The ACCUSED
One doctor’s account of his trial by media

A PERSONAL FAILURE
Dr Dan Cohen on his own shortfall in reliability

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Welcome

Dr Nick Clements – Editor-in-chief
MPS Head of Medical Services

Dr Nick Clements, MPS Head of Medical Services, has taken over as Casebook Editor-in-chief from Dr Stephanie Bown, who left MPS in February 2014. Here, Dr Clements looks towards the task ahead.

As this is my first column as the new Editor-in-chief of Casebook, I would like to say how much I am looking forward to life at the helm of a publication with a prestigious history of some 20-plus years.

Of course, I must also pay tribute to my predecessor Dr Stephanie Bown, who left MPS in February to become Director of the National Clinical Assessment Service (NCAS). Dr Bown has been involved with Casebook since the May 2006 issue, and oversaw numerous successful design upgrades and a renewed focus on producing truly topical content for all of our six regional editions.

Dr Bown worked at MPS for 19 years, beginning as a medicolegal adviser and becoming head of the Medical Services department in London soon after; this after spending more than 12 years as a doctor in acute hospital medicine, then obstetrics and gynaecology before moving into general practice. Dr Bown combined her editorial role with her medicolegal work, and referred her for surgery.

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The keen-eyed among you will have spotted my name in previous editions – in addition to occasionally introducing each edition’s collection of case reports, I have been on the editorial board for a number of years, helping to maintain the accuracy and educational value of each issue.

One thing will not change – and that is we continue to encourage your feedback, opinions and suggestions after each edition. Perhaps I will speak to some of you personally on our advice line…
### Investigation
We asked the patient to give consent so that we could send the complaint to be investigated thoroughly and in an unbiased way by the PCT (Primary Care Trust). After a delay the records were shared and I gave my witness statement. The local PCT determined that I should have a chaperone for every female consultation while the investigation was underway.

In spite of numerous attempts, Mrs B failed to engage with the PCT to give her version of events. The PCT felt they had no choice but to refer the case to the General Medical Council (GMC).

The GMC held an interim order panel meeting. Accompanied by an MPS solicitor, the panel listened to our case. They applied conditions to my registration that I was to have a chaperone for every intimate female examination, and to log each examination. The GMC’s investigation took more than a year to complete and a hearing date was set, 18 months after the initial allegation.

### The hearing
The first day of the hearing didn’t go to plan. I arrived all geared up to defend my corner, but Mrs B did not turn up, so it was adjourned until the following day. When the hearing did commence Mrs B gave a witness statement, and there was a submission from my MPS-instructed barrister, then the panel went away to decide the next course of action. The next day the panel gave their decision that they found the allegation unfounded and uncorroborated, and the case was concluded.

### Personal impact
The experience of having a patient make an unfounded allegation against you is devastating. I would not wish it on my worst enemy. The injustice you feel day in and day out is worse than physical pain. There were days where I could not see any light at the end of the tunnel, like my head was under a guillotine. My mind was fractured; I kept thinking ‘why me, why did this happen to me?’

As a doctor this experience was earth-shattering: it’s the worst thing to be accused of – an allegation of sexual motivation; how can you prove you were acting appropriately? It’s their word against yours. If the GMC found guilty and forced to leave, how would the practice cope?

During the investigation I went to work as normal. Every day I had to face the stigma around me of what I had allegedly done.

### Impact on the practice
It was particularly hard on the practice, having to have a chaperone from beginning to end. We were not just employing a GP; but two healthcare professionals at the same time. This had huge financial and logistical implications for the practice. Not being a big practice we don’t have many nurses or staff, so it was difficult.

We had to consider the future of the business: if I were to be dismissed, how would the practice cope?

### Media coverage
Handling the media was not something I’d really considered. I’d definitely never thought about being on the front page of a national newspaper. Not being a big practice we don’t have many nurses or staff, so it was difficult.

Handling the media was not something I’d really considered. I’d definitely never thought about being on the front page of a national newspaper. We were all worried about it: what would patients do? The stories were angled in a certain way that assumed I was guilty – it would have been nice to be captured in a different way. I remember, during the hearing, getting messages from friends asking if I was ok, as they’d seen the coverage.

Even abroad, it was all over the internet. The practice had huge financial and logistical implications for the practice. It is hard to justify removing a patient simply because they have made a complaint. Good practice management meant that Dr Z did not see Mrs B.

### Legal opinion
By Dr Jo Gavin, MPS medicolegal adviser, who handled the case.

Unfortunately this case is not an isolated one. Mrs B came to the practice specifically asking for her chest to be examined thoroughly. During the examination she perceived that the actions of the GP in question, whom I shall refer to as Dr Z, were sexually motivated. Dr Z said that when he examined her, he explained what he was going to do and explained the depth and pattern of the breathing. His situation was compounded when he locked the door to preserve her confidentiality, as the door had recently accidentally opened into the adjacent waiting room. Mrs B misconstrued this again to be sexually motivated.

### Credibility
The credibility of Mrs B was undermined when she did not turn up for the first day of the hearing – she claimed that her father was in hospital. MPS requested full disclosure of the reasons for her absence. It came to light that she had been explaining her absence from her sister’s house, and her father was not in fact in hospital.

### Support
Throughout the process I worked closely with the local medical committees, my MPS legal team, and the PCT. Without the understanding and professionalism of these people it would have been a much more difficult time. I drew strength from the fact that I knew I was professional and hadn’t done anything wrong – I believed the truth would come out in the end.

I’m most proud of the way the practice dealt with the whole thing – we pulled together like a family. From the first day, I was honest about the allegation and discussed it with my staff, my patients, my family and my colleagues; from then on I informed them of all the developments. I could not have survived the experience if they hadn’t supported me.

I always wanted to be a professional GP, dedicated to my practice and patients, and to be involved in the community as a doctor. Eighteen months have been wiped from my life, and I will never get answers to why Mrs B did what she did. I take some comfort in that justice has been done and I was vindicated – life goes on and I have learnt from it.

Names have been withheld to protect the confidentiality of those involved.

### Chaperones
Doctors are alive to the fact that they need to use a chaperone when performing intimate examinations, but they aren’t always alive to the dangers of some examinations; for example, an accidental brush of the chest can get doctors into difficulty. An important point to make is that Mrs B’s consultation was not an intimate examination – it was a chest examination – but Dr Z still offered Mrs B a chaperone.

MPS conducted an audit of Dr Z’s previous consultations, and were able to prove that it was consistent practice to offer a chaperone and document it. He’d documented contemporaneously in the notes that he had offered a chaperone from Mrs B, and that she had declined – this helped his defence.

### Good record-keeping
There were several important factors that contributed to the outcome: Mrs B had no recollection of this or of when Dr Z did the alleged examination. It was about a different matter. It is unlikely that you would come back voluntarily and visit your GP again perceived to have acted inappropriately.

This raised questions around Mrs B’s recollection of the events. In contrast, Dr Z had documented everything contemporaneously. When there is a factual dispute, the credibility of a complainant is important. In this case there was a factual dispute and the weight of evidence was in Dr Z’s favour.

His notes were further backed up by a GMC-obtained expert report about the correct standard of chest examinations; this proved that Dr Z’s standard of chest examinations was appropriate.

### Professional challenges
The situation presented professional challenges because Mrs B remained a patient at the practice. It is hard to justify removing a patient simply because they have made a complaint. Good practice management meant that Dr Z did not see Mrs B.

### Advice
Dr Z was unlucky, but his contemporaneous note-keeping and good practice helped prove that he had not done anything wrong. He did everything he could to give himself the best protection.

### Learning points
- Always use chaperones for examinations that are perceived to be intimate examinations.
- Good record-keeping is essential.
- Communicate effectively with your practice team.
- Develop good working relationships with your staff and patients.
- Expert evidence is helpful in disputes around standard practice.

For further information about chaperones and maintaining boundaries please visit the factsheets section of www.medicalprotection.org.

### Ends
High reliability in healthcare: a personal failure

In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

As an example, I would like to ‘fillet’ myself and reveal a personal story that has affected me throughout my career. This is a story of multiple systems and personal failures. Fortunately, they were detected and addressed. Though the goals of healthcare professionals are coloured by altruism and compassion, a closer examination reveals that many of our processes for providing care are insufficient, even flawed, and patients continue to be harmed, sometimes fatally. Our hospitals, in particular, are highly complex and hazardous environments, not only for patients but also for staff. Dangers lurk and complacency is pernicious and harmful.

A quintessential characteristic of high-reliability organisations is reliance on the advice and knowledge of those on the frontlines of processes, those at the tip of the spear. In most industries we identify frontline staff as those working where “the rubber meets the road”, and in healthcare this would mean the clinical staff who actually talk to patients and provide care.

The incident

A, a ten-month-old girl, was admitted to an internationally prominent children’s hospital at the weekend for evaluation of a kidney mass, likely a Wilms’ Tumour, a highly curable childhood cancer. I was the paediatric oncology fellow (senior registrar) covering the service for the weekend. This institution’s Wilms’ Tumour protocol required the oncology fellow to administer Actinomycin-D intravenously as soon as the renal vein had been clamped at the time of surgical removal of the tumour. I wrote the orders correctly and legibly using our standard double-check process and then things became complicated.

In addition to covering the inpatient oncology service (about 25 beds in this large centre), I had additional weekend obligations for the outpatient clinic and a two-bed bone marrow transplant unit located in different, though adjacent, hospitals. Usually this multiple coverage obligation was not a problem, but on this particular weekend, two children with leukaemia were to receive outpatient L-asparaginase chemotherapy, and I had to be present in the clinic because of the substantial risk of allergic anaphylactic reactions. I could not be in clinic and the operating room at the same time. Recognising this dilemma, I arranged for the anaesthetist on A’s case to administer the chemotherapy and briefed her thoroughly regarding the dosage, even providing a copy of the prescription. She and I had worked together for several years and I trusted her. She gladly offered to administer the medication.

Unfortunately, an emergent cardiac surgery case occurred on the same weekend and the anaesthetist, being ‘jump-qualified’, had to take responsibility for that case. She briefed a substitute anaesthetist and felt that the situation was well in hand. However, the pharmacist made a decimial point error and instead of preparing a dose of 0.1 mg of Actinomycin-D, he sent up a syringe containing 0.9 mg. The substitute anaesthetist did not recognise the error. This massive overdose was administered intraoperatively.

It was not until several hours later that the error was identified. While I was making evening rounds, I saw the syringe that had contained the Actinomycin-D, still attached to A’s medical record (a standard procedure at that time), and the label revealed the dosage error. I was shocked! Although not immediately toxic, the effect on this child’s bone marrow would be profound, beginning about a week after administration. I was reasonably certain that this child was going to die – and I was ultimately responsible. I called my consultant immediately and, after calming me down, he said some things that really resonated. “Dan, we do not know that A is going to die. We can expect that she will encounter severe bone marrow suppression and gastrointestinal toxicity, but we do not know the outcome of that, and we need to be factual when we talk with the family.”

The following morning we met with A’s parents. My consultant wanted to take the lead in the conversation but I insisted that as A was my patient I wanted, and needed, to do the talking. I was the one who had originally met with the family and this was my responsibility, not his. I carefully explained to the parents that A had received a higher than desired dose of medication and that we were very concerned about this. I apologised for this error and explained that we would investigate this further in order to ascertain how it had happened. I promised to correct any discrepancies in care identified in order to prevent this from ever happening again and then outlined the steps we would take to protect A.

I promised the parents that the comprehensive resources of our institution would mobilise to support A. I did not tell them that I thought she would die because her death was not a certainty, and voicing my concerns would have served little purpose.

Harm and hazards

Though the goals of healthcare professionals are coloured by altruism and compassion, a closer examination reveals that many of our processes for providing care are insufficient, even flawed, and patients continue to be harmed, sometimes fatally. Our hospitals, in particular, are highly complex and hazardous environments, not only for patients but also for staff. Dangers lurk and complacency is pernicious and harmful.

A quintessential characteristic of high-reliability organisations is reliance on the advice and knowledge of those on the frontlines of processes, those at the tip of the spear. In most industries we identify frontline staff as those working where “the rubber meets the road”, and in healthcare this would mean the clinical staff who actually talk to patients and provide care.

However, in healthcare the calculus is even more complicated because the best and safest outcomes require intimate patient and family member engagement and collaboration. Therefore, in this expanded framework, patients and family members are components of the healthcare system, both on the frontline and as experts. Clinicians, patients and family members are frontline experts in their respective domains, and we need to listen to all of them.

Professor James Reason’s ‘Swiss cheese’ metaphor for accident causation is a highly regarded model of how multiple aspects align in causality and how there are prevention barriers that usually, although not always, work to prevent harm.

1. If the healthcare industry is to truly function as a highly reliable organisation, then the kinds of challenges and variances portrayed above must be anticipated beforehand so that appropriate fail-safe mechanisms can be established to provide for all contingencies. This child deserved better from the system, from me, and from others. The Swiss cheese barriers hadn’t worked.

2. Transparent and timely disclosure should be the gold standard for patient care. We are obligated to tell our patients the truth when things are good… and when things are bad.

3. Clinicians are often collateral or “second victims” of patient safety incidents and principles of high-reliability require that hospitals provide necessary support within a just culture framework.

Doctors and nurses do not wake up in the morning intending to harm patients. We go to work each day with every intention of helping our patients. We expect the systems and processes in our workplace to support us in achieving that goal, in other words, we want to work in highly reliable, safe, collaborative and just organisations.

The lessons

Dr Dan Cohen is International Medical Director for Datix Ltd (www.datix.co.uk), a patient safety and risk management company whose software application enables users to spot trends as incidents/ adverse events occur and reduce future harm by prioritising risks and putting in place corrective actions. Dr Cohen can be reached at dcohen@datix.co.uk.

System problems

- The protocol for intraoperative chemotherapy was not evidence-based, ie, it was anecdotal and experimental, and there was no informed consent for this.
- A single oncologist was responsible for coverage in multiple hospital settings, which is usually managed, set the stage for conflicting obligations.
- A cultural barrier forestalled calling for backup unless there was a dire emergency.
- Not all anaesthetists were qualified for all procedures.
- There was no pharmacy double-check process for chemotherapy orders.

Personnel accountability issues

- The primary anaesthetist did not inform the oncology fellow regarding the emergent coverage changes.
- The pharmacist did not recognise the error in preparation of the Actinomycin-D.
- The substitute anaesthetist administered an unfamiliar drug without self-identified need for verification of dose or knowledge of side effects.
- I did not call for qualified back-up!

So… what happened to this little girl? Although she encountered profound bone marrow failure and spent three weeks in isolation with much procedural pain and fear, she came through her experience wonderfully and was cured of her Wilms’ Tumour.
A number of studies undertaken over the last 25 years, starting consequence they came to harm, then we might be sued. A
important first step. I suspect that many of us left medical
sued. and what we as individuals can do to reduce our risk of being

to the Medical Council. While there are factors and influences
been more likely to receive a complaint, claim or be referred
in Ireland have never been better, and yet doctors have never
paradox is that, in general, outcomes from healthcare in
increases litigious intent.7,8 A number of claims are instigated

Dr Mark Dinwoodie, Head of Member Education at MPS, offers
some advice on avoiding litigation

Why patients sue... and how to try and avoid it

Research findings suggest that precipitating factors alone in the absence of predisposing factors are unlikely to lead to a claim.10 So for
two doctors who have been involved in identical adverse outcomes, their individual risk of litigation will be strongly influenced by the relative quality of their interactions with the patient.

Patient expectations and disappointment

Patients embark on any sort of healthcare episode with expectations such as wanting reassurance, the amount of pain they will experience or what ‘success’ will look like. Patients also have increasing expectations about the quality of the interaction they will experience. We often don’t ask patients what their expectations are and instead make assumptions. It is important to think about why the patient may have come to see us and what they are hoping for, and not just what is wrong with the patient and what we need to do to fix it.

If the patient has an experience that is very different from what they are expecting, these unmet expectations lead to a disappointment gap (Box 2) which can be a powerful ‘predisposing factor’ in a decision to take some sort of action. The patient’s perception of the outcome or experience may not reflect from the clinician, and hence it is the patient’s perception that matters in terms of dissatisfaction. In commercial terms this is equivalent to ‘over-promising and under-delivering’.

Some patients will have unrealistic expectations as to what we can achieve and these should be sensitively corrected in advance rather than retrospectively saying: “It was unrealistic to expect that.” We are more likely to meet a patient’s realistic expectations and avoid disappointment if we know what they are, and hence the importance of asking.

Any patient dissatisfaction following an episode of healthcare can turn to anger, which can then lead to blame and then possibly a claim. There is a strong relationship between patient dissatisfaction and the subsequent complaint or claim.11,12

Communication with colleagues

Poor inter-professional communication and teamwork is associated with patient harm.13 In one study, around 90% of litigation was initiated following comments made by another healthcare professional. Poor communication with patients by our staff can act as a predisposing factor for litigation against us.

Why patients sue...

Understanding why patients sue their doctor is an important first step. I suspect that many of us left medical school with a traditional view of the causation of litigation, namely that if we treated a patient, for whom we were responsible, outside acceptable standards of care and as a consequence they came to harm, then we might be sued. A number of studies undertaken over the last 25 years, starting with the seminal Harvard Medical Practice Study published in 1991, suggest that the aetiology may be a little more complex.

Interpersonal skills and litigation

Analysis of claims tends to revolve around the precipitating clinical factors, such as a delay in diagnosis, incorrect surgical technique or medication error. However, the risk of complaint and litigation appears to have much more to do with predisposing factors such as our communication skills, sensitivity to patient needs and management of expectations, than the complexity of the patient’s condition, patient characteristics or technical and clinical skills.4,5

Perhaps not surprisingly, poor communication behaviour increases litigation intent.6 A number of claims are instigated even though there is no evidence of medical negligence, suggesting other drivers may make patients take action.

Reducing the risk of being sued

In contemporary medical practice, patients are seeking not only technical competence but also interpersonal competence. In fact, patients will often use the quality of the interaction as a proxy marker for the quality of care. Effective communication will build trust, increase patient satisfaction, and help ensure that patients receive the care that they both want and need. Patients want to know that you care.5

1. High quality and safe care, professionally delivered

A commitment to safety and quality is a good starting point. Providing high quality care as an individual and ensuring that the systems within the organisation in which you work are reliable, effective and safe will help reduce the likelihood of a precipitating adverse event. Reducing errors and harm is entirely appropriate, but on its own may not significantly impact on rates of litigation without also addressing any predisposing factors highlighted above. Important issues such as clinical governance and risk management are beyond the scope of this article.

2. High quality interpersonal skills with every patient every time

Redeeming the quality of your interactions through active listening and empathy. Establishing patient goals and concerns will show that you care for and respect your patient. Establishing trust. Every time you interact with a patient you have the opportunity to build rapport, show compassion and develop trust.

Box 3

What outcomes are patients seeking by complaint or legal action?

- To receive an acknowledgement, acceptance of responsibility and an apology.
- To enforce accountability.
- To correct deficient standards of care.
- Financial compensation.

Consent and shared decision-making

If a patient has an adverse outcome from their treatment it may question the validity of the consent process. Many patients want to be involved in decisions that affect them, offered choices and warned of risks and benefits of any treatment, including the risk of doing nothing.14 A decision that doesn’t reflect the patient’s values and expectations of a patient may leave them disappointed.

After an adverse outcome

Contrary to popular belief, obtaining compensation is reported by patients as being their primary goal in only around 20% of litigation claims.10,11 Other outcomes desired by patients following an adverse outcome are shown in Box 3. Attention to the first five reduces the desire for compensation.

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Legal reform must help control spiralling costs

MPS has lobbied the government to address the spiralling costs of clinical negligence claims and the increasingly detrimental effect that this is having on health professionals and the public purse. We have made the risks clear and that action is needed.

We have strongly encouraged the government to introduce pre-action protocols – in other words, to introduce a process that provides predictability, discipline and transparency. This is essential for the speedy resolution of clinical negligence claims and therefore controlling legal costs. We have written to the Minister of Justice & Equality seeking the controlling legal costs. We have written to the Minister of Health following introduction of mechanisms that:

- Make it easier to challenge unreasonable legal costs
- Place a greater emphasis on mediation for claims and complaints.
- Avoid passing comment about whether we are responsible or not, may reduce the risk of distress to patients, and complaints and claims for doctors.

3. A rigorous consent and shared decision-making process, reflecting patient preferences and values.

4. Effective handling of an adverse outcome and patient disappointment.

- Undertake open and honest discussions with patients following adverse outcomes, showing compassion and concern. The HSE/SCA published Open Disclosure National Guidelines in November 2013.** Evidence suggests that effective handling of adverse outcomes, whether we are responsible or not, may reduce the risk of litigation.**

5. Effective communication with colleagues.

- Use of standardized and reliable techniques for clinical communication with colleagues.
- Avoid passing comment about the quality of care provided by a colleague.
- A good working relationship with colleagues is likely to lead to support for the patient and ourselves should an adverse outcome occur.
- Model the communication skills you wish your staff to adopt.


So that you are able to respond effectively to any challenge to your professional practice, as well as contribute to clinical care.

Summary

By making healthcare safer while paying attention to the quality of our interpersonal skills, we have the opportunity to reduce the risk of distress to patients, and complaints and claims for doctors.

**Patients don’t care how much you know until they know how much you care**

MPS runs workshops to help develop and enhance these important skills: Mastering Your Risk, Mastering Adverse Outcomes, Mastering Professional Interactions and Mastering Shared Decision Making.

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Concealed sepsis

Mr D, 53, had suffered with osteoarthritis in his right knee since turning 50. This had been confirmed with arthroscopy. He rarely bothered him and he continued to work as a PE teacher. He had experienced a flare-up of knee pain at the start of the autumn term but this settled quickly with analgesia. He visited his GP out-of-hours on the first weekend of the Christmas holidays, complaining of two days of bilateral knee pain, which was unrelated by his usual Gdylovski. A home visit was arranged. He was seen by Dr C, who documented a normal right knee examination, but limited movement in the left knee, with positive meniscal signs and no effusion. Dr C also noticed that Mr D had a painful finger, which he had injured two weeks earlier. Since he was asymptomatic, Dr C attributed the symptoms to OA and advised Mr D should also arrange to get an x-ray of his finger. He had a fracture. She provided him with non-steroidal anti-inflammatory drugs, but no antibiotics were prescribed.

The next day Mr D called Dr C back. Dr C documented a normal right knee, with a partial tear of the posterior cruciate ligament. He also noted some swelling in his hand had reduced, as requested by Dr A. By now he was feeling better, and the swelling in his hand had reduced, but he was feeling “space out” on thecocere analgesia he was now taking. Dr B asked the patient to get out of bed for a full examination, which he was able to do. Mr D’s wife recalled the doctor taking her husband’s blood pressure and advising him to continue his antiarthritic medication. Dr B made no record of this examination. He later recalled that he examined the patient fully, including his temperature, and that he found nothing of concern he did not make a note of. His advice was to complete the course of antibiotics and increase his fluid intake.

Mrs D recalled that her husband became worse towards the end of the day, with slurred speech and generalised weakness. He made an attempt to go to the toilet with the assistance of his son and it took him 40 minutes. Mr D died the next morning on his right side left weak and his voice was slurred. An ambulance was called and took him to the Emergency Department, where a CT scan was performed. An intra-parenchymal bleed with extension into the left ventricle and into the left thalamus was noted. He then became agitated, irritable and started vomiting. His GCS dropped to 7 and he was transferred to ITU, where he was intubated and ventilated. His blood pressure was found to be 200/140. His left pupil was found to be larger than the right and was unresponsive.

Mr J had a left frontal craniotomy, removing 230mL of haematoma blood. He remained ventilated for over a week because of issues with high blood pressure. Mr J was found to have left ventricular hypertrophy on echocardiogram and impaired ventricular function. His hypertension persisted after he was extubated and he was found to have 2 hypertensive retinopathy.

A month later, Mr J was discharged home. He believed he had developed drowsiness and significant cognitive impairment. He needed neurorehabilitation, was unable to work, and required care.

At his nephrology follow-up, his blood pressure was 160/100 despite four antihypertensive drugs, but there was no evidence of UNH on echocardiogram. Mr J made a claim against his GP. He felt that the diagnosis of hypertension was not made early and the delay in treatment had caused his brain haemorrhage. He was alleged that Mr A had failed to take his blood pressure despite persistent headaches and haematuria. He claimed that Dr A had diagnosed somatisation and was not screening him for hypertension.

Expert opinion had only one criticism of Dr A, in that he failed to examine his private fund with him when he presented with headaches in the morning. The opinion of a professor of cardiovascular medicine was also given. He concluded that the intracerebral bleed was likely to be due to a small vascular abnormality rather than due to malignant or accelerated hypertension. He thought that he probably had only mild to moderate hypertension before his bleed because he had been found to have only grade 2 hypertensive retinopathy. There was no proteinuria, haematuria or edema which accompanied accelerated or malignant hypertension.

Expert opinion also felt that the very high blood pressure readings at the time of the stroke represented the usual physiological reaction to a cerebral bleed and did not represent the true ongoing level of hypertension. He discounted the relevance of headaches as a sign of hypertension in this case. He explained that hypertension usually only causes headache if it is malignant or accelerated, which he believed was not the case. The patient was carefully assessed pre-trial and all costs were recovered.

Learning points

■ Good note-keeping is essential. In this case, recording the vital signs and patient’s mobility would have demonstrated that an adequate assessment had been carried out and made the actions of the doctors involved easier to defend.

■ Clinical presentation can change quickly. Expert opinion was critical of a lack of a plausible diagnosis. It is not clear from the note-keeping how unwell Mr D was when assessed by Dr A. It may have been the case that Mr D appeared so well that Dr A felt it unnecessary to document normality. However, without adequate information or a clear diagnosis to prove that a reasonable assessment was carried out, it is difficult to defend her action given the symptoms of polyarthritis with patches of rash and generalised weakness. He made an attempt to go to the toilet with the assistance of his son and it took him 40 minutes. Mr D died the next morning on his right side left weak and his voice was slurred. An ambulance was called and took him to the Emergency Department, where a CT scan was performed. An intra-parenchymal bleed with extension into the left ventricle and into the left thalamus was noted. He then became agitated, irritable and started vomiting. His GCS dropped to 7 and he was transferred to ITU, where he was intubated and ventilated. His blood pressure was found to be 200/140. His left pupil was found to be larger than the right and was unresponsive.

Mr J had a left frontal craniotomy, removing 230mL of haematoma blood. He remained ventilated for over a week because of issues with high blood pressure. Mr J was found to have left ventricular hypertrophy on echocardiogram and impaired ventricular function. His hypertension persisted after he was extubated and he was found to have 2 hypertensive retinopathy.

A month later, Mr J was discharged home. He believed he had developed drowsiness and significant cognitive impairment. He needed neurorehabilitation, was unable to work, and required care.

At his nephrology follow-up, his blood pressure was 160/100 despite four antihypertensive drugs, but there was no evidence of UNH on echocardiogram. Mr J made a claim against his GP. He felt that the diagnosis of hypertension was not made early and the delay in treatment had caused his brain haemorrhage. He was alleged that Mr A had failed to take his blood pressure despite persistent headaches and haematuria. He believed that Dr A had diagnosed somatisation and was not screening him for hypertension.

Expert opinion had only one criticism of Dr A, in that he failed to examine his private fund with him when he presented with headaches in the morning. The opinion of a professor of cardiovascular medicine was also given. He concluded that the intracerebral bleed was likely to be due to a small vascular abnormality rather than due to malignant or accelerated hypertension. He thought that he probably had only mild to moderate hypertension before his bleed because he had been found to have only grade 2 hypertensive retinopathy. There was no proteinuria, haematuria or edema which accompanied accelerated or malignant hypertension.

Expert opinion also felt that the very high blood pressure readings at the time of the stroke represented the usual physiological reaction to a cerebral bleed and did not represent the true ongoing level of hypertension. He discounted the relevance of headaches as a sign of hypertension in this case. He explained that hypertension usually only causes headache if it is malignant or accelerated, which he believed was not the case. The patient was carefully assessed pre-trial and all costs were recovered.

Learning points

■ Timing events don’t always equate to negligence. A CT scan successfully defended the claim by gaining expert opinion from three doctors.

■ It is useful to remind ourselves of the stages of hypertensive retinopathy and to remember to examine the fundus in patients with hypertension.

REFERENCES

2. The NICE guidelines. Available at: https://www.nice.org.uk/guidance/cg287/summary.

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Nervous about neurosarcoidosis

Mrs W was a 44-year-old French teacher who was usually fit and well. She had two children and they enjoyed walking to the same school together in the mornings. On one of these walks Mrs W was troubled by aching in her right buttock and some tingling in her right calf. She mentioned this to her GP, who noted that there had been no acute injury and that she was still managing to walk to school. He advised her to take paracetamol and ibuprofen and suggested some exercises.

A week later the pain was worse so Mrs W made an appointment to see Dr G. Another GP, Dr G, documented that she had acute backache with right-sided sciatica and paraesthesia in the right lower limb. She noted that there were no bladder or bowel symptoms and documented that tone, power and reflexes were normal in both legs. Dr G’s notes stated that she had discussed warping signs that would need review. She prescribed diclofenac and referred Mrs W to physiotherapy.

Three weeks later Mrs W saw Dr G again, complaining that the pain was so bad that she couldn’t work. Dr G noted back pain with right-sided sciatica and paraesthesia but, again, found the power in her legs to be normal. Mrs W was getting indigestion with the diclofenac so Dr G prescribed codeine instead. She gave Mrs W a sick note and Mrs W said she would see a private physiotherapist in the meantime.

She managed to see a private physiotherapist a week later. The physiotherapist’s notes commented on her right buttock and leg pain and numbness in the right foot without weakness. There were clear records of the absence of bladder or bowel symptoms.

Mrs W was struggling to sleep with pain so made another appointment with Dr G. She documented that Mrs W was tearful but keeping active, doing jobs round the house. Dr G prescribed some senokot to help with “codeine related constipation” and a trial of amitriptyline.

Two days later Mrs W felt at home and rang the out-of-hours GP service. She told the triage nurse that her right leg felt numb and weak, and that she felt like she needed to pass urine but couldn’t. An ambulance was called and records in the Emergency Department noted a five-week history of right-sided leg pain and paraesthesia with a one-day history of retention of urine and inability to pass stool. Examination revealed weakness and diminished sensation in Mrs W’s right leg but normal findings on the left. There was reduced anal tone and sensation over the saddle area. She was catheterised and there was no urinary symptoms only occurred on the day she was admitted, and not before as Mrs W claimed.

Mrs W was commenced on a three-day course of intravenous steroids, followed by a further two-day course. An MRI confirmed an extensive high signal throughout the thoracic cord, suggestive of either inflammation or infection; a plasma exchange was begun. There was no change to Mrs W’s condition and doctors noted her developing upper limb symptoms, a 6th nerve palsy and papilloedema. She was therefore treated on the basis that she had neurosarcoidosis, and Mrs W was recommenced on high dose steroids and started on intravenous cyclophosphamide.

Her condition stabilised and the 6th nerve palsy and papilloedema resolved. However, she was left with clumsy hands and paralyses of both lower limbs. Metronidazole was tried, but there was no substantial change to her clinical condition. She did report some improvement in the function of her hands.

Mrs W was left with faecal incontinence in her lower limbs, rendering her unable to move either leg or stand. Her upper limbs were weak. She had a suprapubic catheter and was incontinent of her bowels. Mrs W was devastated and made a claim against Dr G.

Mrs W alleged that she had told the GP of her difficulties in passing urine and opening her bowels several times prior to her admission. She claimed that her GP had failed to examine her adequately and had not referred her urgently. She believed that her disabilities would have been less severe if she had been diagnosed and treated earlier.

MPS’s GP expert reviewed the notes from Dr G, the physiotherapist and the hospital. He felt that there were some vulnerabilities in Dr G’s notes from the second and third consultations because they were rather brief, but considered her examination and management to be reasonable. He noted that Dr G prescribed senocot for constipation but thought it understandable for a patient taking codeine to be constipated.

He felt that constipation in itself was not sufficiently discriminatory to be a red flag necessitating urgent neurosurgical referral. He commented that the physiotherapy notes were clear and that the patient had been specifically asked about bladder or bowel symptoms and that there were none. The hospital notes stated that urinary symptoms only occurred on the day of admission. The records from all the clinicians involved point to Mrs W’s bladder and significant bowel symptoms starting on the day she was admitted, and not before as Mrs W claimed.

MPS also sought the opinion of a professor in neurology. He concurred with the rare diagnosis of neurosarcoidosis. He felt that Mrs W’s acute deterioration was a consequence of cord ischaemia and infarction resulting from inflammatory or granulomatous involvement of the arterial supply to the cord. This would explain the sub-acute illness with a rapid evolutionary phase to the point of severe neurological disability. It was his opinion that there is no proven effective treatment for neurosarcoidosis and that earlier treatment would not have altered the outcome. He noted that it is well recognised that cranial neuropathies, such as Mrs W’s 6th nerve palsy, can resolve spontaneously without treatment, and the improvement in Mrs W’s upper limb symptoms was consistent with the variable natural history of neurosarcoidosis. The cord dysfunction that she had developed remained unchanged despite treatment.

MPS decided to defend the case to trial denying liability, supported by expert evidence. Mrs W discontinued proceedings two weeks before the trial, and MPS is now seeking recovery of all costs.

Learning points

- Good note-keeping is important in patient care but also when defending a claim. Clinical records should include relevant clinical findings, negative findings and relevant negatives when excluding red flags, such as the absence of bladder or bowel symptoms.
- MPS carefully reviewed the records of the GP, the physiotherapists and the hospital. Doctors to see how the notes supported each other to aid the defence.
- It is useful to be reminded of the referral guidelines from primary care for lower back pain.1 Repeated examination is needed to check that there is no progression of neurogenic deficit.
- This case highlights the value of revisiting your diagnosis and not making assumptions when a patient re-presents.

References
1. www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441
Ms X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex. At four weeks, the health visitor’s notes showed that J’s parents were concerned that J’s left eye was smaller than the right, and the health visitor referred the baby to a community paediatrician. A couple of weeks later, the health visitor documented the left eye as being more open, and the referral was cancelled. J was then seen by the family’s GP, Dr A, for a six-week check-up; his vision and hearing were recorded as being “satisfactory”. At three months, Dr A referred J to the ophthalmology department after noticing a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J’s eyes.

At six months, J’s ophthalmology appointment took place. He saw a consultant ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye and that the eye was microphthalmic.

The health visitor had listed initial concerns about the size with her eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 25% chance of restoring J’s visual acuity to a level adequate for driving.

Another expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as the health visitor had listed initial concerns about the size with her eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 25% chance of restoring J’s visual acuity to a level adequate for driving.

The case was settled for a substantial sum.

### Learning points

- Poor communication leads to poor treatment. Here is poor communication at various stages, between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a consultant ophthalmologist until he was six months old, this delay highlights failing at both ends. Dr A’s referral letter did not make the urgency of the appointment clear but, also, the recognised association of microphthalmia with congenital cataract should have prompted the consultant reading the letter to offer an urgent outpatient appointment.

The Swiss cheese

Ms M was a 64-year-old care assistant in a retirement home. She visited her GP with a two-month history of blood in her stools, altered bowel habit, and intermittent lower abdominal discomfort. On examination the GP found haemorrhoids, and referred her to her local hospital to see Dr P, a gastrointestinal surgeon. Mrs M was found to be overweight, with a BMI of 32, and was a smoker. Dr P performed routine blood tests, and booked Mrs M to undergo gastroscopy, proctoscopy, colonoscopy, biopsies, and injection of haemorrhoids, under general anaesthesia.

She was seen preoperatively by Dr D, consultant anaesthetist. Dr D noted Mrs M was on a number of medications, including metoprolol and quinapril for hypertension; simvastatin for raised lipids, and inhalers for a diagnosis of chronic obstructive airways disease. She was documented to be allergic to the antibiotic augmentin, which she had taken some years previously, and had caused a rash and wheeze. Mrs M reported that her brother had suffered a severe reaction to general anaesthesia, and had spent two days in intensive care following a hernia operation. However, she was unable to provide more details, and her brother had subsequently moved overseas. Mrs M had undergone two uneventful general anaesthetics at that hospital.

Dr D decided to proceed with general anaesthesia. The procedure was uneventful, but at one point, Dr D administered 1.25g of augmentin. In the recovery area, Mrs M was noted to have a widespread itchy rash and was complaining of wheezing. However, her pulse, blood pressure, saturations and conscious level remained normal. She was treated with antihistamines and hydrocortisone. As a precaution she was admitted to the hospital overnight, where the rash and wheeze resolved, and she was discharged the following day following a further set of blood tests.

During her stay, she was visited by Dr D, who documented that he had apologised to her for the accidental administration of augmentin. Dr D wrote a letter to the GP explaining what had happened, and gave Mrs M a copy. Dr P was also noted to have visited her, but did not document his visit or discussion in the medical record.

Approximately one week later, Mrs M developed a high fever and abdominal pain and was admitted to the hospital under Dr P. She was noted to be jaundiced and her laboratory function tests were deranged. Investigations suggested a diagnosis of acute cholecystitis, and she was treated with antibiotics. The episode subsequently changed several of its policies and procedures, including implementing a “time-out” check at the start of each endoscopy procedure.

### Learning points

- Adherence to simple protocols, such as the WHO Surgical Safety Checklist, can help prevent problems of this kind, where a known and documented allergy was overlooked. See www.who.int/patientsafety/safety⼿术清单/en/
- In choosing a technique such as general anaesthesia, Dr D was attempting to avoid a rare but dramatic problem, malignant hyperthermia. Mrs M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra attention from a much commoner problem, which is allergy to antibiotics. Take extra.
- Good documentation is the cornerstone of your defence. In this case Dr P didn’t document anything that had been discussed or shared. If a junior doctor is making the notes, ensure you check their entries.
- Human error is inevitable in medicine, but doctors should always be open with patients and their families following an adverse event. An open and frank apology can often help to defuse anger. In this case, Dr D was praised for his handling of the incident afterwards.

Wrong drug, no negligence

SH

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M. was a 17-year-old with a form student, visited Dr B at the end of the summer term of school after a stressful exam period. She was feeling generally unwell with a sore throat and some vomiting. Dr B reassured her that she was probably run down following her exams, and she was likely to have picked up a virus. She had planned to go to America with her family over the summer, so he advised her to return to the surgery if her symptoms persisted when she came home.

One month later, Miss Z felt no better and returned to the surgery, this time seeing Dr Q. She complained of ongoing nausea, neck-pain and headaches. She also noticed that her vision was “blinking out” every few days. Dr Q documented a normal pulse and blood pressure and arranged an appointment with an optician. Miss Z did not recall an eye examination taking place; however, Dr Q maintained that fundoscopy would have been part of his cranial nerve examination. He arranged some blood tests and a review with the result.

Her bloods were all normal and Miss Z was not seen again for a further two months. She again consulted Dr Q, this time complaining of weight loss along with a persistent sickly feeling. She was also experiencing visual loss on a daily basis. No record was made in the notes. Further blood tests were arranged.

Over the next month, Miss Z consulted Dr Q twice, and on both occasions the weight loss was the focus of the consultations. Dr Q attributed the symptoms to stress as deadlines for coursework were looming. He discussed the risk of instrumental delivery and caesarean section as a result. Miss Z was again brought back two weeks later. Dr Q was referred and agreed upon. Dr A made arrangements with the labour ward and used the indication “reduced fluid around the baby”, though he explained to Miss Z that this was to keep the midwife “happy”. An ultrasound scan reassured Miss Z that all was well with the baby.

Miss Z was admitted for induction of labour at 37 weeks gestation. On examination by Dr A the cervix was found to be soft, posterior and partially effaced. Induction by 2mgs intravaginal Prostogel was commenced at 09:30. An amniotomy was performed seven hours later and labour ensued within two hours. The first stage of labour was completed at 00:05 and_push was commenced 45 minutes later. Progress was slow, Mrs G’s temperature increased and the foetus developed a trace of acidosis. The midwife requested a consultant review and Dr A assessed the patient. The baby’s head was in an occiput posterior position but low in the pelvis. There was discussion with the parents about the possibility of ventouse extraction, initially they were reluctant, having seen the effects of ventouse delivery on head shape and facial bruising before. However they consented and the procedure went ahead. A Kiwi cup was used with positive pressure over two contractions to effect delivery. The perineum stretched well and episiotomy was not deemed necessary. A second degree tear was sustained with laceration and was repaired with vicryl under local anaesthesia due to pain.

Later, both the midwife and Dr A noted the perineum to be swollen. Miss Z questioned the possibility of prolapse but this was excluded by Dr A. Soon after, relations with Dr A deteriorated for unknown reasons and Mrs G refused to see him again.

She remained in hospital and saw other doctors and a physiotherapist. Each clinician acknowledged that she had ongoing pain, urinary and faecal incontinence, but none identified a problem with the repair. There was no improvement in function but the anal sphincter was intact. Mrs G was discharged six days following delivery and was improving. Dr B saw her 11 days post-discharge and noted constriiction of the introitus that was thought to be self-limiting (the risk of requiring surgery being 2%). The following week there was no improvement: pain persisted locally, there was difficulty recognising feelings in the bladder and intercourse was impossible. Examination revealed a very tight asymmetrical introitus.

A second opinion gynaecologist, Dr F, recommended a Fenton’s procedure, which was undertaken with ease and without complications ten weeks after delivery. A claim was made against Dr A, alleging breach of duty for using oxytocin inappropriately, failing to rotate the head prior to delivery, using ventouse inappropriately, failing to perform an episiotomy, substandard repair of the perineum and failing to provide adequate postnatal care.

Expert opinion was supportive regarding breach of duty on all counts. Induction on psychological grounds was said to be reasonable, as was the use of oxytocin. Ventouse delivery without head rotation was cited as normal practice, as was allowing the perineum to stretch, avoiding the need for episiotomy. The expert stated that it would be unusual that a consultant of Dr A’s standing would pursue the labia together. The tissues were likely to have healed incorrectly rather than the repair having performed in a substandard fashion. Induction of labour had no bearing on the need for instrumental delivery.

Unfortunately, several key documents were missing from the notes and could not be traced. Despite the supportive expert opinion, however, in the absence of these key documents, we advised it would be very difficult to defend the case. Accordingly it was settled for a moderate sum.
Complications of colonoscopy

A 50 year old accountant, Mrs A, was admitted to hospital with a 3-day history of rectal bleeding and abdominal discomfort. She had a history of haemorrhoids and was otherwise healthy. Physical examination revealed a normal abdomen and normal auscultation of the bowel. A flexible sigmoidoscopy demonstrated a mobile 5mm polyp in the caecum with a stalk and adenoma. A fibre-optic colonoscopy was performed the next day. Mrs A tolerated the procedure well and had a normal bowel habit. The colonoscopy revealed a mobile 5mm polyp in the caecum with a stalk and adenoma. Mrs A had had a stormy ileostomy but Mrs A developed ileus and was kept nil by mouth. An abdominal X-ray revealed sub-diaphragmatic free gas and a haemorrhagic collection. The abdomen was explored and a sub-diaphragmatic abscess was drained and an ileostomy was performed. Dr C recommended a haemorrhoidectomy.

Two weeks later Mrs A remained well and the CT scan had demonstrated no fluid collection. Dr C organised her admission to another hospital for radiologically guided drainage of the abscess, but the abscess was not found. Her condition deteriorated and Dr B, the consultant surgeon on-call at this hospital, undertook an emergency laparotomy to drain the abscesses and perform a defunctioning ileostomy. Mrs A had a stormy postoperative course, initially requiring ITU support, and spent three weeks in hospital. Dr B subsequently reversed her ileostomy but Mrs A developed problems with an incisional hernia, requiring several attempts at repair. She also needed psychological support for a post-traumatic stress disorder, resulting in prolonged absences from work. Two years later, Mrs A brought negligence proceedings against Dr C. It was claimed that Dr C should have acted sooner by performing an x-ray and CT scan, revealing the presence of a mass. Mrs A initially developed pain. It was also alleged that Dr C had selected inappropriate antibiotics and had discharged her too early, allowing the development of her abscess. It was suggested that these acts of negligence had delayed appropriate surgical treatment and directly led to all Mrs A’s subsequent complications.

Expert opinion for MPS did not substantiate any of these claims. It was agreed that non-operative management for perforations after colonoscopy was an acceptable practice if the patient was stable, exhibited no signs of sepsis and the perforation appeared to have sealed. The CT result, together with the carefully documented clinical findings, nursing charts, and Dr C’s explanation of the need for surveillance colonoscopy, was normal and the site of the haemorrhoidectomy was healing nicely. The pathology report of the polyp revealed an excised low grade tubulo-villous adenoma and Dr C explained that the perforation related to this patient’s inflammatory markers over several days, all supported this approach. Microbiology experts agreed that the antibiotics prescribed were appropriate and the length of administration sufficient. Dr C was also able to produce audit evidence of his colonoscopy practice, demonstrating a high volume (400 per annum) with a very low complication rate. MPS defended the case and the claimant discontinued on the first day of trial, with full recovery of costs.

Learning points

- Complications after procedures can occur and are not necessarily the result of negligence. Claims can be defeated if clinicians are able to demonstrate that they acted appropriately in the detection and subsequent management of complications. Evidence of a high-volume practice with a low complication rate (as in this case) can strengthen the defence.
- Claims often arise many years after the event. The careful documentation of events and discussions with the patient can form part of the evidence. It may also be supported by the facts of the case to be established, and a successful defence of the allegations.

A catalogue of errors

As an orthopaedic surgeon, I was concerned about the number of cases related to orthopaedic surgeons in Casebook 22(1), January 2014. I was pleased to see, however, that many of those cases had been defended.

What surprised me was the case “A catalogue of errors”. In that case, a lady underwent a knee replacement that appears to have been mis-positioned, which caused pain in the knee and the need for a revision procedure to be carried out at an early stage. At that revision, carried out by a different surgeon, swabs were taken showing coagulase negative staphylococcus, but this was not thought to be significant. Subsequently, the patient developed an infected knee replacement and staphylococcus epidermidis was grown (the same bacteria as coagulase negative staphylococcus). This pattern of late clinical symptoms from infection is not at all unusual with this low virulence organism.

The importance of this, of course, is that the infection was clearly in the knee following the original operation and would have become symptomatic in due course in any event. The patient would therefore have required a revision knee replacement for this infection, even if the original components had been perfectly placed. I note that the first surgeon was sued and the claim probably was because of the poor technical skill exhibited in carrying out the original knee replacement, and your expert, Mr D, felt that this was a breach of duty which indeed may well have been. However, the infection would not have been a breach of duty as it is a well-recognised risk following any knee replacement, and this would have required a two-stage revision in any event.

I note that the claim was settled for a substantial sum but it would seem that the expert had not understood the management of complications. High evidence of a high-volume practice with a low complication rate (as in this case) can strengthen the defence.

Anatomy of a claim

In Casebook 22(1), January 2014, the feature “Anatomy of a claim” tells a depressingly familiar story. Frequently and incomprehensively termed “discovery” of the vertebrae are commonly missed clinically. The vascular anatomy in the juxta-discal area shows a pattern of tendinous vessels throughout life – hence a vulnerability to infection. The disc is avascular and infection can only occur by direct inoculation, eg, during surgery or discography.

In cases of thoracic spinal infection and in my experience of more than 35 years as a spinal surgeon, careful clinical examination of the spine will invariably disclose clear evidence. Pain and tenderness on local pressure will always be associated with the back pain history. Chest pain or radicular pain may also be present. The ESR is invariably raised.

Given the typical history given by Mr P, Dr C’s conclusion that the symptoms represented “muscular back pain” was made on the basis of symptoms that tenderness on local pressure will always be associated with the back pain history. Chest pain or radicular pain may also be present. The ESR is invariably raised.

The importance of this, of course, is that the infection would not have developed if the patient had not required early revision surgery due to the sub-standard index operation. He was also of the opinion that had the initial procedure been carried out appropriately, the prosthesis would not have needed revision until it failed – in approximately to 15 years to 20 years.

The settlement in this case reflected these issues.

Anatomy of a claim

“Over to you”

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REFERENCES

Response
Thank you for your comments on this article. In this case it is important to note that the case the claimant did not bring any allegations in respect of the surgical treatment provided. The allegations were in respect of Drs A, B and C who saw Mr P at the GP surgery. In accordance with the general principles of medical negligence, the standard on which the three doctors are judged is that of the reasonable general practitioner. On the doctors’ account of the case the GP expert evidence was supportive. Although there was a potential conflict of factual evidence (ie, what actually happened in the case) it was clear that Mr P had no real recollection of what he had told the GPs about his symptoms during the various consultations.

What an assessment at the beginning of the process by a specialist might potentially have resulted in an earlier diagnosis (depending on what symptoms were actually present), the standard to be applied is that of the reasonable GP, and our expert was clear that doctors A, B and C had reached that standard.

Consent templates?
The question of adequate consent and the preparatory documentation of possible risks and complications frequently appear in Casebook. Are there any templates of consent forms available for gynaecological procedures (especially laparoscopic procedures)? Is it not something that MPS should be involved in creating or developing?

Response
Thank you for your observations and comments.

Cutting corners
As an anaesthetist, I was interested to read the case report “Cutting corners”, describing the severe brain damage that befell a four-year-old boy following an anaesthetic mishap (Casebook 22(1)).

The anaesthetist, Dr B, has cut corners on several aspects of his care, including failing to warn the child’s parents of the “risks of anaesthesia”. I should like to know what MPS recommends in this regard, given that in the case quoted, the child was fit and well, with no medical problems or allergies, and was appropriately fasted. He obviously required a general anaesthetic, and in the overwhelming majority of such cases, one would expect this to be uneventful. What should Dr B have told the parents, without alarming them unnecessarily?

Dr Ian R Holmes, Consultant anaesthetist, Newcastle upon Tyne, UK

MPS does not produce specific template forms or templates for use in the consent process. Consent is a process that will vary depending on the circumstances. Although there are some specific exceptions in relation to certain procedures, interventions and circumstances (eg, sterilisation and termination of pregnancy, which require the completion of statutory forms), the actual format of the consent is less important than the accurate documentation of the process.

Controlled drugs
The question of adequate consent and the preparatory documentation of possible risks and complications frequently appear in Casebook. Are there any templates of consent forms available for gynaecological procedures (especially laparoscopic procedures)? Is it not something that MPS should be involved in creating or developing?

Response
Thank you for your observations and comments.

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Thank you for another informative issue of Casebook. I am responding to Helen Moriarty’s article on controlled drug policies - “Controlled drugs - what you need to know”, Casebook 22(1) in New Zealand.

The article is clear and helpful, and the message that prescribing to any dependent person must be by a gazetted practitioner (and sometimes location) or under the specific written authority of such a practitioner, is clear. However, the article does not address the question of colleague or locum prescribing, and I have wondered about this in the past.

Specifically, if the duly gazetted authorised practitioner is away/ unavailable (not just fully booked that day), does a colleague from the practice, or a locum, have the legal right to prescribe for dependent patients?

It is a widespread convention that locums (if not colleagues) are authorised to do all the doctor they are replacing would normally manage, including prescribing to this category of patient.

I shall be grateful for Dr Moriarty’s further advice.

Dr Craig Leitch, Brisbane, Queensland

How reliable is healthcare?
I’d just like to comment on the excellent article “How Reliable is Healthcare?” by Dr Dan Cohen in the current (January 2014) issue of Casebook. As both an airline captain and former surgeon, I have a view from both sides of the debate. I’d like to agree with his views on complacency leading to errors but must disagree on two points.

While I agree that patients are inherently more at risk when flying than aeroplanes, the important point is that aeroplanes (patients) generally don’t cause accidents - it is caused by human error due to the operator (healthcare professional or pilot). Therefore this is where we need to focus our energies, namely in human factors training for staff to help recognise and deal with error.

Also, as in healthcare, we consider our passengers (patients) an integral part of our safety awareness system. Any issue brought to the attention of our cabin crew, such as unusual smells, sounds, ice on the wings or leaks from engines (both of which are much more easily seen by our passengers due to their better view of that area of the aeroplane), are brought immediately to the attention of the captain as part of our crew resource management information gathering system, ie, communication, leadership, situational awareness, leading to decision-making. We regard passengers as much more involved and as passive consumers of our service.

Capt Daniel Downey, FRSCG, Managing Director, Frameworkhealth, Ireland

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Thank you for your observations and comments.

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In respect of rare but potentially serious complications such as awareness, nerve injury, disability and death, the AAGBI (Association of Anaesthetists of Great Britain and Ireland) recommend in their guidance Consent for Anaesthesia Revised Edition 2006 (para 5.3.8), that written information should be provided, and the anaesthetist should be prepared to discuss the risks.

Response
Capt Downey makes some excellent points and his thoughts are aligned with mine. It is certainly true that aeroplane safety relies to some extent on passengers alerting crew to potential problems, and in adopting a healthcare outcomes paradigm, similarly relying on patients for their expertise is crucial.

A difference is that the passengers on an aeroplane, and experts perhaps in the case of a mid-air emergency, do not rely on the crew to instruct them how to be successful passengers (after the initial safety instructions prior to takeoff!), whereas achieving healthcare outcomes uniquely requires clinicians and patients to work very hard together across all aspects of care planning to achieve successful care implementation.

One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are readmitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause of physical, psychological and financial harm; the antithesis of a high-reliability system.

Clinicians and patients are both encumbered with many human factors liabilities and training or interventions for both are likely to serve good purpose.

The processes of diagnosis, therapeutics and of care plan implementation present numerous human factors challenges. If the goal is preventing readmission then planning for that should begin at the time of admission with defining, and then modulating, the human factors that confound success.

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Reviews

FILM: The Enemy Within (50 Years of Fighting Cancer)

Dependable Productions
By Dr Omar Mukhtar, ‘Darzi’ Fellow, Health Education South London, UK

The Enemy Within is an hour-long film presented by Vivienne Parry – it tells the story of the human fight against cancer over the last 50 years. Contributors include the great and the good of cancer research – Professors Robert Weinberg and Tutty, one of many patients, Parry – it tells the story of the human story, the story of those who have succumbed to cancer and those who have survived, feels sanitised – devoid of the emotion we associate with cancer, it describes any number of important events – be that the debate surrounding combination versus sequential, single agent chemotherapy, the provision of palliative care or the realisation that a conservative surgical approach, as opposed to radical mastectomy, might be equally beneficial and less disfiguring for patients with breast cancer. It also focuses on achievements further afield that have helped improve survival rates for many cancers – the vast technological advances that have led to the development of CT, MR and PET imaging, the sequencing of the human genome and the realisation that environmental exposures (smoking, alcohol, obesity and sunbeds) are significant causative factors that need to be addressed. In doing so, it tells a calm and sober story of human endeavour.

Whilst the film also acknowledges the role of survivors, politics and ‘people power’, you sense that the nod to these groups is simply that – a nod. The power of the human story, the story of those who have succumbed to cancer and those who have survived, feels sanitised – devoid of the emotion that might invigorate this short film. Moreover, you can’t help but feel that it glosses over many of the challenges that remain – the failure to diagnose and treat virulent cancers, especially pancreatic and thoracic disease, the inadequacy of treatment in the non-industrialised world, and the considerable costs arising from non-adherence.

This is a non-commercial, editorially independent piece, supported by Cancer Research UK and funded by an educational grant from Roche. The film-makers set out to educate and inform those who are affected by cancer. Whether they have achieved that is questionable, as the focus and language is largely directed towards the medical fraternity. However, in a little over an hour, this film provides a high level overview of what has been achieved in 50 years, which will be enjoyed by many a clinician.

The Checklist Manifesto: How to Get Things Right

Review by Dr Amir Forouzanfar, surgical specialist registrar, Doncaster, United Kingdom

Atul Gawande has written an insightful, in-depth and stimulating book about the challenges of modern medicine. His honest reporting of challenging medical scenarios including personal mistakes, combined with stories from other professions, certainly convinced me that surgical checklists are a good thing. I work as a specialist registrar and we now routinely undertake the WHO operating checklist. I’ve noticed an increase in its uptake and implementation, which can only be a good thing. I see errors picked up on a weekly basis simply by having an easy-to-follow checklist for the whole team to follow.

Gawande distinguishes between errors of ignorance and efforts of ineptitude – the most common and relevant in today’s medical world being the latter. He explains that the high pressured and intense environment that is prevalent in the medical world means mistakes are inevitable. He borrowed a concept from the aviation industry; the checklist, similar to the checklists used by pilots before take-off, and applied it to medicine. He then argues that implementing checklists that walk surgeons through procedures actively prevents mistakes. Good checklists and clear communication amongst the team can significantly reduce errors.

For those among the medical profession who are sceptical about using checklists, or are interested in how the WHO operative checklist came about, I suggest you read this book, as it is powerful enough to make you rethink your ideas. I’ve found myself using examples of Gawande’s book to inform my operating staff of the origins of each checklist, while stressing its importance to us all. Surgeon or paediatrician, GP or psychiatrist – I encourage every doctor to read this well-crafted and fascinating book – it will change the way you think.

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