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

The impact of the global recession continues to be felt in many jurisdictions where MPS operates and the consequences of rising costs in clinical negligence claims will be felt ever more keenly.

Although the medical profession can offer a financially rewarding career, no-one is immune to the kind of cost increases that cause a health practitioner to question the affordability of their medical indemnity. But increases in claims costs, together with an increase in the number of claims – which are continuing seemingly unabated, particularly in the UK, South Africa and Ireland – make this scenario more realistic.

Many members contact us in dismay that they seem to be feeling the hand of the regulator more often than ever before. We have attempted to identify the reasons why claims and complaints are on the rise – depersonalisation of the doctor–patient relationship, higher patient expectations, errors from working in high stress environments with stretched resources; these are all real issues that face each of you every day.

This is where we hope that Casebook has a part to play. No-one can stop all claims from occurring but we can help to highlight what you can do to ensure that you have a robust defence at your disposal.

I do hope that you find Casebook, and the other range of medicolegal publications that MPS produces, to be sufficiently supportive in these trying times. Please get in touch with any comments or suggestions; it is really helpful to receive your feedback.
It was a busy 2011 for MPS Education and Risk Management in Asia. We ran 124 Essential Risk Management Workshop Series events across Hong Kong, Malaysia and Singapore. There were close to 2,000 attendees at these events. This means we have held 336 workshops in the region, with a total attendance of more than 5,000, since the programme began in 2009.

Two new titles, Mastering Professional Interactions and Mastering Difficult Interactions with Patients, were added to the series, bringing the total number of titles to four. The workshops are presented by 16 doctors who practise in the region.

To mark the launch of Mastering Difficult Interactions with Patients, showcase events were held in Hong Kong and Singapore. MPS’s International Programme Director Mark O’Brien presented the workshops to representatives of professional associations, regulatory bodies, colleges, universities and hospitals. John Tiernan, Director of Educational Services, introduced the workshops and shared MPS’s education strategy with the guests.

For 2012, MPS will add a fifth title to the series, Mastering Shared Decision Making. Dates for the new workshop and the existing four workshops will soon be available. Visit www.medicalprotection.org to register your interest.

E-Learning – Members can now access online learning material in core medicolegal and risk management topics through MPS’s E-learning platform. Visit www.medicalprotection.org for more information.
News near you…

**CARIBBEAN AND BERMUDA**

MPS’s Dr Nancy Boodhoo and Al Neaber visited five countries in the region in October to meet with representatives of medical and dental associations, hospital boards and health services authorities.

In November, MPS Senior Consultant Dr Paul Nisselle presented risk management workshops focused on effective communication in conjunction with Cayman Islands Health Services Authority and the South Eastern and Western Regional Health Authorities in Jamaica.

**SOUTH AFRICA**

Chaired by MPS medicolegal consultants Dr Tony Behrman and Dr Liz Meyer, “Ethics for All”, the annual MPS ethics evening, was held in Pretoria (400 attendees) on Monday 21 November and in Cape Town (1,500 attendees) on Wednesday 30 November.

**SINGAPORE**

More than 150 doctors attended a lunchtime seminar on consent at Gleneagles Hospital in September. MPS Head of Medical Services (Asia) Dr Ming-Keng Teoh spoke on “Ethical and legal principles”, Edwin Tong from Allen & Gledhill spoke on “Recent SMC and High Court decisions” and MPS Medicolegal Adviser Dr Janet Page spoke on “Where to from here?”

Dr Teoh and Dr Page met with the new SMC President, Prof Tan Ser Kiat, to discuss recent SMC decisions on consent and better ways of working together.

**UK**

In September, MPS held the Making it Safer: Out of Hours and Unscheduled Primary Care conference, in Westminster, London. The conference attracted nearly 200 medical and clinical directors, chief executive officers, general practitioners, commissioners of out-of-hours (OOH) services and nurses. The packed programme included talks on: the role of the nurse practitioner; top tips on registering with the CQC; telephone triage; vicarious liability; and learning from adverse events.

**HONG KONG**

The second Hong Kong Expert Witness Training Programme, co-organised by MPS and HKMA, and supported by the HK Academy of Medicine, was held in September. The event was heavily oversubscribed, with more than 200 applications for 75 places. Topics included: the litigation process, clinical negligence, how to write a report, MPS claims handling ethos and what the courts wants from experts.

**MALAYSIA**

In November, Dr Ming-Keng Teoh delivered a lecture on medical protection and litigation in Penang. Dr Teoh spoke at the King Edward VII College of Medicine, University of Malaya’s annual alumni reunion.

**EVENT FOCUS – IRELAND**

Unravelling the myths of the consultant post

Fifty delegates attended the second Making the Most of Your Consultant Post conference for members in Ireland in November.

Held at Croke Park Stadium, Dublin, the event armed specialist registrars and newly-qualified consultants with the information they need to succeed in their current or future roles.

The day started with the presentation: “What to expect when you’re a consultant – everything you wanted to know, but were too afraid to ask” and included topics on the importance of open communication, human factors and system errors, and protecting your reputation – the MPS approach.

Professor James Lucey, Medical Director at St Patricks University Hospital and Clinical Professor of Psychiatry at Trinity College, Dublin, spoke on mental health and burn out in medical professionals.

Case studies and ethical dilemmas from the MPS caseload were studied as part of a round-table discussion, with feedback from an expert panel.

The day had some excellent feedback and we look forward to organising similar events for members in Ireland in 2012.

**HKAM – MPS Award for Patient Safety**

Dr Alexander Chiu has been named as the winner of the 2011 MPS – Hong Kong Academy of Medicine (HKAM) Award for Patient Safety. His paper, “Root Cause Analysis Improves Patient Safety: A descriptive study of Root Cause Analysis Framework applied to clinical incident investigation in a University Affiliated Hospital”, was awarded the highest total score by the judges. Dr Chiu was presented with a plaque and a cheque for HK$20,000.

The award aims to encourage medical professionals to promote patient safety and risk reduction. Dr Chiu presented his winning paper at the HKAM – MPS Seminar on Patient Safety on Friday 2 December.

**COUNTRY FOCUS – HONG KONG**

HKAM – MPS Award for Patient Safety

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Anger over human organs trade

An appeal to exonerate Malaysia of any involvement in the illegal practice of human organ trading has been lodged by a group of kidney doctors.

A joint report was made by Malaysian Society of Transplantation president Dr Harjit Singh, Malaysian Society of Nephrology president Dr Wong Hin Seng, and Consumer Association of Subang and Shah Alam (CASSA) president Jacob George.

It follows reports last September that Bangladeshi police are on the trail of an international organ trafficking syndicate, with Malaysia rumoured to be one of the countries implicated in the trade.

Police said that people from remote Bangladeshi villages had been flown to various locations in south-east Asia to have their kidneys harvested, being paid thousands of US dollars for doing so.

The Health Ministry said that it would work with police to investigate the claims.

Dr Singh said: “We should not allow Malaysia’s name to be defamed in such a manner. We do not have any evidence to show whether anyone (here) has ever done this.”

www.freemalaysiatoday.com
Why is effective communication with patients and colleagues so essential to managing risk for doctors? **Dr Jagdeesh Singh Dhaliwal**, MPS Manager and Senior Medical Educator for the Asia-Pacific region, offers some thoughts.

Casebook readers who have never attended any of our risk management workshops and master classes might ask themselves why MPS’s educational programmes focus so heavily on communication.

As doctors, we spend our professional lives seeking to finesse our clinical knowledge and our clinical skills. Fear of becoming “an out-of-date doctor”, coupled with a desire for excellence, probably sums up the strong psychological drivers for study and improvement shared by most members of our profession.

Thinking back to our experiences at medical school, many of us will no doubt remember how difficult it felt to be able to converse with patients and elicit a complete history during the early clinical years. However, we persist and follow through and as our knowledge and practical skills grow, so does our history-taking ability – and we start to become competent and confident as diagnosticians.

It can be a rude shock, therefore, to find oneself in a situation where a patient is unhappy despite an objectively correct diagnosis and an excellently executed surgical or medical management plan. “Why are they unhappy with me, when I did everything correctly?” “How dare they complain…” “I would understand if I had done something wrong… but a complaint when I did everything right is very unfair…”

A negative spiral can ensue where we either get angry at the patient and the family or sad or upset about the unfairness of a complaint that was not the result of a clinical mistake.

MPS’s claims data and international research consistently demonstrates the following: it is patient dissatisfaction with communication by their doctor that fuels the majority of complaints. Moore et al’s study into hospital complaints in Chile has demonstrated that patient dissatisfaction with communication with the doctor is the largest contributing factor leading to a complaint. From the other end of the globe, Hamasaki et al have explored the increasing trend of doctors’ explanations forming a pivotal point of medical malpractice litigation by patients in Japan. These studies build on earlier research from around the world, which emphasises the role of problematic communication as a key reason patients decide to sue following an adverse outcome.

And specifically, it is a failure on the part of doctors to communicate caring that lies at the heart of most patient dissatisfaction with their doctors.

For instance, Ambady et al’s interesting study found that (controlling for content), surgeons’ audiotaped voices that were independently assessed by two patients as...
demonstrating “high dominance over the patient” and “low concern/anxiety for the patient” correlated significantly with those surgeons who had previous claims. Beckman et al’s seminal paper looking at plaintiff depositions demonstrated an association between “perceived lack of caring and or collaboration” and patients’ decisions to litigate against their doctor. Chiu et al in Taiwan have found that a driving motivation for patients and their families for litigating is the emotional desire to achieve comfort or, in other words, a sense of “being cared for”.

Certainly, it seems, the research would point to poor communication and a lack of caring being instrumental in patients’ decisions to sue. But is the converse true? Is being a good communicator and demonstrating caring associated with less risk of sustaining patient complaints?

Amongst other studies, Moore et al have found that positive doctor communication behaviours increase patients’ perceptions of the competence of that doctor and decreases their intention to sue either the doctor or his or her hospital in the event of an adverse outcome. And a very interesting study by Hagihara et al has found that physician explanatory behaviours, including explaining and listening to families, is associated with a markedly lower probability of a court decision of negligent care by judges in Japan.

What might this mean for us as doctors? Perhaps this. That, as well as continuously perfecting our technical expertise in our particular specialty, continuously perfecting our communication and empathy skills is essential to cutting our risk. It is this combination of both technical and emotional performance that appears to single out the route to ongoing overall excellence as a doctor.

Communication skills workshops

MPS has developed a series of communication skills workshops. The following workshops are available:

1. Mastering Your Risk
2. Mastering Adverse Outcomes
3. Mastering Professional Interactions
4. Mastering Difficult Interactions with Patients

As an MPS member you can attend these workshops free of charge as a benefit of your membership. For more information, including forthcoming dates, locations and online booking, please visit: www.medicalprotection.org.

REFERENCES

Inside...Mastering Your Risk

Sara Williams reports from Mastering Your Risk, a workshop from MPS Education and Risk Management that is available to MPS members in Malaysia, Singapore and Hong Kong

What motivates patients to take action against their doctor? For most people, it is because they are dissatisfied with how their doctor has treated them. Studies have shown that most people have already chosen to take action before their doctor has even made an error. Evidence suggests that the likelihood of receiving complaints and claims may be reduced through effective communication.

Background
Up until the early 1990s there was a simplistic view about preventing risk: if doctors were technically good they would be low risk. This is not true. Several studies turned this on its head by revealing that only 2-3% of patients who suffered negligence actually sued their doctor, and 70% of litigation is related to poor communication after an adverse event.

On the back of this research MPS launched a series of risk management workshops to teach doctors how to prevent complaints and claims by improving their interactions with patients and colleagues.

I recently had the pleasure of attending the first workshop in this series: Mastering your Risk.

Inside Mastering Your Risk
Dr Ruth Livingstone, the MPS facilitator for the day, brings with her 30 years’ experience working as a GP. She kicked off the first half of the three-hour workshop by exploring why patients sue their doctors. Interactive discussion ensued as the delegates heard real comments from patients about why they sued their doctors. The role of communication was debated as the delegates watched a video depicting a very poor consultation.

Lively debate dominated the latter part of the workshop, as the delegates learned how they can improve their interactions with patients and put their new-found knowledge into practice on each other.

After a final session on risk-reduction strategies for medical teams, Dr Livingstone ended the workshop on a positive note, reminding delegates that by adopting a range of simple communication skills, their risk of being sued or complained about can be reduced. Her take-home message for delegates was simple: “People are reluctant to sue someone they like.”

MEMBER COMMENTS

Don’t take our word for it; here are some comments from workshop attendees:

“The workshop was easy to grasp; it was very relevant to my day-to-day practice. I found it useful identifying risks from different angles – not just mine but the patient’s too. Learning how to address risks and reduce them makes a lot of sense, particularly for a junior doctor. My take-home message is to attend another workshop, as they are so interactive, practical and relevant.”

Dr Yi-Yang Ng, GP in training

“This workshop has made me realise how important it is to create a good first impression. I’m going to change my opening lines in the future and use what the session has taught me in practice.”

Dr Florian Ruths, cognitive therapist and consultant psychiatrist

“Mastering Your Risk” is the first in a series of communication skills workshops provided by MPS. Other workshops currently available in the series are “Mastering Difficult Interactions with Patients”, “Mastering Adverse Outcomes” and “Mastering Professional Interactions”. Attendance at these workshops is free to all MPS members. For more information, including forthcoming dates, venues and online booking, please visit: www.medicalprotection.org and click on the Education tab.
The exercise of clinical judgment is a fundamental part of a doctor’s everyday practice. From time to time that judgment will be questioned, either by patients or their relatives or, occasionally, fellow professionals, and the doctor may be called upon to justify his actions either before the Medical Council or in response to a clinical negligence claim. What, then, is the doctor’s position when it is the acts or omissions of his staff that are under scrutiny?

Vicarious liability
As an employer, you are vicariously liable in the event of a claim arising out of the acts or omissions of your employees. These include not only administrative staff but also clinical staff; for example, nurses or dispensers. Clinical staff are, however, also independently accountable for their own professional judgment and actions. For this reason it is recommended that they hold their own professional indemnity and do not rely on the vicarious liability of their employers. Investigation of nurses by their regulatory body, for example, will not be covered by employers’ vicarious liability.

The doctor’s responsibilities
When taking on a new member of staff, the doctor is responsible for checking the qualifications and credentials of the prospective employee and his or her suitability for the post. In Hong Kong, doctors who employ or otherwise contract with other healthcare professionals – for example, laboratory technicians, optometrists, physiotherapists or radiographers – are responsible for ensuring the employee in question is appropriately registered. It is an offence for a doctor to employ another healthcare professional who is not so registered.1

New staff should undergo a period of induction to familiarise themselves with the working environment, workplace policies and procedures and, where appropriate, clinical protocols in place that they will be expected to comply with. This will reduce the risk of untoward incidents, many of which are due to unfamiliarity with appropriate procedures.

Delegation
A doctor may delegate a clinical task to a member of staff who has the appropriate skills and qualifications to carry out that task. The doctor is accountable for the appropriateness of the decision to delegate, but the staff member remains professionally accountable for his or her actions when carrying out the delegated task.

Case scenario
During a busy clinic, Dr A asks his clinic nurse to administer routine DPT first booster vaccine to an 18-month-old child. The nurse inadvertently administers MMR, which had been drawn up for another patient. The mother is unhappy as she did not want her child to have the MMR vaccine and sues the clinic. Dr A’s decision to delegate this task to his nurse is acceptable as she had the necessary qualifications and experience to do this. Hence any potential claim against Dr A for inappropriate delegation would be defensible. On the other hand, Nurse B’s actions in administering the wrong vaccine on this occasion are indefensible and below the standard one would expect from a competent nurse. Nurse B would therefore be liable in the event of a claim in negligence against her. As her employer, Dr A could also be held vicariously liable for Nurse B’s error. In this event, it is likely that Dr A’s medical defence organisation would seek an indemnity from Nurse B’s insurer as Dr A’s own indemnity would not cover the acts or omissions of a member of his clinical staff.

The Singapore Medical Council (SMC) places a professional obligation on the delegating doctor to exercise effective supervision over any member of staff to whom a task is delegated and who is not a registered medical

LEARNING POINTS
- Doctors are vicariously liable for the actions or omissions of their employees
- A doctor’s professional indemnity may not cover vicarious liability for clinical staff
- Doctors may delegate tasks to others, provided they are satisfied the delegee has the appropriate skills to carry out the task
- When delegating to non-medical staff, the doctor is responsible for effective supervision of the delegee as part of a recognised training programme.
practitioner. The delegated task must be undertaken as part of a legitimate training programme.2 The Medical Council of Hong Kong (MCHK) makes similar provisions.3

Doctors in Singapore providing cosmetic and aesthetic services should be aware that the Guidelines on Aesthetic Practices for Doctors 2008 set out requirements for the minimum level of competence “to carry out the procedure and manage the anticipated serious complications” for List A and List B procedures. In consequence, as a minimum, only registered medical practitioners holding an appropriate Certificate of Competence are entitled to carry out these procedures which may not, therefore, be delegated to non-medically qualified staff members.4

Indemnity
It is the doctor’s responsibility to ensure that all staff members employed by him are appropriately indemnified. Although as an employer you may be held vicariously liable for the acts or omissions of your employees, it does not follow that this will be covered by your own professional indemnity. As a general rule, MPS subscriptions are set to reflect the liability of the individual member and, with the exception of administrative staff, do not extend to cover employees. It is important, therefore, that separate arrangements are made to indemnify clinical staff.

If in doubt, members are encouraged to contact the MPS membership department for further advice. If you contract with other professionals who are not your employees to provide services, it is recommended that you make it a contractual condition that the healthcare professional holds appropriate indemnity and that you check this carefully to ensure it meets your needs.

Case scenario
Mr C is on warfarin for atrial fibrillation. He attends clinic for a routine INR blood test, which is carried out by the nurse. Unfortunately, when the result is received the next day, although marked as abnormal, it is filed away by a new receptionist who fails to bring it to the attention of Dr D or his nurse. Mr C is subsequently admitted to hospital with a cerebral haemorrhage following a minor fall, which is attributed to the raised INR. Mr C’s family sue Dr D, who is vicariously liable for the actions of his administrative staff. The claim is settled by Dr D’s medical defence organisation.

Public liability insurance
In addition to professional indemnity, it is important to remember that you will also require public liability insurance for your clinic, to protect you against claims for injury other than a result of clinical negligence sustained on your premises – for example, if a patient or visitor slips on a wet floor. This can be arranged through any commercial insurer.

Although as an employer you may be held vicariously liable for the acts or omissions of your employees, it does not follow that this will be covered by your own professional indemnity

REFERENCES
1. Medical Council of Hong Kong, Code of Professional Conduct 2009, para 21.2 (Schedule of the Supplementary Medical Professions Ordinance (Cap 359))
2. SMC, Ethical Code and Ethical Guidelines 2002 para 4.1.1.4
3. MCHK, Code of Professional Conduct 2009 para 21.1
4. Guidelines on Aesthetic Practices for Doctors (issued jointly by SMC, Academy of Medicine, Singapore and College of Family Physicians, Singapore) (October 2008)
Your medicolegal team in Malaysia, Singapore and Hong Kong

MPS has a large team of medicolegal advisers, claims handlers and membership advisers that are dedicated to providing you with guidance and expertise. Over the next few issues of Casebook, we will be showcasing the individuals involved, continuing with the three members of the medicolegal adviser team.

Dr Marika Davies
MA BS MBBS MRCS (Eng) MFFLM
MPS Medicolegal Adviser

Marika graduated from University College London Medical School in 1999 with MBBS and a BSc (Hons) in the History of Medicine. She completed her basic surgical training in London and in 2003 became a member of the Royal College of Surgeons of England. After a stint as medical officer to an expedition in the Philippines she joined MPS as a medicolegal adviser in October 2003 and has been assisting doctors in Hong Kong since then. Marika completed an MA in Medical Law and Ethics with merit at Kings College London in 2006 and has maintained an interest in ethical issues. Marika is enthusiastic about her role supporting and advising doctors in Hong Kong and the UK and also enjoys writing articles on medicolegal issues for medical publications.

Dr John Barker
JP MBBS MRCS LRCP D Oste DMJ FFFLM ACII
MPS Consultant Medicolegal Adviser

Dr John Barker has been around a few years! A sound grammar school education enabled him to embark on his working career with an insurance company before being summoned to serve Her Majesty in the Royal Air Force. Released from national servitude, he became a medical student at Guys Hospital, graduating MBBS in 1961. He practised as a GP in Essex before being appointed a Justice of the Peace and Coroner for the Eastern District of Greater London in 1969. Invited to become a member of the MPS Cases Committee in 1970, he was subsequently elected to its Council, later joining its permanent medical secretariat. Having “retired” as Deputy Medical Director in 1997, he was asked (subject to satisfactory annual appraisals) to remain with MPS as a Consultant Medicolegal Adviser. He is also a Foundation Fellow of the Faculty of Forensic and Legal Medicine.

Dr Julian Pedley
MBBS DTM&H DTPH MSc MA (Med Law & Ethics) FFPHM FFFLM
MPS Consultant Medicolegal Adviser

Dr Julian Pedley was born and brought up in China and India. He trained at Middlesex Hospital Medical School (as did his father and grandfather before him) and undertook postgraduate training in London, Oxford and Buckinghamshire. For a number of years he worked in Nepal, the West Indies and Southern Africa doing general practice and public health work. He also spent several months working in Indonesia (Banda Aceh) 1981-2. Julian has specialist qualifications and interest in Public Health and Tropical Medicine; he was the first Director of Public Health and Chief Executive of the Milton Keynes Health Authority; where he worked for 14 years before joining MPS as a Medicolegal Adviser in 1996. He studied Medical law and Ethics at Kings College, London 1996-8. Until recently Julian was the longstanding Chairman of Willen Hospice in Milton Keynes, as well as chairing a small international charity, Hope Outreach, supporting medical, agricultural and welfare projects in Sri Lanka and South India. He has been married to Ella from the Black Forest region of Germany for 40 years, and they have two children – one a lawyer and the other the proprietor of a tourist lodge in Queenstown, New Zealand (make your bookings through Julian!). Julian and Ella have newly become grandparents but cannot yet offer an advisory service on this important aspect of life!
On the case

Dr Ming-Keng Teoh, Head of Medical Services (Asia), introduces this issue’s round-up of case reports

In “Too quick to clear the spine” on page 14, the multiple injuries Miss T suffered in a road traffic accident made it difficult to localise the pain to her neck. As a result of the other distracting injuries, A&E consultant Dr W missed the C6 fracture and removed Miss T’s spinal collar. A detailed record of the severity of the accident might have alerted Dr W to the potential for severe spinal injury. In this case, the two junior orthopaedic doctors did not challenge Dr W’s diagnosis that Miss T’s c-spine had been cleared, despite the paraesthesia in all her limbs. Clinical decisions which appear irrational should be challenged, even those of senior colleagues.

Similarly, you should always be prepared to revisit your own diagnosis, should symptoms persist. Dr G, in “Double problem, double risk” on page 20, was distracted by Mr E’s multiple complaints and did not reconsider his initial diagnosis. The five-month delay in the diagnosis of squamous cell carcinoma of the tonsil meant that the case could not be defended. In “Too many records spoil the notes” on page 15, ophthalmology consultant Mrs C failed to diagnose Mr M’s glaucoma, despite there being recurrent abnormalities in his vision and a family history of glaucoma. Listening to the patient is imperative; have an open, unbiased mind at each consultation and consider a second opinion if you are unable to account for a patient’s symptoms or clinical signs. Inaccurate record-keeping and retrospective amendments to the patient’s records made this case indefensible.

Conversely, accurate record-keeping can help to build a successful defence against a claim. We often receive feedback from members asking us to feature more successfully defended case reports; “Right patient, wrong sample” on page 17 and “More than a bruise” on page 18 are such examples. In “More than a bruise”, none of the doctors involved were found to be in breach of their duties, despite Mr U’s sudden and unexpected death. Records clearly showed the careful management of his condition, examination, and documentation of symptoms. Had the records not been comprehensive, there could have been reasonable doubt that there were missed symptoms or signs.

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CASE REPORTS

Casebook publishes medicolegal reports as an educational aid to MPS members and to act as a risk management tool. The reports are based on issues arising in MPS cases from around the world. Unless otherwise stated, facts have been altered to preserve confidentiality.

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
Twenty-eight-year-old Miss T was a pillion passenger on her boyfriend’s motorbike going at high speed on a motorway. He lost control of the vehicle and tried to regain it by braking, which threw them both onto the road, landing some distance away. Unfortunately, Miss T’s boyfriend was certified dead at the scene of the accident.

The paramedics who dealt with Miss T removed her helmet, following appropriate guidelines, and then immobilised her neck with a rigid collar and head blocks. She was then moved on a long spinal board and rushed to the local emergency department (ED).

Dr W was the consultant in charge and was already expecting Miss T in the resuscitation room, where he took a brief handover from the ambulance crew. Miss T was fully conscious on arrival with a GCS of 15/15 and was hemodynamically stable. Dr W performed a primary survey and then requested a series of trauma x-rays, including c-spine, pelvis and thorax. On a full secondary survey, Dr W suspected fractures of left clavicle, left wrist, right hand and left tibia and fibula, which were all confirmed soon after by x-rays.

Dr W removed the collar and felt for tenderness in Miss T’s cervical spine processes, but Miss T said that it was not painful; neurological examination was also normal. The cervical spine x-ray only showed down to the top of C6 but didn’t show any fractures so Dr W removed the collar and wrote in his notes: “C-spine cleared”.

The orthopaedic team took over Miss T’s care and she was then moved to theatre for surgical management of her fractured tibia and manipulation of her wrist. When she was still in the recovery room following surgery, Miss T mentioned that she had some tingling in her legs and that her legs felt heavy and weak. This was documented in the nursing notes but was not acted upon.

Once she was moved to the orthopaedic ward, Miss T continued to complain about paraesthesias in all her limbs; she also mentioned that her head felt unstable as if “it was falling backwards”. She also had a long episode of hypotension that did not respond to fluids. Two different orthopaedic junior doctors made entries in her clinical notes about this and they both commented that Miss T’s c-spine had been cleared earlier on by the ED consultant. They both felt that the symptoms could be related to the multiple limb fractures.

Three days after the accident, the orthopaedic consultant in charge requested a c-spine CT during the ward round since Miss T continued to mention that her limbs felt weak and numb. The CT was done but it was not reviewed by the radiologist until the following morning, when he immediately acted upon it and contacted the orthopaedic team; it was finally confirmed that Miss T had a displaced fracture of C6. Unfortunately, the final outcome was not good and Miss T was left tetraplegic.

She made a claim against all the doctors involved in her care and following expert review it became obvious that the case could not be defended. The case was settled for a high sum.

ML

**LEARNING POINTS**

- In severe trauma cases, getting a detailed history and an accurate description from the paramedics is always a good start. The presence of fatally injured victims in the same accident is an indicator of the severity of the trauma sustained by survivors. The kind of vehicles involved, approximate speed, description of surroundings, distance between motorbike and victims, description of witnesses and so on will give you invaluable information.

- Distracting injuries make clinical evaluation of the cervical spine less useful and sometimes completely unreliable. Localising the pain to the neck becomes far more difficult when there is severe pain in other areas of the body, particularly the torso. In most cases of major trauma an adequate three view cervical spine plain film series will be necessary. When clinical assessment is complicated by multiple injuries or mental obtundation, or the plain films are inadequate, further imaging should be considered.

- Most trauma centres would consider doing a full trauma CT scan from the head to pelvis. You should check the adequacy of cervical spine x-rays and make sure that they are reliable; in this case you should ensure that the cervical spine down to C7 has been visualised.

- Relying on the diagnosis of other colleagues when there are worrying symptoms could result in a missed or delayed diagnosis. Diagnosis is a dynamic process and, when necessary, previous clinical impressions by other colleagues need to be challenged, even those of senior colleagues by more junior doctors.

- When patients do not respond as expected, the situation needs reviewing. A hypotensive trauma patient not responding to fluids might be suffering with neurogenic shock, secondary to spinal injury, but unless it is thought about, the diagnosis will remain missed.

- It is important to ensure that all investigations are followed up – remember your responsibilities when you are part of a multidisciplinary team. Ensure that there is continuity of care.
Too many records spoil the notes

Mr M, a 51-year-old primary school teacher, was referred to ophthalmologist Mrs C, following a letter sent by an optometrist to his GP. The optometrist had found Mr M to have an abnormal right optic disc, slightly raised intraocular pressures and significant defects in the visual fields of his right eye with suspected glaucoma. Mrs C reassured the patient that the static visual field defect in the right eye was as a result of an optic disc pit and that there were no signs indicating glaucoma at that time.

Mr M then became a patient of Mrs C when he noted a deterioration in his vision. He followed him up for five years. During this period, Mr M consulted Mrs C regularly. She examined him clinically, took intraocular pressure measurements, made optic disc assessments and performed a number of investigations including serial automated visual fields tests. Mr M expressed concern about the progressive deterioration of his vision. His paternal grandmother went blind due to glaucoma and his father was on treatment for glaucoma. Mrs C did not offer an explanation for the progressive deterioration of his sight. She did not offer a referral for a second opinion or referral to a specialist. Mr M relocated to a new town with his job and was seen by a different ophthalmologist, who found abnormalities consistent with advanced glaucoma in both eyes and significant visual field loss. Mr M was registered partially sighted and lost his driving licence. He underwent rehabilitation at work and was unable to work without the use of low vision aids.

Mr M made a claim against Mrs C. The case notes submitted by Mrs C had recorded normal examinations, which included normal pressures and normal optic discs. However, during the investigation of the case, it transpired that the documentation presented by Mrs C as her clinical notes regarding her patient were actually retyped “summaries” of the original notes. It was found that the original notes recorded the finding of physiological disc cupping with no mention of a disc pit – yet Mrs C had failed to record the cup-disc ratios, which could have helped to monitor deterioration in the health of the discs and to ultimately diagnose Mr M’s glaucoma. It was obvious that the reproduced “summaries” – which neglected to mention the finding of physiological cupping – was an attempt to disguise the original failure to diagnose.

Expert opinion concluded that the vast majority of peers would agree that Mr M was at risk of glaucoma and that he needed to be carefully monitored with detailed recording of the state of the optic discs, and that he had signs consistent with glaucoma when he was first referred to Mrs C. They would have offered treatment for glaucoma and a referral to a glaucoma specialist for further care.

The case was settled for a high sum considering the permanent and severe nature of the damage to vision.

AK

LEARNING POINTS

■ Doctors failing to make the care of the patient their first concern put themselves at the risk of both disciplinary action and medicolegal claims.
■ Early glaucoma is, unfortunately, a diagnosis that is frequently missed. All doctors are responsible for keeping up-to-date with professional knowledge, knowing their limitations and working with colleagues to provide the best level of care for their patients.
■ Listening to the patient and responding to their concerns is vital, not just for making an accurate diagnosis but also for establishing rapport and trust. Be prepared to reconsider a diagnosis that was eliminated on an earlier visit by having an open, unbiased mind at each consultation. Consider getting a second opinion if you are unable to account for a patient’s symptoms or clinical signs.
■ Medical notes have to be considered not only as medical documents but also as legal documents.
■ Disclosure of authentic, original clinical notes is essential when a claim is brought. Failure to do so can make a claim indefensible.

Passing off rewritten records as contemporaneous is a criminal offence and any retrospective change has to be clearly marked, dated and signed, and a reason for the change should be documented. Altering existing medical records, removing records, or adding false records puts a doctor at the risk of referral to a regulatory body for dishonesty.
Mrs T, a 40-year-old secretary, was overjoyed to find herself pregnant for the first time. Unfortunately, a detailed antenatal congenital anomaly scan identified that her baby had a severe congenital heart defect. The pregnancy was closely monitored by the regional cardiology team. Baby T was born in the regional teaching hospital, and first stage cardiac surgery was carried out in the first week of life. Baby T recovered well from this initial surgery. Despite very slow weight gain and some feeding difficulties, she made good developmental progress. Her cardiac function was closely monitored, and definitive surgery was planned for 18 months of age.

One Friday just before her first birthday, baby T became increasingly breathless and hypotensive. Dr Q electively intubated her and proceeded to insert a right femoral catheter to enable intra-arterial blood pressure monitoring. Two hours later, Dr Q reviewed baby T. He noted that the right foot was cold and poorly perfused. Dr Q elected to remove the right femoral artery catheter. Invasive blood pressure monitoring was still clinically indicated, and he therefore sited a catheter in the left posterior tibial artery. Dr Q recorded in the infant’s notes that the right foot was “slightly warmer but the general perfusion still poor”. Before leaving the unit for the weekend Dr Q asked the nurse looking after baby T to “keep an eye on that leg.”

Over the next 24 hours, baby T responded to medical management of her dysrhythmia. However, on the Sunday morning ward round, she was fully examined for the first time since admission. Her right foot was noticed to be mottled and very cold. An urgent ultrasound demonstrated thrombosis of the right femoral artery. The vascular team was contacted. Due to the delay in presentation, medical management with thrombolitics was deemed to be inappropriate. An embolectomy and fasciotomy were performed urgently but unfortunately were not successful. The limb was non-viable, and baby T required a below knee right leg amputation.

While nursing observations had recorded the look and temperature of the left leg throughout her stay on the PICU, no observations had been made on the right leg for over 24 hours. The medical records did not indicate that any specific examination of the right leg had been made by the junior doctor covering the unit for the weekend. There was no record of a formal handover from Dr Q to his consultant colleague covering the unit for the weekend.

A claim was made against Dr Q. Expert opinion was that Dr Q should have left specific instructions for the nursing staff to check on the right leg in addition to the left. The claim was settled for a high sum.

**LEARNING POINTS**

- Iatrogenic vascular thrombosis is a well-recognised complication of arterial catheterisation. The risk is particularly high in infants below two years of age. Where intra-arterial catheters are used for blood pressure monitoring, clear local guidelines should be in place for monitoring the insertion site and the limb distal to the insertion of the catheter for signs of potential vascular compromise. This includes a cold, pale limb with a prolonged capillary refill time and reduced or absent pulses. Arterial occlusion can quickly progress to gangrene.

- When delegating to a colleague you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved.

- It is inappropriate to assume that nurses will anticipate complications of a medical procedure, or to understand the significance of a clinical sign. Where any additional nursing observations are to be undertaken, this should be clearly and explicitly stated. Clear instructions and a good handover are essential.

- In relation to medical negligence claims, good documentation makes the difference. “If it’s not in the notes it didn’t happen” is an aphorism worth remembering.
Mr Q, a 23-year-old student, was admitted to hospital as a surgical emergency with an acute abdomen. A provisional diagnosis of acute appendicitis was made and Mr S, consultant surgeon, performed a laparoscopic procedure. The findings at the time of surgery revealed a normal appendix, which was removed. Mr S undertook a thorough inspection of the rest of the abdominal contents and discovered a small perforation of the body of the stomach with thickening of the surrounding tissue and localised contamination. A biopsy of the perforation site was taken and sent to the pathology laboratory for frozen section analysis by consultant pathologist Dr F.

Dr F called the operating theatre a short time later to discuss the biopsy result, which appeared to demonstrate an undifferentiated malignant tumour. Both Mr S and Dr F considered this to be highly unusual, particularly in view of Mr Q’s age. Dr F was confident in the accuracy of his initial assessment of the specimen, but felt that further histopathological analysis and stains together with a second opinion from colleagues in his department would be helpful. Following this discussion, Mr S decided at this point simply to close the perforation with an omental patch, wash out the contaminated fluid and await further assessment of the biopsy.

Postoperatively, Mr Q made a straightforward recovery. Mr S requested a CT scan that did not reveal any other disease and only demonstrated some gastric wall thickening at the site of the perforation. After further histopathology tests, the final opinion of Dr F and his colleagues was that the initial diagnosis of an undifferentiated malignant tumour was correct. Following careful discussion between Mr S and the patient, Mr Q underwent a total gastrectomy three days after the initial biopsy. Again, Mr Q made an uneventful recovery. The final pathology report from the resected specimen proved to be a normal stomach with no features of malignancy.

On the grounds that his major surgery had been unnecessary, Mr Q made a claim against the doctors involved in his care. The hospital initiated an internal investigation and it became apparent that there had been an error in the pathology laboratory. The frozen section specimen taken from Mr Q had been mislabelled in the pathology department and actually belonged to another patient who had had surgery some hours earlier. The correct specimen taken from Mr Q was entirely benign.

The case was defended successfully on behalf of the member, Mr S. An investigation by the regulatory body (to whom the clinicians involved had been reported) also exonerated Mr S and Dr F. A separate claim against the hospital did, however, result in a substantial settlement for the claimant on the basis of errors in the pathology labelling processes. This is a genuine case and was reported in the media.

LEARNING POINTS

- Many doctors will have a claim made against them during their professional lives. Even when some mistakes occur because of system failures, it is the doctors who may initially be investigated. In this situation the clinicians did go to extra lengths to check the veracity of the pathology report before acting upon it, but were ultimately let down by problems with the hospital’s systems for labelling pathology specimens.
- Misidentification of pathology specimens occurs every year in even the most developed healthcare systems. This can potentially lead to both inappropriate treatment and also delays or false reassurance in the management of unreported conditions. Despite technological advances and improvements in quality control of system processes, clinicians should always be alert to the possibility of a misidentification error when an unexpected result appears.
- Additional opinions from colleagues and further biopsy material can help confirm or refute an unexpected pathology result and prompt investigation into any mistakes in labelling or specimen identification that may have occurred.
- In the case described, it is likely that a wider group of clinicians would have suggested additional biopsy material from an endoscopy and a laboratory check on the identity of the specimen, prior to proceeding with such radical treatment in a very young man.
Mr U, a healthy 30-year-old taxi driver, was on duty when he suffered a minor road traffic accident. He was sitting at the wheel of his car at a red light, when a car hit him from behind. Mr U was wearing a seat belt, and the collision caused the seat belt to impact on his chest, which caused an abrasion and bruising. There was no damage to the other cars involved and Mr U felt no subsequent pain so, after exchanging insurance details, he continued his day as usual.

The following day, Mr U awoke with pains in his shoulder and the upper part of his chest, where the seat belt had restrained him. The pain did not have any worrying features and was very non-specific, but his wife prompted him to visit the local emergency department (ED). On arrival Mr U had his heart rate and blood pressure checked. They were within normal limits; he was then examined fully by Dr F, a junior doctor. Dr F documented that there were no obvious abnormalities, and the chest examination was normal. As the pain seemed severe, he requested a chest x-ray, and no abnormalities were detected. Dr F reassured Mr U that he had a minor chest contusion, probably caused by the seat belt, and that it would settle down without any further problems. He also advised Mr U to take ibuprofen regularly for the next couple of days.

During the next five days, Mr U attended his GP surgery with increasing pain to the traumatised area. Mr U was seen by three different doctors. At every visit he was fully examined and his temperature, oxygen saturation and HR/BP were recorded. In spite of the severe pain, there appeared to be no change in Mr U’s condition. There were no bruises, no crepitus and the breath sounds were normal. The entries on Mr U’s records by all the doctors involved were clear and detailed. Each doctor added a painkiller of increased strength in an attempt to make him more comfortable. All doctors agreed that it was a musculoskeletal pain caused by the contusion.

Six days after the accident, Mr U felt dizzy and looked very unwell. His wife drove him to the ED. On arrival he was hypotensive and tachycardic, his oxygen saturation was low and he was feverish. Mr U was seen again by Dr F, who found on examination a large bruise on his chest. Dr F immediately started treatment with fluids and antibiotics, but as he was waiting for the blood results the bruised area seemed to grow larger than an hour earlier. Suspecting necrotising fasciitis, he called the ICU team, where Mr U was admitted. Mr U was taken to theatre for debridement, but unfortunately he rapidly deteriorated and died from the necrotising fasciitis two days later.

Mr U’s widow made a claim against all the doctors who saw her husband following the accident. The experts reviewed all the medical records and gave supportive evidence, so the decision was made to defend the case, since it was felt that the management had been correct and none of the doctors were in breach of their duties. The case was successfully defended.

**LEARNING POINTS**

- Sudden and unexpected death will leave questions behind that may affect the perceptions of the bereaved. Good quality records are invaluable in demonstrating that care was of the appropriate standard and reasonable in the circumstances.
- Claims and complaints can and will happen in spite of doctors doing their jobs properly.
- It is always safe practice to treat each patient as if they are being seen for the first time. Diagnoses made by colleagues can lead to a false sense of security and a repeat of the wrong diagnosis.
- In this particular case, each doctor examined the patient and documented it; had this not been the case, there could have been reasonable doubt that there were symptoms or signs missed.
- Beware of pain that is out of keeping with the clinical findings.
- Do not be afraid to go back and rethink the initial diagnosis (whether made by you or somebody else), in light of any new evidence or if the condition is not resolving or behaving in the way you thought it would.
- Necrotising fasciitis is not a common condition, but is still a life threatening one. Useful advice can be found at: http://emedicine.medscape.com/article/1348047-overview#aw2aab6b3; Dr S Hasham, Necrotising fasciitis, BMJ (2005; 330:1143) – www.bmj.com/content/330/7495/830.full
Mrs W, a 42-year-old staff nurse, had long-standing poorly-controlled diabetes. While shopping at the weekend, she twisted her right ankle stepping off a kerb to avoid a push chair, and it became swollen and mildly painful.

The following Monday, she asked one of the doctors on the ward where she worked to “have a quick look at it”. Dr J examined the ankle in the ward office and diagnosed sprained ligaments. Dr J did not document this brief consultation.

Forty-eight hours later, the swelling had not improved so Mrs W asked Dr J to have another look at her ankle and he sent for a plain ankle x-ray. Dr J reviewed the film and reassured Mrs W that there was no fracture, insisting she attend a routine outpatient appointment.

Three weeks later, Mr N assessed Mrs W in an outpatient clinic, studied her x-ray, and sent her for ankle-brachial pressure indices (ABPs) and an arterial duplex ultrasound of the lower limbs. Following a further appointment, with the investigations not revealing any significant macrovascular insufficiency, Mr N then referred Mrs W for an outpatient orthopaedic opinion. Almost three months following the initial injury, Mrs W was assessed by Mr B, an orthopaedic surgeon, who diagnosed a total midtarsal and hind-foot Charcot collapse with poor prognosis.

Mrs W made a complaint against all the doctors involved. On examination of the case, there was no documentation from Dr J’s initial consultations and it transpired that Dr J did not even know that Mrs W was diabetic. The plain x-ray requested by Dr J did reveal features of established neuropathic osteoarthropathy of the midtarsal joint of the right foot, which was missed by both Dr J and Mr N. Having been reassured that there was no significant injury, Mrs W had continued to work and weight-bear through the affected foot until the correct diagnosis was finally made. The repeated misdiagnosis had resulted in a delay and failure to initiate potentially effective early treatment.

The experts, although not critical of Dr Y or Mr B, were critical of Dr J and Mr N. Despite two separate consultations and further investigation, the failure of Dr J to document his interactions with Mrs W was criticised. The experts were critical of Mr N’s management, believing it fell below the acceptable standard in that he failed to correctly interpret the history and findings on examination, which contributed to a delay in reaching the correct diagnosis and a poor prognosis for Mrs W.

The case could not be defended and was settled for a moderate sum.

JW

LEARNING POINTS

- Having a member of staff ask for an informal medical opinion is a common event for most doctors. Doing things in a by-the-by way often means not taking a history, or documenting and even dealing with medical problems that are beyond our expertise. However, the medical responsibility remains the same.
- Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal or working relationship.
- Knowing the relevant past medical history of any patient is always useful, even for apparently minor injuries.
- When looking at an x-ray, it is always useful to have a global look at it rather than exclude a diagnosis. The fact that in this case there was no new fracture did not make the x-ray “normal”.
- Severe injury associated with Charcot osteoarthropathy may occur following minimal or unperceived trauma.
- Non-weight-bearing immobilisation in the acute inflammatory stage is crucial to a successful treatment outcome.
- Any patient with peripheral neuropathy who presents with a hot swollen foot should be regarded as having an acute neuropathic osteoarthropathy until proven otherwise. Guidance can be found here – TS Roukis, T Zgonis, The Management of Acute Charcot Fracture-dislocations with the Taylor’s Spatial External Fixation System, Clin Podiatr Med Surg (2006 Apr; 2)
Mr E, a 52-year-old truck driver, visited his GP Dr G, complaining of a tight chest. Mr E had no significant co-morbidities, but had been suffering with coryzal symptoms for more than a week, which were starting to affect his breathing. He had wanted to attend sooner, but due to his job he had not been able to attend the surgery earlier. During the consultation Mr E mentioned that his throat has been bothering him for a couple of weeks, so he had started to cut down on his usual 20 cigarettes a day. After examining Mr E’s chest, Dr G was quite concerned about his widespread wheeze. He administered a nebuliser in the surgery, and gave him some smoking cessation advice, but did not investigate Mr E’s throat.

A few weeks later Mr E reattended with similar symptoms of wheeziness and a cough, which again required another nebuliser. He mentioned that one side of his throat was painful and this was documented in the notes, but his throat was not examined.

During the following month, Mr E saw an ENT specialist Dr W, for a previously organised appointment to discuss a “recurrent sinusitis problem”. While he was at the hospital, Mr E mentioned his ongoing right-sided sore throat to Dr W. Dr W suggested that Mr E “tell his GP to check it”.

A month later at a follow-up appointment to see another ENT specialist, Mr E saw Dr S, who immediately examined his throat. It became clear that there was an abnormal mass in his right tonsil and further tests confirmed squamous cell carcinoma of the tonsil with neck nodes. There was a five-month delay in the diagnosis, which required more aggressive treatment and left a poorer prognosis.

The experts were critical of the management of Mr E by both Dr G and Dr W, so the claim was settled for a moderate amount.


**Learning Points**

1. Patients who present with more than one complaint can easily distract a doctor’s attention, particularly if the patient is unwell and the added complaint seems insignificant in comparison. If there is not sufficient time during a consultation to address multiple problems, a record should be made and a follow-up appointment arranged.
2. A flexible and open approach can avoid situations like the one in this particular case. Sending a patient to see his GP because the new complaint is not related to the reason for the appointment can leave a patient vulnerable.
3. Head and neck cancers are relatively rare, especially those arising from the tonsils. It is important to be aware of national guidance that advises referral for persistent, particularly unilateral discomfort in the throat, for more than four weeks.
4. The most common presenting symptoms of head and neck cancers are also common symptoms of infection, so can be easily dismissed. The key difference is that these symptoms tend to persist; therefore, a patient with unexplained symptoms, who fails to respond to conservative treatment, should be referred for further investigation.
Mrs H was a 35-year-old teaching assistant who also had two school-aged children. She was obese with a BMI of 40. In 2006, she had seen Dr G with left knee pain. Dr G recorded that on examination her knee was tender over her medial joint line but was otherwise stable. He initially prescribed diclofenac and advised her to lose weight. Shortly after, Mrs H returned to see Dr G. She still had knee pain but had also developed epigastric pain. Dr G noted her recent diclofenac use, realised the link and advised her to stop taking it immediately and return in a week if her epigastric pain was not settling. Dr G recorded in the free text of her consultation notes that Mrs H had probably had gastrointestinal side effects to a NSAID but he did not code this as an adverse reaction on her problem list.

Mrs H’s epigastric pain did settle and it was seven months before she was next seen with ongoing aching in her left knee, which was giving her sharp pains when she bent down to talk to the children at school. Her weight was once again discussed and she was referred for physiotherapy.

Mrs H was next seen by Dr J, a locum, with depressive symptoms in late 2009. Fluoxetine was prescribed along with a referral for cognitive behavioural therapy. Mrs H felt better as the weeks and months passed but then her mother died and she became wary of stopping her fluoxetine, fearing a relapse of her depressive symptoms.

She remained on fluoxetine with two monthly reviews by Dr G. The fluoxetine was issued on each occasion as an acute prescription for two months and did not appear on her repeat medication screen on the practice computer system.

In January 2011, Mrs H injured her back while leaning forward to help a child put on a coat at school. After one week of severe pain, she consulted Dr W, a locum GP. Dr W noted that Mrs H was in distress with pain, was not able to work or sleep and was having difficulty caring for her children. He recorded that she was not responding to over-the-counter painkillers.

Dr W checked her problem list and repeat medication screen, both of which were empty, and concluded that other than obesity, she was an otherwise fit 35-year-old. Dr W prescribed naproxen with co-codamol, referred Mrs H for physiotherapy and signed her off work for two weeks. He failed to note past history of dyspepsia and did not document any warnings.

Mrs H saw Dr G ten days later. Her back pain was improving but she was not yet ready to return to work, was still requiring analgesia and was running out of medication. Dr G advised her to stay off work and issued more naproxen and co-codamol.

Four days later Mrs H was admitted with epigastric pain, coffee ground vomiting, and melaena. While in the emergency department waiting to be seen by the medical on-call team, she had a large haematemesis and was taken for urgent endoscopy. Endoscopy revealed a large gastric ulcer but endoscopic intervention failed to control the bleeding and she required emergency laparotomy and a transfusion of five units of blood. Postoperatively she was very unwell and was returned to theatre with recurrent bleeding. She then spent two weeks on ITU. Unfortunately, her recovery was further complicated by a severe wound infection and she spent another three weeks in hospital. It was a further four months before she felt fully fit and able to return to work and fully care for her children without extensive family support.

The large ulcer was attributed to NSAID use in a patient who had previously experienced dyspepsia whilst on NSAIDs, her risk being further increased by concurrent use of an SSRI. She made a claim against Dr G and Dr W. The case was settled for a moderate sum.

**LEARNING POINTS**

- It is important to keep in mind that all drugs, even those we prescribe regularly, might be dangerous to certain patients.
- When repeating prescriptions by a previous doctor, it is important to review indications, interactions with other medications and most importantly contraindications.
- It is important to record adverse medication reactions in a way that will be easily displayed for future reference. In this case, the adverse reaction was buried away in a consultation note from five years previously but had not been coded as a problem that would be prominently displayed on the patient’s problem list or prescribing notes.
Mr B was a 30-year-old garage manager who had just returned from a long trip abroad with his wife. After the flight he developed some chest tightness. This showed no signs of improvement after ten days so Mr B made an appointment with his GP, Dr W. Dr W took a brief history and documented only that he had no cough or sputum. He did not ask about the character, site or radiation of the chest pain, or ask about recent long flights or family history of thrombosis. Despite documenting “no cough, sputum and examination of the chest normal”, he diagnosed a chest infection but also documented that he had queried asthma. Dr W prescribed seven days of amoxicillin and arranged a chest x-ray and an ECG.

Over the next few days Mr B’s chest pain persisted. It was retrosternal and he found himself taking shallow breaths because the pain was worse on inspiration. He walked down to the GP surgery and was quite short of breath just walking down the road. Dr W reviewed him the same day and his examination notes stated “no pain or swelling in the legs”. He looked at the chest x-ray report and the ECG and noted them to be normal, although the ECG had showed a sinus tachycardia. Again there was no record of him taking a detailed history of the chest pain or breathlessness. Dr W changed the antibiotics to erythromycin and added in gaviscon to ease the retrosternal chest pain, which he thought was dyspeptic in nature.

The next day, Mr B became very anxious because he was now breathless just walking around at home. His wife was worried so made him another appointment to see his GP. Dr W documented that he was anxious but that examination was normal breathless just walking around at home. His wife was worried so made him another appointment to see his GP. Dr W documented that he was anxious but that examination was normal other than a slightly raised blood pressure and heart rate, which he put down to anxiety. He prescribed some diazepam for his “nerves”. Almost three weeks after the chest tightness started, Mr B became acutely short of breath and dizzy, then collapsed at home. His wife called emergency services but despite all attempts by the paramedics he was pronounced dead on arrival at hospital. The postmortem showed bilateral pulmonary thromboemboli.

Mr B’s wife was devastated and made a claim against Dr W. The case was settled for a substantial sum.

For patients who keep coming back with the same complaint, it is always wise to review the initial diagnosis. A patient who is not responding to treatment as expected might need to have the whole picture revisited with a fresh pair of eyes. See the article “Tunnel vision”, in Casebook 19(2).

It is important to consider more unusual diagnoses. Although a pulmonary thromboembolus is a relatively rare diagnosis in a healthy young man, it does happen. Unless you think about it you’ll miss it.

It should be remembered that not all pulmonary emboli are preceded by signs of a clear DVT.

When considering the differential diagnosis of breathlessness, it is useful to consider whether it is acute or chronic and to decide whether it is pulmonary, cardiac or physiological in nature.

Great care must be taken when diagnosing anxiety, especially in someone presenting with physical symptoms. Mr B had presented with chest tightness and dyspnoea and had been found to have a tachycardia and an elevated blood pressure. All these symptoms can be attributed to anxiety but this should have only been diagnosed after excluding other causes.
Forty-five-year-old hairdresser Mrs T was diagnosed with an 8cm complex left ovarian mass following some months of left iliac fossa pain. Mrs T had had two previous laparotomies, one for a right oophorectomy and latterly a hysterectomy. The right oophorectomy had been for a dermoid cyst and the hysterectomy for menorrhagia. Mrs T attended the clinic where she saw Mr D, gynaecology consultant, who advised her to have surgery to remove the ovarian mass.

The surgery was complicated due to the presence of considerable adhesions involving the ovarian mass, large bowel and pelvic side-wall. The left ureter was identified and mobilised clear of the left ovarian mass, which was excised as planned.

Some hours after the surgery, Mr D had a family emergency and he had to leave the country for a few days. He asked his colleague Mr G to keep an eye on his patients while he was away. The surgery was complicated due to the presence of considerable adhesions involving the ovarian mass, large bowel and pelvic side-wall. The left ureter was identified and mobilised clear of the left ovarian mass, which was excised as planned.

Mr G reviewed Mrs T a few times and also checked Mr D’s surgical notes. The documentation was scarce and there was no mention of adhesions or any difficulty encountered during surgery. Mr G decided to adopt a conservative approach as Mrs T’s general condition remained stable, even though the wound continued to discharge. He mentioned to other colleagues that he felt it was difficult to interfere with the care of a senior colleague’s patient as he felt intimidated by Mr D. As a precaution, Mrs T was prescribed broad-spectrum antibiotics.

A week after the initial surgery, Mrs T's condition deteriorated and she developed an acute abdomen. She had generalised abdominal pain and vomiting, along with a fever and a raised white cell count. Mr G took her to theatre for an emergency laparotomy to find faecal peritonitis and a loculated pelvic collection. There were several perforations of the sigmoid colon which necessitated partial bowel resection and a colostomy. Further surgery was required before Mrs T was finally discharged home two months later.

The case was settled for a moderate sum. Allegations of negligence were in relation to bowel perforation, delay in diagnosis and poor postoperative care.

GM

Your patient, your responsibility

LEARNING POINTS

- An operative note is for the benefit of all personnel looking after a patient. The record should not only give an account of the operation performed, but it should also accurately reflect any degree of difficulty of the procedure or deviation from the norm. Mr D failed to do this.
- Good surgical documentation can alert colleagues to an ensuing postoperative complication and may facilitate early intervention and treatment.
- It is important to ensure appropriate arrangements are in place when leaving patients in someone else’s care. Mr D did in fact do this by informing his colleague Mr G, but it seems he did not inform the ward nursing staff. It is good practice to advise the nursing staff which doctor will be responsible for your patients in your absence. Not only did Mr D fail to write comprehensive surgical notes, but also he should have conveyed the intraoperative difficulties he had to Mr G.
- If you are covering for a colleague, you must take full responsibility for those patients. A patient’s care should not be compromised for fear of offending a colleague. Mr G’s remark that he found it difficult to interfere with a colleague’s patient is difficult to accept, given that Mr D had asked Mr G to look after his patients. If there is uncertainty over how a patient should be managed, you should consider asking the opinion of a colleague.
- A wound that is discharging offensive material following intraperitoneal surgery should be investigated promptly. You need to consider the possibility of bowel injury. In this case, the use of radiological imaging may have helped confirm a significant complication and facilitated earlier intervention.
Right level, wrong site (1)

I READ THE September 2011 Casebook with interest, specifically the report on “Right level, wrong site” (p21). I know of more than one surgeon who believes that all lumbar disc lesions can be approached surgically from the midline! That is unequivocally untrue as your expert so rightly pointed out.

One of my points comes from your section on learning points in relation to the management of acute lumbar disc lesions. In the lumbar spine the spontaneous resolution rate for acute disc protrusions is closer to 100% than 80%, but specifically time-related. Sadly the world literature is badly biased by the fact that surgeons tend to advocate surgery and it is not in their interest to be promoting conservative management: a cynical but truthful observation. Patients should be advised that the outcome of conservative versus operative treatment is little if no different at 12 to 18 months. Surgery offers the advantage of a short cut but risks not insignificant complications; conservative management has minimal risk but often a drawn-out recovery. Extraordinarily I have read notes that record that patients with lumbar disc lesions will not get better without surgery!

In relation to the time allowed for spontaneous resolution of these lumbar disc lesions, four to six weeks is, I have to say, an exceptionally short period of time to suggest before considering surgery. Certainly there will be occasions, short of cauda equina compression, where in special circumstances early surgery may be considered – but the message that MPS supports such early surgery may not be a good one to be promulgating. I know that the difference between private and public treatment standards in respect of surgical advice exists and I am pleased that you raised that, to try to keep practitioners honest in that respect.

Another interesting point arises in relation to communication. Doctors (surgeons) can be quite foolish on occasions by telling patients that a particular treatment previously given to their patient was wrong simply because it was not their own practice. This is particularly important now that the ‘school of opinion’ defence has been challenged. Doctors should be taught and reminded that they must resist the temptation to portray themselves as the saviour of a situation by denigrating previous unsuccessful but perfectly proper treatment.

As an orthopaedic spinal who performed more than 7,000 open spinal operations, I do speak from a depth of experience. One final point in the form of a question. Are surgical trainees and newly-appointed consultant surgeons being formally and appropriately (not voluntarily) appraised of their responsibilities in relation to medical insurance? It would be difficult if not impossible to argue against mandatory malpractice education as a requirement for medical insurance!

Name and address supplied

Right level, wrong site (2)

Ref “Right level, wrong site” (Casebook 19(3), p21). An interesting case with possible implications wider than the ones you mentioned. Was there a governance structure in place in this doctor’s organisation that reviewed his previous operations to see if he had inappropriately operated on other patients? Do doctors in MPS have an obligation to inform the Medical Council about the possible concerns about this doctor?

Paul Scott, GP, UK

Response

I should reiterate the comment we make in “On the case”, that reports are based on issues arising in MPS cases from around the world, but facts are altered to preserve confidentiality. To that extent the reports are not factual iterations of individual cases. The issue you raise is one MPS takes seriously and during the course of every case we seek to work with the member to identify any risk management issues that could bear on future practice.

Billy LK Wong, junior doctor, UK

Mother knows best (1)

I READ WITH great interest the case “Mother knows best” in the last issue of Casebook, 19 (3). Whilst we continually strive for excellence and perfection, it is impossible for doctors to make accurate diagnoses on every occasion. The difficulty is highlighted in this case where the initial presentation of intermittent twitching without any other symptoms is rather atypical for bacterial meningitis. This can be easily missed. Therefore, the learning points in the article are absolutely valid and correctly emphasised. Parent concerns should always be considered and a high index of suspicion is required to avoid misdiagnosis.

More importantly, it is imperative that junior doctors on-call should always discuss the working diagnosis with a senior colleague in spite of how confident he/she feels or how cumbersome this may seem. Occasionally, patients may re-present 24-48 hours following the first presentation to hospital with worsening or persisting symptoms. It is vital that the patient is seen by a middle grade doctor or above at this stage. Had this been applied to the baby in the above-mentioned case, the outcome might have been very different.

I believe that the learning points from the article apply to all junior doctors regardless of their specialty rotations. Not least will this exercise be life saving, it could also potentially save a budding career.

Billy LK Wong, junior doctor, UK

Avoiding dosing disasters

David Mitchell’s professor is correct (Over to You, Casebook 19(3)). Drug charts should be reviewed on all patients at every ward round, and ideally every day. This ensures that prescriptions have not been made overnight that clash with those drugs already prescribed, that initial prescriptions are reviewed regularly and that drugs no longer needed are stopped. I work in critical care and it is our practice to review the drug chart daily, looking for issues before it is reviewed again by the
Mother knows best (2)

I REMINisce TO my Foundation Year 2 days in the emergency department. I found dealing with children and particularly neonates to be the most challenging part of my medical career so far. From this stems the utmost respect and admiration for all qualified and aspiring paediatricians.

To get back to the subject matter, I do remember taking two lessons away from my brief period spent in the department. The first one relates to history. We are indoctrinated from our earliest days in medical school that over three quarters of the information you need to make a diagnosis or at least decide on the next course of action is in the history. In the case of the young ones still lacking language skills, we can only rely on the mother’s history, even when this is sometimes limited to a story.

I always felt that a mother’s concern was enough to take things forward, especially if a little reassurance was not adequate. There is no substitute for a mother’s sixth sense of something being amiss. None other than she would be able to discern the smallest changes and nuances in the behaviour and hence the overall condition of her baby, and this is proof enough of her worry. There is no way that you could confidently fully discern normality in the short period of contact you have with the child in the department.

The second lesson is if there is a reattendance within the last 24 hours; an expert consult needs to be sought, even if it is to reassure all parties concerned of the benign nature of the presentation. The worst thing that could happen with getting a second opinion is another medical professional doing what he was trained and is paid to do: his job!

With these two skills in hand, it should not be too difficult to navigate the delicate waters of the paediatric department in accident and emergency.

Chris Smith, specialty registrar, Anaesthesia, UK

critical care consultant on the ward round.

Drugs are stopped, doses altered in light of altered renal function and other drugs started if they have been omitted or forgotten. Every day we check if thromboprophylaxis has been prescribed or considered contraindicated, if gastroprophylaxis has been instituted and that appropriate nutrition and anti-pneumonia measures are in place. Analgesics, sedatives, inotropes and vasopressors are reviewed, and antibiotics and steroids stopped if they have run their course.

I strongly agree that focusing solely on the initial prescriber is wrong. The inpatient care of a patient is the responsibility of all of us involved in their care. We should all be reviewing drug charts regularly to minimise prescription errors.

Chris Smith, specialty registrar, Anaesthesia, UK
Reviews

Great Discoveries in Medicine
Edited by William and Helen Bynum (Thames & Hudson, 2011)
Reviewed by Wendy Moore, author and journalist, UK. She can be contacted through her website: www.wendymoore.org.

Both marvellously illuminating and beautifully illuminated, Great Discoveries in Medicine is a perfect marriage of simple, clear text and spellbinding pictures. Editors Helen and William Bynum have amassed a team of experts in their fields to provide a breathtaking journey through the story of human efforts to fight illness and disease from ancient Egypt to the modern day. The book is logically organised into seven sections exploring themes; within each section, academic experts offer snapshots on topics as diverse as bubonic plague and beta-blockers.

Inevitably, given the title, this compendium is chiefly – and unusually for some contemporary medical historians – a celebration of medical achievement, just as it should be. Here are all the familiar heroes and triumphs, like Harvey, Pasteur, Snow and Lister, and their extraordinary stories of dogged determination and maverick insights. Yet there are some extraordinary new stories too, along with welcome spotlights on insufficiently hymned figures.

Among the most fascinating of the less well-known innovations is the story of the incubator. Darwinist ideas discouraged doctors in Britain and the US from attempting to save premature babies, explains Jeffrey Baker. But French obstetrician Stéphane Tarnier (1828-1927) noticed chicken incubators on a trip to a Paris zoo and promptly installed similar devices in his hospital ward. Mortality for underweight babies fell by nearly half. Before long, ‘incubator baby’ shows were popping up as exhibits in shop windows and world fairs. The invention of the defibrillator is another vastly significant yet unfamiliar tale, although the book’s account inexplicably omits the first established case of reviving a patient with electric shocks, in London in 1774, when a three-year-old girl was reportedly resuscitated after falling from a window.

But the real stars in the sparkling firmament of this scintillating book are without doubt the illustrations. Ranging from exquisite anatomical drawings to public health posters, from Islamic tapestries to CT images, these expertly chosen and beautifully reproduced images offer us the best understanding of changing attitudes towards health and disease. Together these wise words and stunning pictures offer a humbling story and a visual feast.

Zero Degrees of Empathy: A New Theory of Human Cruelty
By Simon Baron Cohen (Allen Lane, 2011) Reviewed by Philippa Pigache, honorary secretary of the Medical Journalists Association in the UK.

Simon Baron Cohen is Jewish and grew up hearing stories of the unbelievable cruelty shown to the Jewish population by the Nazis in World War 2. It was this that prompted him to use his book to ask the question: what is the cause of human cruelty? He considers that to attribute it to “evil”, as some do, is a cop-out, for it explains nothing. Why should some people, in otherwise just and caring societies, carry out aberrantly vicious acts? His hypothesis is that underlying such acts is a total inability to put yourself in another person’s shoes, to feel what they feel and act accordingly; a lack of what is called empathy – this he calls “zero degrees of empathy”.

Baron Cohen is a professor of developmental psychopathology at the University of Cambridge, and one of the foremost names in the study of autism and Asperger’s syndrome. He has blurred the boundaries between such extreme mental health conditions and the normal human brain, developing the concept of the autism spectrum and the “extreme male brain”.

He finds support for his hypothesis in neurology and psychology, and demonstrates, with studies using questionnaires, twins and functional magnetic resonance (fMRI), that human beings fall along a spectrum in their capacity for empathy. This empathy spectrum forms a normal distribution curve, where most people cluster in the middle and a few at the extreme ends. At one extreme are those who commit, or perhaps have the capacity to commit, extreme acts of thoughtlessness or cruelty (not necessarily physical), and at the other, those exceptional individuals who devote their lives to caring for others. In the middle are you, me and Joe Public: some are more empathic than others. Interestingly, more men than women fall into the low-average level and more women than men into the high-average group.

Baron Cohen goes on to look at possible explanations for the empathy spectrum and he finds them in childhood experiences, eg, low levels of empathy are associated with childhood abuse, neglect or disturbance, characteristic electrical patterns in the brain and their effect on key neurotransmitters, like serotonin, and in distinct genetic variations, though not upon a single gene. The evidence he cites is inevitably drawn from studies of either mental health patients, or those in conflict with the law in either Europe or the United States.

Does he satisfactorily explain Nazi cruelty? I am not sure he does. I think he explains the behaviour of misfits – mental or penal – in essentially just, caring 21st century societies, but he ignores societal norms. What is regarded as cruel depends on social context. Stoning was not considered cruel 2,000 years ago – such barbaric cruelty was the norm – a mere 100 years ago, callous, insensitive treatment of children was routine and it took exceptional free-thinkers to challenge it. But we still await an explanation for how, in the first half of the 20th century, Nazi doctors treated Jewish people no better than laboratory mice.
MPS has designed these five essential risk management workshops for members to complete over the coming years. Based on MPS’s unrivalled case experience and local knowledge, the three-hour interactive workshops provide proven skills training to reduce your risk of complaints and claims.

To find out more about these workshops visit www.medicalprotection.org
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