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Our latest collection of case reports

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– MEDICATION ERRORS AND SAFER PRESCRIBING
Common problem areas in prescribing

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A look at what our regional education faculty does for members

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97% OF USERS WOULD RECOMMEND
**WELCOME**

Dr Marika Davies  
**EDITOR-IN-CHIEF**

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

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

We are proud to have served members in Hong Kong, Singapore and Malaysia for many years and look forward to continuing to do so long into the future. Medical Protection held a number of events in Singapore and Hong Kong in March focusing on the important issue of consent. On page 6 Dr Ming-Keng Teoh, Head of Medical Services (Asia) explains why the process of taking consent should be regarded as an opportunity to build trust and the doctor-patient relationship.

Medical Protection also held a series of roadshows on medicolegal risks in Malaysia at the end of 2015, in conjunction with the Malaysian Medical Association and Malaysian Ministry of Health. Dr Teoh spoke to attendees about a clinician’s duty to be open and honest with patients when things go wrong. He discusses this on page 11.

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

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

Dr Marika Davies  
**Casebook Editor-in-Chief**

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RISK ALERT
MEDICATION ERRORS AND SAFER PRESCRIBING

Medical Protection Clinical Risk Facilitator Dr David Coombs examines two cases that demonstrate common risks associated with prescribing

Prescribing is one of the greatest risk areas for all clinicians and can be particularly hazardous for the inexperienced doctor. It is fraught with potential pitfalls, ranging from transcription errors and inadvertent dosage mistakes to overlooked drug interactions, allergies and side effects, the consequences of which may be profound both for the patient and the prescriber.

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

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

Below are two case reports highlighting some common potential hazards.

CASE 1

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

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

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

LEARNING POINTS

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

CASE 2

Mr C was on long-term immunosuppressive treatment and went to see his family doctor in September 2013 for his annual flu vaccine. He asked if he could also be given the new shingles vaccine. The nurse said he was not sure and would check with one of the doctors. He waited outside one of the consulting rooms and quickly popped in between patients. Dr D was already running behind with her surgery and after a brief thought said, “Yes, that would be fine.”

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

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

LEARNING POINTS

• Distractions and interruptions are a common cause of error.
• A study in the UK showed that vaccination errors are one of the most frequently reported medication safety incidents reported in primary care1.
• When prescribing or giving advice about a new or unfamiliar drug, be prepared to look up information on your clinical record system, in a formulary or in specific guidelines as appropriate.
• Make contemporaneous records of all contacts/discussions with colleagues about patients.
• Administration of a routine vaccination is not urgent and, although inconvenient for the patient, it may be safer to rebook, allowing time to check facts – particularly if, as here, the patient had a short appointment earmarked just for the flu vaccination.

REFERENCES


The cases mentioned in this article are fictional and are used purely for illustrative purposes.
A doctor, you know that you need to obtain a patient’s consent before beginning clinical treatment. But our experience of helping Medical Protection members – whether through a medical negligence claim, a medical council investigation, or simply by offering professional advice – shows that taking valid consent, with a discussion and documentation of relevant risks, is not always as simple as it might seem.

THE IMPACT OF RECENT CASE LAW
One of the most challenging aspects of taking valid consent is judging how much information to give about the risks associated with a particular clinical treatment. Doctors have always relied on the principle that as long as they have acted reasonably, which is having given advice in accordance with a responsible body of medical opinion (the Bolam test), they will be protected. In many countries, however, courts have increasingly adopted the principle that the doctor has to take the patient’s needs into consideration when deciding how much to warn or inform them of the risks and options. Cases such as Rogers v Whitaker\(^1\) in Australia, and more recently Montgomery\(^2\) in the UK, have reinforced this trend.

WHAT IS VALID CONSENT?
Valid consent requires the patient to be competent, to have given consent freely, and to have received and understood sufficient information to make an informed choice. The information should include the risks, benefits and possible complications of the procedure and any alternative treatment options. It is a process whereby the patient reaches sufficient understanding to make a properly informed choice. The patient should be given the opportunity to ask questions and seek any further information they require.

Giving advice on risks and complications is not merely providing a list; it must be explained clearly in a caring, non-adversarial and sympathetic manner so that the patient can understand and weigh up the pros and cons. It is helpful to provide the information and advice in a balanced way so that it is easier for patients to digest the information. Consider providing leaflets explaining the procedure or treatment.

You must also document clearly what was discussed and the relevant advice given. Good clinical record-keeping is part of good medical practice.

CONSENT IS ABOUT PROTECTING AND HELPING THE PATIENT
Taking valid consent is not about quickly running through a consent checklist just before a clinical procedure takes place. Nor is it just a patient’s signature on a consent form or completing a tick-box exercise.

REFERENCES
1. Rogers v Whitaker (1992) 175 CLR 479
Consent is a dialogue, where you have a responsibility to provide patients with an adequate explanation of their medical condition and options for treatment, so that they can participate in the decision-making process, in the spirit of shared decision making. If a clinical procedure needs to be performed, you should make the patient aware of the benefits, risks and possible complications of the procedure, and any alternatives.

For minor invasive procedures, oral express consent is acceptable, and can be documented in the patient notes. Written express consent is required for major treatments, invasive procedures, and any treatments that carry significant risks.

If you are providing the treatment or performing the procedure, you are responsible for obtaining valid consent. At times when it is impractical or impossible for you to personally explain to the patient to take consent, you must ensure that there is an appropriately qualified colleague or team member who can do this.

**WHY DOES IT MATTER?**

Since the 1990s, the failure to obtain valid consent has become one of the biggest causes of medical negligence claims against doctors in Asia. A significant proportion of cases were settled simply because valid consent was not obtained, or because it could not be proved that it was obtained, due to the lack of supporting documentation.

Respect for patients’ autonomy is expressed in common law; to impose care or treatment on competent people without respecting their wishes and right to self-determination is not only unethical, but also risks civil and disciplinary consequences.

Valid consent protects the patient; they are part of the discussion about what will happen during their clinical treatment, and why. It presents an opportunity to build trust in the doctor-patient relationship, which can help to lessen the likelihood of a complaint or claim should something go wrong. Ensuring you have obtained valid consent protects you, the doctor, too.

As part of our commitment to medico-legal education, Dr Ming-Keng Teoh delivered ‘A practical approach to consent’ to Medical Protection members in Hong Kong and Singapore in early March.

Dr Teoh was joined at the events by Dr Alison Metcalfe, Head of Medical Services (London), and the Chief Executive of MPS, Simon Kayll.

Visit [medicalprotection.org](http://medicalprotection.org) and select ‘Education and Events’ to find upcoming lectures near you.

Words: Sarah Whitehouse
USING CHAPERONES

This flowchart provides a step-by-step guide for doctors in the use of chaperones during intimate examinations.

Medical councils are clear in their guidance that in intimate examinations chaperones should be considered. The Medical Council of Hong Kong, in its Code of Professional Conduct (2009), states that: “An intimate examination of a patient is recommended to be conducted in the presence of a chaperone to the knowledge of the patient. If the patient requests to be examined without a chaperone, it is also recommended to record the request in the medical records.”

The Malaysian Medical Council echoes this in its Code, with the added clause that if the patient declines a chaperone “the practitioner should request the chaperone to be close by in case assistance is needed”.

In the Singapore Medical Council guidelines the additional point is made that the presence of a chaperone protects both the doctor and the patient.

Obvious examples of intimate examinations include those of the breasts, genitalia and rectum, but it can also extend to any examination where it is necessary to touch or be close to the patient; for example, conducting eye examinations in dimmed lighting and palpating the apex beat.

You should let the patient know that they may have a chaperone present if they wish. The offer of a chaperone is for the protection of both the patient and the doctor.

START

CONSENT
Before performing an intimate examination, it is important to explain what the examination will entail and why it is necessary, allow the patient to ask questions and seek permission from the patient.

OFFER CHAPERONE
If the patient gives consent to examination, you then ask the patient if they would like a chaperone to be present.

CHAPERONE REJECTED

CHAPERONE ACCEPTED

PATIENT REJECTS CHAPERONE
If the patient rejects the offer of a chaperone, but you do not wish to continue without one:
• Explain why you want a chaperone present.
• If the patient still declines, the patient’s clinical need takes precedence. Consider: Would delay affect the patient’s health?

YES

NO

PERFORM THE EXAMINATION
The patient’s wellbeing is paramount, so even if you would prefer a chaperone to be present, it would be prudent to still perform the examination if a delay could adversely affect the patient’s health. An alternative option might be to see if a colleague is available to conduct the examination immediately.

You should record any discussion about chaperones and the outcome in the patient’s medical record. If you offer a chaperone and it is declined, state this clearly, along with the clinical reasons why you chose to proceed with the examination.

REFER TO A COLLEAGUE?
If the delay would not affect the patient’s health you might consider referring the patient to a colleague who would be more comfortable performing the examination without a chaperone present.

You should record any discussion about chaperones and the outcome in the patient’s medical record.
AFTER THE EXAMINATION

Following the examination the patient should be given privacy to dress if required. The chaperone should leave and you should then discuss the findings of the examination with the patient.

You should record any discussion about chaperones and the outcome in the patient’s medical record.

If a chaperone is present, you should record that fact and make a note of their identity.
Being a member of Medical Protection is not just about calling for medicolegal advice when you receive a complaint or a claim. Our local knowledge and expertise means that we are with you every step of the way, whether through risk management workshops delivered by our education faculty, or via our e-learning library curated by a dedicated medicolegal team.

Members in Asia have the added benefit of a local educational faculty, made up of highly-regarded doctors from both public and private hospitals, who help to deliver our risk management programme. With more than 120 years’ experience supporting and defending medical practitioners, we have a unique insight into why things go wrong and why litigation and complaints arise, which we translate into practical tips to help you and your team improve patient safety and reduce medicolegal risks.

We have had more than 100,000 participants in our risk management education workshops, on topics including mastering adverse outcomes, dealing with difficult patient interactions, shared decision-making, and achieving safer practice.

Recently, faculty members from Malaysia, Singapore and Hong Kong gathered together to develop their skills and scope out new education opportunities to best meet your needs.

Medical Protection’s Asia Pacific General Manager of Education, Matthew O’Brien, said: “Our faculty helps develop our local curriculum so that we respond to significant and emerging issues members face in both public and private practice.”

He added: “Members who attend our education workshops can be confident they will be presented by respected peers who have undergone extensive training and are accredited to Medical Protection’s high standards.”

Dr T, a well-respected general practitioner, received a complaint from one of his patients, Ms L. In the letter of complaint, Ms L stated she was unhappy with the way Dr T had conducted the consultation: he was abrupt, dismissive of the recurring pain she was having in her knee, and didn’t listen. Dr T’s poor communication meant that Ms L didn’t feel confident in his medical knowledge and so went for a second opinion.

Ms L’s complaint wasn’t the first; Dr T had been the subject of three previous complaints about his attitude. The recurring theme was that he wasn’t listening, simply doling out advice or treatment without discussing first with the patient or listening to their needs.

Following Ms L’s complaint, the general practice manager held a meeting with Dr T. Although he was an excellent doctor, with a busy workload, his poor communication skills were landing him in difficult. Keen to ensure that his poor communication would not lay the foundation for a future claim, his manager suggested Dr T attend Medical Protection’s workshop: Mastering Difficult Interactions with Patients.

During the workshop, the facilitator explained to Dr T that dealing with difficult interactions with patients can be a significant cause of stress, yet the nature of most clinical jobs makes these encounters unavoidable. The workshop then went on to look at why such difficult situations arise, with the facilitator offering Dr T techniques to handle them effectively and manage his internal responses.

Two months after the workshop, Dr T said: “I feel more confident communicating my point of view to patients and involving them in the decision-making process. I am working with my manager to review my communication on a regular basis, but I know that being busy is no longer an excuse for poor communication.”

Medical Protection’s 2016 education programme has just been released. You can find out more by visiting medicalprotection.org and clicking on ‘Education and Events’.

The cases mentioned in this article are fictional and are used purely for illustrative purposes.
At the end of 2015 Medical Protection held a series of roadshows in Malaysia to highlight key medicolegal risks. Medical Protection works closely with the Malaysian Medical Association (MMA) to deliver workshops to doctors and raise awareness of medicolegal issues. We also work with the Malaysian Ministry of Health (MOH) and in November and December 2015 all three organisations worked together to hold a series of roadshows in Ipoh, Seremban and Melaka.

Dr Ming-Keng Teoh, Head of Medical Services (Asia), believes the roadshows provide a fantastic opportunity for Medical Protection to support local doctors. “Medical Protection is about more than just defence – we aim to be a genuine partner in your career. Our world-class education services, such as workshops and e-learning, are just some of the additional ways we can support members,” he said.

The doctor has a duty to disclose even if there is no harm or if there is unlikely to be any harm to the patient. Obviously disclosure in this instance carries the risk of upsetting the parent and a complaint to the Medical Council, but the steps involved in disclosure can help mitigate that risk. These steps are:

- Apologise.
- Explain how the mistake happened.
- Reassure the patient/carer that no harm was caused.
- Explain steps that will be undertaken to prevent a recurrence.
- Provide redress if appropriate.

A culture of no blame and openness is very important to encourage good medical practice and reporting of errors and near misses.

THE BENEFITS OF DISCLOSURE

Studies have shown that patients expect to be informed when things go wrong, especially when there is the potential for harm. Jonathan Cohen, Assistant Professor at the University of Florida College of Law, says that 30% of plaintiff’s in medical malpractice suits claim they wouldn’t have sued if there had been an apology, or if the doctor had expressed concern for their wellbeing.

Above all, it is important to remember that it is the ethical thing to do. Despite our best efforts, errors in healthcare will always occur. Being open and disclosing harm is part of a doctor’s responsibility to act in the best interests of their patients.

REFERENCES

1. Dr Chua Tak-Yi, Open disclosure: The road to success, Casebook Vol 21 No 3 (September 2013).
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FROM THE CASE FILES

Dr Zaid Al-Najjar, Medicolegal Adviser, introduces this edition’s case reports

As a medicolegal adviser and practising GP, I am very aware of the importance of good communication in provision of care to patients, and with the successful defence of healthcare professionals when things go wrong. Having been an avid reader of Casebook even before I joined Medical Protection in 2010, I realised how often breakdowns in communication featured in the cases section. I am always heartened to hear from colleagues just how helpful (and sometimes surprising) they find Casebook and very pleased therefore to be able to present the cases on this occasion.

This edition of Casebook provides an interesting mix of cases, but with common themes. We present those that we have managed to successfully defend along with the matters that needed to be settled, as both provide helpful learning points. Reading through the cases made me reflect on the importance of thinking about the basics, in a world of increasingly complicated and clever medical investigations, even when faced with an unusual or complex clinical presentation. Dr R and Dr M, for example, are criticised for not carrying out a simple test such as a urine dipstick in primary care in cases of grossly deranged renal function and possible pre-eclampsia, respectively, which could have prevented their patients’ acute deterioration.

The cases of Dr G and Dr L highlight the importance of continuity of care and communication between specialists and general practitioners. A clear management plan, with clarity about who is expected to do what, along with regular reviews of any medications prescribed, are all really important to ensure long-term safe care.

A breakdown in communication is also seen in the case against Dr Z (which Medical Protection was able to defend), when an ambulance handed over a patient with pneumonia to a GP, but did not inform the doctor of the abnormal physical observations.

Communication as a key issue also features in a claim brought against Dr S, who provided an anaesthetic and paravertebral block to a patient who needed a mastectomy. He was criticised for not informing the patient of his intent to carry out this block and the risks and benefits of the technique.

Since starting work at Medical Protection, the importance of recording significant negative symptoms and signs, as well as the positives, has never been more apparent to me than in the case of Dr R (whose claim Medical Protection successfully defended), where a child was seen in primary care but sadly went on to deteriorate and develop meningitis. In the UK, the use of the National Institute for Health and Care Excellence’s guidance on the management of the febrile child seems to have been adopted as the gold standard by many when assessing young children with a fever, as it can sometimes be very difficult to distinguish a harmless viral illness from something more sinister. Safety netting plays a huge role here, ensuring that the patient (or parents) knows what to look out for by way of danger signs, and when to seek help from a professional.

The importance of good documentation again comes up in the case of a claim brought because of an undescended testis found in a 15-year-old. Dr E’s thorough note-keeping allowed the medical expert instructed by Medical Protection to gain a clear understanding of his thought process when consulting with the patient in infancy and recording that both testes were palpable at that time.

I do hope that you find the cases interesting and relevant to your practice, regardless of your speciality and seniority. It would be another success for Medical Protection and the Casebook team if our readers can identify one learning point from the cases with a view to trying to incorporate it into their future practice.

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 US$2,000,000+
- SUBSTANTIAL US$200,000+
- MODERATE US$20,000+
- LOW US$2,000+
- NEGligible <US$2,000
C was a 20-month-old boy who had been up all night with a fever. It was the weekend so his mother rang the out-of-hours GP. She explained that his temperature was 39.4 degrees and that he was clingy and sleepy. Dr R assessed him at the out-of-hours centre and documented that there was no rash, vomiting or diarrhoea. His examination recorded the absence of photophobia and neck stiffness. He stated “nothing to suggest meningitis”. Examinations of the ears, throat and chest were documented as normal. He noted that his feet were cool but he appeared hydrated. Dr R diagnosed a viral illness and advised paracetamol and fluids. He advised JC’s mother to make contact if he developed a rash, vomiting, or if she was concerned.

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

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

JC was treated with IV fluids, ceftriaxone and dexamethasone and showed great improvement. Four days later he developed a septic right hip needing aspiration and arthroscopy. The aspirate revealed Haemophilus influenzae. A month later he was assessed at a fracture clinic and was walking unaided and fully weight-bearing.

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

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

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

Learning points

• The National Institute for Health and Care Excellence (NICE) in the UK have a useful traffic light system for identifying risk of serious illness in feverish children under five. Along with other clinical signs, it requires GPs to check pulse, respiratory rate, temperature and capillary refill time in order to categorise them into groups of low, medium or high risk of having serious illness.

• Safety netting is an important part of a consultation. In this case Dr R advised the mother to contact services again if he deteriorated. This helped Medical Protection defend his case.

• In some cases claims can be brought many years after the events. This makes good note-keeping essential as medical records will often be the only reliable record of what occurred.

REFERENCES

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

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

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

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

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

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

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

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

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

1. Dr S had failed to inform Mrs B that he intended to perform a paravertebral block and failed to discuss the risks and benefits of such a technique.
2. He was somewhat critical of the decision to perform the block with Mrs B anaesthetised. He opined that had Mrs B been conscious or lightly sedated, she would have alerted Dr S when the needle was in proximity to nerve tissue. However, Dr M did concede that there was a body of responsible anaesthetists who would support the notion of performing a paravertebral block with the patient anaesthetised.
3. He was critical of Dr S’s decision to keep persisting with the block when he was struggling to locate the correct needle position. He felt that Dr S should have abandoned the block or called for help. He also concluded that the technique used by Dr S was very poor given the complications that followed.
4. Dr M was critical of the levels chosen by Dr S to perform the block. He felt that C7 was too high, given that the dermatomal level of the surgery was approximately T4. He also felt that the surgery was very minor and did not warrant the paravertebral block. Dr M was of the opinion that infiltration of local anaesthetic by the surgeon, combined with simple analgesics, would have sufficed.

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

Learning points
1. Local anaesthetic blocks should only be performed when there is a clear indication.
2. The risks and benefits of the block should be discussed with the patient and clearly documented. The process of consent for any operation should be a detailed conversation between clinician and patient with documented evidence. The incidence and potential impact of any common and potentially serious complications should always be discussed and documented.
3. Local anaesthetic blocks should only be performed by practitioners with appropriate training and expertise.
4. If difficulties are encountered, either the procedure should be abandoned or assistance summoned.

JPA

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

Subsequently, Mr G was seen by both Dr L and his optician, complaining of tired, heavy eyes. No visual field check was carried out on either occasion. Nine months later Mr G returned to see Dr L, requesting a referral to the epilepsy clinic as he had read a newspaper report about the visual side effects of vigabatrin. An appointment was made at the clinic but Mr G failed to attend on two occasions. An urgent referral was ultimately made by Mr G’s optician several months later following detection of a visual field defect on a routine examination. The ophthalmic surgeon, Mr D, noted that Mr G had been on vigabatrin for in excess of 11 years during which time he had not been monitored. His visual fields were noted to be markedly constricted, which was attributed to the vigabatrin. Mr G was referred to another neurologist who recommended a change of anticonvulsant. Mr G was gradually weaned off the vigabatrin.

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

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

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

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

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

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

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

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

**EXPERT OPINION**

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

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

**Learning points**

- Medical Protection were able to defend Dr E in light of his appropriate clinical management, good note-keeping and the expert advice.
- Good documentation helped Dr E’s defence. Doctors should always document the presence or absence of both testes in the scrotum at the six-week check.
- A testis that is retractile or normally situated in the scrotum in infancy can ascend later. NHS Choices in the UK has a useful leaflet for parents outlining that “retractile testicles in young boys aren’t a cause for concern, as the affected testicles often settle permanently in the scrotum as they get older. However, they may need to be monitored during childhood, because they sometimes don’t descend naturally and treatment may be required”.
- The National Institute for Health and Care Excellence (NICE) in the UK have published a Clinical Knowledge Summary that covers the primary care management of unilateral and bilateral undescended testes, including referral. It can be found here: cks.nice.org.uk/undescended-testes.

**REFERENCES**

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

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

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

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

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

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

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

EXPERT OPINION
Medical Protection obtained expert opinions from a GP and a respiratory specialist. The GP was supportive of Dr Z. He noted that cough, fever and malaise are very common symptoms in a young adult. He listened to the recorded consultation and considered Mr B to have been only mildly short of breath and showing no verbal signs of delirium. He felt it was reasonable for Dr Z to suggest attendance at the primary care centre. Dr Z to have been only mildly short of breath and showing no verbal signs of delirium. He felt it was reasonable for Dr Z to suggest attendance at the primary care centre. He also noted that if Mr B had been well enough to attend his own GP four days later, then he could probably have travelled to see Dr Z on the day she spoke to him. He felt it had been neither possible nor necessary to define the diagnosis beyond a respiratory tract infection.
Learning points

• Medical Protection can use recorded data as evidence to support members who are the subject of a claim.

• According to guidelines from the National Institute for Health and Care Excellence (NICE) in the UK, after diagnosing pneumonia GPs should use the CRB65 score to determine the level of risk and help guide decisions on where to manage a patient. One point is given for confusion (AMTS 8 or less or new disorientation in person, place or time), raised respiratory rate (30 breaths per minute or more), low blood pressure (systolic <90mmHg or diastolic <60mmHg), age 65 years or more. A score of 0 is classed as low risk and is associated with less than 1% mortality. A score of 1 or 2 is classed as intermediate risk and is associated with 1-10% mortality. A score of 3 or 4 is classed as high risk and is associated with more than 10% mortality.

• When communicating between healthcare services, it is important to hand over all relevant information. In this case the ambulance crew did not pass on the patient’s low oxygen saturations or his raised pulse rate. These vital signs could have conveyed the severity of the patient’s illness to the out-of-hours GP.

REFERENCES

1. nice.org.uk/guidance/cg191/chapter/1-recommendations

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S, a four-month-old baby, was felt by his mother to be developing a cold and was given oral paracetamol solution, which was effective. The following day his mother noted he was warm and snuffly. His breathing was laboured and he was making moaning noises. He was not feeding well, although he was taking some milk. He apparently had a rash on his back. JS was given oral paracetamol solution but it now had no effect and as his condition was worsening an appointment was made for him to be seen by the GP.

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

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

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

JS is said to have remained unwell during the evening and the mother awoke at 6:30am the following day to find that JS had developed large purple spots. She contacted the doctor. Dr W, who was on call for the practice, arrived at about 8am. On arrival it was immediately apparent to him that the baby was very unwell as he was very drowsy, greyish in colour and also exhibiting a purpuric rash. He immediately took the child to hospital in his car and stated that he administered an intramuscular injection of benzylpenicillin. Meningococcal septicaemia was diagnosed and following treatment JS was found to be profoundly brain damaged. He was later diagnosed with severe microcephaly, cognitive impairment, poor vision and intractable epilepsy.

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

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

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

On the basis of the supportive expert GP report Medical Protection opted to defend the case at trial. The claimant discontinued three days into the trial.
r A was a 25-year-old man who was on lifelong steroid medication for congenital adrenal hyperplasia. He was under the care of Dr F, a consultant endocrinologist. Dr F advised him to change his steroid medication from hydrocortisone to prednisolone, 7.5mg in the mornings and 5mg in the evenings. He gave him a prescription and wrote to Mr A’s GP to advise him of the steroid dose change.

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

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

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

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

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

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

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

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

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

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

The endocrinology expert felt that all the symptoms were attributable to an excess prednisolone dose over a five-month period. He advised that most of the symptoms would be reversible, including the decreased bone density. However, he felt that the stretch marks would be permanent, although would fade to a certain extent over time.

The case was settled for a moderate sum.

Learning points

- Side effects of corticosteroids are dose-related. Doctors should be alert to the potential side effects of long-term corticosteroids. These include all of the symptoms that Mr A was experiencing.
- If a patient complains of new symptoms while on corticosteroid medication, review the current dose and ensure the patient is taking the medication correctly.
- If there is any doubt about a patient’s dose of corticosteroid, have a low threshold for discussing the matter with the patient’s endocrinologist. If Dr T had telephoned Dr F for advice, the excess steroid dose would have been picked up two months earlier and might have reduced the severity of the stretch marks that the patient developed.
- If a patient is receiving long-term corticosteroid treatment, it would be helpful for them to carry a steroid treatment card. This gives clear guidance on the precautions to be taken to minimise the risks of adverse effects, and provides details of the prescriber, drug, dosage, and duration of treatment.
Mr M, aged 39, presented initially to the Emergency Department with headaches, limb weakness and a drooping eyelid, but took his discharge before full investigations were completed. He was reviewed two weeks later by a neurologist who noted numbness in the arm and unsteadiness. He arranged for a CT scan which was normal. The patient did not attend for an MRI scan.

Three months later, Mr M presented to an ophthalmologist with blurred vision. Examination showed retrobulbar neuritis and he was referred to a neurologist.

A few months later the patient was seen by a neurologist, Dr P, who wrote a letter to the patient’s GP, Dr O, indicating a possible diagnosis of multiple sclerosis (MS). She said that an MRI scan had been organised. Mr M was reviewed by the neurologist four months later when he was started on oral methylprednisolone and referred to support services. Dr P wrote that she would review the patient in two months, but no indication was given of the dose or duration of the course of steroids. Five days later, the GP pharmacy records indicate dispensing of the prescription of methylprednisolone as “150 methylprednisolone tablets 16 mg. 5 tablets to be taken daily as directed by your doctor”. The signature of the doctor was not a known doctor at the Practice. There were no entries in the records corresponding to this or in the computerised prescribing records.

The patient received repeat prescriptions of methylprednisolone from Dr O. Four months later, Mr M was admitted to hospital with back pain after lifting a heavy object. He was diagnosed with a fractured T6 secondary to osteoporosis (due to high-dose steroids). Subsequently, further fractures were found between T4 and T12 and L1-L5. The discharge medication included alendronate, prophylactic treatment against steroid-induced osteoporosis. The entry in the computer record under active problems in the GP record notes, “at risk of osteoporosis, see A&E letter”. There is no further record of methylprednisolone in the GP records, although in a consultation with Dr P the long-term steroid regimen was picked up. She recorded the patient should only have taken a single four-day high-dose methylprednisolone course.

Eighteen months after his presentation with fractures Mr M suffered further falls. Suspicions of spinal cord compromise at that time were not confirmed on MRI. His underlying disease and associated disability had progressed steadily. He had not walked independently for over two and a half years and suffered urinary incontinence requiring an indwelling catheter. He had poor feeling in both hands, with coordination, visual and swallowing problems and mid-thoracic pain.

Mr M brought a claim against Dr O and the hospital, alleging that both Dr O and Dr P had allowed the continued repeat prescription of high-dose steroids, which had caused his severe osteoporosis.

EXPERT OPINION
The case was reviewed for Medical Protection by an expert GP. He considered Dr O’s records inadequate, with insufficient details of the patient’s problems, particularly related to his MS. Care was substandard in respect that prescriptions were issued and not recorded. Furthermore, steroid prescription should never have been on a repeat basis. Lack of records about specific details of the patient’s problems, particularly Dr O’s records inadequate, with insufficient information about the initiation dosage and duration of the initial steroid dose. It would be a not unreasonable assumption by the GP that treatment commenced by the consultant was to be continued until the patient saw the consultant again. Clearly there was delay as the patient did not attend regularly. When the over-prescribing was identified, Dr P failed to put in place a clear management plan with appropriate guidance to Dr O.

The steroids caused severe osteoporosis, resulting in multiple vertebral crush fractures and collapse of the vertebral bodies and myopathy. These problems aggravated the disability attributed to the patient’s MS and interfered with his rehabilitation.

The standard of record-keeping made this a difficult claim to defend. It was settled for a small sum with a contribution from the hospital.

Learning points
• When a patient registers at a new Practice, this is an important opportunity to review their notes and medication.
• Careful documentation in clinical records is essential, particularly with chronic disease.
• Good communication with secondary care is vital in relation to patient management.
• Be clear as to who prescribes for the patient who regularly attends secondary care.
• Regular review of repeat prescriptions should be routine.

CS
At that review, eight days later, Dr B noted days after that and the patient was due to ultrasound scan was to be carried out three by Dr P, who took no action as the renal ultrasound.

The repeat bloods showed creatinine 216, an ESR. He also arranged an urgent renal arranged for a repeat set of bloods, including blood count, urea and electrolytes (U&Es), thought was related to her periods. Dr P arranged some investigations, including full blood count, urea and electrolytes (U&Es), liver and thyroid function tests and planned a further review with the results.

The next day, the results were available and alarming revealed some abnormalities. Her eGFR was just 22; urea 14 (2.8–7.2); creatinine 211 (58–96); albumin 33 (35–52). The results were reviewed by a third doctor, Dr B, who arranged to see Ms C the next day. As there were no previous U&Es, Dr B arranged for a repeat set of bloods, including an ESR. He also arranged an urgent renal ultrasound scan.

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

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

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

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

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

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

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

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

EXPERT OPINION

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

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

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

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

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

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

The obstetric expert advised that prodromal symptoms such as headache and nausea are more prominent in ante-partum eclampsia than signs, and blood pressure is often not dramatically increased, hence it is possible that the patient would not have had significant hypertension and/or proteinuria when seen by Dr M. However, the absence of any clinical record of the home visit made it difficult to rebut the claimant's allegation that she should have been admitted to hospital.

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

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

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

Learning points
- It is difficult to defend a case without adequate records and it is important that doctors document home visit consultations in the patient’s notes at the earliest opportunity. This is essential for good communication with others caring for the patient, and can prove invaluable should a complaint or claim arise.
- A failure to carry out or record simple bedside tests (e.g. urine dipstix) and temperature can also make a case difficult to defend, especially where they can help to make a serious diagnosis.
- Prodromal symptoms may be more prominent than signs in the immediate pre-eclamptic state. BP readings in particular may not be dramatically raised.
- Delivery before the onset of eclampsia can have a marked effect on outcome and substantially reduce the risk of cerebral injury.
RISK ALERT – RETAINED THROAT PACKS

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

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

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

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

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

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

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

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

Dr Heather Gallie
Salford
UK

ELBOW ARTHROSCOPY AND RADIAL NERVE PALSY

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

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

I feel this point is lost in the summary.

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

Dr Cormac Kelly
Shoulder and Elbow surgeon
UK

Response

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

POOR NOTES, FATAL CONSEQUENCES

Thank you for such a stimulating and unfortunate case report.

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

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

Dr T Hamouda
Consultant O&G,
New Zealand

REFERENCES

1. nice.org.uk/guidance/cg107

OVER TO YOU
GOING INTO HOSPITAL? A GUIDE FOR PATIENTS, CARERS AND FAMILIES
by Oliver Warren, Bryony Dean and Charles Vincent

Review by: Dr Timothy Knowles (ST2) and Dr Rebecca Smith (Consultant), Department of Anaesthesia, Chelsea and Westminster Hospital, London

Going into Hospital is the collaborative work of three well-respected healthcare professionals – a surgeon, a pharmacist and a psychologist. This book is the first of its kind, providing a road map to help patients, relatives and carers to navigate the complex world of hospital medicine.

The book is designed in a similar fashion to a travel guide, allowing the reader to dip in and out of relevant chapters. It describes the culture of modern healthcare, the roles of various health professionals, and the diverse wards and experiences encountered during a typical patient’s journey.

Throughout the book practical advice is offered to reduce the anxiety often encountered by patients. Checklists are frequently provided, covering topics such as “Questions to consider asking during your outpatient appointment” and “Reducing your risk of deep vein thrombosis while in hospital”. Wherever possible, authentic patient stories and experiences are included. These powerful messages portray the vulnerability and loss of dignity that many people experience when admitted to hospital.

To a doctor, this book serves as a stark reminder of how debilitating an overwhelmingly unfamiliar environment can be. With the demise of paternalistic medicine, it is our responsibility to ensure patients are enlightened and able to participate in their care. Going into Hospital will empower patients to make informed, collaborative decisions with their healthcare team. The book seeks to dispel many of the myths obtained from the media. It helpfully lists reliable, useful sources of information accessible on the internet.

The anxiety of being in hospital for a prolonged period of time can be compounded by the frustration and stress of trying to understand the complex way in which hospital care is delivered. We would encourage anyone being admitted to hospital, or those close to someone going into hospital, to read this book. For healthcare professionals this book is an eloquent reminder of how we all can play our part in reassuring patients on their hospital journey.

BETTER – A SURGEON’S NOTES ON PERFORMANCE
By Atul Gawande

Review by: Dr Rebecca Aning, Medical Protection Medicolegal Adviser

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

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

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

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This is a topic that is a long time overdue – I have had a little awakening
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