THE STORY OF BETH BOWEN

One mother’s harrowing tale of tragedy and secrecy

INFORMED CONSENT
The key aspects, built around some cases from Singapore

IMPARTIAL EXPERTS – WHO NEEDS THEM?
Read our advice on what it takes to be an expert

OVER TO YOU
The place to debate hot topics

REVIEWS
Book, film, app – read our reviews
Reduce your risk with your FREE educational resources

View your educational resources here: www.medicalprotection.org
What’s inside…

What’s inside…

FEATURES

05 Informed consent
Eric Tin, partner and head at Donaldson & Burklinshaw LLP, and Dr Janet Page, senior medicolegal adviser at MPS, look at the key aspects of informed consent, with some analysis of recent cases in Singapore.

06 Impartial experts – who needs them?
Sophie Pearson, solicitor at MPS panel law firm Kennedys, advises on what it takes to be an expert witness.

08 The story of Beth Bowen
In 2007, Clare Bowen’s five-year-old daughter Beth died during surgery at a hospital in the UK. Here she tells her story to Sara Dawson – and relays her hopes that it will reduce the likelihood of such an incident happening again.

04 Welcome
Dr Nick Clements, editor-in-chief of Casebook, comments on some topical issues affecting healthcare.

CASE REPORTS

13 From the case files
Dr Mark Dinwoodie, head of member education at MPS, looks at what can be learned from this edition’s collection of case reports.

CASE REPORTS

14 A pain in the knee
15 The elusive diagnosis
16 Who’s to blame?
17 Missing cauda equina
18 An unwanted pregnancy
19 Transfusion confusion
20 Eyes of the storm
21 A cannula complication
22 High expectations

Every issue…

24 Over to you
A sounding board for you, the reader – what did you think about the last issue of Casebook? All comments and suggestions welcome.

26 Reviews
In this issue Dr John Gilbey reviews Do No Harm: Stories of Life, Death and Brain Surgery by Henry Marsh, while Dr Behrad Baharlo looks at Forks in the Road: A Life In and Out of the NHS by Leslie Turnberg.

Get the most from your membership…

Visit our website for publications, news, events and other information: www.medicalprotection.org
You won’t be surprised to know that a significant proportion of my work at MPS consists of assisting members who have been involved in an adverse event. We always advise members to be open about any errors made during the course of such an event – it is morally and ethically the correct thing to do, and can go a long way towards preventing a claim arising in the aftermath.

This is because we often find that claims derive from an angry or aggrieved (or both) patient or relative feeling they have been denied information and explanations – and, if appropriate, a simple apology – in the wake of an adverse outcome. Openness stands to benefit all parties and yet, quite understandably, there remains nervousness and uncertainty about delivering it.

In New Zealand, there is a statutory obligation for open disclosure; in the United Kingdom, a similar ‘duty of candour’ appears to be the government’s approach of choice, despite MPS believing a change in culture will be much more effective. Readers in Hong Kong may recall a fascinating article by Dr Chui Tak-yi at the Hong Kong Hospital Authority, who wrote in the September 2013 edition of *Casebook* about his systems approach to changing the reporting culture within the organisation. Fear and anxiety over ‘blaming and shaming’ paralyses many healthcare professionals and prevents them from being open about mistakes that they may have made. This edition of *Casebook* features a truly harrowing first-hand account from Clare Bowen, a mother-of-two in England who lost her five-year-old daughter Beth in 2007 during surgery. A wall of silence from all involved in Beth’s care prevented Mrs Bowen and her husband from getting a full explanation of the causes of the tragedy. Our article on page 10 will make sobering reading for anyone involved in healthcare today.

However, this edition may also provide some relief for readers, in that our latest collection of case reports feature a significant number of successfully defended claims. We hope they will provide some reassurance that a mistake is not always judged to be negligent – and that the team at MPS are committed to protecting your reputation.
Informed consent

Eric Tin, partner and head of medicolegal practice group at Donaldson & Burkinshaw LLP, and Dr Janet Page, senior medicolegal adviser at MPS, look at the key aspects of informed consent, with some analysis of recent cases in Singapore.

Informed consent is a fundamental element of all clinical interactions between a doctor and his patient and forms part of his overall duty of care to his patients.

It is trite law,1 and also professional ethics,2 that before a doctor performs a medical procedure, the patient should be adequately advised on their medical condition; the nature of the procedure; the respective benefits, risks and possible complications of the procedure and available alternative treatment options (collectively “relevant information”) so as to enable the patient to participate in a meaningful way in decisions about his own treatment.

The onus remains on the doctor to provide advice, regardless of whether the patient asks any questions, since a patient cannot ask for information if they are unaware of its existence.3 It has also been observed in a Singapore Medical Council (SMC) case involving a treatment of a novel nature that: “It is not for the patient to prove that he had not been given full information about any procedure that he is about to go through. It is for the doctor to prove that he had obtained proper and informed consent from the patient.”4 The patient must be advised if the treatment is novel or experimental and the extent of any known or anticipated risks associated with it. Patients participating in clinical trials should also be made aware of any specific provisions for indemnity and clearly advised where the potential harm to the patient outweighs any potential benefit.
Express or implied?
Consent may be express or implied. It can be expressed verbally during consultation or in print, when the patient signs a consent form after discussion of the relevant information. It may also be inferred from the patient’s conduct, such as when a patient willingly extends his hand to receive an injection. Under the SMC Ethical Code and Ethical Guidelines (2002), discussions of treatment options and informed consent are expected to be documented in sufficient detail in the patient’s medical records to enable proper transfer of care when necessary.5

SMC disciplinary inquiry cases have shown that failure to document per se or inadequate documentation can lead to indefensibility of professional misconduct charges. Written consent should be obtained for all invasive procedures unless the risks are negligible (eg, routine venepuncture). Verbal consent, including details of any discussion with the patient, should be documented in the patient’s record and signed and dated. A proforma checklist of risks and complications is a useful aide memoire and speeds the documentation process, but is not a substitute for a discussion with the patient.

Mental capacity
Informed consent is predicated on a patient’s free will and mental capacity. A person who is sufficiently mature may freely give or withhold consent to any medical treatment.8 If the patient is a minor, or of diminished capacity, information should be explained to their parent or legal guardian, or the person legally responsible for them (eg, a donee or a court-appointed deputy under the Mental Capacity Act9), who will consent on behalf of the patient (“legally authorised consent”).10 No-one else, however close by reason of kinship or friendship, is legally entitled to decide for the patient.11 It is, however, often helpful to involve family members in the discussions if the patient so wishes.

Consent in an emergency
An exception where a doctor may proceed with a medical procedure without actual or legally authorised consent is in a situation of emergency or necessity to save their patient’s life.12 In such a case, the doctor’s only course of action is to act in the best interests of the patient.13 The decision as to what is in the patient’s best interests from the point of view of the doctors is strictly a medical one, and one that is expected to be professionally formed.14 Discussions with the patient’s close family may assist the doctor in deciding where those interests lie if time permits, although the family’s views are not determinative. The decision-making process should be documented in the patient’s records. Apart from this recognised exception, it must be noted that performing a procedure without having obtained prior valid consent can yield dire consequences for a doctor.

No consent: the consequences
In a serious case, the doctor can be prosecuted for the Penal Code offence of use of criminal force, which carries an imprisonment term and a fine.15 Failure to obtain valid consent can also ground a civil case under the tort of negligence16 or tort of battery,17 leading to claims for monetary compensation. It can also be the subject of professional misconduct charges against a doctor upon complaint to the SMC.18 In one SMC case, the disciplinary tribunal held that a failure to obtain informed consent to invasive surgery is a serious form of professional misconduct, and the suspension term it meted out to the respondent doctor was upheld on appeal by the High Court.19 A doctor may therefore be put through the criminal, civil and/or disciplinary justice process for operating without consent.

In medicolegal cases, what was discussed and advised during the consent-taking process is largely a question of fact, and the court or disciplinary tribunal will examine the available oral and documentary evidence of those who partook in the process to determine where the truth lies. Whether the advice to the patient meets the required standard of care (or conversely whether it constitutes a breach of the duty of care), will be a question that usually hinges on expert opinion.

In Singapore, the Bolam-Bolitho test applies to the standard of care for diagnosis, treatment as well as advice. Under this test, a doctor is not liable for negligence if they have acted in accordance with a responsible body of medical opinion, provided that this opinion stands up to logical analysis and scrutiny. In this regard, the court will assess whether the expert opinion in support of a certain standard of care has balanced the comparative risks and benefits relating to the matter, considered and weighed all the countervailing factors relevant to the issue, and arrived at a defensible conclusion that is internally cogent and not contradicted by proven extrinsic facts.20

What the patient needs to know
Where the court considers that a decision not to warn of certain risks is illogical, the court can find against the doctor.21 Thus whilst the standard of advice for patients is based on what doctors consider patients need to know, the court acts as a bulwark against any illogically held standards. This has been the legal position adopted by the Court of Appeal in the case of Gunapathy in 200222 and consistently followed to date in a line of High Court decisions.23 This position differs from jurisdictions such as Australia, Canada, Malaysia and the United States, which have embraced a patient-centric or “reasonable patient” test for informed consent. As the point on informed consent was not fully addressed in Gunapathy, it nevertheless remains open to the court to take a different position in the future.24

There is generally no requirement for doctors to explain risks that an average person is ordinarily aware of, or of which the particular patient has prior knowledge.25 The standard of advice that the doctor should provide to a patient may therefore differ according to the patient’s pre-existing knowledge.26 But a doctor would be in breach of their duty if they simply assumed that their patient had the relevant information by reason of having undergone a previous similar procedure.27 The onus remains on the doctor to take steps to ascertain that the patient indeed had the relevant information for informed consent, and to document the ascertained facts.

Who can take consent?
The giving of information is a process, and not an event, which begins from the moment relevant information is given to the patient until final confirmation of that information before the medical procedure begins.28 The relevant information need not emanate from the same source throughout the process of informing the patient.29 It was held in a High Court case that whilst it is good practice for the doctor performing the procedure to take consent, information can be communicated by other relevant medical professionals such as the primary treating physician, medical officers, nurses, or even through available resources such as information pamphlets.30

It must be added that those individuals should have the appropriate knowledge and expertise of the intended procedure and are in a position to answer any questions the patient may have. In a team care situation, once a team member has advised the patient of certain information, and the patient...
understands the information, the other team members need not repeat the same information to the patient. This judicial view takes into account the practicalities in healthcare institutions like hospitals or medical centres, where a patient is usually attended to by various medical personnel who may individually or collectively communicate advice at different times and places. In such clinical contexts, clear and sufficient documentation, as well as sound protocols for transmitting information amongst the medical team, will help prevent unnecessary communication breakdown that can be detrimental to the patient’s care.

There are certain medical procedures, such as obstetrics, which provide patients with a choice of anaesthetic options. In a recent High Court case, the court held that the anaesthetist and the obstetrician were both responsible for advising on considerations relevant to their own specialty. This requires effective communication between the doctors to ensure that the patient has been apprised of all the relevant considerations to enable her to make an informed choice. The doctors’ actions will be judged in accordance with the Bolam-Bolitho test referred to earlier.

In summary, informed consent is not a one-off event. It is also not a simple matter of obtaining a signature on a consent form. It is a communication process before a medical procedure to provide patients with relevant information so that they can meaningfully participate in decisions about their own medical treatments. Such information can emanate from more than one source, and it will be useful to ascertain the patient’s pre-existing knowledge to help assess the amount of information that needs to be given.

In determining the appropriate standard of care for advice, the Bolam-Bolitho test is still good law in Singapore. Where medical situations call for joint responsibility of different specialists, doctors should communicate with each other and also with the patient to avoid information gaps that can potentially imperil patients. Unless situations of necessity present themselves, a doctor should always obtain consent from a patient or his legally authorised representative, and have the advice adequately documented, before proceeding with a procedure. Where consent cannot be obtained and the patient’s life will be in danger if the necessary medical procedure is not performed, the doctor must always act in the patient’s best interest and record the reasons for his decision.

1. Who should take consent?
   a. Someone with sufficient knowledge and expertise.
   b. Does more than one specialty need to be involved?

2. Capacity to consent
   a. Does the patient understand the nature, purpose and effect of what is proposed? And if not, who is the appropriate person to consent on behalf of the patient? (In an emergency, the doctor must act in the patient’s best interests.)

3. When to take consent
   a. Consent is a process, not an isolated event.
   b. Revisit the process before the procedure especially if there is a delay between the consent and proposed treatment.

4. How to take consent
   a. Provide sufficient information:
      i. The nature, purpose and effect of the proposed treatment
      ii. Alternative options (including doing nothing), risks and benefits
      iii. Consider the use of visual aids, eg, a CD or leaflets
   b. Give time to the patient to consider their decision, have discussions with their family, or take other advice.
   c. In an emergency: assess the patient’s best interests – include the family in the discussion as time permits.

5. Provide evidence of consent
   a. Consent should be written for all invasive procedures.
   b. A signature alone is insufficient as a record of consent being taken.
   c. Document discussions: with whom, any warnings given, etc.

REFERENCES
1. [2011] SGHC 193 at [125]
2. SMC, Ethical Code and Ethical Guidelines, paragraph 4.2.2
3. [2011] SGHC 193 at [103]
4. SMC disciplinary inquiry grounds of decision dated 23 July 2013 at [116]
5. SMC, Ethical Code and Ethical Guidelines, paragraph 4.1.2
6. SMC disciplinary inquiry grounds of decision dated 4 May 2012
7. [2008] 3 SLR(R) 612
8. [2006] 2 SLR(R) 13 at [4].
10. [2006] 2 SLR(R) 13 at [4].
11. [2006] 2 SLR(R) 13 at [4].
13. [2006] 2 SLR(R) 13 at [10].
14. [2006] 2 SLR(R) 13 at [9].
20. [2002] 1 SLR(R) 1024 at [5]-[6].
22. [2002] 1 SLR(R) 1024.
27. [2011] SGHC 193 at [126].
28. [2013] 2 SLR 18 at [69] and [73].
29. [2013] 2 SLR 18 at [69].
30. [2013] 2 SLR 18 at [73].
32. [2013] 2 SLR 18 at [70].
33. [2013] 2 SLR 18 at [75].
34. [2013] 2 SLR 18 at [69], [70] and [72].
Impartial experts – who needs them?

Sophie Pearson, solicitor at MPS panel law firm Kennedys, advises on what it takes to be an expert witness
In the interim report that preceded Hong Kong’s Civil Justice Reform, a damning indictment of the state of expert evidence was lifted from Hong Kong’s Counsel magazine. It read as follows: “Expert witnesses used to be genuinely independent experts. Men of outstanding eminence in their field. Today they are in practice hired guns; there is a new brand of litigation hangers on, whose main expertise is to craft reports which will conceal anything that might be to the disadvantage of their clients.”

That article was published two years before Lord Woolf, then head of the Civil Justice system in the United Kingdom, produced his Access to Justice report ahead of the UK’s own civil justice reforms. That report identified a similar problem with expert evidence. It said: “The purpose of the adversarial system is to achieve just results. All too often it is used by one party or the other to achieve something which is inconsistent with justice by taking advantage of the other side’s lack of resources or ignorance of relevant facts or opinions. Expert evidence is one of the principal weapons used by litigators who adopt this approach.”

The root of the problem

Counsel magazine’s editor thought one origin of the expert “problem” was judges’ wish to review experts’ written evidence before going into court, which unwittingly contributed to the desire to “craft” reports – what litigant would ignore the opportunity to implant his case in the judge’s mind before the hearing began? Lord Woolf considered difficulties arose as a result of the expert being initially recruited as part of the team that investigated and advanced a party’s contentions and then having to change “hats” halfway through in order to provide a report for the court.

Hong Kong’s solution to the problem was two-fold – a new rule stipulating that the duty of an expert is to help the court and that this duty “overrides any obligation to the person from whom the expert witness has received instructions or by whom he is paid” and a code of conduct emphasising, ad nauseam, that an expert is not an advocate for a party.

The heart of the problem lies, of course, in the adversarial model used to solve disputes. The intrinsic defect with this model is that because it is operated by human beings, who are emotional creatures, it tends to polarise positions. This dynamic of polarisation acts rather like a magnetic field, affecting everything in its path, including expert evidence. This remains a significant problem and inexperienced experts alike must be aware of this dynamic and refuse to be drawn into it.

The demands of expert work

For those doctors who think expert witness work is an easy way to make a bit of extra money, they should rethink. It requires a very specific skillset – extensive knowledge of the medical practice that is under scrutiny, impeccable judgment, clarity of thought process and of expression (both oral and written), a robust temperament to withstand the inevitable pounding that goes hand-in-hand with cross-examination in the witness box and, finally, and perhaps most importantly, lack of a hidden agenda.

The agenda may be a conviction that doctors shouldn’t be criticised, or that this doctor shouldn’t be criticised, or that patients should be entitled to higher standards of care, or that claimants drain the healthcare system of money. The list is endless but the point is that these agendas are dangerous, as they have the potential to cloud judgment and introduce bias into the process.

As a lawyer who has worked on both sides of the fence (to continue the adversarial language) but has exclusively represented doctors and hospitals for the last 14 years, it occurs to me that maybe a simple communication gap between the medical and legal professions has led to a misunderstanding about what expert witness work is all about. I consider there to be two myths surrounding expert work.

Before looking at these myths, here are the parameters within which the system operates. As in life, mistakes in medicine are an occupational hazard and when patients receive treatment that falls below a reasonable standard of care and it causes harm, the interests of the patient are uppermost (doctors don’t, after all, treat patients for their own glory) and patients are, and rightly so, entitled to receive financial compensation to put them back, as far as possible, in the position they would have been in but for the negligence. On the other side of the coin, when doctors are accused of negligent treatment, they are entitled to investigate those allegations exhaustively and, where it appears that they have done nothing wrong, to defend them robustly. Experts-in-training who struggle with these parameters had better stop reading now.

The first myth is that defence lawyers automatically defend claims. We don’t, and to that extent ‘defence lawyer’ is a misnomer. We would better be described as investigators and risk assessors. We spend our days investigating liability from a neutral standpoint and deciding whether the risk of the claimant succeeding at trial is a risk that our client should buy off, and at what cost. The term ‘defence lawyer’ is entirely appropriate for those cases that go to trial, but in truth, not many do.

The second myth is that lawyers’ ideas of a good expert is one who will tell us what we want to hear. Wrong again. Undeniably, every lawyer’s idea of a dream day in the office (sad though it may sound) is receiving a supportive report from an expert with vast clinical experience and an impeccable history of medicolegal reporting, but that is beside the point. The experts we need are experts who will carry out a thorough review of all of the evidence and tell us, at an early stage, what their honest view is about the care provided so that we can advise our client properly and deal with the consequences of that opinion promptly. A litigator’s definition of disaster is finding out at a pre-trial conference, when most of both parties’ legal costs – which will now be substantial – have already been incurred, that the expert is wavering in his previously robust view about the standard of care provided. Even more catastrophic is when he gets cold feet in the witness box.

A problem solved

Medical negligence litigation is not about blindly fighting our client’s corner, whether we are for the claimant or defendant. If the system is operated with integrity and competence it is about problem-solving, pure and simple.

A little like doctors who cannot treat their patients properly if they make the wrong diagnosis, for lawyers to do their job properly we also need to know what the problem is, and that is why impartial, independent experts are fundamental to the system.

As Malcolm X once said: “I’m for the truth, no matter who tells it. I’m for justice, no matter who it’s for or against.” The expert-in-training would be well advised to stick this quote to their computer screen as they settle down to prepare their first few reports. The good, experienced expert, the expert who will be instructed time and again, will have it engraved in their mind’s eye.

Sophie Pearson is based at the London office of Kennedys and practised in Hong Kong in 2013.
In 2007 Clare Bowen’s five-year-old daughter Beth died during surgery at a hospital in the UK. Here she tells her story to Sara Dawson – and relays her hopes that it will reduce the likelihood of such an incident happening again.

I’m a mum to three small children who all have spherocytosis, which causes them to become very anaemic and require blood transfusions. The condition made my middle child William very poorly, so in January 2006 a decision was made to remove his spleen – it made a massive difference to his quality of life.

So the following July, we decided that Beth, my eldest daughter, would have the same operation – she had just started school and couldn’t keep up with the other children. We felt confident, as the same team that operated on William would be treating Beth. I remember talking with the doctors beforehand about possible scars on Beth’s tummy, so the spleen would be removed through a lower incision.

We had all the pre-op stuff done and chatted to all the doctors, before arriving at the hospital on 27 July. She went down for her operation at 1pm – we didn’t hear from the doctors for several hours. At 4pm we spoke to a nurse, asking her why it was taking longer than it should.

The nurse said it was fine as these operations usually take a long time. Just after 6pm, the surgeons, the anaesthetist and the nurses came into our tiny waiting room – without any warning they said something awful had happened. The doctors seemed unable to comprehend what had happened. I asked one doctor: “Is she dead?” He said “yes”, adding that she’d lost a lot of blood during the operation as a blood vessel had been cut and she hadn’t survived. He said they’d been trying to save her for an hour and half prior to coming to see us, but she hadn’t survived – she’d lost too much blood.

The immediate aftermath

In the weeks after Beth’s death we received no answers from the hospital – it was very difficult to get them to talk to us. Slowly we gathered bits of information. We found out that at the last minute a new piece of equipment was used called a morcellator – like an apple corer – that removes chunks of flesh through laparoscopic portholes.

It emerged that the surgeons hadn’t used the equipment before, they hadn’t received any training and no risk assessments on the equipment had been undertaken.

It was an adult piece of equipment that was not meant to be used on a child.

The damage to Beth’s body was extensive; they made cuts to her aorta, her stomach, her intestines – she had massive trauma to her body.

Searching for answers

It was only when we enlisted help from a friend with a medical background that we started asking questions that really needed asking. Why did the hospital throw away all the equipment they used that night? Why didn’t they keep the blood that Beth lost? Why didn’t they try and retrieve the items when we’d asked them, even though they were still at the hospital? Everything that could have given us clear answers was disposed of immediately. It didn’t allow us to get the answers we so needed.

It surfaced that the surgeon who carried out Beth’s operation had only ever done three laparoscopic surgeries before – William had been her first. In her head she deemed it ok to try to operate that piece of equipment on my daughter.

Confusion

That was something we as parents could never understand – why would a doctor allow themselves to operate that piece of equipment that they weren’t comfortable with, while their senior was in the room?

I don’t think any of the surgeons understood that there was a technique to what they were doing, one that had to be learned. They had no formal training on how to use the morcellator; a five-minute talk was judged to be enough training. The nurse who was asked to put the morcellator together had never seen it before. No-one felt they had the authority or the ability to halt the operation. If only someone in the theatre that day had said can we stop a minute, can we take a step back, we’ve had no training, we’ve not done a risk assessment, we’ve not really thought this through, is this a good idea?

The inquest

We did not receive an apology before or after the inquest. The hospital admitted they had failed in their duty of care and they were sorry that they had failed to prevent Beth’s death. They didn’t fail to prevent Beth’s death – they caused it.

The three-day inquest took place 18 months after Beth died. Unfortunately, the only way we could afford a solicitor was to take legal action against the hospital, which is something we never really wanted to do.
For us it was never about money; it was about answers.
The only way I can describe the inquest from a parent’s point of view is that it’s like being tortured and you can’t escape. We had to listen to different stories about Beth’s last hours, while trying to fit it all together in our heads – it was horrible. Information that came out in the inquest was contrary to what the hospital had been telling us in the months previously. Photographs were revealed of the theatre and information was shared on Beth’s medication, which she’d been given but we were unaware of. A trainee surgeon was the one specifically holding the morcellator – they had never used it before and she was not allowed to perform surgery on her own.
During the inquest the hospital admitted that they had not received consent from us to carry out the operation on Beth.
I left the inquest room while they showed pictures of Beth’s autopsy, but my husband Richard felt he had failed Beth by allowing the hospital to do the operation, so he remained in the room – the pictures destroyed him. No-one should have to see their child cut up on an autopsy table.
The striking thing during the inquest was the arrogance and complete disregard by the medical professionals in the room for our feelings, and for the part that they played in Beth’s death.
In the months after the inquest, Richard suffered a massive heart attack and died – he was only 31 years old.

On a national level
Beth’s death was reported widely in the media and the UK government became interested in what happened. The Health Select Committee started looking at many incidents where hospitals hadn’t been open and honest with parents and relatives after operations or treatment that had gone wrong.
The Committee published a report about the death of Beth. It generated a lot of dialogue and interest in the subject that wasn’t there before – it was a catalyst for change. That said, I do think there is still a long way to go.
The Committee came up with some good ideas for ways to drive things forward, but it’s not always about rules and making people do things; it’s about a change in culture. Bringing in a law to enforce open candour and openness is not necessarily the right way forward.

Reflections
Attitudes need to change. Some medical professionals are too arrogant to believe they can be any better and that they can make mistakes. With this attitude you blind yourself to mistakes, and you won’t see one heading straight for you.
Medical professionals should be confident in their ability, but they should understand their limitations – “I’m good, but I can be better”. Beth may still be alive if the surgical team’s mindset had been different going into the operation.
Change has to come from the top and the bottom – openness and candour must be championed by everyone but, ultimately, it is the board and the senior doctors who are the ones that need to facilitate the changes.

Visit www.youtube.com/user/MedicalProtectionSoc to see a video interview with Clare Bowen, as she describes her fight for the truth behind the tragedy.
Commentary – Being open
By John Tiernan, MPS Executive Director, Member Engagement

Sadly things do go wrong in medicine. We can’t be totally confident about how frequently things go wrong, but they are not a rare occurrence.

For many years a culture of denial existed, where doctors were heroes who never have adverse outcomes. These expectations led patients to demand perfection and perceive adverse outcomes as unacceptable even when the literature suggests that as many as 50% are not avoidable.

The fear of openness is often driven by a blame culture where the doctor is disproportionately singled out for sanction, regardless of the multifactorial causes of some of these events.

The real challenge is how to change this culture to one where we move from disproportionate blame to one of fair accountability or a just culture, where the emphasis is on learning from adverse events rather than finding someone to blame. The learning culture is balanced by the profession taking accountability when mistakes are made.

A good starting point is encouraging openness after an adverse event has occurred. When something has gone wrong be open and candid with the patient – it is part of the ongoing therapeutic relationship. Say sorry for what has happened and talk honestly with them – don’t run away or deny what’s happened. It isn’t always easy but it is the right thing to do.

Exaining significant events and exploring adverse outcomes is not always an admission of bad practice – it is, however, an essential part of good practice.

Being open can also reduce the risk of complaints and claims. For many patients who have suffered an injury, turning to the law is often a last resort; patients go down this route because they feel it is the only way to have their questions answered.

There is a large amount of evidence that suggests that people lodge a complaint or a claim against a doctor, not primarily because of their injury, but because they’re angry at what happened and want answers.

Which is more professional? To refuse to acknowledge an adverse outcome and cling to the belief that you are incapable of having one, or to acknowledge it, manage it ethically and professionally and, most of all, learn from it?

Which sort of professional would you rather be treated by?

Junior doctors should feel empowered to stand up to cultures that threaten patient safety. They should be able to speak out and be supported by their seniors. They may not be correct all the time, but that should be ok – they shouldn’t be berated for being wrong; they should be rewarded for asking questions and having the courage to say “can we stop; can we check this is right?” Seniors should not view this as frustrating but as affording an opportunity to rethink what they are doing.

Learning to live again
I can’t do anything to bring my daughter back. My daughter has gone – I can’t do anything for her now; I can’t help her. But I can encourage doctors to be safer, to work as a team and to speak out. I want people to understand that once you’ve made a mistake or done something wrong, or been in a situation out of your control where something has gone dreadfully wrong, then you should be open and honest about what’s happened. Allow yourself to be found at fault because that is the only way that people can improve.

No-one can truly understand the pain of losing a child unless you’ve been there, but if you can think – even for a second – that you’re putting someone’s life at risk, stop and consider the pain that I feel every single day. Then I know you’ll do the right thing.

Lucian L Leape MD
Adjunct Professor, Health Policy, Harvard School of Public Health

We’re moving from paternalism with patients – let the doctor tell you what’s right for you – to an openness and a patient partnering, where the patient not only has a right to know, but we want them to know.

Dr Donald Berwick
MD, MPP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement

Don’t think we can become safer secretly. There’s some very inescapable connection between openness and honesty and disclosure and involvement, confession, apology… all acts of openness in building a safe culture. I think this idea of transparency and openness is an essential part of our future.

Professor Charles Vincent
Professor of Psychology, Emeritus Professor of Clinical Safety at Imperial College London, Imperial College, London

Information about errors and adverse events, harmful outcomes in healthcare, has very seldom been studied openly; it’s been treated as a nuisance, something we don’t want to know about, an occasion for shame, guilt, and other sorts of problems. In the last few years in healthcare we’ve come to realise that it can also be – if treated properly – a resource, and an essential way of achieving a safe culture.

Professor Mayur Lakhani
GP and Chairman of the National Council for Palliative Care, UK

When something goes wrong, you need to lose sleep over it. Why did it happen? Do I understand what happened here? Have I made sure that I know the reasons this happened? What can I do to prevent it? Have I said sorry to the patient? Have I involved the patient in this situation? Have I talked to staff? I think that’s a really important obligation of doctors.

Guy Hirst
Former British Airways training captain and human factors expert

Medical teams are human. Medical teams are driven to succeed and have the needs of the patient at heart. They need to be pre-occupied with the possibility that they will make errors. The team leaders, usually consultants, must understand that they will make mistakes and try to break rules in order to achieve results. The safety net is their team who must trap or mitigate the consequences of such errors or violations.

Research shows that if the leader briefs the team in an open, interactive and inclusive manner then team members will speak up in an assertive manner when the situation demands.

REFERENCES
1. Note to non-UK readers: the Health Select Committee is part of the UK parliament, and oversees the operations of the UK Department of Health. Here is a link to the Health Select Committee report – www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151we22.htm
From the case files

This edition Dr Mark Dinwoodie, head of member education at MPS, assesses the key learning from the latest collection of case reports

I’m delighted to have the opportunity to reflect on the cases in this edition of Casebook from an educational and risk management perspective.

The cases of Mr D, with his osteoarthritic knees (“A pain in the knee”, page 14), and Mrs H, with her neuropaxia following cannula insertion (“A cannula complication”, page 21), remind us how record-keeping can contribute to an effective defence against allegations of negligence. Of course, good documentation is also increasingly essential to support good clinical care and enable continuity to be delivered by an increasing range and number of involved healthcare professionals.

It is important that not only should the clinical assessment and any procedure be adequately documented, but also the discussion behind any decision made regarding treatment. It is, of course, a matter of judgment regarding how much to write in the notes and, inevitably, time pressures will contribute to that consideration.

“The elusive diagnosis” for Mr M (page 15) turned out to be diabetes in a patient who had repeatedly attended the GP surgery for several infections. While MPS successfully defended this case, it reminds us of the importance of reconsidering the diagnosis in patients who represent with recurring symptoms or signs. There can be a temptation when a patient returns with no improvement to keep adjusting the treatment, whereas sometimes what is needed is a review of the original diagnosis and adjustment of the treatment to match the reviewed diagnosis.

The system errors of Mrs Y and the blood transfusion (“Transfusion confusion”, page 19) highlight the importance of someone taking responsibility when the patient has suffered an adverse outcome and, following an apology, having an open and honest discussion with the patient, explaining what has happened. It is always appropriate to say that you are sorry for what the patient has experienced. It also shows how patients themselves can make a valuable contribution to patient safety. I hope that you find reading the cases to be interesting and informative. Our range of education risk management products can help you address some of these challenges, and I encourage you to visit www.medicalprotection.org and click on the Education tab for more information.

Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant’s job or the number of children they have) this figure can sometimes be misleading. For case reports in Casebook, we simply give a broad indication of the settlement figure, based on the following scale:

- High US$2,000,000+
- Substantial US$200,000+
- Moderate US$20,000+
- Low US$2,000+
- Negligible <US$2,000

I hope that you find reading the cases to be interesting and informative. Our range of education risk management products can help you address some of these challenges, and I encourage you to visit www.medicalprotection.org and click on the Education tab for more information.
Mr D, a 62-year-old manager, had severe pain in both knees, which caused him trouble walking more than 200 yards. He was referred to an orthopaedic clinic for assessment.

At the assessment, consultant Mr M diagnosed bilateral osteoarthritis of his knees. Two weeks later bilateral knee arthroscopies were carried out. At follow-up clinic a week later, Mr D felt his knees had improved.

However, two months later Mr D complained of extreme pain in the left knee and it was decided he should undergo total left knee replacement.

Following the knee replacement, Mr D had physiotherapy. Two months post-surgery, Mr D was happy with his knee replacement. He had returned to work, was driving, and playing golf.

Four months post-surgery, Mr D was reviewed by Mr M after he complained of developing difficulties flexing his knee. Mr M thought Mr D had developed fibrotic changes within the joint and, as a result, manipulation was undertaken under anaesthetic a few months later. The day after the manipulation, Mr D had a disagreement with one of the physiotherapists and discharged himself from hospital. He declined in and outpatient physiotherapy and arrangements for physiotherapy elsewhere.

Early the following year, Mr M saw Mr D and noted that he had benefited from having later physiotherapy, with movement of 100°. However, a number of months later, Mr D had subsequent difficulties and pain. A second opinion obtained from surgeon Ms H stated that the femoral component was too large and a revision knee replacement was carried out. Mr D claimed his pain had been eradicated.

Mr D made a claim against Mr M, stating that he had failed to recognise, from postoperative x-ray, that the femoral implant of the first knee replacement was too large, failed to advise of the need for a revision procedure, and failed to carry out a revision procedure, or refer Mr D to another surgeon. He also claimed a pointless manipulation was carried out under anaesthetic and he had suffered unnecessary pain and inconvenience for more than two years.

During the revision procedure, significant soft tissue release would have been required and this alone may have been responsible for an increased range of motion in Mr D’s knee. However, experts were critical of the fact that as Mr D was not happy with the result of the knee replacement, the reasons why should have been investigated.

The case was successfully defended at trial and nearly all costs were recovered.

Learning points

■ A poor outcome doesn’t necessarily mean negligence. There was no criticism of the procedure itself by experts.
■ Supportive expert opinion of the technique used in the procedure meant that the case could be defended to trial.
■ Mr M had well-documented the procedure and detailed medical records helped in defence of the case.
CASE REPORTS

SPECIALTY | GENERAL PRACTICE
THEME | SUCCESSFUL DEFENCE

The elusive diagnosis

Mr M, 50 years old, suffered from chronic ill-health due to spinal fusion, chronic bronchitis and asthma. He was a regular attendee at the surgery of Drs C and D, with sinusitis. In March 2005, Mr M saw Dr D with a similar complaint and she administered him with a flu jab, particularly as Mr M often failed to attend chronic monitoring clinics. The notes from the consultation said: “Upper respiratory tract infection NOS. Catarrh following URTI 2/52 ago is well. O/E ENT NAD chest flu jab given.”

A year later, Mr M saw Dr D and the notes said: “Acute sinusitis chest clear. Prescription for doxycycline 100 mg (8).” Dr D advised Mr M how to take the doxycycline and told him to return if the symptoms did not resolve. Three months later, in June 2006, Mr M attended the surgery again, this time as an emergency, and saw Dr C. Dr C’s notes said: “[SC] penis. Cough. EM-Cough prod of green sputum and sore scratch of L-side of corona of penis? infected. Chest clear. RV PRN.” Dr C prescribed Mr M some antibiotics to cover the possibility of both skin and chest infections, and asked Mr M to return if either problem did not clear up.

Three months later, Mr M was again seen by Dr C as an emergency appointment. Mr M presented with a productive cough and a high temperature, and, on examination, there were signs of chest infection at the base of the right lung. Mr M was prescribed antibiotics for a lower respiratory tract infection. Six months later, in January 2006, Mr M suffered a stroke. Upon admission to hospital, diabetes was diagnosed. Mr M remained in hospital for three months and afterwards continued to suffer pain and restrictions to his mobility.

Mr M made a claim against Dr C and Dr D, alleging that over the course of his numerous consultations, they had failed to diagnose, treat and monitor his diabetes; failed to diagnose, treat and monitor his hypercholesterolaemia; and failed to monitor his blood pressure.

Learning points
- The NICE guidelines Preventing Type 2 Diabetes: Risk Identification and Interventions for Individuals at High Risk (2012) are aimed at identifying people at a potential high risk of developing the condition; assessing their individual risk with testing; and, if necessary, offering lifestyle advice (such as advice on diet and exercise), to help prevent the condition in people who are at high risk. The guidelines are available at www.nice.org.uk/guidance/PH38
- It is important to listen to patients who reattend with recurring problems. Doctors must not let an element of “crying wolf” blind their judgment. Maintain an open mind and be willing to revise an initial diagnosis.
- A long-running scenario such as this one is ideal for discussion at a ‘significant event’ meeting, to identify whether anything could have been done differently at each stage of Mr M’s treatment.
Mrs B, 40 years old, was referred by her optician to see an ophthalmologist, Mr F, because of concerns about possible raised intraocular pressure and right-sided amblyopia. Mr F confirmed the diagnosis of right-sided amblyopia, found her to have normal intraocular pressure and documented some visual field loss in both eyes, which he considered was performance-related. He advised reassessment in six months but the patient did not attend for follow-up. Mr A attempted to conduct further follow-up consultations on a number of occasions but Mrs B failed to attend.

Ten years later Mrs B was admitted to hospital with smoke inhalation after an accidental house fire. Her only significant past medical history was a hysterectomy for menstrual disturbance some years previously. The medical consultant on call was an endocrinologist, Dr Y, and she was discharged after two days under his care.

A year later she was seen by consultant gastroenterologist, Dr Z, with hepatomegaly due to alcoholic hepatitis. Soon after, Mrs B was admitted under Dr Z’s care after taking an overdose of chlordiazepoxide. A junior doctor commented in the notes that she had “noticed a change in her appearance” that was “interesting, but not classically like acromegaly” and recommended further investigation. Dr Z had no recollection of hearing such comments and no further investigations were carried out.

Over three years later a brain MRI scan was carried out to investigate mild neurological symptoms and memory impairment following a fall. The MRI scan showed an abnormality in the pituitary gland and a subsequent pituitary MRI scan showed a pituitary macroadenoma measuring 1.5cm. Mrs B was found to have a hoarse voice caused by oedematous vocal cords, and a large tongue, nose and hands. Her prolactin level was elevated and a diagnosis of acromegaly was made. Mrs B underwent uncomplicated transphenoidal surgery to remove the pituitary tumour.

Following surgery Mrs B had numerous medical problems caused by late stage acromegaly and other problems related to the hormonal disturbances brought on by removal of the pituitary gland. An MRI scan the following year showed no signs of tumour recurrence.

Mrs B brought a claim against Mr F, Dr Y and Dr Z, alleging that on three occasions opportunities to diagnose her pituitary tumour were missed.

Expert opinion
Most of Mrs B’s medical problems were the direct effect of undiagnosed acromegaly. The acromegaly could also have contributed to depression, consequent alcoholism and memory loss. The menstrual disturbance may have been due to the hyperprolactinaemia. Early diagnosis and treatment would have given Mrs B a substantially better quality of life.

The claimant’s expert considered that Mr F, Dr Y and Dr Z had “missed opportunities” for making the diagnosis. Significantly, a consultant endocrinologist examined Mrs B when she was admitted with smoke inhalation. The expert commented that it is not unreasonable to expect an endocrinologist to detect the clinical signs of acromegaly during a routine clinical examination.

However, experts instructed by MPS were supportive of the care provided by the doctors. The physical changes of acromegaly are slow to develop and the diagnosis is notoriously difficult to make in the early stages. Mrs B’s alcoholism could also have contributed to the changes in her facial appearance, making the acromegalic features more difficult to pick up.

MPS issued a robust defence to the allegations. Eventually, Mrs B discontinued her claim.

AK
Ms E, a 29-year-old mother, had suffered with ongoing low back pain since the birth of her second child two years ago, which had failed to improve with physiotherapy. She was assessed in orthopaedic outpatients and diagnosed with an L5 disc prolapse and listed for microdiscectomy.

A week after her orthopaedic consultation, she called her local GP surgery and spoke to Dr A, complaining that she was still in pain, and was unable to come down to the surgery to be seen. Dr A noted she was waiting for an operation and gave further analgesia and muscle relaxants.

The following day, Ms E called the out-of-hours service reporting ongoing pain, despite taking the analgesia prescribed by her GP. She also mentioned numbness in her left leg. The triage nurse she spoke to advised her to try an anti-inflammatory and to seek further advice if her symptoms worsened or if she continued to be worried.

Ms E continued to have symptoms so booked an appointment to see Dr A, and was seen three days later. Her pain was ongoing and she had now developed urinary symptoms; Dr A added in naproxen and started antibiotics for a suspected UTI.

The prescribed medication made no difference to her symptoms, and the following evening Ms E presented to her local emergency department, and was diagnosed with cauda equina syndrome. She was transferred to the care of the neurosurgeons and had an urgent MRI. She underwent an L4 laminectomy the following afternoon, but was left with irreversible disturbance of bladder and bowel function and a persisting numbness in both the left leg and the perineal region.

Ms E pursued a claim against Dr A, alleging that he had failed to warn her about the seriousness of red flag symptoms in his first two consultations with her. She also claimed that he had failed to carry out any clinical assessment or suspect cauda equina syndrome and refer appropriately when she had presented at the surgery.

Expert opinion
MPS experts reviewed Dr A’s case notes. The GP expert felt that Dr A had not breached his duty in his initial telephone consultation by failing to warn Ms E about red flag symptoms, on the basis that she was under the care of the orthopaedic team and it was reasonable to assume that they had advised her about cauda equina syndrome and its symptoms. However, his subsequent consultations were viewed as substandard. His note-taking was poor and he failed to document any enquiry about red flag symptoms when the patient presented with urinary symptoms on a background of back pain. Dr A conceded that his usual practice was to document a lack of red flag symptoms if he asks about them and, therefore, it was likely he did not ask and that his diagnosis of a UTI would be difficult to defend.

The neurosurgical expert felt that the onset of cauda equina began with the urinary disturbance, which Ms E consulted Dr A about, and that an urgent referral for surgery within 48 hours of the onset of symptoms would have resulted in a more favourable outcome. He stated that the claimant was likely to have been left with residual low backache without bladder and bowel symptoms or neurological symptoms, and that Dr A’s failure to diagnose cauda equina syndrome led to a significantly less favourable outcome for Ms E.

The claim was settled for a high sum.

Learning points
- As always, good note-keeping is essential – not only for patient care, but when defending a claim. When assessing any patient, negative findings should be routinely documented, and in cases of back pain, repeated examination is often necessary to ensure there are no developing or progressing neurological symptoms.
- Cauda equina syndrome comes up repeatedly in Casebook. Be wary of patients who re-present with ongoing pain and never forget to ask about red flag symptoms (see useful links). In the setting of acute back pain, bowel and bladder symptoms should always prompt careful consideration of a neurological cause.
- It is easy to be reassured when a patient has seen a specialist and is awaiting further treatment, but symptoms can change, and an enquiry should be made about any deterioration in each new contact with the patient.

Useful links
1. www.sheffieldbackpain.com/professional-resources/learning/in-detail/red-flags-in-back-pain
Ms S, a 44-year-old shop assistant, was seven weeks pregnant. She didn’t feel able to continue with the pregnancy and booked an appointment at a clinic for a termination of pregnancy (TOP).

At the clinic, Ms S was seen by Dr F where a full history was taken – Ms S mentioned she had had one miscarriage – before tests were carried out. A pregnancy test proved positive, but an ultrasound scan showed no evidence of a gestation sac. Ms S was treated with mifepristone orally, followed by misoprostol (inserted vaginally) several hours later. Later that day, Ms S was discharged and given a post-treatment leaflet for reference. She was advised to contact the clinic 48 hours later to discuss her treatment, though she did not do so. She assumed that the termination had occurred by the next day.

Three weeks later, Ms S woke in extreme pain and was taken by ambulance to the local Emergency Department (ED). Here, it was discovered that Ms S had an ectopic pregnancy, which had ruptured. As a result, her left fallopian tube had to be removed.

Ms S brought a claim against both the clinic and Dr F, stating that she had been unable to conceive since the event, which had exacerbated her pre-existing depressive disorder. Ms S alleged that Dr F was negligent in failing to investigate the fact that no gestation sac could be seen on the scan prior to performing early medical abortion. She also alleged Dr F was negligent in failing to consider the possibility of ectopic pregnancy and refer her to hospital for further investigation.

Expert opinion
The clinic admitted liability to Ms S at the complaints stage, without contacting Dr F or seeking his opinion. MPS sought expert opinion on behalf of Dr F, which concluded Dr F’s actions were likely to have caused, or materially contributed to, Ms S suffering the loss of her left fallopian tube with some consequent pain and suffering.

However, expert opinion maintained that the loss of one fallopian tube does not necessarily prevent conception, as the probability of pregnancy is not substantially reduced. GP records confirmed that Ms S had been trying to conceive for 18 months and she was still ovulating. Her inability to conceive would at least partly be due to her age (44). Dr F’s actions did not necessarily cause Ms S’s infertility.

GP records indicated that Ms S had an extremely complex, long-standing psychiatric history. She had been taking antidepressants for more than ten years, and had been diagnosed with a mild form of bipolar disorder three years previously. Expert opinion suggested that Dr F’s breach of duty in his actions may have exacerbated Ms S’s long-standing psychiatric condition.

The claim was therefore settled for a moderate sum.

Learning points
- Make sure adequate safety-netting is in place for follow-up of patients. Ms S was advised by Dr F to contact the clinic 48 hours later but did not do so. Follow-up may have made a difference to the outcome.
- Clear communication and sharing information is important when handling complaints, especially when a claim involves more than one healthcare professional. In this case, Dr F was not informed the clinic had admitted liability.
- It is important to carefully consider scans – in this case the ultrasound scan found no evidence of a gestational sac, but this was not acted upon.
- For more information see the RCOG’s guidance, The Care of Women Requesting Induced Abortion: www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion
Mrs Y, 38, was admitted to hospital under the care of consultant Dr F for treatment of anaemia due to excessive menstrual bleeding. A sample of her blood was taken for grouping and cross-matching, for the purpose of a blood transfusion; a pack of compatible A-positive donor blood was sent to the ward for this purpose.

After the transfusion began, Mrs Y asked about the blood grouping, telling the nurse that she thought she might be A-negative. The nurse immediately stopped the transfusion and reported this to the laboratory technician – by which time, three to four drops of blood had already been transfused. However, the technician replied that the cross-matching was compatible, and advised that the transfusion should continue while he rechecked the cross-matching.

A short time later, the technician informed the nurse that Mrs Y was in fact A-negative and that the transfusion should stop; by this time, another six to seven drops of blood had been transfused. A blood sample was taken from Mrs Y and she was immediately administered dextrose saline and hydrocortisone intravenously.

Upon clinical examination and observation, Mrs Y’s condition was normal. Both the pre and post-transfusion blood samples had been tested for haemolysis and antigen-antibody reaction (Coomb’s test), and both tests had shown as negative for any reaction. A day later, Mrs Y was referred to a consultant obstetrician and gynaecologist for a full review of her menorrhagia, and a vial of anti-D was administered to Mrs Y. The following day, Mrs Y was discharged from hospital.

Mrs Y attended the hospital two weeks later where her condition was found to have improved – her haemoglobin level had increased, she was feeling less tired and there were no more palpitations. Mrs Y was asked to attend a further follow-up a month later, but did not attend. She made a claim against both Dr F and the hospital for the errors in her blood transfusion, alleging pain and suffering, and emotional stress and psychiatric injury.

Expert opinion

Although there had been a clear breach of duty in the error made during the blood transfusion, the experts for both MPS and Mrs Y disagreed over causation. Although Mrs Y had suffered no adverse reactions as a result of the transfusion, and had been administered with the necessary remedial measures, she alleged psychiatric injury; the experts instructed by Mrs Y’s legal team stated that she was indeed suffering from major depressive disorder with psychosis, as a result of the erroneous transfusion.

The expert instructed by MPS, a consultant psychiatrist, said that the 17-month period between the blood transfusion and the alleged diagnosis of major depressive disorder was rather prolonged for a connection to be drawn between the two incidents.

MPS also argued there was no liability against Dr F in the claim, stating that although he ordered the blood transfusion and had overall responsibility for the care of Mrs Y, he could not be held accountable for the mistake of the hospital’s laboratory technician.

The allegations against Dr F were subsequently dropped and the blood transfusion service accepted full liability for the incident and Mrs Y’s psychiatric injury, settling the case for a low sum.

Learning points

- Being open about errors following an adverse event is important.
- Listen carefully to the history given by the patient, and don’t hesitate to query a course of treatment even after it has started.
Eyes of the storm

Mr Q, 40 years old, consulted Miss A, a consultant ophthalmologist, with lesions affecting his eyelids. Mr Q’s complex medical history included antiphospholipid syndrome and his drug therapy included anticoagulant and antiplatelet agents, oral corticosteroids and ocular surface lubricants.

Miss A documented lesions on the left upper and lower eyelid margins resembling papillomas. No corneal or tear film abnormality was noted. She advised upper and lower full thickness wedge excision of the lesions under general anaesthesia. Consent was obtained and Mr Q was warned of the risks of bruising, infection, scarring and revision surgery. The surgery was performed a month later and was uncomplicated.

Mr Q reported severe pain in the eye shortly following surgery. Review the next day identified a small central corneal abrasion and two lashes on the lower lid in contact with the cornea. The corneal abrasion was fully healed on the fourth postoperative day and the lid sutures were removed. Ten days postoperatively there was complete dehiscence of the lower lid wound that was repaired under local anaesthesia. Subsequent eye examinations revealed persistent punctate corneal erosions affecting the lower cornea. Mr Q also experienced painful recurrent corneal erosions and a bandage contact lens did not help to alleviate the pain. Over the months that followed, Mr Q continued to experience episodic pain in the left eye despite regular topical therapy. Two years after the initial surgery, worsening symptoms prompted epithelial debridement, stromal puncture and placement of a bandage contact lens but the discomfort persisted.

A subsequent entry in Miss A’s private notes, noted a notch in the centre of the upper eyelid and a note that further surgery may be needed. Her letter to the GP made reference to ocular dryness causing discomfort.

On 24 August 2010, Mr Q saw Mr B, another consultant ophthalmologist, on account of increasing pain in the left eye. He noted a central corneal opacity reducing vision to 6/12 and an overlying area of epithelial loss. Mr B felt the lid notching with central corneal exposure and a deficient tear film were contributing to his corneal problem and referred Mr Q to oculoplastic surgeon, Mr C, for further management.

Mr Q was seen by Mr C in November 2010, who noted a noticeable notch of the upper lid and a subtle notch affecting the lower lid with corneal exposure. He advised surgical correction of the upper lid notch under general anaesthesia.

Mr Q made a claim against Miss A. He alleged that Miss A failed to carry out the first operation correctly, failed to provide adequate aftercare, failed to inform Mr Q of the notches on his eyelids caused by the removal of the warts, and failed to make a proper or adequate examination of Mr Q.

Expert opinion

The expert ophthalmologist was critical of Miss A’s operative technique and aftercare. He also said that during the initial consultation Miss A failed to enquire about dry eye and diseases that can be associated with this. The expert was further critical that Miss A failed to complete consent forms adequately.

The expert believed that a shave excision would have been more appropriate and has fewer risks, so was further critical of the wedge excision of both the upper and lower eyelids, as it was unnecessary and undertaken without careful counselling of the claimant with regard to the effect on the ocular surface disease.

The claim was settled for a moderate sum.

AK

Learning points

■ Careful discussion with the patient of the treatment options and potential complications is important, as is a record of the conversation, decision and consent process. This should include a discussion about the possible interaction(s) with any pre-existing condition.
Mrs H, a 28-year-old massage therapist, was admitted to hospital for laparoscopic tubal ligation. Dr T was the anaesthetist for this surgery.

Before the surgery, Dr T placed a cannula in Mrs H’s right wrist and, after surgery, a patient-controlled analgesia (PCA) was commenced through this cannula. According to the cannula chart, a cannula was also placed in Mrs H’s left hand, although this was not in place following surgery. Mrs H also recalled a cannula site in the left forearm and a further cannula site in the right forearm following surgery, although these were not recorded on the cannula chart.

Records show that a day later, slight blood staining was present at the cannula site in Mrs H’s right wrist. The following day, Mrs H reported the site of the cannula being painful so it was removed. No further problems were recorded and Mrs H left hospital a day later.

A month later, Mrs H attended the hospital in relation to umbilical wound oozing; she also complained of altered sensation in her left thumb and for this was referred back to Dr T. He noted that Mrs H had had two cannula sites over her left arm where she had developed a haematoma and now had paraesthesia over her distal thumb; Dr T referred Mrs H to Dr Q, a consultant orthopaedic surgeon.

Dr Q noted neurapraxic damage to the dorsal branch of the radial nerve, and advised desensitisation exercises. A month later, improvement was noted and Dr Q noted the hyperaesthesia had settled. He further noted that there was 40% function in the dorsal branch of the radial nerve and that there was a reasonable chance that this would recover, at least to a degree.

Mrs H made a claim against Dr T for alleged substandard technique during cannulation, also alleging poor record-keeping in his failure to record two cannula insertions on the cannula chart. Mrs H claimed that when the needle was inserted into her vein, poor technique was employed, resulting in the bevel of the needle cutting through nerves and creating neuromas, causing neurological damage. Mrs H also claimed that the sensory injury had left her disabled, in that she found it extremely difficult to carry out her job.

Learning points

- Good record-keeping is essential for continuity of care – therefore, the medical records you keep should provide a window on the clinical judgment being exercised at the time.
- When inserting a cannula, consider using the patient’s non-dominant hand if possible.
- It is helpful to write a report soon after an adverse event, because of the lengthy time that can sometimes pass before a related complaint or claim arises.
- This case is a reminder that not every adverse outcome is negligent. MPS’s robust approach meant the case was dropped and the allegation withdrawn very quickly.
Mr O was a 24-year-old man who had just enjoyed a holiday overseas. On the return journey he started vomiting. The nausea and vomiting continued after he arrived home and he began to lose weight because of it. When his symptoms did not abate he made an appointment with his GP.

His GP documented a four-week history of nausea and vomiting and, after reviewing normal blood tests, referred him to gastroenterology. The gastroenterologist wrote back concluding that he had found no significant pathology on endoscopy or ultrasound, and that he thought that anxiety was contributing to his ongoing symptoms. Irritable bowel syndrome was also considered to be a factor.

Mr O asked his GP for a private referral to neurology, which he agreed to. The neurologist arranged an MRI scan, which was normal, and felt that Mr O was suffering from a significant depressive illness from which he had partly recovered. Mr O did not agree with this diagnosis and felt that his symptoms had a physical rather than a psychological cause. He did, however, agree to see a psychiatrist, who concurred that his symptoms were due to anxiety and depression. He prescribed venlafaxine and arranged CBT.

Mr O was struggling with fatigue in addition to the nausea and was not coping at work, so he visited his GP again. His GP referred him to a specialist in chronic fatigue who wondered if he may be suffering with post-viral fatigue syndrome.

Mr O was convinced that there was a physical cause for his symptoms and demanded a second neurological opinion. This was sought but nothing abnormal was found on examination, repeat MRI or lumbar puncture. He had mentioned some dizziness and had an audiometric assessment showing abnormal canal paresis to the right. The neurologist concluded in a letter to the GP that “the only abnormality found in spite of extensive investigations was a mild peripheral vestibular disorder”. The letter detailed that he had been seen by a physiotherapist who had instructed him in Cawthorne-Cooksey exercises and that he had been asked to continue these at home.

Despite doing the vestibular rehabilitation exercises at home, Mr O failed to improve. He still felt weak and light-headed and had moved back in with his parents who were worried about him. They made him another appointment with his GP who referred him for an ENT opinion. The ENT consultant took a detailed history and noted the absence of tinnitus, vertigo or deafness. She could not find anything abnormal on examination and thought that a labyrinthine
problem was unlikely to be the problem. She repeated the balance tests, which were normal.

Years went by and Mr O became very focused on his symptoms, feeling sure that a diagnosis had been missed. Opinions were sought from an endocrinologist, a professor in tropical diseases and a private GP. Nothing abnormal could be found and no firm diagnosis was made. A neurootologist thought that his symptoms were due to a combination of “anxiety with an associated breathing pattern disorder, a migraine variant and physical de-conditioning”. A joint neurootology/psychiatry clinic concluded that it was “a confusing story with nebulous symptoms but it was probably a variant of fatigue disorder with a depressive element and derealisation”.

Mr O was very frustrated at the lack of diagnosis or improvement in his symptoms. He felt that the sole cause of his symptoms was a peripheral vestibular disorder. He made a claim against his GP, alleging that he had failed to make the diagnosis and that he had also failed to arrange vestibular rehabilitation.

MPS instructed expert opinion from a GP and a professor in audiovestibular medicine. The experts felt that Mr O’s GP had not been at fault. The professor in audiovestibular medicine was sceptical regarding the diagnosis of a vestibular disorder. He noted that repeat audiograms and tympanograms had been normal and felt there was no robust evidence that he had a peripheral vestibular disorder. He stated that there was no clinical history suggestive of vestibular pathology at the onset of Mr O’s illness. He also commented that there had been no consensus amongst various specialists as to the true cause of Mr O’s symptoms and that to claim that a peripheral vestibular disorder was the sole cause was an overly simplistic view.

The GP expert noted that the neurologist’s letter to the GP referred to Mr O having been instructed by the physiotherapists in Cawthorne-Cooksey exercises. These are vestibular rehabilitation exercises so it was wrong to say that there had been a failure to arrange the exercises or that this was the responsibility of the GP. The expert explained that GPs are not trained to instruct a patient in vestibular rehabilitation exercises and are not likely to have direct access to specialist physiotherapists who could arrange these. The expert noted that a large number of specialists saw Mr O over a prolonged period, all of whom failed to reach a consensus on the cause of his symptoms. The expert’s view was that the treatment provided was reasonable and that the standard that the claimant sought to apply was too high.

Mr O withdrew his claim before it went to court.

Learning points

■ The defence of this claim was helped by the contents of the correspondence to and from specialists, which were relied upon to disprove some of the allegations made. It is important to take the time to write comprehensive referral letters and to read letters from specialists carefully. Correspondence is an important part of the medical record, as well as being important communication between clinicians.

■ Mr O clearly had a very difficult time. There had been a protracted period of time with no clear diagnosis. However, in the circumstances of this case, this did not equate to negligence.

■ This case highlights the standard doctors must meet in order to refute negligence claims – that of a responsible body of their peers (GPs in this case), rather than a specialist in the condition in question.
Wrong drug, no negligence

I enjoyed reading your article “Wrong drug, no negligence” in the May 2014 edition of Casebook. As a trainee anaesthetist, I can remember making exactly the same mistake during my first month of training, i.e., administering a full course of co-amoxiclav to a patient with penicillin allergy whilst under anaesthesia. Fortunately, the patient suffered no ill-effects whatsoever, and postoperatively she admitted that she was sceptical about whether she had a true allergy or not, and was glad that we had inadvertently found out.

Drug administration errors in anaesthesia are common, with some studies suggesting one error in every 133 anaesthetics.1 In your article you state the anaesthetist may have been distracted by the use of the total intravenous anaesthesia technique. This is probably not the only factor, as observational studies have shown that on average an anaesthetist is distracted once every four to five minutes during a routine list.2

Thus the propensity for making errors is huge and it would seem only a matter of time before an error leads to a catastrophe that makes headline news. On wards and on intensive care units, nurses have long ago moved to using a two-person check system prior to the administration of harmful medication. Since anaesthetists have access to some of the most dangerous medications in the whole hospital, how vulnerable are we to litigation claims, given that we still use a single-person check? Should we be pushing to implement a two-person check as well, to protect both us and our patients?

Dr Nikhil Muri Balani
ST4 Anaesthesia and Intensive Care Medicine
Guy’s and St Thomas’ NHS Trust, London

REFERENCES

Response
Thank-you for your letter about this case, and for sharing your own experiences. Your suggestion about the introduction of two-person checking certainly seems to make sense, and steps that may reduce avoidable errors should be encouraged.

Perhaps a discussion with your trust is worthwhile, to consider introducing or trialling such measures.

Manslaughter

I enjoy Casebook, which reminds us that there are always new errors, and that old errors are easily repeated.

You kindly refer on page 11 (“Medicine and manslaughter”, Casebook UK only) to the review that Sarah McDowell and I wrote of medical manslaughter between 1795 and 2005. But you then state that “other widely-reported cases include” and cite Mulhem (2003) and Walker (2004). This might unintentionally suggest that we omitted these from our review. They are, respectively, cases 7 and 14.

Incidentally, the trend towards long prison sentences for surgeons started with R v Garg, which seems to have attracted little attention, and the verdict in the Sellu case was reached in spite of the fact that the judge was reported to have said that the patient might have died even if he had received the proper treatment promptly.

Professor Robin Ferner, Consultant Physician and Clinical Pharmacologist, West Midlands Centre for Adverse Drug Reactions, City Hospital, Birmingham, UK

Response
Thank-you for your letter about the case report “Wrong drug, no negligence” in the last issue of Casebook.

The terminology used in the case may have inadvertently led to some confusion. From a legal perspective, in order for a case to be established in negligence, the claimant has to establish certain key elements: that the defendant owed the claimant a duty of care, that there was a breach of that duty of care, and that the breach of duty was the cause of the loss or harm complained of.
any lay person would not notice but it
would be worthwhile getting a doctor to
check the photos before publication to
avoid similar errors, which look terrible
to doctors. I hope you understand that I am
making the point to improve the journal
rather than be overly critical.
Dr Samantha Dunnet
GP, UK

Response
Thank-you for your letter about
the photograph on page 14 of the
The pictures used in Casebook are not accurate representations of
clinical situations, but rather to
illustrate the general theme of the
case report or article. We do have
a notice to this effect at the foot
of the Casebook contents page, although the font is rather small and
might benefit from being a little more prominent.
The content of each issue of
Casebook is reviewed in its final
form in our layout board meetings, and these always include a number of
doctors from a variety of clinical
backgrounds. Whilst no comment
was passed about the use of the picture in question, your comments
will be a timely reminder for the board
members.

The accused
I was shocked by the account of
a patient making a spurious claim
against the GP in your recent edition of
Casebook. The story left me feeling quite angry
at the fact that the patient in the
matter was able to simply shrug off an
apparent malicious claim against the
GP without any consequence. I can
completely understand the professional
reluctance to do so, but would there be
an argument in this case to pursue a
civil claim of libel, given the significant
impact this claim has had on the doctor
both professionally, emotionally and
undoubtedly financially?

Dr T Broughton
Consultant Forensic Psychiatrist
Norfolk, UK

The accused
The excellent article “The Accused”
(Casebook 22(2), May 2014) leaves
an obvious question, which would be
valuable to consider…
What is MPS’s advice for the
doctor when the patient declines the
chaperone? Is the doctor at risk if they
refuse to proceed with an examination
without a chaperone? What should they
do, in that event?
Other readers may also wish to know
your response – it seems important.
Dr Mark Davis
New Zealand

Response
Thank-you for your letter, which raises
a very important issue.
Generally speaking, if a chaperone
is declined by the patient, and you
don’t want to go ahead without one,
you should clearly explain why you
would like one to be present. You
could also consider referring the
patient to a colleague who would
be willing to examine without a
chaperone. However, the patient’s
clinical needs must come first, and
any such arrangements should
not result in delays that affect the
patient’s health.
The discussion about chaperones,
together with the outcome, should
be recorded in the medical record. If
a chaperone is present, record that
fact, and their identity. If the patient
refuses a chaperone, make a note
that the offer was made and declined.
There are often local guidelines or
protocols that cover this issue, and
members should make sure they are
aware of these and follow them.
Readers in New Zealand can
access the MPS factsheet on
chaperones at the MPS website:
www.medicalprotection.org/
newzealand/factsheets/chaperones

Realistically speaking therefore, it is
unlikely that we will see cases of this
sort being brought.
**Reviews**

If you would like to suggest an app, website or book for review, or write a review, please email sara.dawson@mps.org.uk

---

**Do No Harm: Stories of Life, Death and Brain Surgery**

Henry Marsh, Reviewed by Dr John Gilbey, Core Trainee – Anaesthetics, North Western Deanery, UK

Do No Harm: Stories of Life, Death and Brain Surgery is the memoir of Henry Marsh, a senior consultant neurosurgeon who has previously had his work featured in two television documentaries. In this book he reflects on the events and experiences that have shaped his professional life.

The sentiment of a quote by René Leriche at the start, “Every surgeon carries within himself a small cemetery, where from time to time he goes to pray – a place of bitterness and regret, where he must look for an explanation for his failures”, resonates loudly throughout the book. Difficult decision-making and dealing with mistakes are themes that repeatedly arise. Other topics are also covered including modern medical training, the reality of consent, being ill as a doctor, the modern health service and the meaning of success.

Each chapter presents either clinical cases or other events from Marsh’s life. These are then interspersed with his thoughts on the events. He does mention some success through the book and describes achieving most “when our patients recover completely and forget us completely”. Difficult decision-making and dealing with mistakes is most explicitly demonstrated when recalling a visit to a Catholic nursing home where he finds patients he had previously forgotten and at least one who “I had wrecked”.

The book is written in a way to inform the lay reader of the deepest thoughts of a neurosurgeon. Medical terminology is used throughout, with meanings clearly explained. This is not to say that it does not appeal to a medical audience as simultaneously. The writing style is matter-of-fact without being dry. His stories are moving and in places brutally honest.

Do No Harm certainly gives an insight into the reality of life as a neurosurgeon in a modern hospital. For patients, it provides an insight into the failabilities and difficulties of being a doctor. For students, it is a must-read if you are considering a career in neurosurgery. For doctors, it is a fantastic example of reflection.

---

**Forks in the Road: A Life In and Out of the NHS**

Leslie Turnberg, Reviewed by Dr Behrad Baharlo (Specialty trainee, anaesthetics, Imperial School of Anaesthesia)

Detailing his life from humble beginnings in Lancashire, the former President of the Royal College of Physicians and of MPS takes the reader through his childhood and formative years with humility, which is a consistent theme throughout the book. He charts his many achievements from qualification then into academia, medical politics, the presidency of the RCP and culminating in his nomination as a peer of the realm.

Notably describing his role in the advent of the university department at Salford Hospital “from scratch!” along with its initial shortcomings, as well as comments regarding research (and how not to do it) and the changes in postgraduate medical training of the 1990s, the reader is given a front seat with this account of aspects of the profession that can often seem peculiar if not mysterious. Discussion is made of contemporary issues affecting NHS politics especially pertinent to the New Labour years, and the author is not afraid of casting an opinion or giving fair reflection with the benefit of hindsight.

I found the descriptions around medical training (the eventual establishment of the Academy of Medical Royal Colleges and Postgraduate Medical Education and Training Board) and issues surrounding reform of the NHS of particular interest and found food for thought in aspects concerning financing and NHS interaction with politics and politicians. I couldn’t help feeling that a number of these issues described, including attempts at reform, would have been equally valid when the author commenced his career in the NHS. On matters of NHS reform, financing and political pressures the author clearly had a privileged insight, especially during the term of the Labour government. I would commend the author’s views to anyone interested in such matters. Reflecting his privileged title, the author visits a number of topics of interest that he has spoken about at the House of Lords, and unashamedly bestows opinions ranging from assisted suicide to anonymity in sperm donation. The importance of the author’s Jewish faith is identifiable and his subsequent interest in Middle Eastern politics results in an attempt at summarising and digesting this complex and otherwise problematic issue with numerous good opinions.

The book concludes with a moving tribute to Daniel, the author’s late son, the impact of his passing being vividly and eloquently described, leaving the reader sharing a sense of melancholy if not shedding tears in sympathy with the author’s tragedy.
The right choice – become a Medical Adviser at MPS in New Zealand

We have a fantastic team of Medical Advisers and are keen to expand this team in either our Wellington or Auckland offices. A core part of the Medical Adviser role is to work collaboratively with the team in New Zealand and the wider MPS organisation.

What we can offer you

- A career in legal medicine
- Comprehensive induction and ongoing training
- Opportunities to become involved in MPS initiatives worldwide, including the delivery of advice, education and risk management through presentations, writing and liaison with medical organisations
- Supportive teamworking environment
- Broaden your experience through exposure to the whole MPS business
- Competitive salary and benefits package.

What we expect of you

- Significant clinical post-qualification experience and recognised postgraduate qualification
- A current NZ annual practising certificate (APC)
- Self motivation and keen interest in medicolegal issues
- The ability to analyse and extract key issues from complex cases and provide appropriate solutions
- Rational, logical and lateral thinking
- Excellent communication, interpersonal and advocacy skills
- Experience of working with a wide range of people from diverse backgrounds
- Experience of clinical practice in New Zealand.

If you are attracted to this interesting opportunity please apply with covering letter, full CV and salary details to Rob Woodward at Find Recruitment – email rob.woodward@findrecruitment.co.nz.

Closing date for applications: 3 October 2014  MPS is an equal opportunities employer.

For enquiries call 0064 4 471 0102 or visit www.medicalprotection.org/uk/careers and www.findrecruitment.co.nz
How to contact us

THE MEDICAL PROTECTION SOCIETY
33 Cavendish Square
London, W1G 0PS
United Kingdom
www.medicalprotection.org
www.dentalprotection.org

Please direct all comments, questions or suggestions about MPS service, policy and operations to:
Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

chief.executive@mps.org.uk

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

ASIA MEDICOLEGAL ADVICE

Hong Kong
Medicolegal and membership enquiries Freecall 800 908 433
E querydoc@mps.org.uk

Malaysia
Medicolegal and membership enquiries Freecall 1800 815 837
E querydoc@mps.org.uk

Singapore
Medicolegal and membership enquiries Freecall 800 616 7055
E querydoc@mps.org.uk

MPS is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 290,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

The Medical Protection Society Limited. A company limited by guarantee. Registered in England No. 36142 at 33 Cavendish Square, London, W1G 0PS

www.medicalprotection.org