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Dr Bown focuses on the role of the expert – and describes how they can be key in successfully defending a case.

I write this having just heard that a claim against a member has today been discontinued by a high profile claimant, two days into trial, after the expert evidence had been heard. Fantastic news for the doctor, and vindication for the defence team of the judgments they have made in steering a long and complex journey to success.

There are many elements involved in building a robust and successful defence but, as any seasoned litigator will tell you, the strength of your expert is pivotal in determining the prospects of success or defeat. This is further illustrated in the case reports on pages 16 and 22.

Selecting the right expert is very important; it’s not about being a friend or advocate for the defendant, nor about being a fierce evangelist espousing heavyweight opinion intended to demolish the opposition. The expert’s role is to provide independent assistance to the court through unbiased and evidence-based opinion in relation to matters within his expertise. And before that, the expert plays a critical role in assisting the lawyers to understand the clinical issues and judgments to inform the advice to the member.

This is not just in relation to clinical negligence claims; we are seeing increasing reliance on experts at inquests and medical council hearings in many countries. MPS regularly runs expert training days around the world, to ensure that experts at inquests and medical council hearings are aware of them.

A practitioner must not prescribe, administer, or supply controlled drugs to a person that the practitioner believes to be dependent on that or any other controlled drug, unless treatment is for that dependency.

In that instance, treatment for dependency must be carried out by a gazetted practitioner (and sometimes at a location) nominated by the Minister of Health, or by a practitioner who has the express written authorisation of the gazetted practitioner.

There are few exceptions – emergency treatment in a hospital care institution for up to three days, treatment in an institution pursuant to the Alcoholism and Drug Addiction Act 1966, and treatment of a person subject to a Restriction Notice.

Medicines Control staff deal with licensing, auditing and drug abuse containment activities in the medicines supply chain. Medicines Control advisers are experienced pharmacists who will liaise with the regulatory authorities for health professionals, particularly where prescribing issues are identified.

Medicines Control drug abuse containment activities include monitoring of GP Authority to Prescribe Controlled Drugs (e.g., authorisation of GPs to prescribe methadone for treatment of dependency). There are common knowledge gaps for prescribers, which include the addiction potential of prescription medication, complications of long-term drug administration, awareness of controlled drugs prescribing requirements, restricted persons and authorities to prescribe.
Prescribing competence issues require interface with the Medical Council or relates to an inability to resist inappropriate prescription requests (the doctor with a “soft touch for drugs” reputation). Prescriber advice is also provided on a one-on-one basis to GPs and health services, palliative care and pain clinic clinicians. This advice may include alerts, known past history of a particular individual, issuing of Restriction Notices or Privileged Statements.

A Restriction Notice is a legal document issued by the Medical Officer of Health. The restriction limits prescribing to a named person and often one pharmacy for dispensing. A Restriction Notice is issued in one of two circumstances:

1. Where there is clear evidence that the person has been obtaining medication from a number of different practitioners, over a prolonged period and is likely to seek further supplies, or
2. Is addicted or habitual to a medicine or has been obtaining it from several sources and is likely to seek further supplies.

A Restriction Notice relates to the specific conditions for that person. Approximately twice a year a list of currently restricted persons throughout New Zealand is provided to doctors, pharmacists and appropriate services.

A Privileged Statement is a means of notifying others about a person who is, or is likely to become, dependent on any prescription medicine or restricted medicine. The purpose of the Privileged Statement is to prevent or restrict the supply of medicines to that person, require a supply from only a named source, or to assist in the cure, mitigation, or avoidance of the dependence. Generally there is the expectation that health professionals will only share pertinent information with other health professionals involved in that person’s care. The Privilege extends beyond this, and allows the notification of interested others, not just health professionals.

The following case is an example of drug abuse containment in action, where many of the functions described above were put into play (identifying details have been altered).

Hillbilly heroin: a case study

A routine Ministry of Health prescription audit identified that one patient had collected supplies of oxycodone exceeding the prescribed daily dose. The audit revealed that nine doctors had written overlapping oxycodone prescriptions for this particular patient within a three-month period. The patient had used a different pharmacy to collect the medication from each prescriber, effectively hiding the extent of oversupply from the health professionals.

This pattern of over-supply to one person, doctor-shopping and pharmacy-hopping to hide the extent of the duplication of medication is typical of drug-seekers. The sought substance itself also raised alarm bells. Oxycodone is a strong opioid that has been prescribed at an increasing rate since it was introduced in New Zealand in 2005. Here and overseas, oxycodone has rapidly developed a reputation — illustrated by the street name “hillbilly heroin”. Drug users crush it or chew the tablets for faster effect, or roll the crushed tablet in foil, light the powder and inhale the smoke.

Cutting off the supply

In these circumstances, notification to the pharmacies and prescribers will often put an end to the personal prescription supply chain. In addition, the Medical Officer of Health may write to identified prescribers to offer pertinent advice. In some instances the drug-seeking behavior can be a result of stand-over tactics, where the drug-seeker is working for another person who holds some form of control over them. In that instance, when doctor-shoppers can no longer supply prescription medication, they may require additional help to get out of a risky situation. The drug-seeker’s GP is in a good position to offer support and advice in this situation. Referral could be made to a specialist addiction service or advice given that organisations such as Women’s Refuge or the police, are contacted by the patient.

A random drug urinalysis is often of value to document that the patient has consumed some or all of the prescription issued in their name. Unfortunately, oxycodone does not predictably show up in drug urinalysis (a ‘benefit’ that drug-seekers know about and use to their advantage). However, coincidental use of other drugs (benzodiazepines, cannabis, stimulants and other opiates) may result in a positive urine test for those substances.

If the patient is believed to be obtaining the prescription medication solely for their own use, as was the situation in this instance, then the prescribers will be advised to educate the patient about the risks of self-administering more than the prescriber intended, and also if urinalysis is indicative of mixing this strong opioid with other sedatives.

An end to doctor-shopping: Restriction Notices

One GP may agree to become the regular prescriber, and in that case a Restriction Notice may be indicated to ensure that doctor-shopping cannot continue. Restriction Notices can be issued with or without patient consent, but are most effective when the patient has entered an agreement with the doctor to abide by the conditions of the Restriction Notice and use just one prescriber, and just one pharmacy. However, abiding by a Restriction Notice is a voluntary undertaking and determined patients will change doctors or move to a different locality to avoid the restrictions of a Restriction Notice, and that is what happened in this particular case.

Additional information will often flow into Medicines Control in response to the initial advice to pharmacies and prescribers. In this case, the patient had presented with a chronic pain syndrome, which was the rationale for opiates requests, and used patient-held medical documentation to verify this. The same patient had also accessed prescription benzodiazepines, using the same modus operandi but for alleged epilepsy.

Patient-held records can be problematic because it is not always practical to ensure the veracity on the spot. In this instance, the documentation was not a medical report but rather a list of drug warnings, indications and contraindications. Despite this obvious shortcoming, the documentation had convinced many doctors to prescribe over many months. As time went on, different versions of the same patient-held documentation came to light, some using the name of another person but otherwise identical. Fraudulent use of medical documentation and the use of another person’s identity are crimes and should be reported to the police.

A Privileged Statement is usually issued as a last resort when informing prescribers and pharmacies and issuing restriction notices has failed to contain the doctor-shopping problem. In this case a privileged statement was issued to regional pharmacies. The statement described the patient and the modus operandi. That step did result in even more restrictive actions, in this instance, that information was used to bring the patient help from appropriate authorities.

Learning points

- Chronic pain is the most common presenting complaint used by opioid drug-seekers.
- Epilepsy is a common presenting complaint used by benzodiazepine seekers.
- Patient-held medical documentation may be counterfeit or otherwise altered and should be verified through an official source whenever possible.
- Restriction Notices are most effective when the patient has undertaken voluntary agreement to comply.
- Regional drug-seeker alert networks can be helpful, but only if the health professionals consult them before prescribing or dispensing. Patients should be made aware of policies to notify other members of the network of drug-seeking behaviours. An easy way to do this is to display a poster in the waiting room.
- Medicines Control can provide additional information or advice to prescribers or pharmacists when drug-seeking is suspected. The Medical Officer of Health for Medicines Control may take additional drug abuse containment actions if necessary.


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How reliable is healthcare?

Dr Dan Cohen, an international medical director based in the US, looks at the biggest challenge to healthcare safety: complacency

The healthcare industry is defined by continuous improvement. Emerging technologies may provide great promise for advancing our diagnostic and therapeutic options – but with the increasing frequency and complexity of healthcare interventions, so increases the risk of system or personal failures that can harm patients. Through litigation, these failures can harm institutions and careers. It is highly important that healthcare professionals recognise the hazards associated with providing healthcare services and confront the very real challenge of complacency. Whereas we may see harm when it occurs, more often than not we do not see the “near misses” – and because we do not, this feeds our complacency. We are not truly aware of complicated events that occur on a daily basis, and so increases the risk of system or personal failures that can harm patients.

Every day thousands of patients are harmed or die in modern well-equipped hospitals staffed by highly-trained individuals. Benign neglect is not necessarily translate to safety. The challenge that remains is to understand how things can go wrong, when the intentions are to achieve highest quality outcomes and assure patient safety.

Managing danger

High reliability organisations (HROs) are those that function safely and efficiently in industries that are very dangerous. HROs have established cultures and supporting processes designed to dramatically reduce the likelihood of human error and harm. They recognise that in the interactions between humans and technologies, it is the humans that represent the most substantial sources of risk. Industries commonly considered to portray the attributes of high-reliability include the nuclear power industry, the automotive industry and the aviation industry. In the aviation industry, for example, the airplanes are so well-designed, with redundantly engineered systems, that the risks arise primarily from human factors that are the source of most risks and errors. It has been argued that if the healthcare industry would adopt the attributes and characteristics of HROs, we would move the bars for quality and safety higher. If it is true, then there is so much inertia in our systems of care; inertia that plagues our improvement strategies. Why have we not solved this problem, when so many solutions abound? Complacency is the pernicious complacency. We do not see the sources of harm, the near misses, and especially do not see ourselves as sources of harm. The defining characteristics of HROs have been summarised by Weick and Sutcliffe and, in abbreviated format, are portrayed below:

1. Sensitivity to operations – a constant awareness by leaders and staff to risks and prevention, a mindfulness of the complexities of systems in which they work and on which they rely.
2. Reluctance to simplify – avoidance of overly simplistic explanations for risks or failures and a commitment to delve deeply to understand sources of risk and vulnerabilities within systems.
3. Preoccupation with failure – a focus on predicting and eliminating catastrophes rather than reacting to them; a “collective mindfulness” that things will go wrong and that “near misses” are opportunities to learn.
4. Deference to expertise – leaders and supervisors listening to and seeking advice from frontline staff that know how processes really work and where risks arise.
5. Resilience – leaders and staff trained and prepared to respond when systems fail and that work effectively as teams to overcome urgent challenges.

A natural fit?

Healthcare systems entail many unique factors that are at variance with HRO industries. Even though some HRO-characteristics have been adopted or adapted by healthcare systems, such as the use of checklists, the unique factors of healthcare pose a challenge. These are the increased frequency of human-to-human interactions and associated communication challenges, and the complex vagaries of our diagnostic processes. Healthcare professionals are not engineers or pilots and our way of doing business is fraught with uncertainty and variability. Many of our diagnostic and therapeutic interventions are based on insufficient evidence and are over-utilised, thus increasing risks and the potential for harm. Most importantly, patients are not aeroplanes. They are far more complex than aeroplanes. They have mobilities and comorbidities, genetic predispositions, fears, belief systems, social and economic confounders, intellectual and cognitive challenges, and language and fluency issues.

Because best and safest outcomes are dependent on patient engagement, patients should be viewed as components of the healthcare system, not passive recipients of healthcare services (like passengers sitting in an aeroplane). This perspective is an integral component in a high-reliability system that is focused on avoiding risk.

Dr Dan Cohen is International Medical Director at Datix Inc. In his role as consultant in patient safety and risk management, Dr Cohen advises global thought leaders and speaks at conferences worldwide on improving patient outcomes.

REFERENCES

A case study

Recently, I was admitted to a hospital for an overnight observation after I tore my calf muscle in a falls accident. I was at risk of developing a compartment syndrome that could have been very serious. The people who cared for me were kind, sensitive and caring. However, they were complacent and did not recognise their limitations. Below is the litany of concerns I noted during my care:

I was misidentified and given another patient’s ID band. I then noticed the drug insurance details to the ED (Emergency Department) admissions clerk. The wristband did not include any information that would enable me to identify this discrepancy, and only when a nurse tried to enter orders into the system was the discrepancy detected. This was not corrected for 30 minutes, delaying my evaluation even as my leg was becoming increasingly numb and purple. I was pointing this out to the nurse; there was urgency here; but...

I was seen by several different nurses, technicians, and physicians, and it was the exception rather than the rule that these individuals washed their hands before touching me or touching equipment in the room, even after I jokingly pointed this out.

The x-ray CT scan technician did not offer me any glasses, even though he was scanning my entire right leg, and I did not think to ask.

When I was admitted, unable to ambulate without assistance, I received no formal initial risk assessment. I clearly was at very high risk of a fall and, though the nurse was very pleasant, he did not demonstrate a focus on risk assessment and I was observed rounds, and I had to use the toilet twice during the night. I managed, should have called for help but didn’t, and thus potentially became part of my own problem.

Finally, at discharge, no-one enquired about changes in my gait or mobility. I managed to get to my home situation, I was to be provided a walker as I was not to bear weight on my injured leg. Though I was assured the walker would be delivered on the afternoon of my discharge, it did not arrive until the evening of the following day, significantly increasing my risk of a fall at home.

In each of these instances, complacency was the pernicious confounder, including my own complacency. Fortunately, I did not encounter any real harm, only inconvenience. I doubt I could have been seriously harmed. I encountered many ‘near misses’ that no-one even seemed to be aware of. What I experienced is not unique to any particular hospital; rather it is the common experience in hospitals worldwide.

In my view, if a healthcare system is a forest of complexities then a giant coastal redwood of complacency towers high above the forest floor, a floor covered with the moss of near misses. One colossal tree standing high above the forest floor: it is not all that complicated.
Consent and shared decision-making

Dr Mark Dinwoodie, MPS Head of Member Education, looks at the term ‘shared decision-making’ and asks: what exactly does it mean and what are its benefits?

The increasing sophistication of healthcare, with an expanding number of available treatment options, has made decision-making more complex and challenging for both doctors and patients. It’s perhaps not surprising that a model of decision-making that takes account of these issues, incorporates ethical and legal requirements, respects many patients’ increasing desire for involvement – while also incorporating the expertise of the clinician – has emerged.

Consent and decision-making

The requirements of the discussion process that contributes to the validity of consent have changed significantly over the last 30 years. Neither a paternalistic model of “doctor knows best” nor an informative approach of “here’s all the information, you decide” fulfil the requirements of a decision-making process outlined above. These two styles are different from making the decision in partnership with the patient, where there is an exchange of knowledge and opinion (see Box 1). It is the discussion around the consent process that is likely to satisfy patients’ needs, enable patient autonomy and reduce the risk of medicolegal consequences.

The challenge for many of us is that a wise decision isn’t dictated by science and clinical expertise alone, but requires consideration of the patient’s perspective. It also requires clinicians to move from the ‘general’, ie, what might be the right decision for the majority of patients; to the ‘individual’, ie, what the right decision is for this particular patient. The only way to achieve the latter is to ask the patient what matters to them and involve them.

Doctors contribute their expertise and experience around diagnosis, disease and evidence-based treatment while the patient contributes expertise about what matters to them as patients, such as their preferences, values, attitudes to risk, concerns and expectations reflecting past experience, and frames these in a social context.

What is shared decision-making?

“The idea that clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients’ informed preferences.”

It is an essential component of truly patient-centred care. The goal is to arrive at a decision that is ‘right for them’, from a patient’s perspective. Some cultures and healthcare systems place less emphasis on patient involvement, with either deference to doctors as the decision-makers or to other family members. Increasing patient desire for autonomy and involvement may challenge these traditional approaches.

While many clinicians believe they practise shared decision-making, this is not always borne out in practice.

Decision points and options

If we view a patient’s condition as a healthcare journey over time (see Figure 1 overleaf), at the decision point there are a number of options. If option A is associated with an adverse outcome and they feel worse off than before treatment, the patient may well reflect as to why they had any intervention at all and that perhaps they would have been better with “no action” or conservative management (option B), a different option (option C) or even an option they weren’t told about.

An important task in the decision-making discussion is to help the patient arrive at an appropriate understanding of the risk/benefit analysis of each option, including the option of doing nothing and to compare these in the context of their own values, preferences and expectations of treatment.

Doctors’ recommendations

Consider these three approaches in the context of a 26-year-old female patient, with a young daughter, who is requesting contraception as she has started a new relationship:

SCENARIO A: PATERNALISTIC

Doctor: We find that most women in your situation choose a coil and that’s what I would recommend for you. Let me tell you about the risks and benefits.

SCENARIO B: INFORMATIVE

Doctor: There are lots of choices available. I have a comprehensive information booklet here about their advantages, disadvantages and benefits. Why don’t you have a good look at that and let me know which you would prefer?

SCENARIO C: SHARED DECISION-MAKING

Doctor: What matters to you most about the choice of contraception? Is it reliability, minimal side effects, impact on your bleeding pattern or something else?

Patient: The most important thing for me, doctor, is not to get pregnant so early in a new relationship, so I would like the most reliable method.

Doctor: There are several options, including… Given that you are becoming pregnant in a year’s most important consideration, I would probably recommend the combined pill, assuming there aren’t any contraindications.

What do you know about the pill?
From the case files

Dr Rob Hendry, MPS Medical Director, introduces this issue’s round-up of case reports

MPS works hard to defend claims wherever possible. Part of a strong defence is having knowledgeable and skilled expert witnesses to demonstrate that the doctor in question has acted in the patient’s best interests and in line with good medical practice.

Perhaps the best defence of all is making sure your diagnosis and treatment plans are of the requisite standard; examinations (where necessary) are thorough and well-documented; valid consent is both taken and recorded; and note-keeping is accurate and contemporaneous.

In “The twisted knee” on page 16, Ms C brought a claim against Mr A, alleging, amongst other things, that he had negligently performed an arthroscopy in the absence of an MRI scan and unreasonably diagnosed a meniscal tear. Expert opinion found no liability on the part of Mr A, concluding that his preoperative working diagnosis was eminently reasonable in light of Ms C’s symptoms and signs. As a result, the claim was subsequently discontinued and no payment was made.

Mrs J made a claim against Dr A in “A tear during delivery” (page 18) as she was advised that if Dr A had carried out an episiotomy and avoided the use of “double instruments,” her symptoms would have been avoided. She felt that a diagnosis of a third degree tear had been missed, and that subsequently had a major impact on her life. Expert opinion found that the episiotomy was not essential in this case, and that detailed contemporaneous notes confirmed that the anal sphincter was intact, despite the second degree tear that was observed, despite the second degree tear that was observed.

Sometimes, when a case cannot be defended, MPS works on a member’s behalf to ensure favourable settlement terms.

For example, in “Common can be complicated” on page 14, Miss G’s family alleged she was unable to use public transport unaccompanied due to her persistent symptoms, which they argued would hinder future employment prospects. Investigations by the MPS legal team revealed that Miss G could use public transport independently, therefore reducing the final settlement offer significantly.

Benefits of shared decision-making

- Increases patient involvement in the decision-making process
- Increased patient knowledge and understanding
- Patients share some responsibility for the decision
- More realistic expectations from treatment
- Decisions and choices that align with patients’ preferences and values
- In some cases better health outcomes
- Helps reduce geographical variations in care
- Improves patient satisfaction
- Better adherence to treatment
- Patients are better informed with more accurate risk perceptions
- Helps identify the high-risk decision.

AT A GLANCE: The official guidance

In paragraphs 1 and 2 of Information, choice of treatment and informed consent, the Medical Council of New Zealand says: “1. Trust is a vital element in the patient-doctor relationship and for trust to exist, patients and doctors must believe that the other party is honest and willing to provide all necessary information that may influence the treatment or advice. The doctor needs to inform the patient about the potential risks and benefits of the options available and support the patient to make an informed choice. 2. Informed consent is an interactive process between a doctor and patient where the patient gains an understanding of his or her condition and receives an explanation of the options available including an assessment of the expected risks, side effects, benefits and costs of each option and thus is able to make an informed choice and give their informed consent.”

Furthermore, under Right 5 of the Code of Health and Disability Services Consumers’ Rights, “...you must convey information to the patient in a form, language and manner that enables the patient understands the treatment or advice. This means you should do your best to help your patient to understand any information you provide to them.”

For more information on Mastering Shared Decision Making, a workshop run by MPS in New Zealand, visit www.medicalprotection.org/newzealand/workshops/mastering-shared-decision-making

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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:
**Common can be complicated**

Miss G, 11 years old, was taken by her mother to see GP Dr A with conjunctival symptoms and a discharging right ear. She appeared quite well during the consultation, so Dr A prescribed antibiotics and arranged urgent imaging. This confirmed a cerebral sinus venous thrombosis and a middle ear infection with right mastoiditis. She was transferred to the neurosurgical unit for thrombolyis, CSF drainage and acetazolamide, and discharged 4 days later.

The family lodged a negligence claim against Dr A, stating that he failed to refer for urgent investigation following her second consultation. They asserted that had Miss G received earlier treatment, she would have had a reduced visual acuity or frequent headaches. Expert opinion agreed that, based on Dr A’s account of events and the subsequent notes made by the hospital regarding the onset of visual symptoms, he performed an appropriate examination and provided a reasonable standard of care during her second consultation.

However, it was evident from the course of events that Miss G did deteriorate and the emerging visual symptoms allegedly reported to the nurse adviser did demand an urgent assessment. Failure to arrange immediate review fell below a reasonable standard of care and Dr A’s practice carried vicarious liability for this error. Miss G’s family alleged she was unable to use public transport independently. The reduced facutal settlement offered significantly, although the case was still settled for a substantial amount.

**Patient confusion: patient claim**

Mrs S, a 77-year-old woman whose past medical history consisted of a previous hysterectomy for benign fibroid disease, presented to her GP with a history of intermittent hematuria. Her GP recognised the potential seriousness of this symptom and made an urgent referral to a consultant urologist, Mr F.

Mr F arranged an IVU followed by a CT scan, which suggested a tumour in the left distal ureter. Mrs S was advised this was highly suggestive of carcinoma and required surgical removal. However, Mr F arranged a biopsy of this mass via a ureteroscopy which was reported as inconclusive, containing insufficient material to make a definitive diagnosis; repeat biopsy was recommended by histology. There was nothing documented within the records to show that the implications of the same were discussed with Mrs S.

Mr F proceeded with left radical nephro-ureterectomy; a decision supported by the local multidisciplinary meeting. During surgery, Mrs S was found to have a 5cm tumour and a sigmoid colon adherent to the pelvic sidewall due to multiple adhesions from her prior surgery. The histology of the nephro-ureterectomy specimen showed no evidence of malignancy with endometriosis in the ureteral wall and lumen. This was communicated to Mrs S who felt that she had been misinformed as to the purpose of the surgery (as she had never had cancer).

Unfortunately, the postoperative recovery was complicated by a colo-vaginal fistula, and Mrs S had to go back to theatre for an emergency laparotomy and Hartmann’s procedure. After this, Mrs S developed an incisional hernia, which was repaired along with a reversal of the Hartmann’s one year later.

Mrs S indicated an intention to bring a claim stating that she had undergone surgery based on a false premise. She alleged that she would have requested repeat biopsy (as recommended on the biopsy findings within the records), which would have come back negative for malignancy and thus she would never have agreed to surgery.

The expert opinion on the case indicated that it was reasonable for Mr F to perform an initial ureteral biopsy, but that it must be recognised (and should have been made clear to the patient) that often such biopsies are not diagnostic; hence, repeating the biopsy may not have revealed any further information. The expert was also of the view that the MDT decision to proceed to radical nephro-ureterectomy was justifiable, even if it soon became obvious that the diagnosis of endometriosis had been made. Due to the location and size of the mass radical surgery would still have been warranted.

MPS set out their expert evidence and indicated they would defend Mr F in the event a formal claim was commenced. The case was not subsequently pursued.

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**Learning points**

- The importance of documenting every consultation, including telephone consultations, is highlighted once again with this case. Disciplined documentation of every clinical encounter means that when a claim or complaint arises, you can feel more confident defending your position.
- A reminder regarding telephone consultations is that arrangements should be made for face to face review if any concerns are raised regarding a patient’s clinical condition.
- A patient who develops new symptoms should be reassessed and the diagnosis reviewed. In this case the nurse should not have made a new diagnosis of glandular fever over the telephone without arranging for the patient to be seen.
- This case is a reminder that common ailments can develop rare complications. The majority of cases of otitis media seen in general practice will resolve without complications; however, health professionals should remain vigilant to the possibility of disease progression. Safety netting measures protect you and your patient.
- Asking the patient to attend for a review is an important safety net to put in place, but it is important to be able to follow this up. Lack of available GP appointments means that clinical staff are often in the position of triaging patients without seeing them in person, which can lead to a deteriorating patient being overlooked. Clinical staff should be trained to spot red flags and be aware of developing symptoms that require immediate review.
- Mastitis is now relatively rare. The incidence of the condition following acute otitis media reduced from 50% to 0.4% following the introduction of antibiotics. Prior to this, mortality rates were 2 per 100,000 compared to <0.01 per 100,000 now.

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**REFERENCES**


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**Learning points**

- Communication and documentation is vital. Had the specific purpose and limitations of the biopsy been explained clearly to Mrs S at the outset, and the options for further management discussed thoroughly, she might not have brought the claim. As with many claims, the claimant did not sue based on the outcome of the surgery but rather because of lack of communication and correct information. All medical practitioners must make time to ensure their patients fully understand all aspects of their management.
The twisted knee

M s C, a 42-year-old risk manager, fell from her horse whilst out riding. At the time of the fall she felt her left knee twist, as her left foot had been caught in the stirrup. 

Two days later she presented to her GP who noted that she had no loss of consciousness at any stage, had landed on her outstretched hands and knees and that she had sustained some bruising on her neck. He documented that the medial aspect of the left knee had sustained a bruise, that the cruciate and collateral ligaments were fine and that McMurray’s test was negative. Analgesia, gradual mobilisation and exercise were advised. 

Ten days later Ms C returned to her local clinic. It was noted that an effusion had developed in the left-ankle range of flexion had decreased. Physiotherapy was advised. A week later, Ms C presented to the local emergency department (ED) with persistent pain, at which point an x-ray was requested and Ms C was encouraged to come to the local Emergency Department (ED) with persistent pain. At that time the patient consented for an arthroscopic menisectomy. At arthroscopy a large fragment of the meniscus was resected. In July 2007 the practice nurse prescribed a further six months of the POP without face-to-face consultation, and a further one month’s supply was issued in December 2007. In January 2008 Mrs B presented with stress incontinence, for which a referral to urology was made. At this consultation it was noted that there were “no problems with the POP and the BP was normal.” Six months of the POP was issued. 

In May 2008 Mrs B consulted about mild acne and asked if co-cyprindol could be prescribed. The GP noted that Mrs B’s father had previously suffered a DVT and advised against it. In July 2008 the practice nurse supplied a further six months of the POP. 

In October 2008 Mrs B presented to the practice with an unexplained pregnancy and she was referred to the antenatal clinic. A review of the records revealed that Mrs B had been registered with the practice since 1999. She was then on the combined oral contraceptive (COCP) since 1992, which she had stopped in 2000 when she began trying for a family. At her new patient medical in 1999 it was noted that she was a non-smoker, and there was a family history of diabetes or heart disease. 

The original consultation, when she was prescribed the POP, was in October 2003 after the birth of her first child. The notes read: “16 days post-natal. Wants contraception. Discussed and start Noriday.” 

Over the next four years there were a dozen clinical encounters. Three of these were pill checks with the practice nurse. A typical entry read: “On Noriday. Happy with it. No missed pills, occasional heavy bleeding.” 

There were also five occasions when the POP was issued without face-to-face consultation, and four encounters for unrelated issues. 

Mrs B’s legal team alleged that she should have been advised to change from a COCP to a COCP when she finished breastfeeding her second child in 2007 and this would have helped to prevent her unwanted pregnancy in 2008. Expert opinion was that when prescribing contraception it is a duty to discuss contraceptive choices with a patient – specifically about the pros and cons of a COCP and a POP in this case. The discussion should cover failure rates, the method of taking the pill, common side effects (including effects on menstruation) and the risk of thrombosis. This would allow the patient to reach an informed decision. The expert felt that part of this could have been achieved by advising the patient to read the product information in the packet insert. 

In this case the expert felt that it was reasonable not to prescribe the COCP due to the family history of DVT (and also the relative contraindication of the varicose veins). 

A defence denying liability was served by MPS. Three months later Mrs B discontinued her claim and MPS recovered all costs.
A tear during delivery

Learning points

- The use of sequential instruments is associated with an increased neonatal morbidity, however, the operator must balance the risks of a caesarean section following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction.
- Recognition and documentation of the correct technique in the notes (e.g. ‘Saxthorph-Pajot’ technique for forceps delivery – where the operator’s dominant hand applies horizontal traction, whilst the other hand gently presses downwards on the shank of the forceps) suggests that the accoucheur has adequate experience to carry out the procedure correctly.
- Careful documentation of the technique and assessment for perineal damage is essential, and use of endo-anal USS may help with the definitive diagnosis at a later stage.
- The expert opinion was logical and evidence-based and, with careful documentation and adherence to good medical practice, such cases can be discontinued before they are taken to court.

M rs J, 37 years old, was pregnant with her third child. Dr A carefully examined the perineum and anal canal following the delivery and documented that the “anal sphincter was intact” and there was no evidence of any sphincter damage, and repaired the tear routinely. The patient made an uneventful recovery and, when she was seen by her GP for her six-week check up, it was documented that “she had no problems with her bladder or bowels.”

Unfortunately, 12 months following the birth, Mrs J was referred to obstetrics and gynaecology consultant Mr B, with signs suggestive of utero-vaginal prolapse, menorrhagia and lack of bowel control. An endo-anal ultrasound found only minimal scarring of the external sphincter, and the internal sphincter appeared intact. A clinical neurophysiologist also assessed the patient and felt “there was evidence of bilateral anterior root neuropathy with poor muscle function on the right and left sides”.

Mrs J underwent a vaginal hysterectomy and posterior pelvic floor repair, and her symptoms improved significantly with dietary modifications and biofeedback. Mrs J made a claim, as she was advised that if Dr A had carried out an episiotomy and avoided the use of ‘double instruments’ her symptoms would have been avoided. She felt that a diagnosis of a third degree tear had been missed and, as a consequence, this had a major impact on her life.

Expert opinion on these issues was sought. Although it was acknowledged that an episiotomy is often required in a forceps delivery, the perineal damage sustained was minimal and it was felt that the episiotomy was not essential in this case. The contemporaneous notes confirmed that the anal sphincter was intact. The endo-anal ultrasound and neurophysiology tests also confirmed the presence of marked sphincter damage, and the cause of the bowel problems was felt to be due to pudendal neuropathy.

The venous cup displaced due to the caput on the baby’s head, and the fact that there had been some early episiotomy. The patient had been lying on her side to enable delivery of the baby and then corrected to full lithotomy. Dr A felt the perineum was stretching out well, and did not carry out an episiotomy.

M s M, a 58-year-old woman, saw Dr A, a consultant orthopaedic surgeon, with a history of left-sided knee pain. She had seen him previously, and had been prescribed pain medication, to no avail. She had had an arthroscopy in the past, which had been performed by Dr B at a private hospital. Unfortunately, the operation had been complicated by a perforation of the anterior cruciate ligament, which left her with a pain-free period and then knee pain. Her preoperative diagnosis was posterior cruciate ligament tear.

Prior to the operation, Dr A had informed Ms M of the risks of the procedure, which included: a minor complication, such as the perforation of the anterior cruciate ligament, which left her with a pain-free period and then knee pain. Her preoperative diagnosis was posterior cruciate ligament tear.

The procedure was performed through a midline incision. The ligament and menisci were repaired and the patellar osteophytes were trimmed. Ms M was then referred back to Dr B who performed a diagnostic arthroscopy. This demonstrated a tear in the posterior cruciate ligament, but Ms M would be mobilised – unhapy with this advice, Ms M pursued a second opinion. This was provided by Dr B.

Seven days after the operation, Dr A wrote to Ms M’s GP. In this letter he stated that the operation seemed to go very well but that the postoperative x-ray demonstrated a suboptimal result. He indicated that revision should not be pursued aggressively and that there were both advantages and disadvantages to this conservative approach. Moreover, he reported that most of Ms M’s pain was in the thigh. Three days after the correspondence and ten days after the original operation, revision surgery was undertaken by Dr B. The operating note described the suboptimal position of the tibial component and recorded a fracture of the medial tibial plateau. The component was replaced and the patella resurfaced. A swab taken at the time of revision grew a coagulase negative Staphylococcus but this was thought to be a contaminant. The claimant made a reasonable recovery and was duly discharged four days later.

Follow-up was arranged by Dr B and Ms M was seen six weeks later, 2kg/2cm and concluded that Ms M was progressing well with a stick. The knee was a little stiff but physiotherapy was ongoing.

At this point a second issue superseded. Ms M complained of severe lower back pain and left-sided sciatica – an MRI scan of the spine revealed a fracture of the inferior endplate of the L5 vertebra. A CT scan of the lower lumbar spine demonstrated a L4-L5 disc protrusion. A concurrent CRP of 35 and ESR of 31 were felt to be of questionable relevance and were attributed to delayed wound healing and the MRI finding.

Further follow-up, six months later, found that Ms M was walking without the aid of a stick. The knee was a little warm. The range of movement was 9° to 110° and it was considered that the knee was improving.

Fifteen months after the first operation, Ms M’s GP referred her to a rheumatologist, Dr L, on account of persistent knee and back pain. He requested a bone scan, which was reported as showed probable peri-prosthetic sepsis. Ms M was then referred back to Dr B who performed a diagnostic arthroscopy. This demonstrated an extensive synovitis and Staphylococcus epidermidis was isolated from the biopsies obtained. A protracted course of antibiotic therapy ensued. Two years after the original operation, a stepped explantation of the tibial component was performed, and several months, the operative wounds healed and satisfactory x-ray appearances were obtained. However, Ms M continued to be troubled by persistent pain.

Six months later Ms M made a claim against Dr A. It alleged that Dr A was negligent on multiple counts, in that he had fractured the tibial plateau at the time of the original surgery, failed to identify the fracture during surgery and then failed to take remedial action intraoperatively. Moreover, it alleged that Dr A had been negligent in failing to proceed urgently to revision surgery and in persistently advising Ms M to mobilise, despite her severe pain, the concerns expressed at multidisciplinary team meetings and all the clinical and radiological indications that the knee joint was mal-aligned. Ms M also claimed that were it not for Dr A’s negligence, the total knee replacement would have been successful and she would have recovered swiftly following surgery. Furthermore, Ms M alleged that she would have been relieved of her preoperative symptoms and would not have required a further revision for approximately two decades. It was also suggested that it was initially the revision, the ensuing septic arthitis, the subsequent arthroscopy and the final two-stage revision were all consequent to Dr A’s negligence.

Expert evidence was sought from Dr D, a consultant orthopaedic surgeon, with regards to breach of duty and causation. Although Dr D acknowledged that Dr A was not aware of any adverse event occurring during the original operation, he highlighted that Dr A for a failure to act on the immediate postoperative x-rays, failing to proceed urgently to revision surgery and for repeatedly advising Ms M against an early revision.

He was also critical of the persistent advice to mobilise and acknowledged that, in his opinion, this was one of the worst total knee replacements he had seen. Moreover, Dr D felt that the subsequent operations Ms M underwent were a result of Dr A’s breach of duty during the index operation. In terms of breach of duty, Dr A made the following assertions: the patient presented with evidence of malrotation of the tibial component with fracture of the posterior tibial cortex, which is surgery that falls below an acceptable standard of care. The claim was settled for a substantial sum.

Learning points

- Adverse outcomes and mistakes are part of a doctor’s working life. Acknowledging this, responding to such events in a timely manner and being open, help to reduce the impact of these incidents on both the patient’s wellbeing as well as the doctor’s professionalism.

In this instance, the highly critical expert evidence required swift action. As a result, Dr A’s subsequent treatment was appropriate. Strong expert opinion guides the approach of both MPS and the members involved.

THEME INTERVENTION AND MANAGEMENT

SUCCESSFUL DEFENCE

A catalogue of errors

Learning points

- Recognition and documentation of the correct technique in the notes (e.g. ‘Saxthorph-Pajot’ technique for forceps delivery – where the operator’s dominant hand applies horizontal traction, whilst the other hand gently presses downwards on the shank of the forceps) suggests that the accoucheur has adequate experience to carry out the procedure correctly.
- Careful documentation of the technique and assessment for perineal damage is essential, and use of endo-anal USS may help with the definitive diagnosis at a later stage.
- The expert opinion was logical and evidence-based and, with careful documentation and adherence to good medical practice, such cases can be discontinued before they are taken to court.

THEME OBSTETRICS

SUCCESSFUL DEFENCE

A tear during delivery

Learning points

- The use of sequential instruments is associated with an increased neonatal morbidity, however, the operator must balance the risks of a caesarean section following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction.
- Recognition and documentation of the correct technique in the notes (e.g. ‘Saxthorph-Pajot’ technique for forceps delivery – where the operator’s dominant hand applies horizontal traction, whilst the other hand gently presses downwards on the shank of the forceps) suggests that the accoucheur has adequate experience to carry out the procedure correctly.
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- The expert opinion was logical and evidence-based and, with careful documentation and adherence to good medical practice, such cases can be discontinued before they are taken to court.
Cutting corners

L was a healthy four-year-old boy who had accidentally caught his finger in a bicycle wheel, amputating part of the distal phalanx. In the Emergency Department of the local hospital, it was found that the pulp and nail bed of the finger were lost and the bone of the distal phalanx was exposed. L was admitted under plastic surgery, fasted, and appropriately fasted. Towards the end of the operation, as Dr T was applying the dressings, the theatre sister, Sr S, noted that L’s pulse was very slow at 45 beats per minute. The pulse oximeter showed that the saturations were 52%. Dr B removed the dressings and Sr S’s face was noted to be cyanosed and his pupils widely dilated. Dr B removed the LMA, but the throat was clear. He applied 100% oxygen by facemask and a slow infusion of dextrose saline was administered. An intravenous cannula was inserted and L was aslepp. 15mg of fentanyl and 2mg of ondansetron were given during the case and a slow infusion of dextrose saline was administered.

Upon attempting to wake L, from the anaesthetic, he manifested severe extensor spasms and epileptiform movements of his limbs. He was intubated, sedated and transferred to intensive care. After a prolonged period of care, he was discharged from intensive care with extensive neurological damage consistent with hypoxic brain injury. An extensive inquiry was undertaken, which highlighted several areas of very deficient anaesthetic care. Dr B did not have his parents before the anaesthetic, and had not warned them of the risks of anaesthesia. Dr B said he had finished a 12-hour list with another surgeon and had agreed to help out at short notice. After induction, Dr B had left the reservoir bag concealed under the drapes, where he could not see its movement. He had not used a capnograph to monitor respiration. He had not recorded a blood pressure or respiratory rate at any time during the case. The monitor alarms had all been switched off earlier in the day and the patient gradually broke down and Mr A initiated a claim against Dr C, citing that he had insufficient experience in undertaking laparoscopic procto-colectomy and ileostomy. Mr A and Dr C instead have undertaken an open procedure. He also complained that he provided negligent postoperative care, performing a closure of ileostomy whilst an astigmatic defect remained.

Learning points
- Avoid human and equipment factors that can become more common, including portable electronic devices that can cause reduced vigilance, and is associated with increased risk of error. It does not amount to a defence. The mnemonic HALT reminds all healthcare professionals to be extra careful if they are Hungry, Angry, Late or Tired. Ask yourself: am I safe to work?
- Many anaesthetic machines now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including the need to contact healthcare professionals with text messages and emails.

A restoration problem

M A, a 46-year-old accountant, had a long history of biopsy-confirmed ulcerative colitis. Because of escalating medication, he was referred by his gastroenterologist for consideration of surgery after repeated exacerbations. He saw Dr C, a colorectal surgeon, who discussed the options available. Mr A had been unable to work for several months. He had done some independent research on the internet and concluded that he wished to undergo a restorative procto-colectomy to avoid a permanent stoma. Dr C documented the risks of this complex procedure and warned Mr A of possible leaks, pelvic sepsis and possible future pouchitis. He planned to perform the operation laparoscopically, which would carry the advantages of a quicker recovery, fewer adhesions and minimal scarring.

Mr A underwent a laparoscopic proctocolectomy with complete intra-corporeal ileo-anal pouch formation and a covering loop ileostomy. He made a slow but straightforward recovery. He remained in hospital for ten days, requiring a course of intravenous antibiotics for presumed urinary sepsis and training in the management of his ileostomy. Two days after discharge he re-presented with urinary retention requiring urethral catheterisation. Mr A subsequently developed increasing perineal and pelvic pain. Digital rectal examination revealed separation of the anastomosis, and a subsequent CT scan demonstrated a 60cm pelvic abscess adjacent to the anastomosis. A CT-guided drainage of the area was successfully carried out, and a week later Mr A was discharged home with the drain in situ.

There was a four-month period of ongoing review by Dr C, with a series of CT scans and contrast enemas demonstrating a slow but steady resolution of the abscess cavity with removal of the drain. After such frequent reviews the patient and surgeon were well-acquainted with one another and were on first-name terms.

Mr A was desperate for his ileostomy to be closed so he could return to work and, following a normal water soluble enema, Dr C decided to close the loop ileostomy. Preoperatively he documented the “high risk of pelvic sepsis if there is a persistent anastomotic dehiscence.” Before surgery Dr C performed an examination under anaesthesia, which showed a small defect in the distal segment. After closure of the anastomosis, Dr C proceeded with closure of the ileostomy, in the hope that this would ultimately work.

Mr A then suffered a recurrence of his previous problems with urinary retention, pelvic pain and sepsis. A further 12-month period of repeated hospital admissions ensued, with radiologically-guided drainage of the pelvic collections and treatment with antibiotics. The relationship between surgeon and patient gradually broke down and Mr A was referred to Professor X, who undertook a revision open procedure to resect the pouch, which eventually produced a satisfactory outcome.

Mr A initiated a claim against Dr C, citing that he had insufficient experience in undertaking laparoscopic procto-colectomy and ileostomy. Mr A and Dr C instead have undertaken an open procedure. He also complained that he provided negligent postoperative care, performing a closure of ileostomy whilst an astigmatic defect remained.

Learning points
- Clinicians should always maintain objectivity in the advice given to a patient. Shared decision-making is very important, with a balance between ensuring patient autonomy and making good clinical decisions. MPS’s workshop, Mastering Shared Decision Making, shows such a model is an effective way to ensure that patients make appropriate and informed choices. Visit the Education section of www.medicalprotection.org for more information.
- Many anaesthetic machines now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.
- Avoid human and equipment factors that can become more common, including portable electronic devices that can cause reduced vigilance, and is associated with increased risk of error. It does not amount to a defence. The mnemonic HALT reminds all healthcare professionals to be extra careful if they are Hungry, Angry, Late or Tired. Ask yourself: am I safe to work?
- Many anaesthetic machines now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.
An expert eye

Mrs K was 58 when she saw Dr B, a consultant orthopaedic surgeon, because of her right hip pain. She was finding walking difficult and suffered with night pain: both common symptoms of osteoarthritis. The x-rays only showed mild degenerative changes and Dr B felt it was too early in the course of the disease for an operation.

However, Mrs K’s symptoms worsened and three years later she returned for another consultation. Dr B felt that a total hip replacement was indicated and Mrs K consented to surgery. Prior to surgery, he explained the benefits and risks of a hip replacement. Complications, including a change in leg length, were discussed, though this was not specifically covered on the consent form. Mrs K understood that she should hopefully be pain-free within two months of surgery and go on to make a full recovery by six months post-surgery.

At surgery, several different component sizes of the femoral head were tried. The final implant was chosen to maximise stability of the hip and minimise the risk of dislocation. The operation went well and there were no postoperative problems. Mrs K was recovering as expected when she was seen for review at one month. After three months, however, she complained of discomfort over the lateral aspect of her hip. An x-ray showed that her right leg was 5mm longer than her left, but Dr B thought a shoe raise was not indicated. This lateral pain persisted, though, and Mrs K was provided with a shoe raise to equalise the leg lengths at a further review.

Mrs K sought a CT scan, which confirmed the leg length discrepancy, and she also had injections in her lumbar spine for pain relief, which did not help. Due to these ongoing problems, Dr B organised an aspiration of her right hip replacement, which did not show any evidence of infection, and also referred her to Dr L, an expert in revision hip surgery, for a second opinion.

After reviewing the history of ongoing pain post-surgery, a clinical examination and a new set of x-rays, Dr L could not see any obvious problem with the hip replacement that would account for her symptoms. Dr L explained to Mrs K that the hip was “only very slightly long”. He felt that maybe she was getting some impingement pain from her psoas tendon.

Mrs K was becoming increasingly frustrated and upset, believing that her problems all stemmed from an increase in her leg length, and returned to see Dr B again. She wondered whether further surgery might resolve the pain. Dr B, as well as obtaining a second opinion from Dr L, had discussed the case with other colleagues. They agreed that a 1cm leg length discrepancy should not cause such problems, and that even lengthening by 3 to 4cm is regularly tolerated well by patients. He advised against further surgery, as did his colleagues, but he organised an MRI scan of the hip and spine to try and find a source of Mrs K’s pain.

The MRI showed some degenerative changes in her lumbar spine and also a ‘hot spot’ around the total hip replacement indicating, once again, the possibility of an infection. Another hip aspiration was arranged. For a second time the aspiration grew no organisms on culture, which confirmed that an infection was most unlikely. Dr B also reiterated his view that Mrs K’s leg length discrepancy was minimal. Mrs K was now finding walking for more than an hour impossible. After five minutes she developed steadily worsening pain in her hip, and she struggled with stairs. She brought a claim against Dr B, citing a leg length discrepancy of two and a half centimetres, and failure to plan and perform the surgery adequately.

Dr B denied negligence and the experts involved upheld this. There was only minimal leg length discrepancy, less than had been claimed, and it is a recognised complication. Dr B performed both the surgery and subsequent investigations in an appropriate manner, and sought a second opinion from an expert.

Mrs K’s claim was discontinued.

REFERENCES


A delayed diagnosis

Maris O, a 22-year-old woman, was admitted as a medical emergency with vague abdominal pain and urinary frequency. Clinical examination revealed a right iliac fossa scar from an appendectomy three years earlier and some mild supra-pubic tenderness. Her white cell count was elevated, she had a low grade temperature and urinalysis demonstrated blood and leucocytes. A chest and abdominal radiograph at this stage appeared normal.

A provisional diagnosis of a urinary tract infection was made and Maris O was commenced on intravenous antibiotics.

After five minutes she developed steadily worsening pain in her hip, and she struggled with stairs. She brought a claim against Dr B, citing a leg length discrepancy of two and a half centimetres, and failure to plan and perform the surgery adequately.

Dr B denied negligence and the experts involved upheld this. There was only minimal leg length discrepancy, less than had been claimed, and it is a recognised complication. Dr B performed both the surgery and subsequent investigations in an appropriate manner, and sought a second opinion from an expert.

Mrs K’s claim was discontinued.

Learning points

1. Limb length discrepancy is the second most common cause of litigation in orthopastry surgery, behind nerve injury.
2. Approximately 15% of hip replacement surgery results in a limb length discrepancy. Less than 1cm discrepancy is the ideal goal, but up to 2cm is reported to be tolerable by patients.
3. The importance of good documentation concerning consent of all common and serious complications is vital. Specific complications should be included on the consent form. In this case the limb length discrepancy was discussed with the patient and mentioned in the GP letter.
4. Explaining to a patient why a complication might arise helps them to understand and accept if it happens. In this case, having a stable hip replacement and adequately tensioned soft tissues is more important than a leg length discrepancy, and should be emphasised.

This case highlights the importance of having strong experts. In this case, expert opinion found some of Mrs K’s claims inaccurate and found Mrs K had dealt with the patient in an appropriate manner. MPS robustly defends non-negligent claims.


Learning points

1. The results of investigations should be reviewed promptly and acted upon accordingly. Generally, adhesional small bowel obstruction requires surgical intervention if, after appropriate conservative treatment, there is no sign of clinical improvement.
2. Medicolegal problems often arise long after the clinical encounter. Considerable discussion regarding this case centred upon documentation of when patient reviews occurred and when Miss O’s x-ray investigations were assessed. Accurate and legible entries into the notes (even down to the hour) are the cornerstone to any medicolegal defence.

M Forty-eight hours later, the situation had deteriorated and Miss O now had worsening abdominal pain, nausea and a persistent pyrexia. Overnight, she was reviewed by the resident surgical officer who found a distended abdomen with localised guarding in the right iliac fossa. He advised keeping the patient ‘nil by mouth’ and prescribed intravenous fluids and analgesia. A further abdominal radiograph was requested, a nasogastric tube and urinary catheter were inserted, and the patient was transferred to a surgical bed.

General surgeon Dr S reviewed the patient the following morning and requested an ultrasound scan. This demonstrated the presence of dilated small bowel loops with fluid and free fluid in the peritoneal cavity. When he saw the patient 24 hours later, she remained unwell; review of the abdominal x-ray from 36 hours earlier confirmed the ultrasound suggestion of small bowel obstruction.

Dr S concluded that it was likely a consequence of adhesions from her previous appendectomy and, later that day, he undertook a laparotomy. This revealed small bowel obstruction secondary to a band adhesion. After division of the band and decompression of the small bowel, a 1cm section of ileum required resection and anastomosis.

Initially, Miss O improved and began oral intake and mobilisation. However, on day three following her surgery, she complained of cramp-like abdominal pain and a productive cough. Miss O had mild bilateral abduction and absent bowel sounds. Further x-rays revealed left lower lobe collapse and consolidation and some ongoing dilated small bowel loops. She was reviewed by Dr G, locum general surgeon, as Dr S was on annual leave for three weeks. A diagnosis of pneumonia and fevers was made and intravenous antibiotics were prescribed.

A further period of prolonged nasogastric drainage and parenteral nutrition then ensued. The ‘feats’ failed to resolve and a gastro-graft small bowel study showed delayed passage of contrast through dilated small bowel loops consistent with a low grade obstruction. Dr G recommended further surgery but Miss O and her family were reluctant and wished to persevere with conservative management.

When Dr S returned from annual leave, Miss O was still obstructed and by this stage all were in agreement that further surgery was required. A second difficult laparotomy and division of adhesions was undertaken, revealing an area of possible Crohn’s structure at the anastomosis which was resected and re-anastomosed. Miss O required treatment on the intensive care unit and then developed a severe wound infection and entero-cutaneous fistula. She spent several months in hospital and eventually was discharged with persistent intermittent abdominal pain and altered bowel habit. There was no evidence of inflammatory bowel disease.

Miss O brought a claim against Dr S, citing a delay in the diagnosis and treatment of her small bowel obstruction as the cause for her further surgery, prolonged hospital stay, and subsequent intestinal complications and ongoing symptoms.

Expert opinions were critical of the delay in making the diagnosis of small bowel obstruction and undertaking surgery. They felt that an ultrasound examination had been unnecessary and that Dr S should have reviewed the abdominal x-ray (which clearly showed evidence of obstruction) when he initially reviewed the patient and not the following day. Had he done so, the finding of peritonism three days into her illness may have prompted Dr S to perform early surgery, before the small bowel ischaemia had become irreversible. The case was settled for a moderate sum. SD
Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions. Please address correspondence to: Casebook, MPS, Victoria House, 2 Victoria Place, Leeds LS11 8AE, UK. Email: casebook@mps.org.uk

A confidential issue?

May I comment on the article “On deadly ground” (Casebook 21(8); the case “CONFIDENTIALITY”. I feel that Dr W was not at fault in divulging Miss B’s HIV status with the mother present. The mere fact that Miss B allowed the mother to be present at the consultation gives the doctor the right to discuss ALL problems and queries of the patient. In my opinion Miss B had given permission by allowing her mother in at the consultation.

I always inform my patients when they allow another person into the consulting room that whatever is discussed will be with the patient’s consent and that if they are not comfortable with that we must ask the other person to leave.

It is very difficult to take a complete history and at the same time think twice about what questions should be posed to the patient.

Dr JW van Vreden, South Africa

Response

In this scenario, the GP had wrongly assumed that the patient was content for her daughter to know confidential information regarding her HIV status. The patient, in making her complaint, had not expected that information to be divulged, and the case illustrates the dangers of making assumptions. Fortunately, although the GP had to endure the stress of a complaint to the Medical Council, the case did not proceed to a hearing.

Poor notes: why?

It is a recurring observation that poor record-keeping is one of the major obstacles for MPS in defending complaints of negligence. Yet writing patients’ notes is one of the chores drilled into all of us, especially when we are training as interns.

This practice seems to wane as we get more experience and the notes become shorter and shorter, to end in no notes at all at times! Is this because of too much confidence, laziness or sheer carelessness? I don’t think so. It must be a combination of many factors. I wonder if MPS could design a study to investigate this matter, difficult as it may be. Thanks for a great journal.

Dr Gwede Maboeza, GP, Grahamstown, South Africa

Response

You are quite correct that an otherwise potentially defensible claim is often rendered indefensible if the practitioner’s recollection of events is not reflected in the records. You raise an important interest in trying to understand why this happens. I am not sure how we could study this in a scientifically robust way, but perhaps there are analogies from other daily activities. When learning to drive, we are meticulous in following our instructor’s directions; look in the mirror, indicate and so on, and concentrate on when to depress the clutch, change gear and steer. As we become more experienced, not only does the process become easier, and a subconscious skill, we also sometimes cut corners and do not abide by rules on following all the rules we were taught at the outset.

It is important to is continually reminded of ourselves how important good records are; for continuity of patient care, an as indicator of the standard of our practice, and ultimately to enable unmeritorious claims to be defended. So it’s no surprise that this is the topic in so many of our articles, features and case reports, as well as workshops and seminars.

If you have any ideas about more that MPS could do, I would welcome hearing from you.

Stumbling block

Thank you for highlighting the important case of a nerve injury following a femoral nerve block (“Stumbling block”, Casebook 21(9). However I would dispute your statement that use of ultrasound has revolutionised the safety and efficacy of regional anaesthesia. Published works show a rate of nerve injury whilst using ultrasound to be similar to traditional techniques. Simply the key factors in this case were the use of an unsafe nerve block technique, as well as severe deficiencies in consent and communication. From the details published the decision to use a regional block at all might seem questionable, regardless of technique. The presence of an ultrasound machine would not have made any difference to these factors.

Dr Ben Chandler, Consultant Anaesthetist, Scarborough Hospital, UK

Response

In this case, the claimant had a valid claim, and was entitled to the amount of compensation which was ultimately paid to her. However, she pleaded exaggerated damages, which led MPS to investigate and establish that her injury was less severe than she was claiming.

This would not have impacted on her entitlement to public funding of her claim at the outset, but led to withdrawal of this funding when it was possible to show that a reasonable offer had been made. Given that her claim was in, fact, successful, it would be difficult to secure a conviction in this case. However, I hope that this case class demonstrates how rigorous MPS is in overpaying claims, paying when and where it is right to do so, and at the same time safeguarding members’ funds.

You may have also noted that in the cases reported on pages 19 and 21, where we were successful in our defence, MPS has sought to retrieve our costs from the unsuccessful claimant. Please do not hesitate to let me know if you have any further doubts about this, or other cases.

Poor notes: why?

In this scenario, the GP had wrongly assumed that the patient was content for her daughter to know confidential information regarding her HIV status. The patient, in making her complaint, had not expected that information to be divulged, and the case illustrates the dangers of making assumptions. Fortunately, although the GP had to endure the stress of a complaint to the Medical Council, the case did not proceed to a hearing.

Poor notes: why?

It is a recurring observation that poor record-keeping is one of the major obstacles for MPS in defending complaints of negligence. Yet writing patients’ notes is one of the chores drilled into all of us, especially when we are training as interns.

This practice seems to wane as we get more experience and the notes become shorter and shorter, to end in no notes at all at times! Is this because of too much confidence, laziness or sheer carelessness? I don’t think so. It must be a combination of many factors. I wonder if MPS could design a study to investigate this matter, difficult as it may be. Thanks for a great journal.

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With regards to the claim “A weekend of back pain”, Casebook September 2013, pages 22 and 23. One of the learning points of this case was that the claimant runs a litigation risk when pursuing a payout. The article mentions that the claimant’s legal costs were being reimbursed by the litigant and the claimant would have had to pay a higher than normal legal costs to pursue her claim. The article mentions that the claimant was void of any legal advice at the outset, but led to withdrawal of this funding when it was possible to show that a reasonable offer had been made. Given that her claim was in, fact, successful, it would be difficult to secure a conviction in this case. However, I hope that this case class demonstrates how rigorous MPS is in overpaying claims, paying when and where it is right to do so, and at the same time safeguarding members’ funds.

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Common Neuro-ophthalmic Pitfalls: Case-Based Teaching

By Valerie A Purvin and Aki Kawasaki

(£58.00, Cambridge University Press, 2009)

Reviewed by Dr Sacha Moore, consultant ophthalmologist

This book is part of a series of similar case-based books on different specialties, and is enjoyable and well written. If you are tired of didactic reference textbooks that serve up boring writing on layers of indigestible tedious lists and tables, like sawdust on bread and crackers, then this will be the chance and grasps that render neuro-ophthalmology not just palatable but moreish.

Let’s be honest: most of us non-neuro-ophthalmic specialists shy away from this subject and typically look for the nearest exit or window to jump through when a patient presents with double vision and headaches. Patients almost never present with textbook findings and almost always have confusing, subtle and variable symptoms or signs. This makes for a long corridor of bear traps, at the end of which awaits your own headache and diplodia if you are not careful.

The authors have nicely addressed the main subjects that cause anxiety amongst clinicians in neuro-ophthalmology and use real cases with relevant pictures and simple tables. There are 12 chapters:

- When ocular disease is mistaken for neurologic disease
- When orbital disease is mistaken for neurologic disease
- Misting congenital anomalies for acquired disease
- Radiographic errors
- Incidental findings (seeing but not believing)
- Failure of pattern recognition
- Clinical findings that are subtle
- Misinterpretation of visual fields
- Neuro-ophthalmic look-alikes
- Over-reliance on negative test results
- Over-ordering tests
- Management misadventures.

The style feels like a rewarding one-on-one tutorial and makes you feel like you can act on the advice and deal with similar cases in future. You can dip into it like a textbook or enjoy reading it straight through from start to finish – there are many interesting and surprising facts that I have not found in other textbooks. This book will help you better understand subjects you thought you knew and those you know you didn’t know.

Neuro-ophthalmologists will find this book serves as a good tune-up on their knowledge; non-neuro-ophthalmologists may benefit from the insights, like a full service on the rusty remains of their faded membership memories. It is satisfyingly clinically relevant and not just another book for membership examinations. Overall the book deserves the honour of being well-thumbed and to stand battered and frayed from much use amongst the shiny, thick tables of untouched neuro-ophthalmic monoliths in your, or your institution’s, library.

Erronomics: Why We Make Mistakes and What We Can Do To Avoid Them

By Joseph T Hallinan

(£8.99 Ebury Press, 2009)

Reviewed by Dr Matthew Sargeant, consultant psychiatrist and clinical human factors group member

I learnt so much from this easy-to-read, enjoyable little book. Why We Make Mistakes is available as paper book, ebook or audio book. How we look at things without seeing, forget things in seconds, and are all pretty sure we are way above average are the themes. Such themes are of immediate contemporary clinical relevance to practice and comprehensively described.

The book is good for everyone, whether on a course on clinical human factors or not. For more than 20 years Hallinan, a journalist, collected many errors and obtained comments from academics who study various aspects of human performance and psychology related to human error making. There are many helpful references, a guide to chapters and footnotes. The book is an invaluable primer for academic literature for human factors/ergonomics terminology.

Grouped decoratively simply under 13 chapters, we are told making fewer mistakes is not easy, especially if the reader merely desires to do so without reflection. Hallinan urges: put effort into thinking of the small things we do and do not do, for the consequences are big. To improve patient safety with the very next patient you manage, read the book. The book advises team members to work together, to communicate and to have a supportive and accessible attitude to reduce error in team members. Clinicians are also advised to look up at the organisation they are working in for the sources of errors, as well as down at what they are doing. Clinicians are also told to avoid multitasking. The book implies that designing, investigating, delivering and managing clinical care are onerous responsibilities to promote patient safety.

The book is a lifeline for all medical students and doctors who make the platonic cry “why don’t they teach us about human factors”. If there are any non-believers about human fallibility out there it will help them too. Patients could help too by reading the book to help their clinicians. Hallinan tells us confidence and expertise attained through years of designing, investigating, delivering and managing clinical care are onerous responsibilities to promote patient safety.

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To find out more about these workshops visit www.mps.org.nz
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