On deadly ground

Explore the pitfalls of practice as we look at problems beyond claims

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Get the most from your membership…
Welcome

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

There has been a lot of talk about the rising cost of clinical negligence: the increasing number of claims, and the increasing levels of awards. We also hear the rhetoric that the fear of litigation drives doctors to practise defensive medicine. But I hear members tell me that it is the dread of a complaint to the Medical Council, and the risk of a public hearing, trial by media and reputational damage that concern them much more than a claim.

That is not to disregard the stress of litigation – but, generally speaking, the fact that your indemnity arrangements will step in to meet the financial costs of a claim makes it a less personally traumatic experience than the sanctions you might face at, for example, the hands of your employer, regulator or even the police.

Although the cost of claims is far and away the largest call on members’ funds at MPS, they only represent about 20% of the cases we handle worldwide – the rest are complaints, inquests, disciplinary cases and other medicolegal challenges to a member’s professional practice. Our feature on page 6 illustrates just some of the wide-ranging problems that members contact us for advice on.

It is also possible for a single incident to take a member through a series of procedures. For example, a perinatal death might give rise to complaint, claim, inquiry, inquest, disciplinary and regulatory investigations. And doctors who rely solely on employers’ indemnity have no entitlement to ask for assistance with anything other than the claim for compensation – so you might want to have a word in the ear of a colleague who could unwittingly be leaving themselves exposed to a range of sanctions.

Finally, I hope you enjoy reading the case reports – in this edition we share learning from both settled claims and also some very successful defences.

As always, I welcome your feedback – whether in response to content within Casebook or to share your own experiences.

Under the influence

MPS Medical Director Dr Rob Hendry reminds doctors of their unique opportunities to influence and inspire those working around them

Doctors are often surprised how influential they are within their teams and organisations. The things they do and say and the way they conduct themselves is increasingly being recognised as central to effective healthcare.

Most medical care is now delivered by teams rather than by individual healthcare professionals working in isolation. When teams work well the results can be spectacular, but when teams are dysfunctional, patient care can suffer. Stories in the press about “failing hospitals” are, in fact, often actually about failing teams.

Sadly at MPS we frequently see members getting into difficulties with their employers and their regulators, not because of their lack of specialist knowledge or poor technical skills, but because of the way they interact with their colleagues.

When relationships break down in healthcare teams not only do things go wrong more often, but when they do the impact on everyone involved is usually much greater.

One of the characteristics of being a professional is taking responsibility for one’s actions. Often, choosing to turn a blind eye to problems within a team can lead to problems becoming magnified and intractable.

Product liability and MPS

Issues with product liability have made the headlines in a number of countries around the world recently – notably the DePuy metal on metal hips in South Africa and Ireland, and the PiP breast implants in the UK.

These issues arose from faulty products, where normally responsibility lies with the manufacturer or supplier of the product.

However, in both cases, attempts were made by claimants to include surgeons in the claims – in the DePuy hips case, the justification given was that the surgeons had failed to properly fit the prostheses; with the PiP implants, the insolvent nature of the manufacturer was the motivation for involving the surgeons in the claims.

In both situations, whilst MPS is not providing an indemnity for product liability, MPS is supporting members with these cases by doing whatever is possible to prevent the development of litigation targeting clinicians, when other more appropriate sources of compensation (the manufacturer or supplier) are no longer available.

In the meantime, members can take steps to protect themselves in the event of a claim for product liability, by retaining documentation relating to:

- Evidence of purchase.
- Where possible, the serial number of the item in question – it can be used as evidence of the batch of goods obtained.
- Terms and conditions.
- Express warranties and guarantees.
- Instructions and packaging.
- Correspondence regarding product specification and any alteration.
- Where whole goods are transported by an external logistics company, relevant contracts/terms/correspondence.
- Complaints history relating to product and similar products (if relevant).
- Order forms, emails, faxes. Clinicians should also take care regarding any verbal statements made to patients regarding a product. Statements that erroneously imply a lifetime guarantee, for example, can make a clinician liable in the event of a related allegation or claim.
MPS Associates – here to help

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

Over the next few issues of *Casebook* we will be allowing readers to get to know our Associates a little better – beginning this issue with Hong Kong.

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I am currently a private surgeon working mainly in the areas of minimal invasive surgery and gastrointestinal endoscopy. I liaise and participate in MPS-related activities in Hong Kong and provide professional support to MPS members; I am also an accredited presenter of risk management workshops organised by MPS Educational Services.
I received medical training both in Hong Kong and the USA. I have previously worked at the Department of Surgery, Prince of Wales Hospital, the Chinese University of Hong Kong, where I developed a long-standing interest in medical teaching, research and publication. I also studied law in my leisure time. I hold two postgraduate law degrees and in the medicolegal area, I have developed particular interests in medical communication, clinical risk management, and patients’ rights and dispute resolution.
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I have also pioneered venous arterial ECMO (extra-corporeal membrane oxygenation) in the private sector in Hong Kong, and was instrumental in introducing critical incident reporting in the major private hospitals in Hong Kong. My spare time hobbies include film-based photography and scuba diving.
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I work in the Division of Plastic Surgery, Department of Surgery, Prince of Wales Hospital, Shatin, NT, Hong Kong. Other offices I hold include:

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- Training Programme Director and (ex-) Secretary of the Board of Plastic Surgery, Hong Kong College of Surgeons.
- Chief Examiner in Plastic Surgery Exit Examination, Hong Kong College of Surgeons.
- President, The Hong Kong Society for Plastic, Reconstructive & Aesthetic Surgeons
- Associate, Medical Protection Society since 2012
- Co-opt member, Working Group on Differentiation between Medical Procedures and Beauty Services, Steering Committee on Review of Regulation of Private Healthcare Facilities, Department of Health, Hong Kong.

I have also written more than 50 journal articles and a book, *Legal Issues for the Medical Practitioner*. Email: sywong@surgery.cuhk.edu.hk
On deadly ground

It is a harsh reality of medicine that doctors face multiple avenues of complaint related to their practice. In *Casebook* we often focus on the learning points afforded when a doctor is sued for clinical negligence, but members come to MPS requesting assistance with a wide range of other matters, such as ethical queries, complaints and regulatory body investigations.

Here we present six diverse cases from MPS’s files, listed by theme and not involving claims. They are drawn from incidents around the world (regulatory bodies will be generically referred to as “Medical Council”) and some facts have been altered to preserve confidentiality.

**Doctors should ensure that their conduct justifies patient and public trust in themselves and the profession as a whole. This applies equally online as it does in the consultation room.**

**Learning points**

Doctors should ensure that their conduct justifies patient and public trust in themselves and the profession as a whole. This applies equally online as it does in the consultation room.

Using social media creates new risks, particularly where social and professional boundaries become unclear. If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships, and decline any “friend” requests.

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**Dr P** was working as a junior doctor in general practice. Three months into her new post she received a “friend request” on Facebook from a former patient, Mr T. She had got to know him whilst doing her medical school psychiatry attachment as he had been an inpatient for a brief period of time.

Mr T told her that he was doing really well and was off all his medication. He had started an arts course at the local college. Dr P accepted his friend request. Initially she enjoyed reading Mr T’s posts, but gradually she noticed his comments were becoming more bizarre, culminating in the statement that he felt he was being followed by the CIA. She recognised this as being a symptom of his mental illness and sent him a personal message urging him to go and see his GP.

Mr T replied stating that he didn’t trust his GP. He asked to meet up with Dr P. She told him that she couldn’t do so and suggested she speak to his GP on his behalf. He became angry and upset. Dr P was concerned about Mr T so she contacted his consultant psychiatrist who arranged to review him later that week.

Mr T “de-friended” Dr P a few days later.

A month later Mr T complained to the senior partner at Dr P’s practice. He was unhappy that Dr P had declined to meet him as he had felt that they were friends. He was disappointed that she had contacted his psychiatrist, although he admitted that he was feeling a lot better and back on his medication.

The senior partner and Dr P met with Mr T to discuss his concerns. Dr P apologised to Mr T and stated that she should never have accepted his friend request. She told him that she had been concerned about him and had felt she had to contact his psychiatrist to try to access help for him.

Mr T accepted Dr P’s apology. He asked her to share the experience, anonymously, with her colleagues, so that they could all learn from this incident.
Dr V was carrying out a routine doctor’s round in the segregation unit at a women’s prison. She was accompanied by a healthcare assistant. During the round she was asked by a prisoner, Ms J, for medication for anxiety; Dr V declined. Ms J then made a further request for opiate analgesics for hip pain; Dr V decided to examine her and took the appropriate consent. Dr V discovered a small abscess in the left groin area and prescribed anti-inflammatories and antibiotics. However, Ms J reiterated her original medication request and threatened to report Dr V to the Medical Council.

Ms J carried out her threat, alleging that Dr V’s clinical decision-making was unsound and also that she had been rude and abusive – in particular using racist terms to subdue Ms J. Ms J also alleged that Dr V spoke about her condition in a loud voice, which breached patient confidentiality.

The Medical Council concluded its investigation with no further action necessary. Dr V’s excellent record-keeping ensured a comprehensive account of her clinical decisions and this allegation was rebutted at an early stage. Dr V had been accompanied by her assistant throughout her doctor’s round, and had also been observed at a distance by a member of the prison staff. Both were reliable witnesses and since no concerns were raised by them, Dr V was able to refute Ms J’s allegations of a confidentiality breach and Dr V’s abusive manner.

Learning points
Here the Medical Council was not concerned about the medical care provided, since Dr V had kept a comprehensive and contemporaneous clinical record, but by Dr V’s conduct. The allegations made, if proven, would be serious and might demonstrate impairment of Dr V’s fitness to practise. It should be remembered that the veracity of the allegations need only be demonstrated “on the balance of probabilities”.

In this situation the importance of a chaperone was paramount. Every patient must be afforded dignity and privacy, and this typically means offering a chaperone for an intimate examination. However, this is not the only time when a chaperone should, or can, be offered. It should be remembered that a chaperone also protects the doctor from unfounded allegations, as demonstrated in this case, and if the patient refuses the presence of a chaperone then you may wish to defer the examination or refer the patient on to a colleague who would be willing to conduct the examination, so long as there is not unreasonable delay and the clinical situation does not demand urgent assessment.

Dr H visited his local pharmacy with a private prescription for a benzodiazepine; he had a fear of flying and was due to undertake a long-distance flight for a holiday. The pharmacist had concerns that Dr H might be self-medicating for a more serious psychiatric condition, with potential implications for his ability to practise. Dr H was reported to his Medical Council, who invited him to undergo a full health assessment. He contacted MPS for assistance.

Dr H was angry and embarrassed at this turn of events. He felt that he was facing castigation for an innocuous incident. Dr H was very uncomfortable with the prospect of a health assessment and was also concerned about the potential of being referred to a full panel hearing to assess his fitness to practise. While MPS’s medicolegal adviser advised Dr H on the full range of options open to him, he opted for voluntary erasure, which was accepted by the Medical Council. Dr H was close to retirement and explained that he found voluntary erasure more appealing than a health assessment.

Learning points
Many doctors feel it is their right to prescribe as they see fit, but they risk referral to the Medical Council. In other similar MPS cases, members have undergone health assessments and MPS has advised them to apologise, demonstrate greater awareness of prescribing guidance and undertake only to self-prescribe in emergency situations in future. The temptation to self-prescribe in order to patch yourself up, and avoid taking sick leave, is understandable; however, doctors who do this might be presenting a risk to patients in not having had their condition reviewed independently. Guidance states that doctors should be registered with a GP to ensure treatment of an independent, objective nature. Furthermore, your clinical judgment could be impaired if you are genuinely unwell.

In particular, you must avoid self-prescribing controlled drugs unless there is no-one else available with the legal right to prescribe without a delay that would cause great pain or distress, or a risk to your life. Any decision to self-prescribe should be recorded and your own GP should be notified as soon as possible.

CONTINUED OVERLEAF
Mrs G, an elderly patient with type 2 diabetes, respiratory disease and dementia, fell during the night in the care home where she lived. Her care home called an ambulance immediately as Mrs G was in a lot of pain and was distressed by the fall.

When Mrs G arrived at the hospital she was assessed by the staff in the Emergency Department and an X-ray revealed a fractured neck of femur. Mr L, an orthopaedic surgeon, examined her, and was of the opinion that Mrs G needed surgery. Mrs G was distressed and confused, and Mr L believed that she lacked capacity to consent to surgery. He attempted to contact her next of kin, but he was unable to do so as they were in Greece. As Mrs G lacked capacity to consent to the proposed treatment, Mr L was not sure how to proceed, so he called MPS.

Learning points
Dr W should not have assumed that the daughter was aware of her mother’s HIV status. At the start of the consultation he should have asked Mrs B whether she was happy for her daughter to stay and should not have mentioned anything the patient or daughter had not brought up themselves. If it had been necessary to mention Mrs B’s HIV status he should have asked the daughter to leave as he had a potentially sensitive matter to explore with her mother.

The Medical Council accepted that the breach was inadvertent and that Dr W had reflected appropriately; however, it was usual for the Medical Council to inform employers to establish whether this was part of a pattern of concerns. Dr W was also advised that the patient had raised additional concerns, which needed to be investigated and responded to in accordance with local complaints procedures. MPS reviewed his letter to the patient and advised on tone and content.

Learning points
This query related to an incident in the United Kingdom; the Mental Capacity Act 2005 provides the legal framework for making decisions on behalf of adults who lack mental capacity to make decisions for themselves. Unless there is a personal welfare lasting power of attorney in place, no-one else can provide consent on behalf of another adult. In addition, the Court of Protection can settle disputes over the healthcare and treatment of a person lacking capacity. Any proposed treatment must be in the patient’s best interests.

Mr L was reminded of the factors to take into consideration when assessing mental capacity, as set out in the Mental Capacity Act. It should not be assumed that the patient lacks capacity simply because she has a diagnosis of dementia. In this instance, Mrs G’s immediate family were on holiday and were not contactable.

MPS advised Mr L to gather as much information as possible in order to arrive at a ‘best interests’ decision regarding further treatment if Mrs G was unlikely to regain the capacity to consent. The extent of Mr L’s enquiries depended on the urgency of the treatment. If the proposed treatment was non-urgent Mr L should continue to attempt to contact Mrs G’s family, and gather information from other sources (such as staff at the care home and the GP).

The member of staff who ultimately delivers the treatment is the decision maker, and assessments of capacity and best interests had to be carefully documented in Mrs G’s records.
Dr M was employed by a university to undertake a research project, which was funded by a charity, for two years. After his employment ended, the university’s faculty of medicine agreed that Dr M could continue aspects of his project work, supported by his grant; at the same time Dr M was also beginning specialty training in general medicine. After a period of around eight months, Dr M’s supervisor at the university raised concerns over a number of purchases made by her department, credited to the research grant. These included an expensive piece of specialist equipment and costly travel and accommodation expenses for two overseas conferences. The supervisor discovered that the purchases had been made without her authorisation, including retrospectively amending travel booking details and forging approval letters.

Dr M was eventually reported to the Medical Council, where a panel hearing assessed his fitness to practise. It was found that Dr M’s fitness to practise was severely impaired by his lack of honesty, integrity and probity – the basic attributes of being a good doctor. His attempts at deception and manipulation of colleagues exacerbated his original dishonest acts.

Dr M admitted to the charges but revealed that he had been under severe stress due to the recent death of his sister; further psychiatric examination led to Dr M being diagnosed with a major depressive disorder, which the Medical Council accepted as having contributed to his original actions.

The panel concluded that despite his mental health issues, Dr M’s conduct was unacceptable for a doctor and and brought the profession into disrepute, undermining public confidence in the profession. A three-year set of conditions was imposed on Dr M’s practice, including notifying the Medical Council of any post he accepted which required Medical Council registration; agreeing to the appointment of a workplace reporter, as approved by the Medical Council; and informing the Medical Council of any further formal disciplinary proceedings. Dr M was also placed under the supervision of a medical supervisor, nominated by the Medical Council.

Learning points
Honesty and integrity are central to the role of a doctor, principally because of the extent to which the doctor-patient relationship depends on trust. Doctors have a responsibility to the reputation of the profession to be trustworthy in all aspects of their work, including signing forms, reports and other documents, and in any financial arrangements with patients and employers, insurers and other organisations or individuals. Any doubt surrounding the probity of a doctor can be extremely damaging to the trust invested in the profession by patients.

Doctors are notoriously bad at looking after their own health. Stress and anxiety can affect a doctor’s ability to practise safely, and an impaired practitioner is a significant medicolegal risk. There are usually local support networks for doctors affected by mental health issues, and any concerns about your own health should be raised with senior colleagues. MPS also has a worldwide counselling service available to members.

How can MPS help?
Members sometimes come up against problems that are out of the ordinary. MPS considers borderline requests for assistance on the merits, balancing the individual member’s needs against the responsibility to use members’ funds wisely and in the interests of the membership as a whole. The following are examples of problems where detailed consideration of the exercising of discretion to assist may be warranted.

Criminal proceedings arising from non-clinical practice
We can exercise our discretion to assist with criminal allegations, but this does not usually extend to allegations of fraud or theft, on the basis that these offences arise from the business aspects of practice.

Allegations of fraud
It is unlikely that we would provide assistance in connection with allegations of fraud arising from business dealings. Occasionally, allegations of fraud may have arisen from professional life, for example, errors on a CV, or in research. Such cases are considered on their individual merits.

Defamation
If a member is the named defendant in a defamation claim, we may assist if the alleged defamation stems from their professional practice and their professional reputation is likely to suffer serious harm.

Other employment and disciplinary issues
MPS is unlikely to assist where a member faces a disciplinary investigation or hearing arising from:
- Employment or contractual issues
- Working relationships with colleagues
- The business of practice.

Personal conduct
Assistance is very unlikely to be offered with complaints or claims arising from a member’s conduct that is of a wholly personal nature clearly unrelated to professional practice, or only loosely related to the practice of medicine (for example, by virtue of having been committed at the work/practice premises, or because they happened to involve an employee or working colleague).

Taken from MPS cases handled between June 2012 and May 2013. Words by Gareth Gillespie and Sara Williams
Practice makes perfect?

The demand for cosmetic surgery in Hong Kong is on the rise as more and more patients pursue the “perfect” image. But for doctors, providing these services in an unregulated environment can be risky business. Rachel Seddon investigates

How many times do you need to perform a medical procedure before you feel comfortable doing it without any supervision or reference material to guide you? Some medical schools still use a model of “see one, do one, teach one” to train students in carrying out procedures.1 But if a patient comes to you asking for cosmetic treatment that you have no prior experience in, how would you respond?

For doctors, conducting plastic surgery is an area of practice fraught with difficulties. There are currently no regulations in Hong Kong to govern who can and cannot provide cosmetic treatments; as long as you hold a licence to practise, you are considered qualified.2,3 Clearly, this means inexperienced doctors may end up performing procedures outside their competence; many others may face ethical dilemmas if they fail to fully understand what is expected of them. What’s more, without regulations to govern what doctors can and can’t do, doctors are unsurprisingly finding themselves at the receiving end of more complaints than ever when patients don’t get the end result they were hoping for.

There are currently no regulations in Hong Kong to govern who can and cannot provide cosmetic treatments; as long as you hold a licence to practise, you are considered qualified

This is not a new issue; the Hong Kong Medical Association has been campaigning for regulations to be developed for plastic surgeons for more than ten years. In 2006, it proposed to the Legislative Council that: “All material to be injected, or implanted into the body has to be registered… Such procedures, whether carried out by needle injection or by surgery, will be a medical procedure, and may only be performed by a registered medical practitioner with the necessary training.”4 A recent article featured in the Hong Kong Medical Journal went further, describing the nature of the regulations that are needed. It said: “The ultimate aim of any reform is patient safety… Pertinent measures would need to target relevant practitioners, the procedures they perform, the medications and devices they use, involved institutions, and consumer education.”5

One positive step came with the launch of the Hong Kong Association of Cosmetic Surgery (HKACS) in 2010, which lists promoting “the advancement and safe practice of cosmetic surgery and medicine [and maintaining] a high ethical professional standard in the practice of cosmetic surgery” among its objectives.6 Despite this, definitive government regulations are still needed to provide guidance for doctors and deliver peace of mind for patients.

The lure of advertising

Advertising has its role to play in the problems surrounding the delivery of cosmetic surgery in Hong Kong. Whilst doctors are not allowed to advertise their services, other clinics and beauty salons are – many of whom claim they can provide the same cosmetic treatments as a doctor, but all too often are under-qualified.7

This has meant that patients can find themselves tempted to go to a clinic, which leaves them open to the risk of something going wrong. Inevitably, after experiencing an adverse outcome – instead of going back to the clinic and exposing themselves to more problems, patients go to their trusted doctor to get it fixed. Many surgeons report that fixing someone else’s mistake can be more difficult than doing the procedure themselves in the first place and that it can be more difficult, at this late stage, to set realistic expectations for the patient.

The right person for the job

When you’re consulting with a patient who wants plastic surgery, it is important to think it through carefully before deciding whether you should proceed. Chris Howse, Partner at law firm Howse Williams Bowers, says: “There are three important questions you must ask yourself before administering any cosmetic treatment. Firstly, do you have good grounds, supported where necessary by trial results, to support the procedure? Secondly, do you have the necessary skills, facilities and equipment available to allow you to carry it out safely? Thirdly, do you have a full understanding of the risks involved? Don’t proceed with any treatment without carefully considering these issues.”

If you feel that you are lacking the skill, experience or equipment, you must be honest with the patient. Offer to refer them to a colleague who you know does have all the right credentials, and make sure the patient understands why it is in their best interests that you have refused to treat them. They may think they are better off by having cosmetic surgery, but if you are not the right person to do it then it is always safer to refer.

If you are happy to provide the treatment, you must be confident that the procedure is within your competence and that it is included in the scope of your indemnity. Be prepared to disclose any details of the training you’ve had, as well as that of any assistants who will be involved to the patient if they ask. Before scheduling any treatment, it is crucial that you ask yourself:

- Does the patient fully understand the procedure, along with its associated advantages, disadvantages and risks?
- Does the patient have realistic expectations of their outcome?
- Has the patient provided valid consent for the procedure, and has this discussion been captured in the patient’s notes?

If there is any doubt around whether the patient has provided valid consent, or if you think they haven’t fully understood the risks involved, consider rescheduling the appointment for another day to give them ample opportunity to think it through.

What to do when something goes wrong

Sometimes, even the simplest procedure can go wrong, despite planning for it and being fully trained. If you do receive a complaint, contact MPS who will work with legal advisers on your behalf to:

- Respond to the complaint
- Take a record of your recollection of the situation
- Check all relevant documents and evidence, including the medical notes
- Get the advice of a medical expert, if required
- Communicate with the patient’s legal advisers.

It is important that you seek advice as soon as possible after a complaint is made; delays will only cause the problem to escalate. Despite the absence of regulations, keeping detailed medical records and always practising with the patient’s best interests in mind will stand you in good stead when faced with these potentially risky situations.
FEATURE

FURTHER INFORMATION

- Hong Kong Association of Cosmetic Surgery
- The Hong Kong Society of Plastic, Reconstructive and Aesthetic Surgeons
  www.plasticsurgery.org.hk/node/20
- International Society of Aesthetic Plastic Surgery
  www.isaps.org
- Medical Council of Hong Kong – Code of Professional Conduct
  www.mchk.org.hk/code.htm

MPS ADVICE

- Manage patients’ expectations
- Practise within your limitations
- Don’t be afraid to refer patients, or refuse to carry out treatment if you don’t think it’s in the patient’s best interests
- Only carry out procedures that you know are within the scope of your indemnity – check with MPS before proceeding if you are unsure
- Make sure you always keep detailed notes about any consultations involving discussions around cosmetic surgery, particularly around consent.

REFERENCES

4. HKMA, Call to regulate organizations that provide medical and beauty procedures (9 October 2012) www.hkma.org/english/newsroom/news/20121009.htm
6. The Federation of Medical Societies of Hong Kong, The Hong Kong Medical Diary Vol 15 no 6, June 2010 www.fmshk.org/database/articles/06news_4.pdf
In the past two decades, in the healthcare arena worldwide, there has been increasing recognition of the importance of open disclosure of medical incidents. Disclosure of harm and/or error (error can include problems in practice, products, procedures and systems) has evolved from an individual’s ‘act of goodwill’ in respecting patients’ right to know and decide on their treatment, to a system of meeting public expectation for transparency and accountability.

The global approach
Various governments, healthcare providers and professional bodies have developed their own policy and guidelines related to open disclosure as part of a risk management system and clinical governance. In the US, in 2001, the US Joint Commission on Accreditation of Healthcare Organisations announced a policy that demands disclosure of a critical event by the provider or the institution. In some states, it is a statutory requirement for organisations to notify patients in case of an adverse event. In the UK, from 1 April 2013 the new standard NHS contract requires all NHS and non-NHS providers of services to NHS patients to comply with a “duty of candour” in reporting patient safety incidents.

In 2007, New South Wales Health in Australia defined open disclosure as the process of providing an open, consistent approach to communicating with the patient and their support person following a patient-related incident. This includes expressing regret for what has happened, keeping the patient informed, and providing feedback on investigations, including the steps taken to prevent a similar incident occurring in the future. It is also about providing any information arising from the incident or its investigation relevant to changing systems of care in order to improve patient safety.

How does Hong Kong measure up?
The Hospital Authority (HA) Hong Kong is the statutory body established to manage all public hospitals and general outpatient clinics since 1990. A set of quality standards was established in 1995 and is periodically reviewed. It served as part of the Hospital Annual Planning process for quality improvement and accountability reporting. It gave an overall view of the desired service standards in hospitals and provides quality parameters in essential service areas so that hospital managers can use the parameters as tools for improving the service of their hospitals.

In October 2007, with reference to international practices, the HA established the Sentinel Event Policy, which requires mandatory reporting of nine categories of incidents, and a standard process in reporting, investigation, documentation, identification of root causes, and implementation of recommendations. In 2010, the HA further improved the reporting mechanism by mandating the reporting of two more categories of Serious Untoward Events, namely, medication error and misidentification that could have led to death or permanent harm.

In 2009, the Hong Kong government launched pilots in hospital accreditation systems to enhance healthcare quality in Hong Kong. Hospitals under the HA have taken part in the accreditation exercise since then. In one accreditation standard, the organisation is expected to show how the principles of open disclosure is evident in its system of incident management and how it educates and trains staff in the principles and practices of open disclosure. Through the current accreditation exercise, hospitals in Hong Kong evaluate their current systems in facilitating open disclosure for continuous improvements.

Support system grows for openness
Open disclosure of incidents is strongly encouraged in the HA. The Code of Conduct of the HA, published in 2009, stipulated that professional behaviours that align with Vision (Healthy People, Happy Staff; Trusted by Community), Mission (Helping People Stay Healthy) and Values (People-centred Care, Professional Service, Committed Staff, Teamwork) of the HA includes open
Healthcare professionals may fear that by being honest they will expose themselves to litigation and disciplinary action and damage to their reputation.

Disclosure of adverse events and being honest and open in our interactions with our patients.

In order to equip healthcare professionals with better communication skills in conflict resolution, a scheme to sponsor staff to attend formal training in mediation skills has been introduced. Most of the participants found the principles and skills they have acquired relevant and useful in challenging situations, including the dialogues related to a medical incident.

Dr H Bill Chan, Chief of Service, Paediatric & Adolescent Medicine, United Christian Hospital, Hong Kong Accredited Mediator (Hong Kong International Arbitration Centre) said: “Open disclosure in the event of medical incidents is the prerequisite for regaining trust of our patients and their carers. Barriers to open disclosure include concerns about personal, professional and legal consequences, as well as adequacy of communication skills.

“Mediation focuses on interest-based solutions to meet the immediate needs of the affected patient and their family. It seeks timely sharing of information to promote discovery of systemic problems and to prevent recurrence. Mediation skills like active listening with empathy, reframing, taking win-win approaches, options generation and appropriate assertiveness are skills I find useful in the disclosure conversation to achieve optimal outcomes. Successful mediation brings about reduced anger and punishment behaviour.”

Dr KM Li, Chief of Service, Accident & Emergency Department, United Christian Hospital, Hong Kong, said: “To disclose an incident to patients and/or their family is one of the most difficult tasks for doctors, especially when it is associated with severe adverse outcomes or the death of patients. Not much has been taught in medical school.

“Doctors have to learn and equip themselves in dealing with such situations. I strongly recommend mediation training for doctors in tackling this challenge. The skills taught in mediation training – like how to demonstrate empathy, active listening, create harmony, summarising and reframing, and getting somebody to ‘step into the other’s shoes’ – are all valuable techniques, helping us in the disclosure of medical incidents.”

Putting policy into practice

Establish formal procedures

From the organisational perspective, there should be a clearly stated policy and procedure about open disclosure, which should be consistent with the existing clinical governance framework, quality and safety policies and procedures, supported by senior health professionals using the process, and consistent with corporate direction and government regimes, insurer requirements and employment obligations.

Health services should ensure the procedure that triggers the open disclosure process is in place whenever an adverse event occurs. The disclosure process should incorporate the “no blame” (or “fair blame”) approach and health professionals and managers need to be consistent in their understanding of it. Engagement and culture building in the organisation about open disclosure should be multidimensional and multidirectional. Identifying and establishing local champions would be a useful start.

Healthcare professionals may fear that by being honest they will expose themselves to litigation and disciplinary action and damage to their reputation; they may feel anxious about admitting mistakes or feel incompetent to undertake an open disclosure process. They may also feel that there is a lack of managerial and institutional support if they are involved in open disclosure procedures. Some professionals may not understand what the real purpose of open disclosure and what the real needs of the clients are; they may also be very uncertain about the do’s and don’ts and what they ought and ought not to say to patients and their families during open disclosure.

Provide emotional support and coaching

A disclosure support system has been advocated as an institution support to overcome barriers to error disclosure. The system aims to provide disclosure education, ensure disclosure coaching is available at all times and provide emotional support to the patients and family, the healthcare workers (the “second victim” in an incident), and administration. Sufficient resources should be allocated to sustain the support system. Medical staff are required to engage in disclosure, activities, which are to be integrated with other patient safety and risk management activities.

Plan your response

Open disclosure is communication in a challenging setting where one might find denial, distancing, defence, guilt, blame, mistrust, high emotion, anger, confrontation, demand for compensation and a threat of a lawsuit. In the actual occurrence of an incident with the need for open disclosure, before the disclosure meeting, the care providers and relevant parties who are taking part in the disclosure should role play, practise and plan the disclosure dialogue (including crafting an apology appropriately, identifying a key spokesperson, etc), review the known current facts of the event, prepare to use plain language and consider legal presentation if appropriate.

The inevitability of error

In conclusion, despite much effort, errors in healthcare are still inevitable. The obligation to disclose harm is the physician’s responsibility to act in patients’ best interests. The disclosure of harm not only helps to respect patients’ autonomy, it also ensures that the patient can access timely and appropriate interventions for the harm suffered.

Dr Chui Tak-Yi is Hospital Chief Executive, Haven of Hope Hospital, Hong Kong.

The Hong Kong government is considering plans to introduce legislation enabling public agencies to apologise without fear of legal liability.
Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant’s job or the number of children they have) this figure can sometimes be misleading. For case reports in Casebook, we simply give a broad indication of the settlement figure, based on the following scale:

WHAT’S IT WORTH?

High US$2,000,000+
Substantial US$200,000+
Moderate US$20,000+
Low US$2,000+
Negligible <US$2,000

From the case files

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

In theory, all doctors are aware of the need to keep accurate and comprehensive medical records. But in busy clinical practice, high standards can sometimes slip as a result of the need to see ever-growing patient numbers. In many of the claims MPS handles, we come across examples of patient notes where there is no record of informed consent being taken; there is no record of discussions around potential postoperative complications; or there is no record of test results being ordered. This can make the job of defending a clinical negligence claim very difficult indeed.

No matter how busy you are, it is important not to underestimate the value of detailed notes. Not only do they help if a clinical negligence claim is brought against you, they are the gold standard of good patient care – leading to better communication between colleagues and smoother handovers.

In “Penetrating the eyeball” on page 15, Dr R’s records showed no evidence of discussion of indication, risks or alternatives for Ms J’s periocular injections. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. As a result, the case was indefensible and was settled for a substantial sum.

Good record-keeping means not only recording consent taken and treatments offered, but doing so contemporaneously. In “Rash decisions” on page 16, Dr P made notes retrospectively after Mr M rang the surgery with swelling, throat discomfort and difficulty breathing after he had been taking allopurinol and steroids for severe foot pain. Remember that alteration of records is a probity issue – and any alterations or retrospective entries should be clearly marked and dated.

Good record-keeping also means recording accurate observations at regular intervals. In “A brain-damaged baby” on page 16, experts were critical of the monitoring of the fetal heart rate both during Mrs N’s induction with prostaglandin, as well as during labour. Poor monitoring and documentation of the CTGs, with a failure to record the date and time, meant that labour was allowed to continue in place of a caesarean section, resulting in intrapartum asphyxia. The case could not be defended.

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If you would like to comment on a case, please email casebook@mps.org.uk.
Ms J, a 36-year-old banker with myopia, consulted Mr R, an ophthalmologist, with a one-week history of pain and blurring of vision in the left eye. Mr R diagnosed anterior uveitis and prescribed corticosteroid eye drops, and proceeded to give a sub-tenon’s injection of 0.5ml depotmedrol under local anaesthesia in the lower outer corner of the left eye. The patient felt minor pain with the local anaesthetic injection but felt excruciating pain with the depotmedrol injection. Within seconds a black spot blocked the central vision in the left eye. The spot expanded rapidly until the vision was completely lost. Mr R continued injecting till the full dose was given. On examining the left eye Mr R found that the eye was filled with fluid – he arranged a follow-up consultation the next day.

Ms J called later that afternoon to ask if she could see Mr R immediately but was advised to return the next day. Ms J chose to see another ophthalmologist who diagnosed a localised retinal detachment and referred her to a retinal surgeon, who performed surgery eight hours later. The retinal detachment was caused by two needle punctures penetrating the eyeball and injecting depotmedrol into the eye instead of the intended sub-tenon’s space. She underwent surgery to repair the retinal detachment and remove the intraocular drug but complete removal of the steroid was not possible.

Postoperatively, the retina was flat, but scattered retinal hemorrhage and macular nerve fibre layer oedema was noted. About three weeks later, Ms J developed an inferior retinal detachment, epiretinal membrane and retinal necrosis. She underwent further surgery to remove the epiretinal scar membrane and correct the retinal detachment. Her intraocular pressure was raised postoperatively but was controlled with medical treatment. The iritis subsided, the intraocular pressure normalised and the remaining subretinal steroid dissipated completely within three months. Her final visual acuity was hand movement in the left eye and 6/6 in the right eye. The left eye remained painful and uncomfortable. Ms J had difficulty with near work and computer work, suffered eye strain and easy fatigue in the right eye and experienced frequent headaches and imbalance when walking downstairs.

She was assessed as having 20% impairment of vision and 20% impairment of the whole person, with 50% loss of capacity. She also developed depression and was under the care of a psychiatrist. She returned to work six months later but, due to mental distress and intense eye pain, she had to work part-time in a less intense position, and with a lower salary.

Ms J made a complaint and a civil claim. The claim was indefensible and was settled for a substantial sum.

**Learning points**

- Ample guidance is available through professional bodies and the scientific literature on the management of common eye conditions. Periocular corticosteroids are not indicated for uncomplicated anterior uveitis. Where topical corticosteroids are ineffective, a sub-conjunctival injection of a short acting corticosteroid may be considered. Mr R chose the wrong primary method of treatment, the wrong injectable drug and the wrong route of injecting the drug.

- Periocular injections carry a risk of globe penetration that is much higher in myopic eyes. The records showed no evidence of discussion of indication, risks or alternatives. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. Guidance on the principles of taking informed consent is available in a number of different countries.

- Mr R failed to discontinue the injection when the patient had severe pain and loss of vision. Even though the globe had been injured, the extent of damage may have been reduced had he stopped immediately. Immediate exclusion of a penetration either by ultrasound or by clinical examination is mandatory when patient symptoms suggest globe penetration. Failure to do this established a breach in the duty of care. Early diagnosis and referral for emergency intervention may have reduced the extent of the irreversible damage.

- Adverse outcomes and complications are part of a doctor’s working life. Responding to these events in a timely manner, showing respect, being open and communicating honestly help to reduce the impact of these events on the patient’s wellbeing as well as the doctor’s professionalism.

- A patient can withdraw consent at any time during the procedure. When pain is not what you expect, it is good practice to stop and reconsider your treatment.
Rash decisions

Mr M, a 56-year-old clerical worker, developed severe pain in his left foot and made an appointment to see his usual GP. Dr P. Dr P knew him well, having diagnosed Mr M with chronic kidney disease several years earlier, and supported him when he suffered a stroke. Dr P suspected he was suffering from gout on this occasion and prescribed diclofenac, with omeprazole cover, since he was also taking aspirin.

Less than a month later, Mr M’s symptoms deteriorated and he requested a telephone consultation with his doctor. Dr P arranged for him to have a further prescription issued for diclofenac and omeprazole, and organised blood testing with the nurse to monitor his renal function.

A further month after attending for bloods, Mr M attended his follow-up appointment with Dr P, where he was advised that the blood tests had confirmed gout, alongside the ongoing chronic kidney disease. He was commenced on allopurinol, with the advice that he should double the dose of this after ten days of treatment.

A fortnight after commencing the new medication, with Mr M now on 200mg of allopurinol, Mr M started to feel unwell. He initially reported nausea and a small itchy area on his torso. Over the next few weeks, a similar rash began to appear on his face. He used calamine lotion without success, and eventually returned to see Dr P for advice.

Dr P concluded that the rash was likely to be secondary to a viral illness, and antihistamines were prescribed. That night, the rash seemed to be getting worse, so Mr M consulted with Dr P again the very next day, and a course of prednisolone was commenced. The allopurinol was briefly discussed, and the patient was advised to continue taking it at a dose of 200mg daily.

The situation continued to deteriorate and Mr M had two further appointments with Dr P over the course of the next week. His steroids were initially increased, and when this failed to improve symptoms, the rash seemed to be getting worse, so Dr P suggested the allopurinol should be discontinued. To complicate matters further, Dr P forgot to document the second consultation since he had a busy surgery. Three days later, Mr M developed generalised swelling, throat discomfort and difficulty breathing. Dr P spoke to the patient over the telephone and advised he was likely to be suffering from thrush.

Dr P realised at this stage he had failed to document his previous consultations so made some brief notes, without indicating he was doing this retrospectively.

Dr P went on to say that the rash was likely to be secondary to a viral illness, and antihistamines were prescribed. That night, the rash seemed to be getting worse, so Mr M consulted with Dr P again the very next day, and a course of prednisolone was commenced. The allopurinol was briefly discussed, and the patient was advised to continue taking it at a dose of 200mg daily.

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Dr P realised at this stage he had failed to document his previous consultations so made some brief notes, without indicating he was doing this retrospectively.

Learning points
- The basics can sometimes be overlooked – an apparently trivial rash, as in this case, can herald a more serious condition, which reflects the need for joined up thinking.
- Clear and contemporaneous note-keeping is essential and this case highlights the importance of adequate documentation. Clinical notes are legal documents and any alterations or retrospective entries should be clearly marked and dated. Alteration of medical records is a probity issue.

A brain-damaged baby

Mrs N was admitted for induction of labour at a gestation of 38 weeks. Mrs N had requested induction as she was feeling very tired. Antenatally, there had been no concerns over mother or baby. A cardiotocograph (CTG) was normal. As the cervix was unfavourable, Dr L inserted 1mg prostaglandin gel into the vagina. Dr L asked the midwife to commence continuous fetal heart rate monitoring. However recordings were not documented at regular or consistent intervals.

Six hours later, Mrs N was not in labour and the cervix was still unfavourable. Dr L inserted a second prostaglandin gel. Two hours later, Mrs N was in labour with the cervix 3cm dilated. The membranes were artificially ruptured after five hours, after which labour progressed rapidly, resulting in a normal delivery within two hours. During the induction process and labour, the fetal heart was monitored electronically using a CTG.

The baby was born in poor condition with low Apgar scores and transferred to the neonatal intensive care unit.

Mrs N developed a primary postpartum haemorrhage due to an atomic uterus, which failed to respond to medical intervention. The bleeding was so severe that Mrs N needed a laparotomy and ligation of the internal iliac arteries, which successfully arrested the uterine bleeding.

Analysis of the baby’s blood shortly after birth revealed metabolic acidosis consistent with intrapartum hypoxia. Unfortunately, the baby developed seizures and investigations revealed hypoxic ischaemic encephalopathy. The child now has severe spastic cerebral palsy.

A claim was brought by Mrs N. The experts were critical of the monitoring of the fetal heart rate both during the induction phase with prostaglandin, as well as during labour. There was a combination of inadequate fetal heart rate documentation and inaccurate interpretation by the midwife. The CTGs were incorrectly interpreted as normal when they were actually pathological. Allowing labour to continue, rather than performing a caesarean section, led to intrapartum asphyxia and the resultant brain injury. The obstetric expert was also critical of the poor documentation on the CTGs, with a failure to record the date and time, or contractions in some instances.

There was no criticism of the management of the postpartum haemorrhage.

The case was settled for a high sum.
With any operation it is important to have a valid indication. Discussions with patients should be mandatory for all healthcare professionals working in obstetric units. Misinterpretation of CTGs and failure to act on abnormal CTGs are cited as major factors in maternity claims in the United Kingdom. Between 2000 and 2010, “CTG interpretation” was the second most expensive category in terms of claims by value at over £466 million – Ten Years of Maternity Claims: An Analysis of the NHS Litigation Authority Data (October 2012).


With any operation it is important to have a detailed discussion with patients regarding the potential for complications, so that they can make a balanced decision as to whether they wish to go ahead with the procedure. The discussion should include common/minor side effects as well as rarer, serious adverse outcomes that can produce permanent disability or death. Discussions with patients should always be thoroughly documented. Statistically, decompressive surgery of the thoracic spine has the highest risk of neurological complications, compared to decompressive surgery of the cervical and lumbar spine, given the size of the spinal canal relative to the spinal cord and the spinal cord's relatively poor blood supply in the thoracic spinal canal. It would be expected from the reasonable spinal surgeon to mention the risk of a significant neurological deficit from surgery in this region.

Clinicians are obliged to keep up-to-date in their field and undertake procedures that are recognised as standard by their peers with acceptable outcomes. Clinicians additionally need to demonstrate evidence of continuing professional education as part of their appraisal processes.
Stumbling block

Mr G was a 52-year-old school headmaster. His lifelong enjoyment of sports was becoming more difficult due to increasing pain from his left knee, although there was no injury or trauma to account for it. His GP, Dr M, initially referred him to a physiotherapist with only temporary improvement. Eventually Mr G asked to be referred privately to a specialist and was referred to Ms S.

Ms S assessed the knee thoroughly. The pain originated in the anterior aspect of the knee around the patellar tendon. There was no history of locking, swelling, or giving way. On examination, the only abnormal finding was mild tenderness along the medial joint line. X-rays revealed small osteophytes around the patella, but normal joint architecture and no other abnormality. An MRI scan of the knee revealed mild degenerative change of the medial meniscus, with no tears, and mild arthritis of the patellofemoral joint.

Mr G was keen to have this treated, so Ms S offered him an arthroscopic assessment and lateral release of the patella. This was performed under general anaesthesia, which was administered by Dr H. After induction, but prior to surgery, Dr H placed a femoral nerve block to provide postoperative pain relief. Dr H did not document any discussion about the block beforehand, nor Mr G’s consent. Mr G seemed to recover well and was discharged home the following day. At his ten-day follow-up visit to Ms S, he complained of pain in his heel. Ms S recommended physiotherapy and made a plan to follow Mr G up in two weeks. At this visit, the heel pain had settled, but Mr G was experiencing giving way and locking of the knee, as well as numbness and burning pain in his thigh. Ms S noted marked wasting of Mr G’s left quadriceps, and documented he was barely able to perform a straight leg raise. She referred him for electromyography, and commented that she could not think of any reason why a knee arthroscopy would be associated with quadriceps wasting.

Neurophysiologist Dr R performed EMG studies of Mr G’s lower limbs, which revealed an isolated left femoral nerve lesion. Dr R commented that she could not initially identify a cause for the lesion, but speculated that a femoral nerve block might be responsible. She found documentation of Dr H’s block in the anaesthesia chart, and ascribed the nerve damage to the block.

Twelve months later, Mr G had no recovery from his injury. He had almost complete loss of function of the femoral nerve, and experienced difficulty climbing stairs, rising from a sitting position, and walking even short distances. He was required to use a lockable knee brace. As a result of his symptoms, he had been unable to continue working.

Mr G brought a claim against Dr H, in which he alleged that Dr H had not discussed the femoral nerve block with him, and had not sought his consent. Mr G said that he would not have agreed to undergo the block. Ms S had not known at the time of surgery that a block had been performed, and did not see it being placed.

Dr H’s technique was also criticised. He had used a 25mm blue needle to perform “fan infiltration lateral to the femoral artery using a continuously moving needle technique”. Several of the experts concluded that the nerve had been severely injured by this technique.

Dr H’s failure to obtain informed consent for the block, and his questionable technique, were considered indefensible. The case was settled for a substantial sum.

Learning points

- An important point in this case was the informed consent. Dr H asserted that he had discussed the femoral nerve block with Mr G beforehand, but failed to document any discussion. Consent given by the patient for general anaesthesia does not imply consent to undergo other types of anaesthetic intervention while anaesthetised; for example, a regional nerve block. Where extra procedures are required, their specific risks and benefits should be discussed with the patient, and consent obtained to perform them. These discussions need to be documented.

- Dr H was criticised by the experts for his use of an outdated, unsafe technique. There are several readily-available techniques to make regional blockade safer, including performing the block awake, or the use of a regional nerve block needle, a nerve stimulator, or an ultrasound probe. Ultrasound, in particular, has revolutionised the safety and efficacy of therapeutic nerve blockade.

- Dr H also failed to communicate his block to Ms S. Although it did not affect the outcome, had Ms S known about the femoral block, she may have caught on sooner. The surgeon and the anaesthetist should each know broadly what the other is doing at all times. Dr H should have documented more carefully.

- The WHO surgical safety checklist is a useful tool. Visit: www.who.int/patientsafety/safesurgery/ss_checklist/en
Mrs N was a 26-year-old researcher with a four-year-old daughter. She enjoyed dancing and went to a salsa class with her husband each week. Her right knee was slightly painful so she missed a class to see if it improved but it got gradually worse over the next few weeks.

She made an appointment with her GP, Dr B, to discuss her knee pain and seek his opinion on a skiing holiday she had booked. His notes commented on her right knee pain which was “possibly due to dancing”. He documented some tenderness over the tibial insertion of the medial collateral ligament. He noted that the joint was stable and that there was no effusion. Dr B prescribed diclofenac and explained that he felt her skiing holiday did not need to be cancelled, but that it may not help matters.

Mrs N enjoyed her holiday but was becoming aggrieved by the knee pain, which was troublesome most of the time and when dancing. She saw Dr B and explained that the pain had been ongoing for four months with no improvement and that she couldn’t remember any specific injury. Dr B documented the history and referred her to physiotherapy. His completed musculoskeletal referral form did not highlight any red flags including intractable night pain, weight loss, systemic illness or previous history of cancer.

While she was waiting for her physiotherapy appointment Mrs N rang the surgery again asking for a GP appointment. This was the first appointment she was given with Dr G. Mrs N explained that she had not taken the diclofenac because she was nervous about possible side effects and she felt the pain was getting worse. Dr G’s records stated “history as above” and also noted that there was no locking or giving way. His examination notes were thorough. He commented that she was able to weight bear, that there was no swelling and that the knee was stable with a normal range of movement. He noted mild tenderness medially. He encouraged her to take the diclofenac and to rest, ice and elevate the knee. He advised buying a tubigrip to offer some compression to the knee. He gave safety-netting advice: asking her to return if things got worse while waiting for physiotherapy.

Mrs N saw the physiotherapist, Mr Y, who noted her four-month history of gradual onset knee pain. He recalled the patient saying that the pain intermittently flared. His examination noted a limping gait and an inability to extend her right knee fully due to pain. He noted slight swelling and that the knee was very warm to touch. McMurray’s test was positive. Mr Y’s initial thoughts were an injury, mono-arthritis or cartilage damage. He advised a review after two weeks of anti-inflammatory and ice. At the review it was noted that there was swelling most days and the pain was worse.

Mr Y was concerned that there was an inflammatory cause and suggested inflammatory marker blood tests through Mrs N’s surgery. These were found to be normal but Mr Y referred her to a consultant rheumatologist because her knee was still hot and swollen with no obvious cause.

Mrs N was seen urgently in the rheumatology clinic. Blood-stained fluid was aspirated and an x-ray arranged. The x-ray reported “possible tumour” and a subsequent MRI scan and biopsy confirmed the diagnosis of osteosarcoma of her right tibia.

Mrs N sustained a tibial fracture and was given chemotherapy. She struggled with nausea and fatigue and was devastated when she was told that she needed an above knee amputation because the tumour was aggressive and had not responded to chemotherapy. She later had a prostatectomy fitted.

Mrs N was extremely upset and made a claim against Dr G. She felt that there had been a delay in the diagnosis of her tumour and that earlier diagnosis could have saved her leg from amputation. Mrs N claimed that the first time she had seen Dr G, she had complained of severe pain in the day and night and that the knee was hot and swollen at that time.

Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given.

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Mr P, a 40-year-old office worker, had a long history of sino-nasal problems, and had even had a previous septoplasty operation. Soon after returning from a holiday, he consulted his GP, Dr A, with worsening blockage in the left side of his nose. Dr A saw a polyp on this side and referred Mr P to ENT surgeon Mr E for his opinion.

Soon after this, however, Mr P was admitted to hospital with some breathing problems and sinusitis, and was extensively investigated. These investigations included a CT scan of his sinuses. During this admission, he was seen by Mr E, who also identified the polyp, and a number of other problems on the scan, which he felt would benefit from some endoscopic sinus surgery.

Mr P was readmitted to the hospital a few weeks later for his elective endoscopic sinus surgery. A standard consent form was signed on the morning of the surgery, including a general mention of risk to eye or brain damage generally, but there was no discussion about specific complications. Surgery took place later that day. During the operation, Mr E suspected that he had breached the lamina papyracea (the thin bony wall separating orbit from nasal cavity). Immediately postoperatively, Mr P was noted to have a swollen left eyelid, which became more swollen over the next few hours. In addition, he complained of pain and blurring of vision. Mr P was discharged from hospital and an ophthalmology opinion was arranged for a few days later. This confirmed an orbital haematoma and some limitation of movements, but no evidence of alteration to visual acuity.

A second ophthalmological opinion was requested some months later when the symptoms of double vision did not settle. In addition, Mr P described symptoms of dizziness and discomfort in the affected eye. This limited his ability to drive and rendered him unable to work. Sadly, no curative interventions were available. Varifocal lenses were suggested to try and help Mr P with his vision, along with the hope that things might improve further with the passage of time. More positively, his chronic sinus problem appeared to have been successfully addressed.

Expert opinion determined that the breach in the lamina papyracea and the subsequent orbital haematoma had been the cause of Mr P’s visual problems, by limiting the movements of the superior oblique muscle. This is a rare but well-known complication that can happen even to experienced surgeons.

Expert opinion found a breach in the standard of care around the process of consent. Mr E did not appear to explain that the surgery was for quality of life and therefore not essential, or that ongoing medical treatment was a therapeutic option. Nor did he specifically warn Mr P that orbital damage might result in impairment of vision, including diplopia. The case was settled for a substantial amount.

Learning points

- Informed consent must involve an explanation of the role of medical treatment, or no treatment at all, rather than just surgery, in non-life threatening medical conditions. In this case, Mr P’s chronic sinus condition might have been controlled with steroids and antibiotics.

- The consent process must also include details of the consequences of a complication, not just a general mention of possible adverse events.

- This case is a reminder that even in what might be considered simple or straightforward surgery, significant problems or complications can, and still do, occur.

- MPS’s free workshop for members, Mastering Shared Decision Making, shows how the shared decision making model is an effective way to ensure that patients make appropriate and informed choices about the treatment options available to them. For more information visit the Education section of the MPS website.
It’s all about consent

Mr K, a 37-year-old self-employed businessman, consulted his GP, Dr P, requesting sterilisation. Mr K stated that although he had two children, aged 17 and 9, he wished to undergo a vasectomy. Dr P explained to Mr K that the procedure was irreversible, and Mr K stated he still wished to go ahead and to use his private insurance. Hence, Dr P referred Mr K privately to a consultant urologist, Mr S.

The patient saw the urologist and was subsequently listed for a vasectomy. Mr S then carried out the procedure under local anaesthesia, with no immediate complications. A few days following the procedure, Mr K noticed some weeping from one of the wound sites, and attended Dr P, who prescribed him a course of antibiotics. By the end of the seven-day course, the situation had worsened with increasing weeping at the wound site as well as pain both at the wound site and in the testis and groin on that side; Mr K thus attended the Emergency Department (ED).

On assessment there his pain was reported as 10/10 and constant, thus not allowing him to sleep, despite oral paracetamol. He was discharged with co-codamol. Four days later Mr K attended a different ED and a diagnosis of post-vasectomy haematoma was made, and Mr K was again discharged with yet stronger analgesics. The following day the patient saw Dr P again and was advised to take a week off work. Things did not improve and the patient called Dr P the following day to see him at home, and was then subsequently admitted to hospital with a diagnosis of infected hydrocele/haematoma.

After hospital admission, the wound burst and the patient was taken to the operating theatre where the infected haematoma was drained. Two days later the patient was discharged home, and subsequently reviewed four weeks later in outpatient by Mr W, consultant urologist, who discharged him from further follow-up.

Mr K alleged breach of duty due to lack of informed consent on the part of Mr S. As the complication was handled appropriately and is a recognised complication of vasectomy, no issue of technical incompetence by Mr S was alleged. The claim thus solely related to a lack of informed consent; specifically, Mr K alleged that Mr S did not warn him before he consented about the possible complication he subsequently suffered.

Mr K stated that he was uncertain about whether to go ahead with the vasectomy and if he had known about the potential complications, he would not have undergone the surgery.

The signed consent form was the key piece of evidence in this case. Mr K used a standard form of consent, but one in which all complications were not printed, and thus Mr S handwrote the complications of pain, bleeding, bruising, haematoma and infection at the bottom of the form. It was alleged by Mr K that Mr S did this after the claim was filed, and thus that Mr S doctored the consent form days after the procedure. This was proven to be untrue as a copy of the consent form was sent to Dr P with a letter stating these complications had been explained, on the same day as the initial consultation.

Dr P confirmed that Mr S did not have access to Mr K’s files after the procedure and thus could not have amended the consent form at a later date as alleged. Also, Mr S had a practice nurse sitting in during the consent procedure and she reiterated the complications to Mr K as well herself after the initial consultation, and this practice nurse confirmed that the consent procedure by Mr S was thorough and complete. The claim was therefore discontinued and costs were recovered from the claimant.

Learning points

- This case illustrates one of the commonest reasons for litigation against doctors, and especially surgeons; that of issues of consent before a procedure. It is not uncommon for a patient to feel happy to proceed for a surgical procedure at the time of the procedure, but then to feel unhappy with that decision to proceed when he suffers a well-accepted complication.

- Vasectomy is one of the most litigious procedures for urologists, although it is one of the simplest operations within that specialty. The procedure is typically day case and under local anaesthesia, taking an average of 20 minutes. However, the pre-procedure consent process and consultation typically lasts longer than this. Having copies sent to the patient’s GP and having a nurse during the consultation further safeguards against litigation.

- When surgeons operate on patients in the private sector and their complications are then managed by different doctors in the public sector, patients can often feel aggrieved at the operating surgeon who is now ‘nowhere to be seen’. Good communication between all doctors involved in such situations can facilitate the optimal management of the patient, and thus lessen the risk of future litigation. This case provides a valuable lesson: however straightforward and routine the surgery might be, proper documentation is vital.

- There were two missed opportunities to intervene here. The patient was left unhappy and aggrieved.

- The surgeons should have given their contact details and been responsible for the follow-up arrangements.
A weekend of back pain

This case occurred in the United Kingdom and details procedures and organisations specific to the country.

Mrs P was a 42-year-old housewife who lived with her husband, daughter and their first grandchild. She had suffered with chronic lower back pain for many years, which was helped by regular paracetamol. She had struggled with flare-ups over the years, usually after gardening or lifting the shopping. Symptoms always settled within a few days with co-codamol or ibuprofen prescribed by her GP.

Mrs P had been looking after her granddaughter and had lifted her rather awkwardly into the car. This aggravated her back so she took some co-codamol she had at home from the most recent flare-up. When this failed to relieve the pain, she made an appointment with her GP. She was unable to lift her granddaughter because of pain in her lower back. He prescribed ibuprofen and arranged a follow-up appointment in a week. He referred her to physiotherapy because of the frequent exacerbations.

Her pain became more severe through the week. She took the co-codamol and ibuprofen but couldn’t manage the pain. By the Friday evening she was in tears and her husband suggested she ring the out-of-hours GP service. She was put through to a triage nurse who noted her history of long-standing back problems and worsening pain. The nurse advised Mrs P to keep mobile and to see her GP again after the weekend but her husband demanded that she saw a doctor that evening. The nurse documented that she “would like to see a doctor for stronger meds” and made her an appointment to see the out of hours GP, Dr M, that evening.

Dr M reviewed the triage nurse’s history, in particular the lack of any noted red flags. He documented that she had complained of pain over the coccyx area and that she had claimed she could not sit or lie down due to pain. He therefore examined her standing and noted an absence of spinal tenderness except over the coccyx. He prescribed some dihydrocodeine to help her manage the pain and asked her to ring back if the situation worsened.

On the Sunday, Mrs P became anxious because she felt completely numb at the bottom of her back. She rang the out-of-hours service again and spoke to a triage nurse. She explained that she “felt so numb she couldn’t feel the toilet seat beneath her and that she couldn’t feel the passing of water”. She was also very embarrassed but mentioned that she had been dribbling urine without being aware of it. She explained that despite taking the dihydrocodeine she had developed severe pain at the back of her right leg and near her ankle. She wondered if the dihydrocodeine had constipated her because she was unable to open her bowels. The nurse documented the history and advised her to see her own GP in the morning and to keep the physiotherapy appointment that was pending the following week. She gave her advice on taking senna and lactulose for the constipation.

Mrs P had a dreadful night. She couldn’t sleep because of the pain and when she tried to walk to the toilet she noticed that her right leg felt “floppy” and that she could not feel the floor with her right foot properly. Her husband took her straight to her own GP surgery on Monday morning. Her own GP took a history and examined her, documenting an absent ankle reflex, a straight leg raise which was reduced on both sides and weak anal tone. He diagnosed probable cauda equina syndrome and arranged for an urgent assessment with orthopaedics.

His referral letter stated that she developed the numbness and the voiding difficulties the day before. The orthopaedics team saw her the same day, also noting that her symptoms suggestive of cauda equina had started the day before. They catheterised her due to retention and

Learning points

- Doctors should record the particular red flags that are absent – it is important to record both relevant positive and negative findings in the history and examination.
- When a healthcare team experiences such an incident where a patient has suffered a considerable harm as a result of a delay in diagnosis, the team should conduct an SUI investigation – review. The team should get together and see what lessons can be learnt to prevent similar incidents happening again. There may be issues, for example, for the out-of-hours (OOH) centre – eg, the triaging by the nurse – was she working to a script? In which case the script might be at fault. If so, it might need reviewing. Nurses/GPs working in OOH needs to be appropriately trained and qualified.
- In such cases, the danger for the patient’s registered GP is that with a long-standing back problem he needs professional discipline to ensure that he or she repeatedly checks his patient is also aware of what the red flag symptoms are. It is all too easy with chronic back pain patients to simply focus on analgesia control, rather than what to look out for and contact the doctor urgently about.
- Surveillance is a useful and legitimate tool that MPS can use to strengthen the defence of a claim.
- Doctors should keep clear, accurate, and legible records. It is important to keep contemporaneous notes. The defence in this case was partly based on dates and times of symptoms recorded in the medical notes.
- Remember that referral letters add to consultation notes. They contain important clinical and medicolegal information and should be copied in patients’ medical records. This case was defended partly on information written in referral letters.
- Although Dr M was not criticised, it is still a useful reminder that doctors should take and document their own history from a patient and not rely on someone else’s account.
- This case illustrates that the claimant also runs a litigation risk when pursuing a claim. The general rule in litigation is that all claimants and all defendants are jointly and severally liable for all costs awarded against them.
arranged an MRI scan of her lumbar spine. The MRI showed a massive L4/5 disc prolapse causing severe central canal stenosis and also impinging on the traversing right L5 nerve root. Mrs P subsequently had an L4/5 decompression and discectomy and partial L4/L5 laminectomy.

After the surgery, Mrs P was seen in the spinal clinic. She had no true urinary incontinence following the retention although she still had some difficulty in assessing when she had finished passing urine. Fortunately she had full control of her bowels. She was still upset about worsening right leg pain, which was severe.

Mrs P made a claim against the out-of-hours service, firstly against the nurse for failing to triage appropriately and secondly against the GP, Dr M, for failing to recognise and promptly refer her cauda equina syndrome. She claimed that she had had the cauda equina symptoms on the Friday that she consulted Dr M.

MPS sought the opinion of a GP expert who was not critical of Dr M’s consultation on the Friday evening. The triage notes did not indicate any problems with new symptomatology, specifically no mention of any development of radiation of the pain, altered sensation or problems with micturition and bowels. It was agreed that the limited examination in the absence of these symptoms was reasonable. It was also considered that Dr M’s prescription for stronger analgesia was effective since the patient did not contact a doctor the following day. It was, however, agreed that the triage nurse was in breach of duty on the Sunday when she recorded red flag symptoms and failed to pass the call onto a doctor.

Mrs P’s contemporaneous medical records were analysed carefully. It was agreed that the major deterioration in her condition occurred on the Saturday. Dr M’s records, the GP’s referral letter to orthopaedics and the orthopaedic team’s records all contradicted the claimant’s account and indicated that she did not have symptoms of cauda equina syndrome at the time of consulting Dr M.

MPS represented the out-of-hours provider and the claim was settled with respect to the triage nurse’s breach of duty. Dr M, however, was successfully defended and not found liable.

Mrs P was seeking very substantial damages because she alleged that she could no longer live in her current home and needed to move to a specially-adapted bungalow. She claimed she needed an electric scooter, could not walk unaided, and that she needed constant care both day and night. MPS engaged a surveillance firm to observe the claimant. Over a period of time they assimilated evidence: photographing the claimant carrying a young child, picking up and moving boxes, folding a child’s buggy against her leg, walking without any aids, and carrying a basket of heavy shopping with one hand and waving with the other. The claimant’s legal costs were being paid by public funding. MPS wrote to the Legal Service Commission regarding the evidence and funding was withdrawn. The claim was originally for damages in excess of £2 million but was settled for a fraction of that amount.

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Over to you
We welcome all contributions to Over to you. Please address correspondence to: Casebook, MPS, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK. Email: casebook@mps.org.uk

Suspected epilepsy: when to warn

It was stated in “Suspected epilepsy: when to warn” (Casebook 21(2)) that “there was nothing in the notes to suggest the hospital intended to rule out anything serious, like epilepsy”. Yet an EEG was arranged. I cannot conceive of a reason for EEG other than to rule out something serious – like epilepsy. The mere fact that it was arranged – isn’t it ample proof?

Moreover, presumably the patient’s parents were given the EEG appointment card or information before leaving the hospital; they then chose not to bring the patient for the EEG, without bothering to find out what the test was and what it was for. Don’t they bear some responsibility?

Dr Chun How Ooi, Singapore

Response

I agree with you that the statement you quote in your first paragraph is somewhat illogical.

Regarding the parents’ responsibility, courts generally are reluctant to hold a patient – or in this case the child’s parents – as contributing to the negligent outcome. You can imagine the persuasive power of a parent saying: “Of course if I had been properly informed of what the test was for and why it was important, I would never have knowingly put my child at risk...” And the notes usually do not document the detail of such a conversation.

Many thanks for your interesting and thoughtful comments.

Two cases: one theme

Re: the articles on pages 20 (“A rash oversight”) and 21 (“A failure to monitor”), Casebook 21(2).

Two articles have a common theme. Patients in both cases sued their GP while the healthcare system and government policy neglected to ensure patient safety.

The healthcare industry should take steps to prevent chickenpox in pregnancy. We could have a national immunisation program [here in the UK] like that in the US (www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html). We could also check women for immune status at booking or preconception. As it is we rely on GPs remembering to follow a post-exposure prophylaxis protocol. Murphy’s Law applies so patients suffer and doctors pay, via indemnity subscriptions, to help clear up the mess.

Why does the healthcare system have us install a piece of electronics in a man’s chest without having a way to monitor it? The GP’s notes may have been poor but the responsibility for the device should rest with the company that made it and the clinic that inserted it. A cardiac pacemaker is a ‘mission critical’ device. If it stops the patient might die. In the case you describe recording the pulse or an ECG wouldn’t have given information about its activity over a period longer than a few seconds. There should be systems to ensure that it can’t fall without that failure being detectable in

When normal is wrong

In the section headed “Learning points”, it is written: “The failure rate of vasectomy, either due to failure to remove adequate sections of both vasa or recanalisation, albeit small, is of crucial significance, and must be mentioned and documented.”

Unfortunately, this sentence implies that removing an “adequate section” of vas will prevent failure. Evidence from vasectomy randomised studies shows that the best way to prevent failure is to lightly cauterise the lumen of each vas and to separate the ends by a tissue plane. Separating the ends by a tissue plane but without luminal cautery is nearly as good. The older method of removing a long length of vas is associated with a higher complication rate (bleeding and pain) and higher recanalisation rate.

If any vas is removed then it should only be a small section, not an “adequate section”, as one has to remove a very long section to prevent end approximation and vasectomy failure. Removing very long sections is associated with an unnecessarily higher complication rate and also makes reversal much more difficult should circumstances change. The ideal vasectomy is minimally invasive, has minimal complications, is 100% effective and 100% reversible. No technique perfectly meets these criteria but the no-scalpel technique with fascial interposition and ideally with luminal cautery is the best we currently have.

Tim Hargreave, Consultant genito-urinary surgeon (retired), Current member, research review panel, human reproduction programme, WHO, Geneva. References have been supplied, and are available on request.
real time. At the very least there should be a way to interrogate it to determine how it has behaved in the past.

In critical event analysis we should be looking at ways to improve patient safety. A simple measure would be to change the way we record blood pressure. The data entry box for BP using INPS Vision has no facility except free text for recording pulse rate. It would be very simple to add a mandatory field for pulse rate (and reg/irreg to screen for atrial fibrillation).

I want to see MPS analysing cases to identify areas where putting pressure on government health departments and their suppliers to change policy could prevent future disasters, and then applying that pressure.

Dr Ian Quigley, Partner and GP Principal, Western Road Medical Centre, UK

Response

Many thanks for taking the trouble to write in with your response to two of the reports in the last edition of Casebook. It is useful for us to have feedback like this, and it informs our future publications and lobbying activities. We also plan to share such activities with readers in more detail, in future articles and updates.

A case of renal failure

I found “A case of renal failure” (Casebook 21(2)) rather worrying. It states that Dr T was criticised for failing to notice that Mrs B’s renal function had not been rechecked.

Mrs B had been advised by Dr T to have her bloods rechecked but if she failed to do so, then that is her fault. I see between 36-40 patients a day but do not make a list of which patients have not had the blood tests that I requested them to have.

Is MPS suggesting that this is what we should be doing?

Secondly, the report mentions that the GP should have sent a urine for ACR. My understanding is that an ACR should only be sent for diabetic patients and non-diabetic patients should have a PCR sent instead.

Please do let me know if I am wrong in this.

Dr Muhammad Shahbaz Sharif, Salaried GP, Leicester, UK

Response

We acknowledge the practical challenges of having a system that will pick up patients who do not return with results of tests that have been ordered – it is a frequent source of debate as to whether a court would invariably hold the patient totally responsible for the consequences; a court might take the view that patients are less likely to act in a way that puts them at risk, if they understand those risks. However, there was no excuse for the GP not to have checked her renal function at subsequent visits, and the results were so significant as to suggest that the GP could not have explained the importance to the patient.

Finally I am advised that most CKD guidelines advise annual ACR checks, on all patients with an eGFR under 60, regardless of underlying aetiology.

I hope that this addresses the issues you raised.

A rash oversight

I read with interest your case report regarding the patient who was given incorrect medical advice by non-medical staff (“A rash oversight”, Casebook 21(2)). I notice the doctor involved was criticised for “allowing administrative and nursing staff to provide negligent medical advice”. Although not knowing the full case, I assume that the doctor had no knowledge of his administrative staff giving such advice; so I wonder why the doctor is the subject of the claim and not the member of staff involved?

Secondly, with the increasing use of non-medical practitioners to cross-cover several specialties out-of-hours, who would be responsible overall for any errors in a patient’s management?

One example would be an error made by a member of the Hospital at Night (H@N) team on a surgical ward. The teams are not usually specialty-specific (as medical staff traditionally are) and the consultant responsible for the patient would not line manage the members of the H@N team or be involved in setting out their roles and responsibilities.

With this case report – and the increasing use of non-medical staff – I worry that when I am a consultant I may be deemed responsible for the erroneous actions of a member of staff I do not even know, purely as my name is above the bed.

Dr Callum Kaye, UK

Response

In the first case which took place in general practice, the GPs who employ practice staff are vicariously liable in law for their acts and omissions. And they would be expected as a matter of good practice to have systems and procedures in place regarding the scope of their responsibilities, as a safeguard against people acting outwith the scope of their knowledge.

It would be an unsuccessful defence for the GP to argue that they were unaware of what their staff were doing.

In the hospital setting, whilst each individual is personally responsible (as opposed to liable) for their own actions, any claim would be brought against the hospital, which is liable for the acts and omissions of its employed staff, as well as for any deficiencies in policy and procedure.

I hope that this clarifies the different situations.
Complications: A Surgeon’s Notes on an Imperfect Science
by Dr Atul Gawande (£8.99, Profile Books, 2008)
Reviewed by Dr Omar Mukhtar, ‘Darzi’ Fellow, Health Education South London (UK)

Complications: A Surgeon’s Notes on an Imperfect Science is a collection of essays focusing on the fundamentals and imperfections of modern surgery. With many originally written for The New Yorker magazine, where Atul Gawande has been a staff writer since 1998, the essays provide an honest insight into the world of modern healthcare that extends beyond the operating theatre and the consulting room – ultimately, affording readers an opportunity to reflect on the human condition itself.

Broadly grouped around three central themes – Fallibility, Mystery and Uncertainty – Gawande’s essays slowly dismantle the misconceptions held by the general public whilst challenging the status quo fostered and maintained by the medical hierarchy. He admits freely that medical professionals make mistakes, that much of the knowledge we hold so dear is based on a loose interpretation of facts (often acquired many years ago) and that we do learn ‘on the job’. He also acknowledges that there is much about the human body that remains stubbornly mysterious, that good doctors do go ‘bad’ and that there might be a case for super-specialisation from the outset of medical training.

Written with a clarity often lacking in ‘populist’ musings on healthcare, Gawande’s work draws not only on his experiences as a general/endocrine surgeon at Brigham and Women’s Hospital, Boston, Massachusetts, but also on his experiences as a father. Equally, many of the essays make reference to the scientific literature without resorting to a dry recall of facts, in a manner that must be applauded – regardless of whether they relate to the chronic pain of a stranger or the horror of a life-threatening respiratory infection afflicting his youngest child (born prematurely). That said, despite being a Rhodes Scholar who studied PPE at Oxford, Gawande’s observations tend towards the superficial cliche – perhaps a consequence of the immediacy required when writing for a periodical that is published 47 times a year. Despite this, Complications has a charm, confidence and humility that you suspect is intrinsic to Gawande himself. The first of three books (the others being Better: A Surgeon’s Notes on Performance and The Checklist Manifesto: How to Get Things Right), you might not be wrong in assuming that it is Gawande’s personal testament to a quality and safety agenda that is only now taking root in certain countries – a decade after Complications was first published.

The Secret Anatomy of Candles
By Quentin Smith (£8.99, Troubador Publishing LTD, 2012)
Reviewed by Dr Catherine Walton, CT3 Psychiatry, Wales (UK)

Quentin Smith has delivered a promising debut novel. The Secret Anatomy of Candles is a medicolegal drama with an ethical dilemma that will hook even the most world-weary of medics, and stir them to discuss the central themes with colleagues over coffee.

The ideas and questions raised by the novel are topical and relevant; for example, one important theme of the book is the MMR vaccine. The week I read the novel was during the time of intense media coverage of the measles outbreak in the Swansea area. So it was immediately relevant.

The world of Jasper Candle, a “ruthless compensation lawyer”, is set in the courts, bars and streets of Durham. The description of the city is excellent: Smith shows a flair for this, and it was effortless to conjure up the areas described in my mind’s eye.

The man himself, Jasper Candle, is a character of some depth, with the flaws and nuances one would expect of a successful lawyer of his standing. Unfortunately, the character is perhaps rather too typical – the flaws and nuances feel somewhat unoriginal. It is clear that Candle is troubled by a physical ailment, the development and diagnosis of which is essential to the plot. Unfortunately, as a medic reading this novel, the diagnosis became clear rather sooner than I feel the author would have hoped in order to maintain suspense through to the twist at the end.

However, having discussed the plot with family members, I feel that this would not have been so apparent to a non-medical audience. Other characters within the book are somewhat more intriguing. In particular, the investigator Lazlo is perhaps the most interesting. His clothes and ‘cheap’ piercings put him firmly in the lower class, but he shows understanding and insight into the feelings and motivation of his employer, Candle. The plot itself is complex and several themes run in parallel. This would be confusing were it not for some skill on Smith’s part in keeping the chapters short and succinct. It also had the added benefit of keeping the pages turning. If I had any criticisms of the novel it was the use of cockney rhyming slang to add ‘depth’ to Candle as a character – it felt unnecessary and at times plain out of place. I also think that sometimes Smith utilised long and challenging words and sentences, which over-complicated the style of the book.

Overall, I felt that this was a great read. The storyline is relevant, up-to-date, and made me think about certain issues from a different perspective; it is certainly one to consider for your next bedtime book.
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