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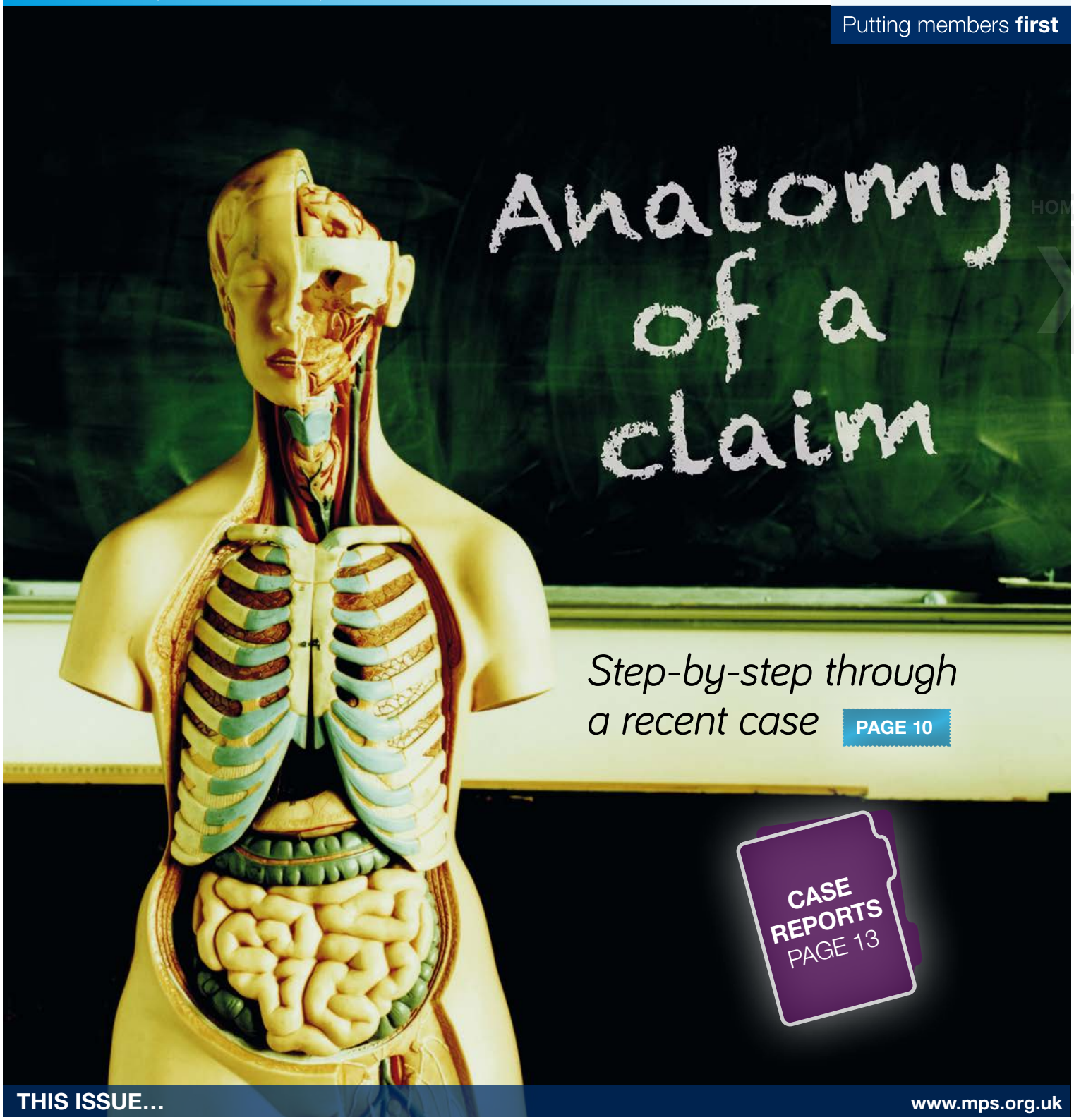

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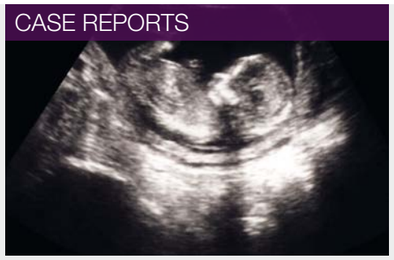

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Welcome

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

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

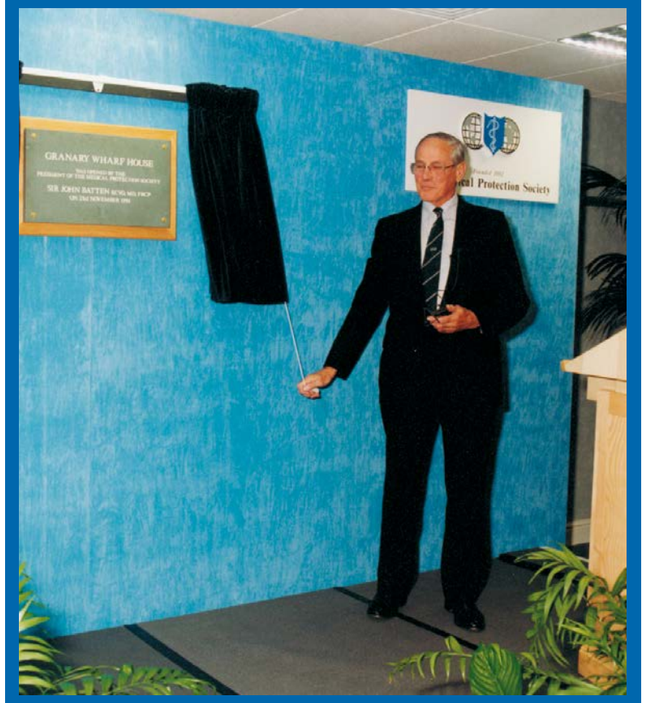
I write this having just heard that a claim against a member has today been discontinued by a high profile claimant, two days into trial, after the expert evidence had been heard. Fantastic news for the doctor, and vindication for the defence team of the judgments they have made in steering a long and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

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

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

This is not just in relation to clinical negligence claims; we are seeing increasing reliance on experts at inquests and medical council hearings in many countries. MPS regularly runs expert training days around the world, to ensure that tomorrow's experts will know what to expect, and provide the strength of opinion that underpins excellence in case handling.

Paying strict attention to detail, answering the questions posed, and providing the independent, objective evidence to support the opinion are key to steering towards just outcomes.



Sir John officially opens the MPS Leeds office in 1994

OBITUARY

Sir John Batten, MD FRCP KCVO 1924-2013

Sir John Batten was invited to become the President of the Medical Protection Society in 1988 and remained in that post until 1997.

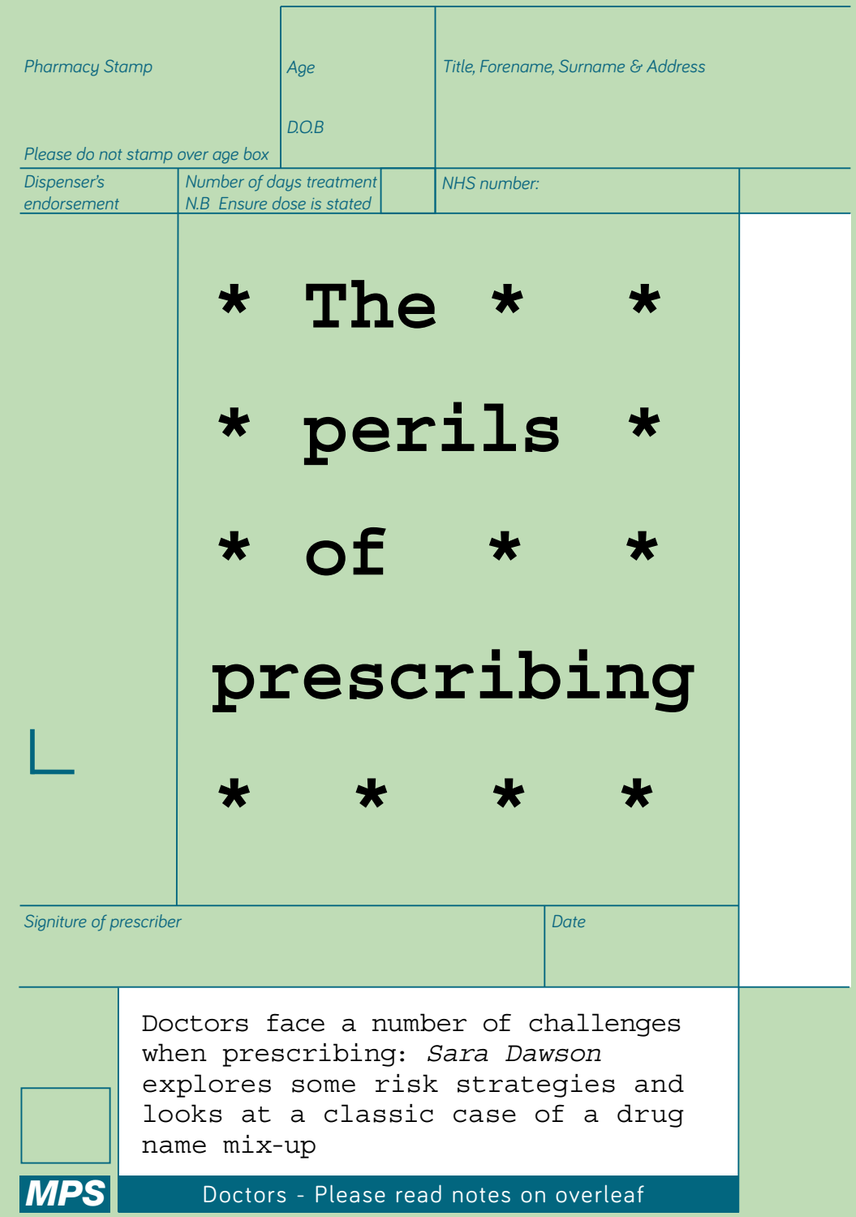
After a distinguished career as a physician at St George's and Brompton Hospitals, and pioneering the treatment of patients with cystic fibrosis, he gave generously of his time to MPS. In addition to his medical wisdom acquired over the years, he was a man of wide interests in the arts, sailing and gardening, no doubt inspired by living in close proximity to Kew Gardens.

He was appointed as physician to the Queen in 1974 until 1980. He was physician to HM Royal Household 1970 to 1974 and Head of HM Medical Household 1982 to 1989.

Sir John joined MPS at a time of major change – the introduction of NHS indemnity for hospital doctors, a radical reorganisation of the governance of MPS with the appointment of a Chief Executive and a slimming down of the MPS Council with the addition of lay members, expansion of the Leeds office and a review of MPS's international commitments. To those of us involved in implementing these changes, he was a tireless supporter, a good friend and though 'walking with kings' (or rather the Queen), he never lost the common touch.

John Bradley, Chairman of Council 1988 to 1996

Roy Palmer, Medical Director 1989 to 1998



Mr G, a 53-year-old migrant worker from Latvia, was a long-term sufferer of ulcerative colitis. One day, his worsening symptoms prompted him to visit his local GP, Dr Q. He explained to Dr Q that he had been feeling generally unwell for three days, with increasingly frequent bowel movements and "bloody diarrhoea".

Dr Q referred Mr G as an emergency admission to the local hospital. At the hospital Mr G was seen and eventually discharged with a prescription of prednisolone and sulfasalazine.

A month later, Mr G attended his local GP practice for a fit note. He was reviewed by Dr F, who provided a prescription for "sulfadiazine tablets 500mgs one to be taken twice a day 56 tablets". Mr G took his prescription to the local pharmacy, which made up the prescription as sulfasalazine tablets 500mgs "take two, three times per day".

Later that year, Mr G was seen by Dr F again in relation to an insurance claim. Again, the same prescription was given and, again, the prescription was made up by the pharmacy. This time the correct dosage was written up, but this time with sulfadiazine.

A month later, Mr G saw Dr Q for follow-up. Dr Q became aware of the previous prescribing errors and informed Mr G that he was taking the incorrect medication and should, in fact, have been prescribed sulfasalazine.

Mr G alleged that Dr F negligently prescribed him an incorrect medication and an incorrect dose. He also alleged that he suffered from abdominal pain and diarrhoea until the error was corrected. Dr F was found to have been in breach of duty in prescribing sulfadiazine instead of sulfasalazine, and the claim was settled for a low sum, with liability being shared equally by the pharmacist and Dr F.

Although there was evidence Mr G suffered abdominal cramps and diarrhoea, he may well have suffered the same symptoms anyway, as he had ulcerative colitis. However, a well-known side effect of most drugs includes abdominal symptoms and bowel disturbance, so it would be difficult to defend the case on this basis.

Fraught with risk

Prescribing for patients is fraught with risk: doctors in both primary and secondary care can face major challenges in prescribing safely. The ageing population and the increasing complexity of high-risk medications, coupled with an already highly-pressured mix of patient juggling and time pressures, are increasing these challenges.

In 2012, Professor Tony Avery led a major GMC-funded study, *The PRACtICe Study: Prevalence and Causes of*

Prescribing Errors in General Practice, in England. His team analysed a 2% random sample of patients' records from 15 general practices across England. Prescribing or monitoring errors were detected for one in eight patients, involving around one in 20 of all prescription items. The majority were of mild to moderate severity, with one in 550 items being associated with a severe error. Given this context it is essential for doctors to do everything they can to mitigate risk.

Keeping up-to-date

According to Professor Avery, it is absolutely essential to have all the information you need on the patient you are prescribing for; this will avoid contraindications and hazardous drug-to-drug combinations, and alert you to a history of allergy. He adds: "Access to up-to-date medical records is critical here, as well as having readily available sources of drug information (such as the *BNF*). Keeping your knowledge of therapeutics up-to-date can also help."

Analytical thinking

Recognising our limitations as doctors and "to err is human" will make us more vigilant in checking that we have not made slips, lapses or mistakes, says Professor Avery. This requires using a type of thinking that is purposeful, conscious and analytical. For example, double-check a prescription before signing it off; don't let it become an automatic process.

High-risk patients on high-risk drugs

High-risk patients are not only those with very serious illnesses, says Professor Avery, but also patients with multiple long-term conditions. These patients are at risk from the range of different medicines they take and have an increased likelihood of suffering drug-related harm, due to their co-morbidities and frailty.

High-risk patients present us with particular challenges because considerable time is needed to manage all of their conditions, and prescribing safety can be overlooked. Professor Avery adds: "High-risk drugs include those that doctors prescribe in shared care arrangements between primary and secondary care, along with commonly used drugs such as warfarin, antiplatelet drugs, cardiovascular drugs, antiepileptics, psychotropics, opioid analgesics, diabetic drugs, systemic corticosteroids and NSAIDs.

"In high-risk patients it is essential to recognise that risks of serious medication-related harm may be considerably higher (possibly 100-fold higher) than in otherwise fit, healthy adults taking relatively safe medicines. We cannot afford to cut corners for our most vulnerable patients."

Communication with patients

Communication problems often contribute to adverse events associated with medication errors, and are sometimes the main cause. The most common problems with communication occur between the doctor and patient, but there are also major issues at the interface between primary and secondary care.

Patients can and do suffer from medication-related adverse events because either they do not have sufficient knowledge of their medical conditions and the medicines they are taking, says Professor Avery, or they have not been given an adequate explanation of how to take the medicines, the side-effects to look out for and what monitoring is needed.

Communication problems resulting in underuse, overuse or incorrect use of medication in general practice are particularly important in the following conditions where preventable drug-related hospital admissions may result:

- asthma
- coronary heart disease with angina
- diabetes mellitus (especially in patients taking insulin)
- epilepsy
- heart failure.

For these conditions it is particularly important to try to make sure that patients have a good level of knowledge and understanding of their medicines. The use of patient information leaflets and websites may also be helpful.

Interface between primary and secondary care

It is not uncommon for patients to suffer medication-related harm as a result of inaccurate or incomplete information at the interface between primary and secondary care. One very important issue is the danger associated with the transfer of medical information on to the practice computer once a patient has been discharged from hospital, or following outpatient visits. Unless this is done – or at least carefully checked – by clinically-trained staff, there are serious risks of inadvertent transcription errors or duplication of medicines.

Tips for safe prescribing

1. Keep yourself up-to-date in your knowledge of therapeutics, especially for the conditions you see commonly.
2. Before prescribing, make sure you have all the information you need about the patient, including co-morbidities and allergies.
3. Before prescribing, make sure you have all the information you need about the drug(s) you are considering prescribing, including side-effects and interactions.
4. Sometimes the risks of prescribing outweigh the benefits and so before prescribing think: "Do I need to prescribe this drug at all?"
5. Check computerised alerts in case you have missed an important interaction or drug allergy.
6. Always actively check prescriptions for errors before signing them.
7. Involve patients in prescribing decisions and give them the information they need in order to take the medicine as prescribed, to recognise important side-effects and to know when to return for monitoring and/or review.
8. Have systems in place for ensuring that patients receive essential laboratory test monitoring for the drugs they are taking, and that they are reviewed at appropriate intervals.
9. Make sure you have safe and effective ways of communicating medicines information between primary and secondary care, and of acting on medication changes suggested/initiated by primary/secondary care clinicians.

The GMC view

***Good Practice in Prescribing and Managing Medicines and Devices* (2013)**

"(12) You should make sure that anyone to whom you delegate responsibility for dispensing medicines in your own practice is competent to do what you ask of them. Advice on training for dispensing support staff can be obtained from the General Pharmaceutical Council.

"(13) You should make sure that anyone to whom you delegate responsibility for administering medicines is competent to do what you ask of them."

Medication monitoring

According to Professor Avery, it is important to monitor patients for the effects of medications and any side-effects. Monitoring for side-effects is particularly important in older people, patients on multiple drugs, and patients with hepatic or renal impairment (where drug metabolism or excretion may be reduced, leading to drug toxicity).

Effective medication monitoring can help to identify problems before they result in serious patient harm. Nevertheless, the evidence base for the benefits of medication monitoring is not strong for many drugs, particularly in terms of the frequency of monitoring.

Even so, it is important to have agreed policies for laboratory test monitoring of drugs, so that patients do not slip through the net and suffer from a complete lack of monitoring. Advice on laboratory test monitoring is available from a number of sources, including the *BNF* and drug datasheets.

Medication review

It is important for patients' medications to be reviewed periodically to ensure that essential laboratory tests are undertaken; side-effects are detected; patients are involved in decisions about their medicines; and therapy is optimised, says Professor Avery, although he notes that this can be challenging.

Controlled drugs

In August 2013, the Care Quality Commission (CQC) released its report, *The safer management of controlled drugs: Annual Report 2012*, which revealed a 1% rise in 2012 – compared to 2011 – in the number of prescriptions issued in primary care for controlled drugs. Except for a steady fall in prescriptions of temazepam since 2007, the use of buprenorphine, morphine sulphate, oxycodone, fentanyl, midazolam and diamorphine is on the rise.

As a result, CQC chief executive David Behan called for "vigilance" around the prescription of controlled drugs – adding that the CQC would be including governance arrangements around controlled drugs as part of their inspections.

The recommendations of the report included:

- Health and social care professionals must ensure they know how to contact their local controlled drugs accountable officer (CDAO) and know the mechanism for reporting controlled drug concerns.
- CDAOs need to ensure they are following the guidance on the CQC's website to update contact details promptly to ensure the CDAO register is accurate.
- Effective systems developed at the local level for secure gathering, sharing and recording of intelligence relating to concerns about safe management of controlled drugs should be preserved and transferred into the new NHS structure.
- CDAOs, clinical commissioning groups and controlled drugs leads must be mindful of their continuing responsibilities for good governance and safe use of controlled drugs to ensure ongoing monitoring and vigilance.

The importance of ongoing monitoring was underlined in a response to the report that was issued by NICE, specifically with regard to the use of drugs to treat moderate attention deficit hyperactivity disorder (ADHD). Reiterating standards recommended in its recent quality standard on ADHD, a press release by NICE said:

"The quality standard calls for people with ADHD who are taking drug treatment to be given a specialist review at least annually to assess their need for continued treatment…people taking the drugs need to be monitored regularly due to the number of side effects associated with drug treatment for ADHD, which can also have the effect of reducing adherence to treatment.

"Furthermore, without regular monitoring there is a greater risk that drugs prescribed to treat ADHD will be misused."

Summary

In 2004 Sir Liam Donaldson said: "To err is human, to cover up is unforgiveable, and to fail to learn is inexcusable." Errors are the product of multiple factors and clinicians have a duty to ward off error by employing defences to prevent it occurring in the first place. By being vigilant and making small changes medicines management can become safer.

USEFUL LINKS

- GMC, University of Nottingham, *The PRACtICe Study: Prevalence and causes of prescribing errors in general practice* (May 2012)
- MPS factsheet, *Safe prescribing* (April 2013)
- CQC, *Controlled Drugs* – www.cqc.org.uk
- GMC, *Good Practice in Prescribing and Managing Medicines and Devices* (2013)
- National Institute of Health and Clinical Excellence – www.nice.org.uk
- MHRA – www.mhra.gov.uk

How reliable is healthcare?

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

The healthcare industry is defined by continuous change, but continuous change does not necessarily mean continuous improvement.

Emerging technologies may provide great promise for advancing our diagnostic and therapeutic options – but with the increasing frequency and complexity of healthcare interventions, so increases the risk of system or personal failures that can harm patients.

Through litigation, these failures can harm institutions and careers. It is highly important that healthcare professionals recognise the hazards associated with providing healthcare services and confront the very real challenge of complacency. Whereas we may see harm when it occurs, more often than not we do not see the "near misses" – and because we do not, this feeds our complacency. We are not truly aware of how often something goes amiss!

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

Managing danger

High reliability organisations (HROs) are those that function safely and efficiently in industries that are very dangerous. HROs have established cultures and supporting processes designed to dramatically reduce the likelihood of human error and harm. They recognise that in the interactions between humans and technologies, it is the humans that represent the most substantial sources of risk.

Industries commonly considered to portray the attributes of high-reliability include the nuclear power industry, the automotive industry and the aviation industry. In the aviation industry, for example, the aeroplanes are so well-designed, with redundantly engineered systems, that the risks arise primarily from the aircrew. Human factors are the source of most risks and errors.

It has been argued that if the healthcare industry would simply adopt the characteristics and methodologies of HROs, we would move the bars for quality and safety higher. If this is true, then why is there so much inertia in our systems of care; inertia that plagues our improvement strategies? Why have we not solved this problem, when so many solutions abound? Complacency is the pernicious confounder. We do not see the sources of harm, the near misses, and especially do not see ourselves as sources of harm.

The defining characteristics of HROs have been summarised by Weick and Sutcliffe[1] and, in abbreviated format, are portrayed below:

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

A natural fit?

Healthcare systems entail many unique factors that are at variance with HRO industries. Even though some HRO characteristics have been adopted or adapted by healthcare systems, such as the use of checklists, the unique factors of healthcare pose a challenge. These are the increased frequency of human-to-human interactions and associated communication challenges, and the complex vagaries of our diagnostic processes.[3]

Healthcare professionals are not engineers or pilots and our way of doing business is fraught with uncertainty and variability. Many of our diagnostic and therapeutic interventions are based on insufficient evidence and are over-utilised, thus increasing risks and the potential for harm.

Most importantly, patients are not aeroplanes. They are far more complex than aeroplanes. They have morbidities and comorbidities, genetic propensities, fears, belief systems, social and economic confounders, intellectual and cognitive challenges, and language and fluency issues.

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

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

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1. Weick K, Sutcliffe K, *Managing the Unexpected: Assuring High Performance in an Age of Complexity, San Francisco*: Jossey-Bass (2001)
2. Chassin M, Loeb J, The Ongoing Quality Improvement Journey: Next Stop, High Reliability, *Health Affairs* 30:559-568 (2011)
3. Groopman J, *How Doctors Think*, Boston and New York: Houghton Mifflin (2007)

A case study

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

- I was misidentified and given another patient's ID wristband, despite the fact that I handed my insurance details to the ED (Emergency Department) admissions clerk. The wristband did not include information that would enable me to identify this discrepancy, and only when a nurse tried to enter orders into the system was the discrepancy detected. This was not corrected for 30 minutes, delaying my evaluation even as my leg was becoming increasingly numb and purple. I was pointing this out to the nurse; there was urgency here, but...
- I was seen by several different nurses, technicians and physicians, and it was the exception rather than the rule that these individuals washed their hands before touching me or touching equipment in the room, even after I jokingly pointed this out.
- The x-ray CT scan technician did not offer me any gonadal shielding, even though he was scanning my entire right leg, and I did not think to ask.
- When I was admitted, unable to ambulate without assistance, I did not receive a standardised falls risk assessment. I clearly was at very high risk of a fall and, though the nurse was very pleasant, he did not complete the formal risk assessment until morning rounds, and I had to use the toilet twice during the night. I managed, should have called for help but didn't, and thus potentially became part of my own problem.
- Finally, at discharge, no-one enquired about challenges in ambulation that might be unique to my home situation. I was to be provided a walker as I was not to bear weight on my injured leg. Though I was assured that the walker would be delivered on the afternoon of my discharge, it did not arrive until the evening of the following day, significantly increasing my risk of a fall at home.

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

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

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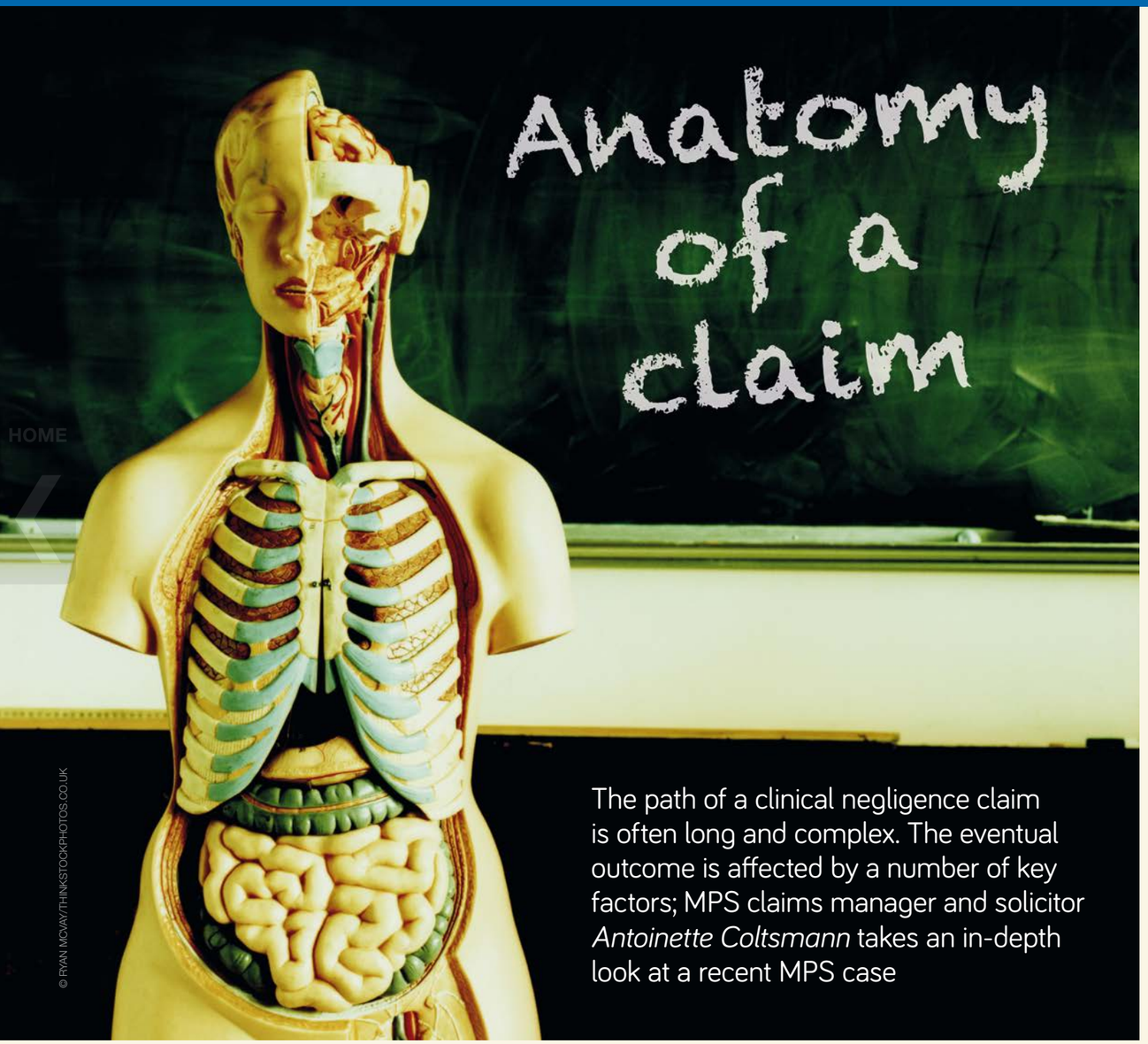

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The path of a clinical negligence claim is often long and complex. The eventual outcome is affected by a number of key factors; MPS claims manager and solicitor *Antoinette Coltsmann* takes an in-depth look at a recent MPS case

THE CASE

Mr P, a high-earning, self-employed management consultant, attended his GP surgery on 10 July 2010 with flu-like symptoms and saw Dr A. He diagnosed a chest infection and prescribed antibiotics; on 15 July Mr P returned with similar symptoms – Dr A referred Mr P for a chest x-ray and prescribed further antibiotics. The x-ray was carried out the next day, after which another GP at the surgery, Dr B, advised Mr P that the x-ray was clear and that he could continue to take his medication.

On 21 July, Mr P was reassessed by Dr C, a locum consultant in infectious diseases. He made a note of a detailed examination in Mr P's records. He concluded Mr P was suffering from muscular back pain, and recommended pain relief and a return visit to Dr A in two weeks' time.

Two weeks later, on 4 August, Mr P reattended the surgery. Dr A noted some chest discomfort and made a referral to physiotherapy for the back pain, which took place five days later. The day after that, Mr P felt unwell and collapsed due to a loss of sensation in his legs. He was admitted to hospital.

At the recommendation of the hospital consultant microbiologist, Mr P's antibiotics were withheld and the following day he was transferred to another hospital, where an MRI scan was performed. This revealed infective discitis at T5/T6. Mr P underwent an emergency laminectomy with open biopsy, where a soft tissue mass was submitted for histology investigations; once the biopsy samples were obtained antibiotics were recommended. Further surgery was carried out the same day and antibiotics (a combination of ceftriaxone and vancomycin) were administered.

Following the surgery, Mr P was left with T4 ASIA A paraplegia. He underwent rehabilitation at a spinal injury centre.

THE CLAIM

Mr P made a clinical negligence claim against Drs A, B and C. He alleged that all three doctors failed to suspect a spinal infection and refer Mr P to an orthopaedic surgeon, who would have referred him for an MRI scan. It was alleged that the MRI scan would have identified infective discitis, which would have led to hospital admission and antibiotic therapy, avoiding Mr P's paraplegia.

Having obtained supportive expert evidence, MPS decided to defend the claim and the case went to trial.

THE EVIDENCE

For any claim for clinical negligence to be successful, a claimant needs to prove that, firstly, there has been a **breach** of the duty of care owed by the doctor (or doctors); secondly, a claimant must succeed on **causation**, ie, that this breach of duty caused or contributed to the injury, loss or damage suffered, and that but for the negligence the claimant's loss would not have occurred.

Before trial, both parties served evidence of breach and causation, in the form of reports from expert witnesses. For Drs A, B and C, a GP (Dr D) reported on breach and a consultant microbiologist (Dr E), consultant neurologist (Mr F) and consultant neuroradiologist (Dr G) reported on causation.

Mr P served evidence on breach of duty from a GP (Dr I) and causation evidence from a consultant neurological and spinal surgeon (Mr J), and a consultant microbiologist (Dr K). Mr P was not relying on neuroradiology evidence.

BREACH

Consultation: 15 July

Dr A vigorously denied he was informed by Mr P that his back pain was worse, preventing him from lying flat on his back and disturbing his sleep. Dr I considered Dr A in breach of duty for failing to arrange blood tests in conjunction with a chest x-ray. He considered "blood tests were mandatory".

If the court accepted Dr A's factual evidence, Dr D agreed Dr A's management was "entirely appropriate". If, however, the court accepted Mr P's factual evidence, Dr D agreed this should have "triggered" a neurological examination and, if Mr P had no neurological symptoms, this should have prompted referral within one to two weeks – either for an MRI scan or "more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan".

Consultation: 4 August

Mr P's GP expert noted that this was the fifth consultation regarding the same illness without a diagnosis. Referral to a physiotherapist without a further examination was "unacceptable care". He considered the appropriate response was to arrange a series of urgent blood tests and once the results were available (which he surmised would have been abnormal), Dr A should have arranged an urgent referral to an orthopaedic specialist/A&E or MRI scan within 24 hours.

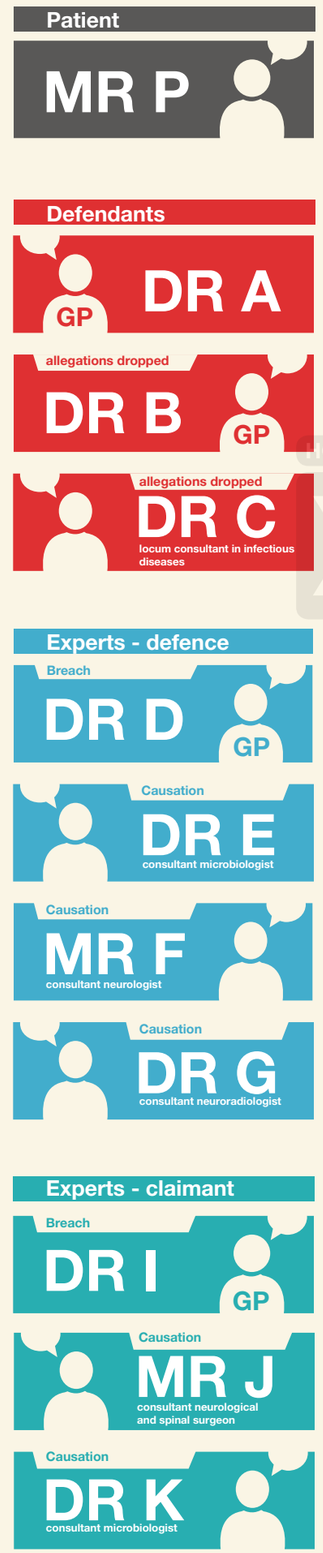
Dr A's GP expert considered that on 4 August, Mr P was not displaying any symptoms or signs that would have alerted a GP to possible infective discitis developing. He considered referral within one to two weeks, based on Mr P's factual evidence, either for an MRI scan or orthopaedic or neurosurgical specialist – who may have requested an MRI scan – appropriate management. He did not consider Dr A in breach of duty based on his factual evidence.

THE LIABILITY

On our assessment, Drs B and C had no culpability. Dr B simply reported the chest x-ray was clear. Dr C undertook a very detailed and thorough assessment and this was recorded in Mr P's contemporaneous GP notes. Indeed Dr A was heavily reliant on Dr C's very detailed consultation notes to assist him in defending his assessment of Mr P on 4 August.

Proceedings were discontinued against Drs B and C shortly before trial.

Mr P alleged Dr A was in breach of duty for failing on 15 July to arrange blood tests and failing on 4 August to suspect infective spinal pathology and arrange a "very urgent orthopaedic investigation". Mr P placed heavy reliance on his assertion that he had made sufficient complaint of back pain on each occasion to prompt suspicion of an infected spinal pathology.



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THE TRIAL

During Mr P's cross-examination at trial it was clear he had no real recollection of the different consultations and could not, with any real accuracy, confirm what he told the GPs regarding his symptoms and, in particular, his back pain. He was, therefore, an unreliable witness. Dr I was discredited as not having been in practice for more than ten years. Dr I also accepted, during his cross-examination, that if all the doctors' factual evidence was accepted for each consultation he would not criticise their practice.

Drs A, B and C came across as honest, reliable and caring witnesses (Drs B and C now appearing as witnesses rather than defendants).

All confirmed that at no stage were they alerted to Mr P's alleged extensive back pain. They were treating flu-like symptoms affecting the chest, and back pain was secondary and caused by the chest infection and coughing. It was not until 4 August that Mr P complained of back pain, which was now the primary need for the consultation as his flu/chest infection symptoms had resolved. Dr A examined Mr P, concluded it was muscular and referred Mr P to a physiotherapist.

CAUSATION

Mr P alleged if he had undergone blood tests following all consultations, the results would have been consistent with bacterial infection. This would have led to further investigations, prompting referral for orthopaedic investigation suspecting infected spinal pathology, including an MRI scan. A diagnosis would have been made, Mr P would have been admitted to hospital and treated with intravenous antibiotics, making a complete recovery.

Dr E maintained Mr P would have had to receive antibiotics for a period of 48 hours to have avoided all neurological sequelae, without surgery. Dr K considered antibiotics 24 hours earlier would have avoided onset of neurological deficit.

Dr K, crucially, accepted at the experts' meeting that Mr P's white cell count and temperature would have been within normal range for each consultation. The neurosurgeons agreed Mr P would have displayed no neurological sequelae at any consultation.

It was accepted that if blood tests and further investigations had been undertaken after all consultations – save 4 August – Mr P would succeed by one way or another. It was vigorously denied that even if blood tests had been undertaken on 4 August they would have altered the outcome.

For Dr A to succeed at trial on causation in relation to the 4 August consultation, the court had to accept:

- Referral to physiotherapist was reasonable based on his factual evidence
- Referral to orthopaedic surgeon on a "non-urgent" basis was reasonable, based on Mr P's factual evidence.

Even if the court did not accept referral on a "non-urgent" basis to an orthopaedic/neurosurgeon was reasonable, Mr P needed to establish that referral and appropriate treatment within a five-day window of opportunity (4-9 August) should include referral to an orthopaedic surgeon, MRI scan, biopsy and broad spectrum antibiotics.

Dr A did not assess Mr P until 5.30pm on 4 August. Accordingly, the earliest that blood tests could have been undertaken, based on a fasting sample, was 5 August, with the results available that afternoon. The earliest Dr A could have seen Mr P is 6 August, and an appointment arranged with an orthopaedic surgeon that afternoon. The earliest an MRI scan could have been arranged is 7 August. The earliest the results could have been available is that same day, with admission to hospital that evening. Mr P was asymptomatic and the appropriate action would have been to undertake a biopsy to identify the pathogen so the appropriate antibiotic was administered.

A biopsy may not have been possible the following day as it was a Sunday and, as Mr P would not have been displaying any symptoms, the need would not have been "urgent" and would have waited until Monday, 9 August. By that stage, even on Mr P's evidence, administering antibiotics would have been too late.

At trial, Dr A's expert neurologist was an excellent witness who spoke authoritatively and gave his opinion in a non-partisan way.

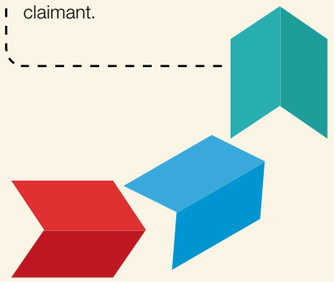
This was a significant and by no means straightforward claim to defend. The value of the claim was in excess of £5 million, with Mr P's legal costs alone estimated to be an additional £1.5m

THE OUTCOME

Mr P abandoned his claim and discontinued proceedings after the conclusion of day 3 of the trial. By that stage all witnesses and experts, save the microbiologists, had given evidence. Mr P had funded his claim by way of a Conditional Fee Arrangement backed by insurance. MPS therefore sought and recovered their costs incurred in defending this claim to trial.

This was a significant and by no means straightforward claim to defend. The value of the claim was in excess of £5 million, with Mr P's legal costs alone estimated to be an additional £1.5m. Given the potential financial exposure to MPS and having taken into consideration the views of the GPs named as defendants, a decision was taken to fight the case at trial.

There were risks, most notably Dr A's brief notes made in the records, but this in itself does not denote poor treatment. This case highlights the importance of obtaining excellent and appropriate experts in relevant fields, at an early stage in the claim. At trial the judge found Dr A's experts to be credible and reliable, and their evidence was preferred to that relied upon by the claimant.



This article is a real MPS case and is published with our member's consent

From the case files

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

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

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

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

Mrs J made a claim against Dr A in "A tear during delivery" (page 18) as she was advised that if Dr A had carried out an episiotomy and avoided the use of 'double instruments,' her symptoms would have been avoided.

She felt that a diagnosis of a third degree tear had been missed, and had subsequently had a major impact on her life. Expert opinion found that the episiotomy was not essential in this case, and detailed contemporaneous notes confirmed that the anal sphincter was intact, despite the second degree tear that was observed.

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

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

CASE REPORTS

Casebook **aims to promote safer practice by sharing experiences that we hope you will find helpful. MPS publishes medicolegal reports as an educational aid to MPS members and as a risk management tool.**

The case reports are based on MPS experience from around the world and are anonymised to preserve the confidentiality of those involved.

The cases described are historic and the expert opinions that follow in specific cases reflect accepted practice at the time. The learning points are applicable today.

If you would like to comment on a case, please email casebook@mps.org.uk.

CASE REPORT INDEX

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 £1,000,000+
Substantial £100,000+
Moderate £10,000+
Low £1,000+
Negligible <£1,000

SPECIALTY GENERAL PRACTICE **THEME** RECORD-KEEPING/INTERVENTION AND MANAGEMENT **SUBSTANTIAL** £100,000+

Common can be complicated

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Miss G, 11 years old, was taken by her mother to see GP Dr A with coryzal symptoms and a discharging right ear. She appeared quite well during the consultation, so Dr A advised symptom control measures for otitis media and advised she return for review in a week.

A week later, the patient was feeling worse, complaining of ear ache and neck stiffness and a poor appetite. Dr A reviewed her as planned and documented a negative Kernig's sign with no evidence of photophobia or rash. He prescribed antibiotics and reassured her that she should recover soon – but that she should return again if she became any worse.

Miss G continued to deteriorate over the next few days, prompting her mother to call the clinic. She spoke with the nurse adviser, explaining that her daughter had no energy and had developed problems with her vision. The nurse told her not to worry and reassured her that these symptoms were consistent with glandular fever, and to come for a review if symptoms were persisting after a week. Four days later, the patient's mother called the surgery to request an emergency appointment and again spoke to the nurse adviser. She was informed that there were no appointments available until the following afternoon. Neither of these telephone consultations were documented in the case notes.

The following day, Miss G attended her emergency appointment with Dr A. Her mother explained that she had been getting worse all week and at one point experienced temporary loss of vision. Dr A noted she had an unsteady gait when she entered the clinic, and on examination had fixed pupils with marked papilloedema. He arranged immediate admission to hospital.

The paediatric team documented palsy of cranial nerves 3, 4, 6 and 7 with gross papilloedema, and arranged urgent imaging. This confirmed a cerebral sinus venous thrombosis and a middle ear infection with a right mastoiditis. She was transferred to the neurosurgical unit for thrombolysis, CSF drainage and acetazolamide, and discharged a month later.

The family lodged a negligence claim against Dr A, stating that he failed to refer for urgent investigation following their second consultation. They asserted that had Miss G received earlier treatment, she would not have suffered from reduced visual acuity or frequent headaches.

Expert opinion agreed that, based on Dr A's account of events and the subsequent notes made by the hospital regarding the onset of visual symptoms, he performed an appropriate examination and provided a reasonable standard of care during his second consultation.

However, it was evident from the course of events that Miss G did deteriorate and the emerging visual symptoms allegedly reported to the nurse adviser did demand an urgent assessment. Failure to arrange immediate review fell below a reasonable standard of care and Dr A and his practice carried vicarious liability for this error.

Miss G's family alleged she was unable to use public transport unaccompanied due to her persistent symptoms, which would hinder future employment prospects. MPS's legal team made use of video surveillance in this case, which provided evidence that Miss G appeared very comfortable using public transport independently. This reduced the final settlement offer significantly, although the case was still settled for a substantial amount.

EW

Learning points

- The importance of documenting every consultation, including telephone consultations, is highlighted once again with this case. Disciplined documentation of every clinical encounter means that when a claim or complaint arises, you can feel more confident defending your position.
- A reminder regarding telephone consultations is that arrangements should be made for face to face review if any concerns are raised regarding a patient's clinical condition.
- A patient who develops new symptoms should be reassessed and the diagnosis reviewed. In this case the nurse should not have made a new diagnosis of glandular fever over the telephone without arranging for the patient to be seen.
- This case is a reminder that common ailments can develop rare complications. The majority of cases of otitis media seen in general practice will resolve without complications; however, health professionals should remain vigilant to the possibility of disease progression. Safety netting measures protect you and your patient.
- Asking the patient to attend for a review is an important safety net to put in place, but it is important to be able to follow this up. Lack of available GP appointments means that clinical staff are often in the position of triaging patients without seeing them in person, which can lead to a deteriorating patient being overlooked. Clinical staff should be trained to spot red flags and be aware of developing symptoms that require immediate review.
- Mastoiditis is now relatively rare. The incidence of the condition following acute otitis media reduced from 50% to 0.4% following the introduction of antibiotics.[1] Prior to this, mortality rates were 2 per 100,000 compared to <0.01 per 100,000 now.[2]

REFERENCES

1. Jose J, Coatesworth AP, Anthony R, Reilly PG, Life threatening complications after partially treated mastoiditis, *BMJ*; 327:41 (2003)
2. Bluestone CD, Clinical course, complications and sequelae of acute otitis media, *Pediatric Infectious Disease Journal*; 19(5 Suppl):S37-46 (2000)

SPECIALTY UROLOGY **THEME** SUCCESSFUL DEFENCE

Patient confusion: patient claim

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Learning points

- Communication and documentation is vital. Had the specific purpose and limitations of the biopsy been explained clearly to Mrs S at the outset, and the options for further management discussed thoroughly, she might not have brought the claim. As with many claims, the claimant did not sue based on the outcome of the surgery but rather because of lack of communication and correct information.[1] All medical practitioners must make time to ensure their patients fully understand all aspects of their management.

REFERENCES

1. B-Lynch C, Coker A, Dua JA, A clinical analysis of 500 medico-legal claims evaluating the causes and assessing the potential benefit of alternative dispute resolution, *Br J Obstet Gynaecol* 103(12):1236-42 (1996)

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

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

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

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

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

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

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

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SPECIALTY ORTHOPAEDICS **THEME** SUCCESSFUL DEFENCE

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The twisted knee

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

Two days later she presented to her GP, who noted that she had not lost consciousness at any stage, had landed on her outstretched hands and knees and that she had sustained some bruising on her neck. He documented that the medial aspect of the left knee had sustained a bruise, that the cruciate and collateral ligaments were fine and that McMurray's test was negative. Analgesia, gradual mobilisation and exercise were advised.

Ten days later Ms C reattended her local clinic. It was noted that an effusion had developed in the left knee and the range of flexion had decreased. Physiotherapy was advised. A week later, Ms C presented to the local Emergency Department (ED) with persistent pain, at which point an x-ray excluded any gross bony injury, a splint was provided and she was re-referred to her GP. Her GP duly sought advice from the local orthopaedic team.

A month after the fall, consultant orthopaedic surgeon Mr T reviewed Ms C in his orthopaedic clinic. He noted the above history and found the knee held in approximately 10° of flexion. Attempts to flex or extend the knee were limited by reticence, rather than pain. A significant effusion was also observed. Exquisite tenderness was elicited on palpation over the medial joint line but upon testing the medial collateral ligament, no abnormality was evident. On balance Mr T felt that Ms C "may simply have sustained bruising along the medial joint line, but any chance of a tibial plateau fracture or a meniscal injury should be excluded". An MRI scan was requested and Ms C was encouraged to mobilise as and whenever possible, whilst wearing a brace.

A fortnight later, Ms C attended a follow-up consultation with Mr A, a consultant orthopaedic surgeon. The MRI had yet to be performed. Mr A noted that Ms C had sustained a significant injury to the left knee and that she was limping heavily. Moreover, she was unable to fully extend the knee and could not flex beyond 20° without severe medial joint line pain.

Concerned about a significant disruption of the medial meniscus with or without an associated injury to the anterior cruciate, Mr A advised Ms C that MR imaging was likely to be academic and that urgent arthroscopy was more appropriate. Admission was arranged a week later and the patient consented for an arthroscopic menisectomy. At arthroscopy a large injury to the medial femoral condyle was observed but the menisci were not torn – Ms C was advised that healing would occur with time. After a brief overnight admission due to pain, Ms C was discharged.

However, 48 hours post-arthroscopy, Ms C developed erythema, pain and swelling of her left calf. On the same day she also developed chest pain, following which she attended the ED. Subsequent venography of the left leg did not demonstrate a DVT but a CT pulmonary angiogram demonstrated a number of sub-segmental pulmonary emboli. She was duly anti-coagulated and discharged.

A year after the accident Ms C was assessed at the local chronic fatigue syndrome (CFS) service. At that time, she described fatigue, memory impairment, diminished concentration, word-finding difficulties, myalgia, sensitivity to light and noise, as well as disturbed sleep. Although not formally diagnosed as having CFS, the reviewing physician noted that Ms C's symptoms were synonymous with those of CFS.

Two years later, Ms C brought a claim against Mr A, alleging that he had negligently performed an arthroscopy in the absence of an MRI scan, unreasonably diagnosed a meniscal tear, failed to obtain informed consent for the procedure, failed to adequately assess the thromboembolic risk postoperatively and failed to administer thromboprophylaxis. As a result of the alleged negligence, she felt that she had undergone an unnecessary arthroscopy, which caused the PE and led to chronic fatigue syndrome.

In defending the claim, expert opinion was sought. Professor D, a consultant orthopaedic surgeon, noted that Mr A's preoperative working diagnosis was eminently reasonable in light of the claimant's symptoms and signs, that it is not routine practice to carry out an MRI preoperatively if the clinician is happy with the working diagnosis, and that appropriate written consent was sought, clearly warning of the risks of DVT.

With regard to the assessment of thromboembolic risk, Professor D noted that when Ms C completed a preoperative health questionnaire, there was nothing to suggest any personal or family history of thromboembolic disease. Moreover, Professor D noted that routine anti-DVT prophylaxis is not standard practice prior to or following arthroscopy.

Had a normal MRI result been obtained, Professor D felt that the claimant would still have undergone an arthroscopy due to the persistent nature of her symptoms. Furthermore, he felt it unlikely that the arthroscopy had caused Ms C's chronic fatigue syndrome.

If the claim had proceeded, MPS's legal team would have considered commissioning expert evidence from a vascular surgeon to confirm the cause of the PE. However, in light of the supportive expert evidence, liability was denied and the claim was subsequently discontinued; no damages or claimant costs were paid.

OM

Learning points

- This case underlines the importance of instructing robust experts – highlighted by Professor D's key role in securing the discontinuance of the claim.
- A swift conclusion to this case ensured any anxiety suffered by Mr A was limited and MPS did not pay any claimant costs.
- It is also important to recognise that a complication does not necessarily amount to negligence. Therefore, it is important to cover complications in the consent process and document such conversations diligently.

SPECIALTY GENERAL PRACTICE **THEME** SUCCESSFUL DEFENCE

An unexpected pregnancy

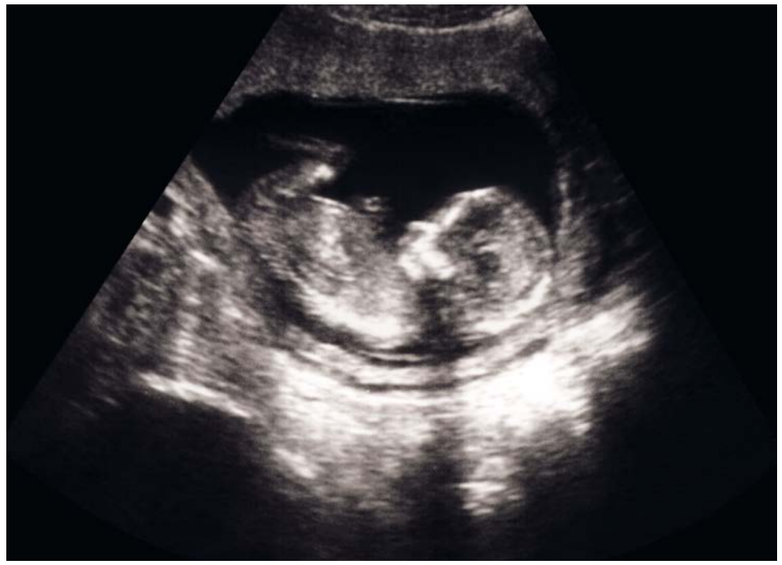
In January 2007, Mrs B, a 33-year-old woman, was seen three weeks after the birth of her second child and was prescribed six months of the progesterone only pill (POP). She was breastfeeding at this stage. She had attended the surgery earlier that month with phlebitis but it was noted that the varicose veins were "clear" at the time of prescribing.

In July 2007 the practice nurse prescribed a further six months of the POP without face-to-face consultation, and a further one month's supply was issued in December 2007. In January 2008 Mrs B presented with stress incontinence, for which a referral to urology was made. At this consultation it was noted that there were "no problems with the POP and the BP was normal". Six months of the POP was issued.

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

In October 2008 Mrs B presented to the practice with an unplanned pregnancy and she was referred to the antenatal clinic.

A review of the records revealed that Mrs B had been registered with the practice since 1999. She had been on the combined oral contraceptive (COCP) since 1992, which she had stopped in 2000 when she began trying for a family. At her new patient medical in 1999 it was noted that she was a non-smoker, and there was no family history of diabetes or heart disease.



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

Over the next four years there were a dozen clinical encounters. Three of these were pill checks with the practice nurse. A typical entry read: "On Noriday. Happy with it. No missed pills, occasional headaches [BP normal]."

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

Mrs B's legal team alleged that she should have been advised to change from a POP to a COCP when she finished breastfeeding her second child in 2007 and this would have helped to prevent her unwanted pregnancy in 2008.

Expert opinion was that when prescribing contraception there is a duty to discuss contraceptive choices with a patient – specifically about the pros and cons of a COCP and a POP in this case. The discussion should cover failure rates, the method of taking the pill, common side effects (including effects on menstruation) and the risk of thrombosis. This would allow the patient to reach an informed decision. The expert felt that part of this could have been achieved by advising the patient to read the product information in the packet insert.

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

A defence denying liability was served by MPS – three months later Mrs B discontinued her claim and MPS recovered all costs.

AK

Learning points

- It is striking that despite so many clinical encounters over many years and her own prolonged use, Mrs B still alleged that she was unaware of key issues with the POP and COCP, including the three-hour window in which to take the POP. It is a timely reminder that giving information is important, but checking that the patient has understood the information is vital. This forms the basis of valid consent to treatment. In this case it would have been all too easy to view the 'pill check' as a routine encounter, make assumptions and be less rigorous in documentation.
- A number of the prescriptions were issued by the practice nurse or as repeats by the administration team in the practice. When devolving responsibility it is important to ensure that there is a clear practice policy on what is expected of staff and that this protocol is thought through, written down and being adhered to.
- Continuing professional development: Newer guidance on contraception UKMEC (UK medicines eligibility criteria) 2009 updates earlier guidance on varicose veins (no contraindication to the COCP), family history of DVT (contraindication if age <45 in the family member) and on contraceptive options when breastfeeding and is a timely reminder of the constant challenge of keeping our knowledge up to date: www.fsrh.org/pdfs/UKMEC2009.pdf

SPECIALTY OBSTETRICS **THEME** SUCCESSFUL DEFENCE

A tear during delivery

Mrs J, 37 years old, was pregnant with her third child. She had an uneventful forceps delivery with her first child and a spontaneous vaginal delivery with her second.

She had been previously diagnosed with irritable bowel syndrome, but endoscopies had revealed no evidence of any other disease. The GP records showed that she had colicky pain with constipation and diarrhoea, but no history of faecal incontinence. This pregnancy had been uneventful and she went into spontaneous labour at 39+5 weeks.

At 5.15pm she was 4cm dilated and, as the contractions had reduced, she was started on an oxytocinon drip. She had an epidural sited and was found to be fully dilated at 9.45pm. As the head was 'high' she was given an hour for it to descend and started active pushing at 11pm. The baby's head had come down to station 0 and appeared to be in the correct position (occipito-anterior) with only minimal caput and moulding.

Dr A, an experienced specialty trainee, was called after Mrs J had been pushing for one and a half hours. She documented that there was no 'head' palpable abdominally (cephalic 0/5) and vaginally confirmed the midwife's findings. She advised Mrs J that she would need to carry out an operative delivery and documented fully in the notes that a verbal consent had been obtained. She deflated the foley catheter, which had been put in place when the epidural was sited.

Dr A then applied a silicone ventouse cup over the 'flexion point' on the baby's head. She increased the pressure to 0.2kg/cm2 and checked there were no maternal tissues under the cup. She then increased the pressure gradually to 0.8kg/cm2 and, with good maternal effort, pulled along the pelvic axis. Despite using the correct technique, the cup slipped off and the suction was lost.

She re-examined the patient and still felt the baby was in the correct position, and that "the head had descended well to station +1". Dr A decided to use the Neville Barnes forceps to complete the delivery. The blades were easily applied and, using the 'Saxthorph-Pajot' technique, the baby's head was delivered with one pull.

Dr A felt the perineum was stretching out well, and did not carry out an episiotomy. The patient was noted to have a second degree tear. Dr A carefully examined the perineum and anal canal following the delivery and documented that the "anal sphincter was intact" and there was no evidence of any sphincter damage, and repaired the tear routinely.

The patient made an uneventful recovery and, when she was seen by her GP for her six-week check up, it was documented that "she had no problems with her bladder or bowels".

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

Mrs J underwent a vaginal hysterectomy and posterior pelvic floor repair, and her symptoms improved significantly with dietary modifications and bio feedback.

Mrs J made a claim, as she was advised that if Dr A had carried out an episiotomy and avoided the use of 'double instruments' her symptoms would have been avoided. She felt that a diagnosis of a third degree tear had been missed and, as a consequence, this had had a major impact on her life.

Expert opinion on these issues was sought. Although it was acknowledged that an episiotomy is often required in a forceps delivery, the perineum was stretching well and it was felt that the episiotomy was not essential in this case. The contemporaneous notes confirmed that the anal sphincter was intact despite the second degree tear that was observed. The endo-anal ultrasound and neurophysiology tests also confirmed no signs of marked sphincter damage, and the cause of the bowel problems was felt to be due to pudendal neuropathy.

The ventouse cup displaced due to the caput on the baby's head, and the fact that there had been some active descent during traction meant that it was deemed acceptable to use a second instrument to achieve the vaginal delivery.

The case was successfully defended.

DD

Learning points

- The use of sequential instruments is associated with an increased neonatal morbidity; however, the operator must balance the risks of a caesarean section following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction. In the UK, the Royal College of Obstetricians and Gynaecology (RCOG) has published *Guideline No 26 Operative Vaginal Delivery* (2011): www.rcog.org.uk/files/rcog-corp/GTG26.pdf
- Recognition and documentation of the correct technique in the notes (eg, 'Saxthorph-Pajot' technique for forceps delivery – where the operator's dominant hand applies horizontal traction, whilst the other hand gently presses downwards on the shank of the forceps) suggests that the accouchere has adequate experience to carry out the procedure correctly. In the UK, the RCOG does support the "restrictive use" of episiotomies for instrumental deliveries and leaves it to the clinical judgment of the operator, but certainly when undertaking a forceps delivery they are often required in multips and almost always on primips.
- Careful documentation of the technique and assessment for perineal damage is essential, and use of endo-anal USS may help with the definitive diagnosis at a later stage.
- The expert opinion was logical and evidence-based and, with careful documentation and adherence to good medical practice, such cases can be discontinued before they are taken to court.

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SPECIALTY ORTHOPAEDICS **THEME** INTERVENTION AND MANAGEMENT **SUBSTANTIAL** £100,000+

A catalogue of errors

Ms M, a 58-year-old woman, saw Mr A, a consultant orthopaedic surgeon, with a history of left-sided knee pain. She had seen him several years previously with a similar complaint – at that time, an arthroscopy had demonstrated degenerative change in both medial and lateral compartments of the knee. Upon being re-consulted, Mr A performed a second arthroscopy – severe degenerative changes and bone-on-bone contact were observed. Ms M was duly listed for a left-sided total knee replacement, which was performed three months later.

When undertaking the consent procedure Mr A indicated that he would be performing a left total knee replacement, that the indications for surgery were pain relief and improved mobility, and that the serious and frequently occurring risks had been fully discussed.

The procedure was performed through a midline incision. The finding, as anticipated, was gross tri-compartmental osteoarthritis. The prosthesis was inserted, the patellar osteophytes were trimmed but the patella was not resurfaced. The operating note does not record any untoward intraoperative events. Routine antibiotics and thromboprophylaxis were prescribed.

The following day an x-ray was performed. This showed that the tibial component of the prosthesis had been sited in a suboptimal position. Over the course of a week, the nursing notes consistently commented that it was very painful for Ms M to move her leg, that she was profoundly immobile and that physiotherapy was almost impossible. Mr A repeatedly suggested that Ms M should be mobilised – unhappy with this advice, Ms M pursued a second opinion. This was provided by Mr B.

Seven days after the operation, Mr A wrote to Ms M's GP. In this letter he stated that the operation seemed to go very well but that the postoperative x-ray demonstrated a suboptimal result. He indicated that revision should not be pursued aggressively and that there were both advantages and disadvantages to this conservative approach. Moreover, he reported that most of Ms M's pain was in the thigh.

Three days after the correspondence and ten days after the original operation, revision surgery was undertaken by Mr B. The operating note described the suboptimal position of the tibial component and recorded a fracture of the medial tibial plateau. The component was replaced and the patella resurfaced. A swab taken at the time of revision grew a coagulase negative Staphylococcus but this was thought to be a contaminant. The claimant made a reasonable recovery and was duly discharged four days later.

Follow-up was arranged by Mr B and Ms M was seen six weeks later. At that time, the wound had healed and Ms M was walking with a stick. The knee was a little stiff but physiotherapy was ongoing.

At this point a second issue supervened. Ms M complained of severe lower back pain and left-sided sciatica – an MRI scan of the lumbar spine demonstrated an L4/5 disc protrusion. A concurrent CRP of 35 and ESR of 31 were felt to be of questionable relevance and were attributed to delayed wound healing and the MRI finding.

Further follow-up, six months later, found that Ms M was walking without the aid of a stick. The knee was a little warm. The range of movement was 5° to 100° and it was considered that the knee was improving.

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

Six months later Ms M made a claim against Mr A. It alleged that Mr A was negligent on multiple counts, in that he had fractured the tibial plateau at the time of the original surgery, failed to identify the fracture during surgery and then failed to take remedial action intraoperatively. Moreover, it alleged that Mr A had been negligent in failing to proceed urgently to revision surgery and in persistently advising Ms M to mobilise, despite her severe pain, the concerns expressed at multidisciplinary team meetings and all the clinical and radiological indications that the knee joint was mal-aligned.

Ms M also claimed that were it not for Mr A's negligence, the total knee replacement would have been successful and she would have recovered swiftly following surgery. Furthermore, Ms M alleged that she would have been relieved of her preoperative symptoms and would not have required a further revision for approximately two decades. It was also suggested that the initial revision, the ensuing septic arthritis, the subsequent arthroscopy and the final two-stage revision were all consequent to Mr A's negligence.

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

He was also critical of the persistent advice to mobilise and acknowledged that, in his opinion, this was one of the worst total knee replacements he had seen. Moreover, Mr D felt that the subsequent operations Ms M underwent were a result of Mr A's breach of duty during the index operation. In terms of breach of duty, Mr A made the tibial cut in the wrong direction. This led to poor placement of the tibial component with fracture of the posterior tibial cortex, which is surgery that falls below an acceptable standard of care.

The claim was settled for a substantial sum.

OM

Learning points

- Adverse outcomes and mistakes are part of a doctor's working life. Acknowledging this, responding to such events in a timely manner and being open, help to reduce the impact of these events on both the patient's wellbeing as well as the doctor's professionalism.
- In this instance, the highly critical expert evidence required swift action to control costs – in cases such as this, prompt settlement was appropriate. Strong expert opinion guides the approach of both MPS and the members involved.

SPECIALTY ANAESTHETICS **THEME** INTERVENTION AND MANAGEMENT **HIGH** £1,000,000+

Cutting corners

L was a healthy four-year-old boy who had accidentally caught his finger in a bicycle wheel, amputating part of the distal phalanx. In the Emergency Department of the local hospital, it was found that the pulp and nail bed of the finger were lost and the bone of the terminal phalanx was exposed. L was admitted under plastic surgery, fasted, and booked for theatre for terminalisation of the finger.

He was assessed for general anaesthesia by consultant anaesthetist Dr B, who noted that L was a fit and well boy weighing 17.5kg, had no medical problems or allergies, and had been appropriately fasted.

Dr B conducted an inhalational induction of anaesthesia, with 70% nitrous oxide, 30% oxygen and 4% sevoflurane via a modified Ayre's T-piece, using fresh gas flows of 8l/min. Dr B inserted a laryngeal mask airway (LMA) to maintain the airway, and maintained the anaesthetic with a mixture of nitrous oxide, oxygen and sevoflurane. An intravenous cannula was inserted once L was asleep; 15mcg of fentanyl and 2mg of ondansetron were given during the case and a slow infusion of dextrose saline was administered.

Plastic surgeon Mr T performed the surgery, which proceeded uneventfully. Mr T performed a ring block with 3ml of 0.5% plain bupivacaine for postoperative analgesia. Towards the end of the operation, as Mr T was applying the dressings, the theatre sister, Sr S, noted that L's pulse was very slow at 45 beats per minute. The pulse oximeter showed that the saturations were 52%.

Dr B removed the drapes and L's face was noted to be cyanosed and his pupils widely dilated. Dr B removed the LMA, but the throat was clear. He applied 100% oxygen by facemask and an oropharyngeal airway. No pulse was palpable after 20 seconds of high flow oxygen, so Dr B instructed the surgeon to perform external chest compressions. He gave 0.1mg of adrenaline and a second dose after two minutes. The second dose was effective in restoring a palpable pulse, and the oxygen saturations recovered to normal.

Upon attempting to wake L from the anaesthetic, he manifested severe extensor spasms and epileptiform movements of his limbs. He was intubated, sedated and transferred to intensive care. After a prolonged period of care, he was discharged from intensive care with extensive neurological damage consistent with hypoxic brain injury.

An extensive inquiry was undertaken, which highlighted several areas of very deficient anaesthetic care. Dr B had not spoken to L's parents before the anaesthetic, and had not warned them of the risks of anaesthesia. Dr B said he had finished a 12-hour list with another surgeon and had agreed to help out at short notice. After induction, Dr B had left the reservoir bag concealed under the drapes, where he could not see its movement. He had not used a capnograph to monitor respiration. He had not recorded a blood pressure or respiratory rate at any time during the case. The monitor alarms had all been switched off earlier in the day and he had not checked or reinstated them. Dr B accepted that there was a protracted period of inadequate vigilance during the case, during which a prolonged episode of severe hypoxia occurred.

This case occurred over a decade ago and L is now a teenager. He has profound impairment of sensation, movement, communication, intellectual function and memory. L's parents made a claim against Dr B, which was settled for a high sum.

AOD

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Learning points

- A series of human and equipment factors interacted in a catastrophic way to bring about this tragic outcome from a trivial initial injury.
- Fatigue can be a powerful cause of reduced vigilance, and is associated with increased risk of error. It does not amount to a defence. The mnemonic HALT reminds all healthcare professionals to be extra careful if they are Hungry, Angry, Late or Tired. Ask yourself: am I safe to work?
- The AAGBI recommends capnography in all patients under general anaesthesia, regardless of their location in the hospital or the type of airway device used.
- Most anaesthetic machines now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.

SPECIALTY GENERAL SURGERY **THEME** INTERVENTION AND MANAGEMENT **SUBSTANTIAL** £100,000+

A restoration problem

Mr A, a 46-year old accountant, had a long history of biopsy-confirmed ulcerative colitis. Because of escalating medication, he was referred by his gastroenterologist for consideration of surgery after repeated exacerbations. He saw Mr C, a colorectal surgeon, who discussed the options available.

Mr A had been unable to work for several months. He had done some independent research on the internet and concluded that he wished to undergo a restorative procto-colectomy to avoid a permanent stoma. Mr C documented the risks of this complex procedure and warned Mr A of possible leaks, pelvic sepsis and possible future pouchitis. He planned to perform the operation laparoscopically, which would carry the advantages of a quicker recovery, fewer adhesions and minimal scarring.

Mr A underwent a laparoscopic procto-colectomy with complete intra-corporeal ileo-anal pouch formation and a covering loop ileostomy. He made a slow but straightforward recovery. He remained in hospital for ten days, requiring a course of intravenous antibiotics for presumed urinary sepsis and training in the management of his ileostomy.

Two days after discharge he re-presented with urinary retention requiring urethral catheterisation. Mr A subsequently developed increasing perineal and pelvic pain. Digital rectal examination revealed separation at the anastomosis, and a subsequent CT scan demonstrated a 6x7cm pelvic abscess adjacent to the anastomosis. A CT-guided drainage of the area was successfully carried out, and a week later Mr A was discharged home with the drain in situ.

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

Mr A was desperate for his ileostomy to be closed so he could return to work and, following a normal water soluble enema, Mr C decided to close the loop ileostomy. Preoperatively he documented the "high risk of pelvis sepsis if there is a persistent anastomotic dehiscence". Before surgery Mr C performed an examination under anaesthesia, which showed a very small dehiscence posteriorly at the pouch-anal canal anastomosis. Nevertheless, Mr C proceeded with closure of the ileostomy, in the hope that this would ultimately heal.

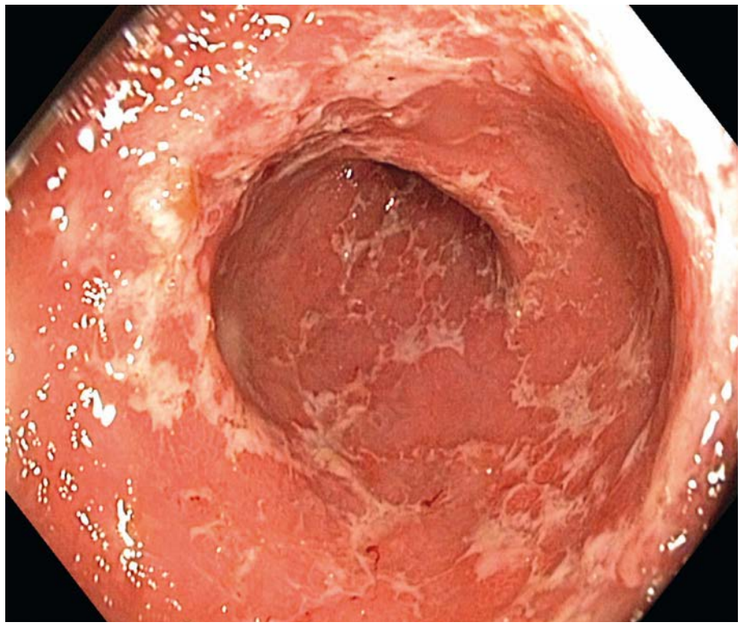
Mr A then suffered a recurrence of his previous problems with urinary retention, pelvic pain and sepsis. A further 12-month period of repeated hospital admissions ensued, with radiologically-guided drainage of the pelvic collections and treatment with antibiotics. The relationship between surgeon and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

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

Expert opinion agreed that the decision to perform a restorative procedure was correct and Mr C had sufficient experience and training to undertake the procedure laparoscopically. They were, however, in agreement that closure of the covering ileostomy – despite the operative finding of a persistent anastomotic defect – was not defensible. Mr C accepted the criticism, but noted that on a personal basis he had felt responsible for the patient's complications, and had been influenced by a desire to help the patient back to a normal life as rapidly as possible.

The case was settled for a substantial sum.

SD



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Learning points

- Clinicians should always maintain objectivity in the advice given to a patient. Shared decision-making is very important, with a balance between ensuring patient autonomy and making good clinical decisions. MPS's workshop, *Mastering Shared Decision Making*, shows such a model is an effective way to ensure that patients make appropriate and informed choices; visit the Education section of www.medicalprotection.org for more information.
- Restorative procto-colectomy is a demanding surgical procedure with a high complication rate. Patient expectations should be matched with a frank discussion regarding complications and outcomes. When working within a multidisciplinary team, the ability to ask for second opinions and advice from colleagues in the event of problems is a strong medicolegal defence, as well as good medical care.

SPECIALTY ORTHOPAEDICS **THEME** SUCCESSFUL DEFENCE

An expert eye

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

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

At surgery, several different component sizes of the femoral neck and head were trialled. The final implant was chosen to ensure appropriate soft tissue tension, in order to ensure maximum stability of the hip and minimise the risk of dislocation.

The operation went well and there were no postoperative problems. Mrs K was recovering as expected when she was seen for review at one month. After three months, however, she complained of discomfort over the lateral aspect of her hip. An x-ray showed that her right leg was 9mm longer than her left, but Mr B felt a shoe raise was not indicated. This lateral pain persisted though, and Mrs K was provided with a shoe raise to equalise the leg lengths at a further review.

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

After reviewing the history of ongoing pain post-surgery, a clinical examination and a new set of x-rays, Mr L could not see any obvious problem with the hip replacement that would account for her symptoms. Mr L explained to Mrs K that the hip

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was "only very slightly long". He felt that maybe she was getting some impingement pain from her psoas tendon.

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

The MRI showed some degenerative changes in her lumbar spine and also a 'hot spot' around the total hip replacement indicating, once again, the possibility of an infection. Another hip aspiration was arranged. For a second time the aspiration grew no organisms on culture, which confirmed that an infection was most unlikely. Mr B also reiterated his view that Mrs K's leg length discrepancy was minimal.

Mrs K was now finding walking for more than an hour impossible. After five minutes she developed steadily worsening pain in her hip, and she struggled with stairs. She brought a claim against Mr B, citing a leg length discrepancy of two and a half centimetres, and failure to plan and perform the surgery adequately.

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

The claim was discontinued.

RMacN

Learning points

- Limb length discrepancy is the second most common cause of litigation in arthroplasty surgery, behind nerve injury.[1]
- Approximately 15% of hip replacement surgery results in a limb length discrepancy. Less than 1cm discrepancy[2] is the ideal goal,[3] but up to 2cm is reported to be tolerable by patients.[4]
- The importance of good documentation concerning consent of all common and serious complications is vital. Specific complications should be included on the consent form. In this case limb length discrepancy was discussed with the patient and mentioned in the GP letter.
- Explaining to a patient why a complication might arise helps them to understand and accept it if it happens. In this case, having a stable hip replacement and adequately tensioned soft tissues is more important than a leg length discrepancy, and should be emphasised.
- This case highlights the importance of having strong experts. In this case, expert opinion found some of Mrs K's claims inaccurate and found Mr B had dealt with the patient in an appropriate manner. MPS robustly defends non-negligent claims.

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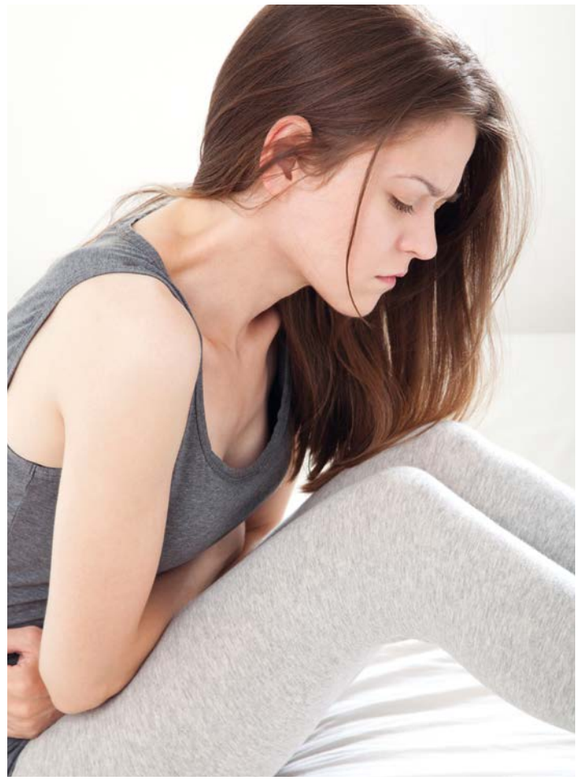
SPECIALTY GENERAL SURGERY **THEME** INVESTIGATIONS/RECORD-KEEPING **MODERATE** £10,000+

A delayed diagnosis



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

Learning points

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

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

General surgeon Mr S reviewed the patient the following morning and requested an ultrasound scan. This demonstrated the presence of dilated small bowel loops with bilateral pleural effusions and free fluid in the peritoneal cavity. When he saw the patient 24 hours later, she remained unwell; review of the abdominal x-ray from 36 hours earlier confirmed the ultrasound suggestion of small bowel obstruction. Mr S concluded that it was likely a consequence of adhesions from her previous appendicectomy and, later that day, he undertook a laparotomy. This revealed small bowel obstruction secondary to a band adhesion. After division of the band and decompression of the small bowel, a 10cm section of ileum required resection and anastomosis.

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

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

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

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

Expert opinions were critical of the delay in making the diagnosis of small bowel obstruction and undertaking surgery. They felt that an ultrasound examination had been unnecessary and that Mr S should have reviewed the abdominal x-ray (which clearly showed evidence of obstruction) when he initially reviewed the patient and not the following day. Had he seen the film, the finding of peritonism three days into her illness may have prompted Mr S to perform earlier surgery, before the small bowel ischaemia had become irreversible.

The case was settled for a moderate sum.

SD

FOREST WOODWARD/ISTOCKPHOTO.

Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions.
Please address correspondence to: *Casebook*, MPS, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK. Email: casebook@mps.org.uk

A confidential issue?

›› May I comment on the article "On deadly ground" (*Casebook* 21(3)); the case "CONFIDENTIALITY". I feel that Dr W was not at fault in divulging Miss B's HIV status with the mother present.

The mere fact that Miss B allowed the mother to be present at the consultation gives the doctor the right to discuss ALL problems and queries of the patient. In my opinion Miss B had given permission by allowing her mother in at the consultation.

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

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

Dr JW Van Vreede, South Africa

Response

In this scenario, the GP had wrongly assumed that the patient was content for her daughter to know confidential information regarding her HIV status.

The patient, in making her complaint, had not expected that information to be divulged, and the case illustrates the dangers of making assumptions. Fortunately, although the GP had to endure the stress of a complaint to the Medical Council, the case did not proceed to a hearing.

Poor notes: why?

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

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

Thanks for a great journal.

Dr Gustav Mutesasira, GP, Grahamstown, South Africa

Response

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

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

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

A weekend of back pain.

›› Regarding the case, "A weekend of back pain", *Casebook* September 2013, pages 22 and 23. One of the learning points of this case was that the claimant runs a litigation risk when pursuing a claim. The article mentions that the claimant's legal costs were being paid for by public funds and this was withdrawn after surveillance showed she was clearly lying regarding her disabilities.

Surely she was attempting fraud by entering a fictitious claim and should be dealt with accordingly – was there any prosecution for this offence?

Has she also committed a fraud by receiving taxpayer funding for her legal action to gain money by deception?

If legally possible, MPS should push hard for prosecution in cases such as these to reduce and deter unwarranted compensation payouts.

Dr Chris Fox, Consultant Physician, East Kent Hospitals NHS Trust

Response

In this case, the claimant had a valid claim, and was entitled to the amount of compensation which was ultimately paid to her. However, she pleaded exaggerated damages, which led MPS to investigate and establish that her injury was less severe than she was claiming. This would not have impacted on her entitlement to public funding of her claim at the outset, but led to withdrawal of this funding when it was possible to show that a reasonable offer had been made.

Given that her claim was, in fact, successful, it would be difficult to secure a conviction in this case. However, I hope that this case does demonstrate how rigorous MPS is in investigating claims, paying when and where it is right to do so, and at the same time safeguarding members' funds.

You may have also noted that in the cases reported on pages 19 and 21, where we were successful in our defence, MPS has sought to retrieve our costs from the unsuccessful claimant.

Please do not hesitate to let me know if you have any further queries about these, or other, cases.

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Stumbling block

›› Thank you for highlighting the important case of a nerve injury following a femoral nerve block ("Stumbling block", *Casebook* 21 (3)). However I would dispute your statement that use of ultrasound has revolutionised the safety and efficacy of regional anaesthesia. Published works show a rate of nerve injury whilst using ultrasound to be similar to traditional techniques.[1] Surely the key factors in this case were the use of an unsafe nerve block technique, as well as severe deficiencies in consent and communication. From the details published the decision to use a regional block at all might seem questionable, regardless of technique. The presence of an ultrasound machine would not have made any difference to these factors.

Dr Ben Chandler, Consultant Anaesthetist, Scarborough Hospital, UK

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Response

You correctly identify the issues of unsafe technique, consent and communication as being the factors which made this claim indefensible; the comment about ultrasound, whilst making no difference to the outcome of this case, was a comment made by one of the experts in passing.

An unavoidable amputation

›› Re: "An unavoidable amputation", *Casebook* 21 (3). Thank you for your interesting case reports, which I always read.

I was trying to gain a better understanding as to why the patient, Mrs N, did not make a claim against Dr B, the initial clinician, or at least claim against both doctors. It seemed her focus was on one doctor rather than the other.

This is relevant to my locum GP work.

Dr Vishal Naidoo, Portfolio GP, UK

Response

One can only presume that the claimant was either herself satisfied with the consultations with Dr B, or that she was advised by her solicitors or their GP expert when examining the record, that Dr B had exercised a reasonable standard of care. Given that the care provided later by Dr G was also considered to be reasonable, it would seem to have been the right decision.

Hospital managers: support needed

›› Dr Rob Hendry makes a very valid point in his article ("Under the influence") on page 4 of the latest edition (Vol 21 No 3, September 2013) of *Casebook* about failing teams being at the root of much of the problems in failing hospitals. He is not precise about which teams he has in mind but the point is valid in all contexts; perhaps in failing hospitals it is the management team that needs most help. There can be considerable antipathy, as well as inability to understand the other's point of view when managers and doctors meet.

This may not be all that surprising when each have very different goals.

People who just cannot get on need outside help. Dr Hendry might like to follow up his comments with a note about where one should turn. I felt this was a lack in the article. His concluding comment was too vague. One needs to be aware of which of one's actions one needs to "take responsibility for", and how to do that.

Behaviours that impact negatively are compounded by communication failures, and some may find it helpful to read something on the subject. I would recommend a book by three American authors, which of the hundreds available and several I have read is really outstanding. Though I have not read the latest edition of 2012 there is every reason to believe it will be as good as earlier ones.

Changing our own approach might encourage change in "the opposition" and avoid the need for involving a third party.

Dr Howard Bluett (retired consultant paediatrician), Tewkesbury, UK

The book recommended by Dr Bluett is Interplay: The Process of Interpersonal Communication, *by Adler et al, published by Oxford University Press, USA; 12 edition (13 Jan 2012) ISBN-10: 0199827427; 1SBN-13: 978-0199827428*

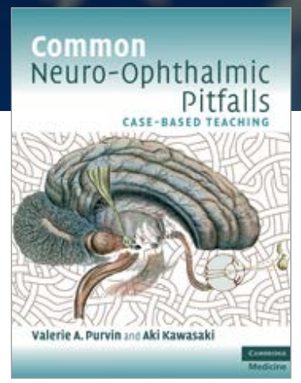
It will be reviewed in a future edition of Casebook.

Casebook and other publications from MPS are also available to download in digital format from our website at:
www.medicalprotection.org

Reviews

If you would like to suggest an app, website or book for review, or write a review, please email sara.dawson@mps.org.uk

★★★★★



Common Neuro-Ophthalmic Pitfalls: Case-Based Teaching

By Valerie A Purvin and Aki Kawasaki
(£58.00, Cambridge University Press, 2009)
Reviewed by Dr Sacha Moore, consultant ophthalmologist

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

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

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

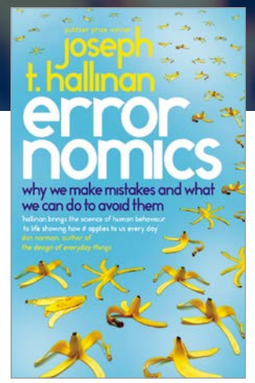
- When ocular disease is mistaken for neurologic disease
- When orbital disease is mistaken for neurologic disease
- Mistaking congenital anomalies for acquired disease
- Radiographic errors
- Incidental findings (seeing but not believing)
- Failure of pattern recognition
- Clinical findings that are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

The style feels like a rewarding one-on-one tutorial and makes you feel like you may actually be able to deal with similar cases in future. You can dip into it like a textbook or enjoy reading it straight through from start to finish – there are many interesting and surprising facts that I have not found in other textbooks.

This book will help you better understand subjects you thought you knew and those you know you didn't know. Neuro-ophthalmologists will find this book serves as a good tune-up on their knowledge; non-neuro-ophthalmologists may benefit from the insights, like a full service on the rusting remains of their faded membership memories.

It is satisfyingly clinically relevant and not just another book for membership examinations. Overall the book deserves the honour of being well-thumbed and to stand battered and frayed from much use amongst the shiny, thick bibles of untouched neuro-ophthalmic monoliths in your, or your institution's, library.

★★★★★



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

By Joseph T Hallinan
(£8.99 Ebury Press, 2009)
Reviewed by Dr Matthew Sargeant, consultant psychiatrist and clinical human factors group member

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

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

Grouped deceptively simply under 13 chapters, we are told making fewer mistakes is not easy, especially if the reader merely desires to do so without reflection. Hallinan urges: put effort into thinking of the small things we do and do not do, for the consequences are big. To improve patient safety with the very next patient you manage, read the book.

The book advises team members to work together, to communicate and to have a supportive and accessible attitude to reduce error in team members. Clinicians are also advised to look up at the organisation they are working in for the sources of errors, as well as down at what they are doing. Clinicians are also told to avoid multitasking. The book implies that designing, investigating, delivering and managing clinical care are onerous responsibilities to promote patient safety.

The book is a lifeline for all medical students and doctors who make the plaintive cry "why don't they teach us about human factors". If there are any non-believers about human fallibility out there it will help them too. Patients could help too by reading the book to [help] their clinicians. Hallinan tells us confidence and expertise attained through years of practice and study can be a major context of error. We are all fallible, the book says. To err is, indeed, human.

Clinicians, buy it: be a good doctor and make patients safer. Patients: buy it and help your doctor deliver to you safer clinical care.

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