DIVERTED BY THE DIAGNOSIS

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Medical matters, unsurprisingly, continue to feature heavily in the headlines and the media in general. There seems to be an endless appetite among the public for such stories, whether they are announcing the arrival of new and better treatments or procedures, or reporting shortfalls, errors or even scandals.

Inevitably this is felt by you on the wards or in your consulting rooms, with increasing patient expectations in the form of unrealistic demands or a raft of self-researched information from the internet. This can make for some challenging situations, at a time when workloads grow in intensity, perhaps due to budgetary cutbacks or other local factors.

It continues to be an important time to be part of an organisation like MPS. We work in partnership with you to protect and support your career at every stage, and this work takes many forms, beyond the litigation work that we are more traditionally associated with. This includes an extensive range of educational products such as online learning, workshops and seminars, as well as continuous consultative work with governments and policy-makers worldwide. The latter is often ‘behind the scenes’ and often not highly-publicised, but you can be reassured that our specialist teams are fighting hard to safeguard your interests.

Many of you got in touch with us following the last edition of Casebook, regarding our cover story on the case of Beth Bowen. While the emotional reaction from a number of correspondents was not surprising, I was heartened by the way the article made everyone think about their own approach to communication, openness and consent. Anger at the treatment of the Bowen family was palpable in some of your letters, and if this deeply tragic case results in reflection and changes in culture and practice, then something positive will have been achieved.

We have published a short response to this correspondence in our “Over to you” section on page 23. I hope you find this edition of Casebook an equally thought-provoking one and, as ever, I am keen to hear your feedback.

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A CASE FOR THE DEFENCE

What can doctors expect from their legal advisers? Sophie Pearson, former MPS panel solicitor, argues, argues the benefits of the ‘reality-testing’ role of the defence lawyer in clinical claims

The litigation landscape continues its inexorable metamorphosis – thank goodness. From the bad old days of trial by ambush, posturing, brinkmanship and one-upmanship, we are lumbering towards a system in which early disclosure of evidence followed by proper litigation risk assessments, mediation and negotiated settlements are the order of the day.

And not a moment too soon. In the notorious (and fictional, of course) case of Jemmy v. Jemmy in the novel Bleak House, Dickens took the adversarial and bellicose approach to litigation to the extreme, wiping out the family’s entire inheritance in legal costs (when the preservation of that inheritance was the very reason for going to law in the first place) and killing the protagonist in the process. Nonetheless, there was more than a grain of truth in the utter devastation that the litigation left in its wake and important lessons to learn from it, even today.

Which brings me to what this article is about, namely, what is the role of the medical negligence defence lawyer in this day and age? How are our doctors best served by us in this climate of increasing medical negligence litigation and what more can we do to help?

First of all, the basic framework. When a doctor comes to us with a letter alleging negligence there are, broadly speaking, four options: getting the case discontinued (because there is no merit in it); taking it to trial (because nothing will convince us that the claim has merit but the patient doesn’t see it that way); settling it – i.e., making an offer (without making any admissions of liability (because there just might be merit in it) and last but not least, setting it on a full admission basis (which hopefully requires no explanation).

To decide which avenue to take, we need to find out exactly what happened and then get independent expert evidence as to whether that particular medical practice was acceptable. We work hard with our doctors to establish what happened on that operating table or during that course of treatment. This is not always straightforward as memory can be unreliable, criticism is the finest way to put people on the defensive and doctors may simply be unclear how much information to share with us (the answer to that question: by the way, is share all of it – we are working with your best interests at heart, lawyer/client communications are entirely confidential and forewarned is forearmed). And, similarly, we work closely and determinedly with our experts to make sure that they have worked through their opinions thoroughly and logically. After all, if we don’t, the patient’s legal team is sure to do so at trial.

During the course of any case – and this is where the dynamic gets interesting – we wear two hats. The first is that of quasi-counselor, the other that of reality-tester. In relation to the first, anyone facing criticism about the work they do with such dedication is likely to feel stung by it and doctors are no exception. Their role is to look after the health of their patients and at the core of the professional mentality is a desire for high standards. Criticism about an isolated incident is often seen as an attack on their general professional competence and can hugely undermine confidence. Similarly, doctors who have built up a rapport with a patient over a period of time can feel betrayed when the patient then turns round and entrones their management.

However calm and collected doctors come across at a first meeting, they usually feel defensive, indignant, upset, vulnerable, angry or all of the above. A vitally important part of our job is to work with that emotional ‘fall-out’ and support the doctor throughout the litigation process. We spend our lives within the arena of dispute resolution, and have a profound understanding of the dynamics of conflict and how it feels to be on the receiving end of a claim.

Our other ‘hat’ is that of reality-tester. There comes a stage in every claim where in order to advise our client properly, we need to sit back, look at the evidence rationally and dispassionately and advise our client on the most appropriate option. This objective analysis of the evidence is vital because it ensures the right decisions are taken at the right time and with the minimum disruption to our clients’ lives, but it can also be the most tricky moment in the lawyer/client relationship. How, after all, is the doctor supposed to believe that we are fully behind him if our advice is that the court will probably consider his actions negligent?

Controversial though it may sound, this stage of any claim is ripe with potential and the litigation process, if dealt with skilfully and constructively, has the power to transform. Once the initial horror of being accused of being negligent has subsided, the whole process of reality-testing the evidence of encouraging our clients to stand back and look at the care they provided rationally and objectively, can be very liberating and provide important lessons if they have the courage to look for them (and, ironically, it is only by looking at a sequence of events dispassionately that the defence lawyer will see where a true defence lies).

The exercise might move the doctor from a sense of outrage (if he thinks he has done nothing wrong) to an acceptance that things could have been done differently, or the doctor (who thinks he has) from feelings of vulnerability and despair to feelings of confidence in his decision-making processes or clinical skills and awareness that he needs to become resilient in the face of criticism. And conversely for patients who are questioning the treatment they have received, it might actually be comforting – outlandish though this may sound to some in the claimant camp – to find out that the care they received was up to standard even if it did not result in the outcome hoped for let alone anything worse than knowing that an injury was caused by carelessness?

But there is a further point. The adversarial approach to litigation often wreaks havoc on doctors’ lives. It puts time on hold and encourages an unhealthy preoccupation with how badly the other side is behaving, which leads to a gradual entrenchment of positions that, in turn, leads to an unwillingness to see where the other side might have a point. In short, it encourages a culture of not listening, not communicating and turning a blind eye to any middle ground that may exist. Sadly, this approach still lingers in some quarters, but those who espouse it do both patients and doctors a disservice.

In the words of one management guru, life is a corridor, we are tennis balls and by hitting the walls on either side we can change direction and move ahead. Those walls, in this context, are the adverse outcomes that many doctors will come across at some point in their careers, and which, if they can learn from them, can propel them forward to new and better pastures.

The days of old-style, war-like litigation are on their way out and the days of forensic and objective analysis of the evidence and of dealing with the consequences sensibly – whatever that may mean – are in. We must continue to work hard with doctors to convince them that this new litigation landscape can be a good thing.

Sophie Pearson practised at the Hong Kong office of MPS panel law firm Kennedys in 2013. She is now Training Solicitor at King’s College Hospital NHS Foundation Trust in the UK.
PATIENT EXPECTATIONS: A SURGEON’S PERSPECTIVE

Dr Danny Lee, a consultant surgeon and MPS faculty presenter in Hong Kong, tackles the ever-growing problem of patient expectations

Dr L was quite certain her symptoms were caused by gallstones. After physical examination, which was unremarkable, Dr L explained the diagnosis and the proposed treatment – laparoscopic cholecystectomy.

“Comment made by a patient to Dr L”

Dr L said: “You probably need a laparoscopic cholecystectomy.”

“That’s what my family doctor told me,” Miss C replied.

“The operation will be done under general anaesthesia, and it will take 60 minutes to finish. You need to stay in the hospital for two days.” Dr L said. “There is a 5% chance that the operation cannot be done by laparoscopic means and, if that happens, I will make an incision, around eight inches long, to remove your gallbladder.”

Pursuing here, Miss C frowned and then said: “Google said patients go home almost immediately after laparoscopic cholecystectomy. My family doctor told me you are the expert in this area, and that’s the reason why I am here today. How could you possibly say that you cannot finish the operation and want to cut me open? You are unprofessional. We are done here.”

Miss C left the clinic without paying any consultation fee. Six months later, it came to Dr L’s attention that Miss C has lodged a complaint and a consultation fee. In this regard, in order to enhance professional interactions and minimise communication risks, it is prudent for referring family physicians to include a generic and open-ended question in the referral documents.2 Such a question would help to inform the consultant. In this regard, in order to enhance professional interactions and minimise communication risks, it is prudent for referring family physicians to include a generic and open-ended question in the referral documents.1

Despite your good intention, you should be mindful when talking to patients and other health care professionals. It may create unrealistic expectations about the consultant. In this regard, it is important for the consultant to enunciate the limits by which the consultant is bound by law and medical ethics. In Miss C’s case, the consultant was bound to inform the patient of the risk of conversion during laparoscopic cholecystectomy.3 In practice, we must be sensitive to patients’ unrealistic expressions, and to respectfully correct or clarify unrealistic expectations. Failure to identify and address patients’ unrealistic expectations could be a significant risk for complaints or claims. In the MPS series of risk management workshops, available to members free of charge, clinicians are encouraged to routinely ask patients for their expectations, to respectfully correct patients’ unrealistic expectations, and to pay particular attention to patients who resist having their unrealistic expectation corrected. In practice, we must be sensitive enough in order to do this well.

First and foremost, we need to establish trust. How? My strategy is to let patients talk first.

In the anecdote, it would have been easier for Dr L to uncover and address Miss C’s expectations if he had asked: “Can you please tell me how much you have learned about the disease and possible treatments?” Such a generic and open-ended question would allow Miss C to tell Dr L what information, queries and concerns she had in her mind. Early patient involvement is a powerful way to build up trust, as enunciated in the shared decision-making model.4 Effective communication should allow a two-way dialogue between the surgeon and the patient, a one-way information delivery from the surgeon to the patient can become dogmatic and should be avoided.

Colleagues should be reminded that it is possible to deliver a fluent account on various risks associated with a particular treatment, without necessarily help to gauge the patient’s concerns and expectations. Failure to establish a trusting doctor–patient relationship and adequately address patients’ unrealistic expectations are two important precipitating factors in many medicolegal disputes that I have been involved with.

SUMMARY

• In the era of MIS, patients have higher expectations for the outcome of their surgery.
• Clinicians play an important role in shaping patients’ expectations.
• Failure to identify and address patients’ unrealistic expectations could be a significant risk for complaints or claims.
• Effective professional interaction would enhance early identification of patients’ unrealistic expectations.
• “Let patients talk first” would be a good strategy to establish a two-way dialogue and trust between doctors and patients.

Dr Danny Lee is a consultant surgeon based in Hong Kong. Dr Lee is a medical associate of MPS, and an accredited presenter of the MPS series of risk-management workshops – to find out more, visit the Education and Events section.

Dr L explained the diagnosis and the proposed treatment – laparoscopic cholecystectomy. As an illustration, we have experienced dramatic advances in the field of minimally invasive surgery (MIS) over the last two decades. Nowadays, surgeons can remove tumors or solid organs without leaving long and ugly scars. Surgical incisions are getting fewer in number (eg, single-port laparoscopic surgery) and shorter in length (eg, robot-assisted surgical access), while the naturally fine endoscopic surgery makes scarless operation a reality.

Although numerous scientific studies have confirmed the benefits of MIS in terms of faster recovery, less pain and even better survival in some cancer surgery, there are caveats and limitations in practice. As surgeons, we understand clearly that MIS is not for everyone or every disease.

The challenge is: some patients may not appreciate or fully understand this.

EXPECTATION HANDLING IN PRACTICE

Let’s examine the following fictional case and see how the encounter could have been improved.

Miss C, a 45-year-old lady, was referred by her family physician to see Dr L, a laparoscopic surgeon, on a Saturday morning. She presented with dyspepsia, and was found to have gallstones on ultrasound examination. Dr L was quite certain her symptoms were caused by gallstones. After physical examination, which was unremarkable, Dr L explained the diagnosis and the proposed treatment – laparoscopic cholecystectomy. Dr L said: “You probably need a laparoscopic cholecystectomy.”

That’s what my family doctor told me,” Miss C replied.

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FROM THE CASE FILES

Melanie Rowles, head of claims management at MPS, introduces this edition’s collection of case reports, and looks at how they are often viewed very differently by doctors and lawyers.

I am pleased for this opportunity to present some of the cases in this edition of Casebook from a claims management perspective. I have been a solicitor for nearly 30 years and the majority of my career has been spent working with doctors. After a few years of working with my medical colleagues, it became clear to me that lawyers and doctors often speak a different language and look at events from a very different perspective.

So having read the cases, I thought I would highlight where I see some of those key differences – and clarify those situations where a lawyer’s advice may seem difficult to understand or even illogical.

As I was reading each case I could see where the story would end before I got there. I think this was because I was seeing them as a lawyer: seeing the whole scenario unfold and not just seeing a snapshot in time. This is exactly how a judge would see a case and I think that is worth reflecting on.

As a doctor you are often dealing with a snapshot in time, and often under significant time pressure. However, it is always worth reflecting on the story as you read the case. The regulator, ‘reflection’ and ‘insight’ are words that inform him on medical issues and look at the expert evidence, and assessed the issues objectively, the chain of events and the outcome for the patient would probably have been better.

When a claim appears before a judge they see the whole picture with all the missing pieces and an adverse outcome. A judge will use the experts to inform them on medical issues and look at the expert opinion, but will apply legal tests and a layman’s view of common sense. With that in mind you will see how easy it is for them to reach a view that if someone had stood back and looked at all that had gone before, and assessed the issues objectively, the chain of events could have been stopped.

Interestingly, having had the opportunity to discuss this with my colleagues who deal with matters before the regulator, ‘reflection’ and ‘insight’ are words that are used repeatedly in that arena. Again, reflection can be the key to a successful outcome.

As a final thought I can see how some may wonder why compensation is still paid even though there is an eventual outcome for a claimant that is the same irrespective of the adverse event. “What has been caused?” you may ask. Legal causation is any path of events that are sufficient that flow from an error and which otherwise would not have been there. So any period of additional pain is compensable, even if it is hours or days.

I will leave you with these thoughts and let you ponder on the words we use and their different meanings, as you read the cases.

What’s it worth?

Since precise settlement figures can be affected by issues that are not related to the learning point of the case (such as the claimant’s job or the number of children they have) this figure can sometimes be misleading. For case reports in Casebook, we simply give a broad indication of the settlement figure, based on the following scale.

HIGH: US$20,000,000

SUBSTANTIAL: US$2,000,000

MODERATE: US$50,000

LOW: US$2,000

NEGIGIBLE: US$2,000

CASE REPORTS

PULLED IN ALL DIRECTIONS

SPECIALITY: ANAESTHESIA

THEME: INTERVENTION AND MANAGEMENT

HIGH: US$2,000,000+

MR was a 32-year-old female patient who had a history of neck pain following a road traffic accident. The pain was localised to the left side of her neck and was a constant ache. She said that any very occasional parasitesthesia in her left hand. Despite regular analgesics and exercises, the pain was still troublesome and she was keen for a specialist opinion.

Mrs J was referred to Dr M, a pain consultant. Dr M noted slight restriction in neck movement on the affected side and elicited tenderness over the left C5/6 and C6/7 facet joints. Imaging revealed fusion of the C3 and C4 vertebrae and some loss of normal cervical spine curvature, but the vertebral bodies and spaces remained otherwise well-preserved.

Dr M recommended C5/6 and C6/7 facet joint treatment and told Mrs J that there was a 50% chance of getting long-term pain relief. He suggested two diagnostic injections with local anaesthetic followed by radiofrequency lesioning if benefit was felt. Dr M went through the risks of the procedure with Mrs J, including lack of benefit, relapse of pain, infection and damage to nerves.

Mrs J returned for the first of the two diagnostic blocks. The block was performed in the lateral position and Dr M injected a mixture of 0.5% levobupivacaine and tramadol. The block provided good pain relief and Mrs J felt it was easier to move her neck.

Mrs J later returned for the second diagnostic injection. Mrs J was placed in the prone position and local anaesthetic infiltrated into the skin. Using bimanual fluoroscopy, 25G spinal needles were inserted toward the C5/6 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and diagnostic substances into the facet joints. Unfortunately, as soon as Dr M started the injection the patient jumped with pain and his left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later the same day developed numbness in her left arm and right leg. She also complained of headache when sitting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr M decided to admit Mrs J for overnight monitoring and analgesia.

The next morning Mrs J was no better. She felt unsteady on her feet and complained of a burning sensation in her right leg, left elbow and left upper arm. Dr M decided that a second opinion was required and referred Mrs J to a neurosurgical colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved but Mrs J continued to suffer from neuropathic pain. It affected many aspects of her daily life and she found it difficult to return to work as she was not able to sit or stand for any length of time. A spinal cord stimulator was inserted by another pain specialist to try and help with the pain, but this was largely unsuccessful and was later removed.

Mrs J subsequently lost her job and, following that, decided to bring a claim against Dr M.

EXPERT OPINION

The case was reviewed for MPS by Dr F, a specialist in pain management. Dr F was of the opinion that the initial assessment and management plan were entirely appropriate. She was somewhat critical of the approach used by Dr M for the diagnostic injection as it was not consistent with the planned approach for the radiofrequency lesioning and, in her opinion, more likely to be associated with the possibility of damage to the spinal cord. She also felt that the use of tramadol in the diagnostic injections could be criticised, as injection of particular matter into the spinal cord is known to be associated with a higher risk of cord damage.

Dr W, an expert neuroradiologist, was concerned that the MRI review was reviewed from the second diagnostic injection. He concluded that neither needle was within the respective facet joint and that the lower needle tip was within the spinal canal at the level of C5, less than 1cm from the midline. Dr W also confirmed that the MRI abnormality corresponded with the position of the lower needle tip.

Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

MPS then instructed a causation expert to comment on Mrs J’s progression of symptoms. Professor concluded that the development of neuropathic pain in the right leg was understandable, although the disabling effects were more than he would have expected. Whilst the patient did have a history of neck pain, the patient’s symptoms were consistent with a lesion affecting the spinothalamic tract on the contralateral side of the cervical spinal cord.

The case was considered indefensible and was settled for a high sum.
S was a 60-year-old lorry driver. He was overweight and smoked, and couldn’t walk because he suffered with pain in his calves.

During a long drive he became aware of pain in his right calf and foot. This became so severe that he attended the out-of-hours service the following evening. The GP measured both calves and found them to be the same. A history of foot pain but no calf tenderness was noted and a DVT was excluded. He told Mr S he likely had a problem with his circulation. Mr S was prescribed aspirin and advised to consult with his own GP for further follow-up.

Mr S struggled to sleep for the next two nights because he had a burning sensation in his right foot and leg, which felt cold and numb. He had to get up and walk around to relieve the pain. He made an appointment with his own GP, Dr A, the next day. Dr A noted the history of numbness and rest pain. He documented that his right foot was pale and felt cold. He requested a non-urgent Doppler assessment because he could not detect any pulses in his right foot and prescribed quinine sulphate.

Mr S’s Doppler scan was arranged for the following week but he rang his GP surgery three days later because the pain in his foot and leg was becoming swollen. Dr A reassured him that an amputation may well occur before an accident happens. He considered that Mr S’s foot would not be saved and that resuscitation can be instituted as soon as the baby is delivered. In this case the baby should be delivered as soon as possible after the diagnosis of fetal distress.

Learning points

- If there is any delay in a patient being resuscitated or diagnosed as having a subtotal stroke, then the patient should be reviewed by the doctor before syncoctinon is prescribed. There should, however, be a delay before this is done because there is the risk of anaphylactic shock. The patient should be fully reassured on an individual basis, eg, sign of fetal distress on the CTG, frequency and strength of the contractions, previous obstetric history etc.
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TOO MUCH OXYGEN

SPECIALTY PEDIATRICS

THEME INTERVENTION AND MANAGEMENT

SUBSTANTIAL US$200,000+

A baby was born by caesarean section at 27 weeks gestation. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first four hours of life, the baby’s oxygen saturations were recorded as ranging between 96-97%. A blood gas taken five hours after delivery showed a pH of 7.48 (normal 7.3-7.4), a PaCO2 of 35.8kPa (normal 6.0-6.6), a PaO2 of 35.8kPa (normal 5-8) and a bicarbonate level of 24.6mmol/L (normal 18-24). This demonstrates the baby was being over-ventilated.

The baby was ventilated for three days, placed on continuous positive airway pressure (CPAP), and then placed on 0.5L nasal cannula oxygen due to recurrent apneic spells. Overall the baby received 204 hours of oxygen with oxygen saturation levels of 96-100% throughout.

The baby was not referred at four to six weeks of age for retinopathy of prematurity (ROP) screening, and was first seen by an ophthalmologist at the age of seven months when a diagnosis of inoperable Grade 5 ROP, causing blindness, was made.

The baby’s parents made a claim against the consultant paediatrician who handled the baby’s care.

EXPERT OPINION

The baby developed severe ROP and blindness due to excessive oxygen administration. The opportunity to limit the condition and save the infant’s vision was missed due to the fact that the child was not referred for screening for ROP. There was negligence on the part of the paediatrician and nursing, in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a four-day period, and failing to refer the child at the appropriate time for an eye examination.

The case was settled for a substantial sum.

Learning points

- Neonatal units should have written guidelines for oxygen saturation levels during the administration of oxygen to very low birthweight premature infants, and these must be adhered to.
- Attention should be paid to weaning oxygen when the saturation levels are more than 90%. The recommended safe levels of both weight infants are between 86% and 92%. Unilateral and prolonged oxygen exposure in very low birthweight infants is associated with significant grades of ROP.
- ROP is a relentless disease that affects premature infants, and can be limited by adhering to the specific guidelines for oxygen administration and monitoring of premature infants at four to seven weeks of age by an ophthalmologist experienced in the identification and treatment of ROP.

CASE REPORTS

A PROBLEM WITH POLYPS

SPECIALTY GENERAL PRACTICE

THEME DIAGNOSIS

HIGHUS$2,000,000+

Mr S was a 35-year-old taxi driver who was visiting his extended family abroad. While he was there he decided to have a routine health check in a private clinic. He told the doctor in the health clinic that he had noticed some rectal bleeding over the previous four months. The doctor did a digital rectal examination and proctoscopy and saw two rectal polyps.

He gave Mr S a letter to take to his GP at home, explaining the findings and recommending a colonoscopy to further investigate his bowel.

Mr S returned from overseas a week later and made an appointment with Dr A. He gave Dr A the letter from the overseas health clinic and explained that he had noticed occasional rectal bleeding and he stated that he had seen one of his colleagues a month before who had seen external haemorrhoids that were bleeding slightly. Dr A advised Mr S to avoid constipation to help with his haemorrhoids. He filed the letter from the health clinic but did not act on it.

The following year Mr S was still bleeding occasionally. He remembered the concerns of the overseas doctor and rang his GP surgery. He was given an appointment with Dr B. He explained that he had seen maroon blood on the toilet paper and in his stool for months and was concerned about the cause. Dr B examined him externally and noticed some small polyps. The doctor noted that Mr S was not keen on medication so advised him to drink more fluids and increase his fibre intake.

Mr S tried following this advice for six months, but the bleeding persisted so he visited Dr B again. Dr B did a purely external examination again and documented “simple external piles”. He prescribed anal suppositories.

Over the next three months Mr S began to lose weight and feel very tired. His wife was concerned that he looked pale. He still had the bleeding episodes and his episodes of diarrhoea and constipation. He made an appointment with Dr C, another GP from his practice, who arranged for some blood tests, which showed significant iron deficiency anaemia. She referred Mr S to the colorectal team, who diagnosed rectal carcinoma.

He had a proctocolectomy and the histological diagnosis was of two synchronous rectal carcinomas, Duke’s stage C1. Multiple adenomas were found, some with high grade dysplasia, and it was considered that Mr S had Attenuated Polyposis Syndrome.

Mr S and his family were devastated. He struggled through chemotherapy and radiotherapy. He was told that it was not possible to reverse his illness and that his five-year survival rate was 45-55%. He was very angry and made a claim against Dr A for not referring him earlier or taking notice of the overseas health clinic’s recommendations.

EXPERT OPINION

MP’s sought the advice of an expert GP. He was critical of Dr A for failing to perform any examination of his own, relying instead on a prior examination by one of his colleagues. He felt that Dr A should have taken a fuller history including possible alteration in bowel habit, weight loss and abdominal pain. He felt that choosing to ignore the recommendations of the overseas clinic without making any attempt to reach his own diagnosis to explain the rectal bleeding failed to provide a reasonable standard of care. He commented that haemorrhoids are a common cause of rectal bleeding in a 35-year-old but the decision to dismiss the clinic’s advice without adequately assessing the patient could not be defended.

The expert GP was also critical of Dr B. The notes from his two consultations gave no indication that any further history was taken. He felt that he should have conducted a digital rectal examination rather than just an external inspection and that this represented an unreasonable standard of care. He felt that a digital rectal examination would have revealed the polyps and thus a more timely referral.

The opinion of a professor in colorectal surgery was sought. He considered that if Dr A had performed a digital rectal examination at Mr S’s first presentation he would have become aware of the polypoid lesion in the lower rectum. This should have raised suspicions such that he would have made the referral for colonoscopy. He felt that Mr S would not have avoided a proctocolectomy because he had multiple other polyps in his colon and was thought to have Attenuated Polyposis Syndrome. He did state that if the resection had been done closer to presentation, the tumour would have been more likely to be a Dukes A or B and he would have had a five-year survival rate of 70-95%.

The case went to court and was settled for a high amount.

Learning points

- Common, normally benign symptoms can on occasion be more serious.
- Be prepared to reassess patients if their symptoms persist and not just taking a detailed history and conducting a thorough examination.
- A diagnosis may need to be revised on subsequent consultations rather than relying solely on former colleagues’ decisions.
- Regardless of the facts someone has a consultation overseas out of context, it is never safe to ignore the findings of those consultations and investigations without properly ruling them out first.

In the UK the National Institute for Clinical Excellence (NICE) has produced guidelines for referring suspected cancer cases—www.nice.org.uk/guidance/cg27/chapter/guidance.
Miss A, a 40-year-old IT consultant, was talking to a colleague at work when she developed a headache, along with blurred vision and nausea. Her symptoms worsened so an ambulance was called. In the Emergency Department (ED), Miss A was triaged as moderate urgency and examined by Dr X who recorded that her head felt “heavy” at work and she’d felt herself breaking out in a cold sweat, with a throbbing frontal headache radiating to each temple.

The next week she attended her GP, Dr X, who listened to her history and read the hospital letter, noting that her head felt “heavy” at work and she’d felt herself breaking out in a cold sweat, with a throbbing frontal headache radiating to each temple. She vomited twice before an ambulance took her to the ED where, on arrival, her GCS was 15. Transfusion was attempted but following a CT scan of her brain, she died. The scan confirmed a large subarachnoid haemorrhage involving the 3rd and 4th ventricle on the right side and a frontal intracerebral haemorrhage.

EXPERT OPINION

Dr X had reasonably considered a vascular event as a cause of the headache. However, he’d planned to wait and arrange an MRI scan if the headache did not settle with treatment. In this case, Dr C, an expert GP instructed by MPS, said it was not reasonable to wait before arranging referral for investigations.

Dr X felt his actions were defensible. After their consultation, Miss A had his telephone number so could have phoned him at any stage. He’d instructed her to return if her condition deteriorated. He’d acted cautiously and responsibly – the patient declined medical follow-up and specialist referral the next day. She’d been investigated at ED before attending him and the diagnosis had been migraine.

Dr X had based his own diagnosis on the reported pulsating headache lasting 4-72 hours of moderate to severe intensity aggrivated by routine exertion and associated photophobia. Miss A had work stress, which may have precipitated a migraine and reinforced the diagnosis. Migraines usually present as unilateral headaches, but bilateral headaches can also occur. Miss A’s headache was frontal to begin with and then bi-temporal when she’d attended Dr X. Although she had no history of aura, migraines without aura are more common. In Dr X’s opinion, it did not matter that Miss A had no past history of migraine – not all patients experienced migraines in the past.

The claim was settled against both Dr X and the hospital for a moderate sum.
M, a 44-year-old architect, attended his GP, Dr C, for a skin check. Dr C diagnosed a seborrhoeic keratosis skin lesion on the upper left arm. A brief record was made in the notes, but there was no detailed description of how the lesion looked and no action was taken.

Five months later, Mr M was seen by another member of the practice, Dr B, for heartburn symptoms and Mr M also mentioned the skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic keratosis with a thin scab on the top” and referred Mr M to the practice’s minor surgery clinic for removal of the lesion.

The following month, a third doctor in the practice, Dr A, saw Mr M and referred him to a dermatologist. In the referral letter, Dr A mentioned that Mr M’s skin lesion had increased in size and was bleeding. Dr A prescribed flucloxacillin as he felt the lesion might be infected and had written a note asking for Mr M to be seen urgently by the dermatologist within two days. There were now palpable axillary nodes and melanoma seemed likely.

One month later, in March, Mr M underwent wide excision and axillary dissection, but his condition deteriorated. Unfortunately, he had developed brain metastasis by April and stage 4 malignant melanoma. He died in July of progressive metastatic disease, despite chemotherapy and radiotherapy.

Mr M’s widow made a claim against the practice for failing to diagnose the skin lesion as malignant. She alleged that Mr M was not seen urgently by the dermatologist within two days. There was no palpable axillary nodes and melanoma seemed likely.

Mr M’s widow made a claim against the doctors at the practice for failing to diagnose the lesion as malignant sooner.

EXPERT OPINION

Claimant expert opinion was critical of the standard of care provided and felt that Mr M should have been referred straight away, rather than three months after the initial presentation. They also felt that the description of the lesion was not adequate or detailed enough, quoting NICE guidelines. Lifting the crust off the lesion did not change the overall outcome. Expert opinion agreed that the Stevens-Johnson syndrome was a rare but not uncommon condition, with a 1 per cent risk of death. The patient’s condition was worsening, and the expert opinion agreed that hospital admission should have been urgently arranged for her. The diagnosis of the Stevens-Johnson syndrome was confirmed by expert opinion.

Mr M’s condition deteriorated, and he was transferred to the ICU where he remained for a month. He was intubated, ventilated and treated with antibiotics, steroids and intravenous immunoglobulin. Despite this, Mr M’s condition continued to deteriorate, and he was transferred back to ICU with severe type 2 respiratory failure attributed to toxic epidermal necrolysis (TEN). He was drug-induced and expert opinion agreed that hospital admission should not have changed the patient’s condition. Expert opinion agreed that hospital admission should have been arranged for Mr M, but was unable to have made a difference to the overall outcome.

The decisions to whether to admit patients, to hospital is often very difficult – documentation of the facts is important so that if there is any uncertainty later, a hospital admission, informed by these notes, could have been made.

Mrs J, a 62-year-old housewife, did not visit her GP often. However, she consulted Dr D with a two-week history of coughing, shortness of breath and blood-choking. She was referred to hospital, where she was found to have a mass in the right lung. She underwent surgery for a lung biopsy which was malignant. She was diagnosed with stage 4 malignant melanoma.

The ambulance transferred them to hospital within 30 minutes. On arrival in the ED a temperature of 39 was recorded. Mrs J was noted to have macules and papules with urticarial plaques and bullous erythema multiforme over her face, scalp and neck as well as her trunk (30% of her body). Oral ulceration and conjunctivitis was present.

A diagnosis of Stevens-Johnson syndrome was made. Mrs J was discharged from ICU with her skin had greatly improved, but she became colonised with pseudomonas and suffered with recurrent chest infections. She had significant muscular weakness, which required intensive rehabilitation.

Another month after being discharged to the ward, Mrs J’s breathing began to deteriorate and she was transferred back to ICU with severe type 2 respiratory failure attributed to toxic epidermal necrolysis (TEN), and severe type 2 respiratory failure attributed to Stevens-Johnson syndrome.

It proved difficult to speculate on whether or not earlier withdrawal of these medications would have affected Mrs J’s outcome.

MPS served a detailed letter of response, defending the claim on a causation basis. As a result, the case was discontinued.
Dr P took a thorough history and neurological examination, including fundoscopy. He concluded that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded and referred him for an early neurological opinion.

As part of his examination, Dr P checked the patient’s blood pressure and found it to be elevated at 150/96. He arranged with the practice nurse a few days later and this had reduced to 132/72. No further action was taken.

Mr H was seen by neuropathologist Dr B some six months after his initial GP presentation, and underwent an MRI scan. The scan was normal and Dr B advised Mr H that his headaches were likely to be related to muscle tension.

Mr H didn’t see Dr P again for another two years. When he re-presented to Dr P, it was found to be his left leg swelling which it was thought was an MAS and bloods to be taken (CRP, LFTs, PV and PSA) and commenced on aspirin. A follow-up visit was arranged, and Mr H’s blood pressure was recorded as 180/100. A follow-up visit was arranged, and Mr H was not followed up until seven months later when he was called in for some routine blood tests. His renal function was notably impaired with a serum creatinine of 262 umol/l, an eGFR of 23 ml/min and a urine of a 173 mmol/l. Investigations were initiated (renal USS was normal) and he was reviewed by consultant nephrologist Dr C. Dr C made note of recurrent LFTs during Mr H’s childhood and his hypertension, and concluded that reflux nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly.

He further noted that the main tool available to delay renal deterioration was judicious use of medication and diet. His blood pressure was recorded as 180/100 and although it would have been good practice to delay renal deterioration was to use an ACE inhibitor, experts agreed that on the balance of probabilities, earlier intervention is unlikely to have significantly affected Mr H’s long-term renal prognosis.

Mr H subsequently discontinued his claim.

Mr H’s 45-year-old solicitor and father of three, visited his GP, Dr P, with a persistent headache. He described two months of symptoms, occurring up to six times per week, mainly in the mornings and with associated nausea. He described two months of symptoms, occurring up to six times per week, mainly in the mornings and with associated nausea.

Mr H was referred to Dr P for another six months, until he decided it should be excluded and referred him for an early neurological opinion.

Mr H mentioned that the headaches had been present for some time but had not been investigated. He was referred to Dr P’s initial management. When Mr H first presented with headaches he had a single mildly elevated blood pressure reading following by two normal results, which would not be consistent with a headache secondary to malignant hypertension or renal disease. Although outside its area of expertise to comment on a GP’s standard of care, he did comment on Dr P’s failure to follow up Mr H more intensively once his hypertension was diagnosed and for failing to assess baseline renal function in conjunction with starting lisinopril. However, since the treatment to delay renal deterioration is to use an ACE inhibitor, experts agreed that on the balance of probabilities, earlier intervention is unlikely to have significantly affected Mr H’s long-term renal prognosis.

Mr H subsequently discontinued his claim.

When starting new anti-hypertensive medication it is important to have a baseline measurement of renal function, and ongoing monitoring of renal function from the outset. The NICE guidelines on Clinical management of primary Hypertension in Adults for more information on the Clinical guidelines. The same principle also applies to patients with cancer, and treatment of newly referred patients with cancer, and treatment of newly referred patients with cancer.

Mr H made a claim against Dr P for alleged breach of duty – stating that renal function could have been tested on several occasions. Mr H also claimed for causation, stating that had renal function been tested when he first presented with headaches, then he would have been diagnosed as a few weeks earlier, which would have allowed him to retain his renal function by a judicious use of medication and diet.

Examination, including fundoscopy. He concluded that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded and referred him for an early neurological opinion.

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**Learning points**

- Communication within the team is important – the nursing staff did not inform the medical team of the patient’s deterioration.
- Good communication and documentation of patient’s condition is essential in the process of consent. Patients must be made aware of the risks of surgery and their implications. This would include common complications as well as any serious adverse outcomes, including new complications, which may result in the patient’s inability or death. It is vital to be able to weigh up the benefits and risks and make an informed decision as to whether they want to proceed.
- Complications can and do occur and are not necessarily a sign of negligence.
- Litigation can be prevented if patients are informed adequately about the risks and adverse sequelae that were recorded.

**SD**

**EXPERT OPINION**

Expert opinion agreed that arterial bleeding from excision of a carotid body tumour is a well-recognised and inherent potential risk of such surgery, and Professor A handled this complication in an appropriate and timely manner. Although questioning the need for three periods of carotid clamping, it was felt that the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks.

Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have prevented thrombus formation, such a high risk of major haemorrhage and was contraindicated.

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to postoperative toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C’s stroke may have led to a worse neurological outcome.

However, the main focus of criticism centred on the consent process. Experts expressed concern that Professor A carried out surgery the day after the initial consultation, given the slow growing nature of carotid body tumours. Miss C’s family felt the process had been rushed and that she had not fully understood the magnitude of the risks of surgery.

Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

The case was settled for a high sum, reflecting the severe neurological outcome and the need for continuous care.

**Casebook 22(3), September 2014**

Our cover story in the previous edition of Casebook, “The Story of Beth Bowen”, drew a powerful and emotional response from many readers – indeed your letters were so numerous that we can only print a small selection in this edition.

The two letters below capture many common themes: respect and admiration for Claire Bowen in speaking openly about her diagnosis, loss and anger and disablement at Mr. Bowen’s struggle to obtain answers and information.

Although mistakes in medicine are unavoidable, many issues in this case combined to contribute to the tragedy and its aftermath: from the surgeon’s misplaced confidence (in terms of the equipment used), to the lack of an appropriate and valid consent process. This was only exacerbated by the institutional behaviour of the hospital, which made it so difficult for the Bowen family to get the explanations and apologies that were their basic right.

MPS has long campaigned for greater openness in healthcare, particularly when things go wrong. This is a challenging and difficult process, which needs the support of culture, colleagues and organisations. The story of Beth Bowen as narrated by her mother in Casebook (22(4): 10-11) is a reminder of the privilege of trust and responsibility that we hold. I hope this article will provide food for thought amongst our profession and for the institutions that we work within.

Dr Nick Clements
Editor-in-chief, Casebook

**Responses**

I am emailing to say thank you for publishing the heart-wrenching story of little Beth Bowen in the September edition of Casebook.

Her mother Claire has shown much courage and strength of character in standing up and speaking out about these harrowing events. One can but only begin to imagine the desolation of losing a daughter and subsequently a husband under such devastating circumstances.

Her words are humbling and a timely reminder for doctors regarding the privileged positions of trust and responsibility that we hold. I hope this article will provide food for thought amongst our profession and for the institutions that we work within.

Dr Rachel Jones, GP
Auckland, New Zealand

I read with such sadness the story of Beth Bowen as narrated by her mother in Casebook (22(4): 10-11). I wish to express my deepest sympathy to the Bowen family and convey Mrs Bowen that the medical profession felt far short of expectations in this case and much needs to be done.

The irony was that the child would not have died 30 years ago, before the widespread introduction of laparoscopic surgery. If she had open splenectomy, a properly qualified surgeon could have completed the operation with minimal risk. Even if a major blood vessel is torn, it could have been controlled without delay.

Laparoscopic surgery denies the surgeon the important faculty of tactile sensation and stereoscopic vision. It also denies the surgeon rapid response to accidental tear of major blood vessels and organs as illustrated in this case. Worst of all, it opens a floodgate and permits the introduction of high risk instruments like the morcellator, which has killed other patients, including adults. And it is not young surgeons that are dangerous; senior surgeons trained in the open classical procedures are even more dangerous if they try their hands on laparoscopic procedure without proper retraining.

It is important to have a small scar that we should compromise safety standards?

John SM Leung, FRCSI, Ed, Hong Kong

I completely agree with the point you make regarding cross-examination in the context of formal legal proceedings. The article was intended to apply more widely to expert reports in general, many of which are written for purposes other than litigation. The role of an expert in the litigation process is different. Even a panel of experts and an expert can be considerably wider and may involve attendance at conferences, provision of supporting evidence in cross-examinations and meeting the expert for the other side with a view to reaching an agreed, joint position.

I will ask the author of the original piece to see whether a follow-up article, dealing with some of these other issues, might be helpful.

Thank you once again for your comments.
**MISSING CAUDA EQUINA**

You report a case of a GP missing a cauda equina syndrome in a patient with a slipped disc (page 17, Casebook September 2014). I do not believe this is within the expertise of a GP and is not even within the expertise of many specialists. I have seen several of these cases not from slipped disc but from anaesthesia either by inserting a needle into the lumbar spine or from the insertion of a plastic catheter to anaesthetise the abdomen or legs. Most anaesthetists claim the procedure is harmless and that such catheters can’t harm. It may be rare but it is completely false to assume it is harmless.

**HIGH EXPECTATIONS**

I am rather puzzled by “High Expectations”, on pages 22 to 23 of the September 2014 issue. From the description of the case, it sounds very likely that this was indeed a case of post viral fatigue syndrome (also known as Myalgic encephalomyelitis or chronic fatigue syndrome). No diagnosis is given in the summary of the possible diagnosis of chronic fatigue or what management was given for the condition.

Post viral fatigue syndrome is a common condition probably affecting about 1% of the population. It is not difficult to diagnose as there are clear diagnostic criteria available today and it would be interesting to know whether this patient fitted the diagnostic criteria or not. They did seem so bizarre to doctors that I feel a misdiagnosis would be unlikely if the criteria were properly used. In addition, in the following paragraph it is stated that the patient “… was convinced that there was a physical cause for his symptoms…” as if this rebutted the specialist opinion. However, it is well-known today that chronic fatigue is indeed an organically-based physical condition. The case was clearly shown at the last conference of 2014 in the United States and it is no longer considered acceptable to consider a non-organic basis for this disease. It is probably a chronic encephalitis but this has not been definitely proven. There is management available for chronic fatigue syndrome.

In my opinion, it is indeed negligent to miss this diagnosis in a patient who fits the criteria for CFS/ME (Caruthers et al 2003 and 2011 – these are the criteria used). In addition the patient’s prognosis can be adversely affected if proper management including management of activity scheduling is not instituted as soon as possible.

Unfortunately, at least in South Africa, this disease now occupies the same space as mental illnesses did in the dark ages and as multiple sclerosis did at the turn of the last century (“Faker’s Disease”). Patients generally do not have the energy or financial means to pursue their cases against doctors regarding diagnosis but in my opinion it certainly should be a source of litigation because of the poor diagnostic skills of most practitioners. Firstly, regard the ignorance about management and the stigma which doctors attach to this disease, greatly increasing the significant suffering of patients.

Dr Elizabeth Murray, Rondobosch Medical Centre, MedClinic Constantiaberg, UCT Private Academic Hospital, South Africa

**THE ELUSIVE DIAGNOSIS**

Re: “The elusive diagnosis”, Casebook September 2014. I am very surprised from the evidence given that the claim for late diagnosis of diabetes (presumably mellitus) was successfully defended. The failure to test the plaintiffs urine is inexcusable.

Many years ago the late Professor Jack Donnelly estimated that in Cape Town there were an estimated 200,000 asymptomatic people with undiagnosed diabetes mellitus. Since then the provincial facility at which I used to practise has tested the urine of every new and return patient for glucose et al. We were newly diagnosing two to three diabetes mellitus patients every week.

Dr Stephen A Craven, Hon Lecturer in Family Medicine, University of Cape Town, South Africa

I read “The elusive diagnosis” (Casebook 22(3), September 2014) with great interest, in particular the mention during two presentations of penile symptoms, described as “sore scratch on L-size of penis” and “a rash on the glans penis.”

Some years ago I submitted with a medical student a paper to the BJM in the hope it would be published as “Lesson of the Week”. We reported case histories of four men, aged 26, 34, 40 and 51 years, who presented to our department of genitourinary medicine in the month of July 2008 and were found on examination to have balanoposthitis, while three of them also had fissuring of the penile skin. All gave a history of a tight prepuce but the diagnosis was not obvious from an examination of the penis. It had been diagnosed in other men with a history of balanoposthitis and at some stage suggestive of balanitis of the balanoposthitis, and the patient had been admitted to hospital for treatment. We were new in patients with a history of balanoposthitis and a history of diabetes mellitus. All four had diabetes managed by their GPs and at least two were prescribed metformin.

These patients all presented with balanoposthitis and at some stage appeared to have associated phimosis. It has been previously suggested that the sudden appearance of these symptoms in a patient without a prior history justifies investigating such patients for possible diabetes.

The paper was not accepted for publication as it was felt that the association with balanoposthitis and diabetes was well-known, although interestingly the 40 and 51-year-old had been advised to attend our department by their GPs.

It is difficult from the description of the penile infections in the case presented in “The elusive diagnosis” to fully assess their relevance in regard to missing the diagnosis of diabetes in this case but balanoposthitis (and vulvitis particularly when recurrent) certainly warrant at least checking the patient’s urine for glycosuria.

Dr Mike Wolzman, Consultant in Genitourinary Medicine, George Eliot Hospital, Nuneaton, UK

**CORRECTION**

The following correction relates to a photo accompanying the case “A cannuila complication” in the previous issue of Casebook. Our photographs are taken from stock image libraries and are chosen to reflect the general theme of an article or case. Here, the case related to the potential risks associated with cannulation, specifically neurological damage to the cranial nerve, and the image was chosen to reflect that theme. In this case a picture of venous cannulation would have been better, and we apologise for any confusion caused by this error.

**REFERENCES**

1. [Fielding M, Datta GR. Phimosis with balanoposthitis in previously undiagnosed diabetes mellitus. BMJ. 1976; 1:946]
REVIEW

BEING MORTAL
Atul Gawande

Review by Dr Sam Dawson
(Specialty trainee, anaesthetics, Northern Ireland)

Atul Gawande barely needs an introduction. He is the author of three bestselling books, winner of multiple awards for writing and Professor at Harvard Medical School. He was also a key figure in the implementation of the WHO checklist revolution.

His new book Being Mortal is a compassionate yet unflinching look at what mortality means in the 21st century. In it he explores the way in which modern medicine is letting our patients down at the ends of their lives whether in nursing homes, hospitals or hospices. At the same time, he reveals the people and institutions redeeming the situation with unparalleled passion and creativity.

Gawande does this by telling the stories of his patients facing cancer; of his neighbours and, most movingly, of his own family as they face old age, decline and death. He weaves together research, philosophy, historical study and personal anecdotes to show that many of us are neither living well in our last days nor dying the way we want.

Most damning of all, however, is the realisation that the medical profession is not only hapless in the face of this suffering but acting harmfully as a result of paternalism, lack of imagination and fear. Gawande’s previous book: The Checklist Manifesto was a significant piece of work, ushering in a new global paradigm of perioperative safety with a simple, yet radical, idea. Being Mortal could do the same for end-of-life care.

I read most of this book in my on-call room, pausing to attend the critically ill in the wards, theatre and emergency department in which I work. This added extra poignancy to what is already an emotional, compelling and challenging book. It isn’t perfect – at times the interlinking of stories is disorientating and the section on assisted dying appears somewhat tacked on. However, this book is for anyone who has ever stared speechlessly into the eyes of someone who knows they are dying, or who has had the difficult task of counselling their relatives. In fact, it is for anyone who wants to live well, help others live well and, in the end, die as well as they can.

What would a new era of ingenuity, empathy and dignity look like for our patients as they approach the end of their lives? It is obvious Gawande is not entirely sure, but in Being Mortal he is asking the right questions and exploring novel solutions to a situation we desperately need to improve.

POSTMORTEM: THE DOCTOR WHO WALKED AWAY
Maria Phalime

Review by Dr Anand Narasibhai
(Intern at New Somerset Hospital, Western Cape, South Africa)

After practising clinical medicine for four years, Maria Phalime decided to stop. Postmortem: The Doctor Who Walked Away tells the story of her search for an explanation and provides a useful commentary on the profession.

The book is divided into two parts. In the first part, Phalime searches outside herself, wondering if there were external factors that played a role in her decision to leave. She interviews others with various experiences in medicine as a way of providing perspective on her own story.

I found reading the first part of the book laborious, although I was interested in her childhood and high school years. From then on the cliches and anecdotes were unoriginal to my ears, regardless of whether I knew them or not. It was clear that the actual stories are what we need to hear.

The second part was far more enlightening. I enjoyed reading the interviews she conducted with those who have either left clinical medicine, or are still practising. For comedian Riaad Moosa, it was a natural progression away from medicine and into comedy. For Nina (pseudonym), it was the combination of clinical depression and being a junior doctor in the South African public health sector. This second part of the book highlighted common but often being accepted issues that we face in the medical profession.

What if there were ways to make clinical service more attractive? What if we were allowed to work at a pace that suits us? People have got to be allowed to take that journey.” Phalime is on her journey, each of us is on our own, and for our patients, maybe the point of what we do by caring for their health, is to give them an opportunity to take their own journey.
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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