The ACCUSED

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From patients to e-patients

Tracy Cheung, solicitor at Kennedys, looks at the challenges and benefits of patients researching health information online.

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Welcome

Dr Nick Clements – Editor-in-chief

Dr Nick Clements has taken over as Casebook Editor-in-chief from Dr Stephanie Bown, who left MPS in February 2014. Here, Dr Clements looks towards the task ahead.

As this is my first column as the new Editor-in-chief of Casebook, I would like to say how much I am looking forward to life at the helm of a publication with a prestigious history of some 20-plus years.

Of course, I must also pay tribute to my predecessor Dr Stephanie Bown, who left MPS in February to become Director of the National Clinical Assessment Service (NCAS). Dr Bown has been involved with Casebook since the May 2006 issue, and oversaw numerous successful design upgrades and a renewed focus on producing truly topical content for all of our six regional editions.

Dr Bown worked at MPS for 19 years, beginning as a medicolegal adviser and becoming head of the Medical Services department in London soon after; this after spending more than 12 years as a doctor in acute hospital medicine, then obstetrics and gynaecology before moving into general practice. Dr Bown combined her editorial duties on Casebook and other MPS publications with high-profile external affairs work.

So it is with slight trepidation but great relish that I step into Dr Bown’s shoes, and build on her success with Casebook.

My role as Head of Medical Services in the UK will continue, and I will try to use this experience to develop thought-provoking content that will be stimulating, informative and directly relevant to today’s doctor, wherever in the world you practise.

The keen-eyed among you will have spotted my name in Casebook before, so I am not entirely new to the magazine – in addition to occasionally introducing each edition’s collection of case reports, I have been on the editorial board for a number of years, helping to maintain the accuracy and educational value of each issue.

One thing will not change – and that is we continue to encourage your feedback, opinions and suggestions after each edition. Perhaps I will speak to some of you personally on our advice line…

Public exposure from complaints and claims can cause doctors to face a trial by media. In 2011, a UK GP was accused of sexually motivated conduct when he examined a patient’s chest – he shares his experience with Sara Dawson.

I seemed like a normal surgery day a couple of years ago. As I was signing scripts, my practice manager knocked on my door and brought in a brown envelope marked private and confidential. I opened it and read it – the contents were highly distressing. The letter contained details of allegations made by a female patient (Mrs B) that, two months previously, I had conducted a sexually motivated examination.

I remember seeing Mrs B in early spring complaining of chest and stomach pain. Initially I offered her a chaperone, but as it is practice policy; she declined, so I performed a thorough chest examination and referred her for surgery.

Her complaint was that during the chest examination I squeezed her breast, and behaved sexually while breathing heavily. She thought my front, back and side examination was inappropriate and not what she’d expected.

I was devastated to hear about the serious nature of the complaint, as it would have ramifications for me, as a doctor, and as a husband and a father, and as an upstanding member of society. My surgery staff were highly distressed and took it very seriously; I immediately contacted MPS.

Continued on page 6
Investigation
We asked the patient to give consent so that we could send the complaint to be investigated thoroughly and in an unbiased way by the PCT (Primary Care Trust). After a delay the records were shared and I gave my witness statement.

The local PCT determined that I should have a chaperone for every female consultation while the investigation was underway.

In spite of numerous attempts, Mrs B failed to engage with the PCT to give her version of events. The PCT felt they had no choice but to refer the case to the General Medical Council (GMC).

The GMC held an interim order panel meeting. Accompanied by an MPS solicitor, the panel listened to our case. They applied conditions to my registration that I was to have a chaperone for every intimate female examination, and to log each examination. The GMC’s investigation took more than a year to complete and a hearing date was set, 18 months after the initial allegation.

The hearing
The first day of the hearing didn’t go to plan. I arrived all geared up to defend my corner, but Mrs B did not turn up, so it was adjourned until the following day. When the hearing did commence Mrs B gave a witness statement, and there was a submission from my MPS instructed barrister, then the panel went away to decide the next course of action. The next day the panel gave their decision that they found the allegation untruthworthy and uncorroborated, and the case was concluded.

Personal impact
The experience of having a patient make an unfounded allegation against you is devastating. I would not wish it on my worst enemy. The insecurity you feel day in day out is worse than physical pain. There were days where I could not see any light at the end of the tunnel, like my head was under a guillotine. My mind was fractured. I kept thinking ‘why me, why did this happen to me?’

As a doctor this experience was earth-shattering: it’s the worst thing to be accused of – an allegation of sexual motivation; how can you prove you were acting appropriately? It’s their word against yours. If the GMC had found in Mrs B’s favour, my licence, my livelihood, my marriage, my social standing would have been demolished just like that.

During the investigation I went to work as normal. Every day I had to face the stigma around me of what I had allegedly done.

Impact on the practice
It was particularly hard on the practice, having to have a chaperone from beginning to end. We were not just employing a GP; but two healthcare professionals at the same time. This was particularly hard on the practice, having to have a chaperone for every intimate female examination, and to log each examination. The GMC’s investigation took more than a year to complete and a hearing date was set, 18 months after the initial allegation.

Media coverage
Handling the media was not something I’d really considered. I’d definitely never thought about being on the front page of a national newspaper. We were all worried about it: what would patients do? The stories were angled in a certain way that assumed I was guilty – it would have been nice to be captured in a different way. I remember, during the hearing, getting messages from friends asking if I was ok, as they’d seen the coverage.

Even abroad, it was all over the internet. The pressure was huge and so upsetting. My name was exposed, I lost my anonymity – I was breakfast gossip. There was a sense of bias – why was I stripped of my anonymity when the person who made the allegations enjoyed full anonymity? The media coverage added salt to my wounds.

Support
Throughout the process I worked closely with the local medical committee, my MPS legal team, and the PCT. Without the understanding and professionalism of these people it would have been a much more difficult time. I drew strength from the fact that I knew I was professional and hadn’t done anything wrong. – I believed the truth would come out in the end.

I’m most proud of the way the practice dealt with the whole thing – we pulled together like a family. From the first day, I was honest about the allegation and discussed it with my staff, my patients, my family and my colleagues; from then on I informed them of all the developments. I could not have survived the experience if they hadn’t supported me.

I always wanted to be a professional GP, dedicated to my practice and patients, and to be involved in the community as a doctor. Eighteen months have been wiped from my life, and I will never get answers to why Mrs B did what she did. I take some comfort in that justice has been done and I was vindicated – life goes on and I have learnt from it.

Names have been withheld to protect the confidentiality of those involved.

Legal opinion
By Dr Jo Galvin, MPS medicolegal adviser, who handled the case.

Unfortunately this case is not an isolated one. Mrs B came to the practice specifically asking for her chest to be examined thoroughly. During the examination she perceived that the actions of the GP in question, whom I shall refer to as Dr Z, were sexually motivated. Dr Z said that when he examined her, he explained what he was doing to explain the depth and pattern of the breathing.

His situation was compounded when he locked the door to preserve her confidentiality, as the door had recently accidentally opened into the adjacent waiting room. Mrs B misconstrued this again to be sexually motivated.

Credibility
The credibility of Mrs B was undermined when she did not turn up for her first day of the hearing – she claimed that her father was in hospital. MPS requested full disclosure of the reasons for her absence. It came to light that she had deliberately crafted an absence by her from her sister’s house, and her father was not in fact in hospital.

Chaperones
Doctors are alive to the fact that they need to use a chaperone when performing intimate examinations, but they aren’t always alive to the dangers of some examinations; for example, an accidental brush of the chest can get doctors into difficulty. An important point to make is that Mrs B’s consultation was not an intimate examination – it was a chest examination – but Dr Z still saw Mrs B as a chaperone.

MPS conducted an audit of Dr Z’s previous consultations, and were able to prove that he was consistent practice to offer a chaperone and document it. He’d documented contemporaneously in the notes that he had offered Mrs B a chaperone and that she had declined – this helped his defence.

Good record-keeping
There were several important factors that further undermined Mrs B’s version of events. During the consultation Dr Z also referred Mrs B to hospital to be treated for a different condition; Mrs B had no recollection of this or of visiting Dr Z a couple of weeks later about a different matter. It is unlikely that you would come back voluntarily and visit your GP again if you perceived him to have acted inappropriately.

This raised questions around Mrs B’s recollection of the events. In contrast, Dr Z had documented everything contemporaneously.

When there is a factual dispute, the credibility of a complainant is important. In this case the actual factual dispute and the weight of evidence was in Dr Z’s favour.

His notes were further backed up by a GMC-obtained expert report about the correct standard of chest examinations; this proved that Dr Z’s standard of chest examinations was appropriate.

Professional challenges
The situation presented professional challenges because Mrs B remained a patient at the practice. It is hard to justify removing a patient simply because they have made a complaint. Good practice management meant that Dr Z did not see Mrs B.

Advice
Dr Z was unlucky, but his contemporaneous note-keeping and good practice helped prove that he had not done anything wrong. He did everything he could to give himself the best protection.

Learning points
 Always use chaperones for examinations that are perceived to be intimate examinations
 Good record-keeping is essential
 Communicate effectively with your practice team
 Develop good working relationships with your staff and patients
 Expert evidence is helpful in disputes around standard practice.

For further information about chaperones and maintaining boundaries please visit the factsheets section of www.medicalprotection.org.

Ends

REFERENCES
1. Note for readers outside England: Primary Care Trusts were local health authorities funded by the National Health Service (NHS) responsible for commissioning primary care services and providing certain services such as dental care. They were abolished in 2013.
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

High reliability in healthcare: a personal failure

A ten-month-old girl, was admitted to an internationally prominent children’s hospital at the weekend for evaluation of a kidney mass, likely Wilms’ Tumour, a highly curable childhood cancer. I was the paediatric oncology fellow (junior registrar) covering the service for the weekend.

This institution’s Wilms’ Tumour protocol required the oncology fellow to administer Actinomycin-D intravenously as soon as the renal vein had been clamped at the time of surgical removal of the tumour. I wrote the orders correctly and legally using our standard double-check process and then things became complicated.

In addition to covering the inpatient oncology service (about 25 beds in this large centre), I had additional weekend obligations for the outpatient clinic and a two-bed bone marrow transplant unit located in different, though adjacent, hospitals. Usually this multiple coverage obligation was not a problem, but on this particular weekend, two children with leukaemia were to receive outpatient L-asparaginase chemotherapy, and I had to be present in the clinic because of the substantial risk of leukaemia were to receive outpatient L-asparaginase chemotherapy, though adjacent, hospitals. Usually this multiple coverage obligation was not a problem as the hospital settings, which, although usually manageable, set the stage for conflicting obligations.

The protocol for intraoperative chemotherapy was not evidence-based, it was anecdotal and experimental, and there was no informed consent for this.

A single anaesthesiologist was responsible for coverage in multiple hospital settings, which, although usually manageable, set the stage for conflicting obligations.

A cultural barrier forestalled calling for backup unless there was a dire emergency.

Not all anaesthesiologists were qualified for all procedures.

There was no pharmacy double-check process for chemotherapy orders.

So—what happened to this little girl? Although she encountered profound bone marrow failure and spent three weeks in isolation with much procedural pain and fear, she came through her experience wonderfully and was cured of her Wilms’ Tumour.

The incident

I conferences the imaging service, I saw the syringe that had contained the Actinomycin-D, still attached to A’s medical record (a standard practice at that time), and the label revealed the dosage error: I was shocked! Although not immediately toxic, the effect on this child’s bone marrow would be profound, beginning about a week after administration. I was reasonably certain that this child was going to die—and I was ultimately responsible— I called my consultant immediately and, after calming me down, he said some things that really resonated. “Dan, we do not know that A is going to die. We can expect that she will encounter severe bone marrow suppression and gastrointestinal toxicity, but we do not know the outcome of that, and we need to be factual when we talk with the family.”

The following morning we met with A’s parents. My consultant wanted to take the lead in the conversation but I insisted that as A was my patient I wanted, and needed, to do the talking. I was the one who had originally met with the family and this was my responsibility, not his. I carefully explained to the parents that A had received a higher than desired dose of medication and that we were very concerned about this. I apologised for this error and explained that we would investigate this further in order to ascertain how it had happened. I promised to correct any discrepancies in care identified in order to prevent this from ever happening again and then outlined the steps we would take to protect A. I promised the parents that the comprehensive resources of our institution would be mobilised to support A. I did not tell them that I thought she would die because her death was not a certainty and voicing my concerns would have served little purpose.

The lessons

1. If the healthcare industry is to truly function as a highly reliable organisation, then the kinds of challenges and variances portrayed above must be anticipated beforehand so that appropriate failure mechanisms can be established to provide for all contingencies. This child deserved better from the system, from me, and from others. The Swiss cheese barriers hadn’t worked.

2. Transparent and timely disclosure should be the gold standard for patient care. We are obligated to tell our patients the truth when things are good…and when things are bad.

3. Clinicians are often collateral or “second victims” of patient safety incidents and principles of high-reliability require that hospitals provide necessary support within a just culture framework.

Doctors and nurses do not wake up in the morning intending to harm patients. We go to work each day with every intention of helping our patients. We expect the systems and processes in our workplace to support us in achieving that goal; in other words, we want to work in highly reliable, safe, collaborative and just organisations.

Dr Dan Cohen is International Medical Director for Datix Ltd (www.datix.co.uk), a patient safety and risk management company whose software application enables users to spot trends as incidents/ adverse events occur and reduce future harm by prioritising risks and putting in place corrective actions. Dr Cohen can be reached at dcohen@datix.co.uk.

Our investigation revealed the following:

System problems

- The protocol for intraoperative chemotherapy was not evidence-based, it was anecdotal and experimental, and there was no informed consent for this.
- A single anaesthesiologist was responsible for coverage in multiple hospital settings, which, although usually manageable, set the stage for conflicting obligations.
- A cultural barrier forestalled calling for backup unless there was a dire emergency.
- Not all anaesthesiologists were qualified for all procedures.
- There was no pharmacy double-check process for chemotherapy orders.

Personnel accountability issues

- The primary anaesthesiologist did not inform the oncology fellow regarding the emergent coverage changes.
- The pharmacist erred in preparation of the Actinomycin-D.
- The substitute anaesthesiologist administered an unfamiliar drug without self-identified need for verification of dose or knowledge of side effects.
- I did not call for qualified back-up!

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Harm and hazards

- Though the goals of healthcare professionals are coloured by altruism and compassion, a closer examination reveals that many of our processes for providing care are insufficient, even flawed, and patients continue to be harmed, sometimes fatally. Our hospitals, in particular, are highly complex and hazardous environments, not only for patients but also for staff. Dangers lurk and complacency is perilous and harmful.

- A quintessential characteristic of high-reliability organisations is reliance on the advice and knowledge of those on the frontlines of processes, those at the tip of the spear. In most industries we identify frontline staff as those working where “the rubber meets the road,” and in healthcare this would mean the clinical staff who actually talk to patients and provide care.

- However, in healthcare the calculus is even more complicated because the best and safest outcomes require intimate patient and family member engagement and collaboration. Therefore, in this expanded framework, patients and family members are components of the healthcare system, both on the frontline and as experts.

- Clinicians, patients and family members are frontline experts in their respective domains, and we need to listen to all of them.

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When doctors make mistakes

Associate Professor Siow-Ann Chong looks at the genesis of a medical error, and reflects on the global push to eradicate mistakes from medicine

Throughout our medical training and in the actual practice of medicine, it is expected that we should always do the best for our patients and their care must be our first and foremost professional concern. In our interaction with patients, it is assumed that we want and understand their preferences and focus exclusively on their problems. Most times we do not at times, it can be difficult. Other irrelevant and unrelated thoughts intrude: that pile of unfinished and overdue medical reports sitting on one’s table, an ailing parent, a child’s impending school enrolment, and all the minutiae of life. And that can lead to unpleasant consequences.

A few years ago in my outpatient clinic, I attended to a patient whom I have known for years and treated for schizophrenia. She still had the occasional auditory hallucination and was otherwise well enough to have meaningful relationships and hold a steady job. It was a routine clinic visit: for me to check that everything was fine for my patient, which, among other things, is meant to reduce dispensing errors by eliminating the illegible scrawl that doctors are infamous for.

Admitting to a mistake can be very difficult for a doctor and the reasons are not noble: there is that personal sense of shame that incites a desire to hide or even cover up; there are the fears of a tarnished reputation, of angry recrimination from the injured patient and family, and of a possible medical liability lawsuit. It is not unusual that healthcare providers, hospital administrators and lawyers would worry that disclosure, apologies and even expressions of regret are an invitation for litigation, and be used as incriminating evidence in malpractice suits.

The value of apologies

The adversarial tort system may give some sort of justice to the patient and family but relatively few cases make it to the court, and research has also found that litigation does not reduce medical errors. Accounts of some of those who sued revealed that they did not so for financial reasons but because they felt frustrated, aggrieved and betrayed when their healthcare providers stonewalled them. This despite the oft-repeated point that being candid and saying sorry may forestall some lawsuits, or would at least lead to a quick settlement and lessen the toll on patients, families and doctors.

“Apologising,” said Lucian Leape, the Harvard professor and former paediatric surgeon, who is acknowledged as the father of the patient safety movement, “may be the most important thing we do after a serious event, both to help the patient begin to heal and to heal ourselves.”

So one afternoon in a room in the hospital ward where my patient was recovering, I sat down with another senior colleague and a hospital administrator, and explained to the patient, her sister and elderly father how that it had happened. (There was an extra layer of checking by the dispensing pharmacist but somehow that failed too.) I apologised for my mistake and acknowledged the distress caused to them. They listened quietly and without interruption to the end; the sister asked about the hospital bed – which of course was waived – and expressed her hope that it would not happen to other patients.

The title of the 1999 report by the Institute of Medicine was To Err is Human; when I next saw this patient and her father in my clinic a week after her discharge from the hospital, they had already forgiven me.

References

3. Leape LL, “No matter what measures are taken, doctors will falter, and it isn’t reasonable to ask that we achieve perfection.”
4. Leape LL, “No matter what measures are taken, doctors will falter, and it isn’t reasonable to ask that we achieve perfection.”

This article was originally published in The Straits Times of Singapore, and is reprinted here with permission.
The term e-patient may not be familiar to doctors – but chances are you have come across them. Widespread access to the internet and an abundance of health information has meant a shift from the traditional role of the unknowing, uncomplaining, passive patient to a new generation of active consumers of healthcare: e-patients.

An e-patient has been defined as a health consumer who uses the internet to gather information about a medical condition of particular interest to them, and who uses electronic communication tools in coping with medical conditions. The term encompasses all those who seek online guidance for their own ailments, and the friends and family members who go online on their behalf.

There are four categories of e-patients:

- The well (the lightest and least frequent users of online health resources)
- The newly-diagnosed (the heaviest and most intensive users of online health resources)
- The chronically ill (regular users of online resources to manage their illnesses and keep updated on their conditions)
- Their caregivers (usually family members).

E-patients use the internet in three different ways: firstly, to play an active role in their healthcare management and encouragement of patients to access online resources for patients worldwide; secondly, to become ‘consumer specialists’ of their own or family member’s condition. This is evidenced by a growing population of extremely knowledgeable and involved e-patients who go on to access support groups, run chat sessions, and design and maintain websites.

There are many benefits in the ready access to health information online, including the ready access to often free online resources for patients worldwide, encouragement of patients to play an active role in their healthcare management and provision of emotional and practical support in coping with illnesses. In today’s time pressured medical practices, physicians can make referrals to useful support groups, run chat sessions, and design and maintain websites.

E-patients have become valuable healthcare resources and healthcare providers should recognize them as such. The sharing of information gathered by e-patients can supplement the professional guidance offered by physicians to improve the quality of healthcare services and the doctor–patient relationship.

From patients to e-patients

Tracy Cheung, solicitor at Kennedys, looks at the challenges and benefits of patients researching health information online.

The internet has made possible additional avenues for communication and the widespread use of social media – blogs, internet forums, content forums (YouTube) and social networking sites (Facebook and LinkedIn) – has meant the widespread dissemination of health information on a global basis.

Some e-patients, particularly those in the chronically ill category and caregivers, have become ‘consumer specialists’ of their own or family member’s condition. This is evidenced by a growing population of extremely knowledgeable and involved e-patients who go on to coordinate support groups, run chat sessions, and design and maintain websites.

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It’s your call

Members call the MPS advice line about a wide range of issues. Our useful infographic reveals what you have been calling us about, and how often. The figures are taken from calls made by MPS members around the world, between January and October 2013.

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<td>Report writing</td>
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<tr>
<td>Inquest (or Fatal Accident Inquiry in Scotland)</td>
<td>758</td>
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<td>Criminal investigation</td>
<td>60</td>
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Concealed sepsis

Mr D, 53, had suffered with rheumatoid arthritis in his right knee since turning 50. This had been confirmed with arthroscopy. He rarely bothered with his knees and continued to work as a PE teacher. He had experienced a flare-up of knee pain at the start of the autumn term but this settled quickly with analgesia. He contacted his GP out-of-hours service on the first weekend of the Christmas holidays, complaining of two days of bilateral knee pain, which was unrelieved by his usual codeine analgesia. A home visit was arranged. He was seen by Dr C, who documented a normal right knee on examination, but limited movement in the left knee, with positive meniscal signs and no effusion. Dr C also noticed that Mr D had a painful swelling of a finger, which he had jammed in the door two weeks earlier. Since he was asleep, Dr C attributed the symptoms to OA and advised Mr D should also arrange to get an x-ray of his finger to exclude a fracture. She provided him with naproxen analgesia. The pain continued after the weekend and Mr D had been unable to leave the house to arrange the x-ray. He spoke to Dr A at his own surgery and an appointment was arranged for the next morning. The following day, Mr D was still unable to get to his car and called the surgery again, this time speaking to Dr A, who agreed to a home visit. Dr D recorded an effusion and worsening right knee pain now radiating to the calf and hip. He also mentioned that Mr D now had swelling over the dorsum of his injured hand, and he also spotted two erythematous patches on the right elbow and left foot. Mr D had not reported feeling feverish and so vital signs were not recorded. Dr A prescribed a course of antibiotics to cover possible infection in the knee joint and recorded that the knee pain was likely to be a strain. She queried gout as a possible cause and recorded that she was uncertain what the satellitae lesions represented. She advised Mr D to check his踇趾 fracture the next day. The next day was Christmas Eve and Dr B was on duty for the day. He visited Mr D at home as requested by Dr A. By now he was feeling better, and the swelling in his hand had reduced, but he was feeling “space out” on the cocaine analgesia he was now taking. Dr B asked the patient to get out of bed for a full examination, which he was able to do. Mr D’s wife recalled the doctor taking her husband’s blood pressure and advising him to omit his antihypertensive medication. Dr B made no record of this examination. He later recalled that he examined the patient fully, including his temperature, and as he found nothing of concern he did not make a note of this. His advice was to complete the course of antibiotics and increase his fluid intake.

Mrs D recalled that her husband became worse towards the end of the day, with slurred speech and generalised weakness. He made an attempt to go to the toilet with the assistance of his son and it took him 40 minutes. Mr D aked the next morning to find his husband was dead. The pathologist who carried out the postmortem concluded that Mr D had died from complications of septicemia, but the focus of the infection remained uncertain. He noted splenomegaly but no lymphadenopathy. Experts agreed that the cause of death was peripartum but that the knee was the least likely site, with either the hand or an upper respiratory tract infection being the most likely causes. Crucially, expert opinion agreed that if intravenous antibiotics and volume replacement had been commenced on 23 or 24 December, then arguably the fatal episode of sepsis could have been avoided. Expert opinion also found that neither Dr A nor Dr B had recorded anything like enough to suggest that their assessments were adequate. In Dr B’s case, with no clinical details recorded and no plausible diagnosis, there would be no possible chance that a court would accept that his assessment was reasonable. Similarly, Dr A had not recorded enough to show that her assessment was reasonable on 23 December.

The case was settled for a substantial sum.

Learning points

- Good note-taking is essential. In this case, recording the vital signs and patient’s mobility were particularly important. A full and adequate assessment had been carried out and made the actions of the doctors involved easier to defend.
- Clinical presentation can change quickly. Expert opinion was critical of a lack of a plausible diagnosis. It is not clear from the note-taking how unwell Mr D was when assessed by Dr A. It may have been the case that Mr D appeared so well that Dr A felt it unnecessary to document normally. However, without adequate information or a clear diagnosis to prove that a reasonable assessment was carried out, it is difficult to defend her action given the symptoms of polyarthritus with patches of erythema suggestive of infection.
- Patients should be advised on the signs to look out for and when to seek further help if they continue to feel unwell.
- Identifying sepsis early can save lives. The diagnosis may not always be immediately obvious and a high index of suspicion is required to make the diagnosis and prevent fatalities. The surviving sepsis campaign, http://survivess.org is an educational resource to train healthcare professionals in the recognition and immediate management of sepsis.

Learning points

- Tragic events don’t always equate to negligence.
- CT/MPS successfully defended the claim by gaining expert opinion from three doctors.
- It is useful to remind ourselves of the stages of hypertensive encephalopathy and remember to examine the fundi in patients with hypertension.

References


Notes:

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Headaches and hypertension

Mr J was 43 and unemployed. He developed headaches and complained that sunshine hurt his eyes and he was bothered by noise. He was referred to a consultant oral maxillofacial surgeon. Mr J thought his headaches were coming from tempo-mandibular joint dysfunction, possibly secondary to a tender wisdom tooth. He had his wisdom tooth extracted under sedation. His blood pressure was not taken at this time. At his review, it was noted that his headaches had improved and could be managed with paracetamol alone. Mr J felt better and had been able to find a job in a supermarket.

The same year Mr J became concerned because he saw blood in his urine. He made an urgent appointment with his GP. Mr J documented that he had no dysuria or suprapubic pain. He noted that Mr J was very anxious about it and referred him to urology to investigate his painless haematuria. There was no evidence of LVH on echocardiogram. Mr J made a claim against his GP. He felt that the diagnosis of hypertension had been missed and the delay in treatment had caused his brain haemorrhage. It was alleged that Dr A had failed to take his blood pressure despite persistent headaches and haematuria. He believed that Dr A had diagnosed somatisation headache instead of examining him.

Expert GP opinion had only one criticism of Dr A, in that he failed to examine his fundi when he presented with headaches in the morning. The opinion of a professor of cardiovascular medicine was also given. He concluded that the intracerebral bleed was likely to be due to a small vascular abnormality rather than due to malignant or accelerated hypertension. He thought that he probably had only mild to moderate hypertension before his bleed because he had been found to have only grade 2 hypertensive retinopathy. There was no papilloedema, haemorrhages or exudates which accompany accelerated or malignant hypertension.

Expert opinion also felt that the very high blood pressure readings at the time of the stroke represented the usual physiological reaction to a cerebral bleed and did not represent the true ongoing level of hypertension. He discounted the relevance of headaches as a sign of hypertension in this case. He explained that hypertension usually only causes headache if it is malignant or accelerated, which he believed was not the case. Mr J had been a cost-effectively defended pre-trial and all costs were recovered.

EW
Nervous about neurosarcoidosis

Mrs W was a 44-year-old French teacher who was usually fit and well. She had two children and they enjoyed walking to the same school together in the mornings.

On one of these walks Mrs W was troubled by aching in her right buttock and some tingling in her right calf. She mentioned this to her GP, who noted that there had been no acute injury and that Mrs W was still managing to walk to school. He advised her to take paracetamol and ibuprofen and suggested some exercises.

A week later the pain was worse so Mrs W made an appointment to see Dr G, another GP. Dr G documented that she had acute backache with right-sided sciatica and paraesthesia in the right lateral leg. She noted that there were no bladder or bowel symptoms and documented that tone, power and reflexes were normal in both legs. Dr G's notes stated that she had discussed warning signs that would need review. She prescribed diclofenac and referred Mrs W to physiotherapy.

Three weeks later Mrs W saw Dr G again, complaining that the pain was so bad that she couldn’t walk. Dr G noted back pain with right-sided sciatica and paraesthesia but, again, found the power in her legs to be normal. Mrs W was getting indigestion with the diclofenac so Dr G prescribed codeine instead. She gave Mrs W a sick note and Mrs W said she would see a private physiotherapist in the meantime.

She managed to see a private physiotherapist a week later. The physiotherapist’s notes commented on her right buttock and leg pain and numbness in the right foot without weakness. There were clear records of the absence of bladder or bowel symptoms.

Mrs W was struggling to sleep with pain so made another appointment with Dr G. She documented that Mrs W was tearful but keeping active, doing jobs round the house. Dr G prescribed some senokot to help with “codeine related constipation” and a trial of amitriptyline.

Two days later Mrs W felt at home and rang the out-of-hours GP service. She told the triage nurse that her right leg felt numb and weak, and that she felt like she needed to pass urine but couldn’t. An ambulance was called and records in the Emergency Department noted a five-week history of right-sided leg pain and paraesthesia with a one-day history of retention of urine and inability to pass stool. Examination revealed weakness and diminished sensation in Mrs W’s right leg but normal findings on the left. There was reduced anal tone and sensation over the saddle area. She was catheterised and one litre of urine was drained. Shortly after, records stated that she had complained of numbness and weakness in her left leg and that power had been found to be reduced in her left leg. Ten minutes later Mrs W had found to have no power in both legs.

Mrs W was commenced on a three-day course of intravenous steroids, followed by a further two-day course. An MRI confirmed an extensive high signal throughout the thoracic cord, suggestive of either inflammation or infection; a plasma exchange was begun. There was no change to Mrs W’s condition and doctors noted her developing upper limb symptoms, a 6th nerve palsy and pappilodema. She was therefore treated on the basis that she had neurosarcoidosis, and Mrs W was recommenced on high dose steroids and started on intravenous cyclophosphamide.

Her condition stabilised and the 6th nerve palsy and papilloedema resolved. However, she was left with clumsy hands and paraesthesia of both lower limbs. Methotrexate was tried, but there was no substantial change to her clinical condition. She did report some improvement in the function of her hands.

Mrs W was left with faecal paraesthesia in her lower limbs, rendering her unable to move either leg or stand. Her upper limits were weak. She had a suprapubic catheter and was incontinent of her bowels. Mrs W was devastated and made a claim against Dr G.

Mrs W alleged that she had told the GP of her difficulties in passing urine and opening her bowels several times prior to her admission. She claimed that her GP had failed to examine her adequately and had not referred her urgently. She believed that her disabilities would have been less severe if she had been diagnosed and treated earlier.

MPS’s-GP expert reviewed the notes from Dr G, the physiotherapist and the hospital. He felt that there were some vulnerabilities in Dr G’s notes from the second and third consultations because they were rather brief, but considered her examination and management to be reasonable. He noted that Dr G prescribed senokot for constipation but thought it understandable for a patient taking codeine to be constipated.

He felt that constipation in itself was not sufficiently discriminatory to be a red flag necessitating urgent neurosurgical referral. He commented that the physiotherapy notes were clear and that the patient had been specifically asked about bladder or bowel symptoms and that there were none. The hospital notes stated that urinary symptoms only occurred on the day of admission. The records from all the clinicians involved pointed to Mrs W’s bladder and significant bowel symptoms starting on the day she was admitted, and not before as Mrs W claimed.

MPS also sought the opinion of a professor in neurology. He concurred with the rare diagnosis of neurosarcoidosis. He felt that Mrs W’s acute deterioration was a consequence of cord ischaemia and infarction resulting from inflammatory or granulomatous involvement of the arterial supply to the cord. This would explain the sub-acute illness with a rapid evolutionary phase to the point of severe neurological disability. It was his opinion that there is no proven effective treatment for neurosarcoidosis and that earlier treatment would not have altered the outcome. He noted that it is well recognised that cranial neuropathies, such as Mrs W’s 6th nerve palsy, can resolve spontaneously without treatment, and the improvement in Mrs W’s upper limbs was consistent with the variable natural history of neurosarcoidosis. The cord dysfunction that she had developed remained unchanged despite treatment.

MPS decided to defend the case to trial denying liability, supported by expert evidence. Mrs Wdiscontinued proceedings two weeks before the trial, and MPS is now seeking recovery of all costs.

Learning points

- Good note-keeping is important in patient care but also when defending a claim. Clinical records should include relevant clinical findings, negative findings and relevant negatives when excluding red flags, such as the absence of bladder or bowel symptoms.
- MPS carefully reviewed the records of the GP, the physiotherapists and the hospital doctors to see how the notes supported each other to aid the defence.
- It is useful to be reminded of the referral guidelines from primary care for lower back pain. Repeated examination is needed to check that there is no progression of neurological deficit.
- This case highlights the value of revisiting your diagnosis and not making assumptions when a patient re-presents.

REFERENCES

1.  www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441

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CASEBOOK

The Swiss cheese

Ms X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex.

At four weeks, J’s ophthalmology appointment took place – J was admitted to hospital as an emergency via Dr A, with conjunctivitis and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J’s eyes.

At six months, J’s ophthalmology appointment took place. He saw a consultant ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

Dr A’s referral letter did not make ends. Dr A’s referral letter did not make clear the urgency of the appointment clear itself.

Another expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present; this would have allowed for appropriate surgical intervention of the cataract that was later diagnosed. This report also criticised the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues.

The case was settled for a substantial sum.

Learning points

- Poor communication leads to poor treatment. Here is poor communication at various stages, between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a consultant ophthalmologist until he was six months old, this delay highlights failings at both ends. Dr A’s referral letter did not make the urgency of the appointment clear but, also, the recognised association of microphthalmia with congenital cataract should have prompted the consultant reading the letter to offer an urgent outpatient appointment.

Wrong drug, no negligence

Mr M was a 64-year old care assistant in a retirement home. She visited her GP with a two-month history of blood in her stools, altered bowel habit, and intermittent lower abdominal discomfort. On examination the GP found haemorrhoids, and referred her to her local hospital to see Dr P, a gastrointestinal surgeon. Mrs M was found to be overweight, with a BMI of 32, and was a smoker. Dr P performed routine blood tests, and booked Mrs M to undergo gastroscopy, proctoscopy, colonoscopy, biopsies, and injection of haemorrhoids, under general anaesthesia.

She was seen preoperatively by Dr D, consultant anaesthetist. Dr D noted Mrs M was on a number of medications, including metoprolol and quinapril for hypertension, simvastatin for raised lipids, and inhalers for a diagnosis of chronic obstructive pulmonary disease.

The episode settled and she was discharged, with a note in the records stating Mrs M was off work for two weeks, and had received antibiotics. The episode settled and she was discharged, with a note in the records stating Mrs M was off work for two weeks, and had received antibiotics.

Mrs M was referred for a sepsis screen. She was documented to be allergic to the antibiotic augmentin, which she had taken some years previously, and had caused a rash and wheeze. Mrs M reported that her brother had been admitted to hospital with a rash and wheeze following the administration of augmentin. She had been discharged on amoxicillin.

Learning points

- Adherence to simple protocols, such as the WHO Surgical Safety Checklist, can help prevent problems of this kind, where a known and documented allergy was overlooked. See www.who.int/patientsafety/safety/ls_checklist/en/
- In choosing a TIVA technique for anaesthesia, Dr D was attempting to avoid a rare but dramatic problem, malignant hyperthermia. Ms M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra care when performing a technique that is unusual for you.
- Good documentation is the cornerstone of your defence. In this case Dr P didn’t document anything that had been discussed or shared. If a junior doctor is making the notes, ensure you check their entries.
- Human error is inevitable in medicine, but doctors should always be open with patients and their families following an adverse event. An open and frank apology can often help to defuse anger. In this case, Dr D was praised for his handling of the incident afterwards.
CASE REPORTS

**No fundoscopy, no defence**

Miss Z, a 17-year-old with ophthalmology in a uncomplicated pregnancy. The consultant, Dr A, documented this consultation in the notes. He discussed the increased risk of fundoscopy, that would have been more concerning than no mention of symptoms at all, when the patient clearly recalled something in the notes.

**Learning points**
- As ever, clear documentation of a consultation is essential. Your standard of note-taking says a lot about your practice. If you can demonstrate that your notes are generally of a high standard, it may assist you if you haven’t mentioned something in the notes.
- If Dr Q had recorded the patient to have “no visual disturbance” and later “normal fundoscopy”, that would have been more convincing than no mention of symptoms at all, when the patient clearly recalled reporting problems.
- Fundoscopy is an essential examination and can assist in the diagnosis of many diseases. In this particular case, early fundoscopy could have prevented loss of vision. Experts commented that if Dr Q had carried out fundoscopy in his initial consultation, it would have prevented the pressure. The tumour was subsequently excised.

**REFERENCES**

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**Record your reasoning**

Mrs G was seen at 35 weeks gestation in an uncomplicated pregnancy. The consultant, Dr A, documented this consultation in the notes. He discussed the risk of fundoscopy, that would have been more concerning than no mention of symptoms at all, when the patient clearly recalled something in the notes.

**Learning points**
- When inducing labour, documentation regarding the counselling and consent process must be robust. The notes in this case were lost, which resulted in the case being indefensible.
- Good record-keeping is imperative throughout pregnancy, but especially so in the intrapartum phase.
- Delivery by ventouse is acceptable for most positions of the foetal head and is preferable to Kelly’s forceps, which should not be used for rotational deliveries except in the most experienced hands.
- Postnatal care is an important component of care and should not be omitted. The care of Mrs G in the postnatal period seems to have been adequate but for reasons that are not clear she refused to see Dr A. When things go wrong it is important to be open, honest, conciliatory and empathetic to the patient.

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**INTERVENTION AND MANAGEMENT/RECORD-KEEPING**

**No fundoscopy, no defence**

**Learning points**
- No fundoscopy, no defence.
- As ever, clear documentation of a consultation is essential. Your standard of note-taking says a lot about your practice.
- Record your reasoning.
- When inducing labour, documentation regarding the counselling and consent process must be robust.
- Good record-keeping is imperative throughout pregnancy, but especially so in the intrapartum phase.
- Delivery by ventouse is acceptable for most positions of the foetal head and is preferable to Kelly’s forceps, which should not be used for rotational deliveries except in the most experienced hands.
- Postnatal care is an important component of care and should not be omitted.
- The care of Mrs G in the postnatal period seems to have been adequate but for reasons that are not clear she refused to see Dr A.
Complications of colonoscopy

A 50-year-old accountant, Mrs A, developed altered bowel habit and rectal bleeding. She saw consultant colorectal surgeon Dr C, who found large prolapsing haemorrhoids and recommended a haemorrhoidectomy and colonoscopy. Dr C removed a 5mm polyp in the caecum with a snare and then went on to perform a haemorrhoidectomy. Both procedures were described as uneventful and Mrs A was stable throughout the anaesthetic.

A few hours later, after the operation, Dr C noted Mrs A was well and ready for discharge. She subsequently developed minor rectal bleeding and abdominal discomfort, and was kept in overnight. The following morning, her routine blood tests revealed a normal white cell count and her observation chart had been unremarkable, but the abdominal pain persisted.

A chest x-ray revealed bilateral sub-diaphragmatic free gas. Dr C prescribed broad-spectrum antibiotics, intravenous fluids and kept Mrs A ‘nil by mouth’. An urgent CT scan confirmed an extensive pneumo-pantenumone but no signs of any fluid collection.

Dr C examined Mrs A and found a ‘completely soft abdomen’ with no peritonism and normal bowel sounds. He explained that the perforation had probably occurred at the polypectomy site, but appeared to have sealed as Mrs A was well and the CT scan had revealed no fluid collection. Dr C recommended conservative management with surgical intervention only in the event of septicaemic complications. Over the next few days, Mrs A remained well, was apyreal and had normal inflammatory markers. She remained nil by mouth and was discharged home with seven days of antibiotics.

Dr C reviewed her at the end of the week and noted she continued to feel well, clinical examination was normal and the site of the haemorrhoidectomy was healing nicely. The pathology report of the polyp revealed grade 1 adenoma. The patient’s inflammatory markers over several days, all supported this approach. Microbiology experts agreed that the antibiotics prescribed were appropriate and the length of administration sufficient. Dr C was also able to produce audit evidence of his colonoscopy practice, demonstrating a high volume (400 per annum) with a very low complication rate.

MPS defended the case and the claimant discontinued on the first day of trial, with full recovery of costs.

Learning points

- Complications after procedures can occur and are not necessarily the result of negligence. Claims can be defended if clinicians are able to demonstrate that they managed the patient appropriately in the detection and subsequent management of complications. Evidence of a high volume practice with a low complication rate.

A catalogue of errors

As an orthopaedic surgeon, I was concerned about the number of cases related to orthopaedic surgeons in Casebook 22(1), January 2014. I was pleased to see, however, that many of these have been defended.

In one case, there was a failure to diagnose a condition, a case of “A catalogue of errors”. In that case, a lady underwent a knee replacement that appears to have been mis-positioned, which caused pain in the knee and the need for a revision procedure to be carried out at an early stage.

At that revision, carried out by a different surgeon, swabs were taken showing coagulase negative staphylococcus, but this was not thought to be significant. Subsequently, the patient developed an infected knee replacement and staphylococcus epidermidis was grown (the same bacteria as coagulase negative staphylococcus). This pattern of late clinical symptoms from infection is not at all unusual with this low virulence organism.

The importance of this, of course, was that the infection was clearly in the knee following the initial operation and would have become symptomatic in due course in any event. The patient would therefore have required a revision knee replacement for this infection, even if the original components had been perfectly placed. I note that the first surgeon was sued and the claim was settled because of the poor technical skill exhibited in carrying out the original knee replacement, and your expert, Mr D, felt that this was a breach of duty which indeed may well have been.

However, the infection would not have been a breach of duty if it was a well-recognised risk following any knee replacement, and this would have required a two-stage revision in any event.

I note that the claim was settled for a substantial sum but it would seem that the claimant had not obtained the original component and then one revision procedure, rather than the eventual poor result with multiple procedures. This was due to the infection and consequence of scavenging rather than anything to do with the original surgical procedure.

Anatomy of a claim

In Casebook 22(1), January 2014, the feature “Anatomy of a claim” tells a depressingly familiar story. Frequently and incorrectly termed “discitis”, infections of the vertebral bodies are commonly misdiagnosed. The vascular anatomy in the junctional discal area shows a pattern of end vessels throughout the disc – hence a vulnerability to infection. The disc is avascular and infection can only occur by direct inoculation, e.g. during surgery or discography.

In cases of thoracic spinal infection and in my experience of more than 35 years as a spinal surgeon, careful clinical examination of the spine will invariably disclose clear evidence. Pain and tenderness on local pressure will always be associated with the back pain history. Chest x-rays may also be present. The ESR is invariably raised. Given the typical history given by Mr P, I thought it clear that the symptoms represented “muscular back pain” was made on the basis of symptoms that must have been present for more than ten days’ duration, and this was Mr P’s third consultation. Events showed this to be a serious misjudgment. Dr A’s second consultation (Mr P’s fourth) 25 days after his original assessment, with an increase in symptomatology and in the absence of a diagnosis, resulted in an entirely inappropriate referral for physiotherapy. This treatment is likely to have caused the onset of neurological symptoms six days later.

Mr P was noted to have a loss of sensation in his legs at the time of hospital admission. An MRI scan undertaken at another hospital disclosed an “Infective discitis at T5-6”. Two laminctomies were undertaken, following which Mr P was rendered paraplegic. Laminectomy has been recognised as contraindicated as a surgical procedure for infections of the thoracic vertebral bodies for over 100 years. The history indicates that the laminectomy directly resulted in the complete spinal cord injury in Mr P at T4 (at least one level higher than the bony pathology). If the indication for surgery existed, a closed biopsy followed by an anterior debridement via a thoracotomy or an approach via a costo-transversectomy should have been undertaken. A majority of cases can be managed by appropriate antibiotics.

If Mr P’s legal advisers had instructed experts who were familiar with the presentation and appropriate treatment of spinal infections, the outcome would have been very different. On the basis of the history, the claim that Drs A and B failed to suspect a spinal infection or arrange correct investigation that should have necessitated an urgent referral meant that Mr P’s claim is self-evidently correct. This was a failure of duty of care. The subsequent surgical investigation and operative treatment was both inappropriate and negligent, and therein lay the liability and causation. This should have been substantiated by Drs E, F, G, and Mr H, had they been familiar with the extensive surgical literature on the subject, Mr H in particular. The indication for surgery was catastrophic outcome was avoidable. The case may represent a satisfactory outcome for the patient, but it also represents a grossly unfair outcome for the patient/claimant.

Aксар G Thompson, Consultant Orthopaedic Spinal Surgeon, Birmingham, UK

Response

Thank-you for your observations on this case.

The expert in this case did carefully consider the issue of causation, and in particular the question of the infection that developed in the knee. His opinion was that the infection would not have developed if the patient had not required early revision surgery due to the sub-standard index operation. He was also of the opinion that had the initial procedure been carried out appropriately, the prosthesis would not have needed revision until it failed – in approximately 15 to 20 years.

The settlement in this case reflected these issues.

Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions. Please address correspondence to: Casebook, MPS, Victoria House, 2 Victoria Place, Leeds LS11 8AE, UK. Email: casebook@mpro.org.uk


Yours faithfully,

Specialty: General Surgery
Theme: Successful Defence

Prevention of complications

The complications that occur after procedures are not uncommon. It is important to recognize the possible complications and to act appropriately to prevent them. This is particularly important when dealing with patients who have chronic medical conditions.

In this case, Mrs A developed altered bowel habit and rectal bleeding following a colonoscopy. She was initially treated conservatively, but eventually required surgery for a perforation of the colon. The surgery was successful, and Mrs A made a full recovery.

The key to preventing complications is to ensure that the patient is adequately prepared for the procedure. This includes ensuring that the patient has had a thorough physical examination, and that any necessary tests have been performed.

In this case, Mrs A had a stormy postoperative recovery, initially requiring ITU support, and spent three weeks in hospital. Dr B subsequently reviewed her febrility but Mrs A developed problems with an incisional hernia, requiring several attempts at repair. She also needed psychological support for post-traumatic stress disorder, resulting in prolonged absences from work.

Two years later, Mrs A brought a claim against Dr C, alleging negligence in the perforation of the colon. The claim was settled on the first day of trial, with full recovery of costs.

The expert in this case did carefully consider the issue of causation, and in particular the question of the infection that developed in the knee. His opinion was that the infection would not have developed if the patient had not required early revision surgery due to the sub-standard index operation. He was also of the opinion that had the initial procedure been carried out appropriately, the prosthesis would not have needed revision until it failed – in approximately 15 to 20 years.

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Yours faithfully,
Consultations. That Mr P had no real recollection (ie, what actually happened in the consultation) was further supported. Although there was a potential conflict of factual evidence (eg, sterilisation and termination of pregnancy, which require the completion of statutory forms), the actual format of the consent is less important than the accurate documentation of the process. MPS has produced a comprehensive guide – Consent to Medical Treatment in South Africa – which is available on our website.

Controlled drugs

This letter refers to an article in the New Zealand edition of Casebook (Conducting controlled drugs – what you need to know).

Response

Thank you for your observations and comments.

What an assessment at the beginning of the process by a specialist might potentially have resulted in an earlier diagnosis (depending on what symptoms were actually present), the standard to be applied is that of the reasonable GP, and our expert was clear that doctors A, B and C had reached that standard.

Consent templates?

The question of adequate consent and the preoperative discussion of possible risks and complications frequently appear in Casebook. Are there any templates of consent forms available for gynaecological procedures (especially laparoscopic procedures)? Is it not something that MPS should be involved in creating or developing?

Dr AA Caruso, Gynaecologist, South Africa

Response

Thank you for your observations and comments.

MPS does not produce specific templates or forms for use in the consent process. Consent is a process that will vary depending on the circumstances. Although there are some specific exceptions in relation to certain procedures, interventions and circumstances (eg, sterilisation and termination of pregnancy, which require the completion of statutory forms), the actual format of the consent is less important than the accurate documentation of the process. MPS has produced a comprehensive guide – Consent to Medical Treatment in South Africa – which is available on our website.

In respect of rare but possible complications such as awareness, nerve injury, disability and death, the AAGBI Association of Anaesthetists of Great Britain and Ireland recommend in their guidance Consent for Anaesthesia Revised Edition 2006 (para 5.3.8) that written information should be provided, and the anaesthetist should be prepared to discuss the risks. MPS does not produce specific templates or forms for use in the consent process. Consent is a process that will vary depending on the circumstances. Although there are some specific exceptions in relation to certain procedures, interventions and circumstances (eg, sterilisation and termination of pregnancy, which require the completion of statutory forms), the actual format of the consent is less important than the accurate documentation of the process. MPS has produced a comprehensive guide – Consent to Medical Treatment in South Africa – which is available on our website.

How reliable is healthcare?

Dr Downey makes some excellent points and his thoughts are aligned with mine. It is certainly true that aeroplane safety relies to some extent on passengers alerting the captain to potential problems, and in adopting a healthcare outcomes paradigm, similarly relying on patients for their expertise is crucial. A difference is that the passengers on an aeroplane, except perhaps in the case of a mid-air emergency, do not rely on the crew to instruct them how to be successful passengers (after the initial safety instructions prior to takeoff!), whereas achieving healthcare outcomes uniquely requires clinicians and patients to work very hard together across all aspects of care planning to achieve successful care implementation. One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are readmitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause for concern of physical, psychological and financial harm; the antithesis of a high-reliability system.

Clinicians and patients are both encumbered with many human factors limitations and training or interventions for both are likely to serve good purpose. The processes of diagnosis, therapeutics and of care plan implementation present numerous human factors challenges. If the goal is preventing readmission then planning for that should begin at the time of admission with defining, and then modulating, the human factors that confound success.

Dr Cohen, MD, FRCPCH, FAAP, International Medical Director, Delta UK Ltd and Delta (USA) Inc. Drshen@deltay.co.uk

Cutting corners

As an anaesthetist, I was interested to read the case report “Cutting corners”, describing the severe brain damage that befell a four-year-old boy following an anaesthetic mishap (Casebook 22 (7)). The anaesthetist, Dr B, was involved in several aspects of his care, including failing to warn the child’s parents of “the risks of anaesthesia”. I would like to know what MPS recommends in this regard, given that in the case quoted, the child was fit and well, with no medical problems or allergies, and was appropriately fasted. He obviously required a general anaesthetic, and in the overwhelming majority of such cases, one would expect this to be uneventful. What should Dr B have told the parents, without alarming them unnecessarily?

Dr John Robinson, Consultant anaesthetist, Newcastle upon Tyne, UK

Response

Thank you for your observations and comments.

It is fair to say that the medicolegal landscape changes with time, and can be dependent on the jurisdiction. The general trend, however, is towards a full disclosure of risk, and a process of joint decision-making with the patient (or in this case, the parents).

Dr Philip Colquhoun, Managing Director, Fraser Healthcare, Ireland

Response

Thank-you for another informative issue of Casebook.

I am responding to Helen Moniriy’s article on controlled drugs – what you need to know. Casebook 22(2) in New Zealand.

The article is clear and helpful, and the message that prescribing to any dependant person must be by a gazetted practitioner (and sometimes location) or under the specific written authority of such a practitioner, is clear.

However, the article does not address the question of colleague or locum prescribing, and I have wondered about this in the past. Specifically, if the duly gazetted authorised practitioner is away/ unavailable (not just fully booked that day), does a colleague from the practice, or a locum, have the legal right to prescribe for dependent patients?

It is a widespread convention that locums (if not colleagues) are authorised to do all that the doctor they are replacing would normally manage, including prescribing to this category of patient.

I shall be grateful for Dr Moniriy’s further advice.

Dr Craig Lassig, Waimate, New Zealand

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The Enemy Within is a ground-breaking, hour-long documentary film presented by Vivienne Parry – it tells the story of the human fight against cancer over the last 50 years. Contributors include the great and the good of cancer research – Professors Robert Weinberg and Umberto Veronesi, Lord Ara Darzi, Professor David Nathan, Professor Brian Druker and many more. Equally, there are contributions from a number of patients, including Karen Lord, a survivor of childhood leukaemia, Julian Tutty, one of many patients who benefited from the development of Gleevec, and Bobbie Ariaudo, who eventually succumbed to cancer.

In chronicling the fight against cancer, it describes any number of important events – be that the debate surrounding combination versus sequential, single agent chemotherapy, the provision of palliative care or the realisation that a conservative surgical approach, as opposed to radical mastectomy, might be equally beneficial and less disfiguring for patients with breast cancer. It also focuses on achievements further afield that have helped improve survival rates for many cancers – the vast technological advances that have led to the development of CT, MR and PET imaging, the sequencing of the human genome and the realisation that environmental exposures (smoking, alcohol, obesity and sunbeds) are significant causative factors that need to be addressed.

In doing so, it tells a calm and sober story of human endeavour. Whilst the film also acknowledges the role of survivors, politics and ‘people power’, you sense that the nod to these groups is simply that – a nod. The power of the human story, the story of those who have succumbed to cancer and those who have survived, feels sanitised – devoid of the emotion that might invigorate this short film. Moreover, you can’t help but feel that it glosses over many of the challenges that remain – the failure to diagnose and treat virulent cancers, especially pancreatic and thoracic disease, the inadequacy of palliative care or the realisation that the nod to these groups is simply that – a nod.

However, in a little over an hour, this film provides a high level overview of what has been achieved in 50 years, which will be enjoyed by many a clinician.

Films such as The Enemy Within are one thing. I see errors picked up on a weekly basis simply by having an easy-to-follow checklist for the whole team to follow. Gawande distinguishes between errors of ignorance and efforts of ineptitude – the most common and relevant in today’s medical world being the latter. He explains that the high pressured and intense environment that is prevalent in the medical world means mistakes are inevitable.
How to contact us

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

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