



CASEBOOK



BACK TO BASICS

HOW A DIAGNOSIS OF CAUDA EQUINA
WAS MISSED IN A PATIENT WITH
LOWER BACK PAIN

PAGE 10

CELEBRATING
125 YEARS
OF MPS

CELEBRATING
25 YEARS
OF CASEBOOK

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OPEN DISCLOSURE

Mr Ken Mealy tells us what
you need to know

REPORTED ABUSE

A child makes an allegation of
abuse

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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 specialist advice and support, and the education and training we provide, 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.

This year Casebook is also marking 25 years of supporting members with learning from case reports and medicolegal and risk management articles.

While we are proud of the support we have provided through Casebook over the years, we must always look to the future. As part of that forward focus, you may notice some changes to Casebook in the coming months, including a greater focus on what you are telling us is of most value to you: case reports.

In this edition, we speak to Mr Ken Mealy, Vice President of the RCSI, about how to overcome some of the potential issues facing doctors concerning open disclosure and communication. Meanwhile, on page 8, we examine some cases 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.

Dr Marika Davies
Editor-in-Chief
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NOTICEBOARD

NEWS & UPDATES FROM
THE CASEBOOK TEAM

25 YEARS OF CASEBOOK

This year marks the 25th anniversary of Casebook, which has been providing medicolegal and risk management advice to members since 1992.

We're very proud to reach this important milestone and look forward to many more years of advising and supporting members.



GENERAL PRACTICE CONFERENCE 2017

Join renowned speakers in a look at the challenges faced by GPs across Ireland at the Medical Protection General Practice Conference 2017: Facing the challenges of modern practice.

The event, which takes place on Saturday 16 September at the Convention Centre in Dublin, will look at the risks you face in modern-day practice and how to combat issues before they escalate.

For more information and to book your place, visit medicalprotection.org/gpconferenceireland

MEDICAL PROTECTION TO HOST INTERNATIONAL CONFERENCE ON MEDICAL LIABILITY

Medical Protection is delighted to be co-hosting an international conference on medical liability in London on 4-6 October on behalf of the Physicians Insurers Association of America (PIAA).

'Change and Disruption: Strategies for managing the evolution of medical liability' will bring together a global audience of healthcare, risk and insurance professionals with an interest in medical liability.

Attendees will review emerging medical liability trends and new care models, as well as patient safety, risk mitigation and the link to litigation. Commercial themes such as investment strategies, reinsurance and underwriting will also be addressed, and there will be opportunities to discuss strategies for how to adapt and respond to the evolving challenges in the medical liability industry.

For more information about the conference, visit the conference website at: piaa2017.com

OPEN DISCLOSURE

WHAT YOU NEED TO KNOW



Doctors have a duty to promote and support open disclosure and a culture of candour, but what are some of the challenges with this, and how can we overcome them? Rosie Wilson talks to Mr Ken Mealy, Vice President of the Royal College of Surgeons in Ireland, about the importance of cultivating an open and honest relationship with patients

WHY IS TRUST SO INTEGRAL TO THE DOCTOR-PATIENT RELATIONSHIP?

We're all increasingly aware that medical error is a growing concern – not just in Ireland, but worldwide.

The public are becoming more conscious of medical error, and so we need to be able to deal with that in a frank, open and honest way – otherwise it will undermine the trust that patients have in healthcare professionals. If we want patients to respect us as doctors, they need to see us being open and honest, even when it is an adverse or unexpected outcome.

WHY ARE APOLOGIES SO IMPORTANT?

I think it's very important for both doctors and patients to understand that 'to err is human'. No doctor is infallible, and there's no such thing as perfection. We need to educate the public and help them to understand that doctors make mistakes too – I don't know of any clinician that has never had issues in relation to judgment, made an error or hasn't retrospectively thought that they might do something differently. That said, when errors are made, there needs to be an understanding that you will investigate the cause, learn from it, and share that learning accordingly.

Putting your hands up, admitting that you did something wrong and apologising doesn't come easily to a lot of individuals. So with training, we're trying to give young doctors the skills they need to be able to do this – healthcare professionals need to learn to be empathetic and reflective in order to give effective apologies.

I don't look upon open disclosure as something that a doctor should 'have' with a patient. Open disclosure is a component of what should be a continuous communication process within the doctor-patient relationship.

WHAT ARE THE DIFFICULTIES OF OPEN DISCLOSURE?

In the hospital setting, it can be difficult to find the time to adequately communicate aspects of medical care, especially when the issues involved are complex. It can certainly be a challenge in an overloaded, time-constrained system to communicate clearly and emphatically.

An important focus of our training systems must be to emphasise the importance of communication skills, despite the structural constraints placed on doctors in our hospitals. When things go wrong, open disclosure should be viewed within the context of the 'communication journey' we should be having with all patients. It is absolutely clear that when things go wrong many patients are most troubled by the lack of explanation and the sense of not being listened to.

To address these issues we need to constantly advocate improvements in our processes of care – by this I mean how we structure our emergency departments, our outpatient clinics, pre-admission clinics and ward rounds, and so forth, to allow adequate time for listening and talking to patients and their families. Additionally, we need to emphasise that all doctors can improve in their listening and communicating skills, irrespective of their level of training.

HOW DOES THE ISSUE OF COMMUNICATION WITH COLLEAGUES – PARTICULARLY BETWEEN PRIMARY AND SECONDARY CARE – FACTOR INTO A DOCTOR'S DUTY OF CANDOUR?

This is very important as failure by hospital consultants to communicate effectively with colleagues, both in hospital and general practice, when things go wrong can cause great difficulty for both the patient and all the doctors involved. While it might be understandable that there can be a reluctance to document adverse outcomes, perhaps due to a fear of litigation, a process of clear communication is very important. A lack of understanding and clarity by the general practitioner only adds to the confusion and doubt that a patient may have regarding their care.

My understanding of a duty of candour involves not only effective communication with the patient, but also all other healthcare practitioners involved with that patient's care.

WITH ALL THIS IN MIND, AND IF YOU ARE OF THE VIEW THAT COMMUNICATION CAN BE TAUGHT AND IMPROVED, HOW MUCH DO YOU THINK OPENNESS AND A WILLINGNESS TO COMMUNICATE EFFECTIVELY IS DOWN TO PERSONALITY TYPE?

I think one of the potential barriers to open disclosure is the fact that doctors are overloaded with a huge number of issues, and it is quite easy to become desensitised to adverse outcomes. Sometimes it is the only way to survive the system when one is under so much pressure.



It is very humbling to be told by a patient “that’s okay doctor, I know you did your best” or “I understand these things happen”

Coupled with the fact that we expect doctors to be decisive and authoritative, especially in higher risk specialties, it can be difficult for doctors to practise empathy, self-reflection and effective communication.

Due to this, it is important that training bodies emphasise the importance of communication skills, particularly within the context of a stressful environment. While some individuals have a greater sense of emotional intelligence, and are more intuitively empathic, I have no doubt many of these communication attributes can be taught and numerous studies have shown this to be the case.

Studies have also shown that, no matter how senior the doctor is, one can always become better at communication. In this regard, a culture of leadership within departments and institutions is also very important in setting an example for all those who work within the system.

WHEN CLINICIANS DO IMPLEMENT OPEN DISCLOSURE INTO THEIR EVERYDAY PRACTICE, SHOULD IT BE NOTICEABLE AND HAVE AN ACTIVE IMPACT?

It is interesting when one watches a clinician who is an expert communicator as the process is clearly much more satisfactory for the patient, and also for the doctor. The opposite is equally true, as poor communication frequently leads to unhappy patients and frustrated medical staff. In the context of open disclosure and effective communication, I have frequently been surprised by the generosity patients show when timely explanations of adverse outcomes are discussed. It is very humbling to be told by a patient “that’s okay doctor, I know you did your best” or “I understand these things happen”.

Of course these conversations can be difficult and not all will end amicably; however, there is some satisfaction in knowing that professionally this was the right thing to do.

THANK YOU, KEN; ANY LAST WORDS ON OPEN DISCLOSURE AND A PRACTITIONER’S DUTY OF CANDOUR?

At the RCSI, we understand that when things do go wrong in surgical healthcare, it is often not because of a lack of clinical or technical skill, but because of problems with communication – with patients, colleagues and administrative or managerial staff. Communication with colleagues and patients is a vital component of what it takes to be a modern doctor. This frequently takes effort, but the rewards are not just better quality healthcare and happier patients, but a more satisfying lifelong career.

The RCSI offers training on open disclosure and duty of candour, including a newly-devised master’s degree programme in Human Factors in Patient Safety. For more information on any of the courses or training offered by the RCSI, visit rcsi.ie

MORE SUPPORT

Medical Protection’s workshop ‘Mastering adverse outcomes’ will give you the skills to successfully communicate with your patients should they suffer an adverse outcome during their care. To find out more, and book your free space, visit:

medicalprotection.org/ireland/education-and-events



BIOGRAPHY

Ken Mealy

Mr Ken Mealy is a general surgeon with a special interest in GI surgery, and is based at Wexford General Hospital. He has been on the Council of the RCSI since 2008.

YOUR ETHICAL AND LEGAL OBLIGATIONS REGARDING OPEN DISCLOSURE

The Medical Council outlines a doctor’s ethical obligations regarding open disclosure and the duty of candour in the *Guide to Professional Conduct and Ethics for Registered Medical Practitioners 2016*. It states:

“Open disclosure is supported within a culture of candour. You have a duty to promote and support this culture and to support colleagues whose actions are investigated following an adverse event. If you are responsible for conducting such investigations, you should make sure they are carried out quickly, recognising that this is a stressful time for all concerned.

“Patients and their families, where appropriate, are entitled to honest, open and prompt communication about adverse events that may have caused them harm. When discussing events with patients and their families, you should:

- acknowledge that the event happened
- explain how it happened
- apologise, if appropriate
- assure patients and their families that the cause of the event will be investigated and efforts made to reduce the chance of it happening again.”¹

With respect to legal obligations, provisions in relation to open disclosure are included in the Civil Liability (Amendment) Bill 2017, currently being considered in the Oireachtas.

REFERENCES

1. *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*. 8th ed. Dublin. Medical Council 2016.

CONFIDENTIALITY MATTERS

Dr Marika Davies describes some cases in which Medical Protection has assisted members following an unintentional breach of confidentiality

We frequently receive calls from members asking whether they should disclose personal information about their patients and, as the IMC guidance sets out, there are exceptional circumstances in which confidentiality can be breached.

Unfortunately, information about patients is sometimes disclosed in error, which can lead to a complaint or request for compensation. We examine three cases in which we have assisted members following an unintentional breach of confidentiality.





Unfortunately, information about patients is sometimes disclosed in error, which can lead to a complaint or request for compensation

CASE 1

Dr X was on call from home and decided to catch up with some paperwork in a local coffee shop. She was writing a report on a patient and called a colleague to discuss the case. She took care not to mention the patient's name given the public setting.

A few days later she was made aware of a complaint. A member of the public who was in the coffee shop at the same time had recognised her and contacted the hospital. They had seen the name of the patient on her laptop screen, and had also overheard personal information about the patient in the doctor's conversation.

The hospital referred the matter to the IMC and its Preliminary Proceedings Committee conducted an investigation. Medical Protection assisted Dr X in preparing a letter of response to the Committee and provided support through the process. After the initial investigation, the committee recommended that the matter be resolved through mediation and did not progress it to a fitness to practise inquiry.

CASE 2

Dr Y was on call overnight and drove home after finishing the morning handover. She left some papers, including her handover sheet, on the back seat of her car, which was parked in the street outside her home.

A member of the public who passed by saw the sheet, which clearly displayed a number of patient names and their diagnoses. She took a photograph, which she sent to the HSE with an expression of concern about the breach of confidentiality.

Dr Y was informed by her medical director that they would be investigating the matter. Medical Protection helped Dr Y to prepare a report, and accompanied her to the investigatory meeting. Dr Y provided a clear explanation and apology, and no further action was taken.

CASE 3

Dr Z called her 16-year-old patient, Miss R, to let her know that a recent chlamydia test result was positive. She got through to the patient's voicemail, and was careful not to disclose the diagnosis when she left a message. Instead, she asked the patient to attend the surgery to collect her results. She attached an advice leaflet to the results, along with a note inviting Miss R to make an appointment.

Dr Z did not realise that the phone number on file actually belonged to the patient's mother. Mrs R came in to the surgery and was given the documents by the receptionist. The patient complained about her breach of confidentiality.

Dr Z sought advice from Medical Protection, and was assisted in preparing a response, which the patient accepted.

LEARNING POINTS:



- ✓ **Be aware of your surroundings when discussing patients or writing notes. As well as wards and emergency departments, other high-risk areas where breaches can occur are lifts, canteens, computers, and printers.**
- ✓ **Be careful not to leave memory sticks or handover sheets lying around. Use a privacy screen on your laptop and avoid leaving messages on unidentified voicemail.**
- ✓ **Make sure all staff are trained on the importance of confidentiality and are aware of the protocols in place to maintain it.**
- ✓ **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.**
- ✓ **Serious breaches should be reported to the Office of the Information Commissioner – take advice from Medical Protection if you find yourself in this situation.**

FURTHER INFORMATION:

IMC – *Guide to professional conduct and ethics for registered medical practitioners* (2016) <https://goo.gl/bTNV3d>

Medical Protection factsheet – Confidentiality
medicalprotection.org/ireland/resources/factsheets

MORE SUPPORT FROM MEDICAL PROTECTION

If you require assistance or advice from one of our medicolegal advisers, please contact **+44 113 241 0200** or querydoc@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 GP service 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 a 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 them with the patient and 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 Gardai.

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 Gardai 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, and that there was 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. All doctors should have confidence to act if they believe a child or young person may be abused or neglected. As long as their concerns are 'honestly held and reasonable' and they take appropriate action, doctors should not face criticism even if the allegations prove unfounded.

Further reading

Medical Protection factsheet – Report writing
[medicalprotection.org/ireland/resources/factsheets](https://www.medicalprotection.org/ireland/resources/factsheets)

IMC - Guide to Professional Conduct and Ethics for Registered Medical Practitioners
 Paragraph 26 - Protection and Welfare of Children

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



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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.



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.

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, 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 plaintiff'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 plaintiff was warned preoperatively.

Proceedings were nevertheless commenced by the plaintiff'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 plaintiff'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 plaintiff'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)



@fangxianuo/Getty Images.co.uk

Ms N, a 33-year-old female 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 the patient 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 record 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

M r M, a 45-year-old lawyer with a substantial income, 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, that 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 vitreoretinal 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 taking consent it is important to consider that different patients will require different levels of information to help them reach an informed decision. The IMC states: "When you give information, you should consider the patient's individual needs and priorities. For example, patients' beliefs, culture, occupation or other factors may have a bearing on the information they need to reach a decision."¹
- 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.

REFERENCES

1. *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*. 8th ed. Dublin. Medical Council 2016.

A space for your comments and opinions on what you've read in Casebook

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 Medical Council 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,
UK**

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 of which 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.

We are aware of the difficulties around the issue of communication of test results between primary and secondary care, and in fact included a feature on this in the November 2016 edition 'A testing problem'. 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 Irish Medical Council 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,
Ireland**

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.



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

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