



CASEBOOK

COSMETIC MEDICINE

Are you practising safely?
Dr Katie Grant advises on best practice
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CELEBRATING
125 YEARS
OF MPS

CELEBRATING
25 YEARS
OF CASEBOOK

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A patient repeatedly attends his GP with worsening back pain

REPORTED ABUSE

A child makes an allegation of abuse

A FRIEND IN NEED

A patient suffers complications during spinal surgery



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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



This year marks a significant anniversary for Medical Protection as we celebrate 125 years of supporting members. We were founded in 1892 as a mutual organisation to provide members with expert advice, support and protection in their professional practice.

Though our purpose remains the same as it always has, the world around us has changed dramatically. Life is faster and more complex, presenting healthcare professionals with even greater opportunities and challenges.

The breadth of highly specialist advice and support, and the risk management we offer to help prevent problems from occurring, has expanded exponentially, not only to keep pace with advances in medicine, but to stay ahead of the curve – anticipating challenges and risks before they emerge.

As a doctor myself, I see the sheer breadth of issues that modern professionals face, whether it is dealing with growing patient demands, keeping up with the latest Medical Council developments or understanding the increasing impact of litigation. If you need support or advice, then I recommend that you contact our team of fellow doctors, who have legal qualifications. Contact details can be found on the back cover.

In this edition, we consider the medicolegal risks of cosmetic and aesthetic medicine and offer advice on best practice. Meanwhile, on page 8, we examine some case studies in which Medical Protection has assisted members following an inadvertent breach of confidentiality.

As always, we welcome your feedback. Please let us know what you think of the changes to *Casebook*, and contact us with any questions or comments on the articles and case reports.

I hope you enjoy this edition.

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HONG KONG – REPORTING DRIVING OFFENCES TO MCHK

Medical Protection has recently seen a rise in the number of queries associated with driving offences, particularly around when a conviction needs to be reported to the Medical Council of Hong Kong (MCHK).

Healthcare professionals must report a conviction that is punishable with imprisonment to the MCHK within 28 days of the conviction, even if the matter is under appeal. For example, this includes convictions for failing to wear a seatbelt or using a vehicle without insurance.

In reporting conviction cases to MCHK, the doctor should provide all relevant document(s), such as certificate of trial.

More information can be found in the *Code of Professional Conduct* which is available at mchk.org.hk.

For advice, contact Medical Protection at **800 908 433** or querydoc@medicalprotection.org.

SINGAPORE – UPDATED GUIDANCE ON CONSENT

Recent case law changes, and revisions to the SMC *Ethical Code and Ethical Guidelines* (2016), have placed a legal and professional obligation to move to a patient-centred approach when providing information and advising of risks and treatment options.

For more information on this change in guidance, visit medicalprotection.org and click on the 'Journals & Resources' tab.

Medical Protection has also updated its resources on consent. To read the factsheet, visit medicalprotection.org.

SINGAPORE – DRUGS GUIDANCE PUBLISHED

The Agency for Care Effectiveness has published 11 drug guidelines providing both the public and medical professionals with an additional source of information to make informed choices on treatments.

These guidelines are available to read at ace-hta.gov.sg.

MALAYSIA – DOCTORS OBLIGED TO ALERT POLICE OF QUESTIONABLE INJURIES

Doctors who are visited by patients seeking treatment for questionable injuries are reminded of their obligation to report such cases to the police.

Malaysian Medical Association President Dr Ravindran R Naidu said: "If patients come in with injuries that are suspected to be caused by assault or abuse, a police report should be made by the doctor, whether in private or public health institutions."

For advice, contact Medical Protection at **800 908 433** or querydoc@medicalprotection.org.



COSMETIC MEDICINE:

ARE YOU PRACTISING SAFELY?

Dr Katie Grant, a Medical Protection medicolegal adviser, advises on best practice

READ THIS ARTICLE TO:



- ✓ Learn how to practise cosmetic medicine safely
- ✓ Understand the medicolegal risks with aesthetic medicine
- ✓ Learn from a common scenario which might occur during practice

Cosmetic and aesthetic medicine is an ever-changing area of practice, where procedures and technologies often develop rapidly. Against this background, patients who choose to undertake these types of treatments may have particularly high expectations.

Medical Protection defines cosmetic or aesthetic procedures as treatments or procedures which have as their primary purpose the alteration of the non-pathological external appearance of the patient. As such, unlike most medical treatments, these procedures are often not provided to treat specific pathology, but at the request of the patient. However, this does not mean that standards or expectations are lower; you should still provide the best possible care for your patient.

Whether you are already regularly performing aesthetic procedures or considering expanding your own area of practice, it is essential you make sure you are doing so safely. In preparation, you may wish to ask yourself the following seven questions:

1. HAVE I GOT THE NECESSARY TRAINING, SKILLS AND EXPERTISE?

Doctors working in cosmetic and aesthetic medicine, like in any area of practice, should ensure they have the necessary training, skills and expertise to assess and treat patients. You should work within your own area of competence. Your actions should do no harm and be seen to benefit the patient positively.

2. AM I WORKING WITHIN THE RELEVANT REGULATIONS AND GUIDELINES?

You are responsible for ensuring that you are appropriately registered according to any relevant medical council or professional guidelines. If you are not certain regarding your obligations, contact Medical Protection's team of medicolegal advisers (fellow doctors with legal training) or one of our local legal advisers for expert guidance (please see links and contacts at the end of this article).

3. AM I ADEQUATELY INDEMNIFIED?

Appropriate professional protection is essential to protect patients and yourself. The Medical Protection membership team is available to discuss the scope of your practice, our

understanding of the type and nature of the procedures you perform ensures you are in the appropriate membership category.

Medical Protection can also assist with a variety of issues that may arise from your clinical practice, including investigations, complaints and Medical Council matters.

4. AM I WORKING IN AN APPROPRIATE SETTING USING THE CORRECT PRODUCTS AND EQUIPMENT?

When offering cosmetic treatments (which may be relatively new to the market), you should be mindful of the evidence of their effectiveness and their safety profile, so that you can explore and discuss whether they are suitable for your particular patient.

In addition, where you work is an important consideration. You should be satisfied that where you are performing the procedures is appropriate, bearing in mind any applicable regulations. Do you have access to the necessary equipment and support in case of a complication or medical emergency?

5. HAVE I SOUGHT INFORMED CONSENT? IS THE PROCEDURE MEDICALLY NECESSARY?

In many cosmetic and aesthetic procedures you will not be curing a disease or treating a medical condition as such, so you should be particularly mindful of the importance of informed consent. Any treatment should still be medically appropriate for your patient. Patients seeking treatment in this area may even be more vulnerable than others.

You should ensure that the patient is of the age and mental capacity to be able to consent to the proposed treatment. They should be aware of the balance of the risks and benefits of any treatment, and any available alternatives. Consenting is a process, not a one-off event, and patients may benefit from a 'cooling-off' period between any initial consultation and agreement to undergo a procedure.

Patients may occasionally have unrealistic views about possible outcomes or what can be achieved. During your discussions, you should be open and honest regarding this, aiming to make clear the limits of any treatment or procedure.

Promotional material and advertisements should not be misleading, and must adhere to any relevant regulations.

6. HAVE I DOCUMENTED EVERYTHING CLEARLY?

Detailed and contemporaneous medical records are essential and may be invaluable in the event of a complaint, claim or Medical Council referral. You should clearly document your assessment of the patient (including history and examination), the consenting process, the details of the procedure or treatment performed, and any follow-up advice provided.

Before discharging the patient, you should consider if they have the necessary information regarding what to expect in their recovery, highlight any potential issues to look out for, and give details of who to contact in case of a problem.

7. WHAT IF THE PATIENT HAS CONCERNS POST-PROCEDURE?

Despite your best efforts, sometimes things go wrong. Occasionally, despite a satisfactory outcome, a patient may be unhappy with the treatment they have received. Providing a detailed and conciliatory response may help reduce the chance of a complaint escalating. Medical Protection is able to advise and assist members in responding to complaints, as well as other issues that may arise from their clinical practice.

Some patients may contact you for advice and treatment if they are dissatisfied with the results obtained from other clinicians. These cases may be more clinically challenging and patients' expectations may be unrealistic. Of course, you are not obliged to treat patients if you do not feel treatment is necessary, nor should you assist if you do not feel you have the necessary skills or expertise.

FURTHER INFORMATION

Hong Kong

The Medical Council of Hong Kong
mchk.org.hk

The Hong Kong Association of
Cosmetic Surgery
acshk.com.hk/home.php

Medical Protection, Practice makes perfect?
goo.gl/oSrJuf

Malaysia

Malaysian Medical Council, Guidelines on
the Ethical Aspects of Aesthetic Medical
Practice
goo.gl/9vK7Hy

Singapore

Singapore Medical Council, Singapore
Guidelines on Aesthetic Practices for
Doctors (2016 Edition)
goo.gl/f93iJ6

Medical Protection, Advice on aesthetic
practice for doctors
goo.gl/iFWyPf

CASE STUDY

A 52-year-old female patient presented to her doctor concerned about her frown lines. She was due to attend a family party and wanted to look "fresher".

She consulted with Dr A, who took a history and examined the patient. He suggested use of Botox® to her forehead, and discussed the potential risks and benefits, alternatives and possible outcomes.

He provided the patient with some written advice to review at her leisure, and asked her to contact the clinic if she wanted to go ahead.

The patient booked in and had Botox® injections ten days later. Although the procedure went without incident, the patient subsequently contacted Dr A requesting "compensation" as she had developed a "droopy eyelid" on the right side. She said because of this she was too ashamed to attend the party.

Dr A contacted Medical Protection and a medicolegal adviser and local specialist lawyer assisted in drafting a conciliatory response to the member. Dr A apologised for any inconvenience experienced by the patient, but explained that he had discussed (and documented) eyelid drooping as a risk of this procedure. He was able to refer back to his detailed records and consent form which specifically listed ptosis as a potential complication. Although he empathised with the patient, he did not offer any compensation. He heard nothing further from the patient after sending his response.

The case mentioned in this article is fictional but is an example of a common scenario that might occur in practice.

MORE SUPPORT FROM MEDICAL PROTECTION

If you have any queries about the scope of your practice and your current membership grade, please contact Medical Protection on:

Hong Kong: **1800 815 837**

Malaysia: **800 908 433**

Singapore: **800 616 7055**

CONFIDENTIALITY MATTERS

Dr Bobby Nicholas, a Medical Protection medicolegal adviser, describes some cases in which we have assisted members following an unintentional breach of confidentiality

READ THIS ARTICLE TO:



- ✓ Understand how breaches of confidentiality can occur
- ✓ Discover useful resources to help you when dealing with confidentiality concerns
- ✓ Learn from typical scenarios which may happen in your practice

Patients have an expectation of confidentiality with regard to the information they provide to doctors, and this duty forms an important part of maintaining trust between a patient and their doctor. Trust is important, so that patients can be open about the information that they provide to a doctor, and receive the best advice possible. When a breach of confidentiality takes place, it can lead to a breakdown of trust which can be difficult to repair. It can also result in complaints, a medical council investigation or even form the basis of civil litigation.

Issues around confidentiality frequently form the basis of requests for assistance from Medical Protection. These can include instances where the doctor is in a difficult situation where providing information might constitute a breach of confidentiality, or where an inadvertent breach of confidentiality has taken place and the doctor is seeking assistance as to how to proceed.

The following are some potential scenarios:



CASE 1

A clinic contacted Medical Protection regarding blood tests that were conducted by Dr X at the clinic. The results were emailed by a non-clinical assistant at the clinic to a third party whom she thought had been authorised by the patient. However, consent from the patient had not been received and the patient subsequently complained. Medical Protection advised on responding to the complaint.

If there is an error, the patient should be informed promptly, and an explanation and apology provided. The apology should specifically address the error and not simply be in relation to any distress caused.

It is important that all staff dealing with patient information have received confidentiality training, and are up-to-date with this. It may be helpful to have confidentiality protocols in place.

CASE 2

A family member phoned a clinic for a test result. He explained that his relative attended the clinic on the previous day for a blood test and was seeking the result on her behalf. He also explained that he is sure that the patient would have no issue, as he brought her to the clinic to have the tests done.

It can be difficult to verify who you are speaking to over the telephone, especially when such calls are from family members. It is particularly important, in such situations, to avoid discussing information pertaining to the patient.

The doctor should check the medical records to establish whether the patient has given her authorisation for sharing the results, or any other information, with anyone else. If there is no such authorisation in place, the doctor should politely explain that information cannot be provided. Even if the relative is willing to attend in person and confirm their identity, the patient needs to confirm their consent to providing the result to the relative.

CASE 3

Dr Y was in the middle of a consultation when he received a telephone call from another patient, whom he had been having difficulty contacting, and therefore had left his direct number to call back. Dr Y briefly took the other patient's contact details and indicated he was already with a patient and would call them back. The patient who was in the consultation made a complaint indicating that the call should not have been taken during a consultation. Dr Y sought advice from Medical Protection and was assisted in preparing a response, which the patient accepted.

When taking telephone calls be aware of your surroundings. It can be tempting to answer a call, particularly if it is simply to take details to call back, but calls should be taken when you can be satisfied that you will not be overheard. Ideally, any calls would not interrupt a consultation, but in the event of having to take an urgent call, you may need to take reasonable steps to avoid any potential breaches in confidentiality. For example, by having the call diverted to a separate room or asking the patient you are seeing if they can wait outside the room for a few minutes.

LEARNING POINTS:

✓ **When making a decision around disclosure of confidential information, you should be aware of, and familiar with, the relevant sections of the medical council guidance.**

✓ **It can be helpful to have protocols in place to deal with requests for patient information from third parties and, even where the third party is a relative, to establish whether the patient has consented.**

✓ **If there is an inadvertent disclosure, you should inform the patient of the error and provide an explanation and apology. The incident should be investigated so that lessons can be learned.**

✓ **Make sure all staff (not just clinicians) are trained on the importance of confidentiality and are aware of the protocols in place to maintain it.**

RESOURCES

Medical councils produce guidance which address confidentiality, which may be useful when having to make a decision around disclosure of confidential information:

MALAYSIA

The Malaysian Medical Council (MMC) approved revised guidelines on confidentiality in 2011. The MMC confidentiality guidelines are available at goo.gl/gRJJQK

It sets out the principles, disclosures required by law, disclosures with consent, in the patient's interest and the public interest, as well as disclosure after a patient's death.

SINGAPORE

The Singapore Medical Council (SMC) produced revised and updated guidance in 2016. Its *Ethical Code and Ethical Guidelines*, along with the *SMC Handbook on Medical Ethics*, is available at: goo.gl/ss8fRT

Section 'C7' on medical confidentiality sets out what upholding medical confidentiality means.

HONG KONG

The Medical Council of Hong Kong (MCHK) has issued a *Code of Professional Conduct* which can be found at: goo.gl/RjQ96D

Under 'Duties of physicians to patients' it states that "a physician shall respect a patient's right to confidentiality" and that "it is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can only be removed by a breach of confidentiality".

MORE SUPPORT FROM MEDICAL PROTECTION FACTSHEETS

Confidentiality - general principles

Visit medicalprotection.org

BACK TO BASICS

A patient repeatedly attends his GP with worsening back pain

Author: Dr Philip White, Medical Claims Adviser at Medical Protection



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Mr B, a 42-year-old builder, attended his GP, Dr S, with a three-week history of back pain and left sided sciatica. Dr S found nothing of concern on further questioning or examination, so made a referral for physiotherapy and recommended ibuprofen. Over the next few weeks the pain increased and the patient required diclofenac and cocodamol to control his symptoms.

Two months later, while still waiting for his physiotherapy appointment, the pain got so bad that Mr B called an ambulance and was taken to the Emergency Department (ED), where he was found to have a slight left foot drop and bilateral straight leg raising of 45 degrees. Mr B's neurology was not examined. The ED doctor thought that this was not sciatica, but simple back pain made worse by moving Mr B's legs. Mr B was sent home with diazepam.

One week later, the pain was even worse and there was now intermittent numbness in both buttocks. Mr B called the out-of-hours centre and was seen at home by Dr T. He told Dr T that he was able to pass small amounts of urine, and Dr T also recorded "no saddle anaesthesia". Dr T carried out a very brief examination of the legs which was unremarkable, started tramadol, and advised Mr B to keep active and see his own GP the following day.

Mr B was reviewed by Dr S the next day, who again recorded in the notes: "No red flags, no loss of bowel or bladder function. No saddle anaesthesia."

Dr S gave Mr B a diclofenac injection and arranged an MRI scan. He too only carried out a very brief examination of the back and legs.

Two days later, due to intolerable pain, Mr B was on his way to the ED again when he suffered urinary incontinence in the ambulance. On admission, he had an MRI scan that showed a large L4/5 central disc pressing on the cauda equina.

Mr B underwent surgical decompression the next day but was left with bilateral foot drop, requiring the use of a wheelchair, and bowel, bladder and sexual dysfunction.

Mr B brought a claim against all the doctors involved in his care. He alleged that they had failed to take a proper history and perform an adequate examination, including assessment of perineal sensation and anal tone. The claim also alleged that they did not give proper regard to bilateral and worsening pain and buttock numbness, and did not refer for urgent assessment.

EXPERT OPINION

Medical Protection instructed an expert GP who was critical of the care provided by both general practitioners. She opined that Dr T did not carry out an adequate assessment after the report of intermittent buttock numbness, and that Dr S conducted a "very severely substandard" examination the next day.

Emergency medicine and orthopaedic experts concluded that the ED doctor's assessment had been inadequate and were critical of the delay before decompression. They also stated that if Drs S or T had assessed Mr B more thoroughly, they would likely have found perineal numbness and/or urinary retention, and the resulting emergency decompression would have left Mr B in a much better condition.

On the basis of the expert opinion, the case was deemed indefensible and was settled for a high sum, shared equally between the hospital, Dr S and Dr T.

Learning points

- Even when referral to physiotherapy has already been made, keep a low threshold for reassessment if things change.
- Issuing analgesia, especially increasing the strength, is an opportunity for reassessment.
- Do not assume that the doctor who saw the patient before you has carried out an adequate assessment, even though nothing might have changed.
- If you ask a patient if they have saddle anaesthesia, make sure they know exactly what that is. It might be useful to ask about rectal function, numbness between the legs or around genitals and anus, and if they have any difficulty getting an erection.
- Any suggestion of perineal numbness or urinary symptoms mandates a thorough assessment of both. Don't forget that urinary tract infections can be caused by retention.
- Giving patients information about the red flags for cauda equina in writing can improve safety netting; however, it is no substitute for discussing these with the patient, explaining how the different red flags can present and what the symptoms may mean.

REPORTED ABUSE

A child makes an allegation of abuse

Author: Dr Clare Redmond, Medicolegal Adviser at Medical Protection

Mrs X asked her GP to refer her eight-year-old daughter, Child F, to be assessed by a consultant psychiatrist in child and adolescent mental health. The GP referral letter stated that Child F had reported to her teacher that her father frequently touched her genitalia. The child's parents had recently separated acrimoniously and the mother had reported the matter to the police.

The consultant psychiatrist, Dr B, obtained a history from Mrs X, who confirmed these details. She then took a history from Child F and wrote a report based on these discussions. The report detailed that Child F had reported numerous incidents of touching by her father, and the descriptions provided by the child indicated the father was sexually abusing his daughter.

The police investigated the allegations but no charges were brought against the father, Mr X. However, Dr B's report was used by the mother in custody proceedings, and the mother gained sole custody of Child F.

In the course of the proceedings, Mr X obtained his own expert psychiatric report. Mr X's expert concluded that Dr B had obtained an inadequate history in three areas. The expert said that Dr B had failed to confirm the history with the school directly, had failed to seek an explanation from Mr X, and had failed to consider that Mrs X may have coached Child F in giving her answers. This expert was less certain that this was a case of sexual abuse, but deemed the child was best placed with her mother, with supervised contact with her father.

Mr X brought a claim for negligence against Dr B, alleging a failure to take an adequate history from a range of sources to evidence her conclusion of sexual abuse.

EXPERT OPINION

Medical Protection obtained further expert opinion from a psychiatrist. This expert concluded that Dr B carried out her interview with Child F appropriately, with no evidence of pressure or undue influence by the mother. She concluded that there may have been some shortcomings in failing to obtain collateral history from the school and Mr X, but that the activity that Child F had described to Dr B, if true, would unequivocally amount to child sexual abuse and that Dr B's conclusions to that effect were reasonable.

Medical Protection successfully defended the claim.



Learning points

- When writing a professional report, you should take reasonable steps to check the information provided, to ensure it is not false or misleading. A report should make clear where a patient has provided information about events or another party, and this should not be recorded as fact. You must not deliberately leave out relevant information even if requested to do so.
- When writing a professional report, you should set out the facts of the case and clarify when you are providing an opinion. Do not be tempted to comment on matters that do not fall within your area of expertise. In this case, Dr B was assisted by her clear and robust report-writing.
- All doctors have a duty to act on concerns about the welfare of children, and child protection work is recognised as challenging and emotionally difficult.

Further reading

Medical Protection factsheet, A guide to writing expert reports
Visit: medicalprotection.org and click on the Resources tab.

NO NEWS IS NOT ALWAYS GOOD NEWS

A newborn is referred with a clicking hip

Author: Dr Mónica Lalanda, Emergency Medicine Physician and Medical Writer



@yacobchuk/gettyimages.co.uk

Child J, a one-week-old baby girl, was noticed to have a clicking right hip when she was seen by the community midwife. A referral to the orthopaedic clinic was requested and Child J was reviewed by orthopaedic junior doctor, Dr M, three weeks later. Dr M confirmed that there was no relevant family history and examined Child J. Dr M documented that there was no clicking of the hips, and Ortolani and Barlow tests for assessing hip stability were negative. Dr M discharged the baby back to the care of her GP.

During a routine check-up at eight months, Child J's GP, Dr X, found she had limited rotation of her right leg and immediately arranged for her to have an x-ray. Two days later, following the x-ray, consultant radiologist Dr R described the results as follows: "The left hip is normal. The right hip appears dislocated with associated moderate acetabular dysplasia."

However, due to a failure in the system, the report was simply filed in the hospital record and Dr X did not receive a copy at his surgery.

Three weeks later, Child J's mother brought her in with a minor cold and asked about the x-ray results. Dr X reassured her that he had not heard anything so it was a case of "no news is good news" but he promised to check up on it. Unfortunately, the clinic was very busy and he forgot to look into it.

Child J was reviewed at 16 months, when her mother complained that she "walked funny". Child J had an obvious limp, and on examination her right hip was clearly abnormal. Dr X made an urgent referral to the orthopaedic clinic and a consultant paediatric orthopaedic surgeon, Miss B, confirmed the diagnosis of developmental dysplasia of the hip.



@stockdevil/gettyimages.co.uk

Child J was initially treated with a closed reduction and immobilisation with hip spica, but on follow up at three months, the hip appeared dislocated again. An osteotomy was performed and appropriate immobilisation applied, but unfortunately, months later, the dislocation reoccurred and the dysplasia also seemed to have deteriorated. Child J was referred to a sub-specialist paediatric orthopaedic unit where she was seen by Mr P, a specialist in hip dysplasia. Mr P arranged for Child J to have specialised physical therapy and explained to her parents that it was likely that Child J would require further surgery within the next few years, although it was still too early to predict when and what kind of surgery Child J would need.

Child J's parents brought a claim against all the doctors involved in the management of their daughter's care. They alleged that Dr M should have requested an x-ray to exclude the dislocation on the initial visit to the orthopaedic clinic. They also alleged that Dr R failed to ensure that the report made it safely to the clinic, and that Dr X had not checked the x-ray but had dismissed their concern. The parents also claimed against the orthopaedic surgeon, Miss B, for failing to treat their daughter's hip appropriately.

EXPERT OPINION

Medical Protection sought expert opinions from a paediatric orthopaedic surgeon and a GP.

The orthopaedic expert considered that Dr M, the junior orthopaedic doctor, had demonstrated an acceptable standard of care. The examination of the baby was normal, with no suggestion of a dislocated hip, and was well-documented. There was no family history to suggest higher risk, therefore an x-ray was not indicated at that time.

The expert GP's opinion on the care provided by Dr X stated that the standard of care was below a reasonable standard, since he failed to follow up the investigation that he had rightly requested. The expert expressed sympathy for Dr X, who had diagnosed the abnormality appropriately, but then failed to follow up on the investigation. If the mother's account of the next consultation was right, he missed a second opportunity to review the x-ray report. All this translated into a long delay of several months in the surgical treatment of Child J's hip.

The orthopaedic expert commented that the surgical treatment by Miss B was in keeping with acceptable practice and that the failure was caused by the advanced state of the dysplasia that made the hip very unstable.

The supportive orthopaedic expert's report enabled Medical Protection to extricate Dr M and Miss B from this action. The hospital accepted that there had been a clear administrative error that allowed the system to file the report without it being sent to the clinical team for action. The failings in this case meant it was considered indefensible and it was therefore settled for a substantial sum, with the hospital contributing half the costs.

Further reading

Medical Protection factsheet, Medical records
Visit medicalprotection.org and click on the Resources tab.

Learning points

- Good history taking and careful documentation of physical examination can make a huge difference if a patient makes a claim against you, which can often be many years after the event.
- When you request a test, you are responsible for ensuring the results are checked and acted upon.
- All systems need a safety net where results are checked so that abnormal results are not missed. It is vital to ensure you have a robust system for acting on tasks that arise from a consultation.
- Poor outcomes are not necessarily the result of negligent medical management. Sometimes poor outcomes are a result of the particular condition. You can help protect yourself from criticism by always ensuring your records outline the rationale for any decision you have taken.

A FAILURE TO MONITOR

A patient attends his GP multiple times with symptoms of dizziness

Author: Dr Ellen Welch, GP



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Retired engineer Mr S, 77, went to see his GP, Dr J, with symptoms of dizziness. He had returned from a pacemaker check at the hospital that morning and while travelling home on the train had started to feel off-balance. He managed to get an emergency appointment to see Dr J, by which time the symptoms were resolving.

Dr J noted that the pacemaker had been fitted for complete heart block six years ago, and had remained in situ without any problems since then. Mr S reported no chest pain or palpitations and Dr J, feeling reassured by the recent pacemaker check and a normal examination, attributed the symptoms to motion sickness and prescribed cinnarizine.

Despite taking the medication regularly, Mr S's dizziness continued, so he returned to the practice two days later to see Dr A, his usual GP. Dr A recorded his BP as 140/50 and attributed the symptoms to benign paroxysmal positional vertigo. No record was made of Mr S's pulse. Dr A advised Mr S to continue the medication prescribed by Dr J.

During the next six weeks, Mr S consulted with Dr A on three further occasions with ongoing symptoms of intermittent dizziness. Note-keeping from all three consultations was sparse, with no defined cause of the symptoms documented, and no further cardiovascular examination or ECG performed. Mr S was given a trial of betahistine for presumed Ménière's disease.

Two months after his initial presentation, Mr S was taken into the Emergency Department after collapsing on the street when out shopping. He was found to be in complete heart block, with a pulse rate of 32 beats per minute. The admission ECG showed atrial pacing but no ventricular spikes, and his symptoms were attributed to a malfunctioning pacemaker.

He was admitted to hospital, and while being monitored on telemetry, the pacemaker activity resumed without intervention. Mr S became acutely confused after admission to the ward. He was treated for a urinary tract infection, and underwent a full confusion screen, which was unremarkable.

A CT scan of his brain showed small vessel disease. The patient continued to deteriorate, leading to him becoming fully dependant. He was discharged into a care home following a prolonged admission.

Mr S's family made a claim against Dr A, stating that the confusion and memory loss developed as a result of hypoxia, linked to the malfunctioning pacemaker.

EXPERT OPINION

Experts agreed that a competent GP would rethink the diagnosis of vertigo and carry out a cardiovascular examination, including an ECG.

Dr A defended his actions by stating that by taking a manual blood pressure reading, he would have listened to the pulse and been aware of any significant irregularity or abnormal rate. However, opinion was divided on the causation of Mr S's decline.

Experts found no evidence to support an episode of circulatory failure significant enough to cause prolonged hypoxic damage. The general deterioration was considered to be due to a pre-existing cognitive impairment, which was exacerbated by the hospital environment and the bradycardia – which experts agreed, would have occurred in any event with an earlier hospital admission.

The case was settled for a low sum to reflect the partial causation defence.

Learning points

- Make clear and detailed notes. Lack of clear documentation makes a case difficult to defend. In this scenario, there was no record in the notes that the patient's pulse had been taken. If an investigation is not written down, it is hard to prove that it took place.
- Be wary of repeat consultations. Dizziness is common, but revisiting a diagnosis and carrying out a basic examination, especially in a patient with a cardiac history, is essential to ensure that good quality care is provided.
- The allegation in this instance was of memory loss as a result of hypoxia. Ultimately, the deterioration of the patient was attributed to pre-existing cognitive impairment, hence the low settlement. From a medicolegal standpoint, this highlights the importance of fully investigating claims, since taking the claim at face value may have resulted in payment of long-term care costs.

A COMPLICATED CLAIM

A surgeon's experience is questioned when he acts as an expert witness

Author: Dr Janet Page, Medical Claims Adviser at Medical Protection



Mr A, an orthopaedic surgeon, was approached by a claimant's solicitors to provide an expert report on behalf of their client. He was advised that the claim related to alleged negligence in the conduct of an L4/5 spinal decompression and fusion with malposition of the pedicle screws, following which the claimant developed right S1 nerve root damage, causing right foot drop. Mr A sent the solicitors his CV – which set out his area of practice – as evidence of his suitability for the role, and agreed to provide the requested report.

In his report, Mr A criticised the conduct of the surgery. His opinion was that the hospital inappropriately allowed a specialist registrar to perform the operation unsupervised, that there was a failure to use an image intensifier and a failure to check the position of pedicle screws immediately postoperatively, resulting in delayed diagnosis of the malposition of the screws and permanent foot drop. A letter of claim was served on the hospital based on Mr A's expert opinion.

In their letter of response, the hospital's solicitors denied liability. They commented that Mr A “does not claim to have expertise in spinal surgery”. They advised that the operation had been performed by a locum consultant, an image intensifier was used, and that foot drop is a recognised complication of spinal decompression and fusion, about which the claimant was warned preoperatively.

Proceedings were nevertheless commenced by the claimant's solicitors. In response, the hospital's solicitors submitted questions to clarify Mr A's expertise in spinal surgery. When answering the questions, Mr A confirmed that he had never held a substantive consultant post in the public sector, that he had last performed spinal surgery 15 years earlier, and that he had not operated at all in three years. He also

stated that he had never performed complex spinal surgery and that he had not personally performed the operation in question, because of the high risks associated with it.

Following this, the claimant's solicitors instructed a new expert. She agreed with Mr A's original opinion that there was a failure to check the position of the pedicle screw immediately postoperatively and that there was a delay in making the diagnosis of foot drop. However, the expert also identified new areas of concern, namely that there was a failure to check the neurovascular status of the limb during the procedure, and that there were deficiencies in the consent that had been taken.

She concluded that, on the balance of probabilities, the neurological damage sustained would have been less severe with earlier diagnosis of the foot drop and subsequent correction of the underlying cause (malposition of the screws).

The claimant's solicitors sought financial redress from Mr A for the increased costs incurred by their client in instructing a second expert and revising their claim. They alleged that Mr A was wrong to maintain that he had sufficient expertise in the field of spinal surgery, and to comment on the current public sector standards and operational procedures on the facts of this case. They pointed out that the hospital's solicitors were quick to notice this weakness, as a result of which their client faced an Adverse Costs Order against him.

EXPERT OPINION

Mr A remained of the view that he had the appropriate expertise to report on the case, relying on the elements of spinal surgery in his training in general orthopaedic surgery and his efforts to keep up to date with developments in this area.

Medical Protection advised that he should seek to settle on the basis that whilst there was no suggestion that Mr A deliberately misrepresented his expertise, he did not make explicitly clear the limits of his knowledge and personal experience. Additionally, although he clearly stated an interest in spinal surgery outcomes, he did not advise that he had not carried out a spinal decompression in 15 years, nor did he advise that he had never carried out the decompression and fusion that was the subject of the original claim.

The matter was settled with Mr A's agreement for a low sum and without admission of liability.

Learning points

- Be clear and explicit about the limits of your expertise to avoid misunderstandings.
- Your credibility is likely to be undermined if you are providing an opinion about an area of practice in which you have no (or no recent) practical experience.
- This case highlights the importance of having understanding and experience appropriate to the location of a claim (for example, private or public sector) in order to avoid making incorrect assumptions about personnel or protocols.

A FRIEND IN NEED

A patient suffers complications during spinal surgery

Author: Mr Ian Stephen, Consultant Orthopaedic Surgeon (Retired)



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Ms N, a 33-year-old accountant, presented to Mr X, a consultant orthopaedic surgeon, with severe lower back pain radiating to both legs. A clinical diagnosis of a central disc protrusion at L4/5 was confirmed on MRI scan. Mr X advised laminectomy with discectomy, to which Ms N consented. Mr X did not record the details of the consent process, but has since stated that he would have warned of potential complications.

Mr X recorded the operation as uneventful, but Ms N rapidly became hypotensive postoperatively and an ultrasound scan revealed a large retroperitoneal haemorrhage. Mr X requested an opinion from Mr Y, a consultant general surgeon, who assessed the patient and advised an emergency laparotomy.

During the laparotomy by Mr Y, retrocolic exploration revealed a clot adjacent to the abdominal aorta. Removal of this clot caused a gush of blood and haemodynamic collapse. The aorta was found to have been transected just below the left renal artery. Mr Y clamped the aorta above the renal artery which controlled the bleeding, and the patient's condition then improved.

Mr Y then attempted to perform an end-to-end anastomosis of the aorta, but this failed. There was bleeding from the left kidney, which proved uncontrollable, so Mr Y took the decision to remove the kidney. Miss Z, a consultant vascular surgeon, was called in and successfully repaired the aorta with a synthetic graft.

Ms N subsequently made a good recovery. She later brought a claim against the orthopaedic surgeon, Mr X, alleging that there had been an indisputable act of gross negligence in damaging the aorta and in causing the left kidney to be removed.

EXPERT OPINION

Medical Protection's medicolegal experts considered the case carefully and concluded that it would be difficult to defend the fact that the aorta was transected during an otherwise straightforward laminectomy procedure. The decision was made to negotiate settlement of the claim as swiftly as possible in order to minimise costs.

The case was therefore settled on behalf of Mr X for a substantial sum.



Learning points

- Work within the limits of your competence. If an emergency arises in a clinical setting you must take into account your competence and the availability of other options for care. Specialist input was sought in this case, which helped to avoid a more serious outcome for the patient.
- Make clear and detailed notes. When things go wrong during a surgical procedure, the absence of any documentation of the consent process makes a claim very difficult to defend. Patients must be given clear, accurate information about the risks of any proposed treatment, and this must be clearly documented in the medical records.
- Vascular and visceral injuries are a recognised complication of surgery for herniated lumbar disc disease, and frequently result in the death of the patient.
- In this case there were clear vulnerabilities and it was considered unlikely that it would be possible to successfully defend the claim. Medical Protection's legal team therefore made every effort to avoid incurring unnecessary legal costs and focused on achieving a satisfactory settlement of the claim as soon as possible. As well as saving costs this also reduced the stress and anxiety to Mr X by shortening the time it took to resolve the matter.

UNFORESEEABLE COMPLICATIONS?

A patient undergoes corneal graft surgery for deteriorating keratoconus

Author: Dr Anusha Kailasanathan, Ophthalmologist

Mr M, a 45-year-old lawyer, consulted Dr L, an ophthalmologist, for the management of deteriorating keratoconus. He had become intolerant of contact lenses and was experiencing visual difficulties. His right eye had a corneal scar secondary to severe keratoconus, and he had keratoconus forme fruste in his left eye. Visual acuity was 6/20 in the right eye and 6/12 in the left eye.

Dr L offered Mr M corneal graft surgery in order to improve his symptom of deteriorating vision. He was counselled regarding complications, specifically that eye infections were a possibility, but he was not told about the rare risk of loss of the eye. Dr L performed uncomplicated corneal graft surgery on the right eye, and before discharging Mr M, provided him with his mobile phone number and a postoperative information leaflet, which informed patients that they should contact him immediately if they experienced any pain or poor vision.

Written records show that Dr L reviewed Mr M on the first day post-surgery. He was satisfied with the eye and prescribed a topical corticosteroid and a topical antibiotic. On the morning of the second day following the surgery, written and telephonic records show that Dr L gave Mr M a courtesy call and that Mr M did not inform Dr L of any pain during this conversation. Twenty-four hours later, Mr M called Dr L and complained of severe, worsening pain in the right eye, which started shortly after Dr L's phone call the previous day. Dr L saw Mr M immediately and observed a fulminant endophthalmitis.

Mr M was referred to Dr G, a vitreo-retinal surgeon, who arranged immediate treatment with intra-vitreous and systemic antibiotics. A posterior vitrectomy and lensectomy were performed, but B-scan ultrasonography later showed a retinal detachment. Bacterial culture of the vitreous revealed a *Serratia marcescens* infection, sensitive to the antibiotics being used. As a result of the retinal detachment Mr M lost all vision in the right eye. His corrected visual acuity in the left eye was 6/36.

Mr M made a claim against Dr L, alleging that he had failed to inform him of the risks of corneal graft surgery or of the significance of pain postoperatively. He further alleged inadequate postoperative care, which led to Mr M developing an uncontrolled infection and subsequent blindness in that eye.

EXPERT OPINION

Medical Protection sought expert opinion from an ophthalmologist. She was supportive of the care provided by Dr L and concluded that the postoperative patient information leaflet had sufficient information about warning signs. She also noted that Dr L did warn that eye infections were a possible complication and opined that loss of vision due to an infection was such a rare complication that the patient did not need to be warned specifically about the risk.

The expert made the additional point that, in Mr M's case, there was a real risk that the natural course of the disease may have led to blindness through the complications of keratoconus itself, in the long term.

The case was considered to be defensible and was taken to trial. The court was satisfied that Dr L's management was appropriate and that there was no evidence of a failure to provide adequate informed consent or negligent after care. Judgment was made in favour of Dr L.

Learning points

- When providing important information in a written format, the patient must be made aware of its importance. Consider providing verbal information as well as written information for important matters.
- When giving written information to sight-impaired patients, the format and font should be suitable for their visual ability. When applicable, consider adjunctive methods to deliver information such as audio or video formats.
- Although the primary purpose of medical records is to ensure continuity of patient care, medical records are used as evidence of care when dealing with complaints and medicolegal claims. Therefore, clear and detailed medical records are in both the patient's and the doctor's best interest.



We welcome all contributions to Over to you.
We reserve the right to edit submissions.

TURNING A BLIND EYE

To summarise this case: two specialists – a virologist and an ophthalmologist – diagnosed a dangerous but treatable disease. They apparently made no attempt to contact the patient, and neither did they phone to discuss the case with the GP, who simply received another letter among the mountain of mail that a GP receives daily. The GP (who had not seen the patient at all) wrote to the patient saying an appointment was needed, but the patient did not respond.

The regulatory advice is that the doctor who does the test is the one who should follow up the result. In this case that is clearly not the GP, but the specialists, and yet the GP is the one who is found to be at fault, with no fault laid at the door of the specialists. What did you expect the GP to do – write about a diagnosis of syphilis in a letter that could be opened by anyone at the address?

This issue needs to be debated.

Dr Ted Willis

Response “ ”

Looking back at the details of the case, it may help to clarify that the ophthalmologist contacted the GP by telephone to inform the GP of the result and the need for urgent treatment. As a result, the GP agreed to take on the responsibility of arranging for specialist referral. In this case, the ophthalmologist could perhaps have done more, but did not breach his duty of care, as he informed the GP who accepted the responsibility of referring the patient. By not taking appropriate timely action (for example with a phone call or by stating that an urgent appointment was required) the GP breached his duty of care and caused irreversible harm.

With regard to your comment on responsibility for following up a test result, doing so includes reviewing the result and either taking action personally or referring the patient to an appropriate person to do so, which the ophthalmologist did in this case.

The outcome of a case will always depend on the individual facts and specific circumstances (including local arrangements). It is often difficult to convey all of the detail of a case in the limited word count we have, and I do hope this explanation helps to clarify your queries.

A HIDDEN PROBLEM

In this case, there is again the increasing problem of GPs being burdened with extra work that is not always appropriate. It is not clear from the report if Mr T had any symptoms at the time of the “private health check”. However, the regulatory guidelines are clear that the clinician who initiates investigations is obliged to complete the entire treatment pathway that he/she has embarked upon; therefore the person providing the “health check” should have been the one to make the referral to the nephrology services for the patient.

I opine that, regardless of subsequent omissions Dr W made in documenting the urine abnormality, it was negligent of the healthcare professional conducting the private health check to hand Mr T a letter and wash his/her hands of the renal failure; at the very least a phone call to Dr W should have been made.

Could a GP who receives an unsolicited report on his/her patient such as this, return it to the sender with a brief reply asking them to ensure complete follow up?

Dr Colman Byrne

Response “ ”

I note your concern that GPs may be burdened with extra work that may not be appropriate, and we are very aware that this is a cause of concern for primary care doctors. I agree entirely that a phone call to notify the GP of a significant result would have been of assistance. Unfortunately, in this case, I have not been able to establish if there was such a call given the time that has passed since the incident.

In general it is in the best interests of the patient that the overall management of their health is under the supervision and guidance of a general practitioner. Although a GP may not have initiated a test, and there is an obligation on the doctor who did to follow it through, a GP may find it hard to justify not taking action on significant information that they have been sent, and could face criticism if an incident were to arise and a patient come to harm.



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