The question
do capacity
When a patient can’t make decisions, how do you fill the gap?
MPS has a wealth of resources that provide medicolegal and risk management advice – but did you know they are literally at your fingertips? Visit the MPS website to access the full range of material that is available to you – and start getting the most from your membership.

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ISSN 1740 0104

Casebook is designed and produced three times a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

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Outside New Zealand, there has been a lot of talk about the rising cost of clinical negligence: the increasing number of claims, and the increasing levels of awards. We also hear the rhetoric that the fear of litigation drives doctors to practise defensive medicine. Although the circumstances are different for members in New Zealand, you may be interested to know that MPS members across the world tell me that it is the dread of a complaint to the Medical Council, and the risk of a public hearing, trial by media and reputational damage that concern them much more than a claim. This may be down to the fact that members’ indemnity arrangements will step in to meet the financial costs of a claim, making it a less personally traumatic experience than the sanctions that might be faced at, for example, the hands of an employer, regulator or even the police.

Although the cost of claims is far and away the largest call on members’ funds worldwide at MPS, they only represent about 20% of the cases we handle worldwide – the rest are complaints, inquests, disciplinary cases and other medico-legal challenges to a member’s professional practice. It is also possible for a single incident to take a member through a series of procedures. For example, a perinatal death might give rise to complaint, inquiry, inquest, disciplinary and regulatory investigations. The scope for multiple jeopardy and the range of mechanisms for holding a doctor to account seems to widen with every reform of healthcare around the world.

Finally, I hope you enjoy reading the case reports – in this edition we share learning from both settled claims from around the world and also some very challenging to a member through a series of procedures. For example, a perinatal death might give rise to complaint, inquiry, inquest, disciplinary and regulatory investigations. The scope for multiple jeopardy and the range of mechanisms for holding a doctor to account seems to widen with every reform of healthcare around the world.

As always, I welcome your feedback – whether in response to content within Casebook or to share your own experiences.

Dr Stephanie Bown – Editor-in-chief
MPS Director of Policy and Communications

Welcome

Under the influence

MPS Medical Director Dr Rob Hendry reminds doctors of their unique opportunities to influence and inspire those working around them

Doctors are often surprised how influential they are within their teams and organisations. The things they do and say and the way they conduct themselves is increasingly being recognised as central to effective healthcare.

Most medical care is now delivered by teams rather than by individual healthcare professionals working in isolation. When teams work well the results can be spectacular, but when teams are dysfunctional, patient care can suffer. Stories in the press about “failing hospitals” are, in fact, often actually about failing teams.

Sadly at MPS we frequently see members getting into difficulties with their employers and their regulators, not because of their lack of specialist knowledge or poor technical skills, but because of the way they interact with their colleagues.

When relationships break down in healthcare teams not only do things go wrong more often, but when they do the impact on everyone involved is usually much greater.

One of the characteristics of being a professional is taking responsibility for one’s actions. Often, choosing to turn a blind eye to problems within a team can lead to problems becoming magnified and intractable.

Product liability and MPS

Issues with product liability have made the headlines in a number of countries around the world recently – notably the DePuy metal on metal hips in South Africa and Ireland, and the PiP breast implants in the UK.

These issues arose from faulty products, where normally responsibility lies with the manufacturer or supplier of the product.

However, in both cases, attempts were made by claimants to include surgeons in the claims – in the DePuy hips case, the justification given was that the surgeons had failed to properly fit the prostheses; with the PiP implants, the insolvency of the manufacturer was the motivation for involving the surgeons in the claims.

In both situations, whilst MPS is not providing an indemnity for product liability, MPS is supporting members with these cases by doing whatever is possible to prevent the development of litigation targeting clinicians, when other more appropriate sources of compensation (the manufacturer or supplier) are no longer available.

In the meantime, members can take steps to protect themselves in the event of a claim for product liability, by retaining documentation relating to:

- Evidence of purchase.
- Where possible, the serial number of the item in question – it can be used as evidence of the batch of goods obtained.
- Terms and conditions.
- Express warranties and guarantees.
- Instructions and packaging.
- Correspondence regarding product specification and any alteration.
- Where whole goods are transported by Express warranties and guarantees.
- Terms and conditions.
- Correspondence regarding product specification and any alteration.
- Where whole goods are transported by

Correspondence regarding product specification and any alteration.

Where whole goods are transported by
Open for better care

Dr Janice Wilson, Chief Executive of the Health Quality and Safety Commission, unveils a new campaign.

In May 2013 the Health Quality and Safety Commission (HQSC) launched a new national patient safety campaign aimed at reducing harm for patients at hospitals and within the wider health system.

Open for better care challenges healthcare workers to be open to acknowledging mistakes and learning from them, open to working closely with patients and consumers, and open to change, improvement and innovation. It will run until mid-2015 and will be measured by quality and safety markers developed in consultation with clinicians.

The campaign focuses on four key areas where evidence shows we can reduce harm: falls, surgery, infections and medication safety. Each topic will be rolled out sequentially, with falls the first area of focus.

The reasons for the campaign aren’t that we’re doing a bad job of keeping our patients safe. Lots of good safety work is happening within health services, but people are sometimes still being injured through falling – and infections, surgical errors and mistakes within medicine still happen more than they should.

While these adverse events can be devastating to hospital staff, they often have serious and long-term impacts for patients and their families, so a single event is one too many.

Open for better care is so named because it seeks to foster an open culture where it is safe to acknowledge that mistakes have been made, to question practices that may be unsafe, and where adverse events are transparently reported. This sort of culture is critical to both avoiding mistakes and to learning from them so they don’t occur again.

Teamwork will also be essential. Teams working together, sharing their knowledge and their partnership with the patient can make all the difference in providing a safe environment in which to work, recover and receive treatment. And teams need leaders who will step up and take responsibility so their team can talk about mistakes, learn how to move forward and find new and better ways of doing things.

We are looking forward to engaging with New Zealand health professionals over the next few years. It’s going to be energising and challenging. There will be plenty of debate along the way and, yes, the campaign itself is open to change.

Find out more about the campaign at www.open.hqsc.govt.nz

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EDUCATION UPDATE

The risk of working with others

Dr Mark O’Brien looks at reducing risk from professional interactions

While poor patient communication has long been established as a major risk factor for complaints, Dr Priya Singh, Executive Director, Professional Services, MPS, notes: “It is important members know that ensuring high quality verbal and written communication between doctors has been identified by MPS as an important strategy to reduce the risk of patient harm and action against members.”

MPS has increasingly identified communication between doctors as a significant source of risk in two critical areas.

Referrals and handovers

Patient care is often passed between doctors, whether in the form of a referral or a handover. In these instances, poor communication can lead to:
- Abnormal investigations not acted on
- Wrong diagnosis made or wrong investigation and treatment undertaken
- High risk treatments not effectively monitored
- Predictable complications not recognised
- Significant co-morbidities not taken into account
- Unnecessary investigation and treatment.

Disagreements between colleagues

Disagreements between clinicians are common and poor communication between doctors in this situation can contribute to patients believing they’ve received poor care.

Helping you to reduce your exposure to these risks

These challenging situations are explored in MPS’s Mastering Professional Interactions workshop. This half-day workshop is offered free of charge to members, as a benefit of membership.

For more information, including forthcoming dates, locations and online booking, please visit The Essential Risk Management Workshop Series page on the education and publications section of: www.medicalprotection.org.
The question of capacity

When a patient lacks the capacity to make decisions about their own healthcare, establishing the most appropriate course of action is often a difficult task. Dr Alan Doris, MPS Head of Professional Services (New Zealand), offers guidance.

“Every person being of adult years and sound mind has the right to determine what shall be done with his own body.”

This succinct and influential judgment was given 100 years ago in New York and neatly summarises the central principle of consent to medical treatment in New Zealand and similar international jurisdictions.

As the population ages, the number of people living with reduced ability to manage their own affairs and make decisions about their healthcare is increasing. It is therefore more important than ever that there are good mechanisms to ensure that appropriate decisions about healthcare can be made despite a patient not being of “sound mind”.

In an urgent situation involving a patient who lacks mental capacity for any reason, and where there is no-one who is entitled to consent on behalf of the patient, treatment may still be provided. It is necessary in these circumstances that the treatment is in the patient’s best interests and, having taken reasonable steps to ascertain the views of the patient, it is considered that the treatment is consistent with what the patient would choose if competent. If it is not possible to know what the patient’s views would be then the views of other people interested in the welfare of the patient, such as family members, who can be consulted, should be taken into account.

In less acute situations there are other processes available to provide care for people who lack mental capacity. The Protection of Personal and Property Rights Act 1988 (PPPR Act) was enacted to protect and promote the personal and property rights of adults who lack competence (for example, due to a learning disability), or who lose competence with the progression of disorders such as dementia.

There are different legal tools available depending on whether decisions need to be made about health or property; whether capacity is partly or wholly lacking; and whether the issue is short-lasting or long-term. There have been a number of cases where uncertainty among health providers about the right decision-making processes to follow has led to complaint and sanction by the authorities and MPS is often contacted by members seeking advice in this area.

**Enduring power of attorney**

Under Part 9 of the PPPR Act, an individual (donor) can give authority to another person (attorney) or persons to make decisions for them. Such an enduring power of attorney (EPOA) can give the attorney the ability to manage a person’s property, make decisions about their care and welfare, or both.

An EPOA for personal care and welfare can effectively make the attorney a proxy decision-maker for the patient when capacity is lost, and the attorney, in general, has the same ability as the patient had before losing capacity. It is important to note, however, that an attorney cannot refuse to consent to any standard medical treatment or procedure to save the donor’s life or to prevent serious damage to the donor’s health. Tightening up of the certification requirements for creating or activating an EPOA, clarification of the duties of attorneys and making it easier for some people to access the Family Court were introduced in 2007 and 2010, because of concerns that some attorneys may not be acting in the best interests of the donor.

Standard forms are used when creating an EPOA. The EPOA must be witnessed by a lawyer or an employee of a trust organisation, who must state that they have no reason to believe the person lacks mental capacity. One or more attorneys may be appointed to manage the donor’s property, though only one can be appointed in relation to personal care and welfare.

An EPOA may provide the attorney with a general decision-making authority or may limit that authority to certain aspects of the donor’s care and welfare or property affairs. It is prudent for a donor to provide a copy of their EPOA for care and welfare to their doctor and ensure that it is kept up-to-date.

Whereas an EPOA for property can take effect at any time, if it is for care and welfare it only takes effect when the donor loses mental capacity. Further, in respect of any “significant matter” relating to the donor’s personal care and welfare, it is necessary that a relevant health professional carries out an assessment and completes the appropriate certificate confirming that capacity is lacking (or alternatively, the court has determined that the donor is mentally incapable).

A relevant health practitioner is one who is registered with their registration body; whose scope of practice enables him or her to assess a person’s mental capacity and who is competent to undertake an assessment of that kind. Such a health professional could be a medical practitioner in general scope of practice, although the donor can specify when creating an EPOA that certification of loss of capacity must be done by a practitioner with a particular scope of practice, for example a psychiatrist or clinical psychologist.

Although there is no prescribed method of assessing capacity for the purpose of this certificate, it is important that the practitioner carefully records the reasons for his or her opinion in case it is challenged, and completes the necessary form.

A relevant health practitioner is one who is registered with their registration body; whose scope of practice enables him or her to assess a person’s mental capacity and who is competent to undertake an assessment of that kind.

A donor who has made an enduring power of attorney is mentally incapable in relation to personal care and welfare if they:

(a) lack the capacity—
(i) to make a decision about a matter relating to his or her personal care and welfare
(ii) to understand the nature of decisions about matters relating to his or her personal care and welfare
(iii) to foresee the consequences of decisions about matters relating to his or her personal care and welfare or of any failure to make such decisions
(b) lack the capacity to communicate decisions about matters relating to his or her personal care and welfare.

As a donor can specify what matters the attorney can make decisions about, it is very important to know exactly what is contained in the EPOA document.

There have been several cases where health providers have been criticised by the Health and Disability Commissioner for not adequately informing the donor who has an EPOA for care and welfare about treatment advice and decisions.

Clause 4 of the Code of Health and Disability Consumers’ Rights defines “consumer” as including someone who is entitled to give consent on behalf of the consumer. It is therefore necessary that an attorney is provided with adequate information to make an informed choice with regards to treatment.

In one case several family members were interested in the care being provided to an elderly relative in a rest home. While a good deal of information was provided by staff to different members of the family the rest home was found in breach of Right 6 (right to be fully informed) because the family member who was the attorney had not been adequately informed.

**Personal orders and welfare guardianship**

If a person has already lost, or never had, competence, then an...
application can be made to the Family Court for a personal order or the appointment of a welfare guardian or property manager for the person. An application is often made by a relative, though could also be made by a doctor, social worker or hospital manager.

A personal order can require specific living arrangements to be made for the person, or that the person receives particular medical treatment or services. In deciding whether to make a personal order, the Family Court must decide whether the person wholly or partly lacks mental capacity to make decisions about their care and welfare, or if they do have mental capacity, are unable to communicate.

A personal order can also appoint someone to manage an individual’s affairs. A personal order may last for up to 12 months or until the time when the matters in the order have been completed. Where there is urgency in providing medical treatment or protecting the individual’s property rights, an interim personal order can be made by the court.

Though personal orders are well-suited for discrete or time-limited issues, the Family Court may appoint a welfare guardian or property manager when long-term substitute decision-making is necessary. For a welfare guardian to be appointed the individual must wholly lack capacity; and appointing a welfare guardian must be the only satisfactory way to ensure that appropriate decisions about care and welfare are made. There is usually only one welfare guardian appointed.

A welfare guardian is able to consent or refuse consent in the same way that the patient would have done if he/she had capacity other than to consent to psycho-surgery, ECT or medical experimentation, or to refuse any standard medical treatment or procedure intended to save the person’s life or prevent serious damage to their health.

The welfare guardian must always act in the individual’s best interests and assist the person in using what capacity they have to make decisions for themselves. It is also necessary that the welfare guardian consults (so far as practicable) with others who are interested in the welfare of the individual, and with any property manager who has been appointed. When a welfare guardian is appointed a date is set by the court to review the situation within three years.

Similarly, the court may appoint a property manager when it is satisfied that an individual is wholly or partly unable to manage their affairs in relation to their property. In deciding to appoint a property manager the court will try to interfere as little as possible in the person’s affairs and allow them to exercise what capacity they have. Property managers must consult with other relevant parties and report regularly to the court actions that have been taken. In some circumstances an application can also be made directly to a trust organisation, such as the Public Trust, to take on the role of property manager for an individual.

It is important to follow the correct processes when providing care to people who lack decision-making capacity. It is not uncommon for providers to be uncertain as to who has authority; the extent of this; and what to do when there is conflict between family members. A crucial starting point is obtaining and scrutinising the relevant documents and, when in doubt, seeking advice from MPS.

**REFERENCES**

1. Schloendorff v Society of New York Hospital 105 NE 92 (1914) (NY Ct of Appt per Cardozo J)
2. Right 7 (4) The HDC Code of Health and Disability Services Consumers’ Rights Regulation 1996
4. Section 94, Protection of Personal and Property Rights Act 1988
5. Section 104, Protection of Personal and Property Rights Act 1988
6. See cases 04HDC18516, 00HDC11595 and 02HDC18190

© MARK THOMAS/SCIENCE PHOTO LIBRARY
The Health Information Privacy Code (HIPC) is a code of practice issued by the Privacy Commissioner pursuant to the Privacy Act 1993. The HIPC sets out a series of rules concerning the collection, use, storage and disclosure of health information.

On 30 April 2013 amendment number 7 came into force. There are only a small number of changes, and those likely to be of interest to health practitioners include the use and disclosure of health information derived from Guthrie Card bloodspots, and the threshold for disclosure to an appropriate authority to protect the health or safety of the public, or an individual.

Bloodspots are collected from newborn babies by the Newborn Metabolic Screening Programme and are held indefinitely on ‘Guthrie Cards’. A new schedule to the HIPC requires all uses and disclosures of information derived from these cards to be conducted with the permission of the individual (or their representative or a close available relative), or to be for a permitted primary or secondary purpose.

Permitted primary purposes are purposes directly connected with the Programme. Permitted secondary purposes include complying with a court order, identifying a victim of crime where no other method is practicable, and carrying out research that has been approved both by the Ministry of Health and an ethics committee.

The HIPC also allows for disclosure of health information to prevent or lessen a threat to public health or safety, or the life or health of an individual. Previously the threat had to be “serious and imminent”. The latest amendment removes the requirement of imminence and defines a “serious threat”. The health professional is required to analyse the risk posed, and reasonably believe the threat to be serious, having regard for the likelihood of the threat occurring, the timing of this, and the severity of the consequences if it does occur.

The other requirements for disclosure have not been altered by the amendment. The permission of the individual should ideally be sought first, but this can be dispensed with where it is not desirable or practicable to obtain an individual’s authorisation. This covers situations where the individual is not competent to give consent, is unable to be found, or has refused to give their consent.

Any disclosure made without the consent of the individual concerned should be made only to the extent necessary to meet the particular purpose, and to someone who can act to minimise the threat, such as the person at risk, or the police.

These decisions must not be made lightly, and it is strongly suggested that members first contact MPS for advice.
Good Medical Practice: An update

The Medical Council of New Zealand recently launched a new, revised version of their *Good Medical Practice* guidance. Sara Williams shares a round-up of the most significant changes.

We all have an opinion of what makes a good consultation with a professional, whether it is being listened to, respected or even compassionate, but what everyone would agree on is that, above all else, we expect professionals to be competent and up-to-date.

The Medical Council of New Zealand (MCNZ) have recently updated their seminal guidance *Good Medical Practice* (GMP), which outlines the professional duties of a good doctor and outlines the clinical standard against which their conduct and decision-making will be measured.

What it is not is an exhaustive code of ethics; it is a guide to assist doctors in understanding and complying with the requirements of legislation.

Why the revision?

GMP was reviewed and subsequently updated to summarise the duties of all doctors in a simple and clear manner. It is a document intended to help doctors monitor their own conduct and that of their colleagues.

Background

Under the Health Practitioners Competence Assurance Act (2003) the MCNZ is tasked with setting the standards, clinical competence, cultural competence and ethical conduct of all doctors. GMP was put out for consultation last year and is the result of feedback from patients, the public, stakeholders and doctors, detailing the standards a competent doctor is expected to meet.

GMP is used by the Health Practitioners Disciplinary Tribunal, the MCNZ’s Professional Conduct Committees, and the Health and Disability Commissioner in determining whether a doctor has acted inappropriately.

The MCNZ says that the new guidance places more emphasis on explaining the key principles and standards in GMP. In this article we will look at the most significant changes to the guidance.

**Professionalism**

Previously, the section most overlooked was the initial foreword. Under a new heading, the ‘Professionalism’ section underlines the key duties and competencies that underpin all professional practice.

The MCNZ expects all doctors to be competent in:

- Caring for patients
- Respecting patients
- Working in partnership with patients and colleagues
- Acting honestly and ethically
- Accepting the obligation to maintain and improve standards.

**Personal data (par 7)**

A new duty has been introduced that doctors take all reasonable steps to ensure that records containing personal data about patients, colleagues or others are kept securely.

**Prescribing (par 10)**

Prescribing guidance previously stated that before prescribing, a face-to-face consultation would “usually” be required; now, before prescribing any medicine, you “should” have a face-to-face consultation with the patient. In the absence of a face-to-face consultation, discuss the patient’s treatment with another health practitioner who can verify the patient’s physical data and identity.

If this is not practical:

- Complete the prescription if providing cover for a colleague or discharging a patient from hospital, and review the patient’s notes
- Renew a prescription of a patient you, or a colleague, have seen previously
- Complete a prescription when you have a relevant history and there is an urgent clinical need to prescribe, providing you inform the patient’s doctor as soon as possible.

**Adverse outcomes (par 24)**

New duties have also been introduced with regards to managing adverse outcomes. Previously, if your patient had suffered serious harm or distress, you were required to act immediately to put it right “where possible”; the revised guidance expressly states that you “should” express regret and apologise if appropriate, then explain fully:

- What has happened
- The likely short-term and long-term effects
- What you and your health service can do to alleviate the problem.

**Reporting abuse (par 27)**

Under new duties on the protection and welfare of vulnerable patients, if you have any concerns about abuse or neglect, you should report them to the appropriate authorities without delay.

You should then inform the patient, and if the patient is under the care of others, you must inform them of your intention to report those concerns. Giving information to others for the protection of a patient may be a justifiable breach of confidentiality and, where a vulnerable adult is at risk of injury, is a legal duty. You should contact MPS for advice if you face a particularly difficult dilemma.

**Informed consent (par 30-34)**

Previous editions of GMP contained little on informed consent, so this section now advises that you familiarise yourselves with the Code of Health and Disability Services Consumers’ Rights and the Health Information Privacy Code.
With rare and specific exceptions you should not provide treatment unless:

- The patient has received all the information that a reasonable patient would expect to receive about their condition and treatment options, including the expected risks, side-effects, costs and benefits of each option
- You have determined that he or she has an adequate understanding of that information
- You have provided the patient with an opportunity to consider and discuss the information with you
- The patient has made an informed choice
- The patient consents to treatment.

The guidance says that you should have a reasonable knowledge of the range of evidence-based treatments that are available, and of how patients can access those that you do not provide, and you must respect and support the patient’s right to seek a second opinion or to decline treatment, or to decline involvement in education or research.

Working with colleagues (par 39)
The MCNZ says that working appropriately with colleagues should apply in all circumstances. A new duty requires you to respect the skills and contributions of your colleagues and recognise the impact of your conduct on other team members, and how it may affect quality care.

Sharing information in public (supplementary guidance)
When sharing information in any public forum, eg, chatting in a hospital cafeteria or posting on a social networking site, the revised guidance says you should not disclose information about yourself that might undermine your relationship with patients. Similarly, do not disclose information that might identify and cause distress to colleagues, patients or their families.

Continuity of care (par 50-52)
Although the new guidance is not intended to impose a duty on doctors to assume responsibility for every patient, it does require them to ensure that someone is personally accountable for each patient’s care.

It also requires that when you delegate care to a colleague, you must make sure they have the appropriate qualifications, skills and experience to provide care for the patient.

Conflicts of interest (par 58)
If you have a conflict of interest, you must be open about the conflict, declaring your interest. You should also be prepared to exclude yourself from related decision-making.

Raising concerns (par 62-69)
New duties have also been introduced with regards to raising concerns. If you have concerns over the competency of a colleague, where previously doctors were required to raise concerns “where possible” you now “should”:

- Raise your concerns with the doctor
- Draw the matter to the attention of the doctor’s employer
- Report your concerns to the registrar of the MCNZ or the Health and Disability Commissioner
- If the matters relate to health information privacy and security, refer to the office of the Privacy Commissioner.

Summary
As mentioned, the revised Good Medical Practice is not an exhaustive code of ethics. There may be obligations or situations that are not specifically covered in Good Medical Practice; in such circumstances your first priority should always be the care of your patient.

If you have a conflict of interest, you must be open about the conflict, declaring your interest. You should also be prepared to exclude yourself from related decision-making.
**Legal Commentary**

**Hanne Janes, Adam Holloway and Sean O’Sullivan,** from DLA Phillips Fox, offer the legal view on the revised aspects of Good Medical Practice

GMP has important consequences for doctors. As acknowledged within GMP, under the Code of Health and Disability Services Consumers’ Rights (Code) patients have “the right to have services provided that comply with legal, professional, ethical, and other relevant standards”. GMP is both intended, and functions, as “the foundation stone” for those standards.

This is why GMP, the way it is drafted, and how it is interpreted is so important. In this legal commentary we offer a perspective on the recent revisions to GMP and discuss some of the issues that might arise for doctors and their advisers.

**Prescribing**

This change reflects increasing use and realities of internet and ‘telemedicine’ prescribing.

Where inconsistencies exist between GMP and the Council’s 2010 Statement on Good Prescribing Practice, it is expected that the overriding duties set by GMP are likely to take precedence. Care needs to be taken however: we are aware of a practitioner who believed themselves to be fully compliant with Council’s Statement on Good Prescribing Practice but is nevertheless currently facing the prospect of being referred for a performance assessment.

While the Health and Disability Commissioner has previously acknowledged that renewal prescriptions will be appropriate in some circumstances, in a 2009 article the Commissioner wrote: “Depending on the nature of the medication, the doctor may be expected to decline a repeat prescription in the absence of a review.” (Repeat scripts for oneself which might undermine relationship with patients is very vague and probably unreasonable. What sort of problem is this addressing?)

… as doctors, we are responsible for making sure information about our patients is private. Information about ourselves is our own business. These concerns remain. There are also some circumstances where a practitioner may feel it could be helpful to the therapeutic relationship to share some limited information about themselves, for example to establish rapport or encourage a patient who is hesitant to share relevant and important information.

As phrased by this GMP guidance, it could effectively capture information about clinical matters (for example, criticism of a colleague or disclosure of inappropriate behaviour within a hospital), as well as any information that might undermine patient relationships (for example, using Facebook to protest against meat-eating in a farming community).

There is a risk that this part of GMP could give rise to collateral investigations into clinical or professional conduct, and it is not clear where agencies will in future demarcate that very fine line between personal and professional boundaries.

**Adverse outcomes (par 24)**

While an appropriate and reasonable expectation, which is also phrased as a “should” requirement and therefore implying flexibility in application, in our view any obligation to provide a “prompt” explanation should always allow for the doctor to have time to assemble relevant facts and to assess matters as calmly and carefully as possible so that incorrect information is not conveyed which may exacerbate later complaints or distress. It should also allow for an opportunity for the doctor to obtain an objective assessment of his or her conduct from an appropriately qualified colleague or specialist.

It is always appropriate that the doctor meet with the patient, express regret that there has, or appears to have, been a complication or adverse outcome, explain what is known at that point in time, and explain the process and timeframe for finding out more about what has happened. It is equally important that the doctor doesn’t speculate or rush to a conclusion.

The standard as written has the potential to place undue pressure on the doctor to make a hasty assessment of his or her conduct, which could have adverse consequences later.

**Reporting abuse (par 27)**

Aspects of this new duty are uncertain. They do, however, go significantly beyond the duties imposed under sections 151, 152, 195 and 195A of the Crimes Act 1961 (introduced in March 2012) to take steps to protect a child or vulnerable adult. For example, s151 provides that everyone who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessities is under a legal duty to take reasonable steps to protect that person from injury.

By reference to the Crimes Act, “vulnerable patients” will likely be interpreted as including “vulnerable children” (those under the age of 18 as established by s152) and “vulnerable adults” (defined in s2 as meaning “a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person”).
There is no definition in GMP of “vulnerable patients” or “abuse or neglect”. There is tremendous scope for confusion for doctors in applying, and thus complying, with this standard, particularly in circumstances where there will inevitably be a number of competing and potentially inherently incompatible considerations and interests.

Nor does GMP provide any guidance on what the “appropriate authorities” might be. In some circumstances doctors might regard a clinical Child Protection Team as more appropriate than the police or child, youth and family.

The term “without delay” could also be subject to differing interpretations. If a doctor notifies too quickly without obtaining and/or checking relevant facts, they could equally be subject of later criticism. In a criminal context, “without delay” has been interpreted as being not synonymous with “immediately”; and that it is a matter of what is reasonable in each case (Elliott v Police HC Dunedin AP15/97, 16 April 1997).

The new duty is also potentially confusing about a doctor’s duty where the reporting of abuse might cause danger. It states: “You should inform the patient, and if the patient is under the care of another person, his or her caregivers of your intention to report your concerns, taking into account that such action might endanger you or the patient.” The extent of the latitude provided by the words “taking into account” remains to be seen. The consultation draft of GMP provided simply that you should inform “unless this action might endanger you or the patient”.

It is suggested that a relevant consideration doctors should be entitled to take into account is whether complying with this new duty may give rise to a danger to themselves or the patient. There will be cases where confronting a suspect abuser will be better and more safely done by the police or another agency.

Informed consent (par 30-34)
Doctors are familiar with the principles of informed consent. They should, however, read these particular standards in conjunction with the earlier stated requirement in GMP that requires them to work in partnership with patients and colleagues, “giving them the information they want or need in a way they can understand and ensuring they understand it”. Doctors may need to incorporate into their informed consent processes a mechanism that demonstrates the patient has “understood” and document this clearly. Medicolegally, this is also desirable so compliance is encouraged.

With the extension to have a “reasonable knowledge of the range of evidence-based treatments” doctors will again have to be able to demonstrate that at the relevant time, they were up-to-date with such evidence-based treatments, provided the information to the patient, and also that they advised the patient where he or she could find information about other evidence-based treatments not discussed. This could be expected to expand the time required to properly obtain informed consent.

Continuity of care (par 50-52)
The ‘supplementary guidance’ to these paragraphs includes: “When you transfer care of a patient to another practitioner, you must [note: not “should”] ensure that the patient remains under the care of one of you at all times.” This is a significant obligation, particularly in some contexts, such as where a professional relationship is being ended.

There are likely to be circumstances (for example, a GP in a small community wanting to stop seeing a patient who is threatening) where it will be very difficult to comply with what GMP says about patient transfer and ending a professional relationship.

In relation to test referrals, the supplementary guidance to paragraphs 50-52 provides that the doctor who orders a test remains responsible for responding to the results and “must have a process for identifying and following up on overdue results”. This has been the expectation reiterated in many Health and Disability Commissioner decisions. With it now becoming an explicit standard under GMP, it will require greater care to personally ensure appropriate systems. This may require employed or locum doctors to challenge the adequacy of the systems provided for them.

The referring doctor “should ensure that the patient is aware of how information about them is being shared and who is responsible for providing treatment, undertaking an investigation and reporting results”. This may prove difficult where, after referral to one service, a patient is referred again for, say, testing without the first referring doctor knowing about this until sometime later.

Raising concerns (par 62-69)
Doctors are encouraged to follow the steps outlined, which starts with speaking to the colleague in a “constructive manner” as a first step, with escalation of reporting of concerns thereafter if the concerns are not appropriately responded to.

While there is an enjoinder that the doctor should “not delay taking action because you yourself are not in a position to put the matter right”, doctors should also ensure that they have all the relevant facts and do not act precipitately.

It may seem self-evident but these new duties should be read in conjunction with the standards under “Working with colleagues”, in particular the requirement to “not make malicious or unfounded criticism of colleagues” and to “not discriminate” against them. Reference is made in GMP to the Health Practitioners Competence Assurance Act 2003 requirements to notify, and doctors should be familiar with the provisions in sections 34 and 45 of that Act.

Doctors are familiar with the principles of informed consent. They should, however, read these particular standards in conjunction with the earlier stated requirement in GMP that requires them to work in partnership with patients and colleagues.
From the case files

Dr Alison Metcalfe, Head of Medical Services, introduces this issue’s round-up of case reports

All doctors are aware of the need to keep accurate and comprehensive medical records. But in busy clinical practice, standards can sometimes slip as a result of the need to meet ever increasing service demands. In many of the claims MPS handles, we come across examples of patient notes where there is no record of informed consent being taken; there is no record of discussions around potential postoperative complications; or there is no record of tests being ordered or results being followed up. This can make defending a clinical negligence claim very difficult indeed.

No matter how busy you are, it is important not to underestimate the value of detailed notes. Not only do they help if a clinical negligence claim is brought against you, they are fundamental to good patient care – leading to better communication between colleagues and smoother handovers.

In “Penetrating the eyeball” on page 15, Dr R’s records showed no evidence of discussion of indication, risks or alternatives for Ms J’s periorcular injections. Additionally no written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. The case was indefensible and settled for a substantial sum.

Good record-keeping means not only recording consent taken and treatments offered, but doing so contemporaneously. In “Rash decisions” on page 16, Dr P made notes retrospectively after Mr M rang the surgery with swelling, throat discomfort and difficulty breathing after he had been taking allopurinol and steroids for severe foot pain. Remember that alteration of records is a probity issue. Any alterations or retrospective entries should be clearly marked and dated according to when they are entered in the record.

Good record-keeping also means recording accurately the results of observation and monitoring. In “A brain-damaged baby” on page 16, experts were critical of the monitoring of the fetal heart rate both during Mrs N’s induction phase with prostaglandin, as well as during labour. Poor monitoring and incorrect interpretation of the CTGs, compounded by poor documentation on the CTGs, with a failure to record the date and time, meant that labour was allowed to continue in place of a caesarean section, resulting in intrapartum asphyxia. The case could not be defended.

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### WHAT’S IT WORTH?

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

- High $3,000,000+
- Substantial $300,000+
- Moderate $30,000+
- Low $3,000+
- Negligible <$3,000

If you would like to comment on a case, please email casebook@mps.org.uk.
Ms J, a 36-year-old banker with myopia, consulted Mr R, an ophthalmologist, with a one-week history of pain and blurring of vision in the left eye. Mr R diagnosed anterior uveitis and prescribed corticosteroid eye drops, and proceeded to give a sub-tenon’s injection of 0.5ml depomedrol under local anaesthesia in the lower outer corner of the left eye. The patient felt minor pain with the local anaesthetic injection but felt excruciating pain with the depomedrol injection. Within seconds a black spot blocked the central vision in the left eye. The spot expanded rapidly until the vision was completely lost. Mr R continued injecting till the full dose was given. On examining the left eye Mr R found that the eye was filled with fluid – he arranged a follow-up consultation the next day.

Ms J called later that afternoon to ask if she could see Mr R immediately but was advised to return the next day. Ms J chose to see another ophthalmologist who diagnosed a localised retinal detachment and referred her to a retinal surgeon, who performed surgery eight hours later. The retinal detachment was caused by two needle punctures penetrating the eyeball and injecting depomedrol into the eye instead of the intended sub-tenon’s space. She underwent surgery to repair the retinal detachment and remove the intraocular drug but complete removal of the steroid was not possible.

Postoperatively, the retina was flat, but scattered retinal hemorrhage and macular nerve fibre layer oedema was noted. About three weeks later, Ms J developed an inferior retinal detachment, epiretinal membrane and retinal necrosis. She underwent further surgery to remove the epiretinal scar membrane and correct the retinal detachment. Her intraocular pressure was raised postoperatively but was controlled with medical treatment.

The iritis subsided, the intraocular pressure normalised and the remaining subretinal steroid dissipated completely within three months. Her final visual acuity was hand movement in the left eye and 6/6 in the right eye. The left eye remained painful and uncomfortable. Ms J had difficulty with near work and computer work, suffered eye strain and easy fatigue in the right eye and experienced frequent headaches and imbalance when walking downstairs.

She was assessed as having 20% impairment of vision and 20% impairment of the whole person, with 50% loss of capacity. She also developed depression and was under the care of a psychiatrist. She returned to work six months later but, due to mental distress and intense eye pain, she had to work part-time in a less intense position, and with a lower salary.

Ms J made a complaint and a civil claim. The claim was indefensible and was settled for a substantial sum.

Learning points

- Ample guidance is available through professional bodies and the scientific literature on the management of common eye conditions. Periocular corticosteroid is not indicated for uncomplicated anterior uveitis. Where topical corticosteroids are ineffective, a sub-conjunctival injection of a short acting corticosteroid may be considered. Mr R chose the wrong primary method of treatment, the wrong injectable drug and the wrong route of injecting the drug.

- Periocular injections carry a risk of globe penetration that is much higher in myopic eyes. The records showed no evidence of discussion of indication, risks or alternatives. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. Guidance on the principles of taking informed consent is available in a number of different countries.

- Mr R failed to discontinue the injection when the patient had severe pain and loss of vision. Even though the globe had been injured, the extent of damage may have been reduced had he stopped immediately. Immediate exclusion of a penetration either by ultrasound or by clinical examination is mandatory when patient symptoms suggest globe penetration. Failure to do this established a breach in the duty of care. Early diagnosis and referral for emergency intervention may have reduced the extent of the irreversible damage.

- Adverse outcomes and complications are part of a doctor’s working life. Responding to these events in a timely manner, showing respect, being open and communicating honestly help to reduce the impact of these events on both the patient’s wellbeing as well as the doctor’s professionalism.

- A patient can withdraw consent at any time during the procedure. When pain is not what you expect, it is good practice to stop and reconsider your treatment.
Rash decisions

Mr M, a 56-year-old clerical worker, developed severe pain in his left foot and made an appointment to see his usual GP. Dr P. Dr P knew him well, having diagnosed Mr M with chronic kidney disease several years earlier, and supported him when he suffered a stroke. Dr P suspected he was suffering from gout on this occasion and prescribed diclofenac, with omeprazole cover, since he was also taking aspirin.

Less than a month later, Mr M's symptoms deteriorated and he requested a telephone consultation with his consultant. Dr P arranged for him to have a further prescription issued for diclofenac and omeprazole, and organised blood testing with the nurse to monitor his renal function.

A further month after attending for bloods, Mr M attended his follow-up appointment with Dr P, where he was advised that the blood tests had confirmed gout, alongside the ongoing chronic kidney disease. He was commenced on allopurinol, with the advice that he should double the dose of this after ten days of treatment.

A fortnight after commencing the new medication, with Mr M now on 200mg of allopurinol, Mr M started to feel unwell. He initially reported nausea and a small itchy area on his torso. Over the next few weeks, a similar rash began to appear on his face. He used calamine lotion without success, and eventually returned to see Dr P for advice.

Dr P concluded that the rash was likely to be secondary to a viral illness, and antihistamines were prescribed. That night, the rash seemed to be getting worse, so Mr M consulted with Dr P again the very next day, and a course of prednisolone was commenced. The allopurinol was briefly stopped. The patient was advised to continue taking it at a dose of 200mg daily.

The situation continued to deteriorate and Mr M had two further appointments with Dr P over the course of the next week. His steroids were increased, and when this failed to improve symptoms, Dr P suggested the allopurinol should be discontinued. To complicate matters further, Dr P forgot to document the second consultation since he had a busy surgery. Three days later, Mr M developed generalised swelling, throat discomfort and difficulty breathing. Dr P spoke to the patient over the telephone and advised he was likely to be suffering from thrush.

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Dr P realised at this stage he had failed to document his previous consultations so made some brief notes, without indicating he was doing this retrospectively.

Learning points

- The basics can sometimes be overlooked – an apparently trivial rash, as in this case, can herald a more serious condition, which reflects the need for joined up thinking.
- Clear and contemporaneous note-keeping is essential and this case highlights the importance of adequate documentation. Clinical notes are legal documents and any alterations or retrospective entries should be clearly marked and dated. Alteration of medical records is a probity issue.

A brain-damaged baby

Mrs N was admitted for induction of labour at a gestation of 38 weeks. Mrs N had requested induction as she was feeling very tired. Antenatally, there had been no concerns over mother or baby. A cardiotocograph (CTG) was normal. As the cervix was unfavourable, Dr L inserted 1mg prostaglandin gel into the vagina. Dr L asked the midwife to commence continuous fetal heart rate monitoring. However recordings were not documented at regular or consistent intervals.

Six hours later, Mrs N was not in labour and the cervix was still unfavourable. Dr L inserted a second prostaglandin gel. Two hours later, Mrs N was in labour with the cervix 3cm dilated. The membranes were artificially ruptured after five hours, after which labour progressed rapidly, resulting in a normal delivery within two hours.

During the induction process and labour, the fetal heart was monitored electronically using a CTG.

The baby was born in poor condition with low Apgar scores and transferred to the neonatal intensive care unit.

Mrs N developed a primary postpartum haemorrhage due to an atonic uterus, which failed to respond to medical intervention. The bleeding was so severe that Mrs N needed a laparotomy and ligation of the internal iliac arteries, which successfully arrested the uterine bleeding.

Analysis of the baby’s blood shortly after birth revealed metabolic acidosis consistent with intrapartum hypoxia. Unfortunately, the baby developed seizures and investigations revealed hypoxic ischaemic encephalopathy. The child now developed severe spastic cerebral palsy.

A claim was brought by Mrs N. The experts were critical of the monitoring of the fetal heart rate both during the induction phase with prostaglandin, as well as during labour. There was a combination of inadequate fetal heart rate documentation and inaccurate interpretation by the midwife. The CTGs were incorrectly interpreted as normal when they were actually pathological. Allowing labour to continue, rather than performing a caesarean section, led to intrapartum asphyxia and the resultant brain injury. The obstetric expert was also critical of the poor documentation on the CTGs, with a failure to record the date and time, or contractions in some instances.

There was no criticism of the management of the postpartum haemorrhage.

The case was settled for a high sum.

GM
Paraplegia after spinal surgery

Mr A, a 50-year-old engineer, was referred to Dr Z, consultant neurosurgeon, with increasingly severe back pain and additionally pain and weakness in his right thigh. Mr A had required high doses of opiate analgesia for pain relief and had been unable to work for several months prior to the consultation.

An MRI scan was organised, which demonstrated severe spinal stenosis at the level of T11/T12. Dr Z advised the patient that the spinal stenosis should be decompressed and that the symptoms in his right leg were related to meralgia paraesthetica, which could be dealt with at the same operation. Mr A underwent posterior discectomy of T11/T12 and decompression of the right lateral cutaneous nerve of the thigh.

Postoperatively Mr A complained of pain and weakness in the left leg and thigh and loss of movement in the right leg. A further MRI scan demonstrated a haematoma at the level of T12. Despite further emergency surgery by Dr Z, there was no improvement in Mr A's lower limbs and three weeks later he was transferred to a long-term rehabilitation unit. After a further three months Mr A was eventually able to return home. He had control of his bladder and bowel, could stand with help but was unable to walk and was no longer able to work.

Mr A commenced legal proceedings against Dr Z, citing inadequacies in informed consent: specifically that Dr Z failed to warn him that the procedure carried the potential risks of severe neurological complications. It was also alleged that Dr Z was negligent in carrying out the thoracic spinal decompression, with particular regard to the posterior transdural approach that he used.

It was evident from the notes and consent form that there was no documented discussion regarding any risk of neurological deficit relating to the operation and Dr Z acknowledged that he had not discussed such potential complications with the patient. A series of up-to-date independent neurological examinations and tests on Mr A demonstrated features entirely consistent with a spinal cord injury at the level of T12, in keeping with surgical trauma from the operation carried out by Dr Z.

Several expert neurosurgeons, commenting on the case, agreed that the posterior transdural approach employed by Dr Z for removal of a central thoracic disc protrusion had a much higher risk of spinal cord injury compared to the preferred anterior approach, as this would have posed less risk of serious neurological injury. They concluded that Dr Z's procedure was not supported by the modern neurosurgical literature, was not the standard surgical approach and fell short of what would be considered reasonable spinal surgical practice. The case was not defensible and settled for a substantial sum.

SD

Learning points

- It is important to have a valid indication for induction.
- A CTG is a tool to monitor the fetal heart rate both during the antenatal period and during labour. In labour it is also used to monitor uterine contractions. The fetal heart rate (FHR) has a number of features that must be examined to allow proper interpretation. There are different levels of abnormality of the FHR. An intrapartum CTG classified as pathological requires urgent intervention.
- Training in CTG interpretation and regular updates should be mandatory for all healthcare professionals working in obstetric units.
- Misinterpretation of CTGs and failure to act on abnormal CTGs are cited as major factors in maternity claims in the United Kingdom. Between 2000 and 2010, "CTG interpretation" was the second most expensive category in terms of claims by value at over £466 million – Ten Years of Maternity Claims – An Analysis of the NHS Litigation Authority Data (October 2012).

Learning points

- With any operation it is important to have a detailed discussion with patients regarding the potential for complications, so that they can make a balanced decision as to whether they wish to go ahead with the procedure. The discussion should include common/minor side effects as well as rarer, serious adverse outcomes that can produce permanent disability or death.
- Discussions with patients should always be thoroughly documented. Statistically, decompressive surgery of the thoracic spine has the highest risk of neurological complications, compared to decompressive surgery of the cervical and lumbar spine, given the size of the spinal canal relative to the spinal cord and the spinal cord’s relatively poor blood supply in the thoracic spinal canal. It would be expected from the reasonable spinal surgeon to mention the risk of a significant neurological deficit from surgery in this region.
- Clinicians are obliged to keep up-to-date in their field and undertake procedures that are recognised as standard by their peers with acceptable outcomes. Clinicians additionally need to demonstrate evidence of continuing professional education as part of their appraisal processes.
Stumbling block

Mr G was a 52-year-old school headmaster. His lifelong enjoyment of sports was becoming more difficult due to increasing pain from his left knee, although there was no injury or trauma to account for it. His GP, Dr M, initially referred him to a physiotherapist with only temporary improvement. Eventually Mr G asked to be referred privately to a specialist and was referred to Ms S.

Ms S assessed the knee thoroughly. The pain originated in the anterior aspect of the knee around the patellar tendon. There was no history of locking, swelling, or giving way. On examination, the only abnormal finding was mild tenderness along the medial joint line. X-rays revealed small osteophytes around the patella, but normal joint architecture and no other abnormality. An MRI scan of the knee revealed mild degenerative change of the medial meniscus, with no tears, and mild arthritis of the patellofemoral joint.

Mr G was keen to have this treated, so Ms S offered him an arthroscopic assessment and lateral release of the patella. This was performed under general anaesthesia, which was administered by Dr H. After induction, but prior to surgery, Dr H placed a femoral nerve block to provide postoperative pain relief. Dr H did not document any discussion about the block beforehand, nor Mr G’s consent.

Mr G seemed to recover well and was discharged home the following day. At his ten-day follow-up visit to Ms S, he complained of pain in his heel. Ms S recommended physiotherapy and made a plan to follow Mr G up in two weeks. At this visit, the heel pain had settled, but Mr G was experiencing giving way and locking of the knee, as well as numbness and burning pain in his thigh. Ms S noted marked wasting of Mr G’s left quadriceps, and documented he was barely able to perform a straight leg raise. She referred him for electromyography, and commented that she could not think of any reason why a knee arthroscopy would be associated with quadriceps wasting.

Neurophysiologist Dr R performed EMG studies of Mr G’s lower limbs, which revealed an isolated left femoral nerve lesion. Dr R commented that she could not initially identify a cause for the lesion, but speculated that a femoral nerve block might be responsible. She found documentation of Dr H’s block in the anaesthesia chart, and ascribed the nerve damage to the block.

Twelve months later, Mr G had no recovery from his injury. He had almost complete loss of function of the femoral nerve, and experienced difficulty climbing stairs, rising from a sitting position, and walking even short distances. He was required to use a lockable knee brace. As a result of his symptoms, he had been unable to continue working.

Mr G brought a claim against Dr H, in which he alleged that Dr H had not discussed the femoral nerve block with him, and had not sought his consent. Mr G said that he would not have agreed to undergo the block. Ms S had not known at the time of surgery that a block had been performed, and did not see it being placed.

Dr H’s technique was also criticised. He had used a 25mm blue needle to perform “fan infiltration lateral to the femoral artery using a continuously moving needle technique”. Several of the experts concluded that the nerve had been severely injured by this technique.

Dr H’s failure to obtain informed consent for the block, and his questionable technique, were considered indefensible. The case was settled for a substantial sum.

Learning points

- An important point in this case was the informed consent. Dr H asserted that he had discussed the femoral nerve block with Mr G beforehand, but failed to document any discussion. Consent given by the patient for general anaesthesia does not imply consent to undergo other types of anaesthetic intervention while anaesthetised; for example, a regional nerve block. Where extra procedures are required, their specific risks and benefits should be discussed with the patient, and consent obtained to perform them. These discussions need to be documented.
- Dr H was criticised by the experts for his use of an outdated, unsafe technique. There are several readily-available techniques to make regional blockade safer, including performing the block awake, or the use of a regional block needle, a nerve stimulator, or an ultrasound probe. Ultrasound, in particular, has revolutionised the safety and efficacy of therapeutic nerve blockade.
- Dr H also failed to communicate his block to Ms S. Although it did not affect the outcome, had Ms S known about the femoral block, she may have caught on sooner. The surgeon and the anaesthetist should each know broadly what the other is doing at all times. Dr H should have documented more carefully.
- The WHO surgical safety checklist is a useful tool. Visit: www.who.int/patientsafety/safesurgery/ss_checklist/en
An unavoidable amputation

Mrs N was a 26-year-old researcher with a four-year-old daughter. She enjoyed dancing and went to a salsa class with her husband each week. Her right knee was slightly painful so she missed a class to see if it improved but it got gradually worse over the next few weeks.

She made an appointment with her GP, Dr B, to discuss her knee pain and seek his opinion on a skiing holiday she had booked. His notes commented on her right knee pain which was “possibly due to dancing”. He documented some tenderness over the tibial insertion of the medial collateral ligament. He noted that the joint was stable and that there was no effusion. Dr B prescribed diclofenac and explained that he felt her skiing holiday did not need to be cancelled, but that it may not help matters.

Mrs N enjoyed her holiday but was becoming aggrieved by the knee pain, which was troublesome most of the time and when dancing. She saw Dr B and explained that the pain had been ongoing for four months with no improvement and that she couldn’t remember any specific injury. Dr B documented the history and referred her to physiotherapy. His completed musculoskeletal referral form did not highlight any red flags including intractable night pain, weight loss, systemic illness or previous history of cancer.

While she was waiting for her physiotherapy appointment Mrs N rang the surgery again asking for a GP appointment. This was the first appointment she was given with Dr G. Mrs N explained that she had not taken the diclofenac because she was nervous about possible side effects and she felt the pain was getting worse. Dr G’s records stated “history as above” and also noted that there was no locking or giving way. His examination notes were thorough. He documented that she was able to weight bear, that there was no swelling and that the knee was stable with a normal range of movement. He noted mild tenderness medially. He encouraged her to take the diclofenac and to rest, ice and elevate the knee. He advised buying a tubigrip to offer some compression to the knee. He gave safety-netting advice: asking her to return if things got worse while waiting for physiotherapy.

Mrs N saw the physiotherapist, Mr Y, who noted her four-month history of gradual onset knee pain. He recalled the patient saying that the pain intermittently flared. His examination noted a limping gait and an inability to extend her right knee fully due to pain. He noted slight swelling and that the knee was very warm to touch. McMurray’s test was positive. Mr Y’s initial thoughts were an injury, mono-arthritis or cartilage damage. He advised a review after two weeks of anti-inflammatory and ice. At the review it was noted that there was swelling most days and the pain was worse. Mr Y was concerned that there was an inflammatory cause and suggested inflammatory marker blood tests through Mrs N’s surgery. These were found to be normal but Mr Y referred her to a consultant rheumatologist because her knee was still hot and swollen with no obvious cause.

Mrs N was seen urgently in the rheumatology clinic. Blood-stained fluid was aspirated and an x-ray arranged. The x-ray reported “possible tumour” and a subsequent MRI scan and biopsy confirmed the diagnosis of osteosarcoma of her right tibia.

Mrs N sustained a tibial fracture and was given chemotherapy. She struggled with nausea and fatigue and was devastated when she was told that she needed an above knee amputation because the tumour was aggressive and had not responded to chemotherapy. She later had a prosthesis fitted.

Mrs N was extremely upset and made a claim against Dr G. She felt that there had been a delay in the diagnosis of her tumour and that earlier diagnosis could have saved her leg from amputation. Mrs N claimed that the first time she had seen Dr G, she had complained of severe pain in the day and night and that the knee was hot and swollen at that time.

Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given.

Learning points

- Although the patient’s circumstances were very tragic, this did not equate to negligence.
- This case reflects the importance of strong expert opinion. The successful defence hinged around the experts’ opinion.
- Good note-keeping is important for good medical practice and essential in defending a case.
- If a patient attends multiple times with the same problem, alarm bells should start ringing. It is useful to stop and think “what could I be missing?”
- Always try to exclude the worst case scenario. It is useful to document the absence of red flags.

Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given.
Mr P, a 40-year-old office worker, had a long history of sino-nasal problems, and had even had a previous septoplasty operation. Soon after returning from a holiday, he consulted his GP, Dr A, with worsening blockage in the left side of his nose. Dr A saw a polyp on this side and referred Mr P to ENT surgeon Mr E for his opinion.

Soon after this, however, Mr P was admitted to hospital with some breathing problems and sinusitis, and was extensively investigated. These investigations included a CT scan of his sinuses. During this admission, he was seen by Mr E, who also identified the polyp, and a number of other problems on the scan, which he felt would benefit from some endoscopic sinus surgery. Mr P was discharged from hospital and an ophthalmology opinion was arranged for a few days later. This confirmed an orbital haematoma and some limitation of movements, but no evidence of alteration to visual acuity.

A second ophthalmological opinion was requested some months later when the symptoms of double vision did not settle. In addition, Mr P described symptoms of dizziness and discomfort in the affected eye. This limited his ability to drive and rendered him unable to work. Sadly, no curative interventions were available. Varifocal lenses were suggested to try and help Mr P with his vision, along with the hope that things might improve further with the passage of time. More positively, his chronic sinus problem appeared to have been successfully addressed.

Expert opinion determined that the breach in the lamina papyracea and the subsequent orbital haematoma had been the cause of Mr P’s visual problems, by limiting the movements of the superior oblique muscle. This is a rare but well-known complication that can happen even to experienced surgeons. Expert opinion found a breach in the standard of care around the process of consent. Mr E did not appear to explain that the surgery was for quality of life and therefore not essential, or that ongoing medical treatment was a therapeutic option. Nor did he specifically warn Mr P that orbital damage might result in impairment of vision, including diplopia.

The case was settled for a substantial amount.

Learning points

- Informed consent must involve an explanation of the role of medical treatment, or no treatment at all, rather than just surgery, in non-life threatening medical conditions. In this case, Mr P’s chronic sinus condition might have been controlled with steroids and antibiotics.
- The consent process must also include details of the consequences of a complication, not just a general mention of possible adverse events.
- This case is a reminder that even in what might be considered simple or straightforward surgery, significant problems or complications can, and still do, occur.
- MPS’s free workshop for members, Mastering Shared Decision Making, shows how the shared decision making model is an effective way to ensure that patients make appropriate and informed choices about the treatment options available to them. For more information visit the Education section of the MPS website.
Mr K, a 37-year-old self-employed businessman, consulted his GP, Dr P, requesting sterilisation. Mr K stated that although he had two children, aged 17 and 9, he wished to undergo a vasectomy. Dr P explained to Mr K that the procedure was irreversible, and Mr K stated he still wished to go ahead and to use his private insurance. Hence, Dr P referred Mr K privately to a consultant urologist, Mr S.

The patient saw the urologist and was subsequently listed for a vasectomy. Mr S then carried out the procedure under local anaesthesia, with no immediate complications. A few days following the procedure, Mr K noticed some weeping from one of the wound sites, and attended Dr P, who prescribed him a course of antibiotics. By the end of the seven-day course, the situation had worsened with increasing weeping at the wound site as well as pain both at the wound site and in the testis and groin on that side; Mr K thus attended the Emergency Department (ED).

On assessment there his pain was reported as 10/10 and constant, thus not allowing him to sleep, despite oral paracetamol. He was discharged with co-codamol. Four days later Mr K attended a different ED and a diagnosis of post-vasectomy haematoma was made, and Mr K was again discharged with yet stronger analgesics. The following day the patient saw Dr P again and was advised to take a week off work. Things did not improve and the patient called Dr P the following day to see him at home, and was then subsequently admitted to hospital with a diagnosis of infected hydrocoele/haematoma.

After hospital admission, the wound burst and the patient was taken to the operating theatre where the infected haematoma was drained. Two days later the patient was discharged home, and subsequently reviewed four weeks later in outpatients by Mr W, consultant urologist, who discharged him from further follow-up.

Mr K alleged breach of duty due to lack of informed consent on the part of Mr S. As the complication was handled appropriately and is a recognised complication of vasectomy, no issue of technical incompetence by Mr S was alleged. The claim thus solely related to a lack of informed consent; specifically, Mr K alleged that Mr S did not warn him before he consented about the possible complication he subsequently suffered.

Mr K stated that he was uncertain about whether to go ahead with the vasectomy and if he had known about the potential complications, he would not have undergone the surgery.

The signed consent form was the key piece of evidence in this case. Mr K used a standard form of consent, but one in which all complications were not printed, and thus Mr S handwrote the complications of pain, bleeding, bruising, haematoma and infection at the bottom of the form. It was alleged by Mr K that Mr S did this after the claim was filed, and thus that Mr S doctored the consent form days after the procedure. This was proven to be untrue as a copy of the consent form was sent to Dr P with a letter stating these complications had been explained, on the same day as the initial consultation.

Dr P confirmed that Mr S did not have access to Mr K’s files after the procedure and thus could not have amended the consent form at a later date as alleged. Also, Mr S had a practice nurse sitting in during the consent procedure and she reiterated the complications to Mr K as well herself after the initial consultation, and this practice nurse confirmed that the consent procedure by Mr S was thorough and complete. The claim was therefore discontinued and costs were recovered from the claimant.

Learning points

- This case illustrates one of the commonest reasons for litigation against doctors, and especially surgeons; that of issues of consent before a procedure. It is not uncommon for a patient to feel happy to proceed for a surgical procedure at the time of the procedure, but then to feel unhappy with that decision to proceed when he suffers a well-accepted complication.

- Vasectomy is one of the most litigious procedures for urologists, although it is one of the simplest operations within that specialty. The procedure is typically day case and under local anaesthesia, taking an average of 20 minutes. However, the pre-procedure consent process and consultation typically lasts longer than this. Having copies sent to the patient’s GP and having a nurse during the consultation further safeguards against litigation.

- When surgeons operate on patients in the private sector and their complications are then managed by different doctors in the public sector, patients can often feel aggrieved at the operating surgeon who is now ‘nowhere to be seen’. Good communication between all doctors involved in such situations can facilitate the optimal management of the patient, and thus lessen the risk of future litigation. This case provides a valuable lesson: however straightforward and routine the surgery might be, proper documentation is vital.

- There were two missed opportunities to intervene here. The patient was left unhappy and aggrieved.

- The surgeons should have given their contact details and been responsible for the follow-up arrangements.
A weekend of back pain

This case occurred in the United Kingdom and details procedures and organisations specific to the country.

Mrs P was a 42-year-old housewife who lived with her husband, daughter and their first grandchild. She had suffered with chronic lower back pain for many years, which was helped by regular paracetamol. She had struggled with flare-ups over the years, usually after gardening or lifting the shopping. Symptoms always settled within a few days with co-codamol or ibuprofen prescribed by her GP.

Mrs P had been looking after her granddaughter and had lifted her rather awkwardly into the car. This aggravated her back so she took some co-codamol she had at home from the most recent flare-up. When this failed to relieve the pain, she made an appointment with her GP. She was unable to lift her granddaughter because of pain in her lower back. She prescribed ibuprofen and arranged a follow-up appointment in a week. She referred her to physiotherapy because of the frequent exacerbations.

Her pain became more severe through the week. She took the co-codamol and ibuprofen but couldn’t manage the pain. By the Friday evening she was in tears and her husband suggested she ring the out-of-hours GP service. She was put through to a triage nurse who noted her history of long-standing back problems and worsening pain. The nurse advised Mrs P to keep mobile and to see her GP again after the weekend but her husband demanded that she saw a doctor that evening. The nurse documented that she “would like to see a doctor for stronger meds” and made her an appointment to see the out of hours GP, Dr M, that evening.

Dr M reviewed the triage nurse’s history, in particular the lack of any noted red flags. He documented that she had complained of pain over the coccyx area and that she had claimed she could not sit or lie down due to pain. He therefore examined her standing and noted an absence of spinal tenderness except over the coccyx. He prescribed some dihydrocodeine to help her manage the pain and asked her to ring back if the situation worsened.

On the Sunday, Mrs P became anxious because she felt completely numb at the bottom of her back. She rang the out-of-hours service again and spoke to a triage nurse. She explained that she “felt so numb she couldn’t feel the toilet seat beneath her and that she couldn’t feel the passing of water”. She was also very embarrassed but mentioned that she had been dribbling urine without being aware of it. She explained that despite taking the dihydrocodeine she had developed severe pain at the back of her right leg and near her ankle. She wondered if the dihydrocodeine had constipated her because she was unable to open her bowels. The nurse documented the history and advised her to see her own GP in the morning and to keep the physiotherapy appointment that was pending the following week. She gave her advice on taking senna and lactulose for the constipation.

Mrs P had a dreadful night. She couldn’t sleep because of the pain and when she tried to walk to the toilet she noticed that her right leg felt “floppy” and that she could not feel the floor with her right foot properly. Her husband took her straight to her own GP surgery on Monday morning. Her own GP took a history and examined her, documenting an absent ankle reflex, a straight leg raise which was reduced on both sides and weak anal tone. He diagnosed probable cauda equina syndrome and arranged for an urgent assessment with orthopaedics.

His referral letter stated that she developed the numbness and the voiding difficulties the day before.

The orthopaedics team saw her the same day, also noting that her symptoms suggestive of cauda equina had started the day before. They catheterised her due to retention and

Learning points

- Doctors should record the particular red flags that are absent – it is important to record both relevant positive and negative findings in the history and examination.
- When a healthcare team experiences such an incident where a patient has suffered a considerable harm as a result of a delay in diagnosis, the team should conduct an SUI – serious untoward incident – review. The team should get together and see what lessons can be learnt to prevent similar incidents happening again. There may be issues, for example, for the out-of-hours (OOH) centre – e.g., the triaging by the nurse – was she working to a script? In which case the script might be at fault. If so, it might need reviewing.
- Nurses/ GPs working in OOH needs to be appropriately trained and qualified.
- In such cases, the danger for the patient’s registered GP is that with a long-standing back problem he needs professional discipline to ensure that he or she repeatedly checks his patient is also aware of what the red flag symptoms are. It is all too easy with chronic back pain patients to simply focus on analgesia control, rather than what to look out for and contact the doctor urgently about.
- Surveillance is a useful and legitimate tool that MPS can use to strengthen the defence of a claim.
- Doctors should keep clear, accurate, and legible records. It is important to keep contemporaneous notes. The defence in this case was partly based on dates and times of symptoms recorded in the medical notes.
- Remember that referral letters add to consultation notes. They contain important clinical and medicolegal information and should be copied in patients’ medical records. This case was defended partly on information written in referral letters.
- Although Dr M was not criticised, it is still a useful reminder that doctors should take and document their own history from a patient and not rely on someone else’s account.
- This case illustrates that the claimant also runs a litigation risk when pursuing a claim. The general rule in litigation is that all claimants and all defendants are jointly and severally liable for all costs awarded against them.
arranged an MRI scan of her lumbar spine. The MRI showed a massive L4/5 disc prolapse causing severe central canal stenosis and also impinging on the traversing right L5 nerve root. Mrs P subsequently had an L4/5 decompression and discectomy and partial L4/L5 laminectomy. After the surgery, Mrs P was seen in the spinal clinic. She had no true urinary incontinence following the retention although she still had some difficulty in assessing when she had finished passing urine. Fortunately she had full control of her bowels. She was still upset about worsening right leg pain, which was severe. Mrs P made a claim against the out-of-hours service, firstly against the nurse for failing to triage appropriately and secondly against the GP, Dr M, for failing to recognise and promptly refer her cauda equina syndrome. She claimed that she had had the cauda equina symptoms on the Friday that she consulted Dr M.

MPS sought the opinion of a GP expert who was not critical of Dr M’s consultation on the Friday evening. The triage notes did not indicate any problems with new symptomatology, specifically no mention of any development of radiation of the pain, altered sensation or problems with micturition and bowels. It was agreed that the limited examination in the absence of these symptoms was reasonable. It was also considered that Dr M’s prescription for stronger analgesia was effective since the patient did not contact a doctor the following day. It was, however, agreed that the triage nurse was in breach of duty on the Sunday when she recorded red flag symptoms and failed to pass the call onto a doctor.

Mrs P’s contemporaneous medical records were analysed carefully. It was agreed that the major deterioration in her condition occurred on the Saturday. Dr M’s records, the GP’s referral letter to orthopaedics and the orthopaedic team’s records all contradicted the claimant’s account and indicated that she did not have symptoms of cauda equina syndrome at the time of consulting Dr M.

MPS represented the out-of-hours provider and the claim was settled with respect to the triage nurse’s breach of duty. Dr M, however, was successfully defended and not found liable. Mrs P was seeking very substantial damages because she alleged that she could no longer live in her current home and needed to move to a specially-adapted bungalow. She claimed she needed an electric scooter, could not walk unaided, and that she needed constant care both day and night. MPS engaged a surveillance firm to observe the claimant. Over a period of time they assimilated evidence: photographing the claimant carrying a young child, picking up and moving boxes, folding a child’s buggy against her leg, walking without any aids, and carrying a basket of heavy shopping with one hand and waving with the other. The claimant’s legal costs were being paid by public funding. MPS wrote to the Legal Service Commission regarding the evidence and funding was withdrawn. The claim was originally for damages in excess of £2 million but was settled for a fraction of that amount.

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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 5AE, UK. Email: casebook@mps.org.uk

Suspected epilepsy: when to warn

It was stated in “Suspected epilepsy: when to warn” (Casebook 21(2)) that “there was nothing in the notes to suggest the hospital intended to rule out anything serious, like epilepsy”. Yet an EEG was arranged. I cannot conceive of a reason for EEG other than to rule out something serious – like epilepsy. The mere fact that it was arranged – isn’t it ample proof?

Moreover, presumably the patient’s parents were given the EEG appointment card or information before leaving the hospital; they then chose not to bring the patient for the EEG, without bothering to find out what the test was and what it was for. Don’t they bear some responsibility?

Dr Chun How Ooi, Singapore

Response

I agree with you that the statement you quote in your first paragraph is somewhat illogical. Regarding the parents’ responsibility, courts generally are reluctant to hold a patient – or in this case the child’s parents – as contributing to the negligent outcome. You can imagine the persuasive power of a parent saying: “Of course if I had been properly informed of what the test was for and why it was important, I would never have knowingly put my child at risk...” And the notes usually do not document the detail of such a conversation.

Many thanks for your interesting and thoughtful comments.

Two cases: one theme

Re: the articles on pages 20 (“A rash oversight”) and 21 (“A failure to monitor”), Casebook 21(2).

Two articles have a common theme. Patients in both cases sued their GP while the healthcare system and government policy neglected to ensure patient safety.

The healthcare industry should take steps to prevent chickenpox in pregnancy. We could have a national immunisation program [here in the UK] like that in the US (www.cdc.gov/vaccines/schedules/hcp/mz/child-adolescent.html). We could also check women for immune status at booking or preconception. As it is we rely on GPs remembering to follow a post-exposure prophylaxis protocol. Murphy’s Law applies so patients suffer and doctors pay, via indemnity subscriptions, to help clear up the mess.

Why does the healthcare system have us install a piece of electronics in a man’s chest without having a way to monitor it? The GP’s notes may have been poor but the responsibility for the device should rest with the company that made it and the clinic that inserted it. A cardiac pacemaker is a ‘mission critical’ device. If it stops the patient might die. In the case you describe recording the pulse or an ECG wouldn’t have given information about its activity over a period longer than a few seconds. There should be systems to ensure that it can’t fail without that failure being detectable in

When normal is wrong

In the section headed “Learning points”, it is written: “The failure rate of vasectomy, either due to failure to remove adequate sections of both vasa or recanalisation, albeit small, is of crucial significance, and must be mentioned and documented.”

Unfortunately, this sentence implies that removing an “adequate section” of vasa will prevent failure. Evidence from vasectomy randomised studies shows that the best way to prevent failure is to lightly cauterise the lumen of each vas and to separate the ends by a tissue plane. Separating the ends by a tissue plane but without luminal cautery is nearly as good. The older method of removing a long length of vas is associated with a higher complication rate (bleeding and pain) and higher recanalisation rate.

If any vas is removed then it should only be a small section, not an “adequate section”, as one has to remove a very long section to prevent end approximation and vasectomy failure. Removing very long sections is associated with an unnecessarily higher complication rate and also makes reversal much more difficult should circumstances change. The ideal vasectomy is minimally invasive, has minimal complications, is 100% effective and 100% reversible. No technique perfectly meets these criteria but the no-scalpel technique with fascial interposition and ideally with luminal cauter is the best we currently have.

Tim Hargreave, Consultant genito-urinary surgeon (retired), Current member, research review panel, human reproduction programme, WHO, Geneva. References have been supplied, and are available on request.
A case of renal failure

I found “A case of renal failure” (Casebook 21(2)) rather worrying. It states that Dr T was criticised for failing to notice that Mrs B’s renal function had not been rechecked.

Mrs B had been advised by Dr T to have her bloods rechecked but if she failed to do so, then that is her fault. I see between 36-40 patients a day but do not make a list of which patients have not had the blood tests that I requested them to have.

Is MPS suggesting that this is what we should be doing?

Secondly, the report mentions that the GP should have sent a urine for ACR. My understanding is that an ACR should only be sent for diabetic patients and non-diabetic patients should have a PCR sent instead.

Please do let me know if I am wrong in this regard.

Dr Muhammad Shabaz Sharif, Salaried GP, Leicester, UK

Response

We acknowledge the practical challenges of having a system that will pick up patients who do not return with results of tests that have been ordered – it is a frequent source of debate as to whether a court would invariably hold the patient totally responsible for the consequences; a court might take the view that patients are less likely to act in a way that puts them at risk, if they understand those risks. However, there was no excuse for the GP not to have checked her renal function at subsequent visits, and the results were so significant as to suggest that the GP could not have explained the importance to the patient.

Finally I am advised that most CKD guidelines advise annual ACR checks, on all patients with an eGFR under 60, regardless of underlying aetiology.

I hope that this addresses the issues you raised.

A rash oversight

I read with interest your case report regarding the patient who was given incorrect medical advice by non-medical staff (“A rash oversight”, Casebook 21(2)). I notice the doctor involved was criticised for “allowing administrative and nursing staff to provide negligent medical advice”. Although not knowing the full case, I assume that the doctor had no knowledge of his administrative staff giving such advice; so I wonder why the doctor is the subject of the claim and not the member of staff involved?

Secondly, with the increasing use of non-medical practitioners to cross-cover several specialties out-of-hours, who would be responsible overall for any errors in a patient’s management?

One example would be an error made by a member of the Hospital at Night (H@N) team on a surgical ward. The teams are not usually specialty-specific (as medical staff traditionally are) and the consultant responsible for the patient would not line manage the members of the H@N team or be involved in setting out their roles and responsibilities.

With this case report – and the increasing use of non-medical staff – I worry that when I am a consultant I may be deemed responsible for the erroneous actions of a member of staff I do not even know, purely as my name is above the bed.

Dr Callum Kaye, UK

Response

In the first case which took place in general practice, the GPs who employ practice staff are vicariously liable in law for their acts and omissions. And they would be expected as a matter of good practice to have systems and procedures in place regarding the scope of their responsibilities, as a safeguard against people acting outwith the scope of their knowledge.

It would be an unsuccessful defence for the GP to argue that they were unaware of what their staff were doing.

In the hospital setting, whilst each individual is personally responsible (as opposed to liable) for their own actions, any claim would be brought against the hospital, which is liable for the acts and omissions of its employed staff, as well as for any deficiencies in policy and procedure.

I hope that this clarifies the different situations.

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www.medicalprotection.org
Complications: A Surgeon’s Notes on an Imperfect Science
by Dr Atul Gawande (£8.99, Profile Books, 2008)
Reviewed by Dr Omar Mukhtar, ‘Darzi’ Fellow, Health Education South London (UK)

Complications: A Surgeon’s Notes on an Imperfect Science is a collection of essays focusing on the fundamentals and imperfections of modern surgery. With many originally written for The New Yorker magazine, where Atul Gawande has been a staff writer since 1998, the essays provide an honest insight into the world of modern healthcare that extends beyond the operating theatre and the consulting room – ultimately, affording readers an opportunity to reflect on the human condition itself.

Broadly grouped around three central themes – Fallibility, Mystery and Uncertainty – Gawande’s essays slowly dismantle the misconceptions held by the general public whilst challenging the status quo fostered and maintained by the medical hierarchy. He admits freely that medical professionals make mistakes, that much of the knowledge we hold so dear is based on a loose interpretation of facts (often acquired many years ago) and that we do learn ‘on the job’. He also acknowledges that there is much about the human body that remains stubbornly mysterious, that good doctors do go ‘bad’ and that there might be a case for super-specialisation from the outset of medical training.

Written with a clarity often lacking in ‘populist’ musings on healthcare, Gawande’s work draws not only on his experiences as a general endocrine surgeon at Brigham and Women’s Hospital, Boston, Massachusetts, but also on his experiences as a father. Equally, many of the essays make reference to the scientific literature without resorting to a dry recall of facts, in a manner that must be applauded – regardless of whether they relate to the chronic pain of a stranger or the horror of a life-threatening respiratory infection afflicting his youngest child (born prematurely). That said, despite being a Rhodes Scholar who studied PPE at Oxford, Gawande’s observations tend towards the superficial cliche – perhaps a consequence of the immediacy required when writing for a periodical that is published 47 times a year.

Despite this, Complications has a charm, confidence and humility that you suspect is intrinsic to Gawande himself. The first of three books (the others being Better: A Surgeon’s Notes on Performance and The Checklist Manifesto: How to Get Things Right), you might not be wrong in assuming that it is Gawande’s personal testament to a quality and safety agenda that is only now taking root in certain countries – a decade after Complications was first published.

The Secret Anatomy of Candles
By Quentin Smith (£8.99, Troubadour Publishing LTD, 2012)
Reviewed by Dr Catherine Walton, CT3 Psychiatry, Wales (UK)

Quentin Smith has delivered a promising debut novel. The Secret Anatomy of Candles is a medicolegal drama with an ethical dilemma that will hook even the most world-weary of medics, and stir them to discuss the central themes with colleagues over coffee.

The ideas and questions raised by the novel are topical and relevant; for example, one important theme of the book is the MMR vaccine. The week I read the novel was during the time of intense media coverage of the measles outbreak in the Swansea area. So it was immediately relevant.

The world of Jasper Candle, a “ruthless compensation lawyer”, is set in the courts, bars and streets of Durham. The description of the city is excellent: Smith shows a flair for this, and it was effortless to conjure up the areas described in my mind’s eye.

The man himself, Jasper Candle, is a character of some depth, with the flaws and nuances one would expect of a successful lawyer of his standing. Unfortunately, the character is perhaps rather too typical – the flaws and nuances feel somewhat unoriginal. It is clear that Candle is troubled by a physical ailment, the development and diagnosis of which is essential to the plot. Unfortunately, as a medic reading this novel, the diagnosis became clear rather sooner than I feel the author would have hoped in order to maintain suspense through to the twist at the end.

However, having discussed the plot with family members, I feel that this would not have been so apparent to a non-medical audience. Other characters within the book are somewhat more intriguing. In particular, the investigator Lazlo is perhaps the most interesting. His clothes and ‘cheap’ piercings put him firmly in the lower class, but he shows understanding and insight into the feelings and motivation of his employer, Candle.

The plot itself is complex and several themes run in parallel. This would be confusing were it not for some skill on Smith’s part in keeping the chapters short and succinct. It also had the added benefit of keeping the pages turning. If I had any criticisms of the novel it was the use of cockney rhyming slang to add “depth” to Candle as a character – it felt unnecessary and at times plain out of place. I also think that sometimes Smith utilised long and challenging words and sentences, which over-complicated the style of the book.

Overall, I felt that this was a great read. The storyline is relevant, up-to-date, and made me think about certain issues from a different perspective; it is certainly one to consider for your next bedtime book.
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