch with James Rose, John Buckley and the team at MPI Group or direct them to our website: **www.otsis.co.uk** (soon to be updated)... And remember, there's a **'thank you' reward of up to £350** for you towards any approved CPD course for any colleagues referred who successfully sign up to OTSIS as a new member and takes out Medical Malpractice insurance through the MPI Group!

And finally, massive congratulations are due to Juliette Mellman-Jones, our Medico-Legal Director at MPI Group, on being featured in the Timewise 2019 Power 50 Awards! This is a list of the top 50 executives in the UK who work part-time or flexibly. Timewise conducted a nationwide call to action for nominations, getting the public to nominate inspirational individuals they knew who work part-time / flexibly at senior levels, and the Top 50 list was then drawn up by a panel of judges consisting of some of the leaders of UK industry. Congratulations Juliette!!

Save the date - 16 November 2019

The Inaugural MPI Group Training Day will be held on 16 November 2019, at WRB's London offices with superb views over the city of London.

High quality speakers will cover topical medico-legal issues including consent and how to deal with a GMC complaint.

It will also provide an opportunity for you to meet your colleagues and friends from all Schemes supported by the MPI Group as well as your Clinical Board.

More details to follow but please save the date!

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Meniscal allograft transplantation in the knee: what is success?

Mr Ian McDermott

Meniscal allograft transplantation is a well-established effective procedure, with 'good' outcomes. It is not new - the first case series was published way back in 1989 by Milachowski[1] and since then there have been thousands of publications on the subject - it's just taken a very long time for this procedure to begin to gain popularity in the UK.

In terms of long-term outcomes, probably the most useful paper is that from Peter (son) and Rene (dad) Verdonk (who are both awesome!), with their great paper: "Twenty-six years of meniscal allograft transplantation: is it still experimental?"[2]. In rough terms, the 'success rate' is in the region of about 85% at 5-year follow-up, but (similar to articular cartilage replacement procedures) with results gradually dropping off with time. As with most things, however, the key thing when it comes to success rates is the issue of how one actually defines 'success'.

> *"In my mind, it's very clear that meniscal transplantation is 'salvage surgery', not restorative. A new donor meniscus is never as good as one's own original meniscus."*

'Success' in cancer treatment is reported quite differently from, for example, 'success' after hip or knee replacement surgery.

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95% survivorship at 10-year follow-up would be considered 'a miracle treatment' for cancer therapy. Improving survivorship by an extra 1 year for arthroplasty surgery would be considered perhaps trivial.

So, before we can decide whether a particular treatment is worthwhile or not – i.e. worth (from the patient's perspective) enduring the associated pain, hassles and risks – we first need to have a clear understanding of what it is that we're actually trying to achieve. In my mind, it's very clear that meniscal transplantation is 'salvage surgery', not restorative. A new donor meniscus is never as good as one's own original meniscus.
Also, meniscal transplantation is not normally performed in people with no meniscus but otherwise entirely normal knees. There might potentially be an argument for considering prophylactic lateral meniscal transplantation in children / adolescents who have suffered complete removal of a torn discoid lateral meniscus, although this concept is contentious and so far unproven one way or the other.

For adults, however, it is difficult (perhaps impossible) to justify subjecting someone to major complex surgery unless their knee is actually significantly symptomatic. If someone's knee is symptomatic after previous meniscal loss, then this is normally a sign that at the very least there is some articular cartilage damage or loss in that compartment of the knee, which is a sign that the knee is going downhill. Replacing a missing meniscus with a substitute meniscus (which is inferior) has a good chance of reducing the patient's symptoms and helping them keep their knee going for longer, but it is not going to reverse whatever damage is already present. Hence, the aim is simply to buy the patient extra time in order to delay, but not necessarily avoid, the eventual requirement for knee replacement surgery, and quite rightly meniscal transplantation has been described as "a bridging procedure".

So, what of those of our colleagues who make statements such as "73% of my patients return to sport after meniscal transplantation"? Well, in my personal opinion, this is ill-advised, at best. What lung surgeon would boast that 73% of their patients get back to smoking after lung transplantation, and what liver surgeon would market a 73% return-to-drinking after liver transplantation?! A doctor's duty is to do the right thing and to look after the long-term interests of their patient, and this includes us sometimes having to upset people by educating them about the harsh realities of what they've got and what the longer-term consequences of their knee pathology might actually be.

Allowing oneself to be complicit in encouraging patients to smash up their knees further is dubious ethics at best. I personally spent a minimum of 1½ (more often 2) hours of proper face-to-face time with each patient prior to listing them for meniscal transplantation, as I consider proper patient education to be essential, not just for 'modern consent' but also to ensure that each patient's expectations are realistic and appropriate.

The best way to end up with an unhappy patient is to start them off with false promises and unrealistic expectations. So, what is 'success' in meniscal transplantation, and hence what are the real outcomes?

Meniscal allograft transplantation in the knee: what is success - continued...

We recently completed a retrospective review of 60 of my meniscal allograft patients, with a mean 3-year follow-up. We used 6 validated outcomes measures, using the IKDC Subjective Score, the KOOS score, the Tegner Activity Index, the Lysholm score, the SF-12 quality of life score and a VAS pain score.

We defined 'clinical failure' as a Lysholm score of <65. We defined 'surgical failure' as removal of most or all of the allograft, allograft revision or conversion to arthroplasty. We also asked our patients "would you undergo the procedure again?". 'Clinical failure' was observed in 20% of patients. 'Surgical failure' was observed in just under 10% of patients; however, if repeat arthroscopy was included in this definition (but without graft removal) then the 'failure rate' was double, at 20%. Interestingly, 40% of patients reported being unhappy with their level of post-op sporting activity; this, despite being advised repeatedly that they should never return to impact type sport / exercise again after their surgery. However, only 15% of patients stated that they would not want to undergo the procedure again. I'm happy enough with these results. They're not 'amazing' – but then meniscal transplantation is not 'amazing': it's a salvage procedure in people with few, if any, other reasonable options, who more often than not also have other concomitant pathology in their knee that needs addressing at the same time, such as articular cartilage grafting, ACL reconstruction/revision and/or osteotomy. These patients represent perhaps one of the most difficult patient groups seen by a soft tissue knee surgeon.

"We, as a profession, must take a proactive lead in educating people properly about the facts of what we do."

Hopefully this short article highlights some of the problems that we, as consultant orthopaedic surgeons, face when it comes to people's perceptions of our outcomes, and whether what we do is 'good' or 'bad', and 'successful' or not. As usual, it's all about appropriate patient selection, proper patient education and counselling, setting realistic expectations and then doing a good job, when needed. The debacle of the recent arthroscopy 'debate' (which was actually a very blinkered one-sided anti-surgery rhetoric) culminating in crass misleading headlines like "arthroscopy doesn't work" simply highlights how we, as a profession, must take a proactive lead in educating people properly about the facts of what we do, and we must remember that it's the details and the definitions that define the facts!

[1]Milachowski KA, Weismeier K, Wirth CJ. Homologous meniscus transplantation, experimental and clinical results. Int Orthop 1989; 13: 1–11.

[2]El Attar M, Dhollander A, Verdonk R, Almqvist K, Verdonk P. Twenty-six years of meniscal allograft transplantation: is it still experimental? A meta-analysis of 44 trials. Knee Surg Sports Traumatol Arthrosc 2011; 19: 147–157.

Insurer Update – W/R/B Underwriting

In recent years, the clear lines of "vicarious liability" have become blurred following several recent court decisions. This has caused concern in the medical profession as to who is liable for what. For example, most surgeons operating at private hospitals commonly do so under Practising Privileges policies, as independent contractors, rather than as "employees" of the hospital. Should a patient bring a claim about their treatment (which could be mixture of surgical and nursing care), who should they direct their claim to?: (a) the surgeon; (b)the hospital; or (c) both?

In the 2018 case of *Barclays Bank Plc v Various Claimants*, Barclays were held vicariously liable for the independent contractor GP who abused people sent for employment medicals. That decision marks the first time that an organisation has been liable for the actions of an acknowledged independent contractor. However, permission has been granted for this case to be appealed to the Supreme Court. When heard later this year, it should provide further clarity on when and where vicarious liability will apply even for "non-employees".

What should surgeons do?

They should review the terms of their Practising Privileges policy, ensure it is up to date, and that they are aware of the terms generally. They should also ensure that they are aware of the complaints procedures, and the patient terms and conditions for the hospitals where they may operate. Surgeons should ensure that they do take part in any early patient grievance or complaint which has been received by the hospital, with assistance from the Medico-Legal Advisory team at the MPI Group. It may surprise some surgeons to know that the hospitals in which they operate may be entitled to take legal action against them personally if the hospital is dragged into a claim.

Daniel Cambage, Claims Solicitor, W/R/B Underwriting.

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The Changing Face Of Medical Indemnification
Caveat Emptor! (Let the buyer beware!)

Prior to 2009, most doctors belonged to one of three organisations that were structured as not for profit mutuals, run by doctors for doctors – Medical Protection Society (MPS), Medical Defence Union (MDU) and Medical and Dental Defence Union of Scotland (MDDUS). These providers traditionally offered discretionary indemnity, meaning that, unlike commercial insurance companies, they had no contractual obligation to meet the cost of any claim against the doctors they covered.

Historically, discretion was rarely exercised against a doctor and so claims against that doctor were accepted and settled with the claimant. Most doctors invariably joined one of the above organisations at a junior stage in their career and, as in the relationship they had with their bank, they never left.

Indemnity for these organisations was also provided on an "occurrence" basis, which meant that, as long as a doctor was a member of the MPS, MDU or MDDUS on the date that the incident occurred, he or she may be covered even if the claim was brought many years later. However, over the last 9 years, there have been a number of pressures on this traditional model, some of which have been highly publicised.

"Professional indemnity cover is a legal and ethical requirement for all GMC-registered doctors. The GMC guidance, "Good Medical Practice" states that all doctors must have adequate and appropriate insurance or indemnity arrangements in place which cover the full scope of a doctor's practice in the UK."

One notable example has been the multiplicity of claims from private patients brought against the breast surgeon, Ian Paterson. His indemnity organisation, the MDU, initially declined to provide cover in relation to these claims and ultimately agreed to do so only following a lengthy court process.

Further concerns relating to the traditional indemnification model include the fact that, unlike insurance companies, these organisations are wholly unregulated from a financial point of view and there is currently no legal obligation upon them to ensure that they have the financial reserves to cover the cost of claims. Competitors from the "claims-made" insurance world have now emerged as disruptive forces to the venerable tradition.

"Claims-made" means that a matter may be covered if it is reported during the policy period and the incident occurred after the date from which a doctor held uninterrupted professional indemnity insurance as specified in the policy (the "retroactive date").

The lack of contractual certainty that the discretionary model provides as well as the relatively high prices associated with pooling risk amongst the different subsets of the medical profession (the majority of the cost of claims relate to obstetric, paediatric and casualty/A&E care) has led to considerable interest in the profession for obtaining insurance-based indemnity and the claims-made market for doctors is currently thriving, with intense competition between several companies.

The Government is also currently consulting on whether the law should be changed to require all doctors undertaking work outside the NHS Crown Indemnity Scheme to hold an insurance-based product, although it seems likely that this proposal will be met with some resistance from the traditional organisations wishing to preserve the status quo.

Almost 10 years on from these disruptive forces coming in to the UK market, the problem for all insurance providers is the same as it ever was. Professional indemnity cover is a legal and ethical requirement for all GMC-registered doctors. The GMC guidance, "Good Medical Practice" states that all doctors must have adequate and appropriate insurance or indemnity arrangements in place which cover the full scope of a doctor's practice in the UK.

While NHS indemnification alone is almost always inadvisable, as this arrangement fails to provide protection, for example during GMC investigations or employment tribunals, in which the interests of the medical practitioner and their NHS employer may not coincide, some doctors have been content to remain with traditional organisations, as changing providers may be perceived as an administrative headache within the context of a busy practice.

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The Changing Face Of Medical Indemnification continued...

Others, aware of the plethora of options available, are far more likely to explore the insurance market, attracted (at least in part) by possible financial savings. Currently, many doctors fail to fully appreciate the nature of their existing cover or to adequately consider the risks of an option they may be considering. This lack of understanding creates risks for the doctor taking the cover. The indemnity requirements of the legal profession, which have generated similar concerns were solved by the introduction of a "minimum wording" that levelled the playing field in terms of disparate policy wordings, ensuring that all insurance providers had to agree to a minimum level of cover.

Such a key regulatory watershed has yet to occur for medical indemnity and many UK medical practitioners are currently making the mistake of shopping around, purely on price, as if they were purchasing car or home insurance, with little thought given to the need to ensure historic or future cover.

"Consultant surgeons in private practice are usually required to have a £10 million minimum level of cover. Whilst shopping around is a healthy feature of an open market economy; the temptation exists to buy purely on price."

Over-enthusiastic sales representatives may offer wholly unrealistic prices, based on a lack of past claims against a particular surgeon but which fail to appreciate the risk of future claims. The extent of cover is also important and the private hospital groups have stepped in to fill the void that arguably the GMC should have done, by having compulsory levels of cover for anyone practising on their premises.

Consultant surgeons in private practice are usually required to have a £10 million minimum level of cover. Whilst shopping around is a healthy feature of an open market economy; the temptation exists to buy purely on price. We are all contributors to this culture which is entirely acceptable for a multitude of products and services but not, we suggest, for professional indemnity insurance, unless a surgeon has a sufficient understanding of the various options and how they differ.

For those surgeons considering taking the plunge and purchasing claims-made insurance cover, there are a number of important factors to bear in mind other than simply cost. The sustainability, stability and credibility of the prospective insurer is essential. Risk management, educational and medico-legal advisory services may be included as an element of the cover and these should be carefully assessed for quality and value for money.

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Access to an expert clinical advisory board of senior colleagues may also be offered, and this should also be carefully reviewed. Surgeons being advised by reputable insurance brokers should have been carefully and repeatedly counselled as to the necessity of notifying the insurer as soon as the surgeon has been made aware of any expression of dissatisfaction. While a claims-made policy offers considerable protection and contractual certainty, it can only do so if the surgeon complies with his or her own contractual obligations. A claims-made policy is usually renewed on an annual basis and it is essential for a surgeon to notify any set of relevant facts which may escalate into a clinical negligence claim against that surgeon within the requisite time frame stipulated in the policy (usually within 30 days of first awareness of any expression of dissatisfaction) and within the relevant policy year.

The potential consequences of poorly planned "indemnity hopping" are best illustrated via the following case study.

Case study - Miss Smith

Miss Smith is a general surgeon with admitting rights at her local private hospital. She carried out an uneventful laparoscopic cholecystectomy on a reality TV star. Pre-operatively, her patient had attended two lengthy consultations to discuss the risks and benefits of the proposed treatment and potential variants to the proposed laparoscopic cholecystectomy including open cholecystectomy. The patient explained that he was very much looking forward to his next role in a reality TV show, which was due to commence a month after the cholecystectomy and was going to earn him a significant amount of money. He wanted to know about all possible complications, even those which were unlikely, because he wanted to be able to return to work as soon as possible. Miss Smith advised him of the possibility of conversion to open surgery, infection, bleeding, injury to the bile duct or surrounding structures and DVT. She did not mention bile leakage from the gall bladder bed as she had never experienced such a complication in thirty years of surgical practice.

Her patient unfortunately developed a serious port site wound infection and bile leakage, such that he was unable to work for several months and unable to appear in the highly-paid reality TV programme. He complained to the hospital and Miss Smith prepared a detailed response explaining her management of the patient and confirming

The Changing Face Of Medical Indemnification continued...

that wound infection was a recognised complication of such surgery and her patient was appropriately counselled about this preoperatively. She went on to explain that bile leakage was a rare complication, occurring in around 1% of cases and, as she had never experienced such a complication previously, she had elected not to mention it pre-operatively. She discussed her response with colleagues before sending it and her colleagues were supportive of her management.

At the time, Miss Smith had a claims-made insurance policy with a reputable insurer but she did not notify this matter to them. Unfortunately, her patient remained unhappy and requested a copy of his clinical records intimating that he wanted to take the matter further and was seeking legal advice. Miss Smith remained confident of her management and did not mention this to her new claims-made insurance provider (to whom she subsequently moved at a significantly reduced price) until she received correspondence from lawyers instructed by her patient alleging lack of informed consent. She then notified her new provider.

Discussion

Miss Smith lost two opportunities to report the matter to her former insurance provider. Firstly when the complaint was received and secondly having received the request for records. Miss Smith's new provider declined to cover her for the claim due to late notification and she was left to fund her own legal defence costs.

The claim was eventually settled and Miss Smith was also responsible for her patient's legal costs as well as the compensation payment, which was significant, given the patient's claim for lost earnings.

A cautionary tale such as this illustrates that moving medical indemnity providers may be possible but it is by no means straightforward and, if not undertaken with appropriate attention to detail, may expose the medical practitioner to risk. These risks may not only be financial, but also professional, if the GMC subsequently, because of a complaint made to them, considers that, in moving insurer, the medical practitioner had put themselves in a position in which they knew (or could have reasonably known) that they failed to have adequate or appropriate insurance or indemnity arrangements which covered the whole of their practice. Surgeons are advised strongly to ensure that they access expert advice from a reputable insurance broker, that they undertake a careful comparison of the increasing variety of the alternatives on offer and that they are in a position at all times to ensure that the indemnification they are obtaining fully covers their past, present and future practice.

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