The first time I came to Moorfields and observed British hospital doctors' very long working days, evenings, and weeks, I really grasped the full meaning of these remarks.

In spite of the international medical profession's scepticism about the working hours of Scandinavian doctors, foreign industrial labour organisations have for a long time considered our working conditions, and especially the region's opportunity for women to be able to go to work, as a model to strive for.

General working time limits in the European Union have gradually approached Scandinavian levels. This is reflected in the present European Working Time Directive (EWTD), which in its latest edition, states that after a maximum transitional period of 7 years, a defined upper working time limit for health personnel of 48 hours a week is to be established. Even if the EWTD thus leads to a substantial reduction in working time, the directive's rules are still not as liberal as in Norway.

Norway is not a member of the European Union, but because of its affiliation to the union Norway is obliged to follow the union's rules. In reality, the EWTD supersedes the Norwegian national regulations, compelling Norway to harmonise its working time rules in accordance with the European Union's.

It is not surprising that British ophthalmology will judge the consequences of the new directive as negative. When the ''Scandinavianisation'' of British working days and weeks eventually has been completed, my prediction is that the present intensive on the job training of British hospital doctors will gradually give way to a system where the doctor will spend more time with the family and also have an opportunity for increased leisure time. The proportion of female hospital doctors will increase. As for the time to acquire medical specialist proficiency of current British standards, this will undoubtedly increase.

Introducing new rules in society can represent somewhat of a trap, especially challenging to eager blinkered bureaucrats whose deepest wish is to exercise power over performers of enviable occupations like doctors, or for that matter, fighter pilots.

Therefore, a word of caution: do not fall into the trap that befell Norwegian defence bureaucrats when they introduced new working time rules for the Norwegian military some years ago. Quite a few unbelieving eyebrows must have been raised under foreign flying helmets when Norwegian fighter pilots in a joint exercise with other NATO pilots over Norwegian territory, suddenly broke off from their formations with the following radio telephone message: ''Sorry, new Norwegian working time rules force us to land so that we can reach our office desk to have lunch in the allotted time.''

Anyway, my dear British friends, I wish you the best of luck in your forthcoming effort to implement the Scandinavian way of a hospital doctor's life!

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Correspondence to: Sigrid Omland, Department of Ophthalmology, Ulleval University Hospital, Oslo, Norway; sigridomland@hotmail.com

Medical Defence Union

Over 120 years of defending ophthalmologists

C Tomkins

Hundreds of ophthalmologists every year turn to us for advice and assistance

The UK medicolegal climate has changed dramatically over the past 120 years. Ophthalmologists now are subject to far greater scrutiny than ever before. We call it multiple jeopardy. From just one single incident ophthalmologists can be held accountable and have their professional conduct scrutinised in numerous ways: by the civil and criminal courts and coroners, by their employers, the National Clinical Assessment Service, and the regulatory body, the General Medical Council (GMC); through the NHS or independent sector complaints procedures and the healthcare regulator, the Healthcare Commission. The editor of the *BJO* suggested a title of ''insuring ophthalmologists'' for this article and, in that context, since 2000, the Medical Defence Union (MDU) has provided MDU members with an indemnity insurance policy for clinical negligence claims. However, as well as claims, hundreds of ophthalmologists every year turn to us for advice and assistance with many other equally important medicolegal matters, which I will touch on too.

INSURANCE—THE CURRENT POSITION

Many doctors do not realise that just under half of the United Kingdom's practising doctors do not have professional indemnity insurance. MDU members have been provided with individual insurance contracts since 2000, a move not yet taken by the other UK defence organisations, whose members are indemnified on a purely discretionary basis.

This may seem strange, given the global medicolegal climate and the dramatic increase in negligence claims worldwide over the past 20 years. Many readers may not even know what discretionary indemnity is. Historically it was widely used as a means of indemnifying doctors, but has caused problems in many countries. Insurance is now mandatory in many EU states, most of the United States, and Australia. Unlike insurance, discretion gives doctors only the right to ask for assistance but not to receive it. We don't believe that discretionary indemnity alone provides sufficient certainty for doctors, or patients, when medical treatment goes wrong. Only insurance provides a contractual guarantee of defence, subject to the terms of the policy.

The UK Department of Health has recently conducted a consultation on a change in legislation to make indemnity mandatory for all doctors. We have suggested that the United Kingdom should get into step with other countries and that, in the interests of doctors and their patients, only insurance will do.

OPHTHALMIC CLAIMS

So what types of ophthalmic claims are we insuring? Looking at medical negligence claims against our members operating in independent practice (since NHS indemnity was introduced in 1990 the MDU has not indemnified NHS hospital claims), the specialty ranks around mid-range in terms of the likelihood of being sued. Our ophthalmic

members could face a claim, on average, once every 15 years from their independent practice. By way of comparison, in the highest risk specialties (such as cosmetic surgery) the average member can expect to be sued once every two years and in the lower risk categories, such as anaesthetics, doctors may expect to face only one claim in their whole career in independent practice. Of course, not all these claims will result in a settlement—only one in three claims against our ophthalmic members does and we successfully rebut the other two thirds.

The highest ever indemnity payment made on behalf of an ophthalmic member was £1.3 million following failure to diagnose a pituitary tumour. Looking at the five highest settlements, three resulted from complications associated with laser eye surgery. It is important to remember, however, that the cost of settling these cases reflects the severity of the injury, the amount of care the patient needs for the rest of his or her life, and the effect on factors such as the patient's earning ability. It bears no relation to the ''gravity'' or otherwise of any negligence as punitive damages are not awarded in the United Kingdom for medical negligence claims.

COMMON REASONS FOR CLAIMS

Patients received compensation as a result of negligence in the following clinical circumstances:

- Cataract treatment, 39%
- Laser treatment, 34%
- Detached retina, 7%
- Glaucoma, 6%
- Medical condition—for example, cerebral tumour, hypertension, 6%
- Blepharoplasty, 3%
- Other, 5%.

Cataract surgery accounted for over a third of settled claims in the specialty. Common causes of claims from cataract surgery included technical and surgical error, postoperative infection, wrong power/size/type of intraocular lens being used, and inadequate consent.

Key factors that led to settlement in the other categories included failure or delay in diagnosis or treatment, technical issues, such as incorrect setting of lasers, prescribing errors, inadequate consent, and postoperative infection.

LASER EYE SURGERY

Laser eye surgery to correct refractive problems became a significant source of claims against MDU members around the year 2000 when we began to receive increasing numbers of claims. They now account for a third of all ophthalmology claims on the MDU's files. On average, the cost of litigation against laser eye surgeons is considerably higher than that of ophthalmic surgeons who do not carry out laser eye work.

Many of the claims cited patients' dissatisfaction with vision postoperatively and corneal scarring. A study carried out by the MDU in 2003 revealed that over the previous 6 years there had been a 166% increase in negligence claims related to laser refractive surgery.[1]

With this is mind, the MDU introduced special subscription rates for ophthalmic members carrying out laser eye surgery in 2003.

In the United States, in November 2003, the American Academy of Ophthalmology estimated that up to 5% of all laser in situ keratomileusis (LASIK) surgery to treat myopia resulted in serious complications and between 5% and 15% of LASIK patients returned for additional procedures to help improve vision after surgery.[2]

And in December last year, the United Kingdom's National Institute for Health and Clinical Excellence (NICE), the organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health, issued guidance on LASIK surgery for refractive errors. The guidance states: ''there are concerns about the procedure's safety in the long term and current evidence does not appear adequate to support its use within the NHS without special arrangements for consent and for audit or research.''[3]

NICE guidance goes on to recommend that surgeons who perform LASIK surgery for the treatment of refractive errors should take the following actions:

- Ensure that patients fully understand the specific risks associated with the procedure and provide them with clear written information, such as that published by NICE
- Audit and review clinical outcomes of all patients having LASIK for the treatment of refractive errors
- Have adequate training before performing the technique.

The Royal College of Ophthalmologists has also produced detailed guidance for those carrying out laser refractive surgery, which includes advice about what information should be given to patients and how to obtain consent.[4]

OTHER MEDICOLEGAL PROBLEMS REPORTED BY OPHTHALMOLOGISTS

Members often contact us about matters other than medical negligence claims. Our advisory helpline regularly receives calls from ophthalmic members seeking advice on medicolegal matters. Last year we took 127 calls from ophthalmologists—about two to three calls each week. Common reasons for contacting the advice line included patient complaints and the need for advice on issues such as patient confidentiality and requests for the disclosure of records.

Our advisory department also opened 59 new case files on behalf of ophthalmologists. The assistance we provided ranged from straightforward advice on retention of private records through to assistance with criminal investigations arising out of patient deaths. A third of files arose as a result of patient complaints either in the NHS or the independent sector. Several ophthalmologists sought assistance with GMC disciplinary investigations into their professional conduct, and a number requested help with local disciplinary procedures brought by their employing hospitals.

While allegations about problems with technical and surgical skills commonly feature in cases members report to the MDU, allegations of poor communication are a common theme in many of the cases we see, particularly in patient complaints. If something does go wrong or a patient is dissatisfied, a conciliatory approach and providing the patient with an explanation, and apology if appropriate, can often defuse potential complaints and claims.

And what about the future? We expect the increasing scrutiny of all aspects of doctors' professional practice, not just their clinical skills, to continue. Also, as the Commission for Regulatory Healthcare Excellence, the ''super regulator'' now refers GMC decisions to the High Court when it considers the GMC has been too lenient, we expect to see a sustained increase in members needing our assistance at the GMC. But, however the future unfolds the MDU is here to help, and defend, our members as we have done for the past 120 years.

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Correspondence to: Christine Tomkins, Medical Defence Union, 230 Blackfriars Road London SE1 8PJ, UK; boyalld@the-mdu.com

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