WHAT TO DO WHEN THINGS GO WRONG

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The problem for doctors and other healthcare professionals is that a single clinical incident lasting just seconds can give rise to multiple investigations including an NHS complaint, a clinical negligence claim, disciplinary action by the trust, investigations by healthcare regulators (the GMC, LMC etc.), an Ombudsman's Inquiry, a police investigation and, in the case of a death, a Coroner's inquest.

Many of these systems have either recently been reviewed or are under review and likely to change in the near future but, no matter what the forum, being able to respond to comments or criticism requires information about what happened at the time which is likely to be based in entries within the clinical record.

The complaints procedure is designed to meet the complainant's needs. The majority of complainants want an explanation of what has happened and why, where appropriate, an apology and an assurance that any deficiencies in the system will be rectified so that the same thing cannot happen to somebody else.

The golden rules of complaints handling are to listen carefully to the complainant to ensure that the complaint is understood, to take time with the complainant so that there is no doubt that their complaint is being taken seriously, to inform them of the process so that they do not become frustrated if expectations of an early reply are not met, to ensure that you understand what has happened before any attempt at explanation is made, to ensure confidentiality is respected so that if the complainant is not the patient, they have the patient's consent or otherwise appropriate authority to complain.

If they are not satisfied by the local procedure, they must be informed of what further action can be taken and how this can be achieved.

Clinical negligence claims require the claimant to prove that there was a duty of care which was breached resulting in damage that would otherwise have been avoided.

In a clinical setting, there is never any dispute over the existence of a duty of care. Breach of duty is judged by reference to the Bolam test which essentially states that a doctor is not negligent if acting in accordance with accepted medical practice. If a deficiency in care is found, the next question is what harm flowed from the shortfall in care, as any harm which would have been avoided but for the negligence of the doctor or other healthcare professional attracts compensation.

The defence in any complaint, claim, GMC investigation or disciplinary procedure essentially turns on being able to demonstrate that the management was appropriate in the circumstances. This often requires expert evidence but unless the factual evidence - usually the clinical notes and other available records – enables experts to establish a clear chronology, it may not be possible to obtain a definitive opinion.

So the medical records are usually the foundation upon which the defence is built. If they are inadequate, otherwise defensible cases may simply be lost. That may suggest a rather defensive approach requiring voluminous records to be kept just in case there is an adverse outcome. But a defensive approach is not necessary or desirable. If the medical records are adequate for continuity of care, they will almost certainly be adequate for evidential purposes. The definition of an adequate medical record is one which enables reconstruction of the events without reference to memory and contains only the information which clinician B will require when taking over the care of a patient from clinician A.

Following an adverse event, clinicians may want to record extra detail which they can remember about the case. There is certainly no harm in doing this either by way of a separate statement or addition to the medical records but in any event it must be clear from that statement or addition that the extra record is being added after the event so that no-one can possibly accuse the author of attempting to mislead subsequent investigators about when that record was written.

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