CLINICAL NEGLIGENCE REFORM

HOW WE ARE ADVOCATING CHANGE

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Our latest collection of case reports

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Common problem areas in prescribing

A FAMILY MATTER
The risks of treating friends and family
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Casebook is designed and produced twice a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

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I am delighted to welcome you to this latest edition of Casebook and my first as Editor-in-Chief. I would like to express my thanks to my predecessor, Dr Nick Clements. Nick has made an enormous contribution to both Casebook and to the work we do on behalf of members for many years, and his considerable knowledge and experience have been an invaluable resource. Fortunately he has not gone far, and we wish him all the best in his new role within Medical Protection.

Having been a medicolegal adviser at Medical Protection for over 12 years I have had the privilege to advise and assist many doctors going through difficulties in their professional lives. I am very aware of the stress and anxiety that doctors experience when they are the subject of criticism or an investigation, and the impact this can have on them both personally and professionally. Helping doctors to avoid such difficulties in the first place through education and awareness of risk is one of the key aims of Casebook, and I hope to continue the tradition of publishing informative, educational articles and case reports that help to improve practice and prompt discussion.

In this edition we also address the difference between the membership we offer for state doctors, and the membership we offer to those working in private practice. We are aware that sometimes there is confusion about the differences between the two, and so we have provided a clear summary of how we support state doctors and why they still need Medical Protection membership. Read more about this on page 10.

In the November 2015 edition of Casebook, we covered our campaign to challenge the rising cost of clinical negligence on your behalf and the work that we are doing to advocate meaningful legal reform. On page 12 we take a look at the work that has continued since the end of last year.

The case reports in this edition have a particular focus on conditions that can lead to claims of particularly high value. While some of these medical conditions may not be that common, they can lead to significant disabilities for the patient, unless diagnosed early and appropriate action taken. One of the challenges for clinicians is identifying those patients that require further investigation in order to establish or rule out serious underlying pathology. As the cases demonstrate, good documentation is essential in order to justify your clinical decisions if there is an adverse outcome.

I hope you enjoy this edition. We welcome all feedback, so please do contact us with your comments or if you have any ideas for topics you’d like us to cover.

Dr Marika Davies
Casebook Editor-in-Chief
marika.davies@medicalprotection.org
Prescribing is one the greatest areas of risk for all clinicians and can be particularly hazardous for the inexperienced doctor. It is fraught with potential pitfalls, ranging from transcription errors and inadvertent dosage mistakes to overlooked drug interactions, allergies and side effects, the consequences of which may be profound both for the patient and the prescriber.

It is imperative that you have a good knowledge of the pharmacology and the legislation surrounding drugs, and any protocols and controlled drug routines that apply within your workplace – if unsure, ask.

To help members control their prescribing risks Medical Protection has developed a new online module on the subject, which can be found on our e-learning platform, Prism.

Below are two case reports highlighting some common potential hazards.

**CASE 1**

Mr A registered with a new GP practice and requested a repeat prescription for his regular medication, which included fluocinolone 0.025% cream (a potent topical steroid). He was asked to attend for a GP appointment with Dr B, who immediately noticed the patient’s “bright red shiny face”. Mr A explained that he had suffered from asthma and eczema for many years and that he had started using the fluocinolone on his face about two years earlier when his eczema had been bad. Although the eczema on his body and limbs had cleared up, he found that as soon as he stopped using the steroid on his face it became very uncomfortable, so he continued to use it.

Dr B discussed the risks of continuing to use the potent steroid on his face and referred him to a local dermatologist who initiated a regime to reduce gradually the strength of topical steroid used on the face. After four months Mr A found he no longer needed to use any topical steroid on his face.

Discussion with Mr A and review of his records revealed that although he had attended for reviews at his previous GP, these had been at the asthma clinic. His records had been coded as “medication review done”. He had initially been prescribed hydrocortisone 1% ointment for his face but had stopped ordering this as well as his emollients when he found the stronger steroid more effective. The prescriptions for fluocinolone cream had simply stated “apply twice daily”.

**LEARNING POINTS**

- A change of GP practice is a good opportunity to review all medication.
- Medication reviews should encompass all items.
- Consider restricting the number of issues allowable for certain drugs, such as potent topical steroids, before a review.
- Include relevant information on the prescription, such as the problem being treated and any monitoring requirements. This will appear on the label once the medication is dispensed and may improve adherence to treatment. For example, “apply twice daily to body, arms and legs for severe eczema only”.
- In some cases it may be preferable not to add as repeat prescription until it is clear that the condition is responding as expected.
- Consider the use of patient information leaflets to explain the management of chronic conditions more clearly.

**CASE 2**

Mr C was on long-term immunosuppressive treatment when he visited his general practice for his annual flu vaccine. He asked if he could also be given the new shingles vaccine. The nurse said he was not sure and would check with one of the GPs. He waited outside one of the consulting rooms and quickly popped in between patients. Dr D was already running behind with her surgery and after a brief thought said, “Yes, that would be fine.”

Mr C was given the vaccine and unfortunately developed an atypical herpes zoster infection. A few months later a complaint and subsequently a claim were made against the GP practice.

A significant event analysis at the practice revealed that Dr D had not accessed the patient notes before giving advice. There was nothing in the clinical notes to record the discussion between the nurse and Dr D.

**LEARNING POINTS**

- Distractions and interruptions are a common cause of error.
- Vaccination errors are one of the most frequently reported medication safety incidents reported in primary care.
- When prescribing or giving advice about a new or unfamiliar drug, be prepared to look up information on your clinical record system, in a formulary or in specific guidelines as appropriate.
- Make contemporaneous records of all contacts/discussions with colleagues about patients.
- Administration of a routine vaccination is not urgent and, although inconvenient for the patient, it may be safer to rebook, allowing time to check facts – particularly if, as here, the patient had a short appointment earmarked just for the flu vaccination.

**REFERENCES**


The cases mentioned in this article are fictional and are used purely for illustrative purposes.
Expert witness work is rife with myths and misconceptions. For some doctors, accepting instructions to act as an expert – be it for a claim, Health Professions Council of South Africa (HPCSA) complaint, disciplinary hearing or inquest – may be driven by the payment on offer; others might see it as a curio, an interesting diversion from the day-to-day duties of clinical work.

Considering what is often at stake – a doctor’s livelihood, perhaps a patient’s hopes for compensation – it is dangerous for anyone to accept expert work with either of the above reasons as the primary goal. Budding experts must approach their duty with a clear understanding of what is expected of them – and of the consequences of failing to meet these expectations. Any expert delivering substandard work may find themselves falling foul of the same sanctions they were originally assisting with.

In the course of Medical Protection’s work, we instruct experts around the world on a regular basis. To help maintain and improve the skills of experts – and potential experts – in South Africa, Medical Protection is looking to introduce expert training days. A hugely experienced team of clinical and legal professionals from across South Africa will be on hand at each event to outline the practicalities – and pitfalls – of working as an expert witness.

WHAT IS AN EXPERT WITNESS?
An expert witness is hired based on their expertise – based on education, training, skill or experience (or all four) – in a particular subject. This specialist knowledge is relied upon when they are asked to provide an expert opinion on the facts of a case.

Above all, an expert witness must maintain the confidentiality of any information they receive on the case – resisting the temptation to discuss it with colleagues – and must be:

• Impartial – the expert witness must only comment on the facts they know about a case and must not speculate: opinions must be based on the facts only and should not be preferential or disparaging towards any doctor involved.

• Competent – an expert witness should not stray outside the boundaries of their own expertise.

• Adequately trained to understand:
  • their duty to the court;
  • the appropriate standard of proof;
  • the rules of the court;
  • the litigation process;
  • how to prepare an expert report;
  • how to give oral evidence in court.

If you are instructed to act as an expert witness, ensure you read the instructions fully and consider the following points:

• Who is instructing me?

• In what capacity am I being asked to provide a report? Clarify it is as an expert witness.

• Am I the right person to do this report?

• Do I have the appropriate expertise?

• Is there a conflict? Do I know the doctor involved, or perhaps the patient or close family?

• Do I have the time?

The last point is particularly important, because expert witness work is not solely writing a report. Accepting instructions to be an expert witness means you are committing to a range of other duties, which can involve:

• Attending meetings with solicitors or doctors involved.

• Attending meetings with other experts.

• Attending court. You may be cross-examined about your expert evidence and this can be daunting. You must be alert to the possibility of being summoned to court – there is no ‘opting out’ because it may seem unappealing.

Gareth Gillespie looks at what it takes to be an expert witness

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THE ROLE OF AN EXPERT

An expert witness can be involved in various scenarios:

1. HPCSA matters

This depends on the charge against the doctor; usually no expert is needed for minor hearings concerning prescription labelling, sick leave certificate management, or practice advertising.

An expert may be needed for situations involving informed consent issues, unconventional treatment, ‘over-service’, and indecent assault.

2. Inquest

Here the role of expert is to:

• Give an opinion on the medical cause of death and associated management issues, on the basis of available evidence – medical records/reports, autopsy report, witness statements.

• Make suggestions to prevent future risks; identify any errors in the system, without opining on an individual doctor’s clinical judgement/decision.

3. Personal injury claims and mediation

• Expert opinion is required to ascertain position in negligence (ie, whether there was breach of duty or causation).

• Experts can also examine patients to give opinion on condition and prognosis, which lawyers use to decide the value of any payout (this often involves orthopaedic surgeons, neurologists or psychiatrists, etc).

4. Test of testamentary capacity

Expert to give opinion on whether the testator:

• Understands the nature of the act and its effect.

• Understands the extent of the property being disposed.

• Is of sufficiently sound mind to be capable of forming the testamentary intentions embodied in the will.

• Is affected by any disorder or disease of the mind that would influence his decisions.

EXPERT REPORTS

A comprehensive guide to writing expert reports is available in the advice section on the Medical Protection website. Essentially the report should include:

• A title page.

• The author’s personal details, name, current post and summary of previous experience.

• A statement of the opinion requested and details of relevant knowledge/experience enabling the author to comment on the issues.

THE LAW OF EVIDENCE IN SOUTH AFRICA

The following principles are relevant for the admissibility and reliability of expert evidence:

Expert evidence will only be admissible:

1. Where the court can receive “appreciable help” from the expert. Expert evidence will not be necessary (and will be inadmissible) where the judge can form an opinion on the basis of ordinary knowledge or skill common to the average person.

2. If the experts are properly qualified to furnish the opinion.

3. If the opinion is based on reasoned conclusions or facts that are common cause.

The further requirements are that:

4. The expert is independent, non-partial.

5. The expert must have academic qualifications and must also show practical experience.

6. The expert must not usurp the function of the court, and make findings of law – for example, whether a contract was concluded or whether a practitioner was negligent.

Experts do not have any immunity when furnishing evidence. Since they express an opinion, if logically reasoned, there will be no basis to find them liable for a certain outcome. However, if the expert did not properly apply his mind, he can be referred to his professional body. Recently there have been some experts who have been referred to the HPCSA for giving evidence that was blatantly fallacious. In a spate of Road Accident Fund Cases, judges have referred experts to the HPCSA. One of these involved a case where a bruised ankle was considered a “serious injury” and it was reported that there was a fractured ankle when there was no evidence of any fracture, not by the plaintiff and certainly not on the radiological reports.

WHAT NOT TO SAY...

• “The patient’s version of events is barely credible...”

• “This is a recognised treatment option that is well documented in the literature [no references].”

• “Dr Y is clearly not guilty of negligence...”
NOT WINNING, NOT LOSING
Managing a claim is not about winning or losing; it is about establishing facts to resolve the dispute. Here both doctors and patients share a common aim – a fair and speedy resolution of the claim, and it is the same for complaints, inquests and any situation where a doctor’s practice is under the spotlight. Good expert opinions expedite resolution of such matters, and ensure fairer decisions while limiting costs. Working as an expert witness is anything but easy, but if approached in the right way it is an important part of an efficient process for doctor and patient alike.

CASE STUDY 1
GP Dr A had been treating his colleague Dr P informally for anxiety. He was asked by Dr P to provide an expert report to say Dr P was unfit to appear at his upcoming HPCSA hearing. Dr A provided the report “because he wanted to help a colleague”, and afterwards he was called to give evidence. When Dr A was cross-examined, no records of his consultations with Dr P were found, and the content of his report was found to be beyond his expertise. Dr A was referred to HPCSA, where he became the subject of an HPCSA hearing in his own right. Dr A was suspended for six months.

CASE STUDY 2
Radiologist Dr T accepted instructions to act as an expert for a patient. She worked across several different sites and the documents were sent to one site where Dr T only attended one half-day a week. The instructions were overlooked, and when they were eventually found, Dr T was travelling overseas for a conference, which meant the report would be late. A complaint was made to the HPCSA and Dr T received a warning.

EXPERT IMMUNITY
Experts are not immune from sanctions themselves. In the UK, in Meadow v General Medical Council (2006) CA, Professor Roy Meadow’s evidence at a murder trial was subsequently found to be “seriously flawed”. The defendant in the murder trial, who had initially been convicted, appealed and was acquitted, while a complaint was lodged about Professor Meadow to the UK’s General Medical Council (GMC). Professor Meadow was found guilty of misconduct and erased from the medical register. Although further appeals saw this decision overturned, Professor Meadow voluntarily relinquished his registration in 2009.

The cases mentioned in this article are fictional and are used purely for illustrative purposes.

WHAT DO YOU THINK?
We want to hear from you. Send your comments to: casebook@medicalprotection.org
A FAMILY MATTER

MEDICAL PROTECTION’S PIPPA WEEKS EXAMINES THE LEGAL AND ETHICAL CONSIDERATIONS OF TREATING FRIENDS AND FAMILY

Medical professionals work in an environment that constantly challenges their ethical judgement. The question of whether to treat a person with whom you have a close personal relationship is just one of the complex ethical dilemmas doctors have to navigate on a regular basis.

The HPCSA’s Guidelines for Good Practice in the Health Care Professions is silent on the issue of treating friends or family. However, it is suggested that doctors should seek to avoid inappropriate relationships, and should maintain professional relationships of trust and confidentiality with their patients.

Internationally, it is a practice strongly discouraged in many professional codes of practice. Emotional attachment affects the objective clinical judgment, and affects the power balance between patient and doctor. However, there are situations where it must occur. The World Medical Association recognises the contentiousness of this area of practice in its Ethics Manual, which states: “Treat family members is strongly discouraged in many medical codes of ethics. However, its application can vary according to circumstances. For example, solo practitioners working in remote areas may have to provide medical care for their family members especially in emergency situations.”

THE RISKS

Many doctors would trust themselves above all others to provide adequate care to their loved ones, but it is hard to imagine that the objective standard of clinical care would not be impacted by an emotional relationship with the patient. Whilst doctors are almost always invested in the continued health and treatment of their patients, the stakes are never higher than when the outcome would personally affect the practitioner and their family. Additionally, the doctor may not feel able to ask sensitive questions or perform intimate examinations, and if the patient is then likely to attend a separate GP as well as their relation, the risk of disjointed care and incomplete records becomes significant.

Similarly, the patient may not feel comfortable discussing intimate or embarrassing issues with close relations, which ultimately could lead to them not receiving the medical assessments or care they need. They may also feel unable to refuse treatment, or to seek an alternative opinion, resulting in a monopolised health/treatment plan. These issues are particularly true for children or adolescents, who may not wish their relations to know details of their lives and who lack the self-conviction to seek alternatives.

Maintaining trust and a confidential relationship between doctor and patient becomes significantly challenging when the doctor and the patient belong to the same family or group. For example, a father who is doctor to his daughter may be pressured to discuss her health with his wife, her mother. Although doctors might feel that this could never happen to them or their family, it is far too important a scenario to dismiss.

Prescribing for family or friends may not be illegal but it can be risky. In order to have a dispassionate appreciation of the medical diagnosis and treatment plan, the prescriber should not be emotionally involved with the patient. If the patient is seeking medical advice from both a family member and a separate GP, the drugs prescribed may be duplicated, or even contraindicated. Disjointed treatment plans and incomplete records may result in inadequate or dangerous healthcare.

Although most jurisdictions recognise that there are situations in which it might be unavoidable, many medical codes establish that the standard of care and the professional relationship between doctor and patient is adversely affected by a concurrent personal relationship and should be avoided wherever possible.

As a doctor, although it may be tempting to offer what you think is helpful medical assistance to a friend or family member, you should also be aware of the ethical and practical concerns raised by doing so, and the potential of exposing those you care about to a very awkward or dangerous situation. In some jurisdictions, doctors may also face disciplinary action if they proceed to treat friends or family against recommended guidance.

1. wma.net/en/30publications/30ethicsmanual/pdf/chap_2_en.pdf

AROUND THE WORLD

AUSTRALIA
States have guidelines from their respective Medical Boards that medical practitioners should avoid treating their immediate family, and that all medical practitioners should have their own general practitioner.

IRELAND
The Medical Council of Ireland says: “Except for minor illnesses and emergencies, it is not advisable for you to treat members of your own family or issue prescriptions, sick certificates or reports for them.”

NEW ZEALAND
The Medical Council says that wherever possible, a doctor should avoid providing medical care to anyone with whom they have a close relationship, due to a lack of objectivity and the possible discontinuity of care. However, they recognise that in certain cases doing so may be unavoidable.

UNITED KINGDOM
The General Medical Council states in Good Medical Practice: “In providing clinical care you must, wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.”

UNITED STATES
The American Medical Association states in the Code of Medical Ethics that physicians generally “should not treat themselves or members of their immediate family”.

WHAT DO YOU THINK?

We want to hear from you. Send your comments to: casebook@medicalprotection.org
HOW WE SUPPORT
STATE DOCTORS

We are aware that sometimes there is confusion about the difference between the membership we offer for state doctors, and the membership we offer to those working in private practice.

We have been providing non-indemnity membership to state doctors for many years and plan to continue doing so long into the future. However, because the state provides indemnity for its employees, the membership that we offer to state doctors does not include the right to request indemnity for negligence claims arising from professional practice. What we do provide is a wide selection of benefits ranging from CEU accredited education to medicolegal support and assistance. Non-indemnity membership also includes assistance with:

- HPCSA investigations;
- disciplinary processes;
- handling complaints from patients;
- report writing;
- inquests;
- media and press relations;
- police investigations arising from the provision of clinical care;
- good Samaritan acts.

As a doctor employed by the state, any claim made against you in respect of a negligent act or omission as a result of your professional practice in a state facility will fall to the state.

We appreciate that, in reality, accessing state indemnity can sometimes be a difficult process to navigate, which is why Medical Protection membership is so important. Our years of experience and expertise mean that we are best placed to exert the necessary pressure required to remind the state of its obligation to the doctors it employs, especially in respect of claims arising from professional practice in state facilities.

WHY STATE DOCTORS STILL NEED MEDICAL PROTECTION

Although the state provides indemnity for its employees, our membership for state doctors is still beneficial for a number of reasons.

We can assist members long before a claim or complaint arises with advice on how best to protect themselves in their professional practice, and can also assist in preparing and checking reports for the State Attorney. In addition, we can provide assistance with media relations to help protect your reputation.

While state indemnity should protect doctors who are employed by the state from the financial consequences of a negligence claim, it would not extend to assistance for internal disciplinaries or HPCSA investigations. Indeed, in internal disciplinary matters, or HPCSA complaints, it is quite possible that the employer is the complainant. Whilst the state probably would assist a doctor in the case of an inquest, it is usually only on the 'coat tails' of its own defence. If a doctor is vulnerable to individual criticism, or there is a conflict of interest between the state and the doctor, individual representation is preferable. State doctors who are Medical Protection members would be entitled to request assistance in these circumstances.

WHAT HAPPENS NEXT...

Scenario 1: If Dr K had state indemnity only

On realising that he had to justify his actions to the hospital, his seniors and also to Mr O’s family, Dr K had no one to turn to. He spoke to his employer, but they couldn’t help him. To make matters worse, by the time the hospital’s internal review came around six months later, Mr O’s medical notes had gone missing. This left Dr K extremely vulnerable, as he had no contemporaneous notes to back up his actions, and there was the fact that the blood results had not been reviewed.

Unfortunately, the next morning Mr O was found dead. Everyone in the department was shocked to hear of the regular attender’s death, but worse was to come when his bloods were reviewed and it was noted that his blood glucose had been 33mmol/l with a high potassium level. While Dr K had assumed Mr O was drunk, he was actually in ketoacidosis, meaning his death that night was probably preventable.

CASE STUDY

The following case demonstrates how Medical Protection membership goes beyond the support offered by the state:

Dr K was working in the Emergency Centre of a busy hospital on a particularly demanding Saturday night when a patient, Mr O, arrived in a semi-conscious state. Mr O was well known to the department; his medical notes revealed a history of alcohol abuse following years of hardship. This was not the first time Mr O had arrived at the Emergency Centre following a binge and he was usually kept in to sleep it off.

It was a busy evening and Dr K was pushed for time. History-taking was difficult as Mr O seemed very sleepy and incoherent, but the sweet smell of imbibed alcohol was enough for Dr K to dismiss his symptoms as simply the effects of excessive alcohol consumption.

An examination did nothing to change Dr K’s mind. Bloods were taken and sent to the lab and an entry was made in the nursing notes for the results to be followed up later. Dr K then took Mr O to a quiet corner of the Centre to sleep it off and continued to attend to other patients.

As expected, the patient’s family brought a claim against the hospital and against Dr K. The hospital used its state indemnity to attempt to defend its systems and protocols, but Dr K – without the medical notes – was clearly vulnerable to criticism. Dr K was then investigated by the HPCSA, following both complaints by the family and concerns raised by the employer.

The cases mentioned in this article are fictional and are used purely for illustrative purposes.
The story attracted some media interest and once Dr K’s local community found out that he was being investigated by the HPCSA, he lost the trust of many of his patients. The damage to his reputation – and subsequently his livelihood – was difficult to repair.

Scenario 2: If Dr K had been a member of Medical Protection

When Dr K was told that Mr O had died, he immediately phoned Medical Protection’s 24-hour helpline for advice.

A medicolegal adviser advised Dr K to write up a full report of the circumstances leading to the patient’s death, and also suggested that he write to the hospital superintendent requesting that a copy of Mr O’s anonymised medical notes be retained for safekeeping. Medical Protection then investigated the hospital protocol for managing patients in the Emergency Centre and prepared to help with the inquest and hospital investigation.

When the internal review came around, a copy of the notes was available as the hospital superintendent had retained a copy as requested (the originals, however, had gone missing) and the full report written by Dr K immediately after the event was available. During the internal review Dr K’s attempt to take a history, and the clinical examination, was pointed out: Dr K’s recollection was that he had wanted to do bedside testing for glucose but the necessary sticks were out of stock, so he had been forced to send away blood for testing instead.

The investigation of hospital protocols in the Emergency Centre also revealed there was no set protocol for following up blood results and, although Dr K had recorded that he had taken blood, the nurses had failed to follow up on it, despite a request being made in the notes.

While the hospital used state indemnity to defend its actions when the claim was made, Dr K was able to turn to Medical Protection for assistance in writing his statement. On the basis that he had written a report of his recollection of the event immediately, and could refer back to the nursing notes and the patient’s past medical notes, Dr K was able to show that his management of the patient was not unreasonable.

A complaint to the HPCSA was made by the family. However, Medical Protection guided Dr K through the process. Medical Protection instructed solicitors to represent Dr K in relation to the HPCSA investigation and a meeting was arranged at their offices to go through the case with Dr K. Thereafter, Medical Protection’s solicitors drafted a letter on Dr K’s behalf to the HPCSA. This served to convince the HPCSA’s preliminary proceeding committee that there was no prima facie case to answer, and the case was closed with no further action.

The Medical Protection press office was also on hand to help Dr K deal with the media intrusion. A statement was compiled to be issued to the press, which helped Dr K retain his reputation.

On closing the case with Dr K, Medical Protection reminded him of the importance of taking detailed notes in case he had to justify his actions again. Dr K took heed of this advice and booked a place on one of Medical Protection’s risk management workshops to develop his skills further.

Contact us to find out more about how to make the most of your membership with Medical Protection.

Further information about the difference between the membership we offer for state doctors, and the membership we offer to those working in private practice originally appeared in the article ‘Public or private: Know your service’ in Casebook Vol. 22 No. 1 (January 2014).
Healthcare professionals are feeling the pressure of escalating claims costs in South Africa. So too is the public purse. Sarah Whitehouse finds out how we are contributing to the debate around the need for clinical negligence reform.

The need for change

So, what can we do? Legal and procedural reforms are needed to begin to tackle some of the factors that have led to this deteriorating claims experience and ensure a fairer and more efficient system for all parties. In addition, a patient-centred, standardised complaints system should be developed to ensure that patient concerns are addressed, where possible, before they become a claim.

Minister Motsoaledi highlighted the need for change in early 2015, and we are keen to contribute to this important debate. More than 70 stakeholders attended our launch event, The deterioration of the claims environment in South Africa and the case for legal reform, in Johannesburg in November 2015, where we outlined our policy paper.

The lively and informative debate highlighted some of the many interesting ideas for reform that should be considered. Representatives from the following organisations contributed to the debate:

- South African Medical Association (SAMA);
- South African Dental Association (SADA);
- Colleges of Medicine of South Africa (CMSA);
- various speciality societies representing obstetricians, surgeons and private practitioners;
- South African Medico Legal Society;
- Hospital Association;
- Mediclinic, Netcare and Life Healthcare;
- leading lawyers with an interest in medical indemnity.

What does reform look like?

Our main proposals are:

Complaints process

- The development of a consistent, efficient, aligned and patient-centred complaints process that allows for local resolution.

Frequency of claims

- The introduction of a Certificate of Merit, as well as further consideration of ways to encourage alternative dispute resolution.

Pre-litigation resolution framework

- The introduction of a pre-litigation resolution framework.

Procedural changes

- Procedural change to ensure:
  - the exchange of factual witness statements;
  - early exchange of expert notices and summaries;
  - mandatory early experts meetings.

Limiting damages awards (general and special)

- Creating a tariff of general damages in statute.
- Introducing a limit on general damages, future care costs, and claims for loss on future earnings.
Prevention is another important theme. We must continue to play our part to promote safe practice in medicine by helping to avert problems in the first place, with open disclosure being a crucial element. When organisations embrace open disclosure, it benefits all involved. Above all, it is the ethical thing to do. Human error in healthcare cannot be completely eradicated, but our role is to support our members to identify and implement ways of managing risk.

Our international medicolegal expertise and international contacts help us to compare and contrast the challenging claims environment in SA with increasingly litigious claims cultures worldwide. Mark Doepel, Partner at Sparke Helmore Lawyers and Associate Professor at the School of Law, University of Notre Dame, spoke at the launch event about his experience of legal reform in Australia.

Mr Doepel said: “In my experience, particularly in Australia, law reform can lead to better mechanisms through which to hold negligent practitioners to account and through which to provide better levels of compensation for victims. In contrast, no-fault compensation schemes often leave victims with inadequate compensation and, since they are government funded and administered, not only are practitioners not held to account, but they are also left without added incentive to be extra vigilant in their practices. “These are just a few of the complex and important issues to be addressed in the campaign for clinical negligence reform in South Africa and that is why this debate is so important.”

THE DEBATE
The debate around the need for clinical negligence reform has received nationwide attention after featuring in the SAMJ (January 2016) with the editorial, ‘Challenging the cost of clinical negligence,’ and an article, ‘High-risk specialities threatened by runaway legal costs’ by Chris Bateman, a journalist who attended our Johannesburg launch.

Simon Kayll, Medical Protection’s CEO, said: “The good news is that this debate is already happening and there have been significant strides forward. Minister for Health, Aaron Motsoaledi, is actively confronting this issue due to his concerns about the escalating ‘crisis’. I congratulate the Minister for Health on his work so far on this, as well as the work of the Department of Justice and the South African Law Reform Commission.”

Mr Kayll added: “I hope that our paper will be one contribution among many to this important and increasingly relevant debate.”

COLLABORATIVE WORKING
We will continue to advocate meaningful clinical negligence reform at a public policy level, but we want our ideas to be debated and challenged. We are only one voice and our reform proposals are not exhaustive. We welcome the opportunity to explore our proposals further and share our experiences with other stakeholders so as to make reform a priority. We welcome your views on the matter, too.

REFERENCES
2. Health 24, SA’s Shocking Medical Malpractice Crisis, 10 March 2015

To find out more about Medical Protection’s recommendations and to read our policy paper, Challenging the Cost of Clinical Negligence: The Case for Reform, visit: medicalprotection.org/southafrica/about-mps/our-policy-work
FROM THE CASE FILES

Dr Volker Hitzeroth, Medicolegal Adviser, introduces this edition’s collection of case reports

This edition of Casebook highlights a number of cases in which Medical Protection was able to successfully defend a claim against a member. In keeping with our ethos of fairness towards members as well as their patients, we investigate each case on its individual merits, consult with the member and then decide on a strategy. Where appropriate, this will lead to a decision to firmly deny and robustly defend the claim.

A successful defence rarely rests in the detailed diagnostic correctness of the medical condition, nor on the minutiae of the treatment trials that the patient has undergone. Rather, a successful defence relies mostly on the appropriate application of basic medical knowledge and skills, good interpersonal relationships and the desire to make a difference to the patient. More often than not, what really matters is your availability when on duty, truly listening to the patient and their family, a thorough history and complete physical examination, and requesting the appropriate special investigations.

Other factors can impact on the successful defence of a claim, such as:

1. Responding timeously and appropriately to a patient or their family’s concerns and questions – always with patient consent recorded in the notes.

2. Detailed recording of all your patient contacts in your clinical notes (including administrative and secretarial staff). Such records are often the only proof of any event having occurred or action having been taken when the matter proceeds to trial many years later. This information often clarifies the background context to your decision-making process.

3. Contacting Medical Protection early in the event of a medicolegal threat. When you have an inkling of risk, Medical Protection can, at times, deflect medicolegal developments before they escalate and impact on your life and livelihood.

I see numerous cases where a member has ignored the family’s concerns, did not respond to messages left at the practice, did not return to re-evaluate a patient’s condition, and did not record all their thoughts and findings in the clinical notes. Additionally, I see many cases where Medical Protection is not contacted after an attorney has been instructed by the family to investigate a claim in negligence and subsequently requests your clinical notes.

When I have contact with clinicians I usually recommend the following:

• Acknowledge and respond to concerns raised by the patient or their family. Be cautious regarding disclosing confidential information to family members unless you have documented the patient’s prior informed consent to do so. Also be wary of simply categorising a concerned patient or family member as attention-seeking or difficult. Document all the concerns, messages and phone calls in your clinical notes with a clear date, time and subsequent intervention. If you are pressed for an immediate response, simply acknowledge the message and its content and undertake to revert back to the patient or family member in due course.

• Ensure that your clinical notes are comprehensive, contemporaneous and truthful. Document your detailed history and thorough examination and also note your thoughts regarding a differential diagnosis, appropriate investigations and follow-up arrangements. Always safety net with the patient by explaining what the next course of action should be if the clinical situation does not improve. Document this discussion in your notes.

• If you are concerned about any potential medicolegal incident, do not hesitate to contact Medical Protection for early advice and guidance.

I hope that you find both the cases and the above suggestions helpful.

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
C was a 20-month-old boy who had been up all night with a fever. It was the weekend so his mother rang the emergency GP. She explained that his temperature was 39.4 degrees and that he was clingy and sleepy. Dr R assessed him at the emergency unit and documented that there was no rash, vomiting or diarrhoea. His examination recorded the absence of photophobia and neck stiffness. He stated “nothing to suggest meningitis”. Examination of the ears, throat and chest were documented as normal. He noted that his feet were cool but he appeared hydrated. Dr R diagnosed a viral illness and advised paracetamol and fluids. He advised JC’s mother to make contact if he developed a rash, vomiting, or if she was concerned.

JC’s mother felt reassured so she took him home and followed the GP’s advice. JC remained tired and off his food over the next two days. The following day he began vomiting and mum could not get his temperature down. He seemed drowsy and was just lying in her arms. She took him straight to the emergency unit.

He was very unwell by the time he was assessed in the unit. The doctors noted that he was pale, drowsy, and only responding to pain. His temperature was 38 degrees and his pulse was 160bpm. A diagnosis of “sepsis” was made. Full examination revealed neck stiffness and he went on to have a lumbar puncture. This confirmed meningitis with Haemophilus influenzae.

JC was treated with IV fluids, ceftriaxone and dexamethasone and showed great improvement. Four days later he developed a septic right hip needing aspiration and arthrotomy. The aspirate revealed Haemophilus influenzae. A month later he was assessed at a fracture clinic and was just lying in her arms. She took him home and followed the GP’s advice.

The professor of infectious diseases thought that JC did not have meningitis when he saw Dr R but was likely to be in the bacteraemic phase of the illness. This phase shares features with many other more trivial infections. He explained that Haemophilus influenzae meningitis can present in an insidious fashion over several days. He felt that JC would have a lifetime risk of having a serious illness.

The orthopaedic surgeon noted the minor x-ray abnormalities in JC’s right hip. He felt that given the patient’s excellent initial recovery and the minor x-ray changes it was difficult to explain the alleged hip symptoms as children with coxa magna generally have no symptoms even with contact sports. He thought that JC would have a lifetime risk of needing hip replacement of 12-20% due to past septic arthritis.

The ENT consultant concluded that JC would need to use hearing aids for the rest of his life. He felt that his speech and language development had also been compromised by poor hearing aid usage.

In response to the Letter of Claim from the claimant’s solicitors, Medical Protection issued a Letter of Response denying liability based on the supportive expert opinion and the claim was discontinued.

Learning points

- The National Institute for Health and Care Excellence (NICE) in the UK have a useful traffic light system for identifying risk of serious illness in febrile children under five. Along with other clinical signs, it requires GPs to check pulse, respiratory rate, temperature and capillary refill time in order to categorise them into groups of low, medium or high risk of having serious illness.
- Safety netting is an important part of a consultation. In this case Dr R advised the mother to contact services again if he deteriorated. This helped Medical Protection defend his case.
- In some cases claims can be brought many years after the events. This makes good note-keeping essential as medical records will often be the only reliable record of what occurred.

REFERENCES


AF
FAILURE TO FOLLOW SPECIALIST ADVICE

SPECIALTY GENERAL PRACTICE/NEUROLOGY
THEME PRESCRIBING

Following a hospital admission for status epilepticus, which was attributed to a previous cerebral insult, Mr G, a 35-year-old clerical officer, was started on an anticonvulsant regime of phenytoin and sodium valproate. Over the next few years, the medication was changed by the hospital several times in response to the patient's concerns that his epilepsy was getting worse. After a further seizure led to hospital admission, the patient was discharged on vigabatrin on the advice of the treating neurologist, Dr W. Readmission for presumed status epilepticus a short while later led the hospital to conclude that there might be a functional element to the seizures. This was supported by psychiatric evaluation. The patient was discharged to psychology follow-up with a recommendation at the end of the discharge summary to gradually wean off the vigabatrin. This advice was overlooked by Mr G's GP, Dr L, who continued to prescribe as before. The error was not picked up by either Dr L or the hospital despite multiple contacts and several hospital admissions over the next five years, for the first three years of which Mr G remained under the care of Dr W.

Subsequently, Mr G was seen by both Dr L and his optician, complaining of tired, heavy eyes. No visual field check was carried out on either occasion. Nine months later Mr G returned to see Dr L, requesting a referral to the epilepsy clinic as he had read a newspaper report about the visual side effects of vigabatrin. An appointment was made at the clinic but Mr G failed to attend on two occasions. An urgent referral was ultimately made by Mr G's optician several months later following detection of a visual field defect on a routine examination. The ophthalmic surgeon, Mr D, noted that Mr G had been on vigabatrin for in excess of eleven years during which time he had not been monitored. His visual fields were noted to be markedly constricted, which was attributed to the vigabatrin. Mr G was referred to another neurologist who recommended a change of anticonvulsant. Mr G was gradually weaned off the vigabatrin.

As a result of the damage to his eyesight, Mr G brought a claim against the hospital for negligent prescription of vigabatrin and failure to warn the claimant of the side effects. Mr G also brought a claim against Dr L for continuing to prescribe vigabatrin against the advice of the neurologist, failing to review the medication at regular intervals, and failing to refer to an ophthalmologist.

EXPERT OPINION
Medical Protection's GP expert was critical of Dr L's failure to act on the neurologist's advice to tail off the vigabatrin and for the absence of any record that Dr L monitored the patient or reviewed his medication. Dr L's decision to refer Mr G to an epilepsy specialist once he was alerted to the potential side effects was appropriate and Dr L could not be held accountable for Mr G's failure to attend a number of hospital appointments, which may have contributed to the delay in diagnosing the visual field defect. The claim was settled on behalf of Dr L and the hospital for a reduced but still substantial sum.

Learning points
- If a doctor signs a prescription, they take responsibility for it – even if it is on the advice of a specialist. Good communication between primary and secondary care is vital to ensure patients receive the appropriate treatment.
- Patients should be informed if there is a need for monitoring or regular review of long-term medications. Where there is shared care with another clinician, agreement should be sought as to the most appropriate arrangements for monitoring. All advice should be clearly documented.
- When alerted to a potentially serious side effect of medication, prompt arrangements for review should be made, with a specialist if appropriate.
aby LM was taken to see his GP, Dr E, for his six-week check. During this examination Dr E noted that his left testis was in the scrotum but his right testis was palpable in the canal. He asked LM’s mother to bring him back for review in a month.

Two weeks later his mother brought him to see Dr E because he had been more colicky and had been screaming a lot in the night. As part of that consultation, Dr E documented that both testes were in the scrotum.

LM was brought for his planned review with Dr E in another two weeks. Both testes were noted to be in the scrotum although this time the left testis was noted to be slightly higher than the right. His mother was reassured.

When LM was 16-months-old he appeared to be in some discomfort in the groin when climbing stairs. His mother was worried so she took him back to Dr E for a check-up. Dr E examined him carefully and documented that both testes felt normal and were palpated in the descended position. He also noted the absence of herniae on both sides. He advised some paracetamol and advised his mother to bring him back if he did not improve.

When LM was 15-years-old he noticed that one of his testicles felt different to the other. At that time he was found to have a left undescended testis which was excised during surgical exploration.

LM’s mother felt that Dr E had missed signs of his undescended testis when he was younger. A claim was brought against Dr E, alleging that he had failed to carry out adequate examinations and that she should have referred to a paediatrician earlier. It was claimed that if Dr E had referred to a paediatrician earlier then this would have resulted in a left orchidopexy, placing the testis normally in the scrotum before the age of two years and thus avoiding removal of the testis.

**EXPERT OPINION**

Medical Protection obtained expert opinions from a GP and a consultant in paediatric surgery. Both were supportive of Dr E’s examination and management. The consultant in paediatric surgery thought that LM had an ascending testis. This is a testis which is either normally situated in the scrotum or is found to be retractile during infancy, and later ascends. He thought that even if LM had been referred in infancy, it would have been likely that examination would have found the testes to be either normal or retractile and he would have been discharged with reassurance. He explained that it is thought that in cases of ascending testis testicular ascent occurs around the age of five years. Therefore, on the balance of probabilities, referral to a paediatrician before the age of four would not have led to diagnosis of an undescended testis.

This claim was dropped after Medical Protection issued a Letter of Response to the claimant’s legal team which carefully explained the expert opinion.

**Learning points**

- Medical Protection were able to defend Dr E in light of his appropriate clinical management, good note-keeping and the expert advice.
- Good documentation helped Dr E’s defence. Doctors should always document the presence or absence of both testes in the scrotum at the six-week check.
- The National Institute for Health and Care Excellence (NICE) in the UK have published a Clinical Knowledge Summary that covers the primary care management of unilateral and bilateral undescended testes, including referral. It can be found here: cks.nice.org.uk/undescended-testes.

AF
Mr B was a 31-year-old man with three children. His mother was staying with him over the weekend because he was in bed coughing and shivering. On Saturday he complained of chest pains so his mother rang an ambulance. The paramedic recorded a temperature of 39 degrees, oxygen saturations of 94%, pulse 134, respiratory rate of 16 and a blood pressure of 120/75. An ECG was done and noted to be normal. The paramedic explained to Mr B that he should be taken to hospital. Mr B declined and was considered to have capacity so the ambulance left.

The ambulance crew called their control centre who in turn contacted an emergency GP, Dr Z. The control centre left a verbal message for Dr Z, explaining the situation, but did not hand over details of Mr B’s vital signs including his oxygen saturations and pulse rate.

Dr Z rang Mr B and noted his history of chest pain triggered by coughing and the normal ECG. She noted his temperature of 39 degrees and that he had taken some ibuprofen to help. She documented “no shortness of breath” and advised some cough linctus and paracetamol. She offered him an appointment at the emergency unit, which he declined, but he did agree to ring back if he was worse. She documented that her advice had been accepted and understood.

Mr B was no better on Sunday so his mother rang the emergency unit again. This time a nurse spoke to Mr B and noted his history of productive cough, fever and aching chest pain. She documented that he had some difficulty in breathing on exertion but that he could speak in sentences over the telephone. Again she offered him an appointment at the emergency unit but he refused, saying he would prefer to see his own GP on Monday.

Three days later Dr B’s mother took him to see his own GP. He found coarse crepitations in his right upper and mid chest but with good air entry. He noted that Mr B was not unduly distressed and had no shortness of breath so opted for oral antibiotics and a review in two days.

Later the same day Mr B’s breathing became rasping and very laboured. He collapsed and an ambulance took him to the emergency unit. Cardiopulmonary resuscitation was attempted but sadly failed. A post mortem was performed, giving the cause of death as “right-sided lobar pneumonia and bilateral pleural effusions”.

Mr B’s mother was distraught and brought a claim against the emergency GP, Dr Z. She claimed that her son had been extremely short of breath on the telephone and that she had not paid adequate attention to this. She was upset that Dr Z had not arranged to visit her son at home and had incorrectly diagnosed a simple chest infection.

EXPERT OPINION
Medical Protection obtained expert opinions from a GP and a respiratory specialist. The GP was supportive of Dr Z. He noted that cough, fever and malaise are very common symptoms in a young adult. He listened to the recorded consultation and considered Mr B to have been only mildly short of breath and showing no verbal signs of delirium. He felt it was reasonable for Dr Z to suggest attendance at the emergency unit. He also noted that if Mr B had been well enough to attend his own GP four days later, then he could probably have travelled to see Dr Z on the day she spoke to him. He felt it had been neither possible nor necessary to define the
A diagnosis beyond a respiratory tract infection during their telephone consultation. He thought it was unhelpful that Dr Z had not received Mr B’s oxygen saturations or pulse rate from the ambulance crew.

The respiratory specialist noted that Mr B was assessed by the ambulance crew on the same day he consulted with Dr Z on the telephone. At that time he was not confused, his respiratory rate was 16 and his blood pressure was satisfactory. This would have given him a CRB65 score of 0, which is associated with a good prognosis. He commented that this, along with clinical judgement, would have supported home-based care for this patient rather than the need for hospital assessment.

It was highlighted that Mr B had refused to go to hospital with the ambulance crew and to attend the emergency unit. This and the supportive expert opinion helped Medical Protection to successfully defend Dr Z.

Learning points

- Medical Protection can use recorded data as evidence to support members who are the subject of a claim.
- According to guidelines from the National Institute for Health and Care Excellence (NICE) in the UK, after diagnosing pneumonia GPs should use the CRB65 score to determine the level of risk and help guide decisions on where to manage a patient. One point is given for confusion (AMTS 8 or less or new disorientation in person, place or time), raised respiratory rate (30 breaths per minute or more), low blood pressure (systolic <90mmHg or diastolic <60mmHg), age 65 years or more. A score of 0 is classed as low risk and is associated with less than 1% mortality. A score of 1 or 2 is classed as intermediate risk and is associated with 1-10% mortality. A score of 3 or 4 is classed as high risk and is associated with more than 10% mortality.
- When communicating between healthcare services, it is important to hand over all relevant information. In this case the ambulance crew did not pass on the patient’s low oxygen saturations or his raised pulse rate. These vital signs could have conveyed the severity of the patient’s illness to the emergency GP.

REFERENCES

1. nice.org.uk/guidance/cg191/chapter/1-recommendations
Mr A was a 25–year–old man who was on lifelong steroid medication for congenital adrenal hyperplasia.

He was under the care of Dr F, a specialist endocrinologist. Dr F advised him to change his steroid medication from hydrocortisone to prednisolone, 7.5mg in the mornings and 5mg in the evenings. He gave him a prescription and wrote to Mr A’s GP to advise him of the steroid dose change.

A few weeks later Mr A had run out of prednisolone and went to see his GP, Dr S. He was prescribed 12.5mg prednisolone in the mornings and 10mg in the evenings. Dr S told him he had recently received a letter from Dr F about this dose.

Three weeks later Mr A started experiencing muscle cramps and mood swings. A few weeks after this his friends commented that his face was becoming swollen. In the subsequent weeks Mr A noticed he felt weaker and was not able to exercise as much at the local gym. He noticed he was bruising more easily.

Four weeks later he noticed he was developing large unsightly stretch marks on his body, especially around his back and abdomen. He consulted with another GP, Dr T, as he was concerned these, and his other symptoms, could be related to his steroid medication. Dr T examined him but advised him to wait and discuss his concerns with his endocrinologist at his appointment two months later.

At his endocrinology review Dr F advised him that all his recent symptoms were attributable to being on too high a dose of prednisolone. He reduced the steroid dose to 5mg prednisolone in the mornings and 2.5mg in the evenings.

Over the next few weeks most of the symptoms resolved, but Mr A was left with stretch marks that he found unsightly and embarrassing. He became very self-conscious and felt he could only go swimming with a T-shirt on. The stretch marks were itchy and uncomfortable, requiring frequent application of emollient, and he was advised that, although they would fade, they would never go away.

A DEXA scan revealed a decreased bone density and Mr A was commenced on Calcium tablets.

Mr A made a clinical negligence claim for undue suffering against Dr S and Dr T.

EXPERT OPINION
The GP expert was critical of both Dr S and Dr T’s actions and felt this constituted a breach of duty.

It appeared that Dr S had misread Dr F’s letter and prescribed an excessively high dose of prednisolone. Mr A continued to receive prescriptions for this medication every 28 days and Dr S and Dr T continued to issue the prescriptions without querying the dose.

He was particularly critical of Dr T for not questioning the dose of steroid when the patient presented with a multitude of steroid-related symptoms as well as new stretch marks.

The endocrinology expert felt that all the symptoms were attributable to an excess prednisolone dose over a five-month period.

He advised that most of the symptoms would be reversible, including the decreased bone density. However, he felt that the stretch marks would be permanent, although would fade to a certain extent over time.

The case was settled for a moderate sum.
Mrs B was a 57-year-old lady with a past history of breast cancer treated with mastectomy and adjuvant therapy. She re-presented to her specialist breast surgeon, Dr F, three years after the original surgery with a worrying 2cm lump in the vicinity of her mastectomy scar. Dr F recommended an urgent excision biopsy of the lump under general anaesthetic.

On the day of surgery, Mrs B was reviewed by consultant anaesthetist Dr S. She told Dr S that she had been fine with her previous anaesthetic and that she had no new health problems. Dr S reassured Mrs B that it should be a routine procedure and that he anticipated no problems. He warned her about the possibility of dental damage and sore throat and promised that he would not use her left arm for IV access or blood pressure readings, because of the previous lymph node dissection on that side.

In the anaesthetic room, Dr S reviewed the anaesthetic chart for Mrs B’s mastectomy procedure. He saw that Mrs B had received a general anaesthetic along with a paravertebral block for post-operative analgesia, and this technique appeared to have worked well. He did not, however, discuss this with Mrs B.

Dr S inserted a cannula in Mrs B’s right arm and induced anaesthesia with fentanyl and propofol. He inserted a laryngeal mask airway and anaesthesia was maintained with sevoflurane in an air/oxygen mixture. Mrs B was then turned on to her side and Dr S proceeded to insert left-sided paravertebral blocks at C7 and T6. Although Dr S used a stimulating needle and a current of 3mA, he had difficulty eliciting a motor response at either level. At T6, Dr S finally saw intercostal muscle twitching after a number of needle passes. Twitches were still just visible when the current was reduced to 0.5mA and Dr S therefore slowly injected 10ml of Bupivacaine 0.375% with clonidine. At the upper level, Dr S could not elicit a motor response despite several needle passes. He eventually decided to use a landmark technique and injected the same volume of local anaesthetic mixture at approximately 1cm below the transverse process.

Dr S then administered atracurium 30mg and Mrs B was ventilated for the duration of the operation. The operation was largely uneventful apart from modest hypotension, which Dr S treated with boluses of ephedrine and metaraminol.

At the end of surgery, Dr S reversed the neuromuscular blockade and attempted to wake Mrs B. However, Mrs B’s respiratory effort was poor and she was not able to move her limbs. Dr S diagnosed an epidural block caused by spread of the local anaesthetic. He reassured Mrs B and then re-sedated her for approximately 40 minutes. Following that she was woken again and her airway was removed. Weakness of all four limbs was still noted.

Over the next five hours Mrs B regained normal sensation and power in her lower limbs and left arm. However, her right arm remained weak, with an absence of voluntary hand movements. She also had gait ataxia on attempting to mobilise. An MRI was performed the following day, which demonstrated signal change and subdural haemorrhage in the spinal cord at a level consistent with her persistent symptoms.

Mrs B remained in hospital for physiotherapy and rehabilitation. Her walking and right hand function gradually improved and she was discharged three weeks after her operation. Six months later, Dr S received an attorney’s letter stating that Mrs B was still having problems with her hand and was seeking compensation.

EXPERT OPINION
Medical Protection instructed Dr M, a specialist anaesthetist, to comment on the standard of care. Dr M was critical of Dr S for four major reasons:

1. Dr S had failed to inform Mrs B that he intended to perform a paravertebral block and failed to discuss the risks and benefits of such a technique.

2. He was somewhat critical of the decision to perform the block with Mrs B anaesthetised. He opined that had Mrs B been conscious or lightly sedated, she would have alerted Dr S when the needle was in proximity to nerve tissue. However, Dr M did concede that there was a body of responsible anaesthetists who would support the notion of performing a paravertebral block with the patient anaesthetised.

3. He was critical of Dr S’s decision to keep persisting with the block when he was struggling to locate the correct needle position. He felt that Dr S should have abandoned the block or called for help. He also concluded that the technique used by Dr S was very poor given the complications that followed.

4. Dr M was critical of the levels chosen by Dr S to perform the block. He felt that C7 was too high, given that the dermatomal level of the surgery was approximately T4. He also felt that the surgery was very minor and did not warrant the paravertebral block. Dr M was of the opinion that infiltration of local anaesthetic by the surgeon, combined with simple analgesics, would have sufficed.

On the basis of the expert evidence Medical Protection concluded that there was no reasonable prospect of defending the claim. The case was eventually settled for a substantial sum.

Learning points
• Local anaesthetic blocks should only be performed when there is a clear indication.
• The risks and benefits of the block should be discussed with the patient and clearly documented. The process of consent for any operation should be a detailed conversation between clinician and patient with documented evidence. The incidence and potential impact of any common and potentially serious complications should always be discussed and documented.
• Local anaesthetic blocks should only be performed by practitioners with appropriate training and expertise.
• If difficulties are encountered, either the procedure should be abandoned or assistance summoned.
S, a four-month-old baby, was felt by his mother to be developing a cold and was given oral paracetamol solution, which was effective. The following day his mother noted he was warm and snuffly. His breathing was laboured and he was making moaning noises. He was not feeding well, although he was taking some milk. He apparently had a rash on his back. JS was given oral paracetamol solution but it now had no effect and as his condition was worsening an appointment was made for him to be seen by the GP.

Dr D reviewed the baby at around 2-3pm that day, stating in his notes that the baby had been unwell and tachypnoeic since the morning, but drinking. The examination findings that Dr D recorded were that the baby felt hot, was alert, had a soft fontanelle and equal and reactive pupils. No abnormality was recorded on examination of the throat, ears, chest and abdomen and there was no photophobia or neck stiffness. A diagnosis of a virus was made and regular oral paracetamol solution recommended, with advice to return if JS did not improve.

Dr D stated that if he had confirmed an abnormally high respiration rate when examining the baby he would have noted it. He was confident he was not told of or shown any rash, and would have noted any history or examination findings in relation to it.

The mother stated that when JS did not improve she sent her other son (aged 11-years-old) to explain that she was concerned that the oral paracetamol solution was not working. This was about 5:30pm. The son apparently spoke to the receptionist who advised that “the oral paracetamol solution needed time to work”. No doctor was spoken to although the receptionists who were working at the time stated that they did not recall the son attending or providing such advice.

JS is said to have remained unwell during the evening and the mother awoke at 6:30am the following day to find that JS had developed large purple spots. She contacted the doctor. Dr W, who was on call for the practice, arrived at about 8am. On arrival it was immediately apparent to him that the baby was very unwell as he was very drowsy, greyish in colour and also exhibiting a purpuric rash. He immediately took the child to hospital in his car and stated that he administered an intramuscular injection of benzylpenicillin.

Meningococcal septicaemia was diagnosed and following treatment JS was found to be profoundly brain damaged. He was later diagnosed with severe microcephaly, cognitive impairment, poor vision and intractable epilepsy.

His mother brought a claim alleging that Dr D failed to take an adequate history and perform an adequate examination, give adequate consideration to the age of the child and the risk of rapid deterioration in his condition, failed to observe and act in the presence of a rash and to consider diagnoses other than a viral infection and failed to refer the baby to hospital. It was also alleged that the practice reception staff failed to seek medical advice and that they provided inappropriate advice to the 11-year-old son about treatment with oral paracetamol solution.

Learning points
- Good clinical records are essential for the resolution of factual disputes.
- Non-clinical staff (such as receptionists) should not provide clinical advice.
- Although the outcome was tragic, this does not always equal negligence.
- Parents should be advised on the signs to look for and when to seek further help, and this should be documented.

EXPERT OPINION
Medical Protection sought expert opinion from a GP, a paediatric neurologist, a paediatric infectious diseases specialist and a medical microbiologist. The expert GP’s opinion on breach of duty stated that if the mother’s account of the consultation with Dr D was accepted, the standard of care was unreasonable. However, on the basis of the records and witness statement, and having seen the member in conference, the expert was satisfied that the doctor’s actions were reasonable. The paediatric infectious diseases expert report on causation indicated that if the baby had been admitted by Dr D and treated in hospital with intravenous antibiotics immediately, his opinion was that JS would have made a full recovery.

On the basis of the supportive expert GP report Medical Protection opted to defend the case at trial. The claimant discontinued three days into the trial.
Ms C, a 43-year-old smoker who was otherwise well, presented to her GP, Dr Q, complaining of a few days’ discoloration to the tip of her right index finger. She explained that her fingers had always felt cold and often turned white and went numb when she was outside.

When Dr Q examined the finger, there was purpuric discoloration of the tip and it felt cold. He noted the presence of good peripheral pulses. Dr Q advised her to stop smoking and made a non-urgent referral to the vascular team.

Nine days later, the patient consulted a second GP, Dr P, as the fingertip had become painful. The records of this consultation were limited, but he diagnosed cellulitis and prescribed flucloxacillin, with an appointment for review in 10 days.

When Ms C returned for review, her finger was much better but she now complained of tiredness with some back pain, which she thought was related to her periods. Dr P arranged some investigations, including full blood count, urea and electrolytes (U&Es), liver and thyroid function tests and planned a further review with the results.

The next day, the results were available and alarmingly revealed some abnormalities. Her eGFR was just 22; urea 14 (2.8-7.2); creatinine 211 (58-96); albumin 33 (35-52). The results were reviewed by a third doctor, Dr B, who arranged an urgent renal ultrasound scan.

The repeat bloods showed creatinine 216, urea 10.7 and ESR 104. These were reviewed by Dr P, who took no action as the renal ultrasound scan was to be carried out three days after that and the patient was due to be seen by Dr B for review thereafter.

At that review, 8 days later, Dr B noted the U&Es were still abnormal and decided to await the results of the ultrasound scan. The ultrasound result was delivered the next day, which stated that “both kidneys demonstrate slight increase in cortical brightness; otherwise both kidneys are normal size, shape and morphology with no pelvi-calycceal dilatation”. The results were filed by Dr P as no major abnormality was demonstrated.

One and a half months later, Ms C was admitted to hospital with a subarachnoid haemorrhage. On admission, her GCS was 11, BP 175/103, and the creatinine 573, urea 50 and albumin 29. The patient was referred to a neurosurgeon who organised a CT scan, which confirmed blood in the interventricular systems. An angiogram was performed, which revealed a left pericallosal aneurysm, which was successfully embolised. There were also noted to be other aneurysms. Ms C was initially aphasic with significant neurological impairment after the first procedure.

Ms C was also seen by a nephrologist in light of her significant renal impairment. She was found to have ++proteinuria and ++blood in her urine. Further investigation revealed raised inflammatory markers, mild anaemia and the presence of antinuclear antibody. A repeat renal ultrasound showed two normal kidneys. A renal biopsy was performed, which revealed acute necrotising glomerulonephritis.

A potential diagnosis of systemic vasculitis was made. She was commenced on peritoneal dialysis, high-dose oral prednisolone and cyclophosphamide. Ms C eventually required renal transplantation, three months after the presentation with subarachnoid haemorrhage. Her kidney function stabilised thereafter.

In conjunction with renal support, Ms C was successfully treated for the multiple aneurysms, and recovered from her aphasia. Her neurological deficit improved, such that she was able to mobilise, albeit with assistance.

Following discharge from hospital, Ms C brought a claim against Dr P and Dr B, alleging they failed to refer her to a renal specialist when the abnormal U&Es results were initially found.

Medical Protection instructed experts in general practice, nephrology, neurology and radiology to assist in managing the claim.

EXPERT OPINION

The GP expert opined that a reasonably competent GP should have checked the patient’s urine on the first consultation after the increased creatinine was noted, as proteinuria and blood in the urine would more than likely have been present. Urgent referral to a renal specialist would have been appropriate at that stage. He was critical of Dr B for waiting for a second blood sample and ultrasound. Furthermore, when the second set of blood results was reviewed and then the ultrasound report received, Dr P should have referred the patient.

The nephrologist expert considered that end stage renal failure would have been deferred but not avoided if the patient had been appropriately diagnosed and treated earlier. As there was no evidence of polycystic renal disease, he did not consider there was any connection between the kidney disease and the cerebral aneurysms. However, it is noted that although the pre-subarachnoid haemorrhage blood pressure was not available, the blood pressures at the time of the haemorrhage were elevated. It was felt that if Ms C had been referred earlier, any hypertension would have been treated aggressively. The neurologist expert considered that strict control of blood pressure would have been sufficient to prevent the subarachnoid haemorrhage.

On the basis of the critical expert reports the case was settled for a substantial sum.
Ms B was 28 weeks pregnant with her first child. She became acutely unwell and visited her GP. Dr M saw the patient, who gave a short history of nausea and headache. She also complained of swollen ankles and puffiness of her fingers and face. Dr M did not have access to the patient’s complete records at the time and did not subsequently make a note of the consultation. However, Ms B showed him her antenatal record card, which documented a weight gain of 25kg. Dr M took Ms B’s blood pressure but performed no other examination. Dr M prescribed Gaviscon and a diuretic and advised Ms B to rest.

A few hours later Ms B developed epigastric pain and loss of vision, followed 20 minutes later by a grand mal seizure. An ambulance was called. During the transfer Ms B suffered two further grand mal seizures, which were treated with IV diazepam. On arrival at hospital the eclampsia protocol was initiated and Ms B underwent an emergency caesarean section. The baby was resuscitated and transferred to paediatric intensive care, where she was subsequently noted to have spastic quadriplegic cerebral palsy with dystonia.

Ms B subsequently brought a claim against Dr M for failing to diagnose pre-eclampsia.

**EXPERT OPINION**

According to our GP expert, a history of nausea, headache and oedema, coupled with the likelihood she had a mildly elevated blood pressure, should have suggested the possibility of pre-eclampsia, and urinalysis to exclude proteinuria was mandatory. In failing to perform this test, or alternatively to arrange it by referral to hospital, Dr M breached his duty of care to Ms B.

Expert opinion from a paediatric neurologist concluded that the marked neurological injury sustained by the baby most likely resulted from an acute severe hypoxic ischaemic insult to the thalamus at or around the time of the seizures and a more chronic hypoxic ischaemic insult prior to delivery, rather than as a consequence of premature delivery at 29 weeks gestation. It is likely, on the balance of probabilities, that had the baby been delivered prior to the onset of maternal seizures she would have sustained mild neurological injury, at most.

The absence of any clinical record of the consultation made it difficult to rebut the claimant’s allegation that she should have been admitted to hospital.

Had Ms B been admitted to hospital at the time and proteinuria detected, it is likely she would have been observed, and antihypertensive treatment would probably have been initiated if the diastolic blood pressure exceeded 110mm/Hg. By the time she complained of epigastric pain, the window of opportunity to alter the outcome would have been missed.

Given the absence of GP records for the crucial consultation, it was difficult to rebut the allegations. The claim was therefore settled for a moderate sum.

**Learning points**

- It is difficult to defend a case without adequate records and it is important that doctors document any consultations in the patient’s notes at the earliest opportunity. This is essential for good communication with others caring for the patient, and can prove invaluable should a complaint or claim arise.

- A failure to carry out or record simple bedside tests (e.g. urine dipsticks) and temperature can also make a case difficult to defend, especially where they can help to make a serious diagnosis.

- Prodromal symptoms may be more prominent than signs in the immediate pre-eclamptic state. BP readings in particular may not be dramatically raised.

- Delivery before the onset of eclampsia can have a marked effect on outcome and substantially reduce the risk of cerebral injury.
RISK ALERT – RETAINED THROAT PACKS

I read with interest the article regarding throat packs. In both cases measures were taken to prevent error yet error still occurred. I think that we as practitioners need to have a more sophisticated understanding of error and our own fallibility.

Firstly, this article illustrates the danger of presumption – the doctor presumed the surgeon removed the throat pack, the doctor presumed delirium (and we may all do the same). If in doubt, check it out, test the hypothesis.

Secondly, a checklist, briefing or standard operating procedure does not in and of itself eradicate error. In fact regular, repeated, routine skills and checks can become so familiar they are performed with little attention thus becoming a potential source of error.

Thirdly, we do not know the details of the WHO checks in these cases but distractions, interruptions or team changes all diminish the effectiveness of the checklist. It is also influenced by culture and belief – if practitioners do not value the tool it has little power to change practice.

I believe that we need to learn how to identify potential error and use the tools available to manage error.

If we use the WHO checklist in terms of threat and error management, we are actively evaluating the case in question, this requires attention. For example, in case 2 the anaesthetist was new to the hospital; this is a “threat” to performance because the team and the routine practices of that department are unknown. This should be stated during the team brief with the request that the team keep the new doctor informed regarding their normal practices.

The use of a throat pack is an “airway threat” and should be stated as such. The anaesthetist should inform the rest of the team how they plan to manage this. This includes the team directly in the management plan promoting team situation awareness and vigilance.

Maybe what is required is a shift in attitude, a change in “mind-set” from a passive “tick box exercise” to an active evaluation for error management, a point when all team members are united and engaged in planning their workload.

Dr Heather Gallie
Salford
UK

ELBOW ARTHROSCOPY AND RADIAL NERVE PALSY

I read with some distress the case regarding elbow arthroscopy and radial nerve palsy. I am an upper limb surgeon who does perform elbow arthroscopy for arthritis.

What bothers me about this case is the management plan where it appears that the surgeon had planned multiple arthroscopic operations to debride an arthritic elbow. Leaving the radial nerve palsy aside, this decision was negligent from the start. This was not an acceptable management plan. One elbow arthroscopy has its risks and planning multiple procedures would certainly increase the risks to the surrounding nerves and vessels.

I feel this point is lost in the summary.

Many of the cases in your magazine are unfortunate and do lack evidence of documentation, which Medical Protection has repeatedly highlighted the importance of. Thus they come to litigation, but this is different.

Dr Cormac Kelly
Shoulder and Elbow surgeon
UK

Response

Thank you for your letter. I note your concerns about the management plan in this particular case. I note your concerns about the management plan in this particular case. As you may know, our case reports are based on cases in which Medical Protection has assisted members around the world. Interestingly, the allegations in this case, as set out by the claimant’s solicitors, focused solely on the operation that caused the radial nerve injury, the post-operative care, and the delay in diagnosis of the nerve injury. The claimant did not allege that there had been any negligence prior to this and as such this was not a point that our expert or Medical Protection had to address.

POOR NOTES, FATAL CONSEQUENCES

Thank you for such a stimulating and unfortunate case report.

I can see a few pitfalls in the management of Mrs Y. First, I would have considered a low dose aspirin as she was at risk of developing early-onset pre-eclampsia. Second, her blood pressure was moderately elevated in the second trimester (where BP is at its lowest). However, methyldopa was considered but never initiated! Third, when she was admitted with severe pre-eclampsia, she was commenced on methyldopa and nifedipine. Methyldopa is known to have a slow onset of action that could last a few hours, and although her BP was never controlled, she was not offered a second-line therapy (eg, IV hydralazine or labetalol) to control the BP before the delivery, which was conducted the next day semi-urgently.

All of the above are basics in the management of hypertension in pregnancy as recommended by NICE guidelines (CG107)” published August 2010.

Dr T Hamouda
Consultant O&G,
New Zealand

REFERENCES

1. nice.org.uk/guidance/cg107
EXPERT EVIDENCE IN CLINICAL NEGLIGENCE: A PRACTITIONER’S GUIDE  
by Patrick van den Heever and Natalie Lawrenson  
Review by: Dr Graham Howarth, Medical Protection Head of Medical Services (Africa)  

The title of the book immediately kindled my interest because, as the book points out, expert witnesses are central to medicolegal cases. This is an excellent book with one deal-breaking caveat for medical experts – the practitioners referred to in the title appear to be more likely legal than medical. This is merely an observation not a criticism.

In South Africa, despite the increasingly litigious medical environment, medical experts, well informed on the legal nuances of medicolegal opinions, remain scarce. As a result of this the pool of experts is small, and engaging experts can be difficult, particularly as claimants have a temporal advantage. Additionally, the realities of supply and demand dictate that it is a sellers’ market thus increasing costs.

The book is full of interesting, enlightening information. Important points are made that are of salient significance to medical experts, but the book concentrates on the legal side of the discipline. Doubtless it may be of interest to the experienced medical expert interested in the legal process. There are also interesting insights into the role of the expert in alternate dispute resolution.

Unfortunately the book will be of little use to the medical expert interested in expanding a portfolio to include medicolegal work. Questions to the nascent expert may be mundane to lawyers: What is a duty of care? What is a breach thereof? What does causation mean? What is balance of probabilities? The importance of language to lawyers, how to express probabilities and uncertainties with some precision.

If you are interested in the legal process and insight into medical expert evidence, then the book is an excellent comprehensive read. If you are interested in expanding your medical expertise to become involved in medicolegal work, then sadly look elsewhere.

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BETTER – A SURGEON’S NOTES ON PERFORMANCE  
By Atul Gawande  
Review by: Dr Rebecca Aning, Medical Protection Medicolegal Adviser  

“Good, better, best, never will I rest, until my good is better and my better is best.” I don’t know a single doctor who wants to be average! But, if you measure our success, it is probable that most of us would hover around the peak of the bell curve. To replicate the positive deviants, we need to know who is at the top. But is anyone willing to be at the bottom, in order that we could all learn to be closer to the best?

Who would have thought that handwashing gurus would take guidance from those encouraging better nutrition in malnourished African children? Or that army medics could find the time to capture 75 pieces of information on every patient to reduce the Golden Hour of Trauma Medicine to the golden five minutes? Do we really need more expensive cures to do the best for our patients? What if doing what we know, well, and making a science out of performance could further improve the care that we offer? Is money important to medics? Does the modern trend towards informality by doctors blur the lines for patients and effectively encourage claims of misconduct? Should we extend compassion and competency to those on death row?

Gawande is a Harvard professor and highly acclaimed. But above all, he has listened to those around him and those that no one cares much to listen to. He trusts that his audience is intelligent enough to understand the points illustrated, consider their importance and be changed by what they read. Not once will you feel lectured, but if you have not reconsidered a single part of your practice or been inspired to improve anything by the end, then I urge you to read this book again.
CPD QUESTIONNAIRE

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

1. Read Casebook: all the answers will be found there.
2. Go to mpc consulting.co.za to answer the questions. Accreditation number: MDB015/574/05/2016

1. In the case ‘Missed Meningitis’ what was JC’s lifetime risk of needing a hip replacement?
   a. 5-10%
   b. 12-20%
   c. 20-30%
   d. 30-40%

2. Which of the following negligent actions was Dr L NOT accused of in ‘Failure to follow specialist advice’?
   a. Continuing to prescribe vigabatrin against the advice of a neurologist.
   b. Failing to review medication at regular intervals.
   c. Failing to take consent.
   d. Failing to refer to an ophthalmologist.

3. According to expert opinion in ‘Undescended testes’, it is thought that in cases of ascending testis that testicular ascent occurs at what age?
   a. Five-years-old.
   b. Seven-years-old.
   c. Two-years-old.
   d. Three-years-old.

4. At which check-up should doctors document the presence or absence of testes in the scrotum?
   a. One week check.
   b. Two week check.
   c. Six week check.
   d. Twelve week check.

5. In ‘Diagnosing Pneumonia’ in what parts of Mr B’s chest did his GP find coarse crepitations?
   a. Right upper chest.
   b. Right lower chest.
   c. Mid chest.
   d. Left upper chest.

6. A CURB65 score of 2 is associated with what percentage of mortality?
   a. Less than 1%.
   b. 1-10%.
   c. 10-20%.
   d. More than 20%.

7. In ‘Stretch marks and steroids’ the case was settled for what amount?
   a. A low sum.
   b. A moderate sum.
   c. A substantial sum.
   d. A high sum.

8. Which of the following did Dr S fail to discuss with Mrs B in ‘Problematic anaesthetic’?
   a. Possible risk of dental damage.
   b. Possible risk of a sore throat.
   c. That he intended to perform a paravertebral block.
   d. Possible risks and benefits of a paravertebral block.

9. What was the outcome of the case in ‘Tragic outcomes don’t always equal negligence’?
   a. Successful defence.
   b. Settled for a moderate sum.
   c. Settled for a substantial sum.
   d. Settled for a high sum.

10. In ‘Failure to diagnose pre-eclampsia’ the GP expert was critical of Dr M’s failure to perform which simple bedside test?
    a. Blood pressure reading.
    b. Urine dipstix.
    c. Ultrasound scan.
    d. Temperature reading.

11. The long-term average claim frequency for doctors in 2015 was how much higher than in 2009?
    a. 10%.
    b. 15%.
    c. 27%.
    d. 39%.

12. Which of the following should not be included in an expert report?
    a. A list of documentation considered and relied upon in reaching the opinion on the case.
    b. A chronology and summary of the relevant evidence.
    c. Details of any examination undertaken or any other investigations performed.
    d. Opinions not backed up by evidence or records.
How to contact us

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Please direct all comments, questions or suggestions about our service, policy and operations to:

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

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