On deadly ground

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

INDEMNITY LIMITS
AN IMPORTANT UPDATE
A response to rising claims costs in the Caribbean

ON LOCATION – JAMAICA AND TRINIDAD
Spreading education and risk management on the latest MPS visit

DATES FOR YOUR DIARY
Find out about healthcare events in the region, taking place during the next few months

BOOK REVIEWS
What pages are being turned this month?
Reduce your risk with education from MPS

MPS is committed to helping healthcare professionals avoid problems and provide the best care for their patients.

We have a dedicated educational services department with a team of more than 100 people organising and delivering education and risk management interventions to healthcare professionals worldwide.

To find out more visit the education section of www.medicalprotection.org

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Get the most from your membership…

Visit our website for publications, news, events and other information: www.medicalprotection.org
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.

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.

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 insolvency 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.
Jamaica and Trinidad

MPS’s Dr Nancy Boodhoo and Dr Brian Charles, consultant to MPS, visited Jamaica and Trinidad in early May to share vital updates on education and risk management.

This latest educational visit by Dr Boodhoo and Dr Charles began at the end of April in Kingston, Jamaica, where a presentation was given to both doctors and dentists on risk management. Entitled “The relevance and relation to quality healthcare”, the presentation was then followed by an interactive discussion involving the audience – principal concerns raised were over resources, communication and open disclosure.

Dr Charles then repeated the presentation at Kingston Public Hospital, introducing a hospital emphasis for the benefit of the doctors and medical students at the hospital. It was then over to the dental school of the University of West Indies, where Dr Charles and Dr Boodhoo spoke to fourth year students on negligence and consent. Following some interactive discussion, there was much interest in MPS’s e-learning platform and its access for students.

Montego Bay was the next destination; MPS’s subsidiary Dental Protection Ltd was sponsoring a dental convention and marketing representative Karen James was on hand to engage with dentists, hygienists and dental nurses. Later that day, Dr Boodhoo and Dr Charles presented to doctors and dentists on risk management, with a particular focus on consent and communication.

The same presentation was given at Cornwall Hospital, which was attended by consultants, registrars, interns, medical students and nurses, and was praised by the hospital’s medical director. During an interactive risk management segment, concerns raised included resources, communication and cultural incorporation of holistic treatment in traditional medicine.

The Jamaica portion of the visit was then rounded off by a talk at a dental convention, a post-event dinner with the President of the Jamaica Dental Association, and various meetings with members of the Association’s Executive team.

Travelling to Trinidad, Dr Charles and Dr Boodhoo discussed the facilitation of a number of workshops at an upcoming conference on anaesthetic and intensive care. With around 100 doctors – including a significant portion of juniors – in attendance, and a mixture of speakers from the Caribbean and abroad, the workshops were to be a great opportunity for MPS to share core medico-legal learning.
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.**

---

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.

**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.
**CHAPERONES**

**FEATURE**

**RAISING CONCERNS ABOUT COLLEAGUES**

**CASEBOOK | VOLUME 21 – ISSUE 3 | 2013 | www.medicalprotection.org**

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.

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**CONTINUED OVERLEAF**

**CASEBOOK | VOLUME 21 – ISSUE 3 | 2013 | www.medicalprotection.org**
CASEBOOK | VOLUME 21 – ISSUE 3 | 2013 | www.medicalprotection.org

FEATURE

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

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.

CAPACITY

GP Dr W was visited by 50-year-old patient Mrs B, with a history of drug dependency, alongside her daughter V. During the consultation, Dr W inadvertently made reference to the fact that Mrs B was HIV positive; V was not aware of this. Dr W immediately apologised for this disclosure. He wrote to Mrs B that evening acknowledging the breach of confidentiality and again apologising for it.

Mrs B was very angry and complained to the Medical Council, forwarding Dr W’s letter, making reference to other concerns about the care she had received. The Medical Council wrote to Dr W indicating that they would not be investigating the matter, but asking him to provide details of his employers.

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.
**PROBITY**

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, or that of the charity providing the funding. Dr M was questioned about this and claimed to have indeed received the necessary authorisation.

It was later found that Dr M had made numerous fraudulent attempts to demonstrate this 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.

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**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).

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Taken from MPS cases handled between June 2012 and May 2013. Words by Gareth Gillespie and Sara Williams.
**IMPORTANT:**

**MPS to introduce indemnity limits**

MPS has recently written to members to explain a change that we are making to how one element of the benefits of membership is being offered.

We are experiencing an increase in high value claims being brought against members. In particular we have seen more cases where special damages are being paid to fund the treatment of patients in a country other than the one where the incident occurred, often at a much higher cost. Legal costs in these claims are also increasing as they take much longer to be resolved and require a greater degree of case management.

Rather than make substantial increases to subscription rates to reflect these extra costs, MPS’s elected Council has indicated that, whilst it always retains absolute discretion, it will limit the maximum amount the organisation will indemnify per claim.

This limit, which has been very carefully considered and assessed, is set at a level that reflects MPS’s experience in each country.

This change will come into effect when members renew with MPS on or after 1 October 2013. If members’ annual renewal date falls before this date, the limit will come into effect upon renewal in 2014. Only claims arising from an incident that occurs after the renewal date will be affected.

This is not the first time that MPS has introduced an indemnity limit; they have been in place in several countries throughout the Caribbean for a number of years. Our experience suggests that introducing this limit is unlikely to affect the vast majority of members. We have deliberately set the threshold at a higher level than almost all cases in which MPS has been involved. For further information, please contact nancy.boodhoo@mps.org.uk

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**SURINAME**

**Surgery error makes headlines**

A claim has been made against a surgeon and Lachimapersad Mungra Hospital of District Nickerie, following a high-profile case in which a bandage was left inside the abdomen of a patient.

An investigation was due to be launched, announced Health Minister Michel Blokland, following the incident – which made local headlines when I saw the bandage, but whatever they found in my wife’s body. I was furious when I saw the bandage, but happy that finally my wife was relieved from the pain.”

He added that as well as making a claim against the hospital, Mr Jairam had filed a complaint against the surgeon.

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**BRITISH VIRGIN ISLANDS**

**National Health Insurance: debate goes on**

A fresh public consultation over the implementation of a National Health Insurance (NHI) system in the British Virgin Islands was due to go ahead again in July.

Premier Dr D Orlando Smith said the public were generally in favour of NHI, but they still had many unanswered questions and concerns. These concerns mainly revolved around making the system mandatory for all legal residents.

Premier Smith said: “A careful review of the actuarial data has confirmed that a single-payer system is the best available option for ensuring the viability and long-term sustainability of a National Health Insurance System in the Virgin Islands.”

“The single-paying National Health System will provide the same excellent care from all your providers in the country, greatly improve hospital care and the same referral process for tertiary care that other insurers provide.”
Barbados

Warning over non-communicable diseases

Continued rises in incidences of non-communicable diseases will have a significant impact on the cost of healthcare, according to Minster of Health John Boyce.

Mr Boyce issued his warning to House of Assembly as he reiterated the plans of the National Chronic Non-Communicable Diseases Commission, which he said was set up to lead the fight against those diseases.

“It’s no point waiting until one has contracted these diseases to say let us now deal with it, because as I said that it is a cost which we cannot contemplate for our country. And as we continue to move in a world where the view is that healthcare should be available to all persons, the reality is that this has become even more urgent and therefore the work in terms of looking at the entire diet, as to what we eat; the question of smoking because there is no question that it has been clearly demonstrated that smoking of tobacco has increased the onset of lung cancer; alcohol abuse, the whole question of alcohol abuse again and the repercussions of hypertension, diabetes in our older years is something which we must be fully aware of,” he said.

Mr Boyce added: “We already have an expansive debate taking place in terms of the cost of providing healthcare in Barbados, and the Ministry of Finance is constantly having to grapple with the demand of the Queen Elizabeth Hospital and the other institutions which I have mentioned. So that one of the strategies that we have employed in this regard, is to try to emphasise the benefit of prevention, and indeed the benefit of treatment of our population at the primary stages of the onset of any of these diseases and I speak specifically to our polyclinic institutions.”

Dates for your diary

A number of healthcare events are taking place across the region during the next few months

October 2013

Current Anesthesia Practice
7-10 October
Paradise Island, Bahamas
www.nwas.com

83rd Annual Meeting of the American Thyroid Association (ATA)
16-20 October
San Juan, Puerto Rico
www.thyroid.org

World Congress of Surgery, Obstetrics, Trauma and Anesthesia
16-17 October
Port of Spain, Trinidad and Tobago
www.hopkinscme.edu

Giant Strides in Anesthesia
20-25 October
Kralendijk, Bonaire
www.nwas.com

29th Annual Fall Conference on Pediatric Emergencies
23-26 October
Paradise Island, Bahamas
http://symposiamedicus.org

20th Cuban Congress of Urology
29 October-2 November
Havana, Cuba
www.eventospalco.com

21st Annual Fall Conference on Issues in Women's Health
30 October-2 November
Guanacaste, Costa Rica
http://symposiamedicus.org

November 2013

Internal Medicine for Primary Care: Endo/Pulm/Derm/Neuro
7-10 November
Atlantis Resort, Bahamas
www.mer.org

14th Annual Fall Conference on Emergency Medicine
13-16 November
Paradise Island, Bahamas
http://symposiamedicus.org

24th MDtravel Fall Conference
16-23 November
Montego Bay, Jamaica
www.mdtravel.ca

Reviews in Anesthesia Practice
17-22 November
Port Maria, Jamaica
www.nwas.com

December 2013

Convenction Internacional de Psicologia: Hóminis 2013
2-6 December
Havana, Cuba

Neurology/Psychiatry for Primary Care
5-8 December
Atlantis Resort, Bahamas
www.mer.org

Current Topics in Anesthesia
8-13 December
Palm Beach, Florida
www.nwas.com

Imaging Warm-up in the Caribbean
8-13 December
St John, US Virgin Islands
www.cme.ucsf.edu
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
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 depomedrol 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 depomedrol 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 depomedrol into the eye instead of the intended sub-tenon’s space. Ms J 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 both 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.
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, 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.

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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. The next day Mr M was admitted to hospital by ambulance and diagnosed with Stevens-Johnson syndrome. He spent a week being treated in ICU with septicaemia and renal failure, but unfortunately died as a result of these conditions.

Causation reports concluded that on the balance of probabilities, the patient developed Stevens-Johnson syndrome due to allopurinol, and experts were critical of Dr P’s decision to initiate the treatment after just one attack of gout, and at an increasing dose.

Experts agreed in this case that Dr P had ample opportunity to make the connection between the rash and the allopurinol, and furthermore, the steroid treatment, which is likely to have contributed towards the ulceration, could have been avoided. The case was indefensible and was settled for a moderate sum.

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.
Paraplegia after spinal surgery

Mr A, a 50-year-old engineer, was referred to Dr Z, consultant neurosurgeon, with increasingly severe back pain and additionally pain and weakness in his right thigh. Mr A had required high doses of opiate analgesia for pain relief and had been unable to work for several months prior to the consultation.

An MRI scan was organised, which demonstrated severe spinal stenosis at the level of T11/T12. Dr Z advised the patient that the spinal stenosis should be decompressed and that the symptoms in his right leg were related to meralgia paraesthetica, which could be dealt with at the same operation. Mr A underwent posterior discectomy of T11/T12 and decompression of the right lateral cutaneous nerve of the thigh.

Postoperatively Mr A complained of pain and weakness in the left leg and thigh and loss of movement in the right leg. A further MRI scan demonstrated a haematoma at the level of T12. Despite further emergency surgery by Dr Z, there was no improvement in Mr A’s lower limbs and three weeks later he was transferred to a long-term rehabilitation unit. After a further three months Mr A was eventually able to return home. He had control of his bladder and bowel, could stand with help but was unable to walk and was no longer able to work.

Mr A commenced legal proceedings against Dr Z, citing inadequacies in informed consent: specifically that Dr Z failed to warn him that the procedure carried the potential risks of severe neurological complications. It was also alleged that Dr Z was negligent in carrying out the thoracic spinal decompression, with particular regard to the posterior transdural approach that he used.

It was evident from the notes and consent form that there was no recorded discussion regarding any risk of neurological deficit relating to the operation and Dr Z acknowledged that he had not discussed such potential complications with the patient. A series of up-to-date independent neurological examinations and tests on Mr A demonstrated features entirely consistent with a spinal cord injury at the level of T12, in keeping with surgical trauma from the operation carried out by Dr Z.

Several expert neurosurgeons, commenting on the case, agreed that the posterior transdural approach employed by Dr Z for removal of a central thoracic disc protrusion had a much higher risk of spinal cord injury compared to the preferred anterior approach, as this would have posed less risk of serious neurological injury. They concluded that Dr Z’s procedure was not supported by the modern neurosurgical literature, was not the standard surgical approach and fell short of what would be considered reasonable spinal surgical practice. The case was not defensible and settled for a substantial sum.

SD

Learning points

- It is important to have a valid indication for induction.
- A CTG is a tool to monitor the fetal heart rate both during the antenatal period and during labour. In labour it is also used to monitor uterine contractions. The fetal heart rate (FHR) has a number of features that must be examined to allow proper interpretation. There are different levels of abnormality of the FHR. An intrapartum CTG classified as pathological requires urgent intervention.
- Training in CTG interpretation and regular updates 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).

Learning points

- 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 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
An unavoidable amputation

Mr 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 skipping 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 documented 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-inflammatories 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 prosthesis 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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Learning points

- Although the patient’s circumstances were very tragic, this did not equate to negligence.
- This case reflects the importance of strong expert opinion. The successful defence hinged around the experts’ opinion.
- Good note-keeping is important for good medical practice and essential in defending a case.
- If a patient attends multiple times with the same problem, alarm bells should start ringing. It is useful to stop and think “what could I be missing?”
- Always try to exclude the worst case scenario. It is useful to document the absence of red flags.
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.

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 hydrocoele/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 outpatients 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 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. PS

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 a 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.
Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions. Please address correspondence to: Casebook, MPS, Victoria House, 2 Victoria Place, Leeds LS11 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 failed 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 fail 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.

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 regard.
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.

Casebook and other publications from MPS are also available to download in digital format from our website at: www.medicalprotection.org
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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