Anatomy of a claim

Step-by-step through a recent case

HOW RELIABLE IS HEALTHCARE?
Tackling the biggest challenge to patient safety: complacency

YOUR MEDICOLEGAL DILEMMAS
Common problems from the MPS advice line

OVER TO YOU
Follow the discussion as readers debate recent cases

BOOK REVIEWS
What pages are being turned this month?
Welcome
Editor-in-Chief Dr Stephanie Bown looks at the key role of the expert and how they can ensure a successful defence.

Common problems
The MPS advice line takes calls on a wide range of queries. Dr Sonya McCullough presents some common dilemmas facing members in Ireland and provides advice and guidance.

How reliable is healthcare?
Dr Dan Cohen looks at one of the greatest challenges facing healthcare: complacency. Dr Cohen provides a case study based on his own experiences, and discusses how the profession can learn from other “high-reliability” organisations.

Anatomy of a claim
The path of a clinical negligence claim is usually a long one – and the outcome can be influenced by numerous factors. MPS solicitor and claims manager Antoinette Coltsmann provides the legal view of a recent MPS case.

From the case files
Dr Sonya McCullough, MPS Medicolegal Adviser, introduces this issue’s round-up of case reports.

From the case files
A dark day for psychiatry?

Anatomy of a claim

From the case files

Every issue...

Welcome

Common problems

How reliable is healthcare?

Anatomy of a claim

From the case files

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MPS has a wealth of resources that provide medicolegal and risk management advice – but did you know they are literally at your fingertips?

Visit the MPS website to access the full range of material that is available to you – and maximise your membership of the world’s leading medical defence organisation.

MPS membership – it all adds up. Visit www.medicalprotection.org
Dr Bown focuses on the role of the expert – and describes how they can be key in successfully defending a case.

I write this having just heard that a claim against a member has today been discontinued by a high profile claimant, two days into trial, after the expert evidence had been heard. Fantastic news for the doctor, and vindication for the defence team of the judgments they have made in steering a long and complex journey to success.

There are many elements involved in building a robust and successful defence but, as any seasoned litigator will tell you, the strength of your expert is pivotal in determining the prospects of success or defeat. This is further illustrated in the case reports on pages 16 and 22.

Selecting the right expert is very important; it’s not about being a friend or advocate for the defendant, nor about being a fierce evangelist espousing heavyweight opinion intended to demolish the opposition. The expert’s role is to provide independent assistance to the court through unbiased and evidence-based opinion in relation to matters within his expertise. And before that, the expert plays a critical role in assisting the lawyers to understand the clinical issues and judgments to inform the advice to the member.

This is not just in relation to clinical negligence claims; we are seeing increasing reliance on experts at inquests and medical council hearings in many countries. MPS regularly runs expert training days around the world, to ensure that tomorrow’s experts will know what to expect, and provide the strength of opinion that underpins excellence in case handling.

Paying strict attention to detail, answering the questions posed, and providing the independent, objective evidence to support the opinion are key to steering towards just outcomes.

Welcome

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

Ms C is a 25-year-old patient at my practice. She is a frequent attender who is rude and aggressive with reception staff but she is not willing to listen to advice, to the extent that I believe the relationship has irretrievably broken down. Today she was shouting at the receptionist before her appointment.

In a word – yes. All doctors are entitled to withdraw their treatment of a patient or refuse to treat a patient. You must, however, follow the ethical standards set out in the Medical Council’s Guide to Professional Conduct and Ethics (2009) (see Sections 8, 9 and 14 for more information). Once you undertake the care of a patient, you still have an ethical duty to continue to care for the patient until alternative arrangements for care are put in place.

Please address correspondence to:
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A two-week-old baby was seen by my partner last month with apparent URI for which he recommended general measures. She was then seen OOH with vomiting and a cough where an antibiotic was prescribed. The next morning she was taken to the Emergency Department but was dead on arrival. The parents now wish for copies of her records. What should I do?

Firstly, remember that your duty of confidentiality to the patient remains after death. If an adult patient wished specific information to remain confidential after death you should respect that wish – though of course that doesn’t apply in this case. You should avoid any disclosure that would compromise the confidentiality of a third party.

If there is a complaint arising after a patient’s death, discuss the relevant information with the family, especially in this case as the patient was a child. If the child held a medical card, the parents are entitled to discuss future management. During the meeting, I realised that her son was covertly recording our conversation. I didn’t say anything to the family at the time, but what should I do?

The first thing to consider in this case is patient confidentiality. You need to confirm that the patient has given her consent to disclosure of information to her family. The Medical Council’s guidance states: “While the concern of the patient’s relatives and close friends is understandable, you must not disclose information to anyone without the patient’s consent.” In this case, Mrs F has given consent to disclose information, as she was happy for her son to be present.

However, a recording of the consultation could be shared elsewhere. Section 32.1 of the Medical Council’s guidance states: “Audio, visual or photographic records of the patient, or relative of a patient, in which that person is identifiable should only be undertaken with their express consent. These recordings should be kept confidential as part of the patient’s record.” Express consent of any family members taking part in the consultation should be obtained prior to the start of any recording. Can you be sure that Mrs F consented to the recording, and that the recording will be kept securely and confidentially afterwards?

As a doctor, you would not be allowed to record any consultation with the patient, except in accordance with section 32 of the Medical Council guidance, where you obtain the prior express consent of the patient. Section 98 of the Postal and Telecommunications Act 1983 clearly makes it an offence to record private conversations without the consent of the individuals involved. Section 13 (3) appears to allow for the recording of telephone calls where either party consents to its recording. Applying this to the scenario of recording a consultation between a doctor and patient, it would appear to allow for the recording with the consent of either the doctor or the patient, but not necessarily both.

The legality of recording private conversations, whether on the telephone or otherwise, has been tested on a limited number of occasions and it would appear that such recordings are permissible in certain circumstances. However, the matter is still quite uncertain and remains to be tested before the Medical Council or the courts. MPS solicitors are of the opinion that the recording of a private medical consultation, particular with the recording undertaken by a third party, would be inadmissible in any such hearing.

There is also your own consent to the recording to take into consideration. Your organisation could consider putting in place a policy concerning the recording of consultations with family members and patients, to ensure that they protect the patient’s rights, but also the rights of clinicians working in the hospital. You may wish to consider a policy prohibiting the recording of any such consultations. This could be incorporated into the terms and conditions of any contractual documentation entered into by the hospital and the patient, with an express provision to be signed by the patient agreeing that any consultation should not be recorded by either the patient themselves, or a family member, or by the treating clinician, unless express consent of the patient has been obtained.
How reliable is healthcare?

Dr Dan Cohen, an international medical director based in the US, looks at the biggest challenge to healthcare safety: complacency

The healthcare industry is defined by continuous change, but continuous change does not necessarily mean continuous improvement. Emerging technologies may provide great promise for advancing our diagnostic and therapeutic options – but with the increasing frequency and complexity of healthcare interventions, so increases the risk of system or personal failures that can harm patients. Through litigation, these failures can harm institutions and careers. It is highly important that healthcare professionals recognise the hazards associated with providing healthcare services and confront the very real challenge of complacency. Whereas we may see harm when it occurs, more often than not we do not see the “near misses” – and because we do not, this feeds our complacency. We are not truly aware of how often something goes wrong! Every day, thousands of patients are harmed or die in modern well-equipped hospitals staffed by highly-trained individuals. Bemused intentions, not necessarily translate to safety. The challenge that remains is to understand how many things can go wrong, when the intentions are to achieve highest quality outcomes and assure patient safety.

Managing danger
High-reliability organisations (HROs) are those that function safely and efficiently in industries that are very dangerous. HROs have established cultures and supporting processes designed to dramatically reduce the likelihood of human error and harm. They recognise that in the interactions between humans and technologies, it is the humans that represent the most substantial sources of risk. Industries commonly considered to portray the attributes of high-reliability include the nuclear power industry, the automotive industry and the aviation industry. In the aviation industry, for example, the astronauts and so well-designed, with redundantly engineered systems, that the risks arise primarily from the system and from human factors are the source of most risks and errors. It has been argued that if the healthcare industry could simply adopt the characteristics and methodologies of HROs, we would move the bars for quality and safety higher. If this is true, then why is there so much inertia in our systems of care; inertia that plagues our improvement strategies? Why have we not solved this problem, when so many solutions abound? Complacency is the pernicious confounder. We do not see the sources of harm, the near misses, and especially do not see ourselves as sources of harm. The defining characteristics of HROs have been summarised by Weick and Sutcliffe (2007) and, in abbreviated format, are portrayed below:

1. Sensitivity to operations – a constant awareness by leaders and staff to risks and prevention, a mindfulness of the complexities of systems in which they work and on which they rely.
2. Reluctance to simplify – avoidance of overly simplistic explanations for risks of failures and a commitment to delve deeply to understand sources of risk and vulnerabilities within systems.
3. Preoccupation with failure – a focus on predicting and eliminating catastrophic failures rather than reacting to them; a “collective mindfulness” that things will go wrong and that “near misses” are opportunities to learn.
4. Deferece to expertise – leaders and supervisors listening to and seeking advice from line staff that know how processes really work and where risks arise.
5. Resilience – leaders and staff trained and prepared to respond when systems fail and that work effectively as teams to overcome urgent challenges.

A natural fit
Healthcare systems entail many unique factors that are at variance with HRO industries. Even though some HRO characteristics have been adopted or adapted by healthcare systems, such as the use of checklists, the unique factors of healthcare pose a challenge. These are the increased frequency of human-to-human interactions and associated communication challenges, and the complex vagaries of our diagnostic processes.

Healthcare professionals are not engineers or pilots and our way of doing business is fraught with uncertainty and variability. Many of our diagnostic and therapeutic interventions are based on insufficient evidence that we do not see the “near misses” – which increases risks and the potential for harm. Most importantly, patients are not aeroplanes. They have mobilities and complex medical conditions, fears, belief systems, social and economic confounders, intellectual and cognitive challenges, and language and fluency issues.

Because best and safest outcomes are dependent on patient engagement, patients should be viewed as components of the healthcare system, not passive recipients of healthcare services (like passengers sitting in an aeroplane). This perspective is an integral component in a high-reliability system that is focused on avoiding risk.

Dr Dan Cohen is International Medical Director at Datix Inc. In his role as consultant in patient safety and risk management, Dr Cohen advises global thought leaders and speaks at conferences worldwide on improving patient outcomes.

A case study
Recently, I was admitted to a hospital for overnight observation after I had a calf muscle tear in a fluke accident. I was at risk of developing a compartment syndrome that could have been very serious. The people who cared for me were kind, sensitive and caring. However, they were complacent and did not recognise their liabilities. Below is the litany of concerns I noted during my care:

1. I was misidentified and given another patient’s ID wristband, thus increasing my risks of any insurance details to the ED (Emergency Department) admissions clerk. The wristband did not include information that would identify this discrepancy, and only when a nurse tried to enter orders into the system was the discrepancy detected. This was not corrected for 30 minutes, delaying my evaluation even as my leg was becoming increasingly numb and purple. I was pointing this out to the nurse; there was urgency here, but…
2. I was seen by several different nurses, technicians and physicians, and it was the exception rather than the rule that these individuals washed their hands before touching me or touching equipment in the room, even after I jokingly pointed this out.
3. The x-ray CT scan technician did not offer me any gauze to cover the area, even though he was scanning my entire right leg, and I did not think to ask.
4. When I was admitted, unable to ambulate without assistance, the nurse did not perform a formal risk assessment. I clearly was at very high risk of a fall and, though the nurse was very pleasant, he did not conduct a formal risk assessment until morning rounds, and I had to use the toilet twice during the night. I managed, should have called for help but did not, and thus potentially became part of my own problem.
5. Finally, at discharge, no one ensured about inadequate gait training or what high risks related to my home situation. I was to be provided a walker, as I was not to bear weight on my injured leg. Though I was assured that the walker would be delivered on the afternoon of my discharge, it did not arrive until the evening of the following day, significantly increasing my risk of a fall at home.

In each of these instances, complacency was the pernicious confounder, including my own complacency. Fortunately, I did not encounter any real harm, only inconvenience; but I could have been seriously harmed. I encountered many ‘near misses’ that no-one even seemed to be aware of. What I experienced is not unique to any particular hospital; rather it is the common experience in hospitals worldwide.

In my view, if a healthcare system is a forest of complexities then a giant coastal redwood of complacency towers high above the forest floor, a floor covered with the moss of ‘near misses’. One colossal tree standing high above the forest floor: it’s not all that complicated.

REFERENCES
THE CASE

Mr P, a high-earning, self-employed management consultant, attended his GP surgery on 10 July 2010 with flu-like symptoms and saw Dr A. He diagnosed a chest infection and prescribed antibiotics; on 15 July Mr P returned with similar symptoms – Dr A referred Mr P for a chest x-ray and prescribed further antibiotics. The x-ray was clear and that he could continue to take his medication.

Mr P felt unwell and collapsed due to a loss of sensation in his legs. He was admitted to hospital.

At the recommendation of the hospital consultant microbiologist, Mr P’s antibiotics were withheld and the following day he was transferred to another hospital, where an MRI scan was performed. This revealed infective discitis at T5/T6. Mr P underwent an emergency laminectomy with open biopsy, which would have led to hospital admission and antibiotic therapy, avoiding Mr P’s paraplegia.

THE LIABILITY

Our assessment, Drs B and C had no culpability. Dr B simply reported the chest x-ray was clear. Dr C undertook a very detailed and thorough assessment and this was recorded in Mr P’s contemporaneous GP notes. Indeed Dr A was heavily reliant on Dr C’s very detailed consultation notes to assist him in defending his assessment of Mr P’s back pain.

Proceedings were discontinued against Drs B and C shortly before trial.

Mr P alleged Dr A was in breach of duty for failing on 15 July to arrange blood tests in conjunction with a chest x-ray. He considered “blood tests were mandatory”. If the court accepted Dr A’s factual evidence, Dr D agreed Dr A’s management was “entirely appropriate”. If, however, the court accepted Mr P’s factual evidence, Dr D agreed this should have triggered a neurological examination and, if Mr P had no neurological symptoms, this should have prompted referral within one to two weeks – either for an MRI scan or “more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan”.

THE EVIDENCE

For any claim for clinical negligence to be successful, a claimant needs to prove that, firstly, there has been a breach of the duty of care owed by the doctor or doctors; secondly, a claimant must succeed on causation, ie, that this breach of duty caused or contributed to the injury, loss or damage suffered, and that but for the negligence the claimant’s loss would not have occurred.

Before trial, both parties served evidence of breach and causation, in the form of reports from expert witnesses. For Drs A, B and C, a GP (Dr D) reported on breach and a consultant microbiologist (Dr E), consultant neurologist (Mr F) and consultant neuroradiologist (Dr G) reported on causation.

Mr P served evidence on breach of duty from a GP (Dr I) and causation evidence from a consultant neurological and spinal surgeon (Mr J), and a consultant microbiologist (Dr K). Mr P was not relying on neuroradiology evidence.

THE CLAIM

Mr P made a clinical negligence claim against Drs A, B and C. He alleged that all three doctors failed to suspect a spinal infection and refer Mr P to an orthopaedic surgeon, who would have referred him for an MRI scan. It was alleged that the MRI scan would have identified infective discitis, which would have led to hospital admission and antibiotic therapy, avoiding Mr P’s paraplegia.

Having obtained supportive expert evidence, MPS decided to defend the claim and the case went to trial.

BREACH

Consultation: 15 July

A vigorously denied he was informed by Mr P that his back pain was worse, preventing him from lying flat on his back and disturbing his sleep. Dr I considered Dr A in breach of duty for failing to arrange blood tests in conjunction with a chest x-ray. He considered “blood tests were mandatory”.

If the court accepted Dr A’s factual evidence, Dr D agreed Dr A’s management was “entirely appropriate”. If, however, the court accepted Mr P’s factual evidence, Dr D agreed this should have triggered a neurological examination and, if Mr P had no neurological symptoms, this should have prompted referral within one to two weeks – either for an MRI scan or “more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan”.

Consultation: 4 August

Mr P’s GP expert noted that this was the fifth consultation regarding the same illness without a diagnosis. Referral to a physiotherapist without a further examination was “inadequate management”. He did not consider the appropriate response was to arrange a series of urgent blood tests and once the results were available (which he surmised would have been abnormal), Dr A should have arranged an urgent referral to an orthopaedic specialist/A&E or MRI scan within 24 hours.

Dr A’s GP expert considered that on 4 August, Mr P was not displaying any symptoms or signs that would have alerted a GP to possible infective discitis developing. He considered referral within one to two weeks, based on Mr P’s factual evidence, either for an MRI scan or orthopaedic or neurosurgical specialist – who may have requested an MRI scan – appropriate management. He did not consider Dr A in breach of duty based on his factual evidence.
**The Trial**

During Mr P’s cross-examination at trial it was clear he had no real recollection of the different consultations and could not, with any real accuracy, confirm what he told the GPs regarding his symptoms and, in particular, his back pain. He was, therefore, an unreliable witness. Dr I was discredited as not having been in practice for more than ten years. Dr I also accepted, during his cross-examination, that if all the doctors’ factual evidence was accepted for each consultation he would not criticise their practice.

**Dr A’s, B and C came across as honest, reliable and caring witnesses (Drs B and C now appearing as witnesses rather than defendants).**

All confirmed that at no stage were they alerted to Mr P’s alleged extensive back pain. They were treating flu-like symptoms affecting the chest, and back pain was secondary and caused by the chest infection and coughing. It was not until 4 August that Mr P complained of back pain, which was now the primary need for the consultation as his flu/chest infection symptoms had resolved. Dr A examined Mr P; he concluded it was muscular and referred Mr P to a physiotherapist.

**Casebook**

Introduces this issue’s round-up of case reports

Dr Sonya McCullough, MPS Medicolegal Adviser, introduces this issue’s round-up of case reports

MPS works hard to defend claims wherever possible. Part of a strong defence is having knowledgeable and skilled expert witnesses to demonstrate that the doctor in question has acted in the patient’s best interests and in line with good medical practice.

Perhaps the best defence of all is making sure your diagnosis and treatment plans are of the requisite standard; examinations (where necessary) are thorough and well-documented; informed consent is both taken and recorded; and note-keeping is accurate and contemporaneous.

In “The twisted knee” on page 16, Ms C brought a claim against Mr A, alleging, amongst other things, that he negligently performed an arthroscopy in the absence of an MRI scan and unreasonably diagnosed a meniscal tear. Expert opinion found no liability on the part of Mr A, concluding that his preoperative working diagnosis was eminently reasonable in light of Ms C’s symptoms and signs. As a result, the claim was subsequently discontinued and no payment was made.

Mrs J made a claim against Dr A in “A tear during delivery” (page 18) as she was advised that if Dr A had carried out an episiotomy and avoided the use of ‘double instruments’, her symptoms would have been avoided. She felt that a diagnosis of a third degree tear had been missed, and had consequently had a major impact on her life.

Expert opinion found that the episiotomy was not essential in this case, and detailed contemporaneous expert notes confirmed that the anal sphincter was intact.

Sometimes, when a case cannot be defended, MPS works on a member’s behalf to ensure a favourable settlement. For example, in “Common can be complicated” on page 14, Miss G’s family alleged she was unable to use public transport because she was advised to avoid heavy lifting due to her persistent symptoms, which they argued would hinder future employment prospects. MPS’s legal team made use of video surveillance, which provided evidence that Miss G could use public transport independently; therefore reducing the final settlement offer significantly.

**Casebook aims to promote safer practice by sharing experiences that we hope you will find helpful. MPS publishes medical reports as an educational aid to MR members and as a risk management tool.**

The case reports are based on MPS experience from around the world and are anonymised to preserve the confidentiality of those involved.

The cases described are historic and the expert opinions that follow in the case reports reflect accepted practice at the time. The learning points are applicable today.

If you would like to comment on a case, please email casebook@mps.org.uk.

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**Published Case Reports**

Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case, we simply give a broad indication of the settlement figure, based on the following scale:

- High (≥150,000+)
- Substantial (10,000–150,000+)
- Moderate (1,000–10,000+)
- Low (<1,000+)
- Negligible (<1,500)

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**Case Report Index**

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Specialty</th>
<th>Subject Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Common can be complicated</td>
<td>GENERAL PRACTICE</td>
<td>RECORD-KEEPING INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>15</td>
<td>Patient confusion: patient claim</td>
<td>UROLOGY</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>16</td>
<td>The twisted knee</td>
<td>ORTHOPAEDICS</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>17</td>
<td>An unexpected pregnancy</td>
<td>GENERAL PRACTICE</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>18</td>
<td>Tear during delivery</td>
<td>OBSTETRICS</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>19</td>
<td>A catalogue of errors</td>
<td>ORTHOPAEDICS</td>
<td>INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>20</td>
<td>Cutting corners</td>
<td>ANAESTHETICS</td>
<td>INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>21</td>
<td>A resolution problem</td>
<td>GENERAL SURGERY</td>
<td>INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>22</td>
<td>An expert eye</td>
<td>ORTHOPAEDICS</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>23</td>
<td>A delayed diagnosis</td>
<td>GENERAL SURGERY</td>
<td>INVESTIGATING REMEDY-KEEPING</td>
</tr>
</tbody>
</table>
CASE REPORTS

Common can be complicated

Miss G, 11 years old, was taken by her mother to see GP Dr A with coryzal symptoms and a discharging right ear. She appeared quite well during the consultation, so Dr A prescribed an antibiotic and arranged urgent urgent imaging. This confirmed a cerebral sinus venous thrombosis and a middle ear infection with right mastoiditis. She was transferred to the neurological unit for thrombolysis, CSF drainage and acetazolamide, and discharged a week later.

The family lodged a negligence claim against Dr A, stating that he failed to refer for urgent investigation following her second consultation. They asserted that had Miss G received earlier treatment, she would not have suffered from reduced visual acuity or frequent headaches.

Expert opinion agreed that, based on Dr A’s account of events and the subsequent notes made by the hospital regarding the onset of visual symptoms, he performed an appropriate examination and provided a reasonable standard of care during his second consultation.

However, it was evident from the course of events that Miss G did deteriorate and the emerging visual symptoms allegedly reported to the nurse adviser did demand an urgent assessment. Failure to arrange immediate referral fell below a reasonable standard of care and Dr A and his practice had Miss G’s legal team made use of video surveillance in this case, which provided evidence that Miss G appeared very comfortable using public transport independently. This reduced the final settlement offer significantly, although the case was still settled for a substantial amount.

EW

Learning points

■ The importance of documenting every consultation, including telephone consultations, is highlighted once again with this case. Disciplined documentation of every clinical encounter means that when a claim or complaint arises, you can feel more confident defending your position.

■ A reminder regarding telephone consultations is that arrangements should be made for face to face review if any concerns are raised regarding a patient’s clinical condition.

■ A patient who develops new symptoms should be reassessed and the diagnosis reviewed. In this case the nurse should not have made a new diagnosis of glaucomatous fever over the telephone without arranging for the patient to be seen.

■ This case is a reminder that common ailments can develop rare complications. The majority of cases of otitis media seen in general practice will resolve without complications; however, health professionals should remain vigilant to the possibility of disease progression. Safety netting protects you and your patient.

■ Asking the patient to attend for a review is an important safety net to put in place, but it is important to be able to follow this up. Lack of available GP appointments means that clinical staff are often in the position of triaging patients without seeing them in person, which can lead to a deteriorating patient being overlooked. Clinical staff should be trained to spot red flags and be aware of developing symptoms that require immediate review.

■ Mastoiditis is now relatively rare. The incidence of the condition following acute otitis media reduced from 50% to 0.4% following the introduction of antibiotics. Prior to this, mortality rates were 2 per 100,000 compared to <0.01 per 100,000 now.

REFERENCES


Patient confusion: patient claim

Mrs S, a 77-year-old woman whose past medical history consisted of a previous hysterectomy for benign fibroid disease, presented to her GP with a history of intermittent hematuria. Her GP recognised the potential seriousness of this symptom and made an urgent referral to a consultant urologist, Mr F.

Mr F arranged an IVU followed by a CT scan, which suggested a tumour in the left distal ureter. Mrs S was advised this was highly suggestive of carcinoma and required surgical removal. However, Mr F arranged a biopsy of this mass via a ureteroscopy which was reported as inconclusive, containing insufficient material to make a definitive diagnosis; repeat biopsy was recommended by histology. There was nothing documented within the records to show that the implications of the same were discussed with Mrs S.

Mr F proceeded with left nephro-ureterectomy; a decision supported by the local multispecialistic meeting. During surgery, Mrs S was found to have a 3cm tumour and a sigmoid colon adherent to the pelvic side wall due to multiple adhesions from her prior surgery. The histology of the nephro-ureterectomy specimen showed no evidence of malignancy with endometriosis in the ureteral wall and lumen. This was confirmed by the pathologist who stated that she had been misinformed as to the purpose of the surgery (as she had never had cancer).

Unfortunately, the postoperative recovery was complicated by a colo-vaginal fistula, and Mrs S had to go back to theatre for an emergency laparotomy and Hartmann’s procedure. After this, Mrs S developed an incisional hernia, which was repaired along with a reversal of the Hartmann’s one year later.

Mrs S indicated an intention to bring a claim stating that she had undergone surgery based on a false premise. She alleged that she would have requested repeat biopsy (as recommended on the biopsy findings within the records), which would have come back negative for malignancy and thus she would never have agreed to surgery.

The expert opinion on the case indicated that it was reasonable for Mr F to perform an initial ureteral biopsy, but that it must be recognised that often such biopsies are not diagnostic; hence, the repeating the biopsy may not have revealed any further information. The view that the MDT decision to proceed to radical nephro-ureterectomy was justifiable, even if the true diagnosis of endometriosis was known. Due to the location and size of the mass radical surgery would still have been warranted.

MPS set out their expert evidence and indicated they would defend Mr F in the event a formal claim was commenced. The case was not subsequently pursued.

PS
The twisted knee

Ms C, a 42-year-old risk manager, fell from her horse whilst out riding. At the time of the fall she felt her left knee twist, as her left foot had been caught in the stirrup.

Two days later she presented to her GP who noted that she had not lost consciousness at any stage, had landed on her outstretched hands and knees and that she had sustained some bruising on her neck. He documented that the medial aspect of the left knee had sustained a bruise, the cruciate and collateral ligaments were fine and that McMurtry’s test was negative. Analgesia, gradual mobilisation and exercise were advised.

Ten days later Ms C returned to her local clinic. It was noted that an effusion had developed in the one and a half range of flexion had decreased. Physiotherapy was advised. A week later, Ms C presented to the local emergency department (ED) with persistent pain, at which point an x-ray excluded any gross bony injury, a splint was requested and Ms C was encouraged to mobilise as and whenever possible, whilst wearing a brace.

A fortnight later, Ms C attended a follow-up consultation with Dr A, a consultant orthopaedic surgeon. The MRI had yet to be performed. Dr A noted that Ms C had sustained a significant injury to the left knee and that she was limping heavily. Moreover, she was unable to fully extend the knee and could not flex beyond 20° without severe muscular pain.

Concerned about a significant disruption of the medial meniscus with or without an associated injury to the anterior cruciate, Dr A advised Ms C that MRI imaging was likely to be academic and that urgent arthroscopy would be more appropriate. The admission was arranged a week later and the patient consented for an arthroscopic meniscectomy. At arthroscopy a large injury to the medial meniscal condyle was observed but the meniscal was not torn – Dr A advised that healing would occur with time. After a brief overnight admission due to pain, Ms C was discharged.

However, 48 hours post-arthroscopy, Ms C developed erythema, pain and swelling of her left calf. On the same day she also developed chest pain, following which she attended the ED. Subsequent venography of the left leg did not demonstrate a DVT but a CT pulmonary angiogram demonstrated a number of sub-segmental pulmonary emboli. She was duly anticoagulated and discharged.

A year after the accident Ms C was assessed at the local chronic fatigue syndrome (CFS) clinic. At that time, she described fatigue, memory impairment, diminished concentration, word-finding difficulties, myalgia, sensitivity to light and noise, as well as disturbed sleep. Although not formally diagnosed as having CFS, the reviewing physician noted that Ms C’s symptoms were synonymous with those of CFS.

Two years later, Ms C brought a claim against Dr A, alleging that he had negligently performed an arthroscopy in the absence of an MRI scan, unreasonably diagnosed a meniscal tear, failed to obtain informed consent for the procedure, failed to adequately assess the thromboembolic risk postoperatively and failed to administer thromboprophylaxis. As a result of the alleged negligence, she felt that she had undergone an unnecessary arthroscopy, which caused the PE and led to chronic fatigue syndrome.

In defending the claim, expert opinion was sought. Professor D, a consultant orthopaedic surgeon, noted that Dr A’s preoperative working diagnosis was eminently reasonable in light of the claimant’s symptoms and signs, that it is not routine practice to carry out an MRI preoperatively if the clinician is happy with the working diagnosis, and that appropriate written consent was sought, clearly warning of the risks of DVT.

With regard to the assessment of thromboembolic risk, Professor D noted that when Ms C completed a preoperative health questionnaire, there was nothing to suggest any personal or family history of thromboembolic disease. Moreover, Professor D noted that routine anti-DVT prophylaxis is not mandatory post arthroscopy.

Had a normal MRI result been obtained, Professor D felt that the claimant would still have undergone an arthroscopy due to the persistent nature of her symptoms. Furthermore, he felt it unlikely that the arthroscopy had caused Ms C’s chronic fatigue syndrome.

If the claim had proceeded, MPS’s legal team would have considered commissioning expert evidence of thromboembolic disease. At arthroscopy a large injury to the medial meniscal-condyle was observed but the meniscal was not torn – Dr A advised that healing would occur with time. After a brief overnight admission due to pain, Ms C was discharged.

An unexpected pregnancy

In January 2007, Mrs B, a 33-year-old woman, was seen three weeks after the birth of her second child and was prescribed six months of the progesterone only pill (POP). She was breastfeeding at this stage. She had attended the surgery earlier that month with phlebitis but it was noted that the headache and fever were “clear” at the time of prescribing.

In July 2007 the practice nurse prescribed a further six months of the POP without face-to-face consultation, and a further one month’s supply was issued in December 2007. In January 2008 Mrs B presented with stress incontinence, for which a referral to urology was made. At this consultation it was noted that there were “no problems with the POP and the BP was normal.” Six months of the POP was issued.

In May 2008 Mrs B consulted about mild acne and asked if co-cyprindiol could be prescribed. The GP noted that Mrs B’s father had previously suffered a DVT and advised against it. In July 2008 the practice nurse supplied a further six months of the POP.

In October 2008 Mrs B presented to the practice with an unplanned pregnancy and she was referred to the antenatal clinic. A review of the records revealed that Mrs B had been registered with the practice since 1999. She had been on the combined oral contraceptive (COCP) since 1992, which she had stopped in 2000 when she began trying for a family. At her new patient medical in 1999 it was noted that she was a non-smoker, and there was a family history of diabetes or heart disease.

The original consultation, when she was prescribed the POP, was in October 2003 after the birth of her first child. The notes read: “16 days post-natal. Wants contraception. Discussed and start Noriday.”

Over the next four years there were a dozen clinical encounters. Three of these were pill checks with the practice nurse. A typical entry read: “On Noriday, Happy with it. No missed pills, occasional headaches” (PGD).

There were also five occasions when the POP was issued without face-to-face consultations and four encounters for unrelated issues.

Mrs B’s legal team alleged that she should have been advised to change from a POP to a COCP when she finished breastfeeding her second child in 2007 and this would have helped to prevent her unwanted pregnancy in 2008.

Expert opinion was that when prescribing contraception there is a duty to discuss contraceptive choices with a patient – specifically about the pros and cons of a COCP and a POP in this case. The discussion should cover failure rates, the method of taking the pill, common side effects (including effects on menstruation) and the risk of thrombosis. This would allow the patient to reach an informed decision. The expert felt that part of this could have been achieved by advising the patient to read the product information in the pill packet.

In this case the expert felt that it was reasonable not to prescribe the COCP due to the family history of DVT (and also the relative contraindication of the varicose veins).

A defence denying liability was serves by MPS. Three months later Mrs B discontinued her claim and MPS recovered all costs.

Learning points

- This case undermines the importance of instructing robust experts – highlighted by Professor D’s key role in securing the diagnosis of CFS.
- A swift conclusion to this case ensured any anxiety suffered by Dr A was limited and MPS did not pay any claimant costs.
- It is also important to recognise that a complication does not necessarily amount to negligence. Therefore, it is important to cover complications in the consent process and document such conversations diligently.

- It is striking that despite so many clinical encounters over many years and her own prolonged use, Mrs B still alleged that she was unaware of key issues with the POP and COCP, including the three-hour window in which to take the POP. It is a timely reminder that giving information is important, but checking that the patient has understood the information is vital. This forms the basis of valid consent to treatment. In this case it would have been too easy to view the “pill check” as a routine encounter, make assumptions and be less rigorous in documentation.

- A number of prescriptions were issued by the practice nurse or as repeats by the administration team in the practice. When devolving responsibility it is important to ensure that there is a clear practice policy on what is expected of staff and that this protocol is thought through, written down and being adhered to.
A tear during delivery

Mrs J, a 37-year-old woman, was pregnant with her third child and had an uneventful forceps delivery with her first child and a spontaneous vaginal delivery with her second. She had been previously diagnosed with irritable bowel syndrome, but endoscopies had revealed no evidence of any other disease. The GP records showed that she had colicky pain with constipation and diarrhoea, but she had not seen a GP in the past for further incontinence. This pregnancy had been uneventful and she went into spontaneous labour at 23+5 weeks.

At 5:15pm she was 4cm dilated and, as the contractions had reduced, Mrs J was started on an oxytocin drip. There was an epidural and she was started up at 1pm. The baby’s head had come down to station 0 and she was given an hour for it to descend before a forceps delivery, the perineum was repaired the tear and the incision was repaired the tear.

Mrs J underwent a vaginal hysterectomy and posterior pelvic floor repair, and her symptoms improved significantly with dietary modifications and biofeedback.

Ms M, a 58-year-old woman, saw Dr A, a consultant orthopaedic surgeon, at a clinic with a history of right knee pain. She had been walking with a stick. The knee was a little warm. The range of motion was 98° to 105° and it was considered that the knee was improving.

Fifteen months after the first operation, Ms M’s GP referred her to a rheumatologist, Dr L, on account of persistent knee and back pain. He requested a bone scan, which was reported as showing probable peri-prosthetic sepsis. Ms M was then referred back to Dr B who performed a diagnostic arthroscopy. This demonstrated an extensive synovitis and Staphylococcus epidermidis was isolated from the biopsies obtained. A protracted course of antibiotic therapy ensued. Two years after the original operation, a stepped explantation was performed and, over several months, the operative wounds healed and satisfactory x-ray appearances were obtained. However, Ms M continued to be troubled by persistent pain.

Six months later Ms M made a claim against Dr B. It alleged that Dr B was negligent on multiple counts, in that he had fractured the tibial plateau at the time of the original surgery, failed to identify the fracture during surgery and then failed to take remedial action intraoperatively. Moreover, it alleged that Dr B had been negligent in failing to proceed urgently to revision surgery and was persistently advising Ms M to mobilise, despite her severe pain, the concerns expressed at multidisciplinary team meetings and all the clinical and radiological indications that the knee joint was mal-aligned. Ms M also claimed that it was not for Dr B’s negligence, the total knee replacement would have been successful and she would have recovered swiftly following surgery. Furthermore, Ms M alleged that she would have been relieved of her preoperative symptoms and would not have required a further revision for approximately two decades. It was also suggested that it would not have been appropriate to have proceeded to revision surgery.

Expert evidence was sought from Dr D, a consultant orthopaedic surgeon, with regards to breach of duty and causation. Although Dr D acknowledged that Dr B was not aware of any adverse event occurring during the original operation and was not advised of any early problems, he advised Ms M to mobilise, despite her severe pain, the concerns expressed at multidisciplinary team meetings and all the clinical and radiological indications that the knee joint was mal-aligned. Ms M also claimed that it was not for Dr B’s negligence, the total knee replacement would have been successful and she would have recovered swiftly following surgery.

Further follow-up, six months later, found that Ms M was walking without the aid of a stick. The knee was a little warm. The range of movement was 98° to 105° and it was considered that the knee was improving.

Mrs J was referred to obstetrics and gynaecology consultant Mr B, with signs suggestive of utero-vaginal prolapse, menorrhagia and lack of bowel control. An endo-anal ultrasound found only minimal scarring of the external sphincter, and the internal sphincter appeared intact. A clinical neurophysiologist also assessed the patient and felt “there was evidence of bilateral external anal sphincter neuropathy with poor muscle function on the right and left sides”.

Dr A then applied a silicone ventouse cup to the ‘flexion point’ on the baby’s head. She increased the pressure to 0.2kg/cm² and checked there were no signs of marked sphincter damage, and, when she was seen by her GP for her six-week check up, it was documented that the “anal sphincter was intact” and there was no evidence of any sphincter damage, and repaired the tear routinely.

The following day an x-ray was performed. This showed that the postoperative x-rays demonstrated a suboptimal result. He indicated that revision should not be pursued aggressively and that there were both advantages and disadvantages to this conservative approach.

She re-examined the patient and still felt the baby was in the correct position, and that “the head had descended well to station +1”. Dr A decided to use the Nevile Barnes forceps to complete the delivery. The blades were wedged in properly, and, using this technique, the baby’s head was delivered with one pull.

Dr A felt the perineum was stretching out well, and did not carry out an episiotomy.

Learning points

• The use of sequential instruments is associated with an increased neonatal morbidity; however, the operator must balance the risks of the caesarean section following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction.

• Recognition and documentation of the correct technique in the notes (eg, ‘Saxthorph-Pajot’) for forceps delivery – where the operator’s dominant hand applies horizontal traction, whilst the other hand gently presses downwards on the shank of the forceps) suggests that the accouchere has adequate experience to carry out the procedure correctly.

• Careful documentation of the technique and assessment for perineal damage is essential, and use of endo-anal USS may help with the definitive diagnosis at a later stage.

• The expert opinion was logical and evidence-based and, with careful documentation and adherence to good medical practice, such cases can be discontinued before they are taken to court.

Mrs J made a claim, as she was profoundly immobile and that physiotherapy was almost impossible. Dr B agreed that Ms M should be mobilised – unphysically with this advice, Ms M pursued a second opinion. This was provided by Dr B.

Seven days after the operation, Dr A wrote to Ms M’s GP. In this letter he stated that the operation seemed to go very well but that the postoperative x-ray demonstrated a suboptimal result. He indicated that revision should not be pursued aggressively and that there were both advantages and disadvantages to this conservative approach.

He was also critical of the persistent advice to mobilise and acknowledged that, in his opinion, this was one of the worst total knee replacements he had seen. Moreover, Dr D felt that the subsequent operations Ms M underwent were result of Dr B’s breach of duty during the index operation. In terms of breach of duty, Dr D made the following observations: poorer patient selection to poor placement of the tibial component with fracture of the posterior tibial cortex, which is surgery that falls below an acceptable standard of care.

The claim was settled for a substantial sum. O&M

In this instance, the highly critical expert evidence required swift action and a prompt settlement was appropriate. Strong expert opinion guides the approach of both MHS and the parties involved.

Learning points

• Adverse outcomes and mistakes are part of a doctor’s working life. Acknowledging this, responding to such events in a timely manner and being open, help to reduce the impact of these events on both the patient’s wellbeing as well as the doctor’s professionalism.
Learning points

- A series of human and equipment factors interacted in a catastrophic way to bring about this tragic outcome from a trivial injury.
- Fatigue can be a powerful cause of reduced vigilance, and is associated with increased risk of error. It does not amount to a defence. The mnemonic HALT reminds all healthcare professionals to be extra careful if they are Hungry, Angry, Tired, or Stressed. Ask yourself: am I safe to work?
- Most anaesthetic machines now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.

Learning points

- Clinicians should always maintain objectivity in the advice given to a patient. Shared decision-making is very important, with a balance between ensuring patient autonomy and making good clinical decisions. MPS's workshop, Mastering Shared Decision Making, shows such a model is an effective way to ensure that patients make appropriate and informed choices. Visit the Education section of www.medicalprotection.org for more information.
- Restorative proctocolectomy is a demanding surgical procedure with a high complication rate. Patient expectations should be matched with a frank discussion regarding complications and outcomes. When working within a multidisciplinary team, the ability to ask for second opinions and advice from colleagues in the event of problems is a strong multidisciplinary defence, as well as good medical care.
An expert eye

Mrs K was 58 when she saw Dr B, a consultant orthopaedic surgeon, because of the pain in her right hip. She was finding walking difficult and had noticed a limp. Both common symptoms of osteoarthritis. The x-rays showed mild degenerative changes and Dr B felt it was too early in the course of the disease for an operation. However, Mrs K’s symptoms worsened and three years later she returned for another consultation. Dr B now felt that a total hip replacement was indicated and Mrs K consented to surgery. Prior to surgery she explained the benefits and risks of a hip replacement.

Complications, including a change in leg length, were discussed, though this was not specifically documented on the consent form. Mrs K understood that she should hopefully be pain-free within two months of surgery and go on to make a full recovery by six months post-surgery. At surgery, several different component sizes of the femoral component were used to equalise the leg lengths at a further review. Mrs K sought a CT scan, which confirmed the leg length discrepancy, and she also had injections in her lumbar spine for pain relief, which did not help.

Due to these ongoing problems Dr B organised an aspiration of her right hip replacement, which did not show any evidence of infection, and referred her to Dr L, an expert in revision hip surgery, for a second opinion. The revision enabled Dr L to review the history of ongoing post-surgery pain, a clinical examination and a new set of x-rays. Dr L could not see any obvious problem with the hip replacement that would account for her symptoms. Dr L explained to Mrs K that the hip was “only very slightly long”. He felt that maybe she was getting some impingement pain from her pisos tendon. Mrs K was becoming increasingly frustrated and upset, believing that her problems all stemmed from an increase in her leg length, and that even lengthening by 2 to 4 cm is regularly tolerated well by patients. He advised against further surgery, as did his colleagues, but he organised an MRI scan of the hip and spoke to find a source of Mrs K’s pain. The MRI showed some degenerative changes in her lumbar spine and also a “hot spot” around the total hip replacement indicating, once again, the possibility of an infection. Another hip aspiration was arranged. For a second time the aspiration grew no organisms on culture, which confirmed that an infection was most unlikely. Dr B also reiterated his view that Mrs K’s leg length discrepancy was minimal.

Mrs K was now finding walking for more than an hour impossible. After five minutes she developed steadily worsening pain in her hip, and she struggled with stairs. She brought a claim against Dr B, citing a leg length discrepancy of two and a half centimetres, and failure to plan and perform the surgery adequately. Dr B denied negligence and the experts involved upheld this. There was only minimal leg length discrepancy, less than had been claimed, and it was a recognised complication. Dr B performed both the surgery and subsequent investigations in an appropriate manner, and sought a second opinion from an expert. The claim was discontinued.

Learning points

- Leg length discrepancy is the second most common cause of litigation in orthopaedy surgery, behind nerve injury.1
- Approximately 15% of hip replacement surgery results in a leg length discrepancy. Less than 1cm “discrepancy” is the ideal goal, but up to 2cm is reported to be tolerable by patients.2
- The importance of good documentation concerning consent of all common and serious complications is vital. Specific complications should be included on the consent form. In this case, consent length discrepancy was discussed with the patient and mentioned in the GP letter.
- Explaining to a patient why a complication might arise helps them to understand and accept it if it happens. In this case, having a stable hip replacement and adequately tensioned soft tissues is more important than a leg length discrepancy, and should be emphasised.

This case highlights the importance of having strong experts. In this case, expert opinion found some of Mrs K’s claims inaccurate and found Mr B had dealt with the patient in an appropriate manner. MPS robustly defends non-negligent claims.

A delayed diagnosis

Miss O, a 22-year-old woman, was admitted as a medical emergency with vague abdominal pain and urinary frequency. Clinical examination revealed a right iliac fossa scar from an appendectomy three years earlier and some mild supra-pubic tenderness. Her white cell count was elevated, she had a low grade temperature and urinalysis demonstrated blood and leucocytes. A chest and abdominal radiograph at this stage appeared normal. A provisional diagnosis of a urinary tract infection was made and Miss O was commenced on intravenous antibiotics.

Learning points

- The results of investigations should be reviewed promptly and acted upon accordingly. Generally, adhesional small bowel obstruction requires surgical intervention if, after appropriate conservative treatment, there is no sign of clinical improvement.
- Medico-legal problems often arise long after the clinical encounter. Considerable discussion regarding this case centred upon documentation of when patient reviews occurred and when Miss O’s x-ray investigations were assessed. Accurate and legible entries into the notes (even down to the hour) are the cornerstone to any medico-legal defence.

Forty-eight hours later, the situation had deteriorated and Miss O now had worsening abdominal pain, nausea and a persistent pyrexia. Overnight, she was reviewed by the resident surgeon who found a distended abdomen with localised guarding in the right iliac fossa. He advised keeping the patient nil by mouth and prescribed intravenous fluids and analgesia. A further abdominal radiograph was requested, a nasogastric tube and urinary catheter were inserted, and the patient was transferred to a surgical ward.

General surgeon Dr S reviewed the patient the following morning and requested an ultrasound scan. This demonstrated the presence of dilated small bowel loops, fluid in the peritoneal cavity. When he saw the patient 24 hours later, she remained unwell; review of the abdominal x-ray from 36 hours earlier confirmed the ultrasound suggestion of small bowel obstruction. Dr S concluded that it was likely a consequence of adhesions from her previous appendicectomy and, later that day, he undertook a laparotomy. This revealed small bowel obstruction secondary to a band adhesion. After division of the band and decompression of the small bowel, a 10cm section of ileum required resection and anastomosis.

Initially, Miss O improved and began oral intake and mobilisation. However, on day three following her surgery, she complained of cramp-like abdominal pain and a productive cough. Miss O had mild abdominal distension and absent bowel sounds. Further x-rays revealed left lower lobe collapse and consolidation and some ongoing dilated small bowel loops. She was reviewed by Dr G, locum general surgeon, as Dr S was on annual leave for three weeks. A diagnosis of pneumonia and ileus was made and intravenous antibiotics were prescribed.

A further period of prolonged nasogastric drainage and parenteral nutrition then ensued. The ‘ileus’ failed to resolve and a gastrostomy small bowel study showed delayed passage of contrast through dilated small bowel loops consistent with a low grade obstruction. Dr G recommended further surgery, but Miss O and her family were reluctant and wished to persevere with conservative management. When Dr S returned from annual leave, Miss O was still obstructed and by this stage all were in agreement that further surgery was required. A second difficult laparotomy and division of adhesions was undertaken, revealing an area of possible Crohns stricture at the anastomosis which was resected and re-anastomosed. Miss O required treatment on the intensive care unit and then developed a severe wound infection and enterocutaneous fistula. She spent several months in hospital and eventually was discharged with persistent intermittent abdominal pain and altered bowel habit. There was no evidence of inflammatory bowel disease.

Miss O brought a claim against Dr S, citing a delay in the diagnosis and treatment of her small bowel obstruction as the cause for her further surgery, prolonged hospital stay, and subsequent intestinal complications and ongoing symptoms. Expert opinions were critical of the delay in making the diagnosis of small bowel obstruction and undertaking surgery. They felt that an ultrasound examination which was not performed was unnecessary and that Dr S should have reviewed the abdominal x-ray (which clearly showed evidence of obstruction) when he initially reviewed the patient and not the following day. Had he seen the film, the finding of peritonism three days into her illness may have prompted Dr S to perform earlier surgery, before the small bowel ischaemia had become irreversible.

The case was settled for a moderate sum.
A weekend of back pain

1SBN-13: 978-0199827428

over to you

Dr Vishal Naidoo, Portfolio GP, UK

Response

Dr Ben Chandler, Consultant Anaesthetist, South Africa

The mere fact that Miss B allowed her legal action to gain money by deception? Surely she was attempting fraud by entering a fictitious claim and making no difference to the outcome. This is relevant to my local GP work.

In this case, the claimant had a valid claim, and was entitled to the amount of compensation which was ultimately paid to her. However, she pleaded exaggerated damages, which led MPS to investigate and establish that her injury was less severe than she was claiming. This would not have impacted on her entitlement to public funding of her claim at the outset, but led to withdrawal of this funding when it was possible to show that a reasonable offer had been made. Given that her claim was, in fact, successful, it would be difficult to secure a conviction in this case. However, I hope that this case does demonstrate how rigorous MPS is in overpaying claims, paying when and where it is right to do so, and at the same time safeguarding members’ funds.

You may have also noted that in the cases reported on pages 19 and 21, where we were successful in our defence, MPS has sought to retrieve our costs from the unsuccessful claimant. Please do not hesitate to let me know if you have any further doubts about this, or other cases.

REFERENCES

1. Fredrickson MJ, Kilfoyle DH, Neurological complication analysis of 1,000 ultrasound guided peripheral nerve blocks for elective orthopaedic surgery: a prospective study, Anaesthesia (2009) 64:836-841

An unavoidable amputation

Dr Vishal Naidoo, Portfolio GP, UK

Response

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Hospital managers: support needed

Dr Rob Hendry makes a very valid point in his article (“Under the influence”) on page 4 of the latest edition (Vol 21 No 3, September 2013) of Casebook about failing teams being at the root of much of the problems in failing hospitals. He is not precise about which teams he has in mind but the point is valid in all contexts; perhaps in failing hospitals it is the management team that needs most help. There can be considerable antipathy, as well as inability to understand the other’s point of view when managers and doctors meet.

This may not be all that surprising when such very different goals.

People who just cannot get on need outside help. Dr Hendry might like to follow up his comments with a note about where one should turn. I felt this was a lack in the article. His concluding comment was too vague. One needs to be aware of which of one’s actions one needs to “take responsibility for”, and how to do that. Illbehaviours that impact negatively are compounded by communication failures, and some may find it helpful to read something on the subject. I would recommend a book by three American authors, which of the hundreds available and several I have read is really outstanding. Though I have not read the latest edition of 2012 there is every reason to believe it will be as good as earlier ones.

Changing our own approach might encourage change in “the opposition” and avoid the need for involving a third party.

Dr Howard B uit Interim consultant paediatrician, Tewkesbury, UK


It will be reviewed in a future edition of Casebook.
Common Neuro-Ophthalmic Pitfalls: Case-Based Teaching
By Valerie A Purvin and Aki Kawasaki
(£58.00, Cambridge University Press, 2009)
Reviewed by Dr Sacha Moore, consultant ophthalmologist
This book is part of a series of similar case-based books on different specialties, and is enjoyable and well written. If you are tired of didactic reference textbooks that serve up boring writing on layers of judgementable tedious texts and tables, like sawdust on bread and crackers, then this will be the chasede and grasps that render neuro-ophthalmology not just palatable but moreish.
Let’s be honest: most of us non-neuro-ophthalmic specialists sit away from this subject and typically look for the nearest exit or window to jump through when a patient presents with double vision and headaches. Patients almost never present with textbook findings and almost always have confusing, subtle and variable symptoms or signs. This makes for a long corridor of bear traps, at the end of which awaits your own headache and diaporia if you are not careful.
The authors have nicely addressed the main subjects that cause anxiety amongst clinicians in neuro-ophthalmology and use real cases with relevant pictures and simple tables. There are 12 chapters:
• When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease; When orbital disease is mistaken for neurologic disease.
Incidental findings (seeing but not believing)
Failure of pattern recognition
Clinical findings that are subtle
Misinterpretation of visual fields
Neuro-ophthalnic looks alike
Over-reliance on negative test results
Over-ordering tests
Management misadventures
The style feels like a rewarding one-on-one tutorial and makes you feel like you may actually be able to deal with similar cases in future. You can dip into it like a textbook or enjoy reading it straight through from start to finish – there are many interesting and surprising facts that I have not found in other textbooks.
This book will help you better understand subjects you thought you knew and those you know you didn’t know. Neuro-ophthalnicists will find this book serves as a good tune-up on their knowledge; non-neuro-ophthalnicists may benefit from the insights, like a full service on the rusting remains of their faded membership memories.
It is satisfyingly clinically relevant and not just another book for membership examinations. Overall the book deserves the honour of being well-thumbed and to stand battered and frayed from use much amongst the shiny, thick tables of untouched neuro-ophthalnic monoliths in your, or your institution’s, library.

Mistaking congenital anomalies for acquired disease; Radiographic errors

Erroncology: Why We Make Mistakes and What We Can Do To Avoid Them
By Joseph T Hallinan
(03.99 Elsevier Press, 2009)
Reviewed by Dr Matthew Sargeant, consultant psychiatrist and clinical human factors group member
I learnt so much from this easy-to-read, enjoyable little book. Why We Make Mistakes is available as paper book, ebook or audio book. How we look at things without seeing, forget things in seconds, and are all pretty sure we are way more average than the average. Such themes are of immediate contemporary clinical relevance to practice and comprehensively described.
The book is good for everyone, whether on a course on clinical human factors or not. For more than 20 years Hallinan, a journalist, collected many errors and obtained comments from academics who study various aspects of human performance and psychology related to human error-making. There are many helpful references, a guide to chapters and footnotes. The book is an invaluable primer for academic literature for human factors/erroncology terminology.
Grouped descriptively simply under 13 chapters, we are told making fewer mistakes is not easy, especially if the reader merely desires to do so without reflection. Hallinan urges: put effort into thinking of the small things we do and do not do, for the consequences are big. To improve patient safety with the very next patient you manage, read the book. The book advises team members to work together to communicate and to have a supportive and accessible attitude to reduce error in team members. Clinicians are also advised to look up at the organisation they are working in for the sources of errors, as well as down at what they are doing. Clinicians are also told to avoid multitasking. The book implies that designing, investigating, delivering and managing clinical care are onerous responsibilities to promote patient safety.
The book is a fabulous for all medical students and doctors who make the plaintive cry “why don’t they teach us about human factors”. If there are any non-believers about human fallibility out there it will help them too. Patients could help too by reading the book to [help] their clinicians. Hallinan tells us confidence and expertise attained through years of practice and study can be a major context of error. We are all fallible, the book says. To err is human. Clinicians, buy it; be a good doctor and make patients safer. Patients: Buy it and help your doctor deliver to you safer clinical care.
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