Anatomy of a claim

Step-by-step through a recent case

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Tackling the biggest challenge to patient safety: complacency

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Extra assistance from MPS – meet your Associates

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CASE REPORTS

Welcome
Editor-in-Chief Dr Stephanie Bown looks at the key role of the expert and how they can ensure a successful defence.

Here to help
Peer support from a medical colleague on non-medicolegal matters is available through MPS – our locally-based team of Associates are just a phone call away. This issue, meet the team from Singapore.

Terminally ill patients
In this advance excerpt from our new risk management handbook – produced jointly with the Hong Kong Medical Association – Dr David Ham looks at the legal position surrounding withholding or withdrawing treatment from terminally ill patients.

How reliable is healthcare?
Dr Dan Cohen looks at one of the greatest challenges facing healthcare: complacency.

Anatomy of a claim
The path of a clinical negligence claim is usually a long one – and the outcome can be influenced by numerous factors. MPS solicitor and claims manager Antoinette Coltsmann provides the legal view of a recent MPS case.

From the case files
Dr Ming-Keng Teh, MPS Head of Medical Services (Asia), introduces this issue’s round-up of case reports.

Over to you
A sounding board for you, the reader – what did you think about the last issue of Casebook? All comments and suggestions welcome.

Reviews
In this issue Dr Matthew Sargeant looks at Errornomics: Why We Make Mistakes by Joseph T Hallinan, and Dr Sacha Moore reviews Common Neuro-Ophthalmic Pitfalls: Case-Based Teaching by Valerie A Purvin and Aki Kawasaki.

Common can be complicated
Patient confusion: patient claim
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An unexpected pregnancy
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A catalogue of errors
Cutting corners
A restoration problem
A delayed diagnosis

Get the most from your membership...

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.
Welcome

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

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

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

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

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

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

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

MPS Associates – here to help

Associates are a group of MPS members who can provide peer support or are there if you need a medical colleague to talk to. They will treat everything in the strictest confidence and if you need medicolegal advice you will be referred to a specialist medicolegal adviser or one of our MPS panel lawyers.

In Casebook we are allowing readers to get to know our Associates a little better – this issue covers Singapore.

Professor TAY Sun Kuie
SIBERIAN CONSULTANT, OBS & DYNAE
CHIEF OF GYNAECOLOGICAL ONCOLOGY
DIRECTOR OF SURGICAL RESEARCH, SINGAPORE GENERAL HOSPITAL

A graduate of University College London, UK, Professor Tay obtained his Doctorate in Medicine (MD) degree at the same university with a thesis on immunity and Human Papillomavirus (HPV). Prof Tay’s other notable achievements are:

- Fellowship of the Singapore Ministry of Health for a special interest in immunotherapy of gynaecological cancer at the MD Anderson Medical Centre and Institute of Tumours, Houston in 1993.
- Fellow of the Academy of Medicine, Singapore (FAMS), and the Royal College of Obstetricians and Gynaecologists (FRCOG) in 1989 and 1998, respectively.
- Extensive experience in the surgery and chemotherapy of women’s cancers, and minimally invasive treatment for women’s cancers and endometriosis. Numerous awards, publications and research trials.
- MPS Associate from 2008
- Current appointments also include Associate Professor, Yong Loo Ling School of Medicine, National University of Singapore (NUS); member of the International Society of Gynaecological Cancers; and Past President of the Society for Colposcopy and Cervical Pathology, Singapore.

Email: tay.sun.kuie@sgh.com.sg

Dr TOH Choon Lai
ORTHOPAEDIC SURGEON, MOUNT ELIZABETH MEDICAL CENTRE

Notable achievements include:

- Singapore Medical Association (SMA) Council Member
- Chair of the SMA Ethics & Indemnity Complaints Committee
- Fellowships – Royal College of Surgeons, Edinburgh; Orthopaedic Trauma, Harvard; Academy of Medicine, Singapore.
- MPS Associate from 2008.

Email: tohchoonlai@yahoo.com.sg

Dr Bertha WOON Ying Yng

Dr Bertha Woon is a specialist in general surgery in Singapore. She is director at her own private practice, Bertha Woon General and Breast Surgery, at Gleangales Medical Centre, Singapore. She completed her practice training contract at the law firm, Dickswell & Co, and was called to the Singapore Bar in July 2013.

She has a long-standing interest in medical education, ethics and professionalism and medicolegal issues, including advocacy for patients and physicians.

She is past-Treasurer and current Executive Council member of the College of Surgeons at the Academy of Medicine, Singapore; as well as a Council Member of the Singapore Medical Association (SMA). She represents the SMA at the Confederation of Medical Associations in Asia and Oceania and is part of the Board at the SMA Centre for Medical Ethics and Professionalism. She is also a committee member of the Ethics Committee of Ang Mo Kio-Thye Hua Kwan Hospital.

Dr Woon has been an MPS Associate since 2012.

Email: bertha.woon@gmail.com

Dr Lim Thiam Chye

Notable achievements include:

- Plastic, Reconstructive & Aesthetic Surgery
- MPS Associate in Singapore
- Worked in plastic surgery since 1985, a consultant since 1995, involved in medical education since 1993
- Fellow of the Royal College of Surgeons (Edinburgh), Fellow of the Academy of Medicine of Singapore (Plastic Surgery).

Email: surilim@nus.edu.sg
In this excerpt from MPS’s new joint risk management handbook with the Hong Kong Medical Association, Dr David Kan advises on withdrawing or withholding treatment from terminally ill patients.

In considering the medicolegal issues concerning withdrawing or withholding treatment from terminally ill patients, it is necessary to consider advance directives and do not resuscitate orders.

Advance directives are directives given by an adult, at a time when he/she is mentally competent, concerning the medical treatment which he/she wishes to receive or does not wish to receive at a future time when he/she will no longer be mentally competent. In other words, these are medical directions given by an individual patient in advance, to be put into effect if and when he/she subsequently becomes (either temporarily or permanently) mentally incompetent.

Advance directives do not allow for patients to require a doctor to provide specific treatment(s) against their clinical judgment.

What are the relevant legal principles?

Advance directives are recognised under common law. Currently, there is no statutory framework. It reflects the principle of self-determination (Airedale NHS v Bland (1993) A.S. 821), according to which respect must be given to the wishes of an adult patient of sound mind regarding his/her medical treatment.

As already stated, at the time of giving his/her directives, the individual patient has to be mentally competent. His/her mental capacity should not be diminished by long-term illness or medication. Further, there should be no undue influence by any third party.

In the same way that a mentally competent patient can validly refuse treatment (and such refusal must be respected), the patient can communicate his/her wishes at an early time before he/she becomes incapable of communicating them.

Those involved in looking after the terminally ill (including patients who have become mentally incompetent) have a duty to respect the wishes of the patients. According to the Hospital Authority’s guidelines (Guidelines on life sustaining treatment in the terminally ill, published by the Hospital Authority) (paragraphs 5.16 to 5.20), validly executed advance directives, including those refusing life-sustaining treatment, should be respected.

Do not resuscitate orders are advance clinical decisions, which are made in writing or orally. If it is revoked in writing, then the revocation should be witnessed by an independent witness who does not have an interest in the case.

In the case of an oral revocation, it should be made before a doctor, lawyer or another independent person (recommendation 8).

On 23 December 2009, the Food and Health Bureau published a consultation paper in response to the above-mentioned report. This consultation addresses the issue of whether the concept of advance directives should be introduced in Hong Kong, the information to be provided to the public as well as the guidance to be provided to the medical profession. It was proposed that procedures and guidelines should be developed for medical and healthcare professionals on the making and handling of advance directives.

Withholding/withdrawing treatment

Assuming that no advance directive has been executed, in deciding whether or not to withhold or withdraw life-sustaining treatment, a medical practitioner should take into account the wishes of the patient as well as those of his family (Code of Professional Conduct for the Guidance of Registered Medical Practitioners; paragraph 34.3).

In general, withholding or withdrawing life-sustaining treatment is appropriate where a mentally competent patient who is in a position to explain to the patient the nature of the treatment, having collected views from the public through a consultation process (published in 2004). The Law Reform Commission have made the following recommendations:

a. The concept of advance directives should be promoted. Initially by non-legislative means, until the community has become more widely familiar with the concept (recommendation 1).

b. The Commission put forward a model form of advance directive. This ensures that the directions given are clear and unambiguous. The form should be witnessed by two witnesses who should be a medical practitioner who is in a position to explain to the patient the nature and implications of the advance directive. Neither witness should have any interest in the estate of the patient (recommendation 7).

c. The model form does not allow the patient to refuse basic or palliative care necessary to maintain the patient’s comfort and dignity, or to relieve pain.

d. If for any reason the patient is unable to make a written advance directive, then an oral advance directive should be made before a doctor, lawyer or another independent person (recommendation 7). It is important that the doctor records such directives/instructions in the medical records.)

e. The advance directive can subsequently be revoked in writing or orally. If it is revoked in writing, then the revocation should be witnessed by an independent witness who does not have an interest in the case.

In the case of an oral revocation, it should be made before a doctor, lawyer or another independent person (recommendation 8).

Do not resuscitate orders

Do not resuscitate orders are advance clinical decisions, made on an individual basis, not to attempt CPR on patients. Such an order would be appropriate if it is undesirable to prolong the process of dying. In an advanced directive, the order to do so should be taken into account. As a doctor should perform treatment, including resuscitation, on a patient only if it is necessary and in the patient’s best interest. It would be appropriate for the doctor to decide not to attempt CPR if it does so not in the patient’s best interest.

The doctor should consider the likely outcome and expected benefit of resuscitation. If an order is made, it should be clearly documented and communicated to all relevant staff. The order should also be reviewed at regular intervals.

For more information on a range of medicolegal topics in the Clinical Risk Management Handbook, visit www.medicalprotection.org/hongkong.

Dr David Kan is a Partner at Howse Williams Bowers, Hong Kong.
How reliable is healthcare?

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

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

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

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

Every day thousands of patients are harmed or die in modern well-equip hospitals staffed by highly-trained individuals. Beneficial interventions not necessarily translate to safety.

The challenge that remains is to understand how things can go wrong, when the intentions are to achieve highest quality outcomes and assure patient safety.

Managing danger

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

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

It has been argued that if the healthcare industry could simply adopt the characteristics and methodologies of HROs, we would move the bars for quality and safety higher. If this is true, then why is there so much inertia in our systems of care; inertia that plagues our improvement strategies? Why have we not solved the challenges in ambulation that might be unique to my case? Why did we not notice the discrepancies detected during my care:

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

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

A natural fit?

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

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

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

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

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

REFERENCES

A case study

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

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

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

In my view, if a healthcare system is a forest of complexities then a giant coastal redwood of complacency towers high above the forest floor, a forest covered with the moss of ‘near misses’. One colossal tree standing high above the forest floor; it’s not all that complicated.
THE CASE
Mr P, a high-earning, self-employed management consultant, attended his GP surgery on 10 July 2010 with flu-like symptoms and saw Dr A. He diagnosed a chest infection and prescribed antibiotics. On 15 July, Mr P returned with similar symptoms – Dr A referred Mr P for a chest x-ray and prescribed further antibiotics. The x-ray was clear and that he could continue to take his medication. On 21 July, Mr P was reassessed by Dr C and spinal surgeon (Mr J), and a consultant neurological and spinal surgeon (Mr J), and a consultant microbiologist (Dr K). Mr P was not relying on his GP to arrange urgent blood tests and once the results were available (which he surmised would have been abnormal), Dr A should have arranged an urgent referral to an orthopaedic specialist/A&E or MRI scan within 24 hours.

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

Before trial, both parties served evidence on breach of duty and causation, in the form of reports from expert witnesses. For Drs A, B and C, a GP (Dr D) reported on breach of duty based on his factual evidence. Mr P’s factual evidence, either for an MRI scan or more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan. Dr D agreed that Dr A’s management was “entirely appropriate”. If, however, the court accepted Dr A’s factual evidence, Dr D agreed that Dr A’s management was “entirely appropriate”. If, however, the court accepted Dr A’s factual evidence, the court should have “triggered” a neurological examination and, if Mr P had no neurological symptoms, this should have prompted referral within one to two weeks – either for an MRI scan or “more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan”. Mr P’s GP expert noted that this was the fifth consultation regarding the same illness without a diagnosis. Referral to a physiotherapist without a further examination was “unacceptable care”. He considered the appropriate response was to arrange a series of urgent blood tests and once the results were available (which he surmised would have been abnormal), Dr A should have arranged an urgent referral to an orthopaedic specialist/A&E or MRI scan within 24 hours.

THE LIABILITY
Our assessment, Drs B and C had no culpability. Dr B simply reported the chest x-ray was clear. Dr C undertook a very detailed and thorough assessment and this was recorded in Mr P’s records. He concluded Mr P was suffering from muscular back pain and recommended pain relief and a return visit to Dr A in two weeks’ time.

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

At the recommendation of the hospital consultant microbiologist, Dr P’s antibiotics were withheld and the following day he was transferred to another hospital, where an MRI scan was performed. This revealed infective discitis at T5/T6. Mr P underwent an emergency laminectomy with open biopsy, where a soft tissue mass was submitted for histology investigations; once the biopsy samples were obtained antibiotics were recommended. Further surgery was carried out the same day and antibiotics (a combination of ceftriaxone and vancomycin) were administered. Following the surgery, Mr P was left with T4 ASIA A paraplegia. He underwent rehabilitation at a spinal injury centre.

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

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

BREACH
Consultation: 15 July
Mr P vigorously denied he was informed by Dr A that his back pain was worse, preventing him from lying flat on his back and disturbing his sleep. Dr I considered Dr A in breach of duty for failing to arrange blood tests in conjunction with a chest x-ray. He considered “blood tests were mandatory”. If the court accepted Dr A’s factual evidence, Dr D agreed Dr A’s management was “entirely appropriate”. If, however, the court accepted Mr P’s factual evidence, Dr D agreed this should have “triggered” a neurological examination and, if Mr P had no neurological symptoms, this should have prompted referral within one to two weeks – either for an MRI scan or “more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan”.

Consultation: 4 August
Mr P’s GP expert noted that this was the fifth consultation regarding the same illness without a diagnosis. Referral to a physiotherapist without a further examination was “unacceptable care”. He considered the appropriate response was to arrange a series of urgent blood tests and once the results were available (which he surmised would have been abnormal), Dr A should have arranged an urgent referral to an orthopaedic specialist/A&E or MRI scan within 24 hours.

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

THE ANATOMY OF A CLAIMESSAYS
Anatomy of a claim
The path of a clinical negligence claim is often long and complex. The eventual outcome is affected by a number of key factors; MPS claims manager and solicitor Antoinette Cotlsmann takes an in-depth look at a recent MPS case.

THE PATH TO A CLINICAL NEGLIGENCE CLAIM

1. BREACH
A doctor’s failure to provide the standard of care

2. CAUSATION
The relationship between the breach and the claimant’s injury

3. SUFFICIENCY
Was the breach sufficient to cause the injury? Would the claimant have been injured even if there had been no breach of duty?

4. CONTRIBUTION
Was the claimant’s own conduct a contributing factor in the injury? Do the claimants contributory factors have any bearing on how the claim is handled?

5. ASSESSMENT
A second opinion on causation

6. PROOF
Evidence in support of negligence

7. ALLEGATIONS DROPPED
The case went to trial.

8. LIABILITY
The court accepts that the breach did not cause the injury

9. COSTS
The court orders the claimant to pay the defendant’s costs

10. SUCCESSThe court awards the claimant compensation

Mr P served evidence on breach of duty

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

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

Mr P alleged Dr A was in breach of duty for failing on 15 July to arrange blood tests and failing on 4 August to arrange urgent blood tests. Mr P was not relying on his assertion that he had made sufficient complaint of back pain on each occasion to prompt suspicion of an infected spinal pathology.

Taking an in-depth look at a recent MPS case, Mr P served evidence on breach of duty and causation. Referral to a physiotherapist without a further examination was “unacceptable care”. He considered the appropriate response was to arrange a series of urgent blood tests and once the results were available (which he surmised would have been abnormal), Dr A should have arranged an urgent referral to an orthopaedic specialist/A&E or MRI scan within 24 hours.

Mr P’s GP expert considered that on 4 August, Mr P was not displaying any symptoms or signs that would have alerted a GP to possible infective discitis developing. He considered referral within one to two weeks, based on Mr P’s factual evidence, either for an MRI scan or orthopaedic or neurological specialist – who may have requested an MRI scan – appropriate management. He did not consider Dr A in breach of duty based on his factual evidence.
was administered. Undertake a biopsy to identify the pathogen so the appropriate antibiotic could have been arranged is 7 August. The earliest the results could have been undertaken, based on a fasting count and temperature would have been normal range for each recovery.

Dr A considered antibiotics 24 hours earlier would have avoided onset of recovery. A diagnosis would have been made, Mr P would have been admitted to hospital and treated with intravenous antibiotics, making a complete recovery.

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

Dr E maintained Mr P would have needed to establish that Mr P needed to establish that any further investigations had been undertaken after all consultations – save 4 August – Mr P would succeed by one way or another. It was vigorously denied that even if blood tests had been undertaken on 4 August they would have altered the outcome. For Dr A to succeed at trial in causation in relation to the 4 August consultation, the court had to accept: 1. Referential to orthopaedic surgeon on a ‘non-urgent’ basis was reasonable, based on Mr P’s factual evidence.
2. Even if the court did not accept referral on a ‘non-urgent’ basis for an orthopaedic/neurosurgeon/synovialis, Mr P needed to establish that referral and appropriate treatment within a five-day window of opportunity (4–9 August) should include referral to an orthopaedic surgeon, MRI scan, and further investigations.

Dr A did not assess Mr P until 5.30 pm on 4 August. Accordingly, the earliest that blood tests could have been undertaken, based on a fasting count and temperature would have been normal range for each recovery. The earliest Dr A could have seen Mr P is 6 August, and an appointment arranged with an orthopaedic surgeon that afternoon. The earliest an MRI scan could have been arranged is 7 August. The earliest the results could have been available is that same day, with admission to hospital that evening.

Mr P was asymptomatic and the appropriate action would have been to refer Mr P to a physiotherapist.

THE TRIAL

Dr A’s expert neurologist was an excellent witness who spoke by one way or another. It was vigorously denied that even if blood tests had been undertaken, based on a fasting count and temperature would have been normal range for each recovery. All confirmed that at no stage were they alerted to Mr P’s alleged extensive back pain. They were treating flu-like symptoms affecting the chest, and back pain was secondary and caused by the chest infection and coughing. It was not until 4 August that Mr P complained of back pain, which was now the primary need for the consultation as his chest/fust infection symptoms had resolved. Dr A examined Mr P, concluded it was muscular and referred Mr P to a physiotherapist.

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

THE OUTCOME

Mr P abandoned his claim and discontinued proceedings 23 days after the conclusion of day 3 of the trial. By that stage all witnesses and experts, save the microbiologists, had given evidence. Dr K considered antibiotics 24 hours earlier would have avoided onset of recovery.

If you would like to comment on a case, please email casesbook@medpro.org.uk.
Miss G, 11 years old, was taken by her mother to see GP Dr A with conjunctival symptoms and a discharging right ear. She appeared quite well during the consultation, so Dr A prescribed anti-microbial drops and arranged urgent ENT control. The next day she presented for a consultation, so Dr A prescribed antibiotics. He prescribed steroids and arranged urgent ENT control. This confirmed a cerebral sinus venous thrombosis and a middle ear infection with acute mastoiditis. She was transferred to the neurosurgical unit for thrombolysis, CSF drainage and acetazolamide, and discharged home a week later.

The family lodged a negligence claim against Dr A, stating that he failed to refer for urgent investigation following their second consultation. They asserted that had Miss G received earlier treatment, she would not have been admitted to hospital.

Neither of these telephone consultations were documented in the case notes. The paediatric team documented palsy of cranial nerves 3, 4 and 6 with gross left-sided weakness and brain imaging. This confirmed a cerebral sinus venous thrombosis and a middle ear infection with acute mastoiditis. She was transferred to the neurosurgical unit for thrombolysis, CSF drainage and acetazolamide, and discharged home a week later.

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The following day, Miss G attended the clinic, and on examination had fixed pupils with marked papilloedema. He arranged immediate admission to hospital. The paediatric team documented palsy of cranial nerves 3, 4, 6 and 7 with gross left-sided weakness and brain imaging. This confirmed a cerebral sinus venous thrombosis and a middle ear infection with acute mastoiditis. She was transferred to the neurosurgical unit for thrombolysis, CSF drainage and acetazolamide, and discharged home a week later.

The family lodged a negligence claim against Dr A, stating that he failed to refer for urgent investigation following their second consultation. They asserted that had Miss G received earlier treatment, she would not have been admitted to hospital.

A reminder regarding telephone consultations is that arrangements should be made for face to face review if any concerns are raised regarding a patient’s clinical condition.

A patient who develops new symptoms should be reassessed and the diagnosis reviewed. In this case the nurse should not have made a new diagnosis of glaucoma before telephone consultation for an urgent appointment.

The case is a reminder that common ailments can develop rare complications. The majority of cases of otitis media seen in general practice will resolve without complications; however, health professionals should remain vigilant to the possibility of disease progression. Safety netting measures protect you and your patient.

Asking the patient to attend for a review is an important safety net to put in place, but it is important to be able to follow this up.

Lack of available GP appointments means it is important to be able to follow this up.

Safety netting measures protect you and your patient.

Learning points

The importance of documenting every consultation, including telephone consultations, is highlighted once again with this case. Disciplined documentation of every clinical encounter means that when a claim or complaint arises, you can feel more confident defending your position.

A reminder regarding telephone consultations is that arrangements should be made for face to face review if any concerns are raised regarding a patient’s clinical condition.

A patient who develops new symptoms should be reassessed and the diagnosis reviewed. In this case the nurse should not have made a new diagnosis of glaucoma before telephone consultation for an urgent appointment.

Miss G indicated an intention to bring a claim stating that she had undergone surgery based on a false premise. She alleged that she would have requested repeat biopsy (as recommended on the biopsy findings within the records), which would have come back negative for malignancy and thus she would never have agreed to surgery. The expert opinion on the case indicated that it was reasonable for Mr F to perform an initial unilateral biopsy, but that it must be recognised (and should have been made clear to the patient) that such often biopsies are not diagnostic; hence, repeating the biopsy may not have revealed any further information. The expert opinion was also of the view that the MDT decision to proceed to radical nephro-ureterectomy was justifiable, even if the diagnosis of endometriosis had been made. Due to the location and size of the mass radical surgery would still have been warranted.

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

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

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

Ten days later Ms C reattended her local clinic. It was noted that an effusion had developed in the knee, pain was evident. On balance Dr T felt that Ms C had sustained bruising along the medial joint line but upon testing the medial joint line but upon testing the medial joint line the knee was unstable and there was a clear往来 pain. He felt that there was no need to consider an MRI scan and that a review in a week or so would be appropriate. Ms C was counselled on the need for rest and gentle exercise.

Two days later she presented to her local orthopaedic surgeon Dr A who performed a thorough assessment of the knee. He noted that the knee had sustained a significant ligamentous injury to the medial collateral ligament and that the knee was unstable and that there was tenderness on palpation over the lateral joint line. Dr A advised Ms C that mobilisation and exercise were advised. Ms C was discharged.

A week later, Ms C presented to her local clinic. It was noted that an effusion had developed in the knee, pain was evident. Ms C was counselled on the need for rest and gentle exercise. She was discharged.

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Learning points

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

An unexpected pregnancy

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

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

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

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

A review of the records revealed that Mrs B had been registered with the practice since 1999. She was on the combined oral contraceptive (COC) since 1992, which she had stopped in 2000 when she began trying for a family. At her new patient medical in 1999 it was noted that she was a non-smoker, and there was a family history of diabetes or heart disease.

The original consultation, when she was prescribed the POP, was in October 2003 after the birth of her first child. The notes read: “16 days post-natal. Wants contraception. Discussed and start Noriday.” Over the next four years there were a dozen clinical encounters. Three of these were pill checks with the practice nurse. A typical entry read: “On Noriday. Happy with it. No missed pills, occasional headaches POP.” There were also five occasions when the POP was issued without face-to-face consultations and four encounters for unrelated issues.

Mrs B’s legal team alleged that she should have been advised to change from a POP to a COCP when she finished breastfeeding her second child in 2007 and this would have helped to prevent her unwanted pregnancy in 2008. Expert opinion was that when prescribing contraception it is a duty to discuss contraceptive choices with a patient – specifically about the pros and cons of a COCP and a POP in this case. The discussion should cover failure rates, the method of taking the pill, common side effects (including effects on menstruation) and the risk of thrombosis. This would allow the patient to reach an informed decision. The expert felt that part of this could have been achieved by advising the patient to read the product information in the patient pack.

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

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

Learning points

- It is striking that despite so many clinical encounters over many years and her own protracted use, Mrs B still alleged that she was unaware of key issues with the POP and COCP, including the three-hour window in which to take the POP. It is a timely reminder that giving information is important, but checking that the patient has understood the information is vital. This forms the basis of valid consent to treatment. In this case it would have been all too easy to view the “pill check” as a routine encounter, make assumptions and be less rigorous in documentation.
- A number of prescriptions were issued by the practice nurse or as repeats by the administration team in the practice. When devolving responsibility it is important to cover complications in the consent process and document such conversations diligently.
A tear during delivery

The patient was noted to have a second degree tear. Dr A carefully examined the perineum and anal canal following the forceps delivery and documented that the "anal sphincter was intact" and there was no evidence of any sphincter damage, and repaired the tear routinely.

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

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

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

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

Expert opinion on these issues was sought. Although it was acknowledged that an episiotomy is often required in a forceps delivery, the perineal stretching was well and it was felt that the episiotomy was not essential in this case. The contemporaneous notes confirmed that the anal sphincter was intact. The endo-anal ultrasound and neurophysiology tests also confirmed signs of marked sphincter damage, and the cause of the bowel problems was felt to be due to pudendal neuropathy. The ventouse cup displaced due to the caput on the baby’s head, and the fact that there had been some active descent during the traction meant that it was deemed acceptable to use a second instrument to achieve the vaginal delivery, the case was successfully defended.

Learning points

- The use of sequential instruments is associated with an increased neonatal morbidity, however, the operator must balance the risks of a caesarean section following failed vacuum extraction with the risks of forceps delivery causing failed vacuum extraction.
- Recognition and documentation of the correct technique in the notes (e.g. ‘Saxthorph-Pajot’ technique for forceps delivery – where the operator’s dominant hand applies horizontal traction, whilst the other hand gently presses downwards on the shank of the forceps) suggests that the accoucheur has adequate experience to carry out the procedure correctly.
- Careful documentation of the technique and assessment for perineal damage is essential, and use of endo-anal USS may help with the definitive diagnosis at a later stage.
- The expert opinion was logical and evidence-based and, with careful documentation and adherence to good medical practice, such cases can be discontinued before they are taken to court.

M & S, a 43-year-old woman, was pregnant with her third child. She had an uneventful forceps delivery with her first child and a spontaneous vaginal delivery with her second child. She had been previously diagnosed with irritable bowel syndrome, but endoscopies had revealed no evidence of any other disease. The GP records showed that she had colicky pain with constipation and diarrhoea, but she had history of facial incontinence. This pregnancy had been uneventful and she went into spontaneous labour at 32+6 weeks.

At 5:15pm she was 4cm dilated and, as the contractions had reduced, Mrs J was started on an oxytocin drip. She had an episiotomy and was found to be fully dilated at 9.45am. As the head was ‘high’ and suction was lost, an episiotomy was not essential in this position. The blades were easily applied and, using the ‘Saxthorph-Pajot’ technique, the baby’s head was delivered with one pull.

Dr A felt the perineum was stretching out well, and did not carry out an episiotomy.

Learning points

- Adverse outcomes and mistakes are part of a doctor’s working life. Acknowledging this, responding to such events in a timely manner and being open, help to reduce the impact of these events on both the patient’s wellbeing as well as the doctor’s professionalism.

M & S, a 58-year-old woman, saw Dr A, a consultant orthopaedic surgeon, with a history of left-sided knee pain. She had seen him previously for revision surgery. The patient had presented to her GP some years ago with a pain complaint – at that time, an arthroscopy had demonstrated degenerative change in both medial and lateral compartments of the knee. Upon being re-consulted, Dr A performed a second arthroscopy – several degenerative changes and bone-on-bone contact were observed. Ms M was duly listed for a left-sided total knee replacement, which was successfully performed.

When undertaking the consent procedure Dr A indicated that he would be performing a left total knee replacement, that the indication was advanced and improved (OA) grade, that the serious and frequently occurring risks had been fully discussed. The procedure was performed through a midline incision. The finding, as anticipated, was gross tri-compartmental osteoarthritis. The prosthesis was inserted, the patellar osteotomies were trimmed but the patella was not resurfaced. The operating note does not record any untoward intraoperative events. Routine antibiotics and thromboprophylaxis were prescribed.

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

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

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

Follow-up was arranged by Dr B and Ms M was seen six weeks later. She was told that the surgery had been a success and that Ms M.M was walking without the aid of a stick. The knee was a little stiff but physiotherapy was ongoing. At this point a second issue superseded. Ms M complained of severe pain in the proximal patellar – an MRI scan of the lumbar spine demonstrated an L4/S5 disc protrusion. A concurrent CRP of 35 and ESR of 31 were felt to be of questionable relevance and were attributed to delayed wound healing and the MRI finding. Further follow-up, six months later, found that Ms M was walking without pain. She was able to carry on her normal activities of daily living.

Learning points

- In this instance, the highly critical expert evidence required swift action. The claim was settled before the court eventuated and the claimant was not delayed in obtaining late surgery. It was felt the financial award was reasonable and appropriate. Strong expert opinion guides the approach of both MPS and the members involved.
**Cutting corners**

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

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

Dr B conducted an inhalational induction of anaesthesia, with nitrous oxide, 30% oxygen and 4% sevoflurane. An intravenous cannula was inserted once L was asleep; 15mg of fentanyl and 2mg of ondansetron were given during the case and a slow infusion of dextrose saline was administered.

Dr T performed the surgery, which proceeded uneventfully. Dr T performed a ring block with 3ml of 0.25% plain bupivacaine for postoperative analgesia. Towards the end of the operation, as Dr T was applying the LMA, but the throat was clear. He had not used a LMA, but noted that L’s pulse was slow at 45 beats per minute. The pulse oximeter showed there were no saturations recorded a capnograph to monitor respiration. He had not recorded a blood pressure or respiratory rate at any time during the case. The monitor alarms had all been switched off earlier in the day and he had not checked or reinstated them. Dr B accepted that there was a protracted period of inadequate vigilance during the case, during which a prolonged episode of severe hypoxia occurred. This case occurred over a decade ago and L is a healthy child. Learning points

- A series of human and equipment factors interacted in a catastrophic way to bring about this tragic outcome from a trivial injury.

- Fatigue can be a powerful cause of reduced vigilance, and is associated with increased risk of error. It does not amount to a defence. The mnemonic HALT reminds all healthcare professionals to be extra careful if they are Hungry, Angry, Late or Tired. Ask yourself: am I safe to work?

- Most anaesthetic machines now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.

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**A restoration problem**

A 46-year-old accountant, had a long history of biopsy-confirmed ulcerative colitis. Because of escalating medication, he was referred by his gastroenterologist for consideration of surgery after repeated exacerbations. He was intubated, sedated and transferred to intensive care. After a prolonged period of care, he was discharged from intensive care with extensive neurological damage consistent with hypoxic brain injury.

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

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- Most anaesthesiologists now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.
Learning points

- Limb length discrepancy is the second most common cause of litigation in arthroplasty surgery, behind nerve injury.1
- Approximately 15% of hip replacement surgery results in a limb length discrepancy. Less than 1 cm discrepancy is the ideal goal, but up to 2 cm is reported to be tolerable by patients.2
- The importance of good documentation concerning consent of all common and serious complications is vital. Specific complications should be included on the consent form. In this case, the consent form was not completed.
- Explaining to a patient why a complication might arise helps them to understand and accept it if it happens. In this case, Dr B should have explained why the surgical decision was made.
- Dr B denied negligence and the experts involved upheld this. There was only minimal leg length discrepancy, less than had been claimed, and it is a recognised complication. Dr B performed both the surgery and subsequent investigations in an appropriate manner, and sought a second opinion from an expert. The case was dismissed.

References


Case 2

A delayed diagnosis

after four days, the condition had stabilised and Miss O was discharged home.

On returning to her home, Miss O began to feel unwell. She developed a high temperature and a cough. She complained of chest pain and was admitted to hospital. A chest X-ray showed an area of consolidation in the left lower lobe. A CT scan of the chest and abdomen was performed.

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

Learning points

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

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

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

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

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

Miss O brought a claim against Dr S, citing a delay in the diagnosis and treatment of her small bowel obstruction as the cause for her further surgery, prolonged hospital stay, and subsequent intestinal complications and ongoing symptoms. Expert opinions were critical of the delay in making the diagnosis of small bowel obstruction and undertaking surgery. They felt that an ultrasound examination had been unnecessary and that Dr S should have reviewed the abdominal x-ray (which clearly showed evidence of obstruction) when he initially reviewed the patient and not the following day. Had he done so, the finding of peritonism three days into her illness may have prompted Dr S to perform earlier surgery, before the small bowel ischaemia had become irreversible. The case was settled for a moderate sum.

SD

The final implant was chosen to maximise stability of the hip and minimise the risk of dislocation. The operation went well and there were no postoperative problems. Mrs K was recovering as expected when she was seen for review at one month. After three months, however, she complained of discomfort over the lateral aspect of her hip. An x-ray showed that her right leg was 10mm longer than her left, but Dr B felt a shoe raise was not indicated. This lateral pain persisted though, and Mrs K was provided with a shoe raise to equalise the leg lengths at a further review.

Mrs K sought a CT scan, which confirmed the leg length discrepancy, and she also had injections in her lumbar spine for pain relief, which did not help. Due to these ongoing problems Dr B organised an aspiration of her right hip replacement, which did not show any evidence of infection, and she was referred to Dr L for an expert hip revision scan, for a second opinion. After reviewing the history of ongoing pain post-surgery, a clinical examination and a new set of x-rays, Dr L could not see any obvious problem with the hip replacement that would account for her symptoms. Dr L explained to Mrs K that the hip was ‘only very slightly long’. He felt that maybe she was getting some impingement pain from her psoas tendon. Mrs K was becoming increasingly frustrated and upset, believing that her problems all stemmed from an increase in her leg length, and returned to see Dr B again. She enquired whether further surgery might resolve the pain. Dr B, as well as obtaining a second opinion from Dr L, had discussed the case with other colleagues. They agreed that a 1cm leg length discrepancy should not cause such problems, and that even lengthening by 2 to 4cm is regularly tolerated well by patients. He advised against further surgery, as did his colleagues, but he organised an MRI scan of the hip and sent to try and find a source of Mrs K’s pain.

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

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

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

References

A confidential issue?

May I comment on the article “On deadly ground” (Casebook 21(3); the case “CONFIDENTIALITY”, I feel that Dr W was not at fault in divulging Miss B’s HIV status with the mother present. The mere fact that Miss B allowed the mother to be present at the consultation gives the doctor the right to discuss ALL problems and queries of the patient. In my opinion Miss B had given permission by allowing her mother in at the consultation.
I always inform my patients when they allow another person into the consulting room that whatever is discussed will be with the patient’s consent and that if they are not comfortable with that we must ask the other person to leave. It is very difficult to take a complete history and at the same time think twice of what questions should be posed to the patient.

Dr JW Van Weerde, South Africa

A weekend of back pain

“Over the weekend of back pain”, Casebook—September 2013, pages 22 and 23. One of the learning points of this case was that the claimant runs a litigation risk when pursuing a claim. The article mentioned that the claimant’s legal costs were being paid for by public funds and this was withdrawn after surveillance showed she was clearly lying regarding her disabilities. Surely she was attempting fraud by bringing a malicious claim and should be dealt with accordingly—was there any prosecutorial for this offence? Has she also committed a fraud by receiving taxpayer funding for her legal action to gain money by deception? If legally possible, MPS should push hard for prosecution in cases such as these to reduce and deter unmeritorious compensation claims.

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

Stumbling block

Thank you for highlighting the important case of a nerve injury following a femoral nerve block (“Stumbling block”, Casebook 21(6)). However I would dispute your statement that use of ultrasound has revolutionised the safety and efficacy of regional anaesthesia. Published works show a rate of nerve injury whilst using ultrasound to be similar to traditional techniques. I fear the key factors in this case were the use of an unsafe nerve block technique, as well as severe deficiencies in consent and communication. From the details published the decision to use a regional block at all might seem questionable, regardless of technique. The presence of an ultrasound machine would not have made any difference to these factors.

Dr Howard Bluett (retired consultant anaesthetist), Teeside, UK


REFERENCES

Dr Bluett suggests a book for more reading on the subject of communication and adds: “The book recommended by Dr Bluett is Interplay: The Process of Interpersonal Communication.” This book is a great resource for those interested in improving their communication skills and understanding how to effectively interact with others. It provides a comprehensive guide to the principles of communication and offers practical strategies for improving interpersonal skills. The book covers topics such as body language, active listening, and conflict resolution, making it a valuable resource for anyone looking to enhance their communication abilities. Whether you are a medical professional, a student, or simply someone interested in personal development, Interplay: The Process of Interpersonal Communication is a must-read. It offers valuable insights and practical tips that can be applied in various contexts, making it a versatile and informative read.
Common Neuro-Ophthalmic Pitfalls: Case-Based Teaching
By Valerie A Purvin and Aki Kawasaki
(£58.00, Cambridge University Press, 2009)
Reviewed by Dr Sacha Moore, consultant ophthalmologist

This book is part of a series of similar case-based books on different specialties, and is enjoyable and well written.

If you are tired of didactic reference textbooks that serve up boring writing on layers of indistinguishable tedious lists and tables, like sawdust on bread and crackers, then this will be the choice and grappling that render neuro-ophthalmology not just palatable but more-ish.

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

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

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

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

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

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

Errnomics: Why We Make Mistakes and What We Can Do To Avoid Them
By Joseph T Hallinan
(£8.99 Ebury Press, 2009)
Reviewed by Dr Matthew Sargeant, consultant psychiatrist and clinical human factors group member

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

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

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

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

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

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

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