



CASEBOOK

NEW LAW MAKES IT EASIER TO SAY SORRY

**APOLOGY LEGISLATION WAS RECENTLY
PASSED INTO LAW. WHAT DOES THIS
MEAN FOR YOU?**

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From the case files.....

ANTIBIOTIC ALLEGATIONS

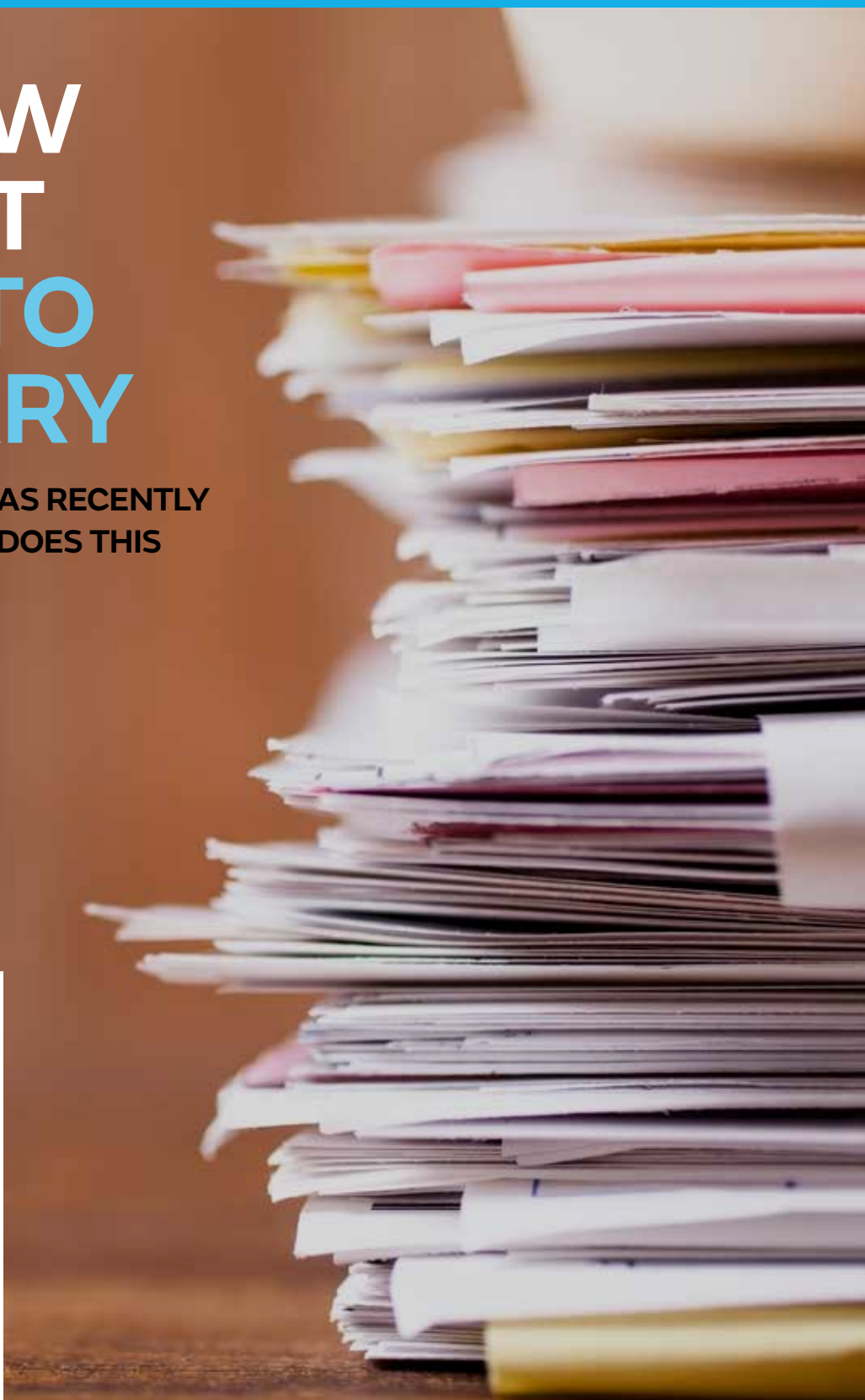
Was a GP negligent for not prescribing antibiotics?

A DISCIPLINARY ON DESKILLING

We represent a surgeon facing a disciplinary over deskilling.

AN ELUSIVE FOREIGN BODY

A child, a plastic toy – and pneumonia?



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NEW ANNUAL REPORT FROM MPS

MPS's Annual Report and Accounts 2016 is now available on our website.

The report contains MPS's full financial statements, together with our strategic report, report of the Council and statements by Kay-tee Khaw (Chairman of the Council), Simon Kayll (Chief Executive) and Howard Kew (Executive Director – Finance and Risk).

In previous years, MPS has posted a summary version of our Annual Report to all members worldwide. Following feedback from members, the report will no longer be posted out and, instead, will be published in full on our website each year, representing a cost saving for members.

To view the 2016 Annual Report, please visit the About section of www.medicalprotection.org.

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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



As in all editions of Casebook, we seek to address the latest medicolegal news in Hong Kong by offering practical advice to you as practising doctors. In this issue, we report on the new Apology Bill which came into force in July 2017.

At Medical Protection, we are encouraged by the announcement of this legislation. We have long advised members that an apology is not an admission of liability; rather, it is an acknowledgement that something has gone wrong and a way of expressing empathy. On page 5, we discuss how the law has changed, how it will affect you in future practice and provide advice on how to form an apology.

In August this year, Medical Protection appointed Mr Harris Shum as the new Regional Director for Asia. The appointment is a considerable boost to our aim of providing you with world class service. Mr Shum is responsible for managing and co-ordinating all aspects of Medical Protection business across Hong Kong, Malaysia and Singapore. You can hear more from Mr Shum on page 6, where he answers your frequently asked questions.

Away from claims, here at Medical Protection our medicolegal advice team manages many other types of cases that you can become involved in. This wide variety of cases isn't always reflected in Casebook, where traditionally we have devoted much of the focus to clinical negligence claims, perhaps because of the sheer costs that are often associated with them.

Claims form around 20% of our caseload at Medical Protection, with the rest comprised of advice and assistance with report writing, complaints, medical council procedures, inquests, employer disciplinarys and police investigations. From this edition on, the Casebook team will be working hard to bring you case reports from these different areas of medicolegal jeopardy, painting a more complete picture of the modern landscape in which you practise and the range of services available to you as a Medical Protection member.

I hope you enjoy these new case reports and the rest of this edition – please do get in touch with your views and comments.

Dr Marika Davies
Editor-in-Chief

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NEW LAW MAKES IT EASIER TO SAY SORRY

Apology legislation was recently passed into law. *Kirsty Sharp* looks at what this means for you

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

Medical Protection has long advised members that an apology is not an admission of liability; rather, it 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 actually cause them.

Hong Kong was the first region in Asia to enact apology legislation when, in July this year, the Apology Bill was passed into law by the Legislative Council.

HOW HAS THE LAW CHANGED?

This new legislation seeks to encourage the making of apologies, with a view to preventing the escalation of disputes and facilitating their amicable resolution.

It marks a departure from previous legislation, where officials and individuals were often reluctant to deliver a prompt apology for fear of possible legal liabilities.

Under the law, an apology or expression of regret or sympathy (oral, written or by conduct) will not be admissible as evidence to determine fault or liability in civil and other non-criminal proceedings, subject to certain exemptions.

WHEN DOES THE APOLOGY LEGISLATION APPLY?

The apology legislation will apply to an apology made on or after the start date of the legislation, regardless of whether the matter or the applicable proceeding began before, on or after that date. The applicable proceedings include: judicial, arbitral, administrative, disciplinary and regulatory proceedings.

The apology legislation does not apply to:

- an apology made in a document filed or submitted in applicable proceedings
- an apology made in a testimony, submission or similar oral statement given at a hearing of applicable proceedings

- an apology adduced as evidence in applicable proceedings by, or with the consent of, the person who made it.

To see a copy of the legislation, visit goo.gl/CDcx6P

WHEN SHOULD AN APOLOGY TYPICALLY BE OFFERED?

An apology should be offered as soon as it becomes apparent that an adverse incident has occurred (regardless of fault), or the patient is unhappy with their care.

It is important that patients, or their families, receive a meaningful and timely apology. It may be some time before all the facts, and perhaps the reasons why and how the events occurred, are understood. However, this consideration should not delay a prompt apology.

Depending on the circumstances, the process may require a number of meetings with the patient and/or their family over a period of time, as the full picture of what has happened is established. At the initial contact, the doctor may not have answers to all the patient's questions or adequate explanations. If so, the doctor should say so, but commit to establishing them and reporting back to the patient.

The culture within a clinical setting should allow doctors the freedom to apologise. It is ethically and professionally the right thing to do – irrespective of the cause.

WHAT IS AN 'APPROPRIATE' APOLOGY?

An apology is appropriate when a patient has suffered harm from their healthcare or experienced disappointment.

For instance *I am sorry this happened to you*

Rather than *I am sorry I caused this to happen to you and it's my fault...*

READ THIS ARTICLE TO:



- ✓ Discover what the new apology legislation is about and how this affects you
- ✓ Understand what an appropriate apology is
- ✓ Learn when an appropriate apology should be offered

An appropriate apology should be tailored to the situation – reflecting the patient's perception of the issue. It should also be put into context, so all parties understand the purpose of the apology. Ownership should also be taken by a senior clinician. Fundamentally, an apology should be offered willingly, and not perceived to have been given reluctantly.

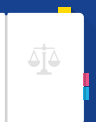
Medical Protection would always advocate a full and objective review of the event, with the patient being informed about any resulting learning points. A commitment should be made to understand and learn from what has happened, to reduce the likelihood of it reoccurring and happening to someone else.

WORKSHOP

Our workshops are FREE as a benefit of membership.

The Mastering Adverse Outcomes workshop provides training in the skills associated with appropriate discussions in these situations.

To book your place, visit medicalprotection.org and click on 'Education and events'.



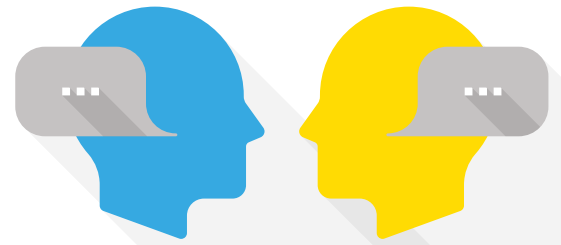
MORE ADVICE

Our expert medicolegal advisers can provide advice if needed.

For support, email querydoc@medicalprotection.org



YOUR QUESTIONS ANSWERED



Medical Protection's newly-appointed Regional Director for Asia Harris Shum answers some of your frequently asked questions. He is joined by Dr Ming-Keng Teoh, Head of Medical Services for Asia, who discusses the key medicolegal challenges facing doctors in the region

Harris Shum

Medical Protection's
Regional Director for Asia



WHY ARE SOME OTHER COMPANIES CHARGING LESS THAN MEDICAL PROTECTION?

Companies may offer different products at different terms and conditions and market entry strategies, which lead to price difference. This happens in every industry: new entrants or opportunistic players may enter a market with lower pricing, and then exit it when there are no profits in the short to medium term. However, given that it can be many years between an incident happening and a claim being made, it is crucial that doctors ask themselves whether their provider of professional protection is offering a long-term solution.

Medical Protection has decades of experience in dealing with complex clinical negligence cases in Asia. We're able to use this experience to more accurately price the risks and defend our members when in need.

Unlike other companies, we have a team of medicolegal experts who are available to respond to your urgent queries and medicolegal emergencies 24 hours a day. As doctors themselves, they can offer impartial advice to help you resolve problems arising from your clinical practice.

We also provide unique education and risk management to doctors through a series of educational programmes. These workshops and online learning resources provide ongoing learning and development opportunities to help you avoid complaints and claims. These are added benefits of membership with us in addition to your right to request indemnity.

Healthcare is constantly changing and is rarely straightforward. Our business model ensures flexibility and means we can offer help in unusual circumstances, or where developments in the delivery or regulation of healthcare gives rise to new issues.



IS IT TRUE THAT MEDICAL PROTECTION IS OPENING A REGIONAL OFFICE IN SOUTH EAST ASIA?

Yes, the office will open this month. We have listened to your feedback and received the clear message that you want Medical Protection to be more local.

We're proud to have supported thousands of healthcare professionals in the region over the past 60 years. Whilst many other organisations have come and gone, we want to continue supporting professionals in Asia for many years to come.



HOW DOES MEDICAL PROTECTION SET MEMBERSHIP SUBSCRIPTIONS?

When setting subscriptions, we carry out a detailed and robust actuarial assessment of the cost of supporting members in each country. This involves looking closely at trends in both the cost of individual claims and the number of claims in each area of practice in your country.

This information is then reviewed by an industry-leading actuarial firm, who we commission to ensure that our calculations are as accurate as they can be.

This is a long and detailed process to ensure we can be confident that Medical Protection collects enough funds from members to meet the needs of doctors in your country.



WHAT MAKES MEDICAL PROTECTION MEMBERSHIP DIFFERENT TO AN INSURANCE COMPANY?

I have worked in the insurance sector for almost two decades and can identify many differences between Medical Protection and traditional insurance companies. In the commercial world, traditional insurance companies are profit driven and may enter the market with attractive pricing strategies, leaving the market when claims start to flood in over the subsequent years.

As a member-focused organisation formed on the principle of doctors for doctors, the entire purpose is to serve you with long term support, advice and protection over the course of your career. Medical Protection has been in Asia for more than 60 years without leaving the market, whereas many insurance companies have come and gone.



WILL YOU AUTOMATICALLY REFUSE TO RENEW MY MEMBERSHIP IF I HAVE A CLAIM MADE AGAINST ME?

We would not automatically refuse to renew your membership based upon a claim being made against you. Complaints and claims are a recognised risk when practising medicine, and as an established provider of indemnity to the healthcare sector, we understand these risks and want to work with you to help prevent incidents occurring.

Occasionally, some doctors experience higher risks than their colleagues who work in the same area of practice, often through no fault of their own. In these circumstances, our approach to managing risk is to carefully balance the needs of individual members with those of the whole membership.



WHAT ACTION DOES MEDICAL PROTECTION TAKE FOR DOCTORS THAT HAVE LOTS OF CLAIMS MADE AGAINST THEM?

In these rare circumstances, we aim to work with the member to identify and reduce the problems they are facing. We may also consider raising their membership subscription to reflect their increased level of risk. If we didn't act, it would mean that subscriptions for everyone else would have to increase to cover these additional costs.

It is only in exceptional cases, where a member's claims history far exceeds the norm of their colleagues, that we would consider ending their membership, or declining to renew it.

We are owned by members and are well aware of the potential impact such a decision could have on a member's career. However, we believe that the interests of the majority of members should not be compromised by a small minority who have received a comparatively high volume of claims or complaints, which can have a significant impact on subscriptions.

Dr Ming-Keng Teoh

Medical Protection's Head of Medical Services for Asia



IN MEDICAL PROTECTION'S EXPERIENCE, WHAT ARE THE COMMON CAUSES OF COMPLAINTS AND CLAIMS?

Common reasons for complaints and claims include a failure or delay in diagnosis, or incorrect treatment such as a prescribing error. Poor communication, for example if doctors do not explain treatment options clearly or communicate what they are doing to do, can also be a contributing factor.



WHAT CAN MEDICAL PROTECTION DO TO HELP REDUCE THE NUMBER OF COMPLAINTS AND CLAIMS AGAINST DOCTORS?

We are committed to helping to prevent problems from occurring in the first place, not just helping to resolve a claim or complaint once it has occurred, and we actively work to help reduce the number of complaints and claims being made. Because we believe that prevention is better than cure, we provide resources to individual doctors and partner with healthcare organisations to provide risk management solutions. Through our local knowledge and international expertise, we have a deep commitment to supporting the continuous improvement of healthcare.

MORE ADVICE

To keep abreast of medicolegal news and updates, visit medicalprotection.org

If you need advice, contact a medicolegal adviser at querydoc@medicalprotection.org



WORKSHOP

Our risk management workshops are free to Medical Protection members and delivered by practising doctors. For more information, visit medicalprotection.org and click on 'Education & events'.



PROBLEMATIC PACEMAKER PLACEMENT

A patient undergoes multiple procedures due to problems with their pacemaker placement

Author: Dr Rachel Birch, medicolegal adviser at Medical Protection



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Mr U, a 29-year-old teacher, was referred to Dr N, a consultant cardiologist, with a history of several episodes of dizziness, perspiration and palpitations. A 24-hour ECG had shown episodes of tachycardia and bradycardia, and second-degree Mobitz type II heart block was demonstrated when symptomatic.

Dr N recommended a procedure to insert a permanent pacemaker, to which Mr U consented. The procedure was straightforward, with the post-procedure chest x-ray and pacemaker check both recorded as satisfactory. Mr U was discharged home.

Six weeks later, a routine pacemaker check demonstrated a high threshold in the ventricular lead (which could signify potential pacemaker failure), despite satisfactory positions on the chest x-ray. Dr N prescribed a short course of steroids.

The following month, Mr U was admitted to hospital with left-sided chest pain and episodes of tachycardia and bradycardia. Dr N undertook an exploration of the pacemaker system and replaced the ventricular lead. Dr N reviewed the post-intervention chest x-ray and felt it was satisfactory; the patient was discharged.

Mr U was readmitted by ambulance late that evening: a pacemaker check demonstrated that the ventricular lead did not capture the ventricle.

The following day Dr N re-sited the ventricular lead and re-advanced the atrial lead. Again, the post-procedure chest x-ray and pacemaker check were felt by Dr N to be satisfactory. Mr U was kept under observation for two days and advised to keep his arms still. Dr N's notes stated that he suspected Twiddler's Syndrome, which occurs when a patient manipulates the pacemaker's pulse generator and dislodges the leads from their intended location.

A week later, another pacemaker check demonstrated a failure of the pacemaker and the ventricular lead. Mr U, unhappy with his care so far, asked to see a second cardiologist.

He was referred to Dr B, who undertook a revision of the pacemaker. She found the suture sleeves to be loose and that both leads were mobile. Following the procedure, a pacemaker check and chest x-ray were both satisfactory and Mr U was discharged home. He had no further problems with his pacemaker following Dr B's intervention.

Mr U made a clinical negligence claim against Dr N, alleging that, in the second and third procedures, he had failed to secure the leads to prevent them from moving, and that he had failed to check appropriate lead positioning during and after the procedures.

EXPERT OPINION

Medical Protection sought expert opinion from a consultant cardiologist. The expert was critical of several aspects of the care provided by Dr N.

First, the expert cited that the post-procedure chest x-rays from the second and third procedures showed unsatisfactory lead positions, which would have made lead dislodgement likely. Also, she could find no evidence of Twiddler's Syndrome on any chest x-ray.

The expert also noted that, in the fourth procedure, Dr B could not find evidence of lead sutures, suggesting that the leads were not secured adequately.

Based on the expert opinion, the case was deemed indefensible and was settled for a moderate sum.

Learning points

- It is important to take extra care suturing the leads during a revision procedure, especially if there has already been an episode of lead migration.
- Twiddler's Syndrome is a well-known but infrequent cause of pacemaker malfunction. A chest x-ray would usually show the two leads migrated to the same degree and rotation of the pulse generator, so making the diagnosis.

DESKILLED DISCIPLINARY PROCEEDINGS

A surgeon faces disciplinary action from his employer following accusations he has become deskilled

Author: Dr Gordon McDavid, medicolegal adviser at Medical Protection

Mr H was a senior consultant general and breast surgeon who worked in a district general hospital. He was recognised by his colleagues as an expert in breast surgery and an informal arrangement was put in place to transfer all patients with breast problems to Mr H. This arrangement was endorsed by the hospital clinical director but was not formally agreed.

A reciprocal arrangement was put in place so Mr H's general surgery colleagues would take over the care of any patients admitted under Mr H while he was on-call that did not have breast issues. As a result of this arrangement, Mr H was rarely involved in general surgery operations.

Mr H received a letter from his employer stating that they were instigating formal disciplinary action against him. The letter alleged Mr H's general surgical operating technique was felt to be deficient. This followed concerns being raised by Mr H's general surgical colleagues, who were concerned at his postoperative complication rates in emergency general surgery patients and that he may be deskilling.

Mr H was restricted to non-clinical duties pending an investigation. Mr H contacted Medical Protection for advice and support.

His employer refused to clearly articulate the reasons for Mr H being restricted to non-clinical duties, given that no concerns had been raised about his breast practice. Despite repeated requests from Medical Protection, the hospital refused to outline the allegations against Mr H.

Medical Protection made formal representations to the hospital, stating that they had failed to follow their disciplinary process, and in particular fallen foul of a basic tenet of natural justice by not setting out the specific allegations against Mr H.

The hospital refused to correct the procedural irregularity and Medical Protection proceeded to instruct solicitors to threaten court action (an injunction) against the employer to compel them to comply with fair process.

While the hospital attempted to articulate the allegations about Mr H's deskilling in general surgery, they also raised new concerns in relation to his decision-making regarding patients with breast conditions, and suspended Mr H from duty.

Medical Protection made robust submissions on Mr H's behalf and, following the threat of court action, the hospital finally particularised the allegations and supplied copies of the relevant patient records.

Medical Protection accompanied Mr H to multiple meetings with senior hospital management, and an investigatory meeting following the preparation of a detailed written statement once the allegations were articulated.

EXPERT OPINION

The hospital instructed an independent expert surgeon to review a selection of case notes. In short, the only criticism was in relation to record-keeping and there appeared to be no issue with Mr H's surgical performance and abilities.

Medical Protection engaged with the hospital and the expert to ensure a productive dialogue, enabling the hospital management team to better understand the subtleties involved in managing breast patients, and the different skill set required for breast surgery vs general surgery.

The investigation concluded that the concerns did not warrant ongoing suspension. Medical Protection made representations to the employer that the suspension should be lifted and were required to again threaten legal action, which forced the employer to lift the suspension. Mr H was able to return to clinical practice following further negotiation with the employer.

It took two years for the case to reach a conclusion. The external legal costs of ensuring that fair process was followed, and that there was acceptable decision making in this case, were significant.

Learning points

- The importance of clear medical records cannot be overstated. Mr H may have avoided much of the criticism of his breast practice if more detailed notes had been made that set out his rationale for surgery in each patient. Mr H was ultimately commended on his acceptance that his clinical records had been lacking in detail and the steps he took to address this.
- It is important to seek advice early from appropriate professional organisations if you are in difficulties. If you are in doubt, contact Medical Protection for advice.
- Clear communication with seniors and managers in your organisation can help avoid escalation to formal disciplinary action or suspension from duties.
- The effect that a disciplinary process can have is devastating and Medical Protection's team of medicolegal advisers are on hand to ensure members have robust advice, support and advocacy through these complex procedures.



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AN ELUSIVE FOREIGN BODY

A child suffers recurrent episodes of pneumonia following the inhalation of a plastic toy

Author: Dr Mónica Lalanda, emergency medicine physician



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Child H, a three-year-old boy, was brought into the Emergency Department (ED) of a private hospital by his mother, having inhaled or swallowed a little building brick. They brought a similar piece with them. Child H was seen by a doctor, Dr W, who documented that he appeared well, with no signs of respiratory distress and a normal auscultation. Dr W arranged for him to have a chest x-ray, which both Dr W and a radiologist considered normal.

Two months later, Child H became unwell with a cough and a high temperature. His mother brought him to the ED where, following a chest x-ray, he was diagnosed with right lower lobe pneumonia. Child H's mother mentioned to Dr F – the doctor who saw them – that they had been to the ED not long ago after Child H “swallowed” a little toy. All this was documented.

During the next two years, Child H suffered recurrent episodes of pneumonia and attended the local ED five times. He saw a different doctor on every occasion and had five more chest x-rays. All of them were reported as “right lower lobe pneumonia with collapse and some pleural fluid”. There were no indications in the ED cards to suggest that previous cards or x-rays were looked at.

In view of the recurrent chest infections, Child H's GP referred him to the paediatric team for further investigations. Paediatric consultant Dr Q saw Child H in clinic, looked at all the x-rays and became suspicious of the presence of a foreign body. An urgent bronchoscopy was organised and a large piece of plastic removed. Child H required further surgery as the foreign body had caused fibrosis of the pulmonary parenchyma, which required excision.

Child H's mother made a claim against the private hospital and all the hospital doctors involved during those two years.

EXPERT OPINION

The experts commented that “a case of a possible inhaled foreign body has to be followed up closely and even without a clear history of inhalation of a foreign body, this should be considered a possibility in cases of recurrent pneumonia in children with persistent x-ray changes”.

The case was deemed to be indefensible and was settled for a moderate amount.

Learning points

- Taking a good history can save a lot of mishaps in clinical practice; it is important to listen. Digging into the details of what happened to this child could have made it clear whether the foreign body was swallowed or inhaled. The sudden onset of respiratory difficulty, with coughing, stridor or wheezing, needs to be specifically investigated. If inhalation is suspected, careful follow-up is required to determine the need for a bronchoscopy.
- Many types of plastic are radiolucent and will not show up on an x-ray.
- Asking the radiographers to place an example of a foreign body, if brought in by the parents, next to the patient they are going to x-ray will easily determine whether it is a radio-opaque object or a radiolucent one.
- Previous attendances to the ED by children might be relevant in a significant number of cases. Hospital note-gathering systems may be helpful in picking up previous ED attendances. Reviewing old notes is therefore always important and might offer unexpected background to a new presentation.
- With modern computerised radiographic storing systems, there is little excuse not to look at previous x-rays. Both clinician and radiologist would have been alerted to the fact that the changes in the chest x-ray were chronic and would therefore be suspicious of a foreign body being present.



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LIVING UP TO EXPECTATIONS

A surgeon fails to inform a patient about a complication that may have occurred

Author: Dr Rafael Sadaba, cardiac surgeon

Mr G was a 62-year-old office worker; he was overweight (BMI 29) and suffered from exercise-related angina. Mr G had several risk factors for ischaemic heart disease including smoking, diabetes mellitus and hypercholesterolaemia. Following a positive exercise test, a coronary angiography confirmed triple vessel coronary artery disease with a left ventricular ejection fraction of 45%. He was referred to Mr F, a consultant cardiothoracic surgeon, for consideration of coronary artery bypass graft (CABG) surgery.

Based on his symptoms and the severity of his coronary artery disease, Mr F strongly advised Mr G to undergo surgery on both prognostic and symptomatic grounds. He also explained the risks of the operation, stating that the risk of death was below 3%. In view of the seriousness of his condition, Mr G accepted to be put on the waiting list for CABG. He was strongly advised by Mr F to stop smoking and lose weight before the operation.

Mr G underwent an uneventful triple bypass. Mr F documented the use of bilateral internal mammary artery and saphenous vein grafts. Following surgery, Mr G made a good recovery, although a control chest x-ray showed an elevation of the right hemidiaphragm. Mr F and his team decided not to share this finding with Mr G in order to avoid giving him unnecessary reasons for concern. Mr G was eventually discharged home on the seventh postoperative day, having made a good recovery.

Six weeks later, Mr G attended clinic for a postoperative surgical review. He mentioned that he was angina-free but complained of dyspnoea on moderate exertion. Mr F put this down to the fact that Mr G was still recovering from the operation and said that "things would get better soon". Mr G was discharged from the clinic back to the care of his own GP.

The shortness of breath persisted during the next few months and Mr G mentioned this to his cardiologist, Dr T. Dr T reviewed the chest x-rays and arranged an echocardiogram, which showed a poor left ventricular function with significant dyskinesia in the inferior and lateral walls of the left ventricle. Pulmonary function test showed a mild reduction in total lung capacity. A chest fluoroscopy test revealed paralysis of the right hemidiaphragm. The final diagnosis was right phrenic nerve palsy secondary to surgical damage.

Mr G made a claim against Mr F because of the damage to his right phrenic nerve during the operation. The case was defended successfully, based on the facts that damage to the right phrenic nerve is a rare, but known, complication of right mammary artery harvesting and that his deteriorated heart function, rather than the paralysed diaphragm, was the likely cause of his breathlessness.

Learning points

- Mr G was not open about the complication; he should have warned Mr F as soon as it happened, as part of the ongoing consenting process. If he had disclosed the complication and explained why it had occurred, the claim may never have arisen.
- Patients should not be given false expectations. Surgical procedures do not always result in a complete cure, but can slow down deterioration and reduce the risks of serious complications. In this case, Mr F was led to believe that the operation would rid him of all his angina and dyspnoea.
- Surgical complications are not necessarily a result of medical negligence. However, when these do occur, giving an open clear explanation to the patient of the possible causes and consequences decreases the likelihood of complaints and claims.



DELAYED DIAGNOSIS

A patient repeatedly attends the surgery over a number of years, with persistent abdominal symptoms

Author: Dr Ellen Welch, GP



Mrs F, a 30-year-old housewife, visited her GP, Dr O, with a four-week history of diarrhoea. Dr O arranged a stool sample for microscopy and culture (which was negative) and prescribed codeine. Four months later, Mrs F was still having diarrhoea, especially after meals, and she had started to notice some weight loss. She returned to the surgery and this time saw Dr P, who examined her and found nothing remarkable, but decided to refer her to gastroenterology in view of her persistent symptoms.

Mrs F was seen four months later by the outpatient gastroenterology team, who attributed her symptoms to irritable bowel syndrome (IBS). She underwent a sigmoidoscopy which revealed no changes, and was diagnosed with functional bowel disease.

Four years later, Mrs F developed difficulty passing stools after the birth of her second child. She was referred to the colorectal team and underwent a further sigmoidoscopy, which revealed no abnormalities. She was referred for pelvis physiotherapy.

Two years later, Mrs F returned to her GP and consulted Dr G with the sensation of a lump in her rectum preventing her from defecating. She reported incomplete bowel emptying and the need to manually evacuate. She was referred back to the colorectal surgeons, who arranged a barium enema, which was reported as normal.

Three months later, Mrs F visited the practice again with a two-week history of diarrhoea and abdominal cramps. Dr B saw her on this occasion and diagnosed her with possible gastroenteritis. He arranged a stool culture, coeliac screen and routine bloods.

Mrs F returned a week later for follow-up with Dr Y, reporting ongoing diarrhoea with no rectal bleeding. Dr Y noted the recent normal barium enema and sigmoidoscopy and normal stool culture. The blood tests remained pending so Dr Y sent Mrs F to hospital to get them done. The results for the coeliac screen were normal.

Another three months later, Mrs F was still symptomatic and attended Dr P with diarrhoea and bloating. No abnormalities were found on abdominal and PR examination. Dr P diagnosed IBS and prescribed amitriptyline.

Over the next three weeks, frustrated at the lack of resolution of her symptoms, Mrs F had several GP appointments with Dr G, Dr P, Dr O, Dr B and Dr Y. She was referred for a colonoscopy and pelvic ultrasound – all of which were normal. She was re-referred to the colorectal surgeons and a family history of pancreatic insufficiency was discussed during the outpatient appointment. Faecal elastase confirmed pancreatic insufficiency and a CT of her abdomen revealed obstructing pancreatic duct calculi. She underwent ERCP and a Frey's procedure, which failed to resolve her symptoms and, at the time of the claim, Mrs F was considering a total pancreatectomy.

A claim was brought against Dr P, Dr Y and Dr O, for failing to take into account Mrs F's family history of chronic pancreatitis and arranging a specialist referral and follow-up investigations.

EXPERT OPINION

On the basis of the medical records and the evidence provided by the doctors involved, the GP expert was supportive of Dr P, Dr Y and Dr O. Given that Mrs F did not mention her family history of chronic pancreatitis, there was no reason to suspect pancreatic insufficiency as a cause for her symptoms. The claim subsequently discontinued.



Learning points

- Where patients are repeat attenders with ongoing symptoms, it is important to consider alternative causes for their symptoms.
- Careful documentation of consultations is imperative and greatly assists when defending claims.
- Where patients are repeat attenders, it is important to consider all past consultations, particularly if patients do not see the same practitioner each time, to ensure that continuity of care is not impacted.

ANTIBIOTIC ALLEGATIONS

A patient alleges her GP was negligent for failing to prescribe antibiotics

Author: Clare Devlin, medical claims adviser at Medical Protection

Miss G, 23, presented to GP Dr Q with a four-day history of fever, cough and green/brown phlegm. On examination, she was afebrile with no chest signs except expiratory wheeze.

Dr Q's clinical impression was of a viral infection. The clinical findings were supported by the fact that Miss G was on day four of a five-day course of amoxicillin, prescribed by her dentist, which had not produced an improvement in her symptoms.

Given the history and examination findings, Dr Q did not feel Miss G required a further course of antibiotics; in any event, Miss G was already receiving the correct antibiotic and course duration, as set out in the national guidelines for empirical cover of low risk community-acquired pneumonia.

Dr Q advised Miss G about viral infection, and performed appropriate safety-netting with instructions in the event of the symptoms worsening, new symptoms developing or a failure to improve.

Miss G did not re-present to Dr Q, but did see other doctors when her cough failed to improve, and she received further courses of antibiotics at this point. She later fractured a rib during a bout of coughing, but made a full recovery.

Miss G made a claim against Dr Q, alleging a failure to prescribe any or an adequate dosage of antibiotics to treat the symptoms of fever and productive cough. She also alleged there was a failure to advise against continuing amoxicillin, which allegedly had not been prescribed for Miss G's symptoms and which had only one more day left of the course, and finally alleged that her chronic cough led to her rib fracture.

EXPERT OPINION

In this case, Medical Protection was able to serve a robust response denying liability, based on our legal team's assessment and the quality of Dr Q's medical records, supplemented by a helpful detailed account provided by Dr Q.

This approach by Medical Protection enabled the claim to be dealt with rapidly, without the need to instruct an independent expert witness or generate expenditure on an expert report.

The response served by Medical Protection highlighted the appropriate history and examination performed by Dr Q and the lack of clinical indication for antibiotics. It also explained that Miss G was already on first-line empirical antibiotic treatment, started by another clinician for a different problem, and that advice to stop the course a day early would not have been appropriate because incomplete antibiotic courses promote the growing problem of antibiotic resistance.

Miss G's solicitors discontinued the claim after receiving the firm response from Medical Protection.

Learning points

- On being notified of a claim, members may be shocked and aggrieved to see allegations that are factually incorrect and may in addition be medically misconceived. In this case, we see contradictory allegations, where Dr Q is simultaneously being criticised for failing to stop an antibiotic and for failure to prescribe an antibiotic.
- Medical Protection is accustomed to allegations of this nature and takes care to address them fully, with a comprehensive rebuttal of all factual and clinical inaccuracies. In this we are greatly assisted by thorough accounts of incidents from our members, and especially quality documentation in the form of contemporaneous medical records.



A CASE OF MISTAKEN HAEMORRHOIDS

A patient presents with symptoms of haemorrhoids but is it something more sinister?

Author: Dr Emma Green, medical claims adviser at Medical Protection

Mr F, a 33-year-old policeman, attended his GP, Dr B, with a six-month history of abdominal pain and rectal bleeding. The abdominal pain had become more constant over the preceding few weeks and laxatives reportedly eased the pain; the pain had eased on the day of the consultation. The blood was bright red in the toilet bowl and on the stool and paper, there was no mucus in the stool and no family history of cancer. Dr B documented no weight loss or joint pains. A telephone consultation earlier the same day, with another GP, had referred to Mr F "straining" to pass his stool.

The examination revealed a soft abdomen with slight lower abdominal tenderness. There were no masses and no organomegaly, and a rectal examination revealed an empty rectum with no masses.

Given the age of the patient and the description of the blood, Dr B felt this was most likely haemorrhoids secondary to constipation, which was being eased by the laxatives. He advised further laxatives, blood tests to look for inflammatory bowel disease and for Mr F to return in four weeks, if no better.

Mr F did not attend for blood tests nor did he return to see Dr B. One year later he was admitted to hospital and diagnosed with metastatic colorectal cancer, from which he died within a year.

A claim was made against Dr B by Mr F's family, alleging he was negligent in diagnosing haemorrhoids when these were not visualised, instead of referring to secondary care for further assessment. It was alleged that these failures resulted in a 12-month delay in diagnosis and a nine-month reduction in life expectancy.

EXPERT OPINION

A GP expert considered that the history of straining with fresh red blood on defecation would be consistent with a diagnosis of haemorrhoids. The recorded history in the records was felt to be detailed enough to support Dr B and his logical reasoning that constipation was the most likely cause of the abdominal pain, the improvement with laxatives and the straining to pass stool. The blood tests and safety netting were also considered appropriate and it was felt there was no breach of duty. In addition, the expert was supportive of the diagnosis of haemorrhoids in the absence of visualisation, noting that haemorrhoids are frequently not palpated but diagnosed following a history consistent with them that lacks features suggesting something more sinister.

An expert oncologist instructed in the case did not support the claim that Mr F would have survived for a further nine months had the tumour been diagnosed earlier.

Medical Protection served a robust response denying both breach of duty and causation and the claim was discontinued against Dr B.

Learning points

- Record-keeping was the most important aspect in defending this case. Important positive findings and relevant negatives should be recorded to enable a clear logical reasoning to be followed.
- Rectal examination should always be performed in patients presenting with rectal bleeding. When a patient declines this examination, it should be clearly documented that they are aware of the implications this could have on diagnosis.
- Although uncommon, malignancy can be a cause of rectal bleeding in younger patient groups.



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A PAIN IN THE KNEE

An 11-year-old girl repeatedly attends her GP complaining of knee pain

Author: Dr Janet Page, medical claims adviser at Medical Protection

Miss F, an overweight 11-year-old, attended her GP, Dr A, complaining of knee pain and clicking for two months following a twisting injury whilst playing football.

Examination was unremarkable, with straight-leg raising to 90 degrees and a full range of movement in the knee. Dr A treated with simple analgesia and arranged for an x-ray of the knee the following week. The x-ray was normal and Miss F was advised to see her GP for review.

Miss F next attended the practice seven weeks later, when she was seen by Dr B. She was complaining of pain in the right groin, which was worse on walking or standing. Dr B recorded in her notes that it was “probably muscle strain or too much pressure on hip joint because of her weight”. She prescribed diclofenac.

Five days later, Miss F attended the emergency department (ED) at the local hospital complaining of a painful right hip with difficulty walking. A diagnosis of ligament sprain was made.

Two days later, Miss F again attended the practice and was seen by Dr C. Examination revealed reduced range of movement in the right hip. Dr C arranged a routine appointment for a hip x-ray for the following week.

The day before the appointment, Miss F attended the ED in severe pain. Hip movements, particularly flexion and internal rotation, were noted to be limited. The diagnosis of slipped femoral capital epiphysis was confirmed on x-ray and classified as “mild” (less than 30 degrees). Miss F subsequently underwent pinning of the epiphysis.

Over the course of the next few years, Miss F attended her GP and the hospital on multiple occasions, complaining of intermittent hip pain. Her weight continued to rise and at age 15 her BMI was 41.4. MRI of the hip three years later showed deformity of the right hip with a CAM abnormality (bony deformity of femoral head resulting in femoro-acetabular impingement) and degenerative changes. The features were reported as being consistent with an angle of displacement of 50 degrees (severe slippage).

A claim was brought against Dr A alone, alleging a failure to recognise or appreciate that pain in the knee could be referred pain from the hip, failure to examine the hip and failure to refer for x-ray of the hip. It was additionally alleged that, because of Dr A's failures, Miss F suffered premature osteoarthritis and was likely to require a primary hip replacement in her late 30s, and two further revisions in her lifetime.

EXPERT OPINION

Medical Protection sought opinion from a GP expert. The expert was critical of Dr A, stating that a reasonably competent general practitioner would know that a slipped upper femoral capital epiphysis is more common in adolescents who are overweight. He also opined that a reasonably competent GP being presented with an overweight adolescent complaining of knee pain should have been aware that this may have been referred pain from the hip. In these circumstances the GP should have carried out an examination of the hip and, if any abnormality had been found, should have considered the possibility of slipped upper femoral capital epiphysis and referred the claimant for an x-ray.

The expert said that there was also a failure by Dr A, and subsequently Dr B, to consider the diagnosis and to carry out an appropriate examination of the hip. For the same reason, the expert was also critical of the care provided by the ED doctors and of Dr C for failing to make an urgent referral to hospital the same day.

Based on the critical expert opinion, the case was deemed indefensible and was settled on behalf of Dr A for a moderate sum, with a contribution from Dr B and the hospital.



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Learning points

- SUFE is more common in obese adolescents (particularly boys) and may present following an acute, minor injury.
- Pain may be poorly localised. Pathology in the hip can present as referred pain to the knee; hence a full assessment of the joints on either side of the affected joint should be undertaken.
- There may be an associated limp with out-toeing of the affected limb.
- Diagnosis is confirmed on x-ray, which may require a “frog lateral” view for confirmation.

CAUGHT BY CONSENT

A private neurosurgeon faces questions regarding consent following a lumbar microdiscectomy sciatica and back pain

Author: Philip White, medical claims adviser at Medical Protection



Mrs P, a 40-year-old nurse, attended her GP complaining of back pain and was prescribed simple analgesia.

After a month, the pain was no better so she consulted a private neurosurgeon, Mr S, who advised conservative measures.

One month later, Mrs P phoned Mr S to tell him her back pain had not improved and that she now had left-sided sciatica. This was confirmed by her GP, who arranged an MRI scan, which showed the disc bulge responsible for it. Overall, her condition was worse and she had been off work for over a month.

As Mrs P now had sciatica, Mr S felt that a microdiscectomy was a reasonable approach. He discussed the options with her over the phone, and explained the operation and its pros and cons. Mr S did record the phone call in the medical records, but did not state exactly what was discussed. Mrs P was happy to proceed and so the operation was arranged. Mr S wrote a letter to the GP informing him of the plan.

Mr S next saw Mrs P on the day of the operation as she was brought in to be anaesthetised. He had a brief conversation with her, confirming that she was happy to go ahead and that she had no questions. She then signed the consent form, which listed none of the pros and cons of the operation.

The operation was straightforward and there were no observed complications. However, two months after the operation Mrs P felt that her pain was worse, and she had genital numbness and urinary symptoms. Her urodynamic investigations were normal but she was numb in the S3 dermatome.

Mrs P brought a claim against Mr S, alleging that he had taken inadequate consent and had not informed her that the operation could make her pain worse. She also alleged that the operation had been negligently performed, damaging the left L5 root and the S2 and S3 roots bilaterally.

EXPERT OPINION

Medical Protection sought expert opinion from a consultant neurosurgeon. The expert advised that although the consent form was inadequate, the overall consenting process, including the phone consultation and the brief discussion on the day of the operation, was just about acceptable.

The expert also opined that it was very unlikely that an experienced neurosurgeon, such as Mr S, would have damaged the nerves without noticing and recording it. He noted that there was no suggestion of nerve damage in the immediate post-operative period and suggested that deterioration occurring two months after the operation was more suggestive of a chronic pain syndrome.

The case was deemed defensible and taken to trial. The judge concluded that there had been no negligence during the operation, but that Mr S had taken inadequate consent. The ruling stated that Mrs P had not been warned of a 5% risk that the surgery could make her back pain worse and, if she had been, she would not have gone ahead. Mrs P was awarded a moderate sum.

Learning points

- Doctors must ensure that significant risks and risks of serious consequences even if the probability is low are disclosed to the patient.
- It is important to make a record of the consent discussion in the patient's notes.

COMPLICATIONS OF NITROFURANTOIN

A patient on long-term medication begins to feel short of breath

Author: Dr Anna Fox, GP



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Mrs D was a 70-year-old retired teacher who had struggled with recurrent UTIs. Urologists had advised her to take antibiotics in the long term as a prophylactic measure and advised alternating between trimethoprim and nitrofurantoin.

Sixteen months after commencing nitrofurantoin, Mrs D began to feel short of breath, especially when she was walking her dog. She was also feeling tired and generally unwell so she visited Dr W, her GP. Dr W documented a detailed history, noting that there was no orthopnoea, ankle swelling or palpitations. He also noted the absence of cough, wheeze or fever. Dr W referred back to a recent echocardiogram that was normal and mentioned that Mrs D was an ex-smoker. He conducted a thorough examination including satisfactory BP, pulse and oxygen saturation, and commented in the notes that Mrs D's chest had bilateral air entry with no crackles or wheeze and no dullness on percussion. Dr W stated that her heart sounds were normal and that there was no pitting oedema. He organised a CXR initially.

The CXR reported patchy peribronchial wall thickening and suggested a degree of heart failure. Dr W advised a trial of diuretics, which made no difference. Mrs D continued to feel short of breath and drained over the next few weeks. Gradually her breathlessness got worse and she noticed it even when she was sitting reading.

Four months later, Mrs D was admitted to hospital in respiratory failure. A high-resolution CT scan showed pulmonary fibrosis, with the likely diagnosis being subacute pneumonitis secondary to treatment with nitrofurantoin.

Within a month of withdrawal of nitrofurantoin she improved clinically, becoming less breathless, and her respiratory failure resolved. At a respiratory follow-up ten months later, she was found to be breathless after about 400 yards of walking and quite fatigued but able to do all her daily activities, including walking her dog.

Mrs D made a claim against Dr W. She alleged that he had failed to consider that the long-term use of nitrofurantoin may have caused her symptoms.

EXPERT OPINION

Medical Protection sought expert opinion from a clinical pharmacologist and a GP. The clinical pharmacologist referred to relevant guidance, which stated on nitrofurantoin: "Cautions: on long-term therapy, monitor liver function and monitor for pulmonary symptoms especially in the elderly (discontinue if deterioration in lung function)."

She commented that although the guidance states the need to monitor periodically, the exact definition of "periodically" is not given. In her view, it should have been every six months.

The expert GP said that many doctors would be unaware of the need for monitoring and that it was probably rarely done in practice. However, he accepted that when prescribing an unfamiliar drug, a GP would need to reference relevant guidance.

Medical Protection served a response rigorously defending Dr W's actions, pointing out that he had seen Mrs D early in her clinical course, had documented a very thorough history and examination and made a reasonable initial management plan. As a result of this, the case against Dr W was dropped. However, the practice partners, who were members of another medical defence organisation, faced a claim regarding the alleged lack of a practice system for monitoring for lung and liver complications in patients on long-term nitrofurantoin. This claim was settled with no contribution sought from Medical Protection.

Learning points

- Detailed contemporaneous notes assist in defending cases. GPs should document a thorough history and examination, including any negative findings.
- Medical Protection sees a number of claims regarding inadequate monitoring of long-term nitrofurantoin with patients developing hepatic or pulmonary complications. Many claims relate to inadequate practice systems for monitoring.
- Expert opinion sought on these claims advises that guidance for monitoring should be followed.
- To screen for hepatic complications, repeat prescribing of nitrofurantoin should generate liver function tests (LFTs), at least six monthly.
- To screen for pulmonary complications such as pulmonary fibrosis, doctors should advise patients starting on nitrofurantoin to attend urgently if they develop breathing problems. They could be reviewed for respiratory symptoms at the points of taking LFTs at least six monthly, with consideration of more frequent monitoring.

REPORTED ABUSE

Thank you for the latest edition of Casebook. It is always informative, if sobering. I have a comment about one case report: the “Reported abuse” case.

The training that I have received on safeguarding guides me to report incidences of alleged abuse to my local safeguarding team without undertaking investigation or corroboration myself. If the abuse is clear and actual, the report should be direct to the police, or local sexual assault centre (SARC).

The reason for this has been explained as being twofold. Firstly, the safeguarding team is multidisciplinary and is able to undertake a more comprehensive investigation that will be robust in the face of a cross-examination, should it come to that. Secondly, the safeguarding team is privy to a wide range of information, so even small additions may be important.

Notwithstanding the fact that Mrs X told her GP that she had reported the allegation to the police, in this circumstance, as a GP I would have also reported the allegation to my local safeguarding team, informing Mrs X of this action, of course. I should have expected the teacher and Dr B to have done the same thing. I would not have checked with the school myself.

The expert for Mr X reported that Dr B failed to corroborate the allegation with the school. My training would suggest that the expert was wrong in making that comment. Perhaps an example of an expert opining beyond her/his area of expertise as considered in “A complicated claim”.

Whilst this is slightly outside the case, and you do make a general comment about our duty to act in the third learning point, I feel it is important to emphasise the critical nature of collaborative and consistent team working when it comes to safeguarding. All the investigations into failed cases have come to that conclusion. It needs to be reiterated until it is a reflex action across all of health and social care.

Dr Michael Innes

Response



Thank you for your correspondence – we are always pleased to hear from readers and welcome your comments on this case.

Our case reports are taken from different countries around the world where we represent members, and so local practices and policies can differ. However, I agree entirely with your comments on the importance of collaboration and team-working in these cases, as well as liaison with the safeguarding team where appropriate, which are valuable learning points.

NO NEWS IS NOT ALWAYS GOOD NEWS

The article on missed hip dysplasia states that Dr R was alleged to have failed to ensure the report made it to clinic. May I be clear? Is this a system error or is there a duty for Dr R to have phoned the abnormal result?

Incidentally, I don't think it is great journalism to illustrate a case of hip dysplasia with a radiograph of a normal hip.

Dr Jules Dyer

Response



Thank you for your email regarding the case report “No news is not always good news”, in the latest edition of Casebook.

The allegation that Dr R (the radiologist) failed to ensure that the report made it safely to the clinic was an allegation brought by the claimant (the parents) in this case. The claim was investigated and the hospital accepted that there had been “a clear administrative error” that allowed the system to file the report without it being sent to the clinical team for action. It would be a matter for an expert radiologist to comment on whether Dr R should have phoned the result or taken any other action. This wasn't explored in this particular case given the hospital's acceptance that there had been an administrative error.

I note your comment on the radiograph used to illustrate the case report. The pictures we use in Casebook are for illustrative purposes only and are not intended to be actual representations of the individual cases, and I do hope it did not detract from your learning or enjoyment of this case.



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

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