Medical records
WHY POOR RECORDS CAN END YOUR CAREER
PAGE 10

The risks of laparoscopic surgery
HIGH CLAIMS ON THE RISE

One step at a time
HOW TO IMPROVE COMMUNICATION

120 years of MPS
LOOKING BACK AT THE MILESTONES
A new international conference focusing on quality and safety in healthcare, making a difference.

A conference addressing quality, patient experience, safety culture, cost and professionalism.

15-16 November 2012
Church House Conference Centre
Westminster • London

www.mpsinternationalconference.org
ON THE COVER

10 Medical records
Failing to keep accurate medical records can have grave consequences for your career.

7 The risks of laparoscopic surgery
An increase in the number of laparoscopic procedures has been mirrored by a rise in high claims – Sarah Whitehouse looks at the risks.

12 One step at a time
Dr Jagdeesh Singh Dhaliwal describes how a step-by-step approach can mitigate the risks posed by poor communication.

27 Questions for CPD
Earn three CPD ethics points by answering 20 medicolegal questions.

ALSO THIS ISSUE

4 Your MPS
In addition to MPS Medical Director Dr Priya Singh’s regular column, you can also explore MPS’s history as the organisation celebrates 120 years.

14 On the case
Dr Graham Howarth, MPS Head of Medical Services (Africa), introduces this issue’s selection of case reports.

15 Case reports
15 Oh by the way, doctor
16 A dangerous cough
17 Where is the consultant?
18 A normal appendix
19 A pain in the neck
20 Trouble behind her back
21 Suffer the little children
22 Too much bleeding
23 A friend in need

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

26 Book reviews
This issue, Dr Mike Baxter reviews If Disney Ran Your Hospital: 9 ½ Things You Would Do Differently, by Fred Lee, while Dr Rebecca Smith and Dr Chris Jones review The Wisdom of Whores: Bureaucrats, Brothels and the Business of Aids, by Elizabeth Pisani.

GET THE MOST FROM YOUR MEMBERSHIP

MPS
Visit our website for further Casebook issues, a wealth of publications, news, events and other information:
www.medicalprotection.org

Opinions expressed herein are those of the authors. Pictures should not be relied upon as accurate representations of clinical situations. © The Medical Protection Society Limited 2012. All rights are reserved.

ISSN 1740 0090
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.

GLOBE (logo) (series of 68) is a registered UK trade mark in the name of The Medical Protection Society Limited.

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

Cover: © 1joe/iStockphoto.com

Welcome

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

As this year marks 120 years since MPS was formed, we have provided an interesting account of our history on pages 4 and 5. Coincidentally, this year also marks the 20th anniversary of Casebook, and in keeping with the Casebook style we have published some excerpts from cases that MPS has been involved in over the years.

The 20th anniversary of Casebook is particularly significant because it represents a milestone in terms of the breadth of risk management advice and support that MPS now provides for members. I touched on the success of this material in the September 2011 edition of Casebook, after a survey of our members found that Casebook continued to play a key role in the safe practice of healthcare.

The range of benefits on offer to members now covers workshops, e-learning, conferences and lectures, while our suite of publications continues to be targeted at more specific areas of the MPS membership. This means that we can tailor our updates and advice to ensure you receive news that is directly relevant to your field of practice.

Reaching the 20th anniversary of publishing Casebook has reaffirmed to me the responsibility we have to protecting patient safety and in promoting effective risk management. I hope that this is a timely example of our commitment to supporting and guiding you in whatever way we can.

You can rest assured that we will continue to focus on ensuring our publications deliver medicolegal advice and support that is relevant, interesting and which you can rely on. As ever, please get in touch with any comments or suggestions; your feedback helps to shape our service to you.

Stephanie Bown
120 years of MPS

Over a century of service

MPS Medical Director Dr Priya Singh pays tribute to the cornerstone of MPS's longevity – quality of service to members

This year marks the 120th anniversary of the founding of MPS. These two pages look back at how MPS has responded to member needs and legislative changes over this period by adapting and transforming services to become the world's leading medical defence organisation.

It is this commitment to service that I believe is the foundation on which MPS has been built. From the very start, as the London and Counties Medical Protection Society, the ethos has been focused on putting members' needs first, reflecting members' values and ensuring a personalised, proactive and professional service.

MPS is committed to providing the breadth of assistance that anticipates members' needs throughout a career and an indemnity that offers the best possible protection from the costs of clinical negligence claims. Together with the security offered by MPS's financial strength, this is a potent combination that gives confidence that MPS will be there for you when you need us, with the voice to protect and promote the interests of members and the wider profession.

The development of education and risk management tools has been designed to help avoid problems occurring and the collective expertise of MPS is now available to members in an unparalleled range of publications, workshops, e-bulletins and conferences, reflecting more than a century of experience.

As a mutual, not-for-profit organisation, MPS is owned by and accountable to members; your subscriptions do not go to shareholders or commercial partners – the mutual fund is there to provide the best protection for you. This financial strength has enabled MPS to remain independent: here solely to meet members' needs long into the future.

On 1 May 1892 the London and Counties Medical Protection Society was formed. Sarah Whitehouse looks back at 120 years of providing indemnity for doctors.

In the 19th century, before medical defence organisations were established, local groups of doctors would subscribe to each other's legal costs to challenge defamation cases – in essence, working as local defence organisations. With membership costing around a guinea or less, this informal arrangement suited doctors whilst issues could be settled cheaply and easily. As legal costs and the value of claims began to rise, so too did the public's expectations of the medical profession. In 1858 the Medical Act laid down the basis for a minimum standard of medical education, leading to the formation of the General Medical Council (GMC).

Between 1910 and 1923 MPS handled more than 50 cases of libel, slander and "patients grizzling about their doctors".

Amidst this evolving medical backdrop, 1885 saw the birth of the Medical Defence Union, a national rather than local organisation. But the union’s turbulent early years, plagued by accusations of irregularity and lack of accountability to members, resulted in a breakaway group forming an alternative defence organisation; the London and Counties Medical Protection Society. The rest, as they say, is history.

Led by the surgeon Sir Jonathan Hutchinson and doctors George Heron, George Mead and Hugh Woods, the new society aimed to “support and safeguard the character...
of legally qualified practitioners and to advise and defend members when attacked. The society went from strength to strength. By 1894, the London and Counties Medical Protection Society had grown to 1,000 members – with an annual subscription rate of ten shillings. Premises were taken in Sloane Square, London, and Le Brasseur and Oakley were retained as solicitors – the start of a lasting association, as the firm’s successor, Radcliffe LeBrasseur, remains one of MPS’s panel law firms today.

Until 1910, MPS only bore its members’ own legal costs, which could cause serious hardship for members if there was an adverse outcome. In 1911, MPS purchased collective insurance for members, to fund adverse costs and damages up to £2,000 for any individual member and up to £20,000 in any one year, at an additional cost of ten shillings. By 1935, some hospitals and authorities had made membership of a defence organisation a compulsory pre-requisite to employment, which boosted MPS membership, and in 1939, MPS launched the Overseas Indemnity Scheme to afford protection to members practising outside the UK.

The “London and Counties” part of MPS’s title was dropped in 1947, but it was still affectionately referred to as “the London and Counties” by older members. With the advent of the National Health Service in 1948 and the Legal Aid fund in 1960, costs to members began to rise substantially, as did requests for assistance. In 1962, MPS introduced unlimited indemnity for overseas members, resulting in another substantial increase in membership. Schemes of co-operation were agreed with the Medical Defence Association of Western Australia, the Medical Defence Association of Tasmania, and the Trinidad and Tobago Medical Protection Society.

By 1985, MPS had established a general practice advisory board and had expanded its number of medicolegal advisers – dealing with more than 1,000 claims each year. The first £1 million claim was settled in the UK in 1986; a watershed moment in high claims. Faced with such spiralling costs, an NHS indemnity scheme was introduced in the UK in 1990 to assume the costs of claims against hospital doctors. MPS membership remained strong, however, to ensure that hospital doctors had access to advice and assistance for a range of medicolegal matters not covered by the scheme, and to provide cover for GPs. Today, MPS has offices in London, Leeds, Edinburgh, Brisbane, Wellington and Auckland; which provide assistance for more than 270,000 members in more than 40 countries, including the UK, Ireland, Hong Kong, Malaysia, New Zealand, Singapore, South Africa, and the Caribbean and Bermuda. MPS’s most notable presence outside the UK is in South Africa, where it has been active for more than 50 years.

In its 120th year, MPS has chosen to hold its first international conference – Quality and Safety in Healthcare: Making a Difference – which will bring together international experts from around the world to share their knowledge, experience and expertise on quality and safety. With an increasing focus on education and risk management, MPS looks set to remain at the heart of the medical profession for the next 120 years, responding to the needs of members in an ever-changing medicolegal climate. Further details of the international conference are available on the MPS website.

TIMELINE

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1892</td>
<td>1 May – London and Counties Medical Protection Society formed</td>
</tr>
<tr>
<td>1894</td>
<td>Sloane Square, London, office opens</td>
</tr>
<tr>
<td>1947</td>
<td>Name changes to Medical Protection Society</td>
</tr>
<tr>
<td>1947</td>
<td>First overseas scheme of co-operation (Medical Defence Society of Queensland)</td>
</tr>
<tr>
<td>1970</td>
<td>Leeds office opens in Park Square</td>
</tr>
<tr>
<td>1994</td>
<td>Leeds office relocates to Granary Wharf House</td>
</tr>
<tr>
<td>2007</td>
<td>Brisbane office opens (acquisition of Cognitive Institute)</td>
</tr>
<tr>
<td>2009</td>
<td>Edinburgh office opens</td>
</tr>
<tr>
<td>2011</td>
<td>Wellington office opens</td>
</tr>
</tbody>
</table>

In the early days, challenges to the medical profession would often arise from quackery. MPS members would act as decoy patients to try and catch those posing as doctors with weird and wonderful treatments. A group of “Hindoo Oculists” boasted of a cure for blindness by excising the ‘skin’ over the cornea. They were driven out after MPS brought a prosecution against them for falsely styling themselves as doctors.

In 1936, the first action was brought against the estate of a deceased doctor (Rubra Ats Connolly). Damages of £5,000 were awarded to the plaintiff and paid by MPS – the benefits of membership extend beyond the grave.
MPS defends doctors’ professionalism

MPS has played down suggestions that the rising cost of claims in South Africa is due to a decline in medical professionalism.

MPS figures have revealed a 132% rise in the cost of reported claims in 2011, compared to figures from 2009, causing concern at the HPCSA. Dr Kgosi Letlape, acting CEO at the time, told Business Day that a decline in the levels of professionalism was behind the increase in clinical negligence claims, and MPS has written to Business Day to outline the other factors behind the increase.

In the letter, Dr Graham Howarth, MPS Head of Medical Services (Africa), said that the cost of claims was down to heightened patient awareness and claimant lawyer attention. Dr Howarth added that the cost of patient care packages is also increasing, as technology improves, and this had a significant impact on the size of awards in clinical negligence cases.

www.businessday.co.za

EFFECTIVE HANDLING OF DIFFICULT INTERACTIONS

Dealing with difficult interactions with patients can be a significant cause of stress for doctors, yet the nature of most clinical jobs makes these encounters unavoidable. Approximately 15% of clinical interactions are classified by doctors as “difficult” (Hahn et al 1994, Jackson and Kroenke 1999). These types of interactions can induce a range of distressing emotions in both doctors and patients. They can also often lead to increased medicolegal risk.

To assist you in handling difficult interactions and avoiding the negative outcomes that may result, MPS will be launching Mastering Difficult Interactions with Patients, the latest in MPS’s “Mastering” series of communication skills workshops.

Mastering Difficult Interactions with Patients explores the causes of difficult interactions and provides techniques to handle these situations effectively.

Workshops will start becoming available in the second half of 2012. As a member of MPS you can attend free of charge as a benefit of your membership.

The following workshops are also available in the series:

- Mastering Your Risk
- Mastering Adverse Outcomes
- Mastering Professional Interactions

All of the workshops in the “Mastering” series are focused on minimising your risk of complaint and litigation through effective communication.

For further information and online booking, please visit: www.medicalprotection.org/southafrica/education.

ANC calls for openness in HIV policy

The African National Congress (ANC) is campaigning for new policies that say patients with HIV must tell their partners and their families about their condition.

The ANC says that the Department of Health and South African National AIDS Council should draft policy guidelines to this effect and implement the policy.

It believes such a policy would help the government collect reliable statistics on HIV infection rates, which would help it plan for future guidance and regulations. It says the policy would also help health authorities deal more effectively with epidemics and widespread outbreaks.

This forms part of a wide range of ANC policy proposals on education and health. www.timeslive.co.za

State hospitals to be managed by registered doctors

The government has announced that it plans to recruit only registered doctors to head up its state hospitals.

It says it will consider any doctor or dentist for the roles as long as they have a postgraduate qualification in public health or management and at least ten years’ managerial experience in the public sector. The salary on offer is thought to be around R1 million per year.

The government has also said that central hospitals will be responsible for delivering highly specialised care and will be linked to medical schools as training hospitals and for research purposes.

The new regulations mean provinces will no longer be responsible for outlining the job requirements for executive managers at the hospitals.

www.witness.co.za

NHI scheme to launch in two KZN districts

The National Health Insurance (NHI) scheme will be launched in two KwaZulu-Natal districts this year, according to the Premier of KwaZulu-Natal, Zweli Mkhize.

Mkhize said the government needs to focus on sorting out compliance matters from national, provincial and local government levels before the launch, as well as work on recruiting staff. He said it may be necessary to “fast-track” the training of nurses in order for enough nurses to be ready in time.

The two districts will be announced by Health MEC Sibongiseni Dhlomo. www.iol.co.za
The benefits of laparoscopic surgery are clear but when complications occur, they tend to be serious. In 2010, the highest laparoscopic surgery settlement MPS experienced was for more than R11 million, for a laparoscopic Nissen fundoplication with complications. Between one third and one half of all major complications occur at the time of surgical entry. Postoperatively, complications from otherwise successful laparoscopic procedures include incisional hernias, wound infections and/or haematoma and adhesion formation.

What types of claims are associated with laparoscopic surgery?
Patients make a claim against surgeons for a variety of reasons. Many claims arise out of or include an allegation of a lack of training. As with any clinical practice, it is important to act within the limits of your own competence and be able to prove that you are sufficiently qualified. In some instances, a laparotomy may be a more appropriate form of treatment, rather than a laparoscopy, and complications may arise as a result of the wrong choice of surgery. Make sure that it is accepted clinical practice to perform a certain procedure laparoscopically in cases similar to yours.

Claims may also be made because of a delay in recognising complications postoperatively. Such cases can be difficult to defend, particularly if the patient’s medical records do not document that they have been closely monitored and any deterioration in their condition managed in a timely and appropriate fashion.

Managing expectations
Managing patient expectations and ensuring that they are fully informed of the risks and benefits of laparoscopic surgery is essential. The HPCSA, in Seeking Patients’ Informed Consent: The Ethical Considerations, states that during the consent process, you should provide the patient with information including:
- “The purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure, including common and serious side effects.”

You must warn patients explicitly about the risks with laparoscopic surgery, says Dr Graham Howarth, MPS Head of Medical Services (Africa). “With laparoscopic surgery, patients go into theatre expecting small-scale surgery to take place, but if there are complications and the patient has to have a laparotomy, and they are not warned that this could be a possibility before the procedure, they could be left very shocked and make a claim.”

Although patients tend to think of laparoscopic surgery as minor surgery, it is major surgery with the potential for major complications – visceral injury and bleeding, injury to the bowel, or injury to the bladder. Something minor is enhanced by the fact that patients are usually discharged the following day, or sometimes even the same day as surgery.

Once all the relevant risks and benefits have been discussed, it is important to check back that the patient understands the procedure. A signed consent form does not in itself prove valid consent to treatment – the important factors will always be the quality, extent and accuracy of the information given beforehand. Make sure that discussions around patient expectations are reflected in the patient’s notes. Dr Howarth says: “If there are no notes, it is difficult to say that such a conversation has taken place.”
Postoperative vigilance and care

Often, technical problems that occur during a procedure may go unnoticed until a patient becomes seriously unwell. The Physician Insurers Association of America found in a study of laparoscopic cholecystectomy cases that a failure to recognise complications until after the procedure was reported in more than 70% of claims.¹

Failing to detect complications promptly is compounded by the fact that there often seems to be reluctance amongst surgeons to respond appropriately and/or efficiently when complications become apparent postoperatively.

Professor Leon Snyman, Associate Professor in Obstetrics and Gynaecology at the University of Pretoria, and an expert on gynaecological laparoscopic surgery, says: “Unlike a laparotomy, where patients should be seen to improve on a daily basis, in laparoscopic surgery they should be improving on an hourly basis.”

Time is almost concertinaed in laparoscopic surgery – improvements, and deterioration, in a patient’s condition happen quickly. It is important that you ensure the patient is monitored frequently, and this is recorded. If there is no note in the patient’s records of these checks, it makes defending a claim very difficult.

The complication itself may not be the result of a negligent act, eg, a perforated bowel, but if a surgeon adopts a wait-and-see approach, or sits on the problem and manages it with painkillers and antibiotics, this could result in a negligence claim. If a patient has been discharged and contacts their surgeon complaining of pain, they are often advised to take paracetamol, wait, and ring back if the pain persists into the next day. Often, this might be too late. The response may then have to be surgical – which often involves the big jump to a laparotomy.

When taking informed consent for a procedure, you should ensure that patients are educated about the possible risk of postoperative complications, and warned of the signs to look out for so that they know when to seek treatment once they have been discharged from hospital.

There should also be clear guidelines for the patient to know who to contact should there be a problem out of hours, so that they know to go to their surgeon rather than another doctor. This helps to ensure continuity of care.

Conclusion

While laparoscopic surgery has its many benefits, not least minimal recovery time, it is important to be aware of the risks, and ensure that the patient is fully informed about these prior to surgery. Careful management of patient expectations helps to ensure that they will be satisfied with the treatment given and are able to recognise quickly the warning signs of potential complications post-surgery.
Mrs F, a 45-year-old accountant, was referred to Dr M with a clinical history of biliary colic. An ultrasound confirmed the presence of several stones. Mrs F was fully consented for a laparoscopic cholecystectomy and booked in for surgery in five weeks’ time.

During the procedure, Dr M divided what he thought was the cystic artery and duct. He documented that inflammation was partially obliterating Calot’s triangle. Apart from this, the procedure was uneventful.

Mrs F was not eager to mobilise following recovery from the general anaesthetic, seeming generally listless and complaining of pain. The next day, she refused breakfast, saying she had no appetite and felt nauseous. Later in the day, she developed some respiratory symptoms with cough, moderate grade temperature and bilateral consolidation of both lung bases. Her condition then deteriorated very quickly and she became tachycardic and tachypnoeic.

She was transferred to ICU, where she was intubated and ventilated. Minimal yellowish fluid was noticed in her abdominal drain. Within the next few days, her renal function deteriorated, her white cell count became very high and her Hb dropped to 7g/dl. She had several episodes of melaena. An abdominal ultrasound revealed a multiloculated collection in the right upper quadrant; 300ml of clear orange fluid was drained.

All attempts to stabilise her situation and take her back to theatre were unsuccessful, and Mrs F died in ICU three weeks after surgery.†

The postmortem examination confirmed that the cause of death was septicemia shock due to peritonitis, as a consequence of the common bile duct being damaged.

**Learning points**

- Damage to the common bile duct is the most common complication in laparoscopic cholecystectomy. This is often due to inflammation, which makes it difficult to distinguish the common bile duct from the cystic duct. This is encountered in about 5% of cases.
- The signs and symptoms of complications in patients who have had laparoscopic surgery are often subtle, so careful postoperative observation is vital.
- The Association of Laparoscopic Surgeons of Great Britain and Ireland (ALSGBI) recommends taking the following precautions during surgery:
  - Maintain the best possible vision at all times.
  - Avoid the use of sharp instruments unless absolutely necessary.
  - Take extreme care with the use of diathermy, or ultrasonic devices (remember that the tip of the instrument may remain hot even if the power has been switched off).
  - Check that the bowel has not been injured during access.
  - Before leaving the abdominal cavity take care to check all areas where injury to tissue or bleeding may have occurred.
  - Inspect all cannulation sites after withdrawal of the cannula at the conclusion of the operation. (Lightly place a finger over the skin wound at the time of inspection so that any bleeding will run into the abdominal cavity and be seen easily.)
  - Where necessary, use a drain.5
- Finally, ensure that all patients are given appropriate contact details and instructed to contact the hospital, rather than their GP or another hospital, if any problems occur.

Unless otherwise stated, facts have been altered to preserve confidentiality.
Medical records: which path will you take?

Dr Graham Howarth, MPS Head of Medical Services (Africa), and Gareth Gillespie show how the course of your career can hinge on your record-keeping

The main reason for maintaining medical records is to ensure continuity of care for the patient

It is, perhaps, easy to be flippant about a medical record. You may think of it as a bureaucratic sideline to the buzz and unpredictability of practising medicine; a tiresome, superfluous chore that is carried out to keep the suits in the HPCSA happy.

But to underestimate or disregard altogether the importance of keeping good medical records is to potentially deal a severely damaging blow to your career. Whether you have received a complaint or a claim for clinical negligence, or you are at an inquest, the presence of a complete, up-to-date and accurate medical record can make all the difference to the outcome. In this article, we have drawn on a real MPS case in South Africa (with some facts altered to preserve confidentiality) to demonstrate how not to manage medical records.

Why are they important?
You are obliged by the HPCSA to keep adequate medical records – whether electronic or handwritten – as they are essential for the continuity of care of your patients. Adequate medical records should be comprehensive enough to allow a colleague to carry on where you left off.

The HPCSA defines a medical record as “any relevant record made by a health care practitioner at the time of or subsequent to a consultation and/or examination or the application of health management”.

The main reason for maintaining medical records is to ensure continuity of care for the patient. They may also be required for legal purposes if, for example, the patient pursues a claim following a road traffic accident or an injury at work. For health professionals, good medical records are vital for defending a complaint or clinical negligence claim; they provide a window on the clinical judgment being exercised at the time.

What are medical records?
This probably sounds like an obvious question. However, medical records cover an array of documents that are generated as a result of patient care. According to the HPCSA, these include:

2.1.1 Hand-written
The essentials

Good medical records summarise the following minimum documentation of injury on duty. Disability assessments and contemporaneous notes taken by the health care practitioner.

- Made contemporaneously, the time, date and place of every consultation.
- The time, date and place of every consultation.
- The assessment of the patient's condition.
- The proposed clinical management of the patient.
- The medication and dosage prescribed.
- Details of referrals to specialists, if any.
- The patient's reaction to treatment or medication, including adverse effects.
- Test results.
- Imaging investigation results.
- Information on the times that the patient was booked off work and the relevant reasons.
- Written proof of informed consent, where applicable.

Medical records must be:
- Objective recordings of what you have been told or discovered through investigation or examination.
- Clear and legible.
- Made contemporaneously, signed and dated.
- Kept securely.

The bio-psychosocial history of the patient, including allergies and idiosyncrasies.

- Information on record-keeping

The time, date and place of every consultation.

- Test results.

The patient's reaction to treatment or medication, including adverse effects.

Objective recordings of what you have been told or discovered through investigation or examination.

Clear and legible.

Made contemporaneously, signed and dated.

Kept securely.

Learning points

This case demonstrates the value of keeping detailed and accurate contemporaneous medical records. There is a popular misconception that no - or very scanty - records can work in your favour and make a case difficult to prosecute. This can be the case but it is also more difficult to defend a case where it might be difficult for the claimant to show there was negligence, it makes it just as difficult for MPS to show that the patient was managed appropriately. The adage “no records, no defence” has a ring of truth to it.

Furthermore, if you need to add something to a medical record or make a correction, make sure you enter the date of the amendment and include your name, so no-one can accuse you of trying to pass off the amended entry as contemporaneous. Do not obliterate an entry that you wish to correct – run a single line through it so it can still be read. There is only one thing more damaging than absent or poor notes and that is fabricated notes.

You must always inform MPS if there has been a request for records where there is even a remote risk of litigation.

SCENARIO

Dr V received a request for a copy of a patient’s records from a group of attorneys; he didn’t feel he was at risk so he disclosed the records without informing MPS. Two years passed before he received a summons. Realising he was to be the subject of a clinical negligence claim he then contacted MPS for assistance and our lawyers requested a copy of the patient’s records. By this time, Dr V had forgotten the original request from two years previously so when he reviewed the records prior to sending them to MPS, he realised they were somewhat scanty and decided to embellish them. Dr V had no intention to mislead, but he wanted to add extra clarity for the lawyers, and enhance his own reputation to the defence team. One year later, MPS started to prepare a defence based on the records disclosed to us; our case collapsed when our “original” records were compared to the claimant’s copy of the true original records. Had Dr V not tampered with the records, this would probably have been a defensible claim.

Conclusion

The standard of your record-keeping can make all the difference with regards to a clinical negligence claim being successfully defended, and will provide a rigid back-up in any HPCSA investigation. In the next edition of Casebook we will look at the law surrounding the disclosure of medical records – both to patients and third parties.

For more comprehensive information on record-keeping in South Africa, read the MPS booklet Medical Records in South Africa: An MPS Guide – accessible on the MPS website.

Abbreviations

Although abbreviations are a time-saver, you should take care to use them only where their meaning is unambiguous and would be easily understood by your colleagues.

Be aware, also, that patients may access their records – it is essential that you avoid insulting or derogatory remarks, which have no place in a clinical record. The HPCSA says: “Self-serving or disapproving comments should be avoided in patient records. Unsolicited comments should be avoided (i.e. the facts should be described, and conclusions only essential for patient care made).”

REFERENCES

2,3,4. Ibid
Most colleagues will be aware from reading previous Casebook articles that poor communication contributes to approximately 70% of clinical negligence claims against doctors. Nevertheless, communication issues continue to surface, with depressing regularity, with each new series of claims and complaints assisted by MPS. Doctors clearly do not communicate poorly on purpose. As a group, we have a strong ethical drive of wanting to do the best for the patient and this is combined with a pragmatic desire to avoid being sued.

Why do communication failures persist?

A report by the British Medical Association’s (BMA) Board of Education has highlighted key barriers to effective communication. Several of these barriers link to personal traits and attitudes. Such barriers include:

- Negative attitudes towards communication. Doctors give it a low priority, preferring to focus on treating an illness rather than the patient’s overall needs.
- A lack of inclination to communicate with a patient, especially when a doctor doesn’t have a lot of time, is dealing with an uncomfortable subject or is lacking in confidence.
- Doctors having personality differences compared to their patients. Research in the UK suggests that doctors may differ significantly to adult population norms in the areas of personality related to preferred mode of understanding. This opens up the possibility of misunderstandings in communication between doctors and patients.
- Undervaluing the importance of communications: doctors may not appreciate the importance of keeping patients informed. This may reflect a wider imbalance in the doctor–patient relationship.
- A lack of understanding of the communication process, such as the need to provide information in language that a patient understands, or listening to a patient’s views, to encourage two-way communications.
- A lack of knowledge or training in communication skills, especially in non-verbal communication, such as body language.

The same report recommended that more communication skills training programmes should be developed for doctors. MPS Educational Services offers members a number of three-hour workshops that aim to support doctors’ communication skills. Small interactive workshops, like those offered by MPS, have been shown to be effective in changing doctors’ behaviours. And after attending a workshop, 80% of participants say they will change their practice.

As doctors, we know from our own experiences of supporting patients with behaviour change, such as quitting smoking or addressing weight problems, that good intentions on their own often aren’t enough. Overcoming barriers, especially when they are related to attitudes or personal traits, requires support, reflection and reinforcement.

One step at a time

Dr Jagdeesh Singh Daliwal, MPS Manager and Senior Medical Educator for the Asia-Pacific region, offers some thoughts on what it takes for doctors to improve their communication skills.

It is for this reason that MPS offers members a series of communication skills workshops. The workshops each focus on a different area of communication. This was another recommendation of the BMA’s Board of Medical Education.

The areas covered by the workshops include:

- Basic communication skills
- Non-verbal communications
- Communicating after an adverse outcome
- Inter-professional communications
- Difficult interactions
- Shared decision-making.

Different techniques and skills are provided for each area but all the workshops share key themes. Starting with Mastering Your Risk and working through Mastering Adverse Outcomes, Mastering Professional Interactions, Mastering Difficult Interactions with Patients and the new Mastering Shared Decision-Making, the workshops build upon one another. Each workshop also encourages doctors to reflect on their own actions and behaviours.

The aim is that over time, by gradually helping members challenge and change their attitudes towards communications, the workshop will ultimately produce a step change in their communication skills. This will lead to a reduction in risk for the doctor and an improved patient experience.
Helping members in **South Africa** for more than **50 years**

Reduce your risk with education from MPS

**Workshop features:**
- Three hour workshops
- **FREE OF CHARGE** to MPS members
- Attract six ethical CEU (CPD) points

**Excellent – a must for all doctors from all medical backgrounds**

Just one of the many benefits of being a member of the world’s leading medical indemnity organisation

For more information visit [www.medicalprotection.org/southafrica/education](http://www.medicalprotection.org/southafrica/education)

*MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.
The Medical Protection Society Limited, a company limited by guarantee. Registered in England No. 36142 at 33 Cavendish Square, London, W1G 0PS.*
On the case

**Dr Graham Howarth**, Head of Medical Services (Africa), introduces this issue’s round-up of case reports, a number of which focus on missed infections.

In “Where is the consultant?” on page 17, Mr W’s endocarditis was missed by the cardiologist Dr H, who only saw him once during his inpatient stay. Mr W was not consulted about his progress, results of investigations or plans for discharge or follow-up. In this case, team working and fractured continuity of care created an “I thought you did it” situation; required tasks were not completed and an outpatient clinic appointment was not arranged. Safe systems should be in place to ensure that results are acted upon and that the relevant investigations are carried out.

Similarly, there was poor continuity of care in “A pain in the neck,” on page 19. Mr P was not fully examined on any subsequent visits to his GP, Dr W, despite progression of his neurological symptoms. The problem here was Mr P’s hostile and challenging behaviour, which meant that clinical examination was usually difficult. All the healthcare professionals involved in his care missed the large tubercular abscess in his neck, which resulted in Mr P becoming tetraplegic. This case is a pertinent reminder that despite an aggressive or difficult patient, you should maintain a professional approach and rule out any underlying pathology. To do otherwise is indefensible – expert opinion found Mr P was not examined early enough, despite repeatedly attending with his symptoms.

Preconceptions of a particular patient can hinder diagnosis. In “Suffer the little children” on page 21, M’s generally unhealthy demeanour and frequent contact with the GP masked the extent of her symptoms. Her puffy eyes were put down to “looking rather ill, as usual”, rather than the severe bilateral orbital cellulitis she was eventually diagnosed with and which resulted in her becoming blind. Extra care should be taken with frequent attenders, particularly if there are repeated calls – always revisit your diagnosis if symptoms persist or appear to be getting worse. You should have a low threshold for examination when conducting telephone consultations, and, as this case shows, effective triage is essential. Non-clinical staff should be educated to recognise potential red flag symptoms and pass on vital information to the healthcare team.

**CASE REPORTS**

Casebook publishes medicolegal reports as an educational aid to MPS members and to act as a risk management tool. The reports are based on issues arising in MPS cases from around the world. Unless otherwise stated, facts have been altered to preserve confidentiality.

**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** R15,000,000+
- **Substantial** R1,500,000+
- **Moderate** R150,000+
- **Low** R15,000+
- **Negligible** <R15,000
Mrs R was a receptionist in a local estate agent’s office. One evening, she noticed that her 11-year-old son, Y, was limping as he walked towards her in the kitchen. Y was overweight and had been grumbling to his mother about his left knee hurting intermittently for the previous month. On this occasion, when she asked why he was limping, Y told his mother he had slipped on ice in the playground earlier in the day. The fall had caused his leg to be sore. He had pointed at his thigh and said his knee was hurting again. The following day, Mrs R was booked to visit her GP, Dr G, to review her contraceptive medication. She decided to bring her son along with her, without an appointment. At the end of her consultation, Mrs R asked the doctor if he would take a look at her son. She explained what had happened yesterday and told Dr G that Y had been limping at home. There was a computer record of the consultation with Mrs R, but not with Y.

Mrs R reported that Dr G carried out a cursory examination of Y, while Y was sitting in the chair. She said that the doctor told them this was most likely a hip sprain, but to come back if the pain did not settle. Dr G remembered Mrs R attending for a review of her medication, and then asking for her son to be seen at the same time. He recalled feeling rushed and that Mrs R was quite insistent that Y be examined. Dr G could not remember carrying out the examination and thought he had asked Mrs R to rebook an appointment for Y. As there was no formal record of this, there was therefore no note of such a request, or an examination being performed.

When they returned home, the boy continued to complain of pain in his leg. Mrs R decided to bring Y to the local Emergency Department (ED) three weeks later, where a doctor requested bilateral hip x-rays and subsequently diagnosed slipped upper femoral epiphysis (SUFE). The case was discussed with the orthopaedic team on call and Y was admitted immediately for internal fixation. After his treatment, Y’s legs were of unequal length and one year later, he still walked with a persistent limp, which he found extremely distressing. The family had learnt it was likely that Y would require an early hip replacement in the future.

Mrs R made a claim against Dr G. As there were no records of the consultation, experts found it difficult to make a definitive assessment of the case, but they did find that Dr G’s management had not been appropriate. The case was settled for a high sum.

GMcK

Remember the importance of contemporaneous record-keeping. Good documentation is the basis of good medical practice, and can help to defend a claim. Even if Y’s problem was mentioned by Mrs R as a “by-the-by”, Dr G should have made a clinical record of the events.

If you are going to assess a patient, even in someone else’s appointment, the history and examination should be carried out appropriately. Had Dr G done it at the time, he may have realised that there was a significant problem with the child’s leg. Otherwise, Dr G should have asked Mrs R to wait until the end of surgery for Y to be seen if urgent, or rebook an appointment for Y at a later date, when a more thorough history and examination could be carried out, if the problem could wait. Dr G should have made a record of this discussion.

A limp in a child can have multiple aetiologies: Perthes’ disease/trauma/transient synovitis/septic arthritis/osteomyelitis. Slipped upper femoral epiphysis usually affects boys aged 10-15 years old. Incidence is 1:100,000 and is bilateral in 20% of cases. It occurs more frequently in obese children with delayed secondary sexual development and tall thin boys.

Remember referred pain to the knee as an early clinical symptom of SUFE.

Examine both hips and check for restricted movement, particularly internal rotation.

FURTHER INFORMATION

- Lalanda M, A Limping Child, Casebook 15(2)
- Anthony S, Getting to Grips with Children’s Hips, Casebook 12(3)
Mrs T, a 58-year-old music teacher, was admitted to her local hospital for an elective total abdominal hysterectomy for post-menopausal bleeding. She was seen on the day of surgery by consultant anaesthetist Dr Q, who noticed she had a cough. Mrs T said she had recently had a chest infection and had been prescribed a course of antibiotics from her GP. However, she was vague about how long she had had her cough, and whether she had finished the antibiotics. She dismissed her symptoms as a “smoker’s cough” and was insistent that the operation should go ahead, as she wanted it to be “all over and done with” in time for her son’s wedding a few weeks later. She also requested a general anaesthetic.

Dr Q did not discuss the case with the consultant gynaecologist Dr R. Later it was revealed that they had “fallen out following a disagreement”. Dr Q agreed to proceed with general anaesthesia.

Dr Q induced general anaesthesia using a standard technique and intubated the trachea. However, he found the airway pressures unexpectedly high. He reasoned that the cause was bronchospasm. He adjusted the ventilator settings, deepened anaesthesia and administered intravenous salbutamol to relieve the spasm. After a few minutes, things seemed to improve and the operation went ahead. Mrs T was coughing on the tube at the end of the operation, but was extubated. However, she continued to cough vigorously in the recovery area and was clearly in difficulty, with very low oxygen saturations and a high respiratory rate.

Shortly afterwards Mrs T rapidly developed subcutaneous surgical emphysema and suffered a cardiac arrest. Cardiac compressions were performed and intravenous adrenaline was administered. A circulation returned, although she remained very unstable. A chest x-ray was performed and intravenous adrenaline was administered. A circulation returned, although she remained very unstable. A chest x-ray was performed, which showed a tension pneumothorax. A chest drain was inserted, which improved stability, and she was reintubated. She was transferred to the intensive care unit, where she was found to have signs of a right lower lobar pneumonia. Oxygenation was very difficult. She had a prolonged and turbulent course in intensive care, complicated by pneumonitis and multi-organ failure, and was eventually found to have cognitive impairment consistent with hypoxic brain injury.

There were limited records of what happened during induction, anaesthesia and recovery, and most of the medical record was found to have gone missing. The recovery nursing notes included an incident form for “difficult airway maintenance” and she was noted to have arrived in recovery in a “very poor state”. A claim was brought on Mrs T’s behalf against Dr Q, which was settled for a high sum.

**Learning Points**

- Your first obligation is to act in the patient’s best interests and you should not be pressurised by the patient into doing anything that is counter to this. In elective surgery, it is important to avoid pressure to proceed. In this case, finding out that Mrs T had pneumonia might have prevented this outcome.
- When administering anaesthesia during an elective procedure, it is preferable to stop should you encounter difficulties and reassess for surgery another time.
- Good communication between professionals is essential in patient care. Had the anaesthetist and the surgeon discussed this patient, it might have been possible to perform a vaginal hysterectomy under spinal anaesthesia, or the case could have been postponed until later.
- Good, careful, well-kept records help provide a good defence. In this case, the nursing records and their understanding of the events were the only written documents to go by. Safeguarding the integrity of records is even more important after an adverse event.
- Bronchospasm is an important and treatable cause of high airway pressures and tension pneumothorax during ventilation, but not the only one. The differential diagnosis includes endobronchial intubation, foreign body in the airway, and equipment problems such as kinks and obstructions.
A 48-year-old driver, Mr W, was sent to hospital by his GP with a one-week history of unremitting back pain and associated mild shortness of breath. On direct questioning, he also reported non-specific malaise for at least three months with 3kg weight loss but no symptoms of fever. There was no previous history of cardiac problems and no recent dental or other invasive procedures.

Initial investigations demonstrated a mild leucocytosis with normal biochemistry. The ECG and chest x-ray were normal and there was no elevation of troponin, BNP or D-dimers. There was some concern about the possibility of an aortic dissection but a CT scan of the chest was also normal. Inflammatory markers were not measured.

The consultant cardiologist Dr H saw Mr W only once – on the post-take ward round after being admitted – and requested an echocardiogram after hearing “an aortic murmur”. The medical records indicate that he did not see Mr W again during his in-patient stay – nor was he consulted about his progress, results of investigations or plans for discharge or follow-up. Mr W’s temperature was recorded once daily. The echocardiogram demonstrated a bicuspid aortic valve with moderate aortic regurgitation and no other abnormality. The template report included the statement: “endocarditis is not excluded”. He was discharged directly from the medical assessment unit without senior review, with a diagnosis of musculoskeletal back pain and possible atypical pneumonia, with a plan for outpatient follow-up in four weeks’ time to assess progress and review the results of the echocardiogram.

The GP received only an interim discharge summary, which did not show an appointment had been arranged.

Eight weeks later, Mr W was readmitted to hospital with a high temperature, further weight loss, and shortness of breath secondary to pulmonary oedema. He was anaemic with an ESR of 104mm/hr and six out of six blood cultures were positive for Streptococcus mutans. A clinical diagnosis of infective endocarditis was made and confirmed by echocardiography, which demonstrated a large vegetation on the aortic valve with destruction of the non-coronary cusp and severe aortic regurgitation. He was treated appropriately after microbiological consultation with intravenous benzylpenicillin and gentamicin and his case discussed with the local cardiothoracic surgical centre. Unfortunately, within 24 hours, and before he could be transferred, Mr W deteriorated acutely with hypotension and pulmonary oedema refractory to diuretics and could not be resuscitated. The postmortem showed large vegetations on the aortic valve and extensive destruction of both leaflets of the bicuspid aortic valve secondary to bacterial endocarditis.

The case was settled for a moderate amount.

**LEARNING POINTS**

- The diagnosis of infective endocarditis is difficult and depends upon a low threshold of suspicion (see Beynon R, Bahl VK, Prendergast BD, Infective endocarditis, BMJ 333:334-339(2006)). The disease may present in a variety of forms to a variety of clinical specialties.
- Senior medical input to the care of seriously ill patients is important.
- There is little purpose in requesting investigations if the results are not carefully reviewed and acted upon at an appropriately early stage. There were several diagnostic clues in this particular case, which should have alerted the clinical team to the earlier diagnosis and management of infective endocarditis.
- The pressure to discharge patients and create beds for further admissions means that the results of important investigations are easily overlooked.
- Clear and comprehensive communication with the patient and GP is essential.
- Team working and fractured continuity of care can easily create “I thought you did it” situations where required tasks are not completed. The outcome for this unfortunate patient may have been different had an early follow-up appointment been arranged.
- Safe systems should be in place to check that outpatient clinics are arranged. It is worthwhile telling the patient that they should get in touch if plans are not confirmed.
Mr A, a 35-year-old accountant, was admitted to hospital overnight as an emergency under the care of consultant general surgeon Dr Q. He described an acute onset of severe right iliac fossa pain. Clinical examination revealed lower abdominal tenderness with localised peritonism in the right iliac fossa. Routine blood tests revealed an elevated white cell count whilst urinalysis was negative. A provisional diagnosis of appendicitis was made and the patient was commenced on intravenous antibiotics, and kept nil by mouth pending review by Dr Q in the morning. When Dr Q saw Mr A she was unconvinced by his physical signs and organised an ultrasound scan, which did not demonstrate any abnormality. The appendix was not visualised. Twenty-four hours later the patient’s condition had not improved and Dr Q made a decision to perform an appendicectomy.

Open surgery was carried out by an experienced surgical trainee on behalf of Dr Q, who found no sign of any intra-abdominal pathology to account for Mr A’s symptoms. Dr Q then performed the operation saw Mr A prior to discharge. The junior staff caring for Mr A simply informed him that an appendicectomy had been carried out and he left hospital under the impression that he had had an inflamed appendix removed. Subsequent histopathological examination of the appendix showed no evidence of inflammation.

Over the next few weeks and months Mr A continued to suffer from intermittent abdominal pain. He consulted his GP on numerous occasions and also attended the Emergency Department (ED) at times when the pain was severe. He received antibiotic treatment for a proven urinary tract infection on two occasions but his symptoms persisted. Further blood tests and a urological assessment (including a cystoscopy) all proved to be negative. Mr A was eventually referred to another surgeon, Dr B, who arranged a CT scan, which suggested there was a Meckel’s diverticulum in the terminal ileum. A subsequent radio-nucleotide scan confirmed evidence of active disease at this site. Dr B recommended a further operation and Mr A underwent a laparotomy, division of adhesions and Meckel’s diverticulectomy.

Mr A made a claim against Dr Q for performing an unnecessary appendicectomy and for failing to identify the Meckel’s diverticulum. The opinion of the experts consulted on behalf of MPS was supportive of Dr Q’s decision to remove the appendix at the time of surgery. They were, however, critical of the failure by Dr Q and her team to adequately communicate to the patient the operative findings and the subsequent negative histology and were critical of the consent process. The failure to identify the diverticulum at the first operation was also criticised but it was pointed out that in the absence of a perforation it was not certain that the diverticulum was the cause of Mr A’s initial presentation. The case was subsequently discontinued.

LEARNING POINTS

- In the consent process for appendicectomy it is important to warn patients that the appendix may be normal and other causes for the pain may (or may not) be identified.
- When open surgery is performed it is common surgical practice to remove the appendix even if it is not inflamed. This prevents the lifetime risk of future appendicitis and occasionally other pathology may be found in the appendix at the time of histopathological examination.
- A Meckel’s diverticulum is a common congenital abnormality and may be found in up to 2% of the population. It can contain ectopic gastric mucosa, which can occasionally bleed or ulcerate causing pain or perforation. In the absence of obvious appendicitis at the time of an operation the terminal ileum should be thoroughly inspected and if a Meckel’s diverticulum is found (typically two feet from the ileo-caecal valve) a diverticulectomy can easily be performed.
- Good communication between clinicians and a patient is essential. Ideally, the operating surgeon should discuss a procedure directly with the patient. This should be supported by clear written instructions to all staff involved in the patient’s care. In this case, had the patient understood that he did not have appendicitis and the rationale behind his appendicectomy, he may have been less likely to pursue a claim.
- Although in this case the experts found the communication to be sub-optimal, it did not amount to negligence.
A pain in the neck

Fifty-five-year-old Mr P emigrated from his home country ten years ago and secured a job as an administrator in a factory. He went to see GP Dr W soon after arriving in the country and mentioned during his first appointment that he had suffered with long-standing back pain for over a decade.

Mr P became well-known at the surgery, as he was often argumentative and confrontational towards staff. Over a period of three months, Mr P, attended his GP several times complaining of neck pain, stiffness and loss of strength in both arms. It was documented that he would routinely demand sick notes from Dr W in an aggressive manner and was adamant that the doctor didn’t like him. He repeatedly insisted that he should be provided with an orthopaedic chair for work, to ease his neck.

The hostile behaviour of the patient meant that clinical examination was usually difficult and Dr W would try to keep the consultations as short as possible. Full neurological examination was only performed once when Mr P first presented and it appeared normal at this time. Despite reported progression of his neurological symptoms, examination was never repeated again in subsequent consultations. Mr P began to complain of increased heaviness in his arm, which prompted Dr W to request a cervical x-ray, which showed some age-related degenerative changes. A routine referral was then made to rheumatology. Once again, no neurological examination was conducted.

While awaiting his appointment with the rheumatologists, Mr P was admitted to hospital after a fall; he was found to be tetraplegic. Further investigations confirmed his symptoms were due to a large tubercular abscess in the neck with destruction of the C4 vertebrae and pus in the epidural space. Mr P required extensive treatment and following a long hospital stay, he remained tetraplegic on discharge and required help with all normal activities of daily living.

The case could not be defended as expert opinion found that Mr P was not examined early enough, despite repeatedly attending with his symptoms. It is likely that a full recovery would have been made if diagnosis had been made sooner.

The case was settled for a high sum.

LEARNING POINTS

- Management of challenging patients can be very complicated and in cases like this can have devastating results. Despite the multitude of negative emotions introduced by an aggressive patient, it is important to maintain a professional approach and rule out any underlying pathology. Neglecting basics such as physical examination and reassessing for evolving signs is indefensible.

- Dr Monica Laland’s article on “The challenging patient” offers advice on dealing with these difficult encounters and reflects on the elements that often contribute to a patient’s behaviour.

- It is important to revisit your diagnosis and examination for evolving signs. See the Casebook article “Tunnel Vision” for more information.

- Dealing with conflict from aggressive patients can be a significant source of stress for doctors and can lead to a breakdown in the therapeutic relationship. Training in communication skills can be helpful in dealing with challenging scenarios. MPS runs a workshop, Mastering Difficult Interactions with Patients; visit www.medicalprotection.org and click on the Education tab.

REFERENCES

Housekeeper Mrs L, 58, was a poorly-controlled diabetic patient who was well-known to her GP, Dr V. One day, she presented with a swollen foot, and Dr V discovered an extensive area of skin breakdown on the ball of the foot discharging purulent fluid. He diagnosed an infected diabetic ulcer and referred her immediately to hospital.

At hospital the ulcer was debrided and she was treated with intravenous antibiotics. The diabetes multidisciplinary team reviewed her diabetes management and warned her several times that she might need an amputation. Fortunately, the infection was controlled, the tissues remained viable and amputation was not needed. She was then discharged for ongoing care in the community.

Mrs L continued to make progress as the ulcer gradually resolved, but during the recovery period she developed pleuritic chest and back pain. Dr V saw Mrs L several times at home and in surgery and diagnosed this as a chest infection. Each time he took time to carefully document Mrs L’s symptoms and his management.

One month following her hospital admission, Mrs L developed severe back pain and acute urinary retention. She was admitted as an emergency admission to hospital, where investigations revealed vertebral osteomyelitis at T10 with spinal cord compression and an epidural abscess. In spite of aggressive treatment Mrs L was left with paraplegia.

Mrs L made a claim against the hospital and Dr V for a delay in diagnosis of the abscess, which caused her paralysis.

Expert opinion reviewed the medical notes, which included details of every visit, and were strongly supportive of Dr V’s management. The case was successfully defended.

LEARNING POINTS

- Complications can, and do, occur in almost any clinical scenario, even when treatment is meticulous.
- Comprehensive and contemporaneous notekeeping is vital and the foundation of good practice.
- Infections are a significant problem in diabetes, especially when their control is poor. Microvascular and macrovascular complications of diabetes, as well as defects in cell-mediated immunity, increase with age, so increasing the risk of infection. Infections may also disrupt metabolic homeostasis and glycaemic control, so prompt recognition and treatment is therefore critical. Access a good overview here: http://enotes.tripod.com/dm_infections.pdf
- The importance of good foot care should be emphasised to patients – diabetic foot complications are the most common cause of non-traumatic lower extremity amputations in the industrialised world. Early detection and appropriate treatment of diabetic ulcers may prevent up to 85% of amputations. There is useful advice at:
  - Evaluation and Treatment of Diabetic Foot Ulcers – http://clinical.diabetesjournals.org/content/24/2/91.full
  - ABC of Diabetes – www.bmj.com/content/326/7396/977.full
- There may be an identifiable nidus from which the infection seeds through the blood stream, but 30-70% of patients with vertebral osteomyelitis have no obvious prior infection. Read more on the management of spinal infections at: http://emedicine.medscape.com/article/1266702-overview#aw2aab6b2b1aa
- Medicines used to treat the primary infection can obscure the presentation of symptoms from complications elsewhere, eg, a prolonged course of antibiotics and painkillers used to treat an infected diabetic foot ulcer may temper signs of infection elsewhere, rendering the secondary infection occult.
Suffer the little children

M had always been a rather sickly child who missed a lot of school through minor illness. Her mother brought her to see the GP frequently with her asthma, eczema and possible food intolerances. Most of the entries in her medical records had remarks about her low weight, small size and generally unhealthy appearance. M’s mother would often request home visits and they were regular users of the surgery.

When M was 12 years old she became unwell with a cold. Her mother requested a home visit. This was declined and standard advice for a non-specific viral illness was given. Over the following ten days M’s mother rang the surgery several times to report what appeared to be minor influenza symptoms. She described a mild fever, a runny nose and aching muscles. She spoke to her GP Dr T and several of the other partners who documented this and advised giving paracetamol and plenty of fluids.

M’s mother became increasingly anxious because she felt her daughter was not improving and “just didn’t seem right”. She started to ring the surgery more often. She spoke to different GPs and reported new symptoms of swollen eyes, severe headache and general weakness. She felt frustrated because she had the impression that the GPs were not listening to her concerns. She stated later that the doctor on the other end of the line would keep saying “aha” or “I see” and seem disinterested in her worries.

The GPs asked her to bring M down to the surgery but her mother said she was too ill to leave the house so a home visit was arranged by Dr C. His notes from the visit described M as “looking rather ill, as usual” and the puffy eyes were put down to a flare up of her longstanding eczema. Dr C prescribed some hydrocortisone cream for use around her eyes and advised M to get out of bed and try to get back to normal.

The next day M felt very weak but her mother tried to get her out of bed, like the GP had suggested. She collapsed on the floor and her mother called an ambulance that took her to the emergency department. She was diagnosed with severe bilateral orbital cellulitis and scans showed bilateral cavernous sinus thrombosis. Unfortunately, in spite of aggressive treatment, M became blind.

M’s mum made a claim against all the GPs involved. Experts could not support the GPs’ treatment. The case was settled for a moderate amount.

**LEARNING POINTS**

- Patients who see their doctors with minor ailments all the time may eventually present with a serious complaint. It is important to be mindful of frequent attenders whose serious symptoms can be missed. Extra care should be taken.
- Repeated calls should be a red flag. They should always make doctors stop and think.
- Doctors must always be able to justify any decisions they make and have a low threshold for having a face-to-face consultation.
- Telephone consultations are challenging where it is hard to make a proper assessment of the patient. Effective telephone triage is essential. Listen to a podcast on how to improve your patient triage over the telephone – [www.medicalprotection.org/uk/podcasts/Telephone-triage-managing-uncertainty](http://www.medicalprotection.org/uk/podcasts/Telephone-triage-managing-uncertainty).
Mrs C, a 25-year-old mother of two, had an elective caesarean with her first pregnancy as that baby was breech, and she experienced a failed attempt at a VBAC (Vaginal Birth After Caesarean) with her second pregnancy.

Her third pregnancy was uneventful and she was booked in for an elective caesarean section at 39 weeks. Dr A, an obstetrics medical officer, carried out the operation under spinal anaesthetic. The operation was felt to be “routine” and there was minimal scarring from the previous caesareans. After initial observations concluded that everything was normal, the patient and her 3.5kg baby girl were returned to the postnatal ward.

Three hours later, Mrs C started to feel unwell with dizziness. Dr A was called by the midwifery staff, but as he was busy in the delivery suite, he sent his registrar, Dr Q, to check on Mrs C. Dr Q was keen to get back to theatre and the documentation that had been made in the notes.

As soon as she was reassessed on the delivery suite, she had become more tachycardic (P120) with profound hypotension (BP70/50 mm Hg), and tachypnoeic with a respiratory rate of 28/min. Only minimal urine was noted in the catheter bag and a decision for an immediate laparotomy was made. Dr A found 1.5l of blood within the peritoneal cavity and a tear at the left extremity of the uterus incision, extending into the broad ligament. This was successfully repaired, but Mrs C required a transfusion of three units of blood and stayed in the high dependency unit for 24 hours.

Both Mrs C and her baby were discharged home a week later and physically recovered well. However, Mrs C made a complaint against Dr A and his team for poor management of her condition. An internal investigation was begun. Expert opinion on the issue was sought and there was agreement that although this was an unusual complication, it can be caused by the angle at which the baby’s head was delivered, and it should have been recognised and treated at the time of the initial caesarean section. There was also considerable criticism regarding the delay in taking the patient back to theatre and the documentation that had been made in the notes.

Following a face-to-face meeting where the case was discussed in detail, the complaint was resolved and no further action ensued.

**LEARNING POINTS**

- Although a caesarean section is a common operation nowadays, it is still a major surgical procedure. Mistakes do happen and complications do occur, even if you have done the same procedure thousands of times before.
- The operating surgeon takes the ultimate responsibility for the patient’s outcome. Although it may be appropriate to delegate suitably trained personnel to review some patients, cases of pre-imminent shock need urgent assessment by appropriately experienced staff at the most senior level available.
- Postpartum haemorrhage is an obstetric emergency.
- It is important to remember the physiological changes that occur during a normal pregnancy (eg, increased circulating volume, increased cardiac output etc), such that the common signs of hypovolaemia (ie, tachycardia, increased respiratory rate, oliguria, narrowed pulse pressure, etc) may not become apparent until a significant amount of blood has been lost.
- The abdomen can act as a “silent reservoir”, so the visible blood loss (ie, per vaginum) may not be apparent and hypotension is often a very late sign.
- Postpartum haemorrhage may be caused by the 4Ts:
  - Tone – atonic uterus accounts for 70% of cases and should be treated with uterotonic agents
  - Tissue – check the notes that the placenta and membranes were “complete” during the delivery
  - Trauma – cervical/vaginal tears, ruptured uterus from previous scars, extension of uterine angles at time of caesarean section
  - Thrombin – clotting problems – often this can be a late complication after significant blood loss.
- Although administrative procedures and teaching are important they should not be allowed to interfere with patient care.
Mr A was a 55-year-old newsagent who had smoked 20 cigarettes a day for 30 years. He had been good friends with his GP, Dr B, for years – since they were children playing in the same rugby team. Mr A had suffered with asthma since childhood. He visited Dr B regularly with exacerbations causing wheeziness and coughing, especially during the winter months. The visits were always kept very informal since they were friends, and Dr B’s medical notes were very brief, with minimal entries regarding Mr A’s presenting complaints or clinical examinations. Entries often comprised only the date and the prescription of inhalers.

Mr A had started suffering with back pain, which had not responded adequately to analgesia. It became severe enough to require hospital admission. A hospital CT scan revealed extensive mediastinal lymphadenopathy and parenchymal lung deposits. Mr A underwent bronchoscopy with biopsy, which confirmed the diagnosis of non-small cell carcinoma of the bronchus. Further scanning showed his disease to be metastatic involving his thoracic and lumbar spine, with a very poor prognosis. Unfortunately, Mr A deteriorated very rapidly, becoming very dyspnoeic and cachexic. He died just a few weeks after the diagnosis.

Mr A’s widow was devastated and made a claim against Dr B. She thought that her husband should have been investigated much earlier for severe breathing difficulties and weight loss. Dr B claimed from memory that Mr A had remained in good health with no breathing difficulties or weight loss till the weeks prior to his death. Dr B’s notes were so minimal it would have been impossible to confirm this. Experts looking into the case reviewed Dr B’s minimal notes but also, fortunately, had the benefit of the hospital notes. The hospital notes confirmed that Mr A’s symptoms of weight loss and severe dyspnoea started after his hospital admission. There was heavy criticism of Dr B for his poor documentation. However, it was also agreed that since Mr A’s tumour was rapidly growing and aggressive, earlier diagnosis would not have improved his prognosis. The case was settled for a low amount.

Mr A’s widow was devastated and made a claim against Dr B. She thought that her husband should have been investigated much earlier for severe breathing difficulties and weight loss. Dr B claimed from memory that

Mr A’s widow was devastated and made a claim against Dr B. She thought that her husband should have been investigated much earlier for severe breathing difficulties and weight loss. Dr B claimed from memory that

Clear and comprehensive notes are your defence when things go wrong. In this particular case the claims made by the deceased’s wife that the patient had been ill for a long time, could only be confirmed because of someone else’s medical records.

Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship. When treating those close to you, it could be easy to make assumptions, eg, regarding the way a patient is feeling if a doctor knows them already and does not ask the relevant questions, or it could be possible to over-identify with patients and lose objectivity.

FURTHER INFORMATION
- Rourke L, Rourke J, Close friends as patients in rural practice, Can Fam Physician (June 1998)
- GMC, Good Medical Practice (2011)
We have received a number of letters from readers about this article, in particular the statement: “If, after careful consideration, clinical evidence suggests that it is not in the patient’s best interests to perform CPR should it be needed, this must be discussed fully with the patient.” We accept the criticisms raised that the use of the phrase “must be discussed” is incorrect and does not apply to every clinical situation.

The purpose of the article was to emphasise the need for good communication in this area, given the rising number of complaints about DNACPR decisions being made without the knowledge of patients or their families, and the generally accepted best practice approach of involving patients in decisions about their care (“no decision about me, without me”). However, there are situations where clinical judgment will determine that such discussions are not appropriate, or timely – for example, in the case of the dying patient.

For clarification we set out below the relevant section from the GMC guidance Treatment and Care towards the End of Life: Good Practice in Decision Making, which states:

134. “If a patient is at foreseeable risk of cardiac or respiratory arrest and you judge that CPR should not be attempted, because it will not be successful in restarting the patient’s heart and breathing and restoring circulation, you must carefully consider whether it is necessary or appropriate to tell the patient that a DNACPR decision has been made. You should not make assumptions about a patient’s wishes, but should explore in a sensitive way how willing they might be to know about a DNACPR decision. While some patients may want to be told, others may find discussion about interventions that would not be clinically appropriate, burdensome and of little or no value. You should not withhold information simply because conveying it is difficult or uncomfortable for you or the healthcare team.”

Guidance published by the BMA/RCN/Resuscitation Council in 2007 on this issue also states: “In considering this clinicians need to take account of the fact that patients are legally entitled to see and have a copy of their health records, so it may be preferable for them to be informed of the existence of a DNAR decision and have it explained to them rather than for them to find it by chance. It may be distressing for them to find out by chance that a DNAR decision has been made without them being involved in the decision or being informed of it.”

The guidance goes on to advise doctors to record the reasons why a patient has not been informed about a DNACPR order if the decision is made not to inform the patient.

We are pleased to respond to the concerns raised by readers, and welcome all feedback.
Double problem, double risk

The report on the patient with tonsillar cancer surprises me; it is hard to believe that an ENT surgeon consulted about “a recurrent sinus problem” does not perform a full ear nose and throat examination, or at the very least an inspection of the oral cavity and pharynx. To read that the patient mentioned “ongoing ... sore throat” and that the ENT surgeon suggested that the patient get his GP to check it reflects professional laziness or incompetence on the part of the specialist.

If indeed the specialist did examine the throat, it seems likely that it was not a competent examination, as within a month there was an obvious tonsilar carcinoma evident on inspection, and accompanying metastases in the cervical nodes.

I am also surprised that the learning points did not conclude that the initial ENT assessment was inadequate, and that the specialist’s response to the patient’s expressed concern about his throat was unacceptable. At the very least the specialist should have examined the throat in the light of the information provided. Given the findings one month later, an adequate initial specialist assessment, in all probability, should have raised the alarm at that time.

Randall Morton, professor of otolaryngology – head and neck surgery, University of Auckland, New Zealand

Response

The points you make about the consultation are very valid, and it is only a limitation on space that means we are unable to include all of the learning points from every case. The focus of this case report was to highlight the need for vigilance when patients present with more than one complaint, but there were clearly other issues of concern, as you have pointed out, that led to this claim being settled. Thank you for taking the time to share your views on this article with us.

Dr CJF Potter, retired, UK

“Just a quick look” can be costly

As a recently graduated doctor, I read “Just a quick look” can be costly (Casebook 20(1), p19) with interest. Despite my relative inexperience, I am frequently asked to review other hospital staff who drop into my ward “as a favour”. My initial instinct is to accommodate such requests out of a sense of professional courtesy and fear of being labelled a jobsworth should I decline. After all, we are all very busy people working to help others and taking a quick look for a colleague very often seems like the right thing to do.

However, I am increasingly concerned that such behaviour represents neither best practice nor a good use of NHS time and resources. Requests for advice or review are rarely accompanied by paperwork highlighting past medical history, allergies or current medications and there is no pathway in place to allow for vital communication back to the individual’s GP. Additionally the pressure to arrive at a quick decision often leaves minimal time to take a history and form a considered diagnosis.

Since recently starting a new rotation, I have found the problem to be more of an issue in otolaryngology, perhaps as examination often necessitates more specialist equipment often not found on other wards. Although I am becoming more proficient in many ENT investigations and procedures, diagnoses are not always the most obvious or easily formulated, which can lead to disappointment, uncertainty or even anxiety.

Worryingly neither my department nor hospital has a defined policy of how to handle these cases of “quick looks”. The GMC stipulates that contemporaneous notes should be kept in keeping with good medical practice but offers little other advice. Although my trust has no guidelines on the subject and seems to take a neutral attitude to the issue, I have come across areas where such impromptu consultations are tacitly encouraged if they reduce time taken off work.

Given the potential medicolegal pitfalls and consequences highlighted when dealing with such cases, I feel I would benefit from greater guidance either from individual hospital trusts or the GMC on how to manage such cases, so that I am able to alleviate and reduce any anxiety both for me or my unsolicited patients.

Timothy Batten, junior doctor, UK

Casebook and other publications from MPS are also available to download in digital format from our website at: www.medicalprotection.org
The Wisdom of Whores: Bureaucrats, Brothels and the Business of Aids
By Elizabeth Pisani
(Granta Books, 2008)

Reviewed by Dr Rebecca Smith
and Dr Chris Jones, specialist registrars in Anaesthesia.

Elizabeth Pisani set out on an unusual path towards a career in sex and drugs, and she achieved it. The Wisdom of Whores is a passionate debate, dedicated to unmasking the HIV epidemic in Asia. The winding tale leads you through a murky world of brothels, public needle exchange services, boardrooms and international conference centres. You will learn a new language on your journey, of MARPS (Most At Risk Populations), FSWs (Female Sex Workers) and Waria (male sex workers that are culturally considered to be female). At every turn you will be shocked by chilling statistics and controversial comments.

Surprisingly, the book is fairly humorous. It pokes fun at some of the governments’ initiatives, for example, peer outreach – in a competitive industry, like prostitution, where rivals have to covet each others’ clients in order to survive – whoever thought this could work?! Some of the difficulties faced in accurate data collection are also revealed – it must be challenging to gather meaningful statistics when you are asking an intoxicated prostitute questions in a poorly lit nightclub in the early hours.

Having read Classical Chinese at University, Pisani first worked as a foreign correspondent in Hong Kong. She then undertook a Masters degree at the London School of Hygiene and Tropical Medicine, and entered into a career of Epidemiology. Transferring to Family Health International in Jakarta, Indonesia in 2001, Pisani became part of the “HIV surveillance mafia”, dedicating her time to building international surveillance systems to help develop HIV prevention programmes. What may have started off as a mere intellectual pursuit became an intensely personal battle as she met the faces behind the statistics, and fought to save her friends. Pisani brings home the lesson that there is no purity in science. Epidemiological facts are distorted by a smokescreen of money, power, politics, religion and the media. It’s unfashionable and unpopular to dedicate money to prostitutes and junkies – it won’t win you votes in elections.

This book is dedicated to realism. It is an abrasive and raw account of the battle between science and politics. It is a disturbing read, but a must for any enquiring mind.

If Disney Ran Your Hospital: 9½ Things You Would Do Differently
By Fred Lee (Second River Healthcare Press, 2004)

Reviewed by Dr Mike Baxter, independent medical consultant and former Medical Director at Ashford and St Peter’s Hospitals NHS Foundation Trust

If Disney Ran Your Hospital changed my view of how hospitals should work and the correct avenues to pursue to deliver effective change and improvement. This book also reads very well in the context of current definitions of quality, where outcome, safety and experience are given equal weighting. Whilst outcomes and safety are familiar currencies that we easily understand, experience is less comfortable and much more alien to the medical community.

Indeed, we have been drawn into the world of “customer satisfaction” and have been persuaded that service delivery models aimed at high levels of patient satisfaction represent the desired goals in healthcare.

However, Fred Lee makes the case that it is so much more than this. Experience is about how you are made to feel: it is an emotional interface that relies on genuine human interaction with spontaneous and reflex elements that make it real and unique for each patient. He makes it clear that the generation of an experience is how you make lasting impressions and, if good, generates loyalty and trust.

He reminds us that the single most important element to all successful human relationships, especially in healthcare, is compassion. Until we recognise, develop and reward compassion, we are destined to have services that may be good, but are vulnerable to veering into average or poor, consistently underwhelming in terms of experience.

Fred describes, for me, what was a confirmation of my own anxiety – that process redesign does not take into account this human element/emotion and, although it can deliver efficient care process, it cannot deliver great care because ultimately it does not create an emotional and therefore memorable experience.

If, like the Disney Corporation, we aspire to deliver excellence in our hospitals, we must create a truly unforgettable experience where compassion is a core value and all staff provide predictive, selfless care.

I do believe that this book is the potential guide to a better land. I believe if we were run by Disney that the values of compassion delivered by naturally talented and/or appropriately motivated staff would create an environment for a safe service with good outcomes, which would also deliver the elusive goal of a great experience.
CPD Questionnaire

CPD questionnaires must be completed online via www.cpdjournals.co.za. After submission you can check the answers and print your certificate.

Instructions:
1. Read Casebook: all the answers will be found there.
2. Go to www.cpdjournals.co.za to answer the questions.

Accreditation number: MDB001/034/10/2011

1. If a mother brings her child to her consultation and, during the course of the consultation, consults you about a medical problem that the child has, you are not obliged to examine the child.
   True or False

2. Your first obligation is to always act in the patient’s best interests, so if the patient informs you he or she wants something to be done, you are obliged to do it.
   True or False

3. Good communication between professionals is an essential part of patient care.
   True or False

4. Good, careful, well-kept records are unlikely to be of any assistance in litigation.
   True or False

5. If you are not going to check, or have them checked, special investigations are not worth doing.
   True or False

6. During the consent process for an appendectomy, you are not obliged to inform the patient that the appendix may be normal and something else may be responsible for the pain.
   True or False

7. Ideally the surgeon responsible for a surgical procedure should discuss the procedure with the patient.
   True or False

8. Challenging patients are their own worst enemy and are largely responsible for any misdiagnosis as a result of their difficult behaviour.
   True or False

9. Comprehensive and contemporaneous note-keeping is vital in the foundation of good practice.
   True or False

10. Complications seldom occur in the absence of negligence.
    True or False

11. When holding a telephonic consultation with a patient you should be able to justify any decision that you make and have a low threshold for suggesting a face-to-face consultation.
    True or False

12. It is important to be mindful of frequent attenders whose serious signs and symptoms can be missed.
    True or False

13. The operating surgeon takes the ultimate responsibility for the patient’s outcome.
    True or False

14. Teaching and administration are important to doctors and should take preference over patient care.
    True or False

15. Whenever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship.
    True or False

16. During the consent process patients’ expectations should also be managed appropriately, so if a complication does occur they appreciate that it does not necessarily equate to negligence.
    True or False

17. Your discussion during the consent process and talks about expectation management do not need to be documented – the patient will remember anyway.
    True or False

18. When sued for negligence it is not always the complication per se for which the patient sued, but the delay in picking up the complication.
    True or False

19. Damage to the common bile duct is the most common complication in laparoscopic cholecystectomy.
    True or False

20. The signs and symptoms of complications of patients who have had laparoscopic surgery are often subtle.
    True or False
How to contact us

THE MEDICAL PROTECTION SOCIETY

33 Cavendish Square
London, W1G 0PS
United Kingdom

www.medicalprotection.org
www.dentalprotection.org

General enquiries (UK)
Tel +44 113 243 6436
Fax +44 113 241 0500
Email info@mps.org.uk

MPS EDUCATION AND RISK MANAGEMENT

MPS Education and Risk Management is a dedicated division providing risk management education, training and consultancy.
Tel +44 113 241 0696
Fax +44 113 241 0710
Email education@mps.org.uk

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

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

AFRICA medicolegal advice

South Africa, Botswana, Lesotho, Namibia, Swaziland and Zimbabwe
Dr Tony Behrman, Cape Town
Tel +27 083 270 7439 (cell phone)
Email cpctb@mweb.co.za
Dr Liz Meyer, Pretoria
Tel +27 082 653 5755 (cell phone)
Email lmeyer@connectit.co.za

AFRICA membership enquiries

South Africa, Botswana, Lesotho, Namibia, Swaziland and Zimbabwe
South African Medical Association
Tel 0800 225 677 (toll-free within South Africa)
Tel +27 (0)12 481 2070 (calls outside South Africa)

South Africa
Membership and Marketing Agents
Tel 0800 118 771 (toll-free within South Africa)
Tel +27 (0)11 887 0197 (calls outside South Africa)
Ian Middleton
Email medprotection@global.co.za
Alikha Maharaj
Email mps@iburst.co.za

Kenya
Jacky Keith
Tel +254 (0)20 243 0371 or +254 (0)20 351 2928
Mobile +254 (0)722 736470
Email mps@africaonline.co.ke