THE STORY OF BETH BOWEN

One mother’s harrowing tale of tragedy and secrecy

FIT TO FLY
Doctors often experience requests for declarations that patients are ‘fit to fly’ – here we present three case scenarios

BREACHING CONFIDENTIALITY
We highlight two recent dilemmas regarding a doctor’s duty to breach patient confidentiality

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You won’t be surprised to know that a significant proportion of my work at MPS consists of assisting members who have been involved in an adverse event. We always advise members to be open about any errors made during the course of such an event – it is morally and ethically the correct thing to do, and can go a long way towards preventing a claim arising in the aftermath.

This is because we often find that claims derive from an angry or aggrieved (or both) patient or relative feeling they have been denied information and explanations – and, if appropriate, a simple apology – in the wake of an adverse outcome. Openness stands to benefit all parties and yet, quite understandably, there remains nervousness and uncertainty about delivering it.

In New Zealand, there is a statutory obligation for open disclosure; in the United Kingdom, a similar ‘duty of candour’ appears to be the government’s approach of choice, despite MPS believing a change in culture will be much more effective. Readers in Hong Kong may recall a fascinating article by Dr Chui Tak-yi at the Hong Kong Hospital Authority, who wrote in the September 2013 edition of Casebook about his systems approach to changing the reporting culture within the organisation.

Fear and anxiety over ‘blaming and shaming’ paralyses many healthcare professionals and prevents them from being open about mistakes that they may have made. This edition of Casebook features a truly harrowing first-hand account from Clare Bowen, a mother-of-two in England who lost her five-year-old daughter Beth in 2007 during surgery. A wall of silence from all involved in Beth’s care prevented Mrs Bowen and her husband from getting a full explanation of the causes of the tragedy. Our article on page 10 will make sobering reading for anyone involved in healthcare today.

However, this edition may also provide some relief for readers, in that our latest collection of case reports feature a significant number of successfully defended claims. We hope they will provide some reassurance that a mistake is not always judged to be negligent – and that the team at MPS are committed to protecting your reputation.
GP's often experience requests for declarations that patients are “fit to fly”. Sessional GP and medicolegal consultant Dr Rachel Birch presents three case scenarios advising what you can do to support patients while minimising your risks.
Case 1 – Can I fly after surgery?

Mrs B came to see Dr A in the middle of a busy on-call surgery. She said she wouldn’t take up much of his time, but that she needed him to complete a form. She had undergone an elective laparoscopic cholecystectomy five days ago in the local private hospital. She had booked a flight to France for the following day as she wanted to visit her sister and recuperate there.

Since she had undergone recent surgery, the airline insisted that she produce a medical travel clearance form. She asked Dr A to complete the form there and then as she had lots to organise before her flight tomorrow.

Dr A explained to her that he didn’t feel he had the expertise to comment on her fitness to fly. Mrs B became quite distressed and started to cry. Dr A arranged to see Mrs B at the start of his afternoon surgery, as he felt that he couldn’t fully address this issue within a busy on-call morning.

Dr A didn’t feel he had the competency or experience to be able to assess Mrs B’s fitness to fly and was reluctant to complete a form to state that she was “fit to fly”.

When Mrs B returned, Dr A took a full history of the date and type of surgery and how she had been in the postoperative period. He noted the absence of any symptoms of complications. He examined her abdomen and was satisfied that she appeared to be making a good recovery after her procedure.

He discussed with her whether or not she should actually be flying so soon after surgery, and whether or not she should ask for assistance at the airport with the walking distances involved. He advised her to discuss her recent surgery with her travel insurance company.

Dr A offered to write a factual letter for the airline, stating the date and type of surgery. However, she was adamant that she required a medical travel clearance form.

Dr A contacted her surgeon, Dr C, at the private hospital. He agreed to review the patient that evening and advise her on her travel arrangements.

Dr C was not happy with the patient travelling the following day. He advised her to wait a full ten days until after her abdominal surgery prior to flying. However, he issued her with a medical travel clearance form for ten days post op and she changed her flight and travel plans accordingly.

Case 2 – A trip of a lifetime

Mrs H had insulin dependent diabetes mellitus and came to see Dr K in a routine diabetic clinic appointment. She was delighted as her husband had organised to take her to Australia for their ruby wedding anniversary. She had read that people with diabetes may require medical travel clearance from their doctors before being allowed to board an aircraft. She had downloaded information from the airline’s website to show Dr K and she asked him to provide a letter stating that she was “fit to fly”.

Dr K undertook a routine diabetic review with Mrs H. They discussed her medication regime, and she denied any hypoglycaemia symptoms. He looked at her recent blood results and conducted a physical examination. It appeared that her diabetic control was good and her condition was stable.

They discussed what she would need to carry with her on the flight. She would require needles, insulin, a blood sugar testing kit and medications for diabetic emergencies.

Dr K arranged for her to see the diabetic specialist nurse at the local hospital to discuss the insulin regime she would require for the flight, and agreed to provide a typed letter outlining her diagnosis and the fact that her condition appeared to be stable with no recent deterioration. On this basis he felt able to state that there appeared to be “no reason why this patient should not be fit to travel”.

Dr K also planned to outline in the same letter the equipment and medication that Mrs H would be carrying in her hand luggage and the reason why she needed to carry it.

He advised Mrs H to contact the airline in advance to discuss the fact that she would be carrying equipment and medication and to discuss her dietary requirements for the flight.

Learning points

- Clinicians should work within their competence. Dr A was correct not to provide a certificate for Mrs B when he felt this was outwith his expertise as a GP.
- It is appropriate to ask consultant surgeons for advice on travel after surgical procedures and they are likely to wish to be involved in such discussions.
- Patients should be advised to check with their travel insurance companies if there are any doubts about their fitness to travel.

- Airlines may ask patients to provide letters or medical certificates confirming that a person’s medical condition is currently stable and the patient is “fit to fly”.
- GPs should consider the wording of statements for airlines carefully, and where possible offer factual information about a patient’s condition, the stability of it and presence or absence of recent deterioration.
- If asked to comment on fitness to fly, avoid stating a patient is “fit to fly” as the latter could be perceived as a guarantee of a patient’s fitness.
- Try to word statements carefully, using phrases such as “this patient’s condition appears to be stable” or “I know of no reason why this patient shouldn’t be fit to fly”.

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Learning points
Summary

Air travel is widely accessible and it is increasingly common for people to go abroad for holidays. Patients may not always consider that air travel is risky and consider that it is a routine matter for a GP to sign a fitness to fly statement.

Doctors may wish to consider discussing with the patient whether air travel could adversely affect a pre-existing medical condition. Factors to consider include the effect of decreased air pressure in the cabin, immobility, timings of medication, the mental and physical effect of navigating through airports and the need for health insurance.

Doctors may wish to contact individual airlines’ medical advisors if they have specific queries.

Fitness to fly can be an emotive area. Patients may have special reasons for wanting to travel and doctors may feel pressure to complete forms and declarations of fitness to fly. However, it is important that GPs act in their patients’ best interests and only make statements that are truthful and honest and not misleading.

Rather than signing a statement of “fitness to fly” doctors may wish to consider providing a factual letter outlining the recent course and stability, or not, of the patient’s medical condition. The final decision as to whether a patient may fly rests with the airlines and information provided from the GP will assist them in this decision.

Case 3 – Last holiday before the baby comes along

Dr B received a form in the post regarding Mrs F, a new patient to the practice who was 30 weeks pregnant. She had never met this patient before. In fact, her only medical record entry was when she became pregnant. She saw Dr B’s partner and was referred to the midwife.

The form was for medical confirmation of fitness to fly. It asked the doctor or midwife completing the form to state that the pregnancy was uncomplicated, providing the estimated delivery date and confirming that the patient was “fit to fly”.

The following day, Mrs F had a telephone consultation with Dr B. She told her that she had booked a long weekend in Prague with her husband, as they felt it was important to have a holiday before the baby arrived. She would be 32 weeks pregnant at the time of the trip.

Dr B took a history from Mrs F. It appeared she was fit and well and had had no problems during her pregnancy at all. This was her first pregnancy and she had been seeing the midwife regularly.

Dr B felt that before she could complete the form, she would like to see Mrs F for a face-to-face appointment and review her maternity notes. Mrs F was not keen to do this, as she was still working full-time and had already taken time off work to see the midwife the following day.

Dr B discussed her concern about signing a form to state that Mrs F was “fit to fly” without seeing her. Mrs F fully appreciated her dilemma.

After a discussion, they decided that it would be most appropriate for the midwife to complete the form for Mrs F, as she had been regularly seeing her throughout her pregnancy.

The following week Dr B received a message from Mrs F to let her know that her midwife had completed the form and she was off to Prague.

Learning points

Dr B was correct to wish to review Mrs F in person and review her maternity record to ensure that the information was correct.

Most airlines ask for a medical confirmation of fitness to fly once a pregnancy has reached 28 weeks’ gestation. They ask for this to be completed by either a doctor or a midwife. In the above situation it was appropriate for the midwife to complete the form, as Dr B had never met Mrs F.

Airlines have rules about how late in a pregnancy a patient may travel and it is important that patients check the rules with the individual airlines.
Breaching confidentiality

A doctor’s duty to breach patient confidentiality and report concerns can come into play in a number of scenarios. Gareth Gillespie highlights two recent dilemmas from the MPS caseload in Trinidad.

CASE 1: Foreign bodies
Mr Y was taken to hospital by his relative after complaining of stomach pains and bowel obstruction. Following his admission, he underwent a laparotomy, where 20 pellets of carefully-packaged cocaine were found in his abdominal cavity. During the surgery, it was found that Mr Y’s bowel was perforated, as nine of the pellets had penetrated the bowel; although 17 pellets were successfully removed and three passed from the body in Mr Y’s stools, shortly after surgery Mr Y’s condition deteriorated and he developed sepsis as a result of the bowel perforation. After being transferred to intensive care, Mr Y’s condition eventually improved and he was discharged after making a full recovery.

However, the surgeon who removed the cocaine pellets instructed the other clinical staff present not to take any photographs of them, and to instead repackage them in a resealable storage bag. They were then returned to Mr Y.

The matter leaked to the media who focused on the failure by the clinical staff to report the illegal drugs.

At the time of Casebook going to press, the matter is still being investigated.

MPS advice
The case raises an important issue about when a doctor should breach a patient’s confidentiality. In this case, the surgeon – and anyone else in the clinical team who was aware of the nature of the objects within Mr Y’s body – should have reported the presence of suspected illegal drugs in Mr Y’s possession. Failure to do so potentially exposes clinicians to two particular laws.

Criminal Law Act
Under Section 5 of the Criminal Law Act, a person may be guilty of an offence if he assists a person who he knows or believes is guilty of an arrestable offence. He must, however, know or believe the individual to be guilty or charged of an arrestable offence, or has committed an arrestable offence or does any act to impede the individual’s apprehension or prosecution.

Dangerous Drugs Act
Under Section 27 of the Dangerous Drugs Act, any person who attempts, aids, abets, counsels or procures the commission of drug trafficking is guilty of an offence.

It is to be noted that neither Act explicitly states (as does the Sexual Offences Act and Coroners Act) that there is a general statutory duty to report illegal activity.

CASE 2: Child protection
A debate in the Trinidad press was sparked off earlier this year by comments relating to the country’s ongoing issue with underage pregnancies.

After Education Minister Dr Tim Gopeesingh revealed that there were around 2,500
schoolgirl pregnancies in Trinidad each year, one finger of blame was pointed at the country’s doctors for their role in such pregnancies – which essentially equate to statutory rape – going unreported. Margaret Sampson-Browne, head of the police victims and witness support unit, was quoted as saying: “Children are going into the hospitals and the health centres and having children, and the doctors are not informing the police, and this cannot continue. We have to hold some of these doctors to account and start jailing them.”

Health Minister Dr Fuad Khan then added to the debate by saying that doctors were bound by doctor–patient confidentiality. “To go against this is a breach of the privacy law,” Dr Khan said, “and therefore paves the way for the doctor and the medical institution for medical litigation, whether private or public.”

This prompted a concerned MPS member to get in touch for advice and guidance.

MPS advice
It may help to relate to the situation as it is in the UK, since in strict legal terms there is very little difference. We cannot comment on the likely tariffs that would be handed out by the English courts but in terms of the legality of it, even consensual sexual relations with a girl under the age of 16 is technically regarded in English law as statutory rape. There is no distinction made regarding the age of the girl’s partner. The law is even stricter if the girl is under the age of 13.

However, built into the legal system is discretion in how the authorities pursue and prosecute a case. In England the police, on completing their investigation, will recommend whether or not to pursue a case to the Crown Prosecution Service (CPS), who will weigh up the severity of the crime, the nature of the crime and the public interest as well as the individual perpetrator’s criminal history, before determining whether a prosecution should be brought. The police also have some discretion of their own as to whether they pursue a criminal action against a particular individual.

Thus with respect to statutory rape very different views would be taken, for example, of a 15-year-old-boy sleeping with a 14 or 15-year-old-girl and a 31-year-old man sleeping with a 15-year-old-girl. Anyone sleeping with someone aged under 13 years is very likely to end up with a prosecution, even if they themselves are of a very similar age, because the law is that much stricter.

The confidentiality of the relationship between doctor and patient is of extreme importance for the reasons clearly explained by Dr Khan in his interview with the Trinidad and Tobago Guardian. English law, again, recognises the importance of this relationship and for the most part will not obligate a doctor to breach that relationship, even where the doctor is aware that a patient has committed a crime. There are clearly statutory occasions where doctors have to provide information that will in essence breach that relationship, but those are few and far between and would need to be justified for good reason. In the event the police need information from a doctor where the doctor is not prepared to provide it, because it would breach that duty of confidentiality, the police do have the option to obtain court orders from a judge to force the doctor to reveal the relevant information.

That said, Medical Councils make it clear that there are circumstances in which a doctor may justify a breach of his duty of confidentiality, even though it undermines all the principles that Dr Khan clearly lays out. With reference to the circumstances outlined in the current controversy, not all cases of statutory rape would fall into the categories that a UK doctor would regard as justifying a breach of confidentiality. Where the relationship was clearly consensual and the age difference minimal, most doctors would contend that the breach of their relationship with their patient would be wholly inappropriate. It is likely that the authorities would agree with them. In the case of a child under 13, however, such is the strictness of the law, the doctor would be obliged to report the case to the child protection teams, though not necessarily directly to the police.

Of course, the issue of patient consent is also raised here. Where the disclosure of medical information is required by law, consent from the patient is not required. Doctors should not disclose any more information than is absolutely necessary and the patient should be made aware of the disclosure, and informed about why the information is being disclosed, 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 that is disclosed.

Many young people under 16 have the capacity to consent to the disclosure of their medical records and doctors should therefore consider whether to discuss disclosing the information with them and whether it will be possible to obtain their consent. If a child or young person under 16 refuses consent, doctors 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 otherwise justifiable in the public interest.

In the context of what might amount to a serious sexual offence involving a child, a doctor would have to be particularly alert to the possibility of other children who might be at risk.

Doctors should also follow up their concerns if they believe that their concerns have not been acted on appropriately, leaving a child or young person at risk of, or suffering, abuse or neglect. This may involve taking those concerns to the next level of authority. In this situation a doctor’s first concern must be the safety of children and young people. Doctors must inform an appropriate person or authority promptly of any reasonable concern that children or young people are at risk of abuse or neglect, when that is in a child’s best interests or necessary to protect other children or young people.

Doctors must be able to justify a decision not to share such a concern, having taken advice from a named or designated doctor for child protection or an experienced colleague, or a defence or professional body. Concerns, discussions and reasons for not sharing information in these circumstances should also be carefully recorded.

The serious cases, however, are those where there is a substantial age discrepancy between the girl and the man with whom she is having a sexual relationship. Quite what constitutes a significant age difference clearly is a matter of judgment, but most people would suggest that for a girl under the age of 16 a man who is no longer in his teenage years is already substantially older, both chronologically and in maturity, and may be able to exert undue influence and control over that girl so as to bring into question the consensuality of the relationship. The doctor may or may not be able to elicit information that identifies how much concern to have about their relationship, but most doctors who identify such differences in age would be likely to have a discussion with the authorities involved in child protection, if not with the police, in such circumstances.

While a legal system must provide laws that are clearly stated in black and white, it must also have built into it a system to allow discretion to account for specific circumstances. Thus for the situations outlined by this controversy doctors must have the discretion and the training to manage that discretion, to determine when it is appropriate to protect the confidentiality of their relationship with their patient and when the legal technical criminality of their activity results in the need for medical attention but also warrants the doctor breaching that confidentiality, because the crime is of a degree that the criminal authorities need to be involved in order to protect the child.

Of course, conveying the complexity of this issue in a public forum, where debate is often at a level of simplistic soundbites, can be very difficult.

With thanks to Dr Jonathan Bernstein for his assistance with this article
THE STORY OF BETH BOWEN

In 2007 Clare Bowen's five-year-old daughter Beth died during surgery at a hospital in the UK. Here she tells her story to Sara Dawson – and relays her hopes that it will reduce the likelihood of such an incident happening again.

I'm a mum to three small children who all have spherocytosis, which causes them to become very anaemic and require blood transfusions. The condition made my middle child William very poorly, so in January 2006 a decision was made to remove his spleen – it made a massive difference to his quality of life.

So the following July, we decided that Beth, my eldest daughter, would have the same operation – she had just started school and couldn't keep up with the other children. We felt confident, as the same team that operated on William would be treating Beth. I remember talking with the doctors beforehand about possible scars on Beth's tummy, so the spleen would be removed through a lower incision.

We had all the pre-op stuff done and chatted to all the doctors, before arriving at the hospital on 27 July. She went down for her operation at 1pm – we didn't hear from the doctors for several hours. At 4pm we spoke to a nurse, asking her why it was taking longer than it should. The nurse said it was fine as these operations often take a long time.

Just after 6pm, the surgeons, the anaesthetist and the nurses came into our tiny waiting room – without any warning they said something awful had happened. The doctors seemed unable to comprehend what had happened. I asked one doctor; “Is she dead?” He said “yes”, adding that she'd lost a lot of blood during the operation as a blood vessel had been cut and she hadn't survived. He said they’d been trying to save her for an hour and half prior to coming to see us, but she hadn’t survived – she'd lost too much blood.

The immediate aftermath

In the weeks after Beth's death we received no answers from the hospital – it was very difficult to get them to talk to us. Slowly we gathered bits of information. We found out that at the last minute a new piece of equipment was used called a morcellator – like an apple corer – that removes chunks of flesh through laparoscopic portholes.

It emerged that the surgeons hadn’t used the equipment before, they hadn’t received any training and no risk assessments on the equipment had been undertaken.

It was an adult piece of equipment that was not meant to be used on a child.

The damage to Beth's body was extensive; they made cuts to her aorta, her stomach, her intestines – she had massive trauma to her body.

Searching for answers

It was only when we enlisted help from a friend with a medical background that we started asking questions that really needed asking.

Why did the hospital throw away all the equipment they used that night? Why didn’t they

keep the blood that Beth lost? Why didn’t they try and retrieve the items when we’d asked them, even though they were still at the hospital? Everything that could have given us clear answers was disposed of immediately. It didn’t allow us to get the answers we so needed.

It surfaced that the surgeon who carried out Beth’s operation had only ever done three laparoscopic surgeries before – William had been her first. In her head she deemed it ok to try to operate that piece of equipment on my daughter.

Confusion

That was something we as parents could never understand – why would a doctor allow themselves to operate a new piece of equipment that they weren’t comfortable with, while their senior was in the room?

I don’t think any of the surgeons understood that there was a technique to what they were doing, one that had to be learned.

They had no formal training on how to use the morcellator; a five-minute talk was judged to be enough training. The nurse who was asked to put the morcellator together had never seen it before. No-one felt they had the authority or the ability to halt the operation. If only someone in the theatre that day had said can we stop a minute, can we take a step back, we’ve had no training, we’re not done a risk assessment, we’ve not really thought this through, is this a good idea?

The inquest

We did not receive an apology before or after the inquest. The hospital admitted they had failed in their duty of care and they were sorry that they had failed to prevent Beth’s death. They didn’t fail to prevent Beth’s death – they caused it.

The three-day inquest took place 18 months after Beth died. Unfortunately, the only way we could afford a solicitor was to take legal action against the hospital, which is something we never really wanted to do.
For us it was never about money; it was about answers.
The only way I can describe the inquest from a parent’s point of view is that it’s like being tortured and you can’t escape. We had to listen to different stories about Beth’s last hours, while trying to fit it all together in our heads – it was horrible. Information that came out in the inquest was contrary to what the hospital had been telling us in the months previously. Photographs were revealed of the theatre and information was shared on Beth’s medication, which she’d been given but we were unaware of. A trainee surgeon was the one specifically holding the morcellator – they had never used it before and she was not allowed to perform surgery on her own.

During the inquest the hospital admitted that they had not received consent from us to carry out the operation on Beth.
I left the inquest room while they showed pictures of Beth’s autopsy, but my husband Richard felt he had failed Beth by allowing the hospital to do the operation, so he remained in the room – the pictures destroyed him. No-one should have to see their child cut up on an autopsy table.

The striking thing during the inquest was the arrogance and complete disregard by the medical professionals in the room for our feelings, and for the part that they played in Beth’s death.

In the months after the inquest, Richard suffered a massive heart attack and died – he was only 31 years old.
On a national level
Beth’s death was reported widely in the media and the UK government became interested in what happened. The Health Select Committee started looking at many incidents where hospitals hadn’t been open and honest with parents and relatives after operations or treatment that had gone wrong.
The Committee published a report about the death of Beth. It generated a lot of dialogue and interest in the subject that wasn’t there before – it was a catalyst for change. That said, I do think there is still a long way to go.
The Committee came up with some good ideas for ways to drive things forward, but it’s not always about rules and making people do things; it’s about a change in culture. Bringing in a law to enforce open candour and openness is not necessarily the right way forward.

Reflections
Attitudes need to change. Some medical professionals are too arrogant to believe they can be any better and that they can make mistakes. With this attitude you blind yourself to mistakes, and you won’t see one heading straight for you.
Medical professionals should be confident in their ability, but they should understand their limitations – “I’m good, but I can be better”. Beth may still be alive if the surgical team’s mindset had been different going into the operation.
Change has to come from the top and the bottom – openness and candour must be championed by everyone but, ultimately, it is the board and the senior doctors who are the ones that need to facilitate the changes.

Visit www.youtube.com/user/MedicalProtectionSoc to see a video interview with Clare Bowen, as she describes her fight for the truth behind the tragedy.
Commentary – Being open
By John Tiernan, MPS Executive Director, Member Engagement

Sadly things do go wrong in medicine. We can’t be totally confident about how frequently things go wrong, but they are not a rare occurrence.

For many years a culture of denial existed, where doctors were heroes who never have adverse outcomes. These expectations led patients to demand perfection and perceive adverse outcomes as unacceptable even when the literature suggests that as many as 50% are not avoidable. The fear of openness is often driven by a blame culture where the doctor is disproportionally singled out for sanction, regardless of the multifactorial causes of some of these events.

The real challenge is how to change this culture to one where we move from disproportionate blame to one of fair accountability or a just culture, where the emphasis is on learning from adverse events rather than finding someone to blame. The learning culture is balanced by the profession taking accountability when mistakes are made.

A good starting point is encouraging openness after an adverse event has occurred. When something has gone wrong be open and candid with the patient – it is part of the ongoing therapeutic relationship. Say sorry for what has happened and talk honestly with them – don’t run away or deny what’s happened. It isn’t always easy but it is the right thing to do.

Examining significant events and exploring adverse outcomes is not always an admission of bad practice – it is, however, an essential part of good practice.

Being open can also reduce the risk of complaints and claims. For many patients who have suffered an injury, turning to the law is often a last resort; patients go down this route because they feel it is the only way to have their questions answered.

There is a large amount of evidence that suggests that people lodge a complaint or a claim against a doctor, not primarily because of their injury, but because they’re angry at what happened and want answers.

Which is more professional? To refuse to acknowledge an adverse outcome and cling to the belief that you are incapable of having one, or to acknowledge it, manage it ethically and professionally and, most of all, learn from it?

Which sort of professional would you rather be treated by?

Professor Charles Vincent
Professor of Psychology, Emeritus Professor of Clinical Safety at Imperial College London, Imperial College, London

Information about errors and adverse events, harmful outcomes in healthcare, has very seldom been studied openly; it’s been treated as a nuisance, something we don’t want to know about, an occasion for shame, guilt, and other sorts of problems. In the last few years in healthcare we’ve come to realise that it can also be – if treated properly – a resource, and an essential way of achieving a safe culture.

Professor Mayur Lakhani
GP and Chairman of the National Council for Palliative Care, UK

When something goes wrong, you need to lose sleep over it. Why did it happen? Do I understand what happened here? Have I made sure that I know the reasons this happened? What can I do to prevent it? Have I said sorry to the patient? Have I involved the patient in this situation? Have I talked to staff? I think that’s a really important obligation of doctors.

Lucian L Leape MD
Adjunct Professor, Health Policy, Harvard School of Public Health

We’re moving from paternalism with patients – let the doctor tell you what’s right for you – to an openness and a patient partnering, where the patient not only has a right to know, but we want them to know.

Dr Donald Berwick
MD, MPP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement

Don’t think we can become safer secretly. There’s some very inescapable connection between openness and honesty and disclosure and involvement, confession, apology... all acts of openness in building a safe culture. I think this idea of transparency and openness is an essential part of our future.

Guy Hirst
Former British Airways training captain and human factors expert

Medical teams are human. Medical teams are driven to succeed and have the needs of the patient at heart. They need to be pre-occupied with the possibility that they will make errors. The team leaders, usually consultants, must understand that they will make mistakes and try to break rules in order to achieve results. The safety net is their team who must trap or mitigate the consequences of such errors or violations. Research shows that if the leader briefs the team in an open, interactive and inclusive manner then team members will speak up in an assertive manner when the situation demands.

REFERENCES
1. Note to non-UK readers: the Health Select Committee is part of the UK parliament, and oversees the operations of the UK Department of Health. Here is a link to the Health Select Committee report – www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151we22.htm
I’m delighted to have the opportunity to reflect on the cases in this edition of Casebook from an educational and risk management perspective.

The cases of Mr D, with his osteoarthritic knees (“A pain in the knee”, page 14), and Mrs H, with her neuropraxia following cannula insertion (“A cannula complication”, page 21), remind us how record-keeping can contribute to an effective defence against allegations of negligence. Of course, good documentation is also increasingly essential to support good clinical care and enable continuity to be delivered by an increasing range and number of involved healthcare professionals.

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The system errors of Mrs Y and the blood transfusion (“Transfusion confusion”, page 19) highlight the importance of someone taking responsibility when the patient has suffered an adverse outcome and, following an apology, having an open and honest discussion with the patient, explaining what has happened. It is always appropriate to say that you are sorry for what the patient has experienced. It also shows how patients themselves can make a valuable contribution to patient safety. I hope that you find reading the cases to be interesting and informative. Our range of education risk management products can help you address some of these challenges, and I encourage you to visit www.medicalprotection.org and click on the Education tab for more information.

Dr Mark Dinwoodie, head of member education at MPS, assesses the key learning from the latest collection of case reports.

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Mr D, a 62-year-old manager, had severe pain in both knees, which caused him trouble walking more than 200 yards. He was referred to an orthopaedic clinic for assessment.

At the assessment, consultant Mr M diagnosed bilateral osteoarthritis of his knees. Two weeks later bilateral knee arthroscopies were carried out. At follow-up clinic a week later, Mr D felt his knees had improved.

However, two months later Mr D complained of extreme pain in the left knee and it was decided he should undergo total left knee replacement.

Following the knee replacement, Mr D had physiotherapy. Two months post-surgery, Mr D was happy with his knee replacement. He had returned to work, was driving, and playing golf.

Four months post-surgery, Mr D was reviewed by Mr M after he complained of developing difficulties flexing his knee. Mr M thought Mr D had developed fibrotic changes within the joint and, as a result, manipulation was undertaken under anaesthetic a few months later. The day after the manipulation, Mr D had a disagreement with one of the physiotherapists and discharged himself from hospital. He declined in and outpatient physiotherapy and arrangements for physiotherapy elsewhere.

Early the following year, Mr M saw Mr D and noted that he had benefited from having later physiotherapy, with movement of 100°. However, a number of months later, Mr D had subsequent difficulties and pain. A second opinion obtained from surgeon Ms H stated that the femoral component was too large and a revision knee replacement was carried out. Mr D claimed his pain had been eradicated.

Mr D made a claim against Mr M, stating that he had failed to recognise, from postoperative x-ray, that the femoral implant of the first knee replacement was too large, failed to advise of the need for a revision procedure, and failed to carry out a revision procedure, or refer Mr D to another surgeon. He also claimed a pointless manipulation was carried out under anaesthetic and he had suffered unnecessary pain and inconvenience for more than two years.

Expert opinion
Expert opinion was supportive and there was no criticism of the initial procedure carried out by Mr M. The femoral component was found to be in reasonable size limits and it was stressed that the management of painful stiff knee post-replacement is notoriously difficult – many factors can come into play.

During the revision procedure, significant soft tissue release would have been required and this alone may have been responsible for an increased range of motion in Mr D’s knee. However, experts were critical of the fact that as Mr D was not happy with the result of the knee replacement, the reasons why should have been investigated.

The case was successfully defended at trial and nearly all costs were recovered.

Learning points
- A poor outcome doesn’t necessarily mean negligence. There was no criticism of the procedure itself by experts.
- Supportive expert opinion of the technique used in the procedure meant that the case could be defended to trial.
- Mr M had well-documented the procedure and detailed medical records helped in defence of the case.
The elusive diagnosis

Mr M, 50 years old, suffered chronic ill-health due to spinal fusion, chronic bronchitis and asthma. He was a regular attendee at the surgery of Drs C and D, with sinusitis. In March 2005, Mr M saw Dr D with a similar complaint and she administered him with a flu jab, particularly as Mr M often failed to attend chronic monitoring clinics. The notes from the consultation said: “Upper respiratory tract infection NOS. Catarrh following URTI 2/52 ago is well. O/E ENT NAD chest flu jab given.”

A year later, Mr M saw Dr D and the notes said: “Acute sinusitis chest clear. Prescription for doxycycline 100 mg (8).” Dr D advised Mr M how to take the doxycycline and told him to return if the symptoms did not resolve. Three months later, in June 2006, Mr M attended the surgery again, this time as an emergency, and saw Dr C. Dr C’s notes said: “[SO] penis. Cough. EM-Cough prod of green sputum and sore scratch of L-side of corona of penis? infected. Chest clear. RV PRN.” Dr C prescribed Mr M some antibiotics to cover the possibility of both skin and chest infections, and asked Mr M to return if either problem did not clear up.

Three months later, Mr M was again seen by Dr C as an emergency appointment. Mr M presented with a productive cough and a high temperature, and, on examination, there were signs of chest infection at the base of the right lung. Mr M was prescribed antibiotics for a lower respiratory tract infection. Six months later, in February 2007, Mr M saw Dr C with a rash on his glans penis and also on his left hand. Dr C considered that the rash looked like a bacterial infection rather than a fungal infection. He prescribed an antibacterial steroid cream.

Five months later, Mr M consulted Dr C over the phone. Mr M said he was coughing up phlegm and that his ears felt blocked. With Mr M’s previous presentations with chest infections in mind, Dr C prescribed an antibiotic suitable for respiratory tract infections. Six months later, in January 2008, Mr M suffered a stroke. Upon admission to hospital, diabetes was diagnosed. Mr M remained in hospital for three months and afterwards continued to suffer pain and restrictions to his mobility.

Mr M made a claim against Dr C and Dr D, alleging that over the course of his numerous consultations, they had failed to diagnose, treat and monitor his diabetes; failed to diagnose, treat and monitor his hypercholesterolaemia; and failed to monitor his blood pressure.

Expert opinion

MPS instructed GP expert Dr K to report on breach of duty. Dr K raised no criticisms of the care provided by either Dr C or Dr D, and did not consider either to be in breach of duty. However, Dr K did warn that a lack of a screening programme at the surgery, to screen for diabetes in at-risk patients, posed a litigation risk.

Professor V, a consultant physician, reported on causation for MPS. He said that had the diabetes been diagnosed and controlled, together with treatment of his blood pressure and cholesterol, on the balance of probabilities Mr M’s stroke would have been prevented or, at least, delayed for a few years. Professor V deferred to Dr K’s view that there had been no breach in the duty of care.

Due to supportive expert evidence, MPS resolved to defend the case; Mr M’s legal team discontinued the claim and MPS was able to recover some of its costs.

Learning points

■ The NICE guidelines Preventing Type 2 Diabetes: Risk Identification and Interventions for Individuals at High Risk (2012) are aimed at identifying people at a potential high risk of developing the condition; assessing their individual risk with testing; and, if necessary, offering lifestyle advice (such as advice on diet and exercise), to help prevent the condition in people who are at high risk. The guidelines are available at www.nice.org.uk/guidance/PH38

■ It is important to listen to patients who reattend with recurring problems. Doctors must not let an element of “crying wolf” blind their judgment. Maintain an open mind and be willing to revise an initial diagnosis.

■ A long-running scenario such as this one is ideal for discussion at a ‘significant event’ meeting, to identify whether anything could have been done differently at each stage of Mr M’s treatment.
Mrs B, 40 years old, was referred by her optician to see an ophthalmologist, Mr F, because of concerns about possible raised intraocular pressure and right-sided amblyopia. Mr F confirmed the diagnosis of right-sided amblyopia, found her to have normal intraocular pressure and documented some visual field loss in both eyes, which he considered was performance-related. He advised reassessment in six months but the patient did not attend for follow-up. Mr A attempted to conduct further follow-up consultations on a number of occasions but Mrs B failed to attend.

Ten years later Mrs B was admitted to hospital with smoke inhalation after an accidental house fire. Her only significant past medical history was a hysterectomy for menstrual disturbance some years previously. The medical consultant on call was an endocrinologist, Dr Y, and she was discharged after two days under his care.

A year later she was seen by consultant gastroenterologist, Dr Z, with hepatomegaly due to alcoholic hepatitis. Soon after, Mrs B was admitted under Dr Z’s care after taking an overdose of chlordiazepoxide. A junior doctor commented in the notes that she had “noticed a change in her appearance” that was “interesting, but not classically like acromegaly” and recommended further investigation. Dr Z had no recollection of hearing such comments and no further investigations were carried out.

Over three years later a brain MRI scan was carried out to investigate mild neurological symptoms and memory impairment following a fall. The MRI scan showed an abnormality in the pituitary gland and a subsequent pituitary MRI scan showed a pituitary macroadenoma measuring 1.5cm. Mrs B was found to have a hoarse voice caused by oedematous vocal cords, and a large tongue, nose and hands. Her prolactin level was elevated and a diagnosis of acromegaly was made. Mrs B underwent uncomplicated transphenoidal surgery to remove the pituitary tumour.

Following surgery Mrs B had numerous medical problems caused by late stage acromegaly and other problems related to the hormonal disturbances brought on by removal of the pituitary gland. An MRI scan the following year showed no signs of tumour recurrence.

Mrs B brought a claim against Mr F, Dr Y and Dr Z, alleging that on three occasions opportunities to diagnose her pituitary tumour were missed.

Expert opinion
Most of Mrs B’s medical problems were the direct effect of undiagnosed acromegaly.

The acromegaly could also have contributed to depression, consequent alcoholism and memory loss. The menstrual disturbance may have been due to the hyperprolactinaemia. Early diagnosis and treatment would have given Mrs B a substantially better quality of life.

The claimant’s expert considered that Mr F, Dr Y and Dr Z had “missed opportunities” for making the diagnosis. Significantly, a consultant endocrinologist examined Mrs B when she was admitted with smoke inhalation. The expert commented that it is not unreasonable to expect an endocrinologist to detect the clinical signs of acromegaly during a routine clinical examination.

However, experts instructed by MPS were supportive of the care provided by the doctors. The physical changes of acromegaly are slow to develop and the diagnosis is notoriously difficult to make in the early stages. Mrs B’s alcoholism could also have contributed to the changes in her facial appearance, making the acromegalic features more difficult to pick up.

MPS issued a robust defence to the allegations. Eventually, Mrs B discontinued her claim.

AK
Ms E, a 29-year-old mother, had suffered with ongoing low back pain since the birth of her second child two years ago, which had failed to improve with physiotherapy. She was assessed in orthopaedic outpatients and diagnosed with an L5 disc prolapse and listed for microdiscectomy.

A week after her orthopaedic consultation, she called her local GP surgery and spoke to Dr A, complaining that she was still in pain, and was unable to come down to the surgery to be seen. Dr A noted she was waiting for an operation and gave further analgesia and muscle relaxants.

The following day, Ms E called the out-of-hours service reporting ongoing pain, despite taking the analgesia prescribed by her GP. She also mentioned numbness in her left leg. The triage nurse she spoke to advised her to try an anti-inflammatory and to seek further advice if her symptoms worsened or if she continued to be worried.

Ms E continued to have symptoms so booked an appointment to see Dr A, and was seen three days later. Her pain was ongoing and she had now developed urinary symptoms; Dr A added in naproxen and started antibiotics for a suspected UTI.

The prescribed medication made no difference to her symptoms, and the following evening Ms E presented to her local emergency department, and was diagnosed with cauda equina syndrome. She was transferred to the care of the neurosurgeons and had an urgent MRI. She underwent an L4 laminectomy the following afternoon, but was left with irreversible disturbance of bladder and bowel function and a persisting numbness in both the left leg and the perineal region.

Ms E pursued a claim against Dr A, alleging that he had failed to warn her about the seriousness of red flag symptoms in his first two consultations with her. She also claimed that he had failed to carry out any clinical assessment or suspect cauda equina syndrome and refer appropriately when she had presented at the surgery.

Expert opinion
MPS experts reviewed Dr A’s case notes. The GP expert felt that Dr A had not breached his duty in his initial telephone consultation by failing to warn Ms E about red flag symptoms, on the basis that she was under the care of the orthopaedic team and it was reasonable to assume that they had advised her about cauda equina syndrome and its symptoms. However, his subsequent consultations were viewed as substandard. His note-taking was poor and he failed to document any enquiry about red flag symptoms when the patient presented with urinary symptoms on a background of back pain. Dr A conceded that his usual practice was to document a lack of red flag symptoms if he asks about them and, therefore, it was likely he did not ask and that his diagnosis of a UTI would be difficult to defend.

The neurosurgical expert felt that the onset of cauda equina began with the urinary disturbance, which Ms E consulted Dr A about, and that an urgent referral for surgery within 48 hours of the onset of symptoms would have resulted in a more favourable outcome. He stated that the claimant was likely to have been left with residual low backache without bladder and bowel symptoms or neurological symptoms, and that Dr A’s failure to diagnose cauda equina syndrome led to a significantly less favourable outcome for Ms E.

The claim was settled for a high sum.

Learning points
- As always, good note-keeping is essential – not only for patient care, but when defending a claim. When assessing any patient, negative findings should be routinely documented, and in cases of back pain, repeated examination is often necessary to ensure there are no developing or progressing neurological symptoms.
- Cauda equina syndrome comes up repeatedly in Casebook. Be wary of patients who re-present with ongoing pain and never forget to ask about red flag symptoms (see useful links). In the setting of acute back pain, bowel and bladder symptoms should always prompt careful consideration of a neurological cause.
- It is easy to be reassured when a patient has seen a specialist and is awaiting further treatment, but symptoms can change, and an enquiry should be made about any deterioration in each new contact with the patient.

USEFUL LINKS
www.sheffieldbackpain.com/professional-resources/learning/in-detail/red-flags-in-back-pain
Ms S, a 44-year-old shop assistant, was seven weeks pregnant. She didn’t feel able to continue with the pregnancy and booked an appointment at a clinic for a termination of pregnancy (TOP).

At the clinic, Ms S was seen by Dr F where a full history was taken – Ms S mentioned she had had one miscarriage – before tests were carried out. A pregnancy test proved positive, but an ultrasound scan showed no evidence of a gestation sac. Ms S was treated with mifepristone orally, followed by misoprostol (inserted vaginally) several hours later. Later that day, Ms S was discharged and given a post-treatment leaflet for reference. She was advised to contact the clinic 48 hours later to discuss her treatment, though she did not do so. She assumed that the termination had occurred by the next day.

Three weeks later, Ms S woke in extreme pain and was taken by ambulance to the local Emergency Department (ED). Here, it was discovered that Ms S had an ectopic pregnancy, which had ruptured. As a result, her left fallopian tube had to be removed.

Ms S brought a claim against both the clinic and Dr F, stating that she had been unable to conceive since the event, which had exacerbated her pre-existing depressive disorder. Ms S alleged that Dr F was negligent in failing to investigate the fact that no gestation sac could be seen on the scan prior to performing early medical abortion. She also alleged Dr F was negligent in failing to consider the possibility of ectopic pregnancy and refer her to hospital for further investigation.

Expert opinion
The clinic admitted liability to Ms S at the complaints stage, without contacting Dr F or seeking his opinion. MPS sought expert opinion on behalf of Dr F, which concluded Dr F’s actions were likely to have caused, or materially contributed to, Ms S suffering the loss of her left fallopian tube with some consequent pain and suffering.

However, expert opinion maintained that the loss of one fallopian tube does not necessarily prevent conception, as the probability of pregnancy is not substantially reduced. GP records confirmed that Ms S had been trying to conceive for 18 months and she was still ovulating. Her inability to conceive would at least partly be due to her age (44). Dr F’s actions did not necessarily cause Ms S’s infertility.

GP records indicated that Ms S had an extremely complex, long-standing psychiatric history. She had been taking antidepressants for more than ten years, and had been diagnosed with a mild form of bipolar disorder three years previously. Expert opinion suggested that Dr F’s breach of duty in his actions may have exacerbated Ms S’s long-standing psychiatric condition.

The claim was therefore settled for a moderate sum.

SW
Transfusion confusion

Mrs Y, 38, was admitted to hospital under the care of consultant Dr F for treatment of anaemia due to excessive menstrual bleeding. A sample of her blood was taken for grouping and cross-matching, for the purpose of a blood transfusion; a pack of compatible A-positive donor blood was sent to the ward for this purpose.

After the transfusion began, Mrs Y asked about the blood grouping, telling the nurse that she thought she might be A-negative. The nurse immediately stopped the transfusion and reported this to the laboratory technician – by which time, three to four drops of blood had already been transfused. However, the technician replied that the cross-matching was compatible, and advised that the transfusion should continue while he rechecked the cross-matching.

A short time later, the technician informed the nurse that Mrs Y was in fact A-negative and that the transfusion should stop; by this time, another six to seven drops of blood had been transfused. A blood sample was taken from Mrs Y and she was immediately administered dextrose saline and hydrocortisone intravenously.

Upon clinical examination and observation, Mrs Y’s condition was normal. Both the pre and post-transfusion blood samples had been tested for haemolysis and antigen-antibody reaction (Coomb’s test), and both tests had shown as negative for any reaction. A day later, Mrs Y was referred to a consultant obstetrician and gynaecologist for a full review of her menorrhagia, and a vial of anti-D was administered to Mrs Y. The following day, Mrs Y was discharged from hospital.

Mrs Y attended the hospital two weeks later where her condition was found to have improved – her haemoglobin level had increased, she was feeling less tired and there were no more palpitations. Mrs Y was asked to attend a further follow-up a month later, but did not attend. She made a claim against both Dr F and the hospital for the errors in her blood transfusion, alleging pain and suffering, and emotional stress and psychiatric injury.

Expert opinion

Although there had been a clear breach of duty in the error made during the blood transfusion, the experts for both MPS and Mrs Y disagreed over causation. Although Mrs Y had suffered no adverse reactions as a result of the transfusion, and had been administered with the necessary remedial measures, she alleged psychiatric injury; the experts instructed by Mrs Y’s legal team stated that she was indeed suffering from major depressive disorder with psychosis, as a result of the erroneous transfusion.

The expert instructed by MPS, a consultant psychiatrist, said that the 17-month period between the blood transfusion and the alleged diagnosis of major depressive disorder was rather prolonged for a connection to be drawn between the two incidents.

MPS also argued there was no liability against Dr F in the claim, stating that although he ordered the blood transfusion and had overall responsibility for the care of Mrs Y, he could not be held accountable for the mistake of the hospital’s laboratory technician.

The allegations against Dr F were subsequently dropped and the blood transfusion service accepted full liability for the incident and Mrs Y’s psychiatric injury, settling the case for a low sum.

Learning points

- Being open about errors following an adverse event is important.
- Listen carefully to the history given by the patient, and don’t hesitate to query a course of treatment even after it has started.
Eyes of the storm

Mr Q, 40 years old, consulted Miss A, a consultant ophthalmologist, with lesions affecting his eyelids. Mr Q’s complex medical history included antiphospholipid syndrome and his drug therapy included anticoagulant and antiplatelet agents, oral corticosteroids and ocular surface lubricants.

Miss A documented lesions on the left upper and lower eyelid margins resembling papillomas. No corneal or tear film abnormality was noted. She advised upper and lower full thickness wedge excision of the lesions under general anaesthesia. Consent was obtained and Mr Q was warned of the risks of bruising, infection, scarring and revision surgery. The surgery was performed a month later and was uncomplicated.

Mr Q reported severe pain in the eye shortly following surgery. Review the next day identified a small central corneal abrasion and two lashes on the lower lid in contact with the cornea. The corneal abrasion was fully healed on the fourth postoperative day and the lid sutures were removed. Ten days postoperatively there was complete dehiscence of the lower lid wound that was repaired under local anaesthesia. Subsequent eye examinations revealed persistent punctate corneal erosions affecting the lower cornea. Mr Q also experienced painful recurrent corneal erosions and a bandage contact lens did not help to alleviate the pain. Over the months that followed, Mr Q continued to experience episodic pain in the left eye despite regular topical therapy. Two years after the initial surgery, worsening symptoms prompted epithelial debridement, stromal puncture and placement of a bandage contact lens but the discomfort persisted.

A subsequent entry in Miss A’s private notes, noted a notch in the centre of the upper eyelid and a note that further surgery may be needed. Her letter to the GP made reference to ocular dryness causing discomfort.

On 24 August 2010, Mr Q saw Mr B, another consultant ophthalmologist, on account of increasing pain in the left eye. He noted a central corneal opacity reducing vision to 6/12 and an overlying area of epithelial loss. Mr B felt the lid notching with central corneal exposure and a deficient tear film were contributing to his corneal problem and referred Mr Q to oculoplastic surgeon, Mr C, for further management.

Mr Q was seen by Mr C in November 2010, who noted a noticeable notch of the upper lid and a subtle notch affecting the lower lid with corneal exposure. He advised surgical correction of the upper lid notch under general anaesthesia.

Mr Q made a claim against Miss A. He alleged that Miss A failed to carry out the first operation correctly, failed to provide adequate aftercare, failed to inform Mr Q of the notches on his eyelids caused by the removal of the warts, and failed to make a proper or adequate examination of Mr Q.

Expert opinion

The expert ophthalmologist was critical of Miss A’s operative technique and aftercare. He also said that during the initial consultation Miss A failed to enquire about dry eye and diseases that can be associated with this. The expert was further critical that Miss A failed to complete consent forms adequately.

The expert believed that a shave excision would have been more appropriate and has fewer risks, so was further critical of the wedge excision of both the upper and lower eyelids, as it was unnecessary and undertaken without careful counselling of the claimant with regard to the effect on the ocular surface disease. The claim was settled for a moderate sum.

AK

Learning points

- Careful discussion with the patient of the treatment options and potential complications is important, as is a record of the conversation, decision and consent process. This should include a discussion about the possible interaction(s) with any pre-existing condition.
Mrs H, a 28-year-old massage therapist, was admitted to hospital for laparoscopic tubal ligation. Dr T was the anaesthetist for this surgery.

Before the surgery, Dr T placed a cannula in Mrs H’s right wrist and, after surgery, a patient-controlled analgesia (PCA) was commenced through this cannula. According to the cannula chart, a cannula was also placed in Mrs H’s left hand, although this was not in place following surgery. Mrs H also recalled a cannula site in the left forearm and a further cannula site in the right forearm following surgery, although these were not recorded on the cannula chart.

Records show that a day later, slight blood staining was present at the cannula site in Mrs H’s right wrist. The following day, Mrs H reported the site of the cannula being painful so it was removed. No further problems were recorded and Mrs H left hospital a day later.

A month later, Mrs H attended the hospital in relation to umbilical wound oozing; she also complained of altered sensation in her left thumb and for this was referred back to Dr T. He noted that Mrs H had had two cannula sites over her left arm where she had developed a haematoma and now had paraesthesia over her distal thumb; Dr T referred Mrs H to Dr Q, a consultant orthopaedic surgeon.

Dr Q noted neurapraxic damage to the dorsal branch of the radial nerve, and advised desensitisation exercises. A month later, improvement was noted and Dr Q noted the hyperaesthesia had settled. He further noted that there was 40% function in the dorsal branch of the radial nerve and that there was a reasonable chance that this would recover, at least to a degree.

Mrs H made a claim against Dr T for alleged substandard technique during cannulation, also alleging poor record-keeping in his failure to record two cannula insertions on the cannula chart. Mrs H claimed that when the needle was inserted into her vein, poor technique was employed, resulting in the bevel of the needle cutting through nerves and creating neuromas, causing neurological damage. Mrs H also claimed that the sensory injury had left her disabled, in that she found it extremely difficult to carry out her job.

**Expert opinion**

MPS obtained an expert report on breach a short time after the letter of claim was received. Professor I, an expert in anaesthesia and intensive care, produced the report and was robust in his defence of Dr T. Professor I stated that he considered Dr T’s technique to be entirely appropriate and that he could not see any evidence of substandard care. He considered it likely that the nerve damage did arise from the unsuccessful cannulation but did not in any way reflect bad technique. Professor I also found Dr T’s record-keeping to be appropriate, as he would not expect failed cannulations to be documented.

The MPS legal team was aware that Mrs H’s own legal advisers were still to obtain their report on breach of duty, and considered that issuing them with a quick response that was supportive of Dr T would dissuade them from pursuing the matter. MPS served its expert evidence along with the letter of response a short time after the letter of claim was received.

Mrs H withdrew her allegations and the claim was discontinued.

**Learning points**

- Good record-keeping is essential for continuity of care – therefore, the medical records you keep should provide a window on the clinical judgment being exercised at the time.
- When inserting a cannula, consider using the patient’s non-dominant hand if possible.
- It is helpful to write a report soon after an adverse event, because of the lengthy time that can sometimes pass before a related complaint or claim arises.
- This case is a reminder that not every adverse outcome is negligent. MPS’s robust approach meant the case was dropped and the allegation withdrawn very quickly.
Mr O was a 24-year-old man who had just enjoyed a holiday overseas. On the return journey he started vomiting. The nausea and vomiting continued after he arrived home and he began to lose weight because of it. When his symptoms did not abate he made an appointment with his GP.

His GP documented a four-week history of nausea and vomiting and, after reviewing normal blood tests, referred him to gastroenterology. The gastroenterologist wrote back concluding that he had found no significant pathology on endoscopy or ultrasound, and that he thought that anxiety was contributing to his ongoing symptoms. Irritable bowel syndrome was also considered to be a factor.

Mr O asked his GP for a private referral to neurology, which he agreed to. The neurologist arranged an MRI scan, which was normal, and felt that Mr O was suffering from a significant depressive illness from which he had partly recovered. Mr O did not agree with this diagnosis and felt that his symptoms had a physical rather than a psychological cause. He did, however, agree to see a psychiatrist, who concurred that his symptoms were due to anxiety and depression. He prescribed venlafaxine and arranged CBT.

Mr O was struggling with fatigue in addition to the nausea and was not coping at work, so he visited his GP again. His GP referred him to a specialist in chronic fatigue who wondered if he may be suffering with post-viral fatigue syndrome.

Mr O was convinced that there was a physical cause for his symptoms and demanded a second neurological opinion. This was sought but nothing abnormal was found on examination, repeat MRI or lumbar puncture. He had mentioned some dizziness and had an audiometric assessment showing abnormal canal paresis to the right. The neurologist concluded in a letter to the GP that “the only abnormality found in spite of extensive investigations was a mild peripheral vestibular disorder”. The letter detailed that he had been seen by a physiotherapist who had instructed him in Cawthorne-Cooksey exercises and that he had been asked to continue these at home.

Despite doing the vestibular rehabilitation exercises at home, Mr O failed to improve. He still felt weak and light-headed and had moved back in with his parents who were worried about him. They made him another appointment with his GP who referred him for an ENT opinion. The ENT consultant took a detailed history and noted the absence of tinnitus, vertigo or deafness. She could not find anything abnormal on examination and thought that a labyrinthine
problem was unlikely to be the problem. She repeated the balance tests, which were normal.

Years went by and Mr O became very focused on his symptoms, feeling sure that a diagnosis had been missed. Opinions were sought from an endocrinologist, a professor in tropical diseases and a private GP. Nothing abnormal could be found and no firm diagnosis was made. A neurootologist thought that his symptoms were due to a combination of “anxiety with an associated breathing pattern disorder, a migraine variant and physical de-conditioning”. A joint neurootology/psychiatry clinic concluded that it was “a confusing story with nebulous symptoms but it was probably a variant of fatigue disorder with a depressive element and derealisation”.

Mr O was very frustrated at the lack of diagnosis or improvement in his symptoms. He felt that the sole cause of his symptoms was a peripheral vestibular disorder. He made a claim against his GP, alleging that he had failed to make the diagnosis and that he had also failed to arrange vestibular rehabilitation.

MPS instructed expert opinion from a GP and a professor in audiovestibular medicine. The experts felt that Mr O’s GP had not been at fault. The professor in audiovestibular medicine was sceptical regarding the diagnosis of a vestibular disorder. He noted that repeat audiograms and tympanograms had been normal and felt there was no robust evidence that he had a peripheral vestibular disorder. He stated that there was no clinical history suggestive of vestibular pathology at the onset of Mr O’s illness. He also commented that there had been no consensus amongst various specialists as to the true cause of Mr O’s symptoms and that to claim that a peripheral vestibular disorder was the sole cause was an overly simplistic view.

The GP expert noted that the neurologist’s letter to the GP referred to Mr O having been instructed by the physiotherapists in Cawthorne-Cooksey exercises. These are vestibular rehabilitation exercises so it was wrong to say that there had been a failure to arrange the exercises or that this was the responsibility of the GP. The expert explained that GPs are not trained to instruct a patient in vestibular rehabilitation exercises and are not likely to have direct access to specialist physiotherapists who could arrange these. The expert noted that a large number of specialists saw Mr O over a prolonged period, all of whom failed to reach a consensus on the cause of his symptoms. The expert’s view was that the treatment provided was reasonable and that the standard that the claimant sought to apply was too high.

Mr O withdrew his claim before it went to court.

Learning points
- The defence of this claim was helped by the contents of the correspondence to and from specialists, which were relied upon to disprove some of the allegations made. It is important to take the time to write comprehensive referral letters and to read letters from specialists carefully. Correspondence is an important part of the medical record, as well as being important communication between clinicians.
- Mr O clearly had a very difficult time. There had been a protracted period of time with no clear diagnosis. However, in the circumstances of this case, this did not equate to negligence.
- This case highlights the standard doctors must meet in order to refute negligence claims – that of a responsible body of their peers (GPs in this case), rather than a specialist in the condition in question.
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

Wrong drug, no negligence

I enjoyed reading your article “Wrong drug, no negligence” in the May 2014 edition of Casebook. As a trainee anaesthetist I can remember making exactly the same mistake during my first month of training, ie, administering a full dose of co-amoxiclav to a patient with penicillin allergy whilst under anaesthesia. Fortunately the patient suffered no ill-effects whatsoever, and postoperatively she admitted she was sceptical about whether she had a true allergy or not, and was glad that we had inadvertently found out.

Drug administration errors in anaesthesia are common, with some studies suggesting one error in every 133 anaesthetics. In your article you state the anaesthetist may have been distracted by the use of the total intravenous anaesthesia technique. This is probably not the only factor, as observational studies have shown that on average an anaesthetist is distracted once every four to five minutes during a routine list.

Thus the propensity for making errors is huge and it would seem only a matter of time before an error leads to a catastrophe that makes headline news. On wards and on intensive care units, nurses have long ago moved to using a two-person check system prior to the administration of harmful medication. Since anaesthetists have access to some of the most dangerous medications in the whole hospital, how vulnerable are we to litigation claims, given that we still use a single-person check? Should we be pushing to implement a two-person check as well, to protect both us and our patients?

Dr Nikhail Murti Balani
ST4 Anaesthesia and Intensive Care Medicine
Guy’s and St Thomas’ NHS Trust, London

Response

Thank you for your letter about this case, and for sharing your own experiences. Your suggestion about the introduction of two-person checking certainly seems to make sense, and steps that may reduce avoidable errors should be encouraged.

Perhaps a discussion with your trust is worthwhile, to consider introducing or trialling such measures.

Photo criticism

I just wanted to let you know that I find Casebook really helpful, well-presented and useful (if a little frightening at times!). I also wanted to make a small criticism about some of the photos that let down the otherwise professional approach.

I am a bit behind on reading them but a case in point was the Jan 2014 edition (volume 22), page 14, which showed an otoscope being held completely wrongly, in the wrong hand and without an earpiece. I suspect

Manslaughter

I enjoy Casebook, which reminds us that there are always new errors, and that old errors are easily repeated.

You kindly refer on page 11 (“Medicine and manslaughter”, Casebook UK only) to the review that Sarah McDowell and I wrote of medical manslaughter between 1795 and 2005. But you then state that “other widely-reported cases include” and cite Mulhem (2003) and Walker (2004). This might unintentionally suggest that we omitted these from our review. They are, respectively, cases 7 and 14.

Incidentally, the trend towards long prison sentences for surgeons started with R v Garg, which seems to have attracted little attention, and the verdict in the Sellu case was reached in spite of the fact that the judge was reported to have said that the patient might have died even if he had received the proper treatment promptly.

Professor Robin Ferner, Consultant Physician and Clinical Pharmacologist, West Midlands Centre for Adverse Drug Reactions, City Hospital, Birmingham, UK

Response

Thank-you for your letter about the case report “Wrong drug, no negligence” in the last issue of Casebook.

The terminology used in the case may have inadvertently led to some confusion. From a legal perspective, in order for a case to be established in negligence, the claimant has to establish certain key elements: that the defendant owed the claimant a duty of care, that there was a breach of that duty of care, and that the breach of duty was the cause of the loss or harm complained of.
any lay person would not notice but it would be worthwhile getting a doctor to check the photos before publication to avoid similar errors, which look terrible to doctors. I hope you understand that I am making the point to improve the journal rather than be overly critical.

Dr Samantha Dunnet
GP, UK

Response
Thank-you for your letter about the photograph on page 14 of the January 2014 edition of Casebook. The pictures used in Casebook are not accurate representations of clinical situations, but rather to illustrate the general theme of the case report or article. We do have a notice to this effect at the foot of the Casebook contents page, although the font is rather small and might benefit from being a little more prominent.

The content of each issue of Casebook is reviewed in its final form in our layout board meetings, and these always include a number of doctors from a variety of clinical backgrounds. Whilst no comment was passed about the use of the picture in question, your comments will be a timely reminder for the board members.

The accused
I was shocked by the account of a patient making a spurious claim against the GP in your recent edition of Casebook. The story left me feeling quite angry at the fact that the patient in the matter was able to simply shrug off an apparent malicious claim against the GP without any consequence. I can completely understand the professional reluctance to do so, but would there be an argument in this case to pursue a civil claim of libel, given the significant impact this claim has had on the doctor both professionally, emotionally and undoubtedly financially?

Dr T Broughton
Consultant Forensic Psychiatrist
Norfolk, UK

Response
Whilst it might seem an attractive proposition to contemplate some form of legal redress in these circumstances, there are a number of significant practical issues to consider.

Firstly, MPS experience is that nearly all complaints of this type are made by genuine complainants who have misunderstood or misinterpreted a clinically appropriate examination carried out in a reasonable and responsible manner.

The second point to consider is that as a matter of public policy, most legal systems provide some form of protection against allegations of defamation for complainants who take their concerns through appropriate channels. This is because otherwise there would be a very chilling effect on the ability of members of the public to raise concerns, particularly where a defendant may be able to access much greater resources than the complainant.

Additionally, in criminal cases, the decision to prosecute rests with the prosecuting authority rather than the complainant. In England and Wales, for example, this rests with the Crown Prosecution Service, who will weigh up the issues before deciding to proceed with a case. This includes assessing whether there is sufficient evidence, whether the evidence is reliable and credible, and whether a prosecution is in the public interest.

Finally, even if there were no other hurdles, and it was possible to consider an action in an individual case, it would be an unattractive case, which would be liable to attract adverse publicity, and in the event of success, given the financial position of most complainants, a doctor (or their MOD) had they agreed to undertake the matter would be unlikely to recover their costs, let alone any damages actually awarded.

Realistically speaking therefore, it is unlikely that we will see cases of this sort being brought.

The accused
The excellent article “The Accused” (Casebook 22(2), May 2014) leaves an obvious question, which would be valuable to consider…

What is MPS’s advice for the doctor when the patient declines the chaperone? Is the doctor at risk if they refuse to proceed with an examination without a chaperone? What should they do, in that event?

Other readers may also wish to know your response – it seems important.

Dr Mark Davis
New Zealand

Response
Thank-you for your letter, which raises a very important issue.

Generally speaking, if a chaperone is declined by the patient, and you don’t want to go ahead without one, you should clearly explain why you would like one to be present. You could also consider referring the patient to a colleague who would be willing to examine without a chaperone. However, the patient’s clinical needs must come first, and any such arrangements should not result in delays that affect the patient’s health.

The discussion about chaperones, together with the outcome, should be recorded in the medical record. If a chaperone is present, record that fact, and their identity. If the patient refuses a chaperone, make a note that the offer was made and declined.

There are often local guidelines or protocols that cover this issue, and members should make sure they are aware of these and follow them.

Readers in New Zealand can access the MPS factsheet on chaperones at the MPS website: www.medicalprotection.org/newzealand/factsheets/chaperones
Reviews

If you would like to suggest an app, website or book for review, or write a review, please email sara.dawson@mps.org.uk

Do No Harm: Stories of Life, Death and Brain Surgery

Henry Marsh, Reviewed by Dr John Gilbey, Core Trainee – Anaesthetics, North Western Deanery, UK

Do No Harm: Stories of Life, Death and Brain Surgery is the memoir of Henry Marsh, a senior consultant neurosurgeon who has previously had his work featured in two television documentaries. In this book he reflects on the events and experiences that have shaped his professional life.

The sentiment of a quote by René Leriche at the start, “Every surgeon carries within himself a small cemetery, where from time to time he goes to pray – a place of bitterness and regret, where he must look for an explanation for his failures”, resonates loudly throughout the book. Difficult decision-making and dealing with mistakes are themes that repeatedly arise. Other topics are also covered including modern medical training, the reality of consent, being ill as a doctor, the modern health service and the meaning of success.

Each chapter presents either clinical cases or other events from Marsh’s life. These are then interspersed with his thoughts on the events. He does mention some success through the book and describes achieving most “when our patients recover completely and forget us completely”. Difficult decision-making and dealing with mistakes is most explicitly demonstrated when recalling a visit to a Catholic nursing home where he finds patients he had previously forgotten and at least one who “I had wrecked”.

The book is written in a way to inform the lay reader of the deepest thoughts of a neurosurgeon. Medical terminology is used throughout, with meanings clearly explained. This is not to say that it does not appeal to a medical audience as simultaneously. The writing style is matter-of-fact without being dry. His stories are moving and in places brutally honest.

Do No Harm certainly gives an insight into the reality of life as a neurosurgeon in a modern hospital. For patients, it provides an insight into the fallibilities and difficulties of being a doctor. For students, it is a must-read if you are considering a career in neurosurgery. For doctors, it is a fantastic example of reflection.

Forks in the Road: A Life In and Out of the NHS

Leslie Turnberg, Reviewed by Dr Behrad Baharlo (Specialty trainee, anaesthetics, Imperial School of Anaesthesia)

Charting the life and times of Lord Leslie Turnberg of Cheadle, this candid and eloquently written autobiography gives the reader insight into some of the most defining events affecting not only the medical profession, but also healthcare in the United Kingdom over the last 40 years. To say that the author bore witness to such events would be understating the active role he clearly executed not only in postgraduate training but also healthcare policy.

Detailing his life from humble beginnings in Lancashire, the former President of the Royal College of Physicians and of MPS takes the reader through his childhood and formative years with humility, which is a consistent theme throughout the book. He charts his many achievements from qualification then into academia, medical politics, the presidency of the RCP and culminating in his nomination as a peer of the realm.

Notably describing his role in the advent of the university department at Salford Hospital “from scratch!” along with its initial shortcomings, as well as comments regarding research (and how not to do it) and the changes in postgraduate medical training of the 1990s, the reader is given a front seat with this account of aspects of the profession that can often seem peculiar if not mysterious. Discussion is made of contemporary issues affecting NHS politics especially pertinent to the New Labour years, and the author is not afraid of casting an opinion or giving fair reflection with the benefit of hindsight.

I found the descriptions around medical training (the eventual establishment of the Academy of Medical Royal Colleges and Postgraduate Medical Education and Training Board) and issues surrounding reform of the NHS of particular interest and found food for thought in aspects concerning financing and NHS interaction with politics and politicians. I couldn’t help feeling that a number of these issues described, including attempts at reform, would have been equally valid when the author commenced his career in the NHS. On matters of NHS reform, financing and political pressures the author clearly had a privileged insight, especially during the term of the Labour government. I would commend the author’s views to anyone interested in such matters. Reflecting his privileged title, the author visits a number of topics of interest that he has spoken about at the House of Lords, and unashamedly bestows opinions ranging from assisted suicide to anonymity in sperm donation. The importance of the author’s Jewish faith is identifiable and his subsequent interest in Middle Eastern politics results in an attempt at summarising and digesting this complex and otherwise problematic issue with numerous good opinions.

The book concludes with a moving tribute to Daniel, the author’s late son, the impact of his passing being vividly and eloquently described, leaving the reader sharing a sense of melancholy if not shedding tears in sympathy with the author’s tragedy.
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