TREATING JEHOVAH’S WITNESSES
Your legal obligations in a range of scenarios

A PERSONAL FAILURE
Dr Dan Cohen on his own shortfall in reliability

ASPECTS OF CONFIDENTIALITY
Unusual dilemmas – the third in our series

REVIEWS
Book, film, app – read our reviews

Doctor in the dock
One doctor’s account of his trial by media

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CASE REPORTS

Welcome:
Dr Nick Clements is the new Editor-in-chief of Casebook – here he reflects on predecessor Dr Stephanie Bown’s time at the helm.

The accused - Doctor in the dock:
Public exposure from complaints and claims can cause doctors to face a trial by media. In 2011, a UK GP was accused of sexually motivated conduct when he examined a patient’s chest – he shares his experience with Sara Dawson.

High reliability in healthcare: a personal failure
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

The challenges of treating Jehovah’s Witnesses
The sensitivities surrounding medical treatment for Jehovah’s Witnesses can place doctors in difficult medicolegal dilemmas. Nicola Caine and Karen Zybrands, of MacRobert Attorneys, explain the legal position behind a range of scenarios.

Aspects of confidentiality: social media
One of the most commonly recurring issues that feature on the MPS advice line is confidentiality. In each edition of Casebook we will highlight an unusual scenario, at the heart of which lies a difficult dilemma around confidentiality. This edition, we look at a dilemma involving young patients’ parents discussing their treatment on social media.

Record your reasoning

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.

Casebook
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ISSN 1740-0090

Casebook

Every issue...

Over to you:
In this issue Dr Omar Mukhtar reviews The Enemy Within, an hour-long documentary chronicling the last 50 years of the fight against cancer. Also, Dr Amir Forouzanfar reviews The Checklist Manifesto: How to Get Things Right, by Atul Gawande.

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Welcome

Dr Nick Clements – Editor-in-chief

Dr Nick Clements has taken over as Casebook Editor-in-chief from Dr Stephanie Bown, who left MPS in February 2014. Here, Dr Clements looks towards the task ahead.

As this is my first column as the new Editor-in-chief of Casebook, I would like to say how much I am looking forward to life at the helm of a publication with a prestigious history of some 20-plus years.

Of course, I must also pay tribute to my predecessor Dr Stephanie Bown, who left MPS in February to become Director of the National Clinical Assessment Service (NCAS). Dr Bown has been involved with Casebook since the May 2006 issue, and oversaw numerous successful design upgrades and a renewed focus on producing truly topical content for all of our six regional editions.

Dr Bown worked at MPS for 19 years, beginning as a medicolegal adviser and becoming head of the Medical Services Department in London soon after; this after spending more than 12 years as a doctor in acute hospital medicine, then obstetrics and gynaecology before moving into general practice. Dr Bown combined her editorial duties on Casebook and other MPS publications with high-profile external affairs work.

So it is with slight trepidation but great relish that I step into Dr Bown’s shoes, and build on her success with Casebook and other MPS publications with high-profile external affairs work.

One thing will not change – and that is we continue to encourage your feedback, opinions and suggestions after each edition. Perhaps I will speak to some of you personally on our advice line…

Public exposure from complaints and claims can cause doctors to face a trial by media. In 2011, a UK GP was accused of sexually motivated conduct when he examined a patient’s chest – he shares his experience with Sara Dawson

It seemed like a normal surgery day a couple of years ago. As I was signing scripts, my practice manager knocked on my door and brought in a brown envelope marked private and confidential. I opened it and read it – the contents were highly distressing. The letter contained details of allegations made by a female patient (Mrs B) that, two months previously, I had conducted a sexually motivated conduct when seeing Mrs B in early spring complaining of chest and stomach pain. Initially I offered her a chaperone, as it is practice policy; she declined, so I performed a thorough chest examination and referred her for surgery.

Her complaint was that during the chest examination I squeezed her breast, and behaved sexually while breathing heavily. She thought my front, back and side examination was inappropriate and not what she'd expected.

I was devastated to hear about the serious nature of the complaint, as it would have ramifications for me, as a doctor, and as a husband and a father, and as an upstanding member of society. My surgery staff were highly distressed and took it very seriously; I immediately contacted MPS.

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**The ACCUSED**

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Handling the media was not something I’d really considered. I’d definitely never thought about being on the front page of a national newspaper.

**Media coverage**

Handling the media was not something I’d really considered. I’d definitely never thought about being on the front page of a national newspaper. We were all worried about it: what would patients do? The stories were angled in a certain way that assumed I was guilty – it would have been nice to be captained in a different way. I remember, during the hearing, getting messages from friends asking if I was ok, as they’d seen the coverage. Even abroad, it was all over the internet.

The pressure was huge and so upsetting. My name was exposed, I’d lost my anonymity – it was breakfast gossip. There was a sense of bias – why was I stripped of my anonymity when the person who made the allegations enjoyed full anonymity? The media coverage added salt to my wounds.

**Support**

Throughout the process I worked closely with the local medical committee, my MPS legal team, and the PCT. Without the understanding and professionalism of these people it would have been a much more difficult time. I drew strength from the fact that I knew I was professional and hadn’t done anything wrong – I believed the truth would come out in the end. I’m most proud of the way the practice dealt with the whole thing – we pulled together like a family. From the first day, I was honest about the allegation and discussed it with my staff, my patients, my family and my colleagues; from then on I informed them of all the developments. I could not have survived the experience if they hadn’t supported me. I always wanted to be a professional GP, dedicated to my practice and patients, and to be involved in the community as a doctor. Eighteen months have been wiped from my life and I will never get answers to why Mrs B did what she did. I take some comfort in that justice has been done and I was vindicated – life goes on and I have learnt from it.

**Legal opinion**

By Dr Jo Galvin, MPS medicolegal adviser, who handled the case.

Unfortunately this case is not an isolated one. Mrs B came to the practice specifically asking for her chest to be examined thoroughly. During the examination she perceived that the actions of the GP in question, whom I shall refer to as Dr Z, were sexually motivated. Dr Z said that when he examined her, he explained what he was going to do and explained the depth and pattern of the breathing. His situation was compounded when he locked the door to preserve her confidentiality, as the door had recently accidentally opened into the adjacent waiting room. Mrs B misconstrued this again to be sexually motivated.

**Credibility**

The credibility of Mrs B was undermined when she did not turn up for the first day of the hearing – she claimed that her father was in hospital. MPS requested full disclosure of the reasons for her absence. It came to light that she had sent the text message explaining her absence from her sister’s house, and her father was not in fact in hospital.

**Chaperones**

Doctors are alive to the fact that they need to use a chaperone when performing intimate examinations, but they aren’t always alive to the dangers of some examinations; for example, an accidental brush of the chest can get doctors into difficulty. An important point to make is that Dr Z did not see Mrs B. MPS conducted an audit of Dr Z’s previous consultations, and were able to prove that it was not a consistent practice to offer a chaperone and document it. He’d documented contemporaneously in the notes that he had offered Mrs B a chaperone, and that she had declined – this helped his defence.

**Good record-keeping**

There were important factors that further undermined Mrs B’s version of events. During the consultation Dr Z also referred Mrs B to hospital to be treated for a different condition. Mrs B had no recollection of this or of visiting Dr Z a couple of weeks later about a different matter. It is unlikely that you would come back voluntarily and visit your GP again if you perceived him to have acted inappropriately.

This raised questions around Mrs B’s recollection of the events. In contrast, Dr Z had documented everything contemporaneously. When there is a factual dispute, the credibility of a complainant is important. In this case there was a factual dispute and the weight of evidence was in Dr Z’s favour. His notes were further backed up by a GMC-obtained expert report about the correct standard of chest examinations; this proved that Dr Z’s standard of chest examinations was appropriate.

**Professional challenges**

The situation presented professional challenges because Mrs B remained a patient at the practice. It is hard to justify removing a patient simply because they have made a complaint. Good practice management meant that Dr Z did not see Mrs B.

**Advice**

Dr Z was unlucky, but his contemporaneous note-keeping and good practice helped prove that he had not done anything wrong. He did conclude that he could give himself the best protection.

**Learning points**

- Always use chaperones for examinations that are perceived to be intimate examinations.
- Good record-keeping is essential.
- Communicate effectively with your practice team.
- Develop good working relationships with your staff and patients.
- Expert evidence is helpful in disputes around standard practice.

For further information about chaperones and maintaining boundaries please visit the factsheets section of www.medicalprotection.org.

**Ends**

**REFERENCES**

1. Notes for readers outside England: Primary Care Trusts were the NHS bodies responsible for commissioning primary, community and secondary health services from providers, including funding GP care. They were abolished in 2013.

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**INVESTIGATION**

We asked the patient to give consent so that we could send the complaint to be investigated thoroughly and in an unbiased way by the PCT (Primary Care Trust). After a delay the records were shared and I gave my witness statement. The local PCT determined that I should have a chaperone for every female consultation while the investigation was underway.

In spite of numerous attempts, Mrs B failed to engage with the PCT to give her version of events. The PCT felt they had no choice but to refer the case to the General Medical Council (GMC).

The GMC held an interim order panel meeting. Accompanied by an MPS solicitor, the panel listened to our case. They applied conditions to my registration that I was to have a chaperone for every intimate female examination, and to log each examination. The GMC’s investigation took more than a year to complete and a hearing date was set, 18 months after the initial allegation.

**The hearing**

The first day of the hearing didn’t go to plan. I arrived all geared up to defend my corner, but Mrs B did not turn up, so it was adjourned until the following day. When the hearing did commence Mrs B gave a witness statement, and there was a submission from my MPS-instructed barrister, then the panel went away to decide the next course of action. The next day the panel gave their decision that they found the allegation untrustworthy and uncorroborated, and the case was concluded.

**Personal impact**

The experience of having a patient make an unfounded allegation against you is devastating. I would not wish it on my worst enemy. The insecurity you feel day in and day out is worse than physical pain. There were days where I could not see any light at the end of the tunnel, like my head was under a guillotine. My mind was fractured; I kept thinking ‘why me, why did this happen to me?’

As a doctor this experience was earth-shattering: it’s the worst thing to be accused of – an allegation of sexual motivation; how can you prove you were acting appropriately? It’s their word against yours. If the GMC had found in Mrs B’s favour, my license, my livelihood, my marriage, my social standing would have been demolished just like that.

During the investigation I went to work as normal. Every day I had to face the stigma around me of what I had allegedly done.

**Impact on the practice**

It was particularly hard on the practice, having to have a chaperone for every female consultation while the investigation was underway.

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During the investigation I went to work as normal. Every day I had to face the stigma around me of what I had allegedly done.

**Impact on the practice**

It was particularly hard on the practice, having to have a chaperone from the beginning. We were not just employing a GP, but two healthcare professionals at the same time. This had huge financial and logistical implications for the practice. Not being a big practice we don’t have many nurses or staff, so it was difficult.

We had to consider the future of the business: if I were to be found guilty and forced to leave, how would the practice cope?**
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

Early on, we may have been reluctant to listen. Sadly, in my view, we have experiences. We have learned much, although in some instances, especially the stories that patients and family members have shared about their organisations.

In his follow-up to last edition’s article on high reliability organisations, the Swiss cheese model of harm and system problems is revisited. A personal experience is shared that formed part of his own steep learning curve.

Dr Dan Cohen is International Medical Director for Datix Ltd (www.datix.co.uk), a patient safety and risk management company whose software application enables users to spot trends as incidents/adverse events occur and reduce future harm by prioritising risks and putting in place corrective actions. Dr Cohen can be reached at drcohen@datix.co.uk.

High reliability in healthcare: a personal failure

With a steadily increasing focus on safety and risk-aversion in the healthcare industry, much attention, appropriately, has focused on the stories that patients and family members have shared about their experiences. We have learned much, although in some instances, especially the stories that patients and family members have shared about their organisations.

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The challenges of treating Jehovah’s Witnesses

The sensitivities surrounding medical treatment for Jehovah’s Witnesses can place doctors in difficult medicolegal dilemmas. Nicola Caine and Karin Zybrands, of MacRobert Attorneys, explain the legal position behind a range of scenarios.

T he Jehovah’s Witness religion is a Christian denomination with millions of members in more than 200 countries worldwide. They actively encourage their members not to receive blood transfusions, which may lead to various challenges for medical practitioners involved in the treatment and management of Jehovah’s Witness patients.

Differing beliefs
Jehovah’s Witnesses believe that it is against God’s will to receive blood and, therefore, they refuse blood transfusions, often even if it is their own blood. The willingness acceptance of blood transfusions by Jehovah’s Witnesses has in some cases led to rejection of medical transfusions by their religious community. However, a minority of Jehovah’s Witnesses do not agree that the Bible prohibits blood transfusions, and will therefore accept transfusions. Some Jehovah’s Witnesses may also believe that it is acceptable to receive blood plasma fractions or the transfusion of their own blood. Given the divergent beliefs about receiving blood amongst followers of the religion, it is imperative that the view of each individual Jehovah’s Witness patient on this aspect be carefully canvassed by the treating practitioner.

A number of possible scenarios are discussed below:

An adult patient who is competent to consent to or refuse treatment

The South African Constitution protects a patient’s right to bodily integrity and autonomy. Accordingly, an adult Jehovah’s Witness is entitled, in terms of our Constitution, to refuse a blood transfusion. An adult patient who is competent to consent or refuse treatment may have an “advance directive” (at a time when he/she had been competent) that he/she does not wish to receive a blood transfusion. Such refusal should be carefully documented by the medical practitioner from all liability following from a failure to administer blood products.

In an emergency, a medical practitioner may not refuse to treat a patient who refuses a blood transfusion and the patient should accordingly be treated without administering blood products. If possible, the consequences of not receiving a blood transfusion should still be explained to the patient. Should a blood transfusion be regarded as medical treatment (as opposed to a surgical operation), the patient’s refusal should be accepted, unless this is deemed to be unreasonable.

Jehovah’s Witness children under 12

According to the Children’s Act of 2005, the best interests of a child are paramount in all decisions regarding children. (A child is defined as a person under the age of 18 years.) In cases where the child is younger than 12 (or older than 12 but of insufficient maturity or unable to understand the benefits, risks and social implications of the treatment), medical treatment or surgery cannot be performed without the consent of the parent or guardian of the child.

In the case of a Jehovah’s Witness patient who is younger than 12, a parent (or guardian) in order to consent to a blood transfusion should be requested to sign a release form, allowing the medical practitioner to administer blood products.

Should a blood transfusion be regarded as surgical treatment, the Jehovah’s Witness parent or guardian in the circumstances of each individual case will have to be considered before a decision is made.

Jehovah’s Witness children under 12

An adult Jehovah’s Witness patient who is unable to consent to or refuse treatment

In terms of the National Health Act, if an adult Jehovah’s Witness is unable to consent to or refuse the administration of a blood transfusion (ie, due to unconsciousness), the decision should be made by the court. In the absence of an emergency, the court will be alive to possible complex family/implications of treatment) may consent to treatment, including the transfusion of blood products, if it is deemed to be unreasonable.

Unrelated the refusal of a minor (an individual who has not yet turned 18) is not absolute and may be overruled either by ministerial consent or an order by the High Court.

Recommenatlions

A medical practitioner should inform the parent(s) of the Jehovah’s Witness child about the alternative choice available. In the event of a disagreement, such a case is better suited to be referred to the Department of Social Development, as the minister of Social Development may consent to the administration of the blood transfusion.

The Jehovah’s Witness patient’s parent(s) or guardian(s) of a Jehovah’s Witness patient who has an “advance directive” (at a time when he/she had been competent) is still entitled to refuse a blood transfusion by reason only of religious or other beliefs, unless the parent can show that there is a medically accepted alternative choice. In the event of a change of mind, the parent should be counselled regarding the risks and consequences for the patient if no treatment is commenced or there is no reason to believe that the patient has changed his/her mind. If a Jehovah’s Witness patient is younger than 12, a parent may refuse to consent to a blood transfusion by reason only of religious or other beliefs, unless the parent can show that there is a medically accepted alternative choice.

In the event of a Jehovah’s Witness patient who is over the age of 12 years (who is sufficiently mature) will be alive to possible complex family/community issues.

In our experience, some Jehovah’s Witness parents may actually wish to consent to receiving blood transfusions but are reluctant to act thereto for fear of being ostracised by their religious community. In order to ensure that patients are not acting under duress, medical practitioners would be well advised to ensure that the patient and all parents are fully aware of the nature of any treatment administered (including blood transfusions) is confidential and will not be disclosed by the practitioner to any third parties, and that third parties cannot access hospital records without the express consent of the patient. It is furthermore advisable to have all discussions about possible blood transfusions to be kept strictly private, to ensure patient confidentiality, and to allow them to disclose their decisions to others without pressure from family or their community.

When treating a child of Jehovah’s Witness parents, practitioners should be alive to possible complex family/community dynamics. It may be that although the parents cannot openly be seen to encouraging their child to consent to a blood transfusion, or to consent on their child’s behalf, they would actively encourage the child to consent to a blood transfusion. As such, it is of utmost importance for the medical practitioner to take steps to ensure that the child’s interests are not compromised.

As in the case of an adult Jehovah’s Witness patient, the benefits, risks, social and other implications of treatment may consent to or refuse treatment without assistance from a parent. In the case of a surgical operation (as opposed to treatment), such a child may only give consent if he/she is duly assisted by a parent or guardian.

In terms of the Guidelines on Informed Consent, published by the Department of Health, Jehovah’s Witnesses are entitled, in terms of our Constitution, to refuse a blood transfusion. The patient should be informed that a blood transfusion should therefore be administered.

The Jehovah’s Witness patient’s parent(s) are consenting thereto, the practitioner should contact the Department of Social Development, as the minister of Social Development may consent to the administration of the blood transfusion.

Should a blood transfusion be regarded as medical treatment (as opposed to a surgical operation, a child over the age of 12 years (who is sufficiently mature) will be alive to possible complex family/community issues.
Aspects of confidentiality: social media

One of the most commonly recurring issues that feature on the MPS advice line is confidentiality. In each edition of Casebook we will highlight an unusual scenario, at the heart of which lies a difficult dilemma around confidentiality.

A 38 year-old anaesthetist in private practice, who mainly works with children, contacted MPS recently with a query regarding social media use. She reported that over the past year, colleagues had noticed a trend emerging among parents of children who have been involved in dramatic/freak accidents.

This saw the parents set up a “support group” using social media (usually Facebook), where they publish daily updates of their child’s progress in great detail, including photos. Our member was concerned that photos of hospital staff and the buildings themselves (inadvertently featuring other patients) are being uploaded, and personal and clinical details are being shared.

What are the medicolegal implications of this?

Advice
Facebook allows a subscriber to choose privacy settings, choosing which information to make available, whether all postings can be made public, or whether only “friends” can have access to the postings. Once a party discloses their personal information and the information is disseminated in accordance with the privacy settings, there is said to be a waiver of their rights to privacy.

The difficulty with the Facebook system, as opposed to other social networks, is that there is no mechanism with which to control what other people place on their profiles. Patients are entitled to disclose confidential information of the patient himself and/or of third parties which, legal steps can be taken to prevent disclosure. Accepting a tagged photograph, however, would of course be a waiver to the right to privacy. In addition, any comments that are disparaging may well be defamatory and the patient should be careful about disseminating that information further.

Based on confidentiality, a practitioner must be careful about posting pictures of a patient without consent and/or befriending a former patient. Whilst a patient may publish their own information, a professional cannot respond on the website to the comments made, nor does it give the professional the right to disseminate the information.

Healthcare professionals should treat personal or private information, including the patient’s name, address, birth date, images, and associated health conditions as confidential. Practitioners should always maintain professionalism whilst conversing with patients via social networking sites.

If a patient makes defamatory comments on a social network about a practitioner, the practitioner should not respond on the network to the comments made, nor does it give the professional the right to disseminate the information. Instead, the patient should be careful about what they post, and the patient should be careful about what they post. If the patient makes defamatory comments on a social network about a practitioner, the practitioner should not respond on the network to the comments made, nor does it give the professional the right to disseminate the information.

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Concealed sepsis

Mr D, 53, had suffered with osteoarthritis in his right knee since turning 50. This had been confirmed with arthroscopy. He rarely bothered him and he continued to work as a PE teacher. He had experienced a flare-up of knee pain the start of the final term but this settled quickly with analgesics. He presented on the first weekend of the Christmas holiday, complaining of two days of bilateral knee pain, which was unrelated by his usual anaesthesia. He was seen by Dr C, who documented a normal right knee on examination, but limited movement in the left knee, with positive meniscal signs and no effusion. Dr C also noticed that Mr D had a paint-splatted left little finger, which he had jammed in the door two weeks earlier. Since he was ambulant, Dr C attributed the symptoms to OA and advised Mr D should also arrange to get an x-ray of his finger to exclude a fracture. He provided him with paracetamol for pain.

The pain continued after the weekend and Mr D had been unable to leave the house to arrange the x-ray. He spoke to Dr A at the surgery and an appointment was arranged for the next morning. Dr A recorded an effusion and worsening right knee pain now radiating to the calf and hip. He also spotted two erythematous patches on the right elbow and left foot. Mr D had not reported feeling febrile and no vital signs were not recorded. Dr A prescribed a course of antibiotics to cover for possible infection in the right hand, and documented that the knee pain was likely to be a strain. She quizzed gout as a possible cause and recorded that she was uncertain what the x-ray showed. She advised Mr D to contact the surgery again the next day.

The next day was Christmas Eve and Dr B was on duty, seeing Mr D at the surgery. By now he was feeling better, and the swelling in his hand had reduced, but he was feeling “spaced out” on the codeine analgesia he was taking. The patient’s fatigue and the clues on the x-ray were not recorded. The patient continued to work as a PE teacher and recovered from the episode. He was told to seek further help if they continue to feel unwell.

Learning points
- Good note-taking is essential. In this case, recording the vital signs on the right hand, and documented that the knee pain was likely to be a strain. She quizzed gout as a possible cause and recorded that she was uncertain what the x-ray showed. She advised Mr D to contact the surgery again the next day.
- Clinical presentation can change quickly. Expert opinion was obtained by gaining expert opinion to support the claim.
- Good note-keeping is essential. In this case, recording the vital signs on the right hand, and documented that the knee pain was likely to be a strain. She quizzed gout as a possible cause and recorded that she was uncertain what the x-ray showed. She advised Mr D to contact the surgery again the next day.

Headaches and hypertension

Mr J was 43 and unemployed. He developed headaches and complained that sunshine hurt his eyes and he was bothered by noise. He was referred for an appointment with his GP. Dr A, explaining that he had tried over-the-counter painkillers but that they did not help when he had one of his pounding headaches. Dr A documented Mr J had presented with headaches with some features of migraine and prescribed some tramadol.

Five years later, Mr J was struggling with headaches. He wondered if he needed a new job in a supermarket.

Confronted with the reality of his headache and unable to find work, he decided to seek help. He was referred to a consultant oral maxillofacial surgeon. He thought his headaches were coming from tempo-mandibular joint dysfunction, possibly secondary to a tender wisdom tooth. He had his wisdom tooth extracted under sedation. His blood pressure was not taken at this time. At his review, it was noted that his headaches had improved and could be managed with paracetamol alone. Mr J felt better and had been able to find a job in a supermarket.

The same year Mr J became concerned because he saw blood in his urine. He made an urgent appointment with his GP. Dr A documented that he had no dysuria or suprapubic pain. He noted that Mr J was very anxious about it and referred him to urology to investigate his painless haematuria. There was no mention of headaches at this consultation and his blood pressure was not taken.

A month later, Mr J fell whilst stacking shelves at work. He couldn’t get up and noticed that his right side felt weak and his vision was blurred. An ambulance was called and took him to the Emergency Department, where a CT scan showed an intra-parachymal bleed with extension into the left ventricle and midline shift. He became agitated, irritable and started vomiting. His GCS dropped to 7 and he was taken to CT at the local TU where he was intubated and ventilated. His blood pressure was found to be 260/140. His left pupil was found to be larger than the right and was unreactive. Mr J had a left frontal craniotomy, releasing 230ml of haematoma blood. He remained ventilated for over a week because of issues with high blood pressure. Mr J was found to have left ventricular hypertrophy on ECG and impaired renal function. His hypertension persisted after he was extubated and he was found to have 2 hypertensive retinopathy. A month later, Mr J was discharged home. When Mr J was discharged home, Mr J developed epilepsy and significant cognitive impairment. He needed neuro rehabilitation, was unable to work, and required care.

At his nephrology follow-up, his blood pressure was 150/100 despite four antihypertensive drugs, but there was no evidence of L/H on echocardiogram. Mr J made a claim against his GP. He felt that the diagnosis of hypotension had been missed and the delay in treatment had caused his brain haemorrhage. It was alleged that Dr A had failed to take his blood pressure despite persistent headaches and haematuria. He believed that Dr A had diagnosed somatisation headache without examining him. Expert GP opinion had only one criticism of Dr A, in that he failed to examine the optical fundi when he presented with headaches in the morning. The opinion of a professor of cardiovascular medicine was also gained. He concluded that the intracerebral bleed was likely to be due to a small vascular abnormality rather than due to malignant or accelerated hypertension. He thought that he probably had only mild to moderate hypertension before his bleed because he had been found to have only grade 2 hypertensive retinopathy. There was no parkinsonism, hemiplegia or exudates which accompany accelerated or malignant hypertension. Expert opinion also felt that the high blood pressure readings at the time of the stroke represented the usual physiological reaction to a cerebral bleed and did not represent the true ongoing level of hypertension. He discounted the relevance of headaches as he did not sign of hypertension in this case. He explained that hypertension usually only causes headache if it is malignant or accelerated, which he believed was not the case.

The case was successfully defended and the claim and the treatment of the patient had been provided and all costs were recovered.

Learning points
- Traumatic events don’t always equal to negligence.
- MPs successfully defended the claim by gaining expert opinion from three doctors.
- It’s useful to remind ourselves of the stages of hypertensive retinopathy and remember to examine the fundus in patients with hypertension.
Ms W was a 44-year-old Afrikaans teacher who was usually fit and well. She had two children and they enjoyed walking to the same school together in the mornings.

On one of these walks Ms W was troubled by aching in her right buttock and some tingling in her right calf. She mentioned this to her GP, who noted that there had been no acute injury and that she was still managing to walk to school. He advised her to take paracetamol and ibuprofen and suggested some exercises.

A week later the pain was worse so Ms W made an appointment to see Dr G, another GP. Dr G documented that she had acute backache with right-sided sciatica and paresthesia in the right lateral leg. She noted that there were no bladders or bowel symptoms and documented that tone, power and reflexes were normal in both legs. Dr G’s notes stated that she had discussed warning signs that would need review. She prescribed diclofenac and referred Mrs W to physiotherapy.

Three weeks later Ms W saw Dr G again, complaining that the pain was so bad that she couldn’t work. Dr G noted back pain with right-sided sciatica and paresthesia but, again, found the power in her legs to be normal. Mrs W was getting indigestion with the diclofenac so Dr G prescribed codeine instead. She gave Mrs W a sick note and Mrs W said she would see a physiotherapist in the meantime.

She managed to see a physiotherapist a week later. The physiotherapist’s notes commented on her right buttock and leg pain and numbness in the right foot without weakness. There were clear records of the absence of bladder or bowel symptoms.

Mrs W was struggling to sleep with pain so made another appointment with Dr G. She documented that Mrs W was tearful but keeping active, doing jobs round the house. Dr G prescribed some senokot to help with “codeine related constipation” and a trial of amitriptyline.

Two days later Mrs W felt at home and rang the GP. She told the nurse that her right leg felt numb and weak, and that she felt like she needed to pass urine but couldn’t. An ambulance was called and records in the Emergency Department noted a five-week history of right-sided leg pain and paraesthesia with a one-day history of retention of urine and inability to pass stool. Examination revealed weakness and diminished sensation in Mrs W’s right leg but normal findings on the left. There was reduced anal tone and sensation over the saddle area. She was catheterised and one litre of urine was drained. Shortly after, records stated that she had complained of numbness and weakness in her left leg and that power had been found to be reduced in her left leg. Ten minutes later Mrs W was found to have no power in both legs.

Mrs W was commenced on a three-day course of intravenous steroids, followed by a further two-day course. An MRI confirmed an extensive high signal throughout the thoracic cord, suggestive of either inflammation or infarction, a plasma exchange was begun. There was no change to Mrs W’s condition and doctors noted her developing upper limb symptoms, an 5th nerve palsy and papilloedema. She was therefore treated on the basis that she had neurosarcoidosis, and Mrs W was recommenced on high dose steroids and started on intravenous cyclophosphamide. Her condition stabilised and the 5th nerve palsy and papilloedema resolved. However, she was left with clumsy hands and paralysis of both lower limbs. Methylprednisolone was tried, but there was no substantial change to her clinical condition. She did report some improvement in the function of her hands.

Mrs W was left with facial palsy in her lower limits, rendering her unable to move either leg or stand. Her upper limbs were weak. She had a suprapubic catheter and was incontinent of her bowels. Mrs W was devastated and made a claim against Dr G.

Mrs W alleged that she had told the GP of her difficulties in passing urine and opening her bowels several times prior to her admission. She claimed that her GP had failed to examine her adequately and had not referred her urgently. She believed that her disabilities would have been less severe if she had been diagnosed and treated earlier.

MPS’s GP expert reviewed the notes from Dr G, the physiotherapist and the hospital. He felt that there were some vulnerabilities in Dr G’s notes from the second and third consultations because they were rather brief, but considered her examination and management to be reasonable. He noted that Dr G prescribed senokot for constipation but thought it understandable for a patient taking codeine to be constipated.

He felt that constipation in itself was not sufficiently discriminatory to be a red flag necessitating urgent neurosurgical referral. He commented that the physiotherapist notes were clear and that the patient had been specifically asked about bladder or bowel symptoms and that there were none. The hospital notes stated that urinary symptoms only occurred on the day of admission. The records from all the clinicians involved pointed to Mrs W’s bladder and significant bowel symptoms starting on the day she was admitted, and not before as Mrs W claimed.

MPS also sought the opinion of a professor in neurology. He concurred with the rare diagnosis of neurosarcoidosis. He felt that Ms W’s acute deterioration was a consequence of cord ischaemia and infarction resulting from inflammatory or granulomatous involvement of the arterial supply to the cord. This would explain the sub-acute illness with a rapid evolutionary phase to the point of severe neurological disability. It was his opinion that there is no proven effective treatment for neurosarcoidosis and that earlier treatment would not have altered the outcome. He noted that it is well recognised that cranial neuropathies, such as Mrs W’s 5th nerve palsy, can resolve spontaneously without treatment, and the improvement in Mrs W’s upper limbs was consistent with the variable natural history of neurosarcoidosis. The cord dysfunction that she had developed remained unchanged despite treatment. MPS decided to defend the case to trial denying liability, supported by expert evidence. Mrs W discontinued proceedings two weeks before the trial, and MPS is now seeking recovery of all costs.

Learning points

- Good note-keeping is important in patient care but also when defending a claim. Clinical records should include relevant clinical findings, negative findings and relevant negatives when excluding red flags, such as the absence of bladder or bowel symptoms.
- MPS carefully reviewed the records of the GP, the physiotherapists and the hospital doctors to see how the notes supported each other to aid the defence.
- It is useful to be reminded of the referral guidelines from primary care for lower back pain. Repeated examination is needed to check that there is no progression of neurological deficit.
- This case highlights the value of revisiting your diagnosis and not making assumptions when a patient re-present.

REFERENCES

1. www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441

Learning points

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REFERENCES

1. www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441
Mrs X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex.

At four weeks, GP Dr B's notes showed that J's parents were concerned that J's left eye was smaller than the right, and Dr B referred the baby to a paediatrician. A couple of weeks later, Dr B documented the left eye as being more open and the referral was cancelled.

J was then seen by GP Dr A for a six-week check-up; his vision and hearing were recorded as being "satisfactory". At three months, Dr A referred J to an ophthalmologist after noticing a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later - before the ophthalmology consultation took place - J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. J was seen by a paediatrician, Dr C, but there was no record from this admission of any examination of J's eyes.

At six months, J's ophthalmology appointment took place. He saw a consultant ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

His parents made a claim against Dr A and Dr C for the delay in the diagnosis of the congenital cataract.

Expert opinion

Expert GP opinion on breach of duty stated that Dr A had not been diligent when initially examining J's eyes at the time of the six-week check. By that time Dr B had listed initial concerns about the size of the eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 20% chance of restoring J’s visual acuity to a level adequate for driving.

Another expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present; this would have allowed for appropriate surgical intervention of this cataract that was later diagnosed. This report also criticised the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues.

The case was settled for a substantial sum.

SH

Learning points

- Poor communication leads to poor treatment. Here there is poor communication at various stages, between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a consultant ophthalmologist until he was six months old, this delay highlights failures at both ends. Dr A’s referral letter did not make the urgency of the appointment clear but, also, the recognised association of microphthalmia with congenital cataract should have prompted the consultant reading the letter to offer an urgent outpatient appointment.

Wrong drug, no negligence

Mrs M was a 64-year-old care assistant in a retirement home. She visited her GP with a two-month history of blood in her stools, altered bowel habit, and intermittent lower abdominal discomfort. On examination the GP found haemorrhoids, and referred her to her local hospital to see Dr P, a gastroenterologist. Mrs M was found to be overweight, with a BMI of 32, and was a smoker. Dr P performed routine blood tests, and booked Mrs M to undergo gastroscopy, proctoscopy, colonoscopy, biopsies, and injection of haemorrhoids, under general anaesthesia.

She was seen preoperatively by Dr D, consultant anaesthetist. Dr D noted Mrs M was on a number of medications, including metoprolol and quinapril for hypertension; simvastatin for raised lipids, and inhalers for a diagnosis of chronic obstructive airways disease. She was documented to be allergic to the antibiotic augmentin, which she had taken some years previously, and had caused a rash and wheeze. Mrs M reported that her brother had suffered a severe reaction to general anaesthesia, and had spent two days in intensive care following a hernia operation. However, she was unable to provide more details, and her surgery had subsequently moved overseas. Mrs M had undergone two unforeseen general anaesthetics at that hospital.

Dr D decided to proceed with general anaesthesia. The procedure was uneventful, but at one point, Dr D administered 1.2g of augmentin. In the recovery area, Mrs M was noted to have a widespread itchy rash and was complaining of wheeze. However, her pulse, blood pressure, saturations and conscious level remained normal. She was treated with antihistamines and hydrocortisone. As a precaution she was admitted to the hospital overnight, where the rash and wheeze resolved, and she was discharged the following day following a further set of blood tests.

During her stay, she was visited by Dr D, who documented that he had apologised to her for the accidental administration of augmentin. Dr D wrote a letter to the GP explaining what had happened, and gave Mrs M a copy. Dr P was also noted to have visited her, but did not document his visit or discussion.

Approximately one week later, Mrs M developed a high fever and abdominal pain and was admitted to the hospital under Dr P. She was noted to be jaundiced and her other liver function tests were deranged. Investigations suggested a diagnosis of cholecystitis and she was treated with antibiotics. The episode settled and she was sent home with an appointment for an elective laparoscopic cholecystectomy. Mrs M brought a claim against Dr D and Dr P, alleging that the incorrect administration of augmentin had brought about her cholecystitis as part of an allergic reaction. Dr D, the anaesthetist, stated that he had given the antibiotic on the directions of the surgeon, Dr P. However, Dr P stated that he had left it up to Dr D to choose which antibiotic to give.

The experts concluded that there had been a clear lapse in standards, where it had been documented that Mrs M had received an antibiotic to which she was allergic. However, they complimented Dr D on his handling of the incident. They concluded that Mrs M’s cholecystitis was unrelated to the accidental administration of augmentin. In the absence of demonstrable causation, Mrs M withdrew her claim.

The hospital subsequently changed several of its policies and procedures, including implementing a “time-out” check at the start of each endoscopy procedure. AID

Learning points

- Adherence to simple protocols, such as the WHO Surgical Safety Checklist, can help prevent problems of this kind, where a known and documented allergy was overlooked. See www.who.int/patientsafety/safety/surgical-safety-checklist/en/
- In choosing the right technique for anaesthesia, Dr D was attempting to avoid a rare but dramatic problem, malignant hyperthermia: Mrs M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra care when performing a technique that is unusual for you.
- Good documentation is the cornerstone of your defence. In this case Dr P didn’t document anything that had been discussed or shared. If someone else is making the notes, ensure you check their entries.
- Human error is inevitable in medicine, but doctors should always be open with patients and their families following an adverse event. An open and frank apology can often help to defuse anger. In this case, Dr D was praised for his handling of the incident afterwards.
Casebook, 6: 4-5

Postnatal care is as important as antenatal and intrapartum care. If Dr Q had recorded the patient to have normal blood pressure and noted “normal cranials”, Miss Z would have been seen by an ophthalmologist and an immediate hospital admission arranged. An astrocystoma of the third ventricle was diagnosed and a shunt inserted that day to relieve the pressure. The tumour was subsequently excised. However, despite resolution of the papilloedema, her vision deteriorated further. She was left with perception of light in the left eye and movement vision in the right, and registered as severely sight impaired.

Expert opinion agreed that the delayed referral led to Miss Z’s visual loss. If an appropriate referral had been initiated when the visual symptoms were first described, then it is likely that significant loss of vision would have been avoided. The case was settled for a high sum.

Learning points
■ As ever, clear documentation of a consultation is essential. Your standard of note-keeping says a lot about your practice. If you can demonstrate that your notes are generally of a high standard, it may assist you if you haven’t mentioned something in the notes.
■ If Dr Q had recorded the patient to have “no visual disturbance” and later “normal fundoscopy”, that would have been more convincing than no mention of symptoms at all, when the patient clearly recalled reporting problems.
■ Fundoscopy is an essential examination and can assist in the diagnosis of many diseases. In this particular case, early fundoscopy could have prevented loss of vision. Experts commented that if Dr Q had carried out fundoscopy in his initial consult (as he said he did as part of a cranial nerve exam) then he failed to identify papilloedema, as it is likely to have been present at this time.
■ If you do suggest a patient consults an optician to obtain a more thorough and immediate check-up, you should ensure that safety-netting is in place by arranging a follow-up consultation.
■ Remember red flag symptoms, especially in patients who may be presenting with vague non-specific symptoms. Ask the important questions, document what has been done and record any important negatives.

REFRENCES

Record your reasoning

Miss Z was seen at 35 weeks gestation in an uncomplicated pregnancy. The consultant, Dr A, documented this consultation and the mode and timing of delivery was discussed. Mrs G was naturally anxious as she had had two miscarriages and Dr A counselled her regarding induction of labour around the due date. He discussed the increased risk of instrumental delivery and caesarean section as a result. Mrs G saw Dr A again two weeks later. Delivery by induction was revisted and agreed upon. Dr A made arrangements with the labour ward and used the indication “reduced fluid around the baby”, though he explained to Mrs G that this was to keep the midwife “happy”.

An ultrasound scan reassured Mrs G that this was to keep the midwife “happy”. Mrs G was admitted for induction of labour at 37 weeks gestation. On examination by Dr A the cervix was found to be soft, posterior and partially effaced. Induction by 2mgs intravaginal Prostrol gel was commenced at 09:30. An amnioncensis was refused but 6 hours later and labour ensued within two hours. Dr A was called when the first stage of labour was completed – this occurred at 00:05 and pushing commenced 45 minutes later.

Progress was slow; Mrs G’s temperature increased and the foetus developed a tachycardia. The midwife requested consultant review and Dr A assessed the patient. The baby’s head was in an occiput posterior position but low in the pelvis. There was discussion with the parents about the possibility of ventouse extraction. Initially they were reluctant, having seen the effects of ventouse delivery on head shape and facial bruising. However they consented and the procedure went ahead.

A Kiid cup was used with positive pressure over two contractions to effect delivery. The perineum stretched well and episiotomy was not deemed necessary. A second degree tear was sustained with labial bruising and was repaired with vicryl under local anaesthesia due to pain. Later, both the midwife and Dr A noted the perineum to be swollen. Mrs G questioned the possibility of prolapse but this was excluded by Dr A. Soon after, relations with Dr A deteriorated for unknown reasons and Mrs G refused to see him again.

She remained in hospital and saw other doctors and a physiotherapist. Each doctor acknowledged that she had ongoing pain, urinary and faecal incontinence, but none identified a problem with the repair. There was neurapraxia and infection but the anal sphincter was intact. Mrs G was discharged six days following delivery and was improving.

Dr B saw the midwife 11 days later and had noted constipation of the introitus that was thought to be self-limiting (the risk of requiring surgery had been allayed previously). There was no improvement; pain persisted locally, there was difficulty recognising feelings in the bladder and intercourse was impossible. Examination revealed a very tight asymmetrical introitus.

A second opinion gynaecologist, Dr F, recommended a Fenton’s procedure, which was undertaken with ease and without complications ten weeks after delivery. A claim was made against Dr A, alleging breach of duty for using oxytocin inappropriately, failing to rotate the head prior to delivery, using ventouse inappropriately, failing to perform an episiotomy, substandard repair of the perineum and failing to provide adequate postnatal care.

Expert opinion was supportive regarding breach of duty on all counts. Induction on psychological grounds was said to be reasonable, as was the use of oxytocin. Ventouse delivery without head rotation was cited as normal practice, as was allowing the perineum to stretch, avoiding the need for episiotomy. The expert stated that it would be unusual that a consultant of Dr A’s standing would surmise the labia together. The tissues were likely to have healed incorrectly rather than the repair having been performed in a substandard fashion. Induction of labour had no bearing on the need for instrumental delivery.

Unfortunately, several key documents were missing from the notes and could not be traced. Despite the supportive expert opinion, in the absence of these key documents, we were advised it would be very difficult to defend the case. Accordingly it was settled for a moderate sum.

KE
Complications of colonoscopy

A 60-year-old accountant, Mrs A, developed altered bowel habit and rectal bleeding. She saw consultant colorectal surgeon Dr C, who found large prolapsing haemorrhoids and recommended a haemorrhoidectomy and colonoscopy. Dr C removed a 5mm polyp in the caecum with a snare and then proceeded to perform a haemorrhoidectomy. Both procedures were described as uneventful and Mrs A was stable throughout the anaesthetic.

A few hours later, after the operation, Dr C noted Mrs A was well and ready for discharge. She subsequently developed minor rectal bleeding and abdominal discomfort, and was kept in overnight. The following morning, her routine blood tests were normal and her observation chart had been unremarkable, but her abdominal pain persisted. A chest x-ray revealed bilateral sub-diaphragmatic free gas. Dr C prescribed broad-spectrum antibiotics, intravenous fluids and kept Mrs A nil by mouth. An urgent CT scan confirmed an extensive pneumoperitoneum but no signs of any fluid collection. Dr C examined Mrs A and found a ‘completely soft abdomen with no peritonism and normal bowel sounds’. He saw her immediately and arranged an ultrasound scan, which revealed a large pelvic abscess. Dr C organised her admission to another hospital for radiologically guided drainage of the abscess, but this proved unsuccessful. Her condition deteriorated and Dr B, a specialist surgeon, undertook an emergency laparotomy to drain the abscess and perform a defunctioning ileostomy. Mrs A had a stormy postoperative recovery, initially requiring ITU support, and spent three weeks in hospital. Dr B subsequently reversed her ileostomy but Mrs A remained in hospital and developed problems with an incisional hernia, requiring several attempts at repair. She also needed psychosocial support for post-traumatic stress disorder, resulting in prolonged absences from work.

Two years later, Mrs A brought negligence proceedings against Dr C. It was claimed that Dr C should have acted sooner by performing an x-ray and CT scan, and administration of aminoglycoside antibiotics. Mrs A initially developed pain. It was also alleged that Dr C had selected inappropriate antibiotics and had discharged her too early, allowing the development of her abscess. It was suggested that these acts of negligence had delayed appropriate surgical treatment and directly led to all Mrs A’s subsequent complications.

Expert opinion for MPS did not substantiate any of these claims. It was agreed that non-operative management for perforations after colonoscopy was an acceptable practice if the patient was stable, exhibited no signs of sepsis and the perforation appeared to have sealed. The CT result, together with the carefully-documented clinical findings, nursing charts, and absence of a rise in inflammatory markers over several days, all supported this approach. Microbiology experts agreed that the antibiotics prescribed were appropriate and the length of administration sufficient. Dr C was also able to produce audit evidence of his colonoscopy practice, demonstrating a high volume (400 per annum) with a very low complication rate.

MPS defended the case and the claimant discontinued on the first day of trial, with full recovery of costs.

A catalogue of errors

As an orthopaedic surgeon, I was concerned about the number of cases related to orthopaedic surgeons in Casebook 22(1), January 2014. I was pleased to see, however, that many of these have been defended. What surprised me was the case “A catalogue of errors”. In that case, a lady was taken under a knee replacement that appears to have been mis-positioned, which caused pain in the knee and the need for a revision procedure to be carried out at an early stage.

At that revision, carried out by a different surgeon, swabs were taken showing coagulase negative staphylococcus, but this was not to be thought of as significant. Subsequently, the patient developed an infected knee replacement and staphylococcus epidermidis was grown (the same bacteria as coagulase negative staphylococcus). This pattern of late clinical symptoms from infection is not at all unusual with this low virulence organism.

The importance of this, of course, is that the infection was clearly in the knee for a long period of time and would have become symptomatic in due course in any event. The patient would therefore have required a revision knee replacement for this infection, even if the original components had been perfectly placed.

I note that the first surgeon was sued but the claim was settled because of the poor technical skill exhibited in carrying out the original knee replacement, and your expert, Mr D, felt that this was a breach of duty which indeed may well have been. However, the infection would not have been a breach of duty as it is a well-recognised risk following any knee replacement, and this would have required a two-stage revision in any event.

I note that the claim was settled for a substantial sum but it would seem that the claimant’s claim for clinical negligence was not pursued appropriately and the legal focus was on the medical management of the condition rather than the eventual poor result with prosthesis pain which is almost certainly due to the infection and consequence of scarring rather than anything to do with the original surgical procedure.

Professor Robert J Grimer, Consultant Orthopaedic surgeon, Honorary professor, University of Birmingham, UK

Response

Thank you for your observations on this case.

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CASEBOOK

Casebook

consultations. Of what he had told the GPs about consultations, at trial it was clear potential conflict of factual evidence supportive. Although there was a potential conflict of factual evidence (ie, what actually happened in the consultation), it was clear that Mr P had no real recollection of what he had told the GPs about his headaches during the various consultations.

What an assessment at the beginning of the process by a specialist might potentially have resulted in an earlier diagnosis (depending on what symptoms were actually present), the standard to be applied is that of the reasonable GP, and our expert was clear that doctors A, B and C had reached that standard.

Consent templates?

The question of adequate consent and the preoperative discussion of possible risks and complications frequently appear in Casebook. Are there any templates of consent forms for anaesthesia procedures? Is it not something that MPS should be involved in creating or developing?

Dr AA Carolissen, Gynaecologist, South Africa

Response

Thank you for your observations and comments.

MPS does not produce specific templates or forms for use in the consent process. Consent is a process that will vary depending on the circumstances. Although there are some specific exceptions in relation to certain procedures, interventions and circumstances (eg, termination and termination of pregnancy, which require the completion of statutory forms), the actual format of the consent is less important than the accurate documentation of the process. MPS has produced a comprehensive guide – Consent to Medical Treatment in South Africa – which is available on our website.

Controlled drugs

(This letter refers to an article in the New Zealand edition of Casebook – consultations, at the time of submission with defining, and Ireland) recommend the standard wording applied in New Zealand. As both an airline captain and former surgeon, I have a view on both sides of the debate. I’d like to agree with his views on the issue of consent to anaesthesia. I should be prepared to discuss the risks.

Casebook

Over to you

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

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CAPT Downey makes some excellent points and his thoughts are aligned with mine. It is certainly true that airline safety relies to some extent on passengers alighting crew to potential problems, and in adopting a healthcare outcomes paradigm, similarly relying on patients for their expertise is crucial. A difference is that the passengers on an aeroplane, except perhaps in the case of a mid-air emergency, do not rely on the crew to instruct them how to be successful passengers (after the initial safety instructions prior to takeoff), whereas achieving healthcare outcomes uniquely requires clinicians and patients to work very hard together across all aspects of care planning to achieve successful care implementation. One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are readmitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause of physical, psychological and financial harm; the antithesis of a high-reliability system.

Clinicians and patients are both encumbered with many human factors liabilities and training or interventions for both are likely to serve good purpose. The processes of diagnosis, therapeutics and of care plan implementation present numerous human factors challenges. If the goal is preventing readmission then planning for that should begin at the time of admission with defining, and then modulating, the human factors that confound success.

Dr Cohen, MD, FRCPCH, FAAP, International Medical Director, Datix (UK) Ltd and Datix (USA) Inc. Dcohendatix.co.uk

References


Response

Thank you for your comments.

It is fair to say that the medicolegal aspect of care planning to achieve successful care implementation. One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are readmitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause of physical, psychological and financial harm; the antithesis of a high-reliability system.

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References


Response

Thank you for your comments.

It is fair to say that the medicolegal aspect of care planning to achieve successful care implementation. One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are readmitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause of physical, psychological and financial harm; the antithesis of a high-reliability system.

Clinicians and patients are both encumbered with many human factors liabilities and training or interventions for both are likely to serve good purpose. The processes of diagnosis, therapeutics and of care plan implementation present numerous human factors challenges. If the goal is preventing readmission then planning for that should begin at the time of admission with defining, and then modulating, the human factors that confound success.

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The Checklist Manifesto: How to Get Things Right

Review by Dr Amir Forouzanfar, surgical specialist registrar, Doncaster, United Kingdom

A tul Gawande has written an insightful, in-depth and stimulating book about the challenges of modern medicine. His honest reportage of challenging medical scenarios including personal mistakes, combined with stories from other professionals, certainly convinced me that surgical checklists are a good thing. I work as a specialist registrar and we now routinely undertake the WHO operating checklist. I’ve noticed an increase in its uptake and implementation, which can only be a good thing. I see errors picked up on a weekly basis simply by having an easy-to-follow checklist for the whole team to follow. Gawande distinguishes between errors of ignorance and errors of inaptitude – the most common and relevant in today’s medical world being the latter. He explains that the high pressured and intense environment that is prevalent in the medical world means mistakes are inevitable.

He borrowed a concept from the aviation industry: the checklist, similar to the checklists used by pilots before take-off, and applied it to medicine. He then argues that implementing checklists that walk surgeons through procedures actively prevents mistakes. Good checklists and clear communication amongst the team can significantly reduce errors. For those among the medical profession who are sceptical about using checklists, or are interested in how the WHO operative checklist came about, I suggest you read this book, as it is powerful enough to make you rethink your ideas. I’ve found myself using examples of Gawande’s book to inform my operating staff or paediatrician, GP or psychiatrist – to whom, I’m sure, it will prove to be a valuable resource.

1. A claim inexorably arises soon after an event.
True/False

2. If a patient develops a complication, negligence is inevitable.
True/False

3. Not only must a doctor warn a patient about the risks of a procedure, but also document the discussion.
True/False

4. A claim following a complication may be defended successfully if it is shown that the complication was not a result of negligent care, and that the complication and its subsequent care were appropriately managed.
True/False

5. Good note-taking is not only important in patient care but may also be helpful in defending a claim.
True/False

6. Clinical records should also include important negative findings.
True/False

7. Once a doctor has made a diagnosis, the doctor should stick by that diagnosis.
True/False

8. If somebody is making notes on a doctor’s behalf, the doctor concerned has no responsibility for the content of the notes.
True/False

9. If something goes wrong as a result of your care, you should be open and honest about it with the patient.
True/False

10. It is reasonable to warn patients to be on the lookout for symptoms or signs that suggest there has been a deterioration in their condition.
True/False

11. The presence of a chaperone may be most useful if allegations are made regarding the appropriateness or manner in which an intimate examination was performed.
True/False

12. A quintessential characteristic of high-reliability organisations is reliance on the advice and knowledge of those on the frontline of the process.
True/False

13. Transparent and timely disclosure should be the gold standard of patient care.
True/False

14. Once something has been posted on social media it is impossible to have it removed.
True/False

15. If a patient allows you to take a photograph of them, you are entitled to post it on social media sites.
True/False

16. Information such as a patient’s name, address and birth date are not confidential information.
True/False

17. As you are generally aware of the view of Jehovah’s Witness patients, there is no point in discussing the need for a blood transfusion with an individual Jehovah’s Witness patient.
True/False

18. If you have a Jehovah’s Witness patient who requires blood and declines to have it administered, you can wait until they are unconscious and then administer it.
True/False

19. In private practice you may decline to perform non-emergency surgery on a Jehovah’s Witness patient, if you feel that the administration of blood may be essential for the patient’s survival and the patient informs you that under no circumstances do they want blood to be administered.
True/False

20. According to the Children’s Act, Act 38 of 2005, the best interests of a child are paramount in all decisions regarding children.
True/False
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