Professional support and expert advice from your leading medicolegal journal

This issue...

FROM THE CASE FILES
Our latest collection of case reports

ACHIEVING SAFER AND RELIABLE PRACTICE
A new workshop for members is helping them create a more reliable healthcare experience

HOW TO HANDLE COMPLAINTS EFFECTIVELY
Practical tips to help you manage the complaints process

DIGITAL COMMUNICATION WITH PATIENTS

THE POTENTIAL PITFALLS INVOLVED IN USING SMS, INSTANT MESSAGING AND EMAIL
PAGE 10
Support your career development with our online learning platform, Prism, which offers interactive modules that can be accessed at a time and place to suit you.

- Free to all members
- Interactive content produced for doctors by doctors
- Track your learning and download certificates in your personal account
- Accessible via desktop, tablet and mobile 24/7

Register now and start your online learning with Prism today.

Visit medicalprotection.org/prism
WHAT’S INSIDE...

FEATURES

06 Digital communication with patients
Dr Justin Cheng examines the potential pitfalls involved in using email, SMS and instant messaging to communicate with patients.

08 How to handle complaints effectively
Dr Katherine Grant provides a series of practical tips to help you manage the complaints process.

10 Achieving safer and reliable practice
Dr Rajesh Singh looks at how a new workshop for members is helping them create a more reliable healthcare experience.

11 Medical Protection regional roadshows
At the end of 2015, Medical Protection held a series of roadshows in Malaysia to highlight key medicolegal risks.

FACTS AND OPINION

04 Welcome
Dr Marika Davies, Editor-in-Chief of Casebook, comments on some topical issues affecting healthcare.

05 Noticeboard
News and updates from the Casebook team.

13 From the case files
Dr Ming-Keng Teoh introduces this issue’s selection of case reports.

CASE REPORTS

15 Diathermy drama
16 Turning a blind eye
17 Tripped up
18 Tunnel vision
19 An unlucky tummy tuck
20 A risk of harm
21 Paediatric brain injury
22 Back to front
24 A missed opportunity?

Every issue...

25 Over to you
What did you think about the last issue of Casebook? All comments and suggestions welcome.

26 Reviews
From books to apps, podcasts to training courses, we invite doctors to review what has helped them improve their practice.

Copyright © 2016 MPS. All rights reserved.
In this edition of Casebook we have a particular focus on different types of communication with patients. In our experience, poor communication between doctor and patient is the root cause of many of the complaints, claims and disciplinary actions we see.

Digital communication is one particular area that has many pitfalls. On page 6, we look at the issues involved in communicating with patients through email, SMS or instant messaging services.

On page 8, we look at communicating with patients while handling a complaint. Good complaint handling and resolving matters at an early stage is key to avoiding them escalating to a claim or a referral to the regulator. Dr Katherine Grant, a medicolegal adviser in our Asia team, provides practical tips to help you through this process.

The case reports in this issue demonstrate yet again the importance of good history taking, performing appropriate examinations, communicating well with colleagues, and keeping full and complete clinical records. These themes are almost a permanent feature of our case reports, but this is because every day we see cases in which a failure to do one or more of these has made it difficult for us to defend a claim brought against a member.

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

Dr Marika Davies
Casebook Editor-in-Chief
marika.davies@medicalprotection.org

Please address all correspondence to:

Casebook Editor
Medical Protection
Victoria House
2-3 Victoria Place
Leeds LS11 5AE
United Kingdom

casebook@medicalprotection.org
NEW NEWSLETTER LAUNCHED FOR MEMBERS IN SINGAPORE, HONG KONG AND MALAYSIA

Presenting MPS Connect, your new e-bulletin

We have launched MPS Connect, a comprehensive update delivering the latest medical indemnity news straight to your inbox. As well as member exclusives on events and upcoming workshops, we answer member questions and deliver content to help you maintain a safe practice. So far, the newsletter has tackled issues such as:

- “When a patient asks me, ‘help me make the decision’, what should I say?”
  Dr Zaid Al-Najjar, one of our expert medicolegal advisers, answered members’ questions surrounding consent, like ‘Is a risk acknowledgment form sufficient proof of consent?’ and ‘How do we check whether our patients have really understood what we have told them? And how do we ensure they don’t forget?’

- “What can I do to protect myself on social media?”
  Dr Harpreet Sarna advised members on issues surrounding social media, including what should be put into a staff confidentiality statement with regards to social media, and the most professional way to handle complaints that may be made about a practice online.

- “What makes good clinical records?”
  Keeping effective notes is an important aspect of the day-to-day running of a practice; not only does it maximise the quality of care for your patients, it may be imperative in the event of a claim. Dr Katherine Grant offers her top tips for writing clear and concise medical records.

To read these articles or find out more, visit medicalprotection.org and click on ‘MPS Connect’ under the ‘Casebook & Resources’ tab.

NEW MEDICAL PROTECTION WORKSHOP

The new Medical Protection workshop is free to members and contributes CPD/CME points to your portfolio.

Achieving Safer and Reliable Practice helps members to improve the quality and safety of their healthcare delivery through practical techniques. The workshop, which is suitable for both GPs and specialists, comprises lectures, reflective exercises and group discussion. Our aim is to give practitioners the knowledge, insight and strategies needed to identify the most critical areas of risk so that they may consistently deliver safe and reliable care.

The workshop runs for three hours and is accredited for 2.5 CPD/CME points. For more on what’s included, read our article on the workshop on page 10.

To book, visit medicalprotection.org and click on the ‘Education and Events’ tab.

NEW CONTACT DETAILS FOR HONG KONG MEMBERS

Medical Protection Hong Kong has updated its contact information.

Going forwards, membership enquiries for Medical Protection, via the HKMA, should be directed to mps@hkma.org.

For workshops and event bookings, please contact mpstraining@hkma.org, or call 2527 8452.

WRITE FOR CASEBOOK

Medical Protection is your organisation, and we want you to be part of it. We are currently seeking new contributors to submit well-crafted and informative feature articles for Casebook. If you would like to have your writing published, or if you have any ideas for content, contact the Casebook editorial team at casebook@medicalprotection.org.

SMC UPDATES ETHICAL CODE AND ETHICAL GUIDELINES

The Singapore Medical Council (SMC) has published a revised edition of its Ethical Code and Ethical Guidelines (2016). It was last updated in 2002, and the new edition addresses changes which have occurred in medical practice since that time. Some of the updates include guidance on the use of social media, paying intermediary fees, aesthetic practice and telemedicine.

Alongside the updated Ethical Code and Ethical Guidelines, the SMC Handbook on Medical Ethics has also been published. This educational resource contains additional material that elaborates on the new Ethical Code and Ethical Guidelines, explains its application and provides advice on best practice.


To download a copy of both of the new publications go to: https://goo.gl/MJukDg
Dr Justin Cheng, one of Medical Protection’s education faculty, looks at the potential pitfalls involved in using email, SMS and instant messaging to communicate with patients.

We undoubtedly live in a digital age. Most people expect that the services and products they use will be digitally accessible in some way, whether it’s providing instant support through online chat forums, giving information and updates via text message, or simply being contactable via email.

Medical practice is no different. Many patients anticipate that they will have some kind of digital access to their doctor. For most, this includes email, SMS text messaging services, and communication and information through the web.

However, while digital communication has enormous benefits to both patients and doctors, there are issues of professionalism, confidentiality and the protection of sensitive data which healthcare professionals must consider.

CONFIDENTIALITY

It is the responsibility of the doctor to ensure patient confidentiality, and different kinds of communication require different kinds of safeguards. Email contact is already a major part of many doctors’ interactions with patients, but issues can still emerge. It’s important to ensure that there are appropriate levels of encryption, when sending emails containing sensitive data, and that any IT systems and email servers used are protected and entirely secure.

A patient’s consent or refusal to be contacted by text, email or instant message should be recorded in the patient’s record. It’s important to also note that any digital correspondence containing medical information constitutes part of the patient’s medical record and should be saved and filed as such.

INSTANT MESSAGING

Use of instant messaging (through apps such as WhatsApp) is a relatively new development when it comes to patient care, and the potential risks are still emerging. As a rule, doctors and practices should avoid sending any sensitive data to patients via instant messaging. It is also important to be extra vigilant against sending messages to the wrong recipient, and every caution should be taken to make sure that the practice has the correct instant messaging contact for a patient.

A doctor must avoid discussing patients in a group chat, whether with a group of patients, colleagues, or both. It’s also useful to bear in mind that instant messaging is assumed to be just that: instant. Patients who are communicating with their doctor via instant messaging are likely to expect very quick responses. In a practice setup, it needs to be made clear whose responsibility it is to manage queries or requests which arrive via instant message.

PROFESSIONALISM

Alongside issues of patient confidentiality, the subject of digital communication also raises concerns around professionalism and the doctor-patient relationship. Doctors should never make use of instant messaging, text or email to promote their services or advertise to patients and non-patients. When using text and instant messaging, a doctor must take extra care to maintain professional boundaries with a patient, and avoid being drawn into conversation which deviates from the strictly professional. Digital communication is still a professional interaction, and this should be reflected in the tone and language used by the doctor or practice.

Digital communication opens up a world of accessibility and ease for doctors and patients alike, and as more and more practices begin to utilise it to its full potential, we become increasingly aware of its risks and benefits. However, it’s important for a practice not to rely on digital messaging alone to issue reminders and updates: getting the most out of digital communication means utilising it as part of a wider strategy.
WHAT THE REGULATORS SAY

HONG KONG
The Medical Council of Hong Kong advises that in communicating with patients “a doctor may provide information about their service” but must avoid putting pressure on patients, and must avoid any communication which could be seen as promoting their practice to non-patients. Doctors should never make use of instant messaging to directly or indirectly promote their practice. Information provided digitally by a doctor or practice must be subject to the same guidelines as non-digital communication.

MALAYSIA
The Malaysian Medical Council stresses the importance of maintaining a patient’s confidentiality, “regardless of the technology used to communicate health information”. When communicating by email or fax, practitioners should consider that they are delivering confidential information in a way which may be accessible to persons other than the intended recipient.

SINGAPORE
The Singapore Medical Council also stresses the importance of confidentiality when using technology. In its Ethical Code and Ethical Guidelines, it states: “You must take reasonable care to ensure confidentiality of medical information shared through technology and ensure compliance with any applicable existing legislation and regulations governing personal data.”

CASE STUDY
A medical practice used its email database to send an email newsletter to patients. However, when attaching the newsletter, a member of staff also mistakenly attached another file, containing the name, occupation, address and telephone numbers of many patients’ emergency contact person. The medical practice explained that the file containing the confidential information had been placed together with the electronic Christmas cards on the desktop.

One of the patients who received the email filed a complaint with the data protection commissioner against the medical practice. The practice’s action was deemed a breach of patients’ confidentiality, as it had disclosed patients’ personal information to unrelated third parties.

The data protection commissioner recommended that the practice implement a number of measures to prevent such mistakes from happening in the future. These included:

• following up the email with another requesting that recipients destroy the file
• reviewing practice guidelines and implementing software to protect all files containing sensitive data with passwords
• setting up an internal review procedure to ascertain whether it is necessary for confidential data to be sent electronically
• employing specified penalties against staff who fail to meet these guidelines.

The case mentioned in this article is fictional and is used purely for educational purposes.

REFERENCES

Words: Jennifer Pritchard
Safe healthcare requires both the expert knowledge and technical skills of healthcare professionals, as well as the reliable delivery and application of that knowledge and skill.

In our new workshop - Achieving Safer and Reliable Practice - reliability is defined as minimal unwanted variability in the care we have determined our patients should receive. Any figure below 80% reliability would be termed ‘chaos’ in other safety critical sectors, and yet in some areas of healthcare we struggle to achieve and sustain consistency at levels of 80% or higher.

Examples of the variation in reliability in healthcare are readily available. The Health Foundation’s report in 2010 found that in nearly one in five operations equipment was faulty, missing or used incorrectly; around one in seven prescriptions for hospital inpatients contained an error; and full clinical information was not available at just under one in seven outpatient appointments. The report also commented on the wide variations in reliability between and within organisations.

HOW RELIABILITY IS QUANTIFIED
Reliability is often expressed in terms of failure rate as a power of 10. For example, a procedure that is reliable nine times out of ten fails 10% of the time, or has $10^{-1}$ reliability. A procedure that fails 20% of the time has a reliability of $>10^{-1}$.

Systems that fall below $10^{-1}$ reliability are generally considered ‘chaotic’.

WHAT LEVEL IS ACHIEVABLE?
Research suggests that healthcare implementation rates for standard procedures that impact patient safety are between 50% and 70%, or $>10^{-1}$.

Other industries such as aviation and nuclear power have achieved reliability levels of $10^{-6}$ in critical processes. In healthcare, anaesthetics has been successful in achieving this level of reliability during the induction of anaesthesia. This and other reliable practices, such as blood transfusions and pathology labelling, can inspire and lead the way for all of us, both in primary or secondary care.

HUMAN FACTORS
The science of human factors examines the relationship between people and the systems with which they interact, with the goal of minimising errors. In healthcare, the knowledge of human factors can help in the design of processes that make it easier for doctors and nurses to do the job right.

Some of the factors that can impede on human performance include:

People
- Perceptual deficits under stress
- Fatigue
  - physical
  - decisional
- Poor interpersonal communication
  - transmission/reception
  - challenge
- Poor understanding of the nature of human error
  - causes
  - extent
  - the weakness of $10^{-3}$ strategies in prevention

Processes and systems
Inadequate:
- Structured decisional support and checking tools
- Measurement, feedback and accountability mechanisms
- Briefing and simulation
- Environmental design and control
- Equipment design

ALWAYS CHECKING
In order to mitigate the risks from these factors, Medical Protection advocates the AlwaysChecking™ approach, which offers five manageable, evidence-based steps to raise reliability in any healthcare setting:

The MPS AlwaysChecking™ approach

Moving to $10^{-2}$

<table>
<thead>
<tr>
<th>Principle</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>We always check each other and welcome being checked</td>
<td>Speaking up</td>
</tr>
<tr>
<td>what we’ve agreed should be done</td>
<td>Checklists</td>
</tr>
<tr>
<td>message sent is message received</td>
<td>repeat back/ read back</td>
</tr>
<tr>
<td>we know how to work together</td>
<td>Briefing and Simulation</td>
</tr>
<tr>
<td>always means always</td>
<td>Measurement and Accountability</td>
</tr>
</tbody>
</table>

Perhaps the most important strategy is that of ‘speaking up’. Safe cultures train and insist on respectful assertive communication. In healthcare, we often find that following an error, one member of the team had ‘seen it coming’ but felt unable to say anything. There are complex reasons for this and simple steps by individual clinicians can transform safety.
Speaking up is only possible in a culture that accepts that everyone will make mistakes. In many teams, the perceived negative consequences of speaking up can be greater than those of not speaking up. Explicitly telling others of your expectation that they will speak up and ‘have your back’, and thanking anyone who challenges you – especially when they are wrong – can help change this perception.

Engaging with those in your team who are reluctant to speak up is also essential. This may require training to ensure that the necessary skills are taught and learnt.

CHECKLISTS

The use of checklists in healthcare has been demonstrated in numerous studies to improve reliability and patient outcomes, yet they are still resisted by some in the profession and are often hotly debated during the workshops.

Some of the benefits of using a checklist:

- Reduce cognitive work
- Facilitate concentration on first order concerns
- Critical in preventing “never events”
- Change the culture of a team
  - validate the importance of a safe process
  - empower team members to speak up

In one example, the successful implementation of a checklist saved lives and millions of dollars by eliminating central venous line infections.

The intervention involved the education of staff, creating a dedicated catheter insertion cart, daily assessment as to whether catheters could be removed, and training and empowering nurses to challenge colleagues if they were not following the checklist.

These efforts resulted in the infection rate falling from 11.3/1000 to 0/1000 catheter days, as well as the prevention of 43 infections and eight deaths.¹

The workshop includes a guide on how to develop effective checklists and implement them in organisations.

MEASUREMENT AND ACCOUNTABILITY

Another key aspect of the AlwaysChecking™ approach is “Measurement and Accountability”. Within many organisations and teams, there will be some clinicians who do not conform to agreed safety procedures. Allowing ‘special rules’ for some is toxic and can sabotage success.

Challenging these individuals can be difficult, but without doing so high reliability and safety cannot be achieved. The handwashing success story from Vanderbilt University Hospital system in the USA demonstrates the importance of measurement, feedback and accountability² – highlighting the power of insisting that “always means always”.

Example: Handwashing programme

<table>
<thead>
<tr>
<th>Year</th>
<th>Handwashing Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>58%</td>
</tr>
<tr>
<td>2010</td>
<td>80%</td>
</tr>
<tr>
<td>2011</td>
<td>92%</td>
</tr>
</tbody>
</table>

- 30% reduction in serious hospital infections.
- Estimated annual net savings of US$4.5m.
- Tenfold reduction in ICU central line infection rate (now one quarter of national benchmark).

Vanderbilt UMC

The results achieved in 2009 (10⁻²) were attained using strategies based on individual memory, diligence and vigilance. In 2010, the centre moved to a detailed monitoring and individualised clinician and team benchmark feedback process, leading to 10⁻³ levels of reliability. In 2011 the centre moved to implement increased personal accountability, since then the level of compliance has been maintained (and even increased again) to 10⁻².

The benefits to patients in terms of morbidity and mortality reduction, along with the economic benefits to the hospital and the decreased risk of complaints and claims for the clinicians employed by Vanderbilt, is a testament to the value of measurement and accountability in achieving 10⁻² reliability.

REFERENCES

1. The Health Foundation, How Safe are Clinical Systems? Primary research into the reliability of systems within seven NHS organisations and ideas for improvement. May 2010

WORKSHOP

Our workshops are FREE as a benefit of membership.

To book your place on a workshop, visit medicalprotection.org and click on ‘Education and Events’.
any doctors will receive a complaint at some time in their career. At Medical Protection, we understand how stressful such matters can be.

Unfortunately, things do occasionally go wrong in healthcare, and it is inevitable that sometimes patients are dissatisfied, disappointed or upset with the care that they have received.

Good complaints handling is key in resolving matters at an early stage. If you provide an open, honest and conciliatory response, it may prevent the patient from pursuing other avenues such as a medical council complaint or financial compensation. It could also potentially reduce the workload involved in responding to the complaint and minimise any damage to your reputation.

COMPLAINTS PROCESSES
Whether you work in a large specialist hospital or a small clinic, it is useful to have a local complaints procedure in place. An effective complaints handling process should be flexible and responsive, allowing both doctor and patient to be clear on how a complaint will be dealt with, and in what approximate timescale.

Ideally, the complaints process should provide you with the opportunity to explore the issues raised, identify any specific learning points and make changes where necessary. Reflection and learning from complaints is a valuable skill for all doctors, and adopting a positive manner and attitude when responding to a complaint can be a sign of true professionalism.

Medicolegal Adviser Dr Katherine Grant provides a series of practical tips to help you manage the complaints process.
The elements of a good response letter are:

- A swift conclusion.
- Conciliatory tone. Can help to bring matters to a complaint to the medical council or a negligence claim. An empathetic and relevant response which blame and resolve matters, not perpetuate further
- Lead to a complaint to the medical council.

The purpose of a complaint response is to try to resolve matters, not perpetuate further correspondence. Responses which blame the complainant or lack reflection may lead to a complaint to the medical council or a negligence claim. An empathetic and conciliatory tone can help to bring matters to a swift conclusion.

The elements of a good response letter are:

- An opening paragraph which sets the response in context; contains an apology or sentiment of regret and acknowledges the patient’s feelings of distress as a result of what happened.

- A summary of the main issues the patient has raised in their letter. This will also help you focus your response.

- An account of what action has been taken to investigate the complaint.

- A clear explanation in response to each of the issues raised, identifying any fallings and apologising as necessary.

- Details of any changes that have been made to reduce the risk of the issue happening again, and any reflections or learning points drawn from the matter.

- An invitation to meet or contact you again if they have any further questions.

- A reiteration of your apology for what occurred.

- Your account should be typed and free of jargon, with any clinical terms or concepts explained.

**APOLOGIES**

Medical Protection supports open communication, and we encourage members to apologise where things have gone wrong, regardless of fault.

An apology, expressing regret about the patient’s experience or emotions, is not an admission of liability and is appropriate when a patient has suffered harm or experienced disappointment. An apology is an acknowledgement that something has gone wrong and a way of expressing empathy. Contrary to popular belief, apologies tend to prevent formal complaints, rather than the reverse.

**MEETINGS AND MEDIATION**

Mediation through meeting with complainants can be valuable in resolving complaints at an early stage. A face-to-face discussion of issues should be considered and offered as part of effective complaints handling.

Pre-meeting preparation is essential in setting boundaries and expectations, as well as making the most of everyone’s time:

- Ensure that the time and place are convenient for all concerned.

- Set a time frame for the meeting.

- Clarify beforehand the particular issues that the complainant would like to discuss.

- Agree who will be present and their role. You should invite the complainant to bring a friend and/or advocate. You may want to have someone else present to take some notes.

- Have any relevant notes, letters, procedures, clinical guidelines or protocols etc. available to refer to if needed.

- Agree in advance that all parties to the meeting will be treated with respect and courtesy. If this does not occur, then the meeting may need to be curtailed.

- Consider whether the complainant has any particular needs – for example, an interpreter or access issues.

At the meeting:

- Make sure phones are switched off or diverted.

- Begin with introductions and confirm whether notes are being taken and by whom. This can often avoid disagreements later over exactly what was said and agreed.

- It is usually helpful at the beginning of a meeting to offer an apology and the hope that matters can be resolved.

- Give the complainant the opportunity to outline their outstanding concerns so that you can then provide a response.

- Do not feel under pressure to answer any questions to which you do not have an immediate answer. You can offer to check on a point and get back to the complainant with a response.

- If notes are taken, it is good practice to share these in draft form with the complainant to ensure that everyone agrees that they are an accurate record of the meeting.

- At the end of the meeting, make sure everyone is clear what the next steps are and provide details of these.

- On occasion, it may be appropriate to waive fees or follow-up costs, or offer some reimbursement of expenses as a gesture of goodwill.

At Medical Protection, we understand that dealing with complaints can be stressful and time-consuming. If handled well, complaints can be a valuable source of feedback. However, poor handling can lead to an escalation of concerns. If you receive a complaint or are asked to provide a response by your employer, contact us for advice.

**MORE ADVICE**

Our expert medicolegal advisers can provide advice if you receive a complaint. For support, email querydoc@medicalprotection.org
WE CAN HELP YOU

AVOID COMPLAINTS OR CLAIMS THROUGH KNOWLEDGE AND INSIGHT
World-class education programmes to help you reduce risks and improve patient care
- FREE interactive skills workshops and seminars
- Fully verifiable CME
- Fully accredited CPE
- Online library of publications, advice booklets and guidance

HANDLE MEDIA ATTENTION
24/7 press support to help with media scrutiny and respond to enquiries quickly. We can support you and your team by...
- Providing expert advice on dealing with the media
- Speaking to journalists on your behalf
- Drafting an appropriate response
- Monitoring coverage and assisting with any follow-up actions

DEFEND AGAINST CLINICAL NEGLIGENCE CLAIMS
Expert claims management and defence services to help resolve matters quickly. You can request assistance with...
- Clinical negligence claims
- Good Samaritan acts
- Humanitarian work

GET THE ANSWERS YOU NEED, WHEN YOU NEED THEM MOST
Independent, impartial advice to help you resolve problems arising from your clinical practice. Available 24 hours a day in an emergency
- Confidentiality
- Record keeping
- Writing reports
- Taking consent
- Patient complaints

PROTECT YOUR REPUTATION AND CAREER
Robust legal representation from our panel of experienced, local lawyers and medicolegal experts. You can request assistance with...
- MCHK investigations
- Disciplinary procedures
- Preparing for inquests
- Criminal proceedings arising from professional practice

For medicolegal advice, contact us on:
800 908 433
querydoc@medicalprotection.org

For membership enquiries, contact us on:
800 908 433
mps@hkma.org
n a world in which technological advances and medical innovation abound, it is very easy to overlook the importance of the fundamental clinical skills of history taking and clinical examination. Yet, as some of the cases you will be reading about in this edition illustrate, a few extra minutes taken to ask pertinent questions and perform relevant examinations pays dividends. Not only may it result in an earlier diagnosis and improved outcome for the patient, but it could also reduce the risk of a clinical negligence claim.

In ‘Tunnel vision’, having failed to take a proper history at the first consultation, Mrs O’s doctors fell into the trap of going along with the earlier presumptive diagnosis. Despite repeated attendances by the patient with worsening symptoms, no further history was elicited and no examination undertaken. The correct diagnosis was ultimately made when Mrs O collapsed, resulting in an emergency admission to the local hospital.

In ‘Tripped up’, Master Y was reviewed twice by his GPs, Dr E and Dr B, three and seven weeks after his fall when he was still complaining of unremitting pain. Despite this, there was no attempt to revisit the history and review the original diagnosis. It was only by chance that an unrelated abnormality on a knee x-ray prompted orthopaedic referral which led to the correct diagnosis being made.

Making a diagnosis is particularly challenging for patients with more than one co-existing condition, as illustrated in ‘Back to front’. In this case, a careful review of the character of Mr W’s pain after he failed to respond to treatment may have prompted consideration of alternative diagnoses.

Communication and process errors are other themes emerging from this edition’s case reports. In Mr T’s case, an abnormal MSU result was marked as “normal” and filed in the records without action. Notwithstanding that Dr W had no record of having received the health-screener’s letter, the practice’s failure to communicate the abnormal result to the patient or to flag it up in the records led to further actions, which compounded the problem and was indefensible. ‘Turning a blind eye’ is another example of how a failure to communicate an abnormal result to a patient can have devastating consequences. In this case Dr L, in his desire not to alarm the patient or to disclose sensitive information in a letter, failed to convey to Mrs R the urgency of his request such that she chose to ignore it. In such circumstances it is imperative that the request is followed up if the patient fails to attend within the anticipated timeframe.

Poor communication between healthcare providers can also lead to problems, as illustrated by ‘A risk of harm’ and ‘Paediatric brain injury’. In both cases the failure to give clear, explicit and documented instructions to nursing staff led to a misunderstanding as to the level of observation required, which contributed to a delay in treatment of a postoperative complication in BC’s case and to Miss A suffering serious harm.

Finally, time and time again, we see the impact of poor record keeping on our ability to defend our members’ actions, particularly when it comes to issues of consent and providing evidence of discussions of risks and complications. The case of Mrs W and Dr D is no exception. Master Y’s doctors, Dr E and Dr B, are also criticised for their poor record keeping. Our GP expert in that case remarks on the discrepancy between their described usual practice and the paucity of the records. Today’s doctors are practising in an increasingly pressured and challenging environment in which the temptation to take shortcuts is a strong one. By continuing to practise those core skills of history-taking, clinical examination and communication, doctors can reduce substantially the risk of a successful claim of clinical negligence being brought against them.

At Medical Protection we are proud to say that we were able to successfully defend 74% of medical claims (and potential claims) worldwide between 2011 and 2015. We believe that through our risk management advice, and the learning taken from case reports such as these, we can help members lower their risk, and improve that figure even further.

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
CASE REPORTS

A HIDDEN PROBLEM

A failure to act on an abnormal test result means a serious diagnosis is missed

Mr T, a 40-year-old accountant, attended a private health check under his employer’s healthcare scheme. Blood and protein were noted on urinalysis and his eGFR was found to be 45 ml/min/1.73 m². He was asked to make an appointment with his GP and was given a letter highlighting the abnormal results to take with him.

Mr T saw his GP, Dr W, shortly after and told her that blood had been found in his urine on dip testing during a health check. Dr W arranged for an MSU to be sent to the laboratory. The MSU showed no infection or raised white cells but did confirm the presence of red blood cells. Unfortunately the result was marked as “normal” and filed in the notes without any action.

A year later Mr T saw Dr W again with a painful neck following a road traffic accident. Dr W prescribed diclofenac tablets to help with the discomfort. A week later he booked an urgent appointment because he had developed a severe headache and felt very lethargic and breathless. He was seen by Dr A, who diagnosed a chest infection and prescribed a course of amoxicillin.

Mr T went home but was taken to hospital later the same day following a fit. He was subsequently diagnosed with malignant hypertension and severe renal failure with pulmonary oedema. Again, blood and protein were found in his urine but this time his eGFR was 12 ml/min/1.73 m². Mr T stabilised but needed assessment for possible kidney transplantation.

Dr W specifically denied that she had been given the letter from the private health check and indeed there was no evidence of it within the GP records. She did however accept that she had erroneously marked the MSU result as normal and had thus not taken any action. In view of this, it was agreed that Dr W was in breach of duty in this matter and the case was settled for a high sum.

EXPERT OPINION

Medical Protection sought the advice of a consultant nephrologist, Dr B. Dr B was of the opinion that Mr T’s renal impairment was probably due to glomerulocentric disease rather than hypertension at the time of the health check. He felt that the diclofenac prescribed caused the clinical situation to deteriorate, leading to the acute presentation of severe hypertension and renal failure. He advised that if Mr T’s condition had been diagnosed earlier, this would have allowed monitoring and control of his blood pressure. It would also have been unlikely that NSAIDs would have been prescribed, thus avoiding the acute presentation. It was Dr B’s opinion that earlier diagnosis and treatment would have delayed the need for renal transplant by a period of between two to four years.

Dr W specifically denied that she had been given the letter from the private health check and indeed there was no evidence of it within the GP records. She did however accept that she had erroneously marked the MSU result as normal and had thus not taken any action. In view of this, it was agreed that Dr W was in breach of duty in this matter and the case was settled for a high sum.

Learning points

• This case raises issues about communication between healthcare providers. Doctors need to consider whether their systems for receiving and recording information, written or verbal, from other healthcare providers are sufficiently robust.
• Mistakes can be easily made when working under stress with high workloads. It is important, however, to be thorough and to ensure that all elements of a test result are reviewed before marking the result as normal.
• The assessment and management of non-visible haematuria in primary care is discussed in a useful clinical review published by The BMJ in 2009.¹

REFERENCES

1. Kelly JD, Fawcett OP and Goldberg LC. Assessment and Management of Non-visible Haematuria in Primary Care, BMJ 338: a3021(2009)
Mr P was a 32-year-old runner. He had a skin tag on his back that kept catching on his clothes when he ran. It had become quite sore on a few occasions and he was keen to have it removed. He saw his GP, Dr N, who offered to remove the skin tag in one of his minor surgery sessions.

The following week Mr P attended the minor surgery clinic at his GP practice. Dr N explained that he was going to use diathermy to remove the skin tag and Mr P signed a consent form.

Mr P lay on the couch and a sterile paper sheet was tucked under him. The assisting nurse sprayed his skin with a topical cryo-analgesic. The spray pooled on his back and soaked into the paper sheet. No time was left for the alcohol-based spray to evaporate. Mr P’s back was still wet when Dr N began the diathermy to remove the skin tag. Unfortunately the paper sheet caught fire along with the pooled spray on his back. Mr P suffered a superficial burn. Dr N and the nurse apologised immediately and applied wet towels and an ice pack. The burn area was treated with Flamazine cream and dressings. Mr P was left with a burn the size of a palm on his back which took two months to heal fully.

Mr P made a claim against Dr N, alleging that his painful burn had been the result of medical negligence. It is well known that alcohol-based solutions pose a risk of fire when diathermy is used, and in failing to ensure the area was dry before applying the diathermy Dr N was clearly in breach of his duty of care. Medical Protection was able to settle the claim quickly, thus avoiding unnecessary escalation of legal costs.

Learning Points

- Flammable fluids employed for skin preparation must be used with caution.
- The fire triangle is a simple model illustrating the three necessary ingredients for most fires to ignite: heat, fuel and oxygen. In clinical situations such as the one described above, diathermy provides the heat and skin preparation fluids provide the fuel.  

REFERENCES

TURNING A BLIND EYE

A delay in sharing an urgent result with a patient results in a loss of vision

Mrs R, a 56-year-old freelance journalist, became aware she had reduced vision in her right eye. She saw her optician who noted that her visual acuity was 6/18 in the right eye and 6/6 in the left eye. Examination confirmed a nasal visual field defect in the right eye with a normal visual field in the left eye. The right optic disc was atrophic but the left appeared normal. Mrs R’s optician referred her to the local ophthalmology emergency unit, where Dr S confirmed his findings and also detected a right afferent pupillary defect and reduced colour vision in the right eye. He made a diagnosis of right optic atrophy and arranged blood tests to investigate this further.

Two weeks later Dr S received a telephone call from the virology department informing him that Mrs R had tested positive for syphilis. Dr S immediately contacted Mrs R’s GP, Dr L, informing him of the result and the need for urgent treatment.

On the same day, Dr L wrote a letter to Mrs R asking her to book an appointment. His letter said: “Please be advised that this is a routine appointment, and there is no need for you to be alarmed.” Mrs R did not take this letter seriously and no appointment was made. Dr L did not pursue the matter.

Seven months later, Mrs R was referred to Dr D in the neuro-ophthalmology clinic for deteriorating vision affecting both eyes. Dr D diagnosed bilateral optic atrophy and repeated the blood tests for syphilis. He arranged for Mrs R to be admitted to hospital, where lumbar puncture and examination of the cerebrospinal fluid confirmed the diagnosis of neuro-syphilis. Mrs R was treated with penicillin and corticosteroids, which cleared the infection. Post-treatment visual acuity in the left eye was 6/5 but she had a severely reduced field of vision. In the right eye her visual acuity was light perception only. Although these changes had stabilised, Mrs R was assessed as legally blind.

Mrs R brought a case against her GP alleging that the delay in treatment led to her losing her sight. Due to this she had lost her driving licence which substantially reduced her earning capacity.

EXPERT OPINION

A GP expert considered that in failing to follow up on an important laboratory result, Dr L was in breach of his duty of care. Ophthalmology expert opinion concluded that the delay in treatment resulted in loss of the remaining 50% of vision in the right eye and 80% of vision in the left eye. The loss of sight impacted substantially on Mrs R’s lifestyle and earning capacity. Both the virology department and the ophthalmologist were deemed to have acted appropriately and promptly.

The case was settled for a substantial sum on behalf of Dr L.

Learning points

• When faced with a serious condition requiring urgent treatment you should be diligent in your attempts to communicate this to the patient promptly and sensitively.

• When communicating urgent information to colleagues, direct conversations are the most effective. It may be useful to follow a conversation with a letter as this may reinforce a point and prompt further action. A letter on its own may be insufficient in that it may be mislaid, misfiled or the importance not understood.

• When communicating sensitive information to patients a face-to-face consultation is most appropriate. Communicating such information in writing could lead to misunderstanding, a breach of confidentiality, or may downplay the urgency of the matter.

• Be aware of local practice: the management of neuro-syphilis is often initiated through neurology or medical teams and the ophthalmologist should consider direct referral when the condition is sight threatening. Ophthalmologists should also be prepared to discuss laboratory results with patients and, where appropriate, emphasise the need for prompt treatment.

AK
TRIPPED UP

A child is unable to weight bear after a fall

Master Y, aged nine, was walking home from school when he tripped and fell. He was usually very stoical, but after the fall he cried with pain when he tried to stand on his right leg. His mother took him into the local Emergency Department (ED) where, after a brief examination, he was discharged home with a diagnosis of a torn quadriceps muscle. No x-rays were taken. He was advised to avoid weight bearing for two weeks.

Master Y was no better three weeks later. His mother rang their GP, Dr E, who saw him the same day. Dr E noted the history of a fall and recorded only “tenderness” and “advised NSAID gel and paracetamol”.

Master Y continued to complain of pain in his thigh and also his knee. A month later, he saw another GP, Dr B, who assessed him and diagnosed “musculoskeletal pain”. There was no record of any examination. Master Y’s knee pain continued over the next month, Dr B reviewed him and arranged an x-ray of his knee. The only entry on the records was “pain and swelling right knee”.

The x-ray showed signs of osteoporosis and features consistent with possible traumatic injury to the right proximal tibial growth plate. The report advised an urgent orthopaedic opinion which Dr B arranged.

The orthopaedic surgeon noted an externally rotated and shortened right leg. An urgent MRI revealed a right-sided slipped upper femoral epiphysis and Master Y underwent surgery to stabilise it. The displacement was such that an osteotomy was required later to address residual deformity.

Despite extensive surgery Master Y was left with a short-legged gait and by the age of 16 he was increasingly incapacitated by pain in his right hip. Surgeons considered that he would need a total hip replacement within 10 years, and that a revision procedure would almost certainly be required approximately 20 years after that.

A claim was brought against GPs Dr E and Dr B, and the hospital for failing to diagnose his slipped upper femoral epiphysis. It was alleged that they failed to conduct sufficiently thorough examinations, arrange imaging and refer for timely orthopaedic assessment.

EXPERT OPINION

Medical Protection instructed a GP expert who was critical of both GPs’ unacceptably brief documentation. He noted the discrepancy between what was actually written down by the GPs in the contemporaneous records and their subsequent recollection of their normal practice. The expert felt that their care fell below a reasonable standard.

Medical Protection also obtained an opinion from a consultant orthopaedic surgeon. The expert was critical of the assessment undertaken in the ED and advised that knee pain can be a feature of slipped upper femoral epiphysis.

The expert considered that the fall caused a minor slippage of the right upper femoral epiphysis, which was a surgical emergency and the appropriate management would have been admission for pinning of the epiphysis in situ. In the presence of a slight slip and subsequent fusion of the epiphysis, recovery without functional disability would have been expected. As a consequence of failure to diagnose an early slip, Master Y lost the chance of early correction. Instead, he developed a chronic slippage with associated disability necessitating osteotomy.

The case was settled for a high sum, with a contribution from the hospital.

CASEBOOK | VOLUME 24 ISSUE 2 | NOVEMBER 2016 | medicalprotection.org

Learning points

• Slipped upper femoral epiphysis is a rare condition in general practice. It usually occurs between the ages of eight and 15 and is more common in obese children. It should be considered in the differential diagnosis of hip and knee pain in this age group.

• Because patients often present with poorly localised pain in the hip, groin, thigh, or knee, it is one of the most commonly missed diagnoses in children. Pain can cause diagnostic error and orthopaedic examination should include examination of the joints above and below the symptomatic joint.

• The medical records were inconsistent with the GPs’ accounts. When records are poor it is very difficult to successfully defend a doctor’s care. Clinical records must be objective, clear and legible.

• Safety-netting is important and follow-up should be arranged if patients are not improving or responding to treatment. This should prompt a thorough review and reconsideration of the original diagnosis.

REFERENCES

Mrs O, a 34-year-old mother of three, visited her GP with a two-month history of worsening vaginal discharge which had recently become malodorous. Her husband had urged her to see the doctor as he was particularly concerned when she had admitted to the discharge being blood-stained.

The first GP she saw, Dr A, took a cursory history and simply suggested she should make an appointment with the local GUM clinic. Of note, Dr A didn’t enquire about the nature of the discharge, associated symptoms or note that she had not attended for a smear for over five years despite invitations to do so. Dr A did not examine Mrs O, nor did he arrange investigations or appropriate follow-up. Mrs O was deeply offended that Dr A had implied the discharge was likely to be secondary to a sexually transmitted infection and did not feel the need to attend a GUM clinic.

She re-presented to another GP, Dr B, several months later complaining that her discharge had worsened. Dr B reviewed the previous notes and encouraged her to make an appointment with the GUM clinic as previously recommended by Dr A. There was no evidence from the notes that a fresh review of the history had been undertaken. No examination was performed and Dr B did not arrange vaginal swabs or scans despite Mrs O’s continued discharge.

A week later, Mrs O re-attended the surgery where Dr B agreed to try empirical clotrimazole on the premise she may be suffering from thrush. Again, no examination or investigations were discussed, and there was no evidence of safety-netting advice documented in the records.

Two months later, Mrs O saw a third GP, Dr C, as the clotrimazole had failed to resolve her worsening symptoms. By now she had started to lose weight, had developed urinary symptoms, and her bloody vaginal discharge had worsened. Despite her malaise and pallor, Dr C again failed to take an adequate history or examine Mrs O and further reinforced the original advice that Mrs O attend the GUM clinic.

Mrs O collapsed later that week and was taken by ambulance to the Emergency Department (ED) of her local hospital. She was found to have urosepsis and was profoundly anaemic with a haemoglobin of 60 g/l. Examination by the ED team revealed a hard, irregular malignant-looking cervix and a large pelvic mass. She was admitted under the gynaecology team, who arranged an urgent scan. The scan revealed an advanced cervical cancer with significant pelvic spread and bulky lymphadenopathy.

After an MDT meeting and a long discussion with her oncologist, Mrs O and her husband elected to try a course of neoadjuvant chemotherapy and debulking surgery. Unfortunately, prior to surgery, she experienced severe pleuritic chest pain and a working diagnosis of pulmonary embolism was made. Further investigations excluded embolic disease but confirmed tumour deposits in the lung and liver.

It was agreed she would forego chemotherapy and Mrs O was referred to the palliative care team. Her symptoms were managed in the community until her death at home two months later.

**Learning points**

- Failure to take an adequate history and examination will make any case difficult to defend.
- It is not advisable to reinforce a colleague’s diagnosis or management advice without first conducting your own assessment of the patient’s symptoms.
- Alarm bells should ring if patients return multiple times for the same problem.
- Where clinically relevant, a screening test should be offered opportunistically to patients who fail to respond to routine invitations.

**EXPERT OPINION**

A claim was brought against all three GPs for failure to take adequate histories, failure to examine, failure to accurately diagnose and failure to safety net. An expert witness was highly critical of the care Mrs O received by all the GPs involved and advised that her death was potentially avoidable with better care and a more robust smear recall system. Breach of duty and causation were admitted and the family’s claim was settled for a high amount.
A 34-year-old lady, Mrs C, consulted a private plastic surgeon, Dr Q, about her lax abdominal skin. Nine days later, she was admitted under his care for an abdominoplasty procedure (tummy tuck). The procedure was uneventful and the patient was discharged after 24-hours.

A fortnight later, at a post-operative nurse-led clinic, Mrs C complained of lower abdominal swelling. This was identified as a seroma and she was briefly admitted for aspiration by Dr Q.

Three months later she was seen again at a nurse-led clinic, on this occasion complaining of peri-umbilical pain. She was reviewed two days later by Dr Q himself, whose examination noted nothing amiss. Her symptoms continued and four months later her GP referred her to the local general hospital, raising the possibility of an incisional hernia. Dr Q was contacted by the hospital and reviewed Mrs C again. He offered to perform a scar revision and to waive his fee.

Three months after this revision surgery was performed, Mrs C had further problems around the scar site, this time manifesting itself as an infection, which developed into an abscess. Initially her GP treated this with antibiotics and dressings. However, despite this intervention, she was seen again by Dr Q, who re-admitted Mrs C for drainage of the abscess and revision surgery to the scarring around the umbilicus.

Mrs C was unhappy with the cosmetic result, and after her discharge from hospital, Dr Q referred her to a colleague, Dr H, for a further opinion. Dr H reviewed Mrs C and replied that in his view the umbilicus and the horizontal scar were placed too high, and he recommended a further revision.

Subsequently, Dr Q received a letter of claim from Mrs C’s solicitors alleging that the surgery had been carried out negligently and she had been left with an unsatisfactory cosmetic outcome requiring further surgery.

EXPERT OPINION
An expert opinion obtained by Medical Protection was critical of a number of aspects of Dr Q’s management, including the positioning of the incision line, consent issues around scarring, and some technical aspects of Dr Q’s wound closure methods.

In the light of the expert’s comments the case was settled for a moderate amount.

Learning points
A patient’s decision to make a claim against his or her clinician often reflects more than one point of dissatisfaction or poor performance. Some of the important points in this case include:

• The interval between Mrs C having her first consultation with her surgeon and the subsequent operation was just nine days. When cosmetic surgery is being considered it is good practice to allow a cooling off period of at least two weeks before the surgery. The patient should be provided with, or directed to, sources of information about the proposed procedure. It is also best practice to offer patients a second consultation, which allows the patient to discuss any doubts or questions which may have arisen. Patients should be under no pressure to proceed with aesthetic surgery.

• Complications can occur after any surgery. In abdominoplasty, issues of scarring and the formation of seromas can occur. It is vital that these possibilities are discussed during the pre-procedure consultations. It is insufficient to simply list them on a consent form, signed in a rush on the morning of operation by a nervous patient.

• It is vital to ensure careful documentation of the pre procedure consultations. This should outline what has been discussed, including the alternatives, potential outcomes and possible risks associated with any procedure. You should also document any literature that has been supplied to the patient or sources of information that were signposted.

• Aesthetic surgery requires a strong element of psychological understanding of the patient, and patients need to feel supported by their surgeon. Good communication and timely reviews are essential in maintaining a good relationship.

• Being asked to provide a second opinion can be an extremely challenging task, particularly where you may disagree with the original doctor. In this case, Dr H was critical of the repeat surgery carried out by Dr Q. Doctors should always convey their honest opinion to patients. However, you should consider the effect that the manner you express an opinion can have. Excessive or derogatory comments to a patient about a colleague are unlikely to be helpful and may encourage a patient to complain or pursue a claim.
A psychiatric patient is placed under close observation

Miss A, a 30-year-old teacher, saw Dr W, a consultant psychiatrist, in the outpatient clinic. Dr W noted Miss A’s diagnosis of bipolar affective disorder, her previous hospital admission for depression and her history of a significant overdose of antidepressant medication. Dr W found Miss A to be severely depressed with psychotic symptoms. Miss A reported thoughts of taking a further overdose and Dr W arranged her admission to hospital.

During Miss A’s admission Dr W stopped her antidepressant medication, allowing a wash-out period before commencing a new antidepressant and titrating up the dose. He increased Miss A’s antipsychotic medication and recommended she be placed on close observation due to continued expression of suicidal ideation. He documented that Miss A appeared guarded and perplexed, did not interact with staff or other patients on the ward, and spent long periods in her nightwear lying on her bed. He did not document the content of her suicidal thoughts. Dr W reiterated to nursing staff that close observation should continue.

During the third week of her admission, Miss A asked to go home. Miss A’s nurse left Miss A alone to contact the doctor to ask whether Miss A required assessment. While alone in her room, Miss A set fire to her night clothes with a cigarette lighter and sustained burns to her neck, chest and abdomen. She was transferred to the Emergency Department and then to the plastic surgical team and remained an inpatient on the burns unit for three months, requiring skin grafts to 20% of her body.

Miss A made a good recovery from this incident and subsequently brought a claim against Dr W and the hospital. She alleged Dr W had failed to prescribe adequate doses of medication to ensure the optimal level of improvement in her mental health symptoms, failed to adequately assess the level of risk she posed, and failed to ensure constant specialist nursing care was provided to supervise her adequately during her hospital stay. She also alleged the hospital had failed to ensure she did not have access to a cigarette lighter. Miss A claimed that she would not have suffered the severe burns and subsequent post-traumatic stress disorder if not for these failings.

EXPERT OPINION
An expert opinion was sought from a psychiatrist. The expert made no criticism of the medication regimen or changes to it, but was critical of the communication between Dr W and nursing staff over the meaning of the words “close observation”, and the lack of a policy setting this out. She was also of the view that additional nursing staff should have been requested to ensure one-to-one nursing of the patient during her admission. She was critical of the hospital for allowing the patient access to a lighter on the ward, and concluded that the incident could have been avoided if these failures had not occurred.

Dr W acknowledged Miss A had been the most unwell patient on the ward at the time and in hindsight agreed that additional nursing staff should have been requested. Dr W highlighted that there was pressure on consultants not to request additional nursing staff due to cost implications. He also acknowledged that by close observations he had expected the patient to be within sight of a member of nursing staff at all times but had not ever communicated this specifically to the ward staff.

The claim was settled for a substantial sum, with the hospital contributing to the settlement.
BC underwent cyst drainage with insertion of a shunt under the care of Dr S, a consultant paediatric neurosurgeon, but it was complicated by an intracranial bleed. Intraoperative exploration revealed that there had been an injury to the temporal lobe that was likely to have been associated with the insertion of the ventricular catheter (which was not inserted entirely under direct vision). The haemorrhage was under control when the operation was concluded.

Following the surgery, BC was transferred to the paediatric ward as a high care patient. Dr S left the hospital having handed over care to Dr K, a consultant paediatrician, and Mr P, a consultant neurosurgeon. Dr S explained that BC had had an intraoperative bleed, that a clotting screen should be checked (to exclude an underlying bleeding disorder) and that regular neurological observations should be undertaken. Unfortunately the handover discussions were not documented in the records.

BC remained stable until early evening when Dr K was asked by the nursing staff to review her because she had started to vomit and had developed a dilated left pupil. A repeat scan demonstrated a haematoma in the Sylvian fissure with consequent displacement of the ventricle, impingement of both the temporal and parietal lobes, together with a midline shift. Mr P was called and immediately returned BC to theatre to evacuate the haematoma.

The parents pursued a claim alleging:

- the original procedure was not indicated (and that non-surgical approaches were not considered)
- the shunt was negligently inserted, which led to the bleeding and associated brain injury
- the bleeding was not adequately controlled in the context of the first procedure
- BC should have been transferred to a paediatric intensive care facility in order that her neurological condition could have been intensively monitored.

EXPERT OPINION
Medical Protection sought an expert opinion from a consultant paediatric neurosurgeon, who was not critical of Dr S’ decision to drain the cyst and insert a shunt. However concerns were raised in relation to the operative technique which, the expert said, was not according to standard practice. The expert indicated that the preferred approach would be to insert the ventricular catheter under direct vision and postulated that there may have been damage to one of the branches of the middle cerebral artery.

The expert was not critical of the decision to transfer BC to a paediatric ward (on the basis that she did not require ventilation and that the monitoring facilities on the ward were appropriate) but was concerned about the lack of written and verbal instructions (particularly directed towards the nursing staff) relating to the post-operative care and neurological observations. In addition, the expert was of the opinion Dr S should have reviewed BC on the ward given that he had performed a surgical procedure on her that had been complicated by bleeding.

In light of the vulnerabilities highlighted by the expert, the claim was resolved by way of a negotiated settlement.

Learning points

- The allegations were wide-ranging and although the expert was supportive of some aspects of Dr S’ involvement in BC’s care, the concerns in relation to the operative technique and handover meant that there was no realistic prospect of successfully defending the case.
- The case emphasises the importance of communication and record keeping, particularly with reference to providing clear verbal and written handover to all relevant staff.
- It may be entirely appropriate to leave the care of a patient in the hands of colleagues at the end of a shift but it would have assisted Dr S’ defence if he had reviewed BC on the ward post-operatively in light of the fact that the neurosurgical procedure had been complicated by bleeding.
Mr W was a 55-year-old diabetic who worked in a warehouse. He began to get pain across his shoulders when he was lifting boxes and walking home. He saw his GP, Dr I, who noted a nine-month history of pain in his upper back and around his chest on certain movements. She documented that the pain came on after walking and was relieved by rest. Her examination found tenderness in the mid-thoracic spine area. Dr I considered that the pain was musculoskeletal in nature and advised anti-inflammatory medication and a week off work.

Two weeks later Mr W returned to his GP because the pain had not improved. This time Dr I referred him to physiotherapy. Mr W did not find the physiotherapy helpful and four months later saw another GP, Dr J, who diagnosed thoracic root pain and prescribed dothiepin. He also requested an x-ray of his spine, which was normal, and referred him to the pain clinic. The referral letter described pain worse on the left side that was brought on by physical activity and stress.

At the pain clinic, a consultant documented a two-year history of pain between the shoulder blades. The examination notes stated that direct pressure to a point lateral to the thoracic spine at T6 could produce most of the pain. Myofascial pain was diagnosed and trigger point injections were carried out.

Three months later Mr W was still struggling with intermittent pain in his upper back. He went back to see Dr J, who referred him to orthopaedics. His referral letter described pain in the upper thoracic region with radiation to the left side, aggravated by strenuous activity and stress. Again, it was recorded that the pain was reproduced by pressure to the left thoracic soft tissues.

Two months later Mr W was assessed by an orthopaedic surgeon who diagnosed ligamentous laxity and offered him sclerosant injections.

Mr W took on a less physically demanding role and the pain came on less often. After a year, however, his discomfort increased and his GP referred him back to the orthopaedic team.

A consultant orthopaedic surgeon found nothing of concern in his musculoskeletal or neurological examination. X-rays were repeated and reported as normal. It was thought that his symptoms were psychosomatic and he was discharged.

Six months later, Mr W was struggling to work at all. He rang his GP surgery and was given an appointment with a locum GP, Dr R. Her notes detailed a several year history of chest and back pain on lifting and exercise that had worsened recently. Pain was recorded as occurring every day and being “tight” in character. It was also noted that he was diabetic, smoked heavily and that his mother had died of a myocardial infarction at age 58. Dr R referred him to the rapid access chest pain clinic.

Angina pectoris was diagnosed and an ECG indicated a previous inferior myocardial infarction. Mr W was found to have severe three-vessel disease and underwent coronary artery bypass grafting, from which he made an uncomplicated recovery. He was followed up in the cardiology clinic and continued to be troubled by some back pain.

Mr W brought a claim against GPs Dr I and Dr J for the delay in diagnosis of his angina pectoris.
Learning points

- Pain that is precipitated by exertion should always raise suspicion of angina. The National Institute for Health and Care Excellence (NICE) in the UK defines stable angina symptoms as being:
  - constricting discomfort in the front of the chest, in the neck, shoulders, jaw, or arms
  - precipitated by physical exertion
  - relieved by rest or glyceryl trinitrate (GTN) within about five minutes.
- People with typical angina have all three of the above features. People with atypical angina have two of the above features.
- Angina can present in uncharacteristic ways. There can be vague chest discomfort or pain not located in the chest (including the neck, back, arms, epigastrium or shoulder), shortness of breath, fatigue, nausea, or indigestion-like symptoms. Atypical presentations are more frequently seen in women, older patients and diabetics.
- Multiple conditions can run alongside each other and we must try to untangle them by careful questioning and listening. Stepping back and looking at the bigger picture can help if patients’ symptoms are persistent.
- Confirmation bias can lead to medical error. The interpretation of information acquired later in a medical work-up might be biased by earlier judgments. When we take medical histories it can be tempting to ask questions that seek information confirming earlier judgements, thus failing to discover key facts. We also can stop asking questions because we have reached an early conclusion. The BMJ published an article about the cognitive processes involved in decision making and the pitfalls that can lead to medical error.

REFERENCES

A MISSED OPPORTUNITY?

A patient suffers complications following spinal surgery

Mrs W, a 58-year-old business manager, consulted Dr D, an orthopaedic surgeon, with exacerbation of her chronic back pain. She had a history of abnormal clotting and had declined surgery three years earlier because of the attendant risks. An MRI scan confirmed degenerative spinal stenosis for which Dr D recommended an undercutting facetectomy to decompress the spinal canal while preserving stability. On this occasion, Mrs W agreed to the proposed procedure. Surgery was uneventful, and she was discharged home on the fourth post-operative day.

At her outpatient review 11 days later, Mrs W complained that she had been unable to open her bowels and that she had also developed a swelling at the wound site, from which Dr D aspirated “turbid reddish fluid”. Suspecting a dural leak, Dr D undertook a wound exploration, which confirmed that the dura was intact. At the same time, a sacral haematoma was evacuated. In the two years following surgery, Mrs W was seen by Dr D and a number of other specialists complaining of ongoing constipation, urinary incontinence and reduced mobility, which, although atypical, was thought to be due to cauda equina syndrome.

Mrs W brought a claim against Dr D, alleging that she had not been advised of the risks of the surgery and that no alternative options were offered to her. Furthermore, she claimed that had she been properly advised, she would have declined surgery, as indeed she had done in the past. She also alleged that Dr D failed to arrange appropriate post-operative monitoring such that her developing neurological symptoms were not acted on, and that she should have undergone an urgent MRI, which would have revealed a sacral haematoma requiring immediate evacuation.

EXPERT OPINION

An orthopaedic expert instructed by Medical Protection made no criticism of the conduct of the surgery, but was very critical of the poor quality of Dr D’s clinical records. Although Dr D was adamant that the risks of surgery and alternative treatment options were discussed with Mrs W, he made no note of this in the patient’s records nor did he make reference to any such discussions in his letter to the GP. Furthermore, despite Dr D’s assertions that he reviewed Mrs W every day post-operatively prior to her discharge, he made no entries in the records to this effect, stating that he had relied on the nurses to do so. The nursing records did not corroborate this.

The claim was predicated on the basis that Mrs W suffered from cauda equina syndrome and that earlier intervention to evacuate the haematoma would have improved the outcome. In the expert’s opinion, there was insufficient evidence to support a diagnosis of cauda equina syndrome, hence it was unlikely that earlier decompression would have made a difference. However, the absence of documentary evidence of her post-operative condition made it very difficult, if not impossible, to rebut this claim.

In any event, Mrs W would have been successful in her claim if she could establish that she was not properly advised of the risks and alternative options, and that if she had been she would have not proceeded with the surgery. This is because, on the balance of probabilities, the complications she suffered would not have occurred had she been properly counselled. The absence of any record of the advice given, coupled with the documented reasons for her earlier refusal of surgery lent significant weight to Mrs W’s claim.

On the basis of the critical expert report the claim was settled for a substantial sum.

Learning points

- Good clinical records are essential to the ability to defend a doctor’s actions in the event of a claim.
- An appropriate clinical note should be made by the attending doctor or explicitly delegated to another appropriately skilled healthcare professional.
- Patients are entitled to expect that they will be advised of all relevant and material risks of a proposed treatment and of any alternative treatment options (including no treatment). Any advice given should be clearly documented.
Thank you for the latest edition of Casebook which I found informative. However I would like to draw your attention to what I believe are a couple of mistakes in the learning points to your article ‘Diagnosing pneumonia out of hours’.

The second paragraph of the advice given states: “According to NICE guidance…GPs should use the CURB65 score to determine the level of risk…One point is given for confusion (MMSE 8 or less ...)”.

I believe that NICE’s guidance for GPs is to use the CRB65 algorithm, and this appears to be the algorithm referred to in the rest of the article. The CURB is slightly different, includes a blood test for urea and is intended mainly for hospital use.

More importantly, NICE advises doctors to assess confusion using the Abbreviated Mental Test Score (AMTS),¹ not the Mini Mental State Examination (MMSE)² as stated in the article. The AMTS is scored out of 10, the MMSE out of 30; so whilst a score of 8/10 on the AMTS is consistent with mild confusion (allowing for the crudity of the AMTS), a score of 8/30 on the MMSE would be indicative of very severe confusion. Use of the MMSE in an acute respiratory infection would be time-consuming and could give false assurance.

Dr Brian Murray

Response

Thank you for pointing out the two errors in the case report from the last edition. You are correct that it should have been the CRB65 algorithm and the Abbreviated Mental Test Score that were referred to. We regret that these were not picked up on clinical review and we apologise for any confusion caused.

Dr M Shah

We welcome all contributions to Over to you. We reserve the right to edit submissions. Please address correspondence to:
Casebook, Medical Protection, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK.
Email: casebook@medicalprotection.org
JOIN THE DEBATE in the Medical Protection forums – read Casebook on medicalprotection.org and let us know your views!

REFERENCES

Finally, the decision-making capacity of the doctor will be impaired if in an unfamiliar location and stressed by congestion and route finding whilst travelling to a patient’s home, as well as consulting without immediate access to the full medical record.

Dr Douglas Salmon

A FAMILY MATTER

I read the case study regarding the doctor prescribing an antibiotic for her daughter. Having retired recently after 25 years as a GP partner it surprises me that common sense is not applied by the GMC in such circumstances.

How this can ever be considered a serious complaint baffles me. Being a GP is stressful enough, and cases like these make me angry that as a profession we have to suffer such indignity when we can’t be trusted to treat our families for minor illnesses.

Dr M Shah

PROBLEMATIC ANAESTHETIC

I read with interest the unfortunate case of neurological injury following attempted paravertebral blockade.

What the learning points do not mention is the expert opinion that this procedure should have been performed awake or under light sedation. Many anaesthetists perform this procedure under anaesthesia with exemplary results, but I have to agree with the expert opinion. When struggling with a procedure we can sometimes get too preoccupied with succeeding. Awake patients do not like needles in places where they should not be and this helps prevent multiple attempts by the operator. In this case it may have led to the doctor abandoning this unnecessary procedure.

Dr Mohammed Akuji

The learning points arising from this case missed arguably the most important learning point – that both patients and doctors are more likely to experience adverse outcomes if patients are seen at home rather than in surgery.

The GP involved was criticised for failing to keep adequate records, an outcome far more likely after a home visit than after an attendance at the surgery, where the computer records system is accessible immediately.

The GP was also criticised for failing to test urine; obtaining a urine sample from patients is far easier to manage in surgery, where the delays involved can be mitigated by seeing other patients whilst the specimen is produced, and where specimen pots and urine test sticks are immediately to hand. A busy GP will simply not have the time for a prolonged wait in a patient’s home until the specimen is eventually produced.

Dr Mohammed Akuji

REFERENCES
**OMNIFOCUS (IOS, MAC)**
OMNI GROUP
omnigroup.com/omnifocus

**Review by: Dr Jennifer Munroe-Birt**

The Omnifocus app can't technically grant you the extra ten hours a day that everyone wishes they had, but what it can do is focus you, organise you, and maximise your productivity so you do in fact seem to end up with more time. At first glance it doesn't seem much of an upgrade on a to-do list – albeit a rather expensive one – but further inspection reveals an intuitive, multi-level application that will afford you levels of organisation you always assumed were beyond you.

For doctors, the app is useful to arrange and categorise the abundance of tasks at hand (projects, meetings, CV, CPD). You can easily categorise individual tasks into bigger projects (holiday, that audit you've been meaning to finish all year) and assign deadlines to each task. Being able to break each ‘project’ into smaller, more manageable chunks will appeal to anyone who has sat down to start a big piece of work and found themselves still on Facebook half an hour later because they are too daunted to take the first step.

Each project can be contextualised to various aspects of your life, and each ‘context’ can be location-based using GPS. This way Omnifocus knows when you're at home (‘paint shelves’), when you're at work (‘arrange educational supervisor meeting’), or even when you're walking past the supermarket (‘buy mustard’).

One of my favourite features is the ability to defer certain tasks once they are out of your control (for example, if you've sent an email and are waiting for a reply) and bring them back into view again once you're required to respond. It seems obvious, but this minor tweak to the interface saves you scrolling through irrelevant tasks, making you feel more motivated and focused on the things that you are able to control.

Currently the app is limited in a clinical setting primarily due to confidentiality issues. Perhaps one day our archaic bleeps will be replaced with hospital-issue encrypted smartphones with apps such as Omnifocus to help co-ordinate tasks...but I won't hold my breath.

---

**RISE**
By Sian Williams

**Review by: Rosie Wilson**

Rise describes itself as a “psychological first aid kit” and it's easy to see how – to a certain reader – it could serve as just that. The autobiographical book follows BBC newsreader Sian Williams’ journey through the treatment of, and recovery from, breast cancer.

From a doctor’s perspective, it is interesting to see the patient’s perception of her medical journey. The book includes a lot of medical jargon, records of what was told to Williams, followed immediately by her confessions of feeling confused and overwhelmed. It can be easy to forget how alien all the information about a disease or condition is to a patient when you’ve been immersed in it for years.

Treat Rise almost as a manual, then: Williams talks in detail about the doctors she liked – and the ones she didn’t – and the differences in their treatment of her. Compassionate, matter-of-fact and not at all pandering, Williams’ accolades for her favourite doctors reflect the sort of praise we might want to hear about ourselves professionally.

From a general human perspective though, the reader is struck by the emotion and candour of the book. Williams’ accolades for her favourite doctors reflect the sort of praise we might want to hear about ourselves professionally.

Thanks to her background as a journalist, Williams understands the balance between facts and feeling. The book is an insight into the typical everyday thoughts of a patient going through long-term treatment – not just for cancer, but for anything that has an impact on day-to-day living.
More support for your professional development

RISK MANAGEMENT WORKSHOPS

The Mastering workshops should be compulsory.
Very informative.

THOUSANDS OF YOUR COLLEAGUES HAVE ALREADY ATTENDED OUR WORKSHOPS. 97% SAY THEY WILL CHANGE THEIR PRACTICE AS A RESULT

FREE TO MEMBERS

Earn CPD/CME

BOOK TODAY
apeducation@medicalprotection.org

NEW DATES LAUNCHED FOR 2017

Malaysia
Tel: 1800815837
Singapore
Tel: 62231264
Hong Kong
Tel: 25278452
How to contact us

**MEDICAL PROTECTION**

info@medicalprotection.org

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

**ASIA MEDICOLEGAL ADVICE**

Freecall 800 908 433
querydoc@medicalprotection.org

**MEMBERSHIP ENQUIRIES**

Freecall 800 908 433
mps@hkma.org