CASEBOOK

CONTRACEPTION AND A CARDIAC ARREST

This issue...

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A look at Caribbean claims 2010-2014

RISK ALERT – RETAINED THROAT PACKS
Why you must remember the WHO checklist

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Our latest collection of case reports

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Casebook is designed and produced twice a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

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STRICTLY CONFIDENTIAL
Knowing when you can or can’t disclose confidential patient details can pose complex challenges – here we provide an overview of the general principles of confidentiality.

Data relating to an identifiable individual should be held securely, there is a range of official guidance on confidentiality that has been produced by various Medical Councils across the Caribbean region. The most extensive is referenced below. The Medical Council of Jamaica says you must respect a patient’s privacy, and maintain confidentiality and safety of his/her medical records”, while also making “appropriate referrals in a confidential manner, in order to provide the best care possible for the patient.”

The Bahamas Medical Council has detailed guidance on confidentiality, which can be summarised in the statement: “It is a doctor’s duty…strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learned directly or indirectly in his professional capacity as a registered medical practitioner.”

The St Vincent and the Grenadines Medical Association says in its guidance: “Keep confidential all individual medical information, releasing such information only when required by law or overriding public health consideration, or to other physicians according to accepted medical practice, or to others at the request of the individual.”

DISCLOSURE
You should take care to avoid unintentional disclosure – for example, by ensuring that any consultations with patients cannot be overheard. Your duty of confidentiality relates to all information you hold about your patients, including demographic data, the dates and times of any appointments your patients may have made, and the fact that an individual may be a patient of yours or registered with your practice.

When disclosing information in any of the situations outlined below, you should ensure that the disclosure is proportional – anonymised if possible – and includes only the minimum information necessary for the purpose.

CONSENT TO DISCLOSURE
Before disclosing any information about a patient to a third party, you should seek the patient’s consent to the disclosure. Consent may be implied or expressed, eg, most patients understand that information about their health needs to be shared within the healthcare team providing care, and so implied consent is adequate in this circumstance.

Implied consent is also acceptable for the purposes of clinical audit within the healthcare team, as long as patients have been made aware of the possibility by notices in the waiting room, for example, and the patient has not objected to having their information used in this way. If the patient does object, their objection should be respected and their data should not be used for audit purposes.

Express consent is needed if patient-identifiable data is to be disclosed for any other purpose, except if the disclosure is required by law or is necessary in the public interest.

VALID CONSENT
In order for consent to disclosure to be valid, the patient needs to be competent to give consent, and provided with full information about the extent of the disclosure. Adult patients are assumed to be competent, unless you have specific reason to doubt this. When taking consent for disclosure of information about a patient, you should ensure the patient is aware of what data will be disclosed, and to whom.

You must take care to avoid coercion, where a patient feels they cannot say “no” to a proposed treatment, or that they cannot challenge your assumption that they would have no objections. You should check that the patient has no apprehensions before proceeding, because “consent” that is not given freely is not valid.

AFTER A PATIENT HAS DIED
Your duty of confidentiality to your patient remains after death. In some situations, such as a complaint arising after a patient’s death, you should disclose relevant information with the family, especially if the patient was a child. If you reasonably believe that the patient wished that specific information should remain confidential after their death, or if the patient has asked, you should usually respect that wish.

If you are unaware of any instructions from the patient, and are considering disclosing information, you should be sensitive to the patient’s surviving partner or relatives. You should take into account whether such a disclosure is likely to cause them distress or be of benefit; you should also consider whether the information will also release details of members of the patient’s family, or anyone else. Overall you should consider the purpose of the disclosure and check whether the information can be anonymised or coded before disclosure.

The “personal representative” of the patient (usually an executor of the will, or an administrator if there is no will) can apply for access to the relevant part of a patient’s medical records (excepting harmful or third party information), as can someone who has a claim arising out of the patient’s death (eg, for a life assurance claim), or a claim in negligence.

DISCLOSURE WITHOUT CONSENT
In some circumstances, you are obliged to disclose information to comply with the law or to prevent serious harm to the patient or others. In such cases, you should disclose the information – even if you do not have the patient’s consent. You must carefully consider the arguments for and against the disclosure and be able to justify your decision.

It would be sensible to seek advice from experienced colleagues, your medical defence organisation, a professional association or an ethics committee.

AN OBLIGATION TO DISCLOSE
When facing a situation where the disclosure of medical information is required by law, consent from the patient is not required. You should not disclose any more information than is absolutely necessary. The patient should be made aware of the disclosure, and informed about why you are disclosing the information, unless it is not practicable to do so; for example, if the patient cannot be contacted quickly enough, or if informing the patient would defeat the purpose of the disclosure. It is important to fully document any decisions about the information you disclose.

DISCLOSURES TO THIRD PARTIES
Usually, you should obtain a patient’s consent before disclosing confidential information to a third party. Before making a disclosure without consent, you must consider the arguments for and against it – and be prepared to justify the decision. It is advisable to document your thought process and the conclusion reached.

You should attempt to seek the patient’s consent, but there are certain circumstances when this will neither be possible nor advisable. These include:

• The patient is not competent to give consent. You should consult the patient’s welfare attorney, a court-appointed deputy, a guardian, or the patient’s relatives, friends or carers.

• You believe seeking consent would put you or others at risk of serious harm.

• Seeking consent is likely to undermine the reason for the disclosure – for example, if it provides the prevention or detection of serious crime.

• When action needs to be taken quickly, such as during an outbreak of a communicable disease and there is no time to contact the patient.

It is important to document any decision you make and your reasons for disclosing the information.

JUSTIFIABLE DISCLOSURES IN THE PUBLIC INTEREST
The disclosure of information about a patient without their express consent may be justifiable, if the public interest in disclosing the information outweighs the patient’s interests in keeping it confidential.

In all cases, you must decide whether or not the possible harm caused to the patient – and the overall trust between doctors and patients – by disclosing this information will outweigh the benefits resulting from the disclosure.

• The patient is not competent to give consent. You should consult the patient’s welfare attorney, a court-appointed deputy, a guardian, or the patient’s relatives, friends or carers.

• You believe seeking consent would put you or others at risk of serious harm.

• Seeking consent is likely to undermine the reason for the disclosure – for example, if it provides the prevention or detection of serious crime.

• When action needs to be taken quickly, such as during an outbreak of a communicable disease and there is no time to contact the patient.

It is important to document any decision you make and your reasons for disclosing the information.
DISCLOSURE TO PROTECT THE PATIENT OR OTHERS FROM HARM

If it has not been possible to seek the patient’s consent, you may disclose personal information without consent if the benefits to an individual or society of the disclosure outweigh both the public and patient’s interest in keeping the information confidential. If the patient has refused consent to the disclosure, you should consider any reasons provided by the patient. If you still consider that disclosure is necessary to protect a third party from death or serious harm, you should disclose information promptly to the appropriate person or authority.

The ultimate decision about whether or not a disclosure was made in the public interest is determined by the courts. Whether you do or don’t disclose the information, you need to ensure that your reasons are clearly documented.

COMMUNICABLE DISEASES

If a patient refuses to allow you to inform someone outside the healthcare team of their infection status, you must respect their wishes unless you consider that failure to disclose the information will put healthcare workers or other individuals at risk of infection. You should pass information about serious communicable diseases to the relevant authorities for communicable disease control and surveillance, using anonymised information if practicable.

CHILDREN AND YOUNG PEOPLE WITHOUT CAPACITY

If the child or young person lacks the capacity to consent to the disclosure of information, those with parental responsibility can consent on their behalf. The consent of only one person with parental responsibility is needed for consent for disclosure. If you do not believe that the decision made by those with parental responsibility is in the best interests of the child or young person, and the disagreement cannot be resolved with discussion and mutual agreement, it may be necessary to seek the view of the courts.

ADULTS LACKING CAPACITY

The overriding principle is that the disclosure of confidential information is made in the best interests of the person lacking capacity. This may involve releasing information about their condition – for example, to their carer, to ensure they receive the best treatment.

If a child or young person under 16 refuses consent, you should nevertheless disclose the information if this is necessary to protect the child, young person or someone else from serious harm, or if disclosure is justified in the public interest.

CHILDREN AND YOUNG PEOPLE WITH CAPACITY

Many young people have the capacity to consent to the disclosure of their medical records. If the child or young person (under 16 years of age) is able to understand the purposes and consequences of disclosure they can consent or refuse consent to the disclosure. You should discuss disclosing the information with them and release it only with the child or young person’s consent.

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If you have not used this area before, you will first need to activate your account. You will then have access to presentations and more than 50 learning modules.

ON THE WEBSITE:

Help and advice – with the largest worldwide team of medicolegal experts, whatever your question, problem or dilemma, we are only ever a phone call away.

For members – you can print off an application form (students can apply online), pay your subscription renewal online, print out a copy of your membership certificate and get access to FAQs and your guide to MPS membership.

Country guide – in this section you can find out all the information specific to your country, including details of how to pay your membership locally and how to contact us to request advice or assistance.

Casebook and resources – access electronic copies of the Medical Protection journal, Casebook, as well as a wide range of booklets, factsheets and case reports.

E-learning – our online learning platform, Prism, allows you to complete free online learning modules around the clock to help you keep your knowledge up to date.

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TOP FACTSHEETS

• Communicating with patients by fax and email
• Communicating with patients by text message
• A guide to writing expert reports
• Confidentiality – general principles
• Confidentiality – disclosures without consent

To see all the changes and make the most of the new content visit our website at: medicalprotection.org

Dr Nancy Boodhoo Head of Operations
Caribbean & Bermuda

The updated Medical Protection website is a fantastic resource for members. It provides fast and easy access to valuable resources such as factsheets, case reports, country guides and a digital version of Casebook, Medical Protection’s journal.

It also allows you to access Prism, our online learning platform, so you can complete free online learning modules to help keep your knowledge up to date and lower your risk.

In this tough environment, Medical Protection is much more than a last line of defence – we strive to be a genuine partner in your career.

Have you visited the Medical Protection website for Caribbean and Bermuda members recently? If it’s been a while since you checked the site, you’ll see that it has a brand new look and feel and is full of new and updated content. There’s a lot of information available, and you can also pay online and print your certificate, so why not take some time to explore?
HOW NOT TO GET SUED

Dr Richenda Tisdale, Medical Protection medical adviser for the Caribbean and Bermuda team, analyses the claims settled across the region over the last five years.

“For auditing the claims settled by Medical Protection on behalf of members in the Caribbean and Bermuda between 2010 and 2014, Dr Tisdale said: “We are seeing a global rise in the number of claims made against doctors, but interestingly the types of claim remain similar year on year.”

In order to bring a successful claim, a claimant must prove that they were owed a duty of care, and that the defendant breached that duty. This can be taken to minimise the chance of receiving a claim, or to assist in the defence of one.”

Claims settled in the Caribbean in the last five years:

- (62%) Complication of surgical procedure
- (15%) Delay in diagnosis
- (9%) Medication including blood products
- (5%) Inappropriate management of condition
- (5%) Failure to consent
- (4%) Other

COMPLICATIONS OF SURGERY

All surgery carries a risk of complications, and some patients will suffer a complication regardless of the surgeon's competence. Almost two thirds of settled claims (62%) arose out of surgical complications.

So apart from refusing to operate, how can you avoid claims in this area?

ENSURING THAT YOU ARE UP TO DATE

with the appropriate techniques, and the selection of any necessary surgical equipment to ensure that it is fit for purpose.

GOOD CLINICAL GOVERNANCE

helps to drive up ethical standards expected of clinicians. This is not only good practice, but is in line with the cornerstone of good clinical governance and allows an investigation to be undertaken to look for the root causes, and to take action to prevent recurrence.

DELAY IN DIAGNOSIS

As clinicians we know that it is not possible to make every diagnosis the first time that a patient attends. The clinical presentation can vary over the course of an illness, and early on there may be little – if anything – to see, or detect on investigation.

Despite this, there is rising patient expectation and patients may be dissatisfied if there is a delay in diagnosis of a condition that are commonly missed on first presentation include appendicitis, ectopic pregnancy, necrotising fasciitis and meningitis.

Conditions that may present over a more chronic course include diagnoses of cancer and autoimmune conditions. Again, clear documentation of the history and examination is essential, as is having a low threshold for investigating a patient who repeatedly consults, even when there is little to find on examination. Some of these patients may have a psychological reason for presenting despite being physically well, but others may have a disease with an insidious onset.

We won’t make every diagnosis on first presentation, but if your notes reflect a detailed history and a thorough examination, and you record a differential diagnosis, including advice for the patient if their symptoms do not settle, then a claim will be far easier to defend.

INAPPROPRIATE MANAGEMENT OF A CONDITION

Where local or national guidelines exist for treatment of a condition, it is important to be mindful of these. If you plan to treat a patient in a non-conventional manner then this should be explained to the patient and their informed consent must be sought. You should be mindful that you could be asked to justify treating patients out with accepted protocols.

ADVERSE EVENTS, COMPLAINTS OR CLAIMS

If you become aware of any adverse event, such as a delay in diagnosis, surgical complication or side effect of medication, then the following steps may reduce the likelihood of you receiving a claim:

- Take ownership of any future management that the patient may need and ensure that this is undertaken to the highest standard.
- Follow local procedures for reporting the adverse event. Notification of adverse events is the cornerstone of good clinical governance and allows an investigation to be undertaken to look for the root causes, and to take action to prevent recurrence.
- Be open and honest with the patient or their family. This is not only good practice, but is in line with the ethical standards expected of clinicians.
- Notify Medical Protection promptly so that we can advise you accordingly on what information if a claim is anticipated, and in handling a complaint before it becomes a claim.

FEATURE

POSTOPERATIVE MANAGEMENT

This is another important area where a surgeon may be vulnerable to a claim, even if any negligence occurs after the surgeon has left the hospital. We advise surgeons to provide clear directions on how frequently the patient should be monitored, and what parameters should prompt action. For example, if you would want to be called if a certain amount of blood is drained, or if the observations were to reach a certain level, then make this clear to staff caring for the patient, along with details of how to contact you.

You should also ensure that the patient is aware of what they should do if they suffer a delayed complication, such as pain or a wound infection.

CONSENT

Informed consent can be key to successfully defending a claim. It can be difficult to defend a claim in which the patient alleges that they would not have undergone the surgery had they known that there was a risk of suffering a particular complication.

If the only note in the records is an abbreviation, for example “NDI” discussed”, as shorthand for risks and benefits discussed with patient, this can make the case difficult to defend. If on the other hand the notes record the specific risks, both common and the rare but serious, and the patient decides to undergo the procedure, then a claim – if the patient does suffer a complication – may be less likely to succeed. Similarly it is helpful to record all of the options offered to the patient, including the option of no treatment where appropriate.

MEDICATION ERRORS

Nine per cent of claims settled by Medical Protection in the Caribbean in the last five years related to prescribing. These include cases arising out of the wrong drug, or wrong dose of a drug being given, or adverse effects arising out of the prescription.

It is not possible to produce a prescribing system that is completely error-proof, particularly when many of the errors in prescribing are human. Automated systems for prescribing can offer some advantages, including flagging up drug interactions and known allergies, but the safest way to reduce errors is to have a rigorous system for reviewing and checking prescriptions. If you are prescribing a medication that you do not commonly use, or prescribing on the advice of a colleague, check the details carefully. Take special care when prescribing for children and the elderly.

It is helpful if you record that you have specifically enquired about drug history, including over the counter medications, previous adverse reactions (with details of any possible allergy) and specific conditions that can impact on the mechanism of action of the drug, such as renal or hepatic impairment. If the dose is age or weight dependent, marking this clearly in your records will show that it was checked.

A patient may be able to bring a successful claim if they suffer a recognised adverse reaction to a medication if they can prove that they were not warned about it in advance. It is advisable to tell the patient about all common and potentially serious side effects and what to do in the event of suffering a reaction, and to document this in your records.
CASE STUDY
Settled Claims in the Caribbean and Bermuda

A 25-year-old male patient, otherwise fit and well, presented to the emergency department (ED) with a two-day history of abdominal pain, vomiting and loose stools. He was alert and his observations were normal, apart from a slightly raised heart rate. He was assessed by a nurse and a junior doctor in the ED and diagnosed with gastroenteritis. He was advised to keep hydrated and prescribed simple analgesia.

Four days later he was brought in with intravascular volume depletion. At laparotomy he was found to have a ruptured appendix. He had a turbulent perioperative course with septicemia, which required treatment in the intensive care unit for four weeks. He made a claim against the doctor for failing to diagnose his appendicitis.

Defending the claim was made easier because the doctor’s notes clearly showed a detailed assessment and, most importantly, she had recorded her ‘safety-netting’ advice, namely that he should seek urgent medical attention if his symptoms worsened or did not settle completely within 24 hours.

For the sake of confidentiality this case is fictional and provides an example of the type of claim that can be brought against a physician.

Throat packs are used commonly in oral and maxillofacial surgery for a number of purposes, including the prevention of unwanted material from entering a patient’s oesophagus or trachea. The packs themselves, however, are capable of causing serious injury by obstructing patients’ airways if they are not removed after surgery.

The WHO Surgical Safety Checklist was launched in 2008 to improve teamwork and thus combat avoidable complications in surgery, such as retained swabs and instruments. Two recent Medical Protection cases, which demonstrate that the risk of retained throat packs has survived the introduction of the WHO checklist.

CASE 1: MRS A
Mrs A opted to undergo facelift surgery. Dr B was the consultant anaesthetist for the procedure and used a throat pack in order to stabilise Mrs A’s airway.

The WHO Checklist Sign-in was performed and the surgery proceeded uneventfully; however, the WHO Checklist Sign-out did not take place. Dr B reversed muscle paralysis, applied suction to the airway and extubated Mrs A. Dr B would usually perform a laryngoscopy at this point but did not on this occasion, as it was difficult to open the patient’s mouth.

Mrs A was handed over to the recovery staff, where slightly obstructed respiratory movements were noted. Dr B attributed these symptoms to emergence delirium, and therefore inserted a nasopharyngeal airway. On examination around 20 minutes later, Mrs A was awake, the artificial airway had been removed and she indicated to Dr B that she was not in any discomfort.

Around three further hours passed before the throat pack was discovered, during which time she experienced significant respiratory distress. The throat pack was removed and Mrs A made a full recovery.

CASE 2: MISS C
Miss C was admitted to hospital for the routine excision of a benign palatal lump. Dr D was the anaesthetist for the procedure, although it was the first time that he had worked in this hospital. The surgery proceeded uneventfully; however, the WHO Checklist Sign-out did not form part of the scrub nurse’s swab count exercise, or as a distinct part of the scrub count exercise, or as a distinct part of the scrub nurse’s swab count exercise, or as a distinct part of the scrub nurse’s swab count exercise.

Further, this throat pack had been obtained from the anaesthetic room, and as such did not form part of the scrub nurse’s swab count. Dr D did, however, place a sticker on Miss C’s head notifying that a throat pack had been used.

The surgery proceeded uneventfully. However, immediately after waking up, Miss C experienced some difficulty breathing. The issue of the throat pack was raised by nursing staff and Dr D mistakenly asserted that it had already been removed. The nursing staff therefore removed the sticker that had been placed on Miss C’s head. A laryngeal mask airway (LMA) was inserted, which improved Miss C’s oxygen saturation levels.

On removal of the LMA around 35 minutes later, Miss C coughed up the throat pack. She also made a full recovery.

The WHO Checklist
When used properly, the WHO Checklist prompts effective team communication to eradicate avoidable risks, such as retained throat packs. Proper usage of the Checklist requires the following:

• All three phases of the list must be performed: Sign-in, Time out, Sign-out.
• The anaesthetist must be present for all three stages. Best practice is to have all members of the surgical team present for all three phases, although the WHO advises that the Sign-in may take place without the surgeon.
• At Sign-in, responsibility for both insertion and removal of throat packs must be assigned.
• At Sign-out, removal of the throat pack must be checked, either as part of the swab count exercise, or as a distinct part of the checklist.
Before joining Medical Protection in 2003, I was a GP and always enjoyed reading the cases in Casebook, irrespective of whether they related to primary or secondary care cases. In my role at Medical Protection I meet many doctors from different specialties and when I introduce myself, invariably the first thing they say is that they enjoy reading the cases in Casebook – with the caveat that it often causes them to reflect on their own practice (which, of course, is one of the reasons why the particular cases are chosen).

In this edition of Casebook there is the usual array of thought-provoking cases, with varying outcomes and learning points. A common issue is that of record-keeping; in the case ‘Poor notes, fatal consequences’, Dr A is criticised for not documenting a thorough history or the fact that Mrs Y was reluctant to be admitted to hospital; and in the case ‘Elbow arthroscopy – radial nerve injury’, the operation note was not deemed to be of an acceptable standard. Conversely, in the case ‘Alleged anticoagulation failure’, the fact that the consultant cardiologist had specifically stated that anticoagulation was not indicated on the advice slip to Dr B was an important feature in defending the claim.

There is a real tension in the context of a busy surgery or outpatient clinic, and other clinical settings, in that patients can perceive that the making of records intrudes into the consultation – yet the records provide the basis of your defence in the event of an adverse outcome. I have often heard it said by patients ‘the doctor did not pay attention to me as they were far too busy tapping into their computer’. The likelihood is that, in fact, the doctor was making a thorough contemporaneous record, hence there is a real art to being able to take thorough and contemporaneous notes without appearing to disengage from the consultation (or without missing what could be very important non-verbal clues). There are several strategies that may be deployed to provide the patient with the reassurances that you remain engaged, whilst allowing an opportunity to make a record of the consultation:

- At the start of the consultation, it is often helpful to maintain eye contact and to listen carefully to what the patient says before making an entry in the records
- At an appropriate point in the consultation, it may help to introduce the fact that it is your intention to make a record of what has been discussed
- In making the record, it is often a helpful opportunity to summarise your understanding of the problem; this can be useful in reaching shared understanding of the issues and demonstrating empathy
- Whilst making the record, it is important to keep glancing in order to make eye contact and to demonstrate to the patient that you remain engaged in the consultation
- When the record has been made, there is an opportunity to explain to the patient (or even show the patient) what you had recorded, which is once more helpful in terms of summarising the concerns and ensuring that both you and the patient are content that the record is accurate
- You might wish to consider developing macros (a standard form of text that can be inserted into the record) or templates for common scenarios pertaining to your particular area of practice, to ease the recording of the consultation (I appreciate that this may not be possible in relation to handwritten notes).

I hope that you find the cases thought-provoking and that they provide you with an opportunity to reflect (amongst other things) on your approach to record-keeping.

What’s it worth?

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

- **HIGH US$2,000,000+**
- **SUBSTANTIAL US$200,000+**
- **MODERATE US$20,000+**
- **LOW US$2,000+**
- **NEGLIGIBLE <US$2,000**
Mrs S was a 51-year-old teacher. At the start of term Mrs S developed a troublesome cough and went to see her GP, Dr B, about it. Dr B diagnosed a chest infection and prescribed antibiotics but also noted that she had an irregular pulse. An ECG was performed at the surgery the same day, which showed that Mrs S was in atrial fibrillation. Dr B sent Mrs S to the medical assessment unit for urgent review.

The hospital doctors confirmed the diagnosis of atrial fibrillation and prescribed warfarin to reduce her risk of thromboembolic stroke and bisoprolol to slow her heart rate. They put Mrs S on the waiting list for a cardioversion procedure and discharged her home.

Mrs S attended for her cardioversion procedure but was found to be in sinus rhythm. The cardiologist (Dr T) advised Mrs S to stop taking her warfarin and to reduce her bisoprolol dose further. Dr B arranged a further ECG for the following week and reduced her bisoprolol dose further. Dr B documented that Mrs S was “awaiting cardiology follow-up” and that she had had a chest infection when the atrial fibrillation was initially diagnosed.

Dr B saw Mrs S again with the cardiologist’s advice slip. Dr B documented that her pulse was regular now (although she was slightly bradycardic). Dr B arranged a further ECG for the following week and reduced her bisoprolol dose further. Dr B documented that Mrs S was “awaiting cardiology follow-up” and that she had had a chest infection when the atrial fibrillation was initially diagnosed.

Dr B circled the response “no longer requires anticoagulation”.

A month later, Mrs S suffered a stroke. There were no other risk factors for stroke identified other than atrial fibrillation, thus the likely cause of Mrs S’s stroke was an embolic event arising as a consequence of thrombus formation within the atrium.

As a result of the stroke, Mrs S felt unsteady and hesitant every time she walked. Despite rehabilitation, her writing was slow and clumsy and she slurred her words. Sadly, teaching was no longer possible and Mrs S had to retire early on grounds of ill health.

Mrs S was devastated. She felt that her stroke could have been prevented if she had been anticoagulated. Mrs S made a claim in negligence against Dr B. It was alleged that Dr B should have prescribed some form of anticoagulation and that he should have contacted the hospital to query the medication position, especially in light of the non-attendance letter from the anticoagulation clinic.

Dr B sent Mrs S to the medical assessment unit for urgent review.

Soon after, Mrs S received a letter asking her to return for another cardioversion procedure. Mrs S rang the cardiologist’s secretary to explain that she had been advised that this was not necessary but that she was waiting for an outpatient appointment.

Dr B received a letter from the warfarin clinic stating that she had not attended for INR testing for at least four weeks.

Dr B explained that she had been advised that this and that she was waiting for cardiology review. Dr B noted her pulse on that day was regular now (although she was slightly bradycardic). Dr B arranged a further ECG for the following week and reduced her bisoprolol dose further. Dr B documented that Mrs S made a claim in negligence against Dr B. It was alleged that Dr B should have prescribed some form of anticoagulation and that he should have contacted the hospital to query the medication position, especially in light of the non-attendance letter from the anticoagulation clinic.

EXPERT OPINION

Medical Protection sought the advice of an expert GP, Dr H. Dr H felt that the care given by Dr B was of a reasonable standard. Dr H did not consider that Dr B had a mandatory duty to prescribe anticoagulation or that he should have contacted the hospital to query the medication position. Dr H noted that the decision to stop anticoagulation had been clearly relayed on an advice slip from a cardiologist. Mrs S had also told Dr B that she was waiting for cardiology review and her subsequent ECG had shown sinus rhythm.

The opinion of a professor in stroke medicine (Professor G) was also obtained by Medical Protection. Professor G confirmed that the likely cause of Mrs S’s stroke was thromboembolic. Professor G pointed out that some patients develop atrial fibrillation secondary to other illness such as chest disease. In such a setting, if the atrial fibrillation resolves when the underlying cause has been treated, and the clinician feels that there is a low risk of it recurring, then it is reasonable not to anticoagulate. Mrs S would have had a CHA2DS2-VASc score of 1 because of her sex but an absence of congestive heart failure, hypertension, diabetes, stroke or vascular disease and age below 75 years, Professor G felt that it would have been quite reasonable not to anticoagulate in this context.

Medical Protection served a letter of response denying liability and Mrs S did not pursue the claim any further.

Learning points

- NICE, Atrial fibrillation: the management of atrial fibrillation (June 2014) state that doctors should consider anticoagulation for men with a CHA2DS2-VASc score of 1 and to offer anticoagulation to people with a CHA2DS2-VASc score of 2 or above, taking bleeding risk into account.

- Documentation of the reasons behind the decision-making was invaluable in defending this case.

AF
Two weeks after commencing the diabetée, Miss F was rushed into hospital with sudden onset chest pain and breathlessness. Miss F was discharged from physiotherapy and had difficulties with verbal and visual recall and cognitive assessment revealed ongoing.

Two months after discharge, a formal imaging of Miss F's brain revealed oedema. Miss F's PE appeared to be soft and non-tender. Dr A prescribed some paracetamol and co-phenotrope and advised her to return if there was no improvement.

Dr B waited for a week but she began to feel worse – she was so nauseous that she still couldn't eat and the diarrhoea had been relentless for ten days. Mrs B was feeling rather weak so she made another appointment with Dr A. Dr A's notes were brief, just stating "diarrhoea". Dr A noted that Mrs B was still receiving a satisfactory pulse and blood pressure. Dr A examined Mrs B's abdomen and found it to be soft and non-tender. He prescribed some codeine linctus and loperamide.

Two days later Mrs B started to feel very faint and lethargic with ongoing diarrhoea. She had been staying with her mother-in-law who had travelled from Pakistan and that she had diarrhoea.

Dr D, another expert GP, disagreed and stated that had Miss F not been exposed to Pakistan and that she had diarrhoea. Dr S explained that viral gastroenteritis with salmonella paratyphi A. Mrs B's family were devastated and made a claim against Dr A. They felt that her diarrhoea could have been avoided if Dr A had investigated and treated her diarrhoea earlier.

Even in cases of bacterial infection, antibiotic treatment is not usually required. As traveler's diarrhoea is self-limiting in the majority of cases, Dr S felt that few GPs would have requested a stool sample on that occasion.

Dr S was, however, critical of Dr A's second consultation. At that time Mrs B had complained of significant diarrhoea for ten days. Dr S felt the clinical records were very brief and did not include a record of the presence or absence of blood in the stool or abdominal pain.

Dr S thought that the patient's ongoing symptoms at this consultation required the identification of a causative organism and that a stool sample should have been arranged. It was his view that the failure to do so represented an unreasonable standard of care. He postulated that if a stool sample had been taken, this would have led to the causative organism being known within four to seven days.

The case was settled for a moderate sum.

Dr E, expert consultant in pharmacology, was also supportive of Dr K, stating that although there is probably an increased risk of TTH with diabetée, the size of this increase is small, and the risk appears to peak between four months and one year of use. The timing of Miss F's PE appeared to be closely linked to switching of microgynon.

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Dr K prescribed a repeat pill to microgynon, advising her to start it when her microgynon cycle finished in another month. Dr D, another expert GP, disagreed and stated that switching of microgynon and wanted to give it a try. In the event, it was small, and the risk appears to peak between four months and one year of use. The timing of Miss F's PE appeared to be closely linked to switching of microgynon.

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Mr K was a 36-year-old man who ran a pub. Mr K smoked and drank heavily. Mr K’s dentist had noticed a painless swelling on the right side of his neck during a routine check-up and asked him to see his GP. Mr K was seen by Dr A, one of the GPs at his surgery, who noted that Mr K was unsure how long the lump had been there, and referred him to the ENT outpatient department.

A letter came back to the practice confirming the presence of a lymph node in the anterior triangle of Mr K’s neck which was felt to be innocuous. The plan was for Mr K to be reviewed in six weeks’ time. Mr K did not attend his follow-up appointments as he was busy at work and did not feel too concerned about the lump because it was not painful. He did not attend his follow-up appointments, and a letter stating this was sent from the hospital to his GP.

Eight months later, Mr K began to get some discomfort in his neck swelling so decided to see his GP again. At this time he was seen by Dr B at the surgery. Dr B noted his painful swelling and also a history of chronic lymphatic lymphoid perforations. Dr B did not initially document his previous referral to the ENT department regarding the lump or the intended follow-up. Dr B’s brief examination notes detailed the tender, swollen lymph node but did not include an examination of the mouth, tongue or throat. Dr B prescribed ibuprofen to help with the discomfort and did not arrange any follow-up.

Over a year later, Mr K was still struggling with his symptoms and went again to see Dr B. This time Dr B made a referral to head and neck surgery. His referral letter stated “intermittent chronic right sided neck swelling in the pre-auricular and submandibular area”. There was no mention of any previous referral in his letter. Dr B documented a differential diagnosis of a possible parotid lesion or salivary gland stone. Mr K’s neck lump subsequently proved to be malignant. As a result he had to have neck surgery and resection of a primary in his tonsil. He had a course of radiotherapy and since has not had recurrence of his disease. Unfortunately he was left with shoulder weakness and a dry mouth, which he found difficult to cope with.

Mr K was angry with Dr B and felt that he caused a delay in his diagnosis. He brought a claim of negligence against Dr B because he felt the delay had necessitated more radical surgery, leaving him with debilitating symptoms.

**EXPERT OPINION**

Medical Protection sought the advice of an expert GP (Dr F). Dr F felt that Dr B bore liability for the delayed diagnosis. He was critical of Dr B’s history-taking and record-keeping. Dr F commented that Dr B had responsibility for establishing the history of his previous referral to the surgical assessment unit. Had Dr B known of that referral, then the duration and the continuing nature of the lymph node would have necessitated immediate re-referral back to that team. Dr F also criticised Dr B’s inadequate examinations, stating that he should have documented an examination of the patient’s neck, mouth, tongue and throat.

The opinion of a professor of otolaryngology (Professor Y) and head and neck surgery was also obtained. Professor Y commented that there was a medical deviation of the delayed diagnosis. He felt that the delayed diagnosis had caused the patient’s neck, mouth, tongue and throat to become weak and consequently had restricted the patient’s range of movement and had caused a further diagnosis of heterotopic ossification (new bone growth), this would have resulted in less function to the shoulder and neck.

In addition, Professor Y considered that it may have been possible to spare radiotherapy if he had been treated earlier. The need for radiotherapy in this case was due to the size of the lymph node in the final specimen and the positive margins, which was evident following removal of the lymph node. Professor Y stated that there was no documented discussion about the risks of the surgery was also a factor in the outcome of the case.

Mr P, a right-handed project manager, developed a stiff right elbow following a previous injury, and had reached the limit of his progress with physiotherapy. X-rays showed degenerative changes and he was referred to an orthopaedic consultant, Mr A, who diagnosed osteoarthritis of his elbow. He advised Mr P that as he had significant anterior and posterior osteoarthritis he may need multiple arthroscopic debridements to achieve a good outcome.

After an arthroscopic anterior debridement, there was no minimal improvement and further surgery was planned. There were another two debridements, the third one being more than six months after the initial procedure, before Mr A was happy with the result.

Two months later Mr P returned with a reduced range of movement in his elbow. X-rays confirmed the presence of massive heterotopic ossification (new bone growth), which was confirmed on CT. Mr A planned a fourth arthroscopic debridement two months later. No discussion relating to the possible risks and complications of surgery was documented. The limited operation note for this complex arthroscopic debridement described significant bone removal and a full range of movement at the end of the procedure.

In clinic two days later Mr P was noted to have a radial nerve palsy, but Mr A felt that some nerve conduction was present and that this was a neurapraxic nerve injury, which should recover completely. He commented that the procedure had been lengthy at over an hour and ten minutes. Mr P returned to work two days later as no change in his symptoms, but Mr A was reassured by the presence of a positive Tinel’s test and felt the nerve palsy would recover. Mr P had been in an open procedure rather than arthroscopic, and that his injury had been diagnosed sooner, and not presumed to be a neurapraxia, then he would have had a better outcome.

On review of the case, an expert felt that as long as Mr A had the necessary experience it was not negligent to carry out the surgery arthroscopically. There is still a risk of radial nerve injury when carrying out this surgery with an open technique. However, Mr A was found to be negligent in causing the nerve injury, keeping poor documentation, and pursuing the arthroscopic nerve conduction studies. The lack of any documented discussions about the risks of the surgery was also a factor in the outcome of the case.

The case was settled for a substantial sum.
Learning points

- It is easier to attribute my new symptoms to the pregnancy district form if all symptoms, which
  were lacking in a clear description of the headache and its associated symptoms. The BP was recorded but
  there was no evidence of any further examination including fundoscopy. The experts felt on the basis of the letter Dr
  A requested a second opinion, the patient was displaying red flag symptoms and a reasonable expectation GP would
  have made arrangements to admit Mrs Y as an emergency to exclude intracranial haemorrhage.

Dr A was also criticised by the experts, particularly regarding his consultation note, which
  consisted of a mix of Wolf’s syndrome, which should be considered on the provocation of this case.

Mrs Y was a 32-year-old Romanian woman who lived with her husband in the UK, became pregnant
  and presented to her local GP surgery to commence antenatal care. Mrs Y’s did not feel the leakage and she
  had previously suffered with a hydrocephalic mole, an early scan was carried out, which
  confirmed a viable pregnancy. Mrs Y received IV hydration and was discharged with oral
  medication to use if the vomiting persisted.

A month later, she was feeling better. The vomiting had resolved and she was no longer
  using the vomiting. The GP Dr A, who noted “had Down’s scan, family member interpreter present, review at 16 weeks”.

Mrs Y’s visited Romania for a holiday to see her family. While she was there she presented to hospital complaining of possible kidney
  problems with a secondary concern over reduced foetal movements. Mrs Y underwent a pelvic ultrasound scan, which appeared to have caused a growth on her right kidney. Mrs Y also claimed she underwent a triple test at this point.

After returning to the UK, Mrs Y attended her routine 16-week check with Dr A. The practice antenatal template was completed and
  Dr A ticked that the Down’s screening test had been done. A month later, Mrs Y was informed of her Romanin triple
  test, which allegedly gave a risk of Down’s Syndrome of 1 in 67. Her combined test in the local secondary care setting, which
  indicated a low risk of Down’s Syndrome with no need for further investigations. Dr A’s account was that he was not told of the
  Romanian result, so was unable to take this into consideration. Dr C maintained that
  the test from Romania, it would have been reasonable for Dr A to have
  considered the test as significant.

Mrs S made a claim against Dr A, stating that she had been given false reassurance regarding her test results, which had also
  failed to be documented adequately in her notes. It was alleged that had she been referred to an obstetrician for amniocentesis, then
  she would have chosen to undergo a termination of pregnancy.

EXPERT OPINION

Expert GP Dr C maintained that Dr A’s standard of care did not fall below that expected of a GP. Dr C felt that Dr A was
  entitled to rely on the screening performed in the local secondary care setting, which
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  if this result had been available, given that it was carried out at 16 weeks – at a time
  when it would be less sensitive – it would have been reasonable for Dr A to have
  confidence in the local test carried out at the appropriate time.

Mrs Y and her husband had no further contact with their GP, and presented to hospital complaining of possible kidney
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  if this result had been available, given that it was carried out at 16 weeks – at a time
  when it would be less sensitive – it would have been reasonable for Dr A to have
  confidence in the local test carried out at the appropriate time.
Mrs L, a teacher, was first prescribed the oral contraceptive pill microgynon by her GP, Dr G, when she was 17. Her blood pressure was taken and recorded as normal. At this time, no other mention was made in the records of her risk profile or family history. Later, Mrs L’s medical records showed that she was changed to ovulan and then ovranette, but there was no explanation why these changes were made. Mrs L was changed again to ovulan SG. The reasoning this time was due to “excessive bleeding on ovranette”. At her review consultation, Mrs L’s blood pressure was taken and recorded as normal.

When she was 26, Mrs L was seen by her GP for antenatal care, where it was recorded that she was smoking one cigarette per day. Her blood pressure was recorded as normal. After her first child had been born, Mrs L was put on a contraceptive pill, before she changed to the combined pill.

Three years later, Mrs L consulted her GP as she was under significant stress. Her records showed that she had increased her smoking to 25 cigarettes per day and did not exercise. Counseling was started and the smoking was stopped. 50mg was prescribed and exercise was advised. In addition, a prescription for microgynon was also issued.

For the next six years, Mrs L was given repeat prescriptions of the microgynon without any record of her blood pressure being taken or her risk factors being assessed. Mrs L was now 35, but Mrs G did not specify. Mrs G did not specify whether or not she was still smoking, under a lot of stress, or whether or not she was still exercising.

Four months after her last repeat script, aged 35, Mrs L presented to the same practice with central chest pain and saw another GP, Dr F. She had been under a lot of stress, but was smoking slightly more—20 cigarettes per day. Her blood pressure was 180/110mmHg and was recorded as normal. Mrs L was noted to be under less stress now and was smoking slightly less at 20 per day. She was advised about smoking. Mrs L was referred to the chest clinic, where she was diagnosed with non-cardiac chest pain.

Mrs L was seen on a number of occasions in the practice for a repeat prescription for microgynon and other matters, including further chest pain, collapse and migraine.

Aged 41, Mrs L collapsed and was admitted to the Emergency Department, where investigations found that she had a stroke. She was unable to return to work due to paralysis affecting her left side.

Mrs L made a claim against Dr F. She alleged that he had been negligent in continuing to prescribe microgynon after she was 35 years old when she had three risk factors: a family history of heart attack, smoking and being over the age of 35.

EXPERT OPINION
Expert opinion found that a reasonably competent GP would have stopped prescribing microgynon from the age of 35 onwards and changed Mrs L to a progestosterone-only pill or at least have warned Mrs L of the increased risks in order that she could have considered the alternative options. Mrs L’s notes show that the practice knew of Mrs L’s family history and her smoking, but despite these risks continued to prescribe the pill.

The case was settled for a substantial sum.

Mrs S was also reviewed by Mr B, consultant vascular surgeon, who planned to introduce an aortic balloon through the femoral artery prior to the tumour resection if required, the balloon could be inflated during the surgical resection in order to reduce blood loss. Mr B sought consent for aortic balloon occlusion and documented that the risks included “femoral artery injury, limb ischaemia and bleeding from rupture”. Separate consent was obtained by the orthopaedic team.

Mrs S’s blood pressure was taken and recorded as normal. After two hours, Mr B was called back to the theatre to inflate the aortic balloon as the risk of death was not specifically mentioned. Mr B received a telephone call to inform him the operation was finishing and he should return to add the sheath and balloon. Mr B was not given any information as to whether or not it was possible to maintain Mrs S’s blood pressure. After a further 20 minutes, the orthopaedic team re-inflated the aortic balloon in an effort to stabilise Mrs S in order to avoid wound closure. There was a transient improvement in Mrs S’s blood pressure and after 40 minutes the orthopaedic procedure was complete.

Mr B gave the patient a telephone call to inform her the operation was finishing and she should return in order to remove the sheath and balloon. Prior to him arriving at the operating theatre, the patient suffered a cardiac arrest and CPR was commenced.

Mrs S had an unrecorded blood pressure and at laparotomy a large retroperitoneal haematoma was discovered secondary to a 2.5cm tear in the anterior aorta. The aorta was surgically repaired but after release of the clamps, Mrs S suffered a further cardiac arrest and died.

Mrs S’s family made a claim against Mr B. It was alleged that delegation of the deflation balloon without guidance may have been acceptable as a last-ditch effort to save the patient’s life under extreme circumstances, the decision to initially inflate the balloon without radiological guidance and to delegate deflation to the orthopaedic team was also criticised.

The case was settled for a high sum.
It seems to me that the crucial error in this case was failing to refer in the knowledge that another doctor had seen two rectal polyps and had recommended further investigation (even if this information came by an unconventional route). A normal DRE, while contributing to a comprehensive assessment, would not influence that decision. It is difficult to see what Dr A could have learned from history or examination that would have trumped the clear recommendation from the overseas clinic. An element of irritation, perhaps understandable, at 9.5% deviation from standard procedure could have clouded Dr A’s judgement.

In most of your GP cases, I can identify with the doctors involved, to the extent that I can envisage circumstances where I might have acted as the involved doctor did, and this is the great value of Casebook; this was not such a case.

Dr Aidan Finnegan Waterford Ireland

Response

Your assessment of the legal situation is quite right. Each professional involved in the care of a patient is responsible for their own actions, and can be held negligent for their actions or omissions. Every consultation will turn upon its own facts, and that will include what information the clinician has at hand, both from their own history and examination, and from any information in the records, or conveyed by others involved in the case.

Whether any individual has been negligent will depend on whether they have breached their duty of care, and whether the alleged injury was caused by or materially contributed to, by the breach of duty (causation).

The claimant and his or her legal advisers will determine which individuals to claim against, based on their understanding of the facts and the opinion of their experts. Of course in the case of individuals to claim against, based on their understanding of the facts and the opinion of their experts. Of course in the case of

I always enjoy reading Casebook and have often thought “there but for the grace of God…”

However, reading the report “A problem with polyphs”, I do find it extraordinary that MPS took this case to court. In the first paragraph a colonoscopy was properly recommended. Not arranging this is, to my mind, completely irresponsible, and the professor’s comment about repeating the rectal examination just ignores the previous proctoscopic findings. The patient’s lawyers must have enjoyed the case at legal expense to MPS.

A B Richards Tadley UK

Response

I regret to say that this is an error on our part, and that this case did not in fact go to court. It was settled without matters going this far – as you correctly point out, there was no doubt that an error had been made by Dr A.

I am not entirely sure how our mistake slipped through but we will correct our online version.

Thank-you for getting in touch and drawing our attention to it.

REFERENCES
How social media savvy are you? If you are a medical student, the chances are that you are online more or less permanently. If, like me, you are a practising doctor who qualified in the last century (read ‘dinosaur’), you might be a bit less comfortable. I’ve been using computers since you could measure the pixels with a ruler, and I carry my smartphone as if it were grafted onto my hand, but even I admit I am feeling a little left behind by the social media tsunami that has arisen around us. Social media is becoming increasingly popular among doctors and patients alike. Where clear ethical and behavioural boundaries are well-established in traditional face-to-face relationships, the online community has developed so rapidly that the medical profession is finding itself in uncharted waters. How do you respond when a patient wants to “friend” you on Facebook? Or when someone harshly criticises your doctoring on a public forum?

My organisation has released guidelines about how to behave online, but they are a series of don’ts. Don’t publish pictures of yourself drunkenly incapacitated on your Facebook page, where employers and patients can see them.

Into this environment come Kevin Pho and Susan Gay, with their book, Establishing, Managing and Protecting your Online Reputation. Pho is himself a doctor, writing for doctors, which gives him immediate authority. His blog, www.kevinmd.com, is well-known and successful.

The central theme of the book is that doctors’ online reputation is just as important as their real-life one. Whether we like it or not, our basic information is already out there, but we usually don’t take any ownership of it. Done properly, we can establish and cultivate an online reputation, which can be professionally and personally rewarding. In short, we can use social media to our professional advantage. To quote: “First, do no harm; second, get an online profile.” Rather than don’ts, this book is full of dos.

The book is informal and readable, and covers the absolute basics well: techno-novices need have no fear. My main criticism is the book’s overwhelmingly American perspective. Patterns of work and ethos of practice are very different where I work, and I don’t need to build myself – or my practice – as a brand, or attract my paying customers. Social media is here to stay, and need not be a threat. We can ignore it, or use it to our advantage, and this book goes a long way toward telling us how.

I’LL SEE MYSELF OUT, THANK YOU: THIRTY PERSONAL VIEWS IN SUPPORT OF ASSISTED SUICIDE

Reviewed by Dr Ellen Welch – GP, London

Following the recent rejection of the Assisted Dying Bill in the UK House of Commons by an overwhelming majority of 330 against to 118 in favour, this collection of essays in support of the issue provides the reader with some of the key arguments in the debate for the legalisation of what the authors term medically assisted rational suicide (MARS).

The book has been compiled by former psychiatrist Colin Brewer and former medical director of the United Nations Michael Irwin, with essays contributed by doctors, priests, politicians, philosophers and, most poignantly, from people suffering with terminal illness.

The writers discuss the facts and the law surrounding the subject in both the UK and overseas, with both ethical and religious perspective offered. Dignitas writes a chapter on their experiences in Switzerland over the last 16 years of their existence. And a chapter is dedicated to palliative care – both its promises and its limitations.

Perhaps the most thought-provoking stories come from people who have been faced with the reality of a painful, undignified death. They tell of their struggle, their pain, the frustration that they feel in a life they no longer want to live, but are unable to end. Several quotes are given from the 2014 House of Lords debate which sum up some of the main arguments.

A major limitation of this book is that it only presents one side of the argument on the debate and it would certainly provide more of a balanced read if there had been contributors from those who oppose assisted dying. Whatever your view may be, it does provide an interesting and comprehensive read in support of the issue.
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