DIVERTED BY THE DIAGNOSIS

HOW A HOSPITAL ASSESSMENT MISLED A GP – PAGE 16

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The place to debate hot topics

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• The Anatomy of a Regulatory Case
• Looking After Yourself

PLUS WORKSHOPS ON
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editorial matters, unsurprisingly, continue to feature heavily in the headlines and the media in general. There seems to be an endless appetite among the public for such stories, whether they are announcing the arrival of new and better treatments or procedures, or reporting shortfalls, errors or even scandals. Politicians frequently feel obliged to step in, but their attempts to remedy things don’t always have the desired response. 

Inevitably this is felt by you on the wards or in your consulting rooms, with increasing patient expectations in the form of unrealistic demands or a raft of self-researched information from the internet. This can make for some challenging situations, at a time when workloads grow in intensity, perhaps due to budgetary cutbacks or other local factors.

It continues to be an important time to be part of an organisation like MPS. We work in partnership with you to protect and support your career at every stage, and this work takes many forms, beyond the litigation work that we are more traditionally associated with. This includes an extensive range of educational products such as online learning, workshops and seminars, as well as continuous consultative work with governments and policy-makers worldwide. The latter is often ‘behind the scenes’ and often not highly-publicised, but you can be reassured that our specialist teams are fighting hard to safeguard your interests.

Many of you got in touch with us following the last edition of Casebook, regarding our cover story on the case of the Bowen family. While the emotional reaction from a number of correspondents was not surprising, I was heartened by the way the article made everyone think about their own approach to communication, openness and consent. Anger at the treatment of the Bowen family was palpable in some of your letters, and if this deeply tragic case results in reflection and changes in culture and practice, then something positive will have been achieved.

We have published a short response to this correspondence in our “Over to you” section on page 23. I hope you find this edition of Casebook an equally thought-provoking one and, as ever, I am keen to hear your feedback.

The claims environment in Ireland has deteriorated in recent years; significantly so in some areas of practice. Gareth Gilsepie looks at what MPS has been doing about it.
At a glance, our recommendations are:

1. GENERAL DAMAGES
   • Tariff of general damages to be created in statute
   • Limit on general damages

2. SPECIAL DAMAGES
   • Limit on future earnings, and future financial losses limited to proven earnings
   • Limit on future care costs

3. FREQUENCY OF CLAIMS
   • Introduction of a 'Certificate of Merit' Cap on lawyers' fees in smaller value cases, to introduce proportionality

4. DEFINITION OF CLINICAL NEGLIGENCE
   • Introduce a Bill that defines the tort of clinical negligence and confirms that a tort is established by both breach of duty and causation – that the breach must have caused the injury. It would also assert that the burden of proof is placed on the plaintiff

5. LENGTH OF LIMITATION PERIODS
   • Full implementation of the recommendation of the 2011 Law Reform Commission review on limitation
   • Ultimate limitation period of ten years

6. PRE-ACTION PROTOCOL
   Another recommendation is the introduction of a pre-action protocol. This may go some way to reducing the legal costs associated with clinical negligence claims, and should make the system more efficient for both plaintiffs and defendants. Essentially such a protocol encourages openness and transparency, and provides the opportunity to investigate a claim and resolve it prior to issuing proceedings. Protocol will set out what information parties must provide to the other side, and in England and Wales there are financial penalties if parties do not attempt to resolve the case in this way before issuing proceedings. MPS was pleased to see widespread support for a pre-action protocol during recent evidence sessions to the Joint Committee on Health and Children. MPS acknowledges and strongly supports the considerable work that has been done by the Working Group on Medical Negligence and Periodic Payments, which was established in 2010. We understand that the group recommended a pre-action protocol and we strongly support such a recommendation. In the meantime, we have written to major law firms in Ireland that represent plaintiffs, to ask for their co-operation in trialling a pre-action protocol.

THE JOINT COMMITTEE ON HEALTH AND CHILDREN

Our call on the government to take action led to an invitation to present at the Joint Committee on Health and Children, in January.

MPS Chief Executive Simon Kayll appeared before the committee, where he presented MPS’s recommendations for tort and procedural reform to the Committee’s deputies and senators. Also called to give evidence were the State Claims Agency, the Irish Hospital Consultants Association and the Irish Medical Organisation.

As well as talking through our proposals for legal reform, Mr Kayll spoke at length about open disclosure, a topic that MPS has campaigned extensively on in the past.

Mr Kayll said: “It was a great opportunity for us to be seen by members to be influencing the debate around clinical negligence. It was very gratifying that the four doctors present, three giving evidence and one on the committee, all took the opportunity to praise the support and education that MPS provides to its members.

“At MPS we strongly believe that those harmed through clinical negligence should receive fair compensation, but that such compensation must be affordable for society. We believe that the extent of compensation currently paid in Ireland is no longer affordable by society and something needs to change.

“MPS significantly increased its subscriptions for private consultants in mid-2014 in response to a deteriorating claims experience and we are acutely aware that this has been very painful for some of our members. We have done what we believe is necessary to ensure the financial security of MPS, so that we will be in a position to support our members long in to the future when they need assistance.

“Recognising the deep concern that our subscriptions are causing for our members and the implications this has for the delivery of healthcare in Ireland, we have taken the step to launch a campaign to raise awareness of the situation and to stimulate debate and have also suggested some solutions around tort law and procedural reform. We will continue to promote these ideas, stimulate debate and seek changes to make clinical negligence indemnity in Ireland more affordable for our members.”

A CALL FOR OPENNESS

As an organisation we are committed to open and early resolution in the interest of all parties. Our part of this commitment is to deliver the skills to frontline healthcare professionals.

Our advice to all members is to have full and open communication with the patient once sufficient facts have been established about any adverse incident, as soon as possible. An explanation may be all that is needed to reassure a service user and avoid unnecessary escalation. Above all, this is the ethical thing to do.

When organisations embrace open disclosure it benefits all involved. It results in safer doctors and greater levels of patient satisfaction, we have seen many complaints and claims arise from poor communication following an adverse outcome. We were pleased to see that our ASSIST framework model, utilised in our educational workshops, is now part of the HEA’s Open Disclosure guidelines.

Although there is consensus that openness should be encouraged in healthcare, there is debate about what measures are needed to achieve this. Some support a statutory duty of candour, which exists in England and Wales. This duty means that healthcare organisations (not individuals) are under an obligation to be open with patients when something goes wrong. This is regulated by the Care Quality Commission.

However, we strongly believe that a change in culture would be far more effective. Healthcare organisations need to facilitate and promote a culture of candour, where healthcare professionals willingly give patients an open and honest explanation when something has gone wrong, as well as an apology where appropriate.

For a cultural shift to be effective and far-reaching, the government and healthcare managers need to encourage organisations to support open communication and the notification of adverse events and near misses. This should include ongoing support, training, mentorship and investment in leadership by example. This will enable staff to effectively participate in open discussions and fulfil their existing professional obligations.

THE CAMPAIGN CONTINUES

MPS met Health Minister Leo Varadkar in April to reiterate our calls for change. It was a productive meeting where we were able to outline our proposals in full. In the meantime, we are continuing to work with key stakeholders to identify and address important issues that could affect our members.

REFERENCES
2. The full MPS report as presented to the government is included in this page as PDF format
3. www.medicalprotection.org/international/education-and-events/learning-adverse-outcomes
4. www.hse.ie/opendisclosure

You can see Simon Kayll’s appearance on the Oireachtas website: www.oireachtas.ie/viewdoc.asp?DocID=287456&Cbid=127
Dr Muiris Houston speaks to two GPs about their reasons for and experiences of practising medicine beyond Ireland

Medical migration from Ireland continues to gather pace. Anecdotes abound of newly-qualified doctors leaving because of what they perceive as difficult working conditions at home and better training opportunities abroad. Some established general practitioners have decided to emigrate for economic reasons, citing the declining economic viability of practice in the Republic, following a series of cuts to medical card fees imposed by government.

The Medical Council’s second annual Medical Workforce Intelligence Report, published in August, puts exact figures on what is happening. In a continuation of a trend identified in its first report, almost one in ten doctors aged 25–29 years exited the practice of medicine in Ireland during the previous year. This represents an annual relative increase of 23% in the exit rate among graduates of Irish medical schools in that age cohort. Some 5% of 25–29-year-old doctors on the medical register were practising outside Ireland.

A relatively low exit rate was observed among doctors enrolled in the specialist division of the register, suggesting the departure of mature practitioners has yet to appear on the statistical radar.

Casebook interviewed two general practitioners now settled in Canada and Australia to get a sense of why they left Ireland, what the major differences between the health systems are and in particular to get a feel for the medicolegal landscape in other jurisdictions.

Dr Sunny Chan is a 1997 graduate of Queen’s University, Belfast. He completed GP training in 2003 and then moved to Dublin to work as a GP and lecturer in general practice at the Royal College of Surgeons in Ireland. After completing his doctorate in 2006, he found a shortage of tenured academic posts in Ireland. And negotiating partnerships in practices proved “a very arduous task”, he says. So in 2012 he decided to emigrate and arrived in Ottawa in January 2013 where he started his own practice in Kanata, just outside the centre of Canada’s capital city.

Dr Deborah Molloy graduated from Trinity College Dublin in 2006 and completed the TCD training scheme in 2013. After some eight months working as a locum in practices around Dublin, during which she considered buying a practice, she moved to Perth, Australia, primarily for financial reasons. She has been a GP there for the last six months. She works in a corporate practice with ten other family doctors in a socially deprived area of the city. It is a bulk-billing practice so patients do not have to pay the practice directly.

Apollo Health, who plan to expand from operating three to six GP centres in Perth, employ a number of different payment structures for doctors. Most have a contract whereby they give 35% of their income to the company as a management fee. “A colleague of mine has described this as being like a sharecropper system whereby small farmers farm the land and give a portion of their earnings to the landowners,” Dr Molloy says.

“At the moment I am seeing between 25-30 patients per day. Consult times vary from 10 to 20 minutes. There is no on-call commitment.”

For Dr Chan, Canada offered a number of potential models to practise as a family physician. Essentially GPs are independent contractors who bill their provincial Health Insurance Plan for work and services carried out on behalf of patients covered by that province. Patients who don’t have a GP or who require emergency care can attend separate ‘walk-in’ clinics.

“Having always worked in a more traditional primary care model based on health prevention and continuity of care, I didn’t feel comfortable with providing ‘fast food’ style care to patients in a walk-in clinic,” Dr Chan says. “I chose to set up my own family practice in a health centre, joining three other GPs who have a similar philosophy in primary care. Within the model I work in there is very minimal ‘on call’...I generally see between 20-25 patients per day.”

What are the biggest differences between the Canadian, Australian and Irish health systems? Dr Molloy points to similarities with the NHS, albeit without the waiting times. Prescribing is tightly regulated; she must contact a state authority before starting anything other than basic treatment. And GPs are expected to take on more responsibility for the management of early pregnancy complications.

Dr Chan says Canada has a universal health system offering free healthcare to all, but with differences between provinces. Many Canadians take out health insurance to cover the cost of medication. However there are long wait times for secondary care appointments and surgical procedures, and these cannot be improved by using private health cover.

Dr Chan says he has noticed that patients in Canada will more readily complain to the provincial governing body if they are unhappy with a doctor, medical centre or even the doctor’s staff. “In Ireland during recent years I had noticed a sharp rise in medicolegal cases, possibly related to recessionary times.”

The medicolegal systems in Australia and Canada are similar to Ireland. Doctors are obliged to have medical indemnity, which is provided by a single body in Canada whereas there is a choice of agencies in Australia. In both countries initial medicolegal advice is available by telephone.

If a patient suffers an adverse outcome in general practice in Australia and wants to seek redress, Dr Molloy outlines the process: “If patients have a grievance the first option open to them is to fill in a form and give it to the administration staff in our clinic. The GP involved has the option of writing their own response.”

“If the complaint is of a more serious nature the patient can write to AHPRA, which is equivalent to the Medical Council. Or alternatively the patient can seek legal advice from a solicitor.”

And when a patient suffers an adverse outcome and seeks redress Dr Chan says they “invariably go straight to their lawyer, who will in turn serve notice on the doctor or health facility.”

Dr Molloy makes an interesting observation when she says that GPs in Ireland tended to get quite distressed about complaints and would be very quick to seek legal advice. “From what I can see the Australians seem to accept that people complain all the time and they seem to take this in their stride.”

Looking back both would like to see some changes to the system in Ireland. Quicker resolution of claims and a more protective Medical Council environment are top of their respective wish-lists.
## Case Reports

### Pulled in All Directions

**SPECIALTY: ANAESTHETICS**  
**THEME: INTERVENTION AND MANAGEMENT**

**HIGH €1,500,000+**

Mrs J was a 32-year-old female patient who had a history of neck pain following a road traffic accident. The pain was localised to the left side of her neck and was exacerbated by very occasional paraesthesia in her left hand. Despite regular analgesics and exercises, the pain was still troublesome and she was keen for a specialist opinion.

Mrs J was referred to Dr M, a pain consultant. Dr M noted slight restriction in neck movement on the affected side and elicited tenderness over the left C5/6 and C6/7 facet joints. Imaging revealed fusion of the C3 and C4 vertebrae and some loss of normal cervical spine curvature, but the vertebral bodies and spaces remained otherwise well-preserved.

Dr M recommended C5/6 and C6/7 facet joint treatment and told Mrs J that there was a 50% chance of getting long-term pain relief. He suggested two diagnostic injections with local anaesthetic followed by radiofrequency lesioning if benefit was felt. Dr M then went through the risks of the procedure with Mrs J, including lack of benefit, relapse of pain, infection and damage to nerves.

Mrs J returned for the first of the two diagnostic blocks. The block was performed in the lateral position and Dr M injected a mixture of 0.5% levobupivacaine and triamcinolone. The block provided good pain relief and Mrs J felt it was easier to move her neck.

Mrs J later returned for the second diagnostic injection. Mrs J was placed in the prone position and local anaesthetic infiltrated into the skin. Using fluoroscopic guidance, 22G spinal needles were inserted toward the C5/6 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and triamcinolone into the foramina. Unfortunately, as soon as Dr M started the injection the patient jumped with pain and her left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later the same day developed numbness in her left arm and right leg. She also complained of headache when setting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr M decided to admit Mrs J for overnight monitoring and analgesia.

The next morning Mrs J was no better. She felt unsteady on her feet and complained of a burning sensation in her right leg well into the cord. Dr M decided to admit Mrs J for overnight monitoring and analgesia.

Mrs J was referred to a neurosurgeon. The MRI scans showed signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved but Mrs J continued to suffer from right leg neuropathic pain. It affected many aspects of her daily life and she found it difficult to return to work as she was often frightened for any length of time. A spinal cord stimulator was inserted by another pain specialist to try to help with the pain, but this was largely unsuccessful and was later removed.

Mrs J subsequently lost her job and, following that, decided to bring a claim against Dr M.

### Expert Opinion

The case was reviewed for MPS by Dr F, a specialist in pain management. Dr F was of the opinion that the initial assessment and management plan were entirely appropriate. She was somewhat critical of the approach used by Dr M for the diagnostic injection as it was not consistent with the planned approach for the radiofrequency lesioning and, in her opinion, more likely to be associated with the possibility of damage to the spinal cord. She also felt that the use of tramadol in the diagnosis of neuropathic pain could be criticised, as injection of particulate matter into the spinal cord is known to be associated with a higher risk of cord damage.

Dr W, an expert neuroradiologist, was concerned about the needle trajectory reviewed from the second diagnostic injection. He concluded that neither needle was within the respective facet joint and that the lower needle tip was within the spinal canal at the level of C5, less than 1cm from the midline. Dr W also confirmed that the MRI abnormality corresponded with the position of the lower needle tip.

Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

MPS then instructed a causation expert to comment on Mrs J’s progression of symptoms. Professor I concluded that the development of neuropathic pain in the right limb was understandable, although the disabling effects were more than he would have expected. Whilst the patient did have a history of neck pain, the patient’s symptoms were consistent with a lesion affecting the spinothalamic tract on the contralateral side of the cervical spinal cord.

The case was considered indefensible and was settled for a high sum.
M's 3.4 child presented to the delivery suite at 12pm, 38 weeks into her first pregnancy.

Her antenatal care had been uneventful apart from measuring slightly "large for dates." She was found to have a longitudinal lie with a cephalic presentation, and was experiencing three contractions every ten minutes. The midwife examined her and found her to be 2cm dilated with a fully effaced cervix and "intact membranes".

At 3.30pm she was re-examined and found to be full dilated and was given 100mg pethidine IM.

At 8.30pm she was examined by the midwife again and still found to be 3cm dilated. The cardiotocograph (CTG), which had been started one hour before, was normal, with a baseline of 140b/min and good variability and good reactivity. Mrs G was new experiencing more painful contractions and an epidural was sited.

At 10pm, she was found to be 3cm dilated and the "membranes were still intact," despite still having regular contractions of three every ten minutes. No artificial membrane rupture was carried out, however, Mrs G was started on a syntocinon regime by the midwife.

At 10.30pm she was re-examined and found to be 1cm dilated. The CTG again showed that there was no clinical evidence of progression of risk. Mrs G was now experiencing the urge to push, with the head at the level of the ischial spine.

At 3am, Mrs G was re-examined and her cervix was found to be 6cm dilated with "intact membranes". The membranes were ruptured and she was found to have grade II meconium. The CTG Baseline had risen to 180b/min and there were deep late decelerations and the contractions were still strong, coming every ten minutes, despite having stopped the syntocinon. Dr A was informed, but he was "busy" and had still not arrived to review the CTG by 3.35am. He was re-contacted and came to assess Mrs G at 4am. He felt she was now "fully dilated" with the head at the level of the ischial spines. He decided to carry out a ventouse delivery, which was started at 4.15am. This was recorded as a "difficult delivery," but no further documentation was made. The 3.9kg baby girl was delivered at 4.35am with an Apgar score of 3 at one minute after birth, and 5 at five minutes. The cord gases showed severe metabolic acidosis with a pH 6.9 and BE-18 (arterial). The paediatricians were called subsequently and the baby was transferred to NICU. Although the baby survived, she had significant hypoxic ischaemic encephalopathy and severe cerebral palsy as a result.

Mrs G made a claim against Dr A and his team for their failure to adequately monitor her baby and recognise signs of fetal distress. This lack of communication between the teams and lack of recognition of the severity of the condition resulted in the infant having severe cerebral palsy, requiring lifelong care.

The claim was settled for a substantial sum.
The baby was born by caesarean section at 27 weeks gestation. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first four hours of life, the baby’s oxygen saturations were recorded as ranging between 96-97%. A blood gas taken five hours after delivery showed a pH of 7.68 (normal 7.3-7.4), a PaCO2 of 30.3KPa (normal 6.5-7.6), a PaO2 of 35.84KPa (normal 5-8) and a bicarbonate level of 24.6mmol/L (normal 18-24). This sensor blood was the baby being over-ventilated.

The baby was ventilated for three days, placed on continuous positive airway pressure (CPAP), and then placed on 0.5L nasal cannula oxygen due to recurrent apnoeic spells. Over the baby’s 204 hours of oxygen with oxygen saturation levels of 96-100% throughout.

The baby was not referred at four to six weeks of age for retinopathy of prematurity (ROP) screening, and was first seen by an ophthalmologist at the age of seven months when a diagnosis of retinopathy of prematurity (ROP) causing blindness, was made.

The baby’s parents made a claim against the consultant paediatrician who handled the baby’s care.

**EXPERT OPINION**

The baby had inappropriately high transcutaneous oxygen saturation levels and PaCO2 levels for a period of 204 hours. During oxygen administration to premature infants, very high blood oxygen levels can develop if saturation levels rise above 96%. Weaning of the Fraction of Inspired Oxygen (FiO2) seldom occurred despite oxygen saturation levels of between 96% and 100%, indicating that the nursing staff had no protocol for weaning of oxygen according to oxygen saturation.

There was no record that an ophthalmological appointment for the screening of ROP was made at the recommended four to six weeks of age. The baby developed severe ROP and blindness due to excessive oxygen administration. The opportunity to limit the condition and save the infant’s vision was missed due to the fact that the child was not referred for screening for ROP.

There was negligence on the part of the paediatrician and nursing, in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a four-day period, and then not referring the child at the appropriate time for an eye examination.

The case was settled for a substantial sum.

MR S was a 35-year-old taxi driver who was visiting his extended family abroad. While he was there he decided to have a routine health check in a private clinic. He told the doctor in the health clinic that he had noticed some rectal bleeding over the previous four months. The doctor did a digital rectal examination and proctoscopy and saw two rectal polyps. He gave Mr S a letter to take to his GP at home, explaining the findings and recommending a colonoscopy to further investigate his bowel.

Mr S returned from overseas a week later and made an appointment with his GP. Dr A. He gave Dr A the letter from the overseas health clinic and explained that he had noticed occult rectal bleeding. The letter advised that he had seen one of his colleagues a month before who had seen external haemorrhoids that were demarcating slightly. Dr A advised Mr S to avoid constipation to help with his haemorrhoids. He filed the letter from the health clinic but did not act on it.

The following year Mr S was still bleeding occasionally. He remembered the concerns of the overseas doctor and rang his GP surgery. He was given an appointment with Dr B. He explained that he had seen maroon blood on the toilet paper and in his stool for months and was concerned about the cause. Dr B examined him externally and noticed some small external haemorrhoids. He predicted that Mr S was not keen on medication so advised him to drink more fluids and increase his fibre intake. Mr S tried following this advice for six months, but the bleeding persisted so he visited Dr B again. Dr B did a purely external examination again and documented “simple external piles”. He prescribed anal suppositories.

Over the next three months Mr S began to lose weight and feel very tired. His wife was concerned that he looked pale. He still had the bleeding and was experiencing episodes of diarrhoea and constipation. He made an appointment with Dr C, another GP from his practice, who arranged for some blood tests, which showed significant iron deficiency anaemia. She referred Mr S to the colorectal team, who diagnosed rectal carcinoma.

He had a panproctocolectomy and the histological diagnosis was of two synchronous rectal carcinomas, Dukes stage C1. Multiple adenomas were found, some with high grade dysplasia, and it was considered that Mr S had Attenuated Polyposis Syndrome.

Mr S and his family were devastated. He struggled through chemotherapy and radiotherapy. He was told that it was not possible to reverse his illness and that his five-year survival rate was 45-55%. He was very angry and made a claim against Dr A for not referring him earlier or taking notice of the overseas health clinic’s recommendations.

**EXPERT OPINION**

MPG’s sought the advice of an expert GP. He was critical of Dr A for failing to perform any examination of his own, relying instead on a prior examination by one of his colleagues.

He felt that Dr A should have taken a fuller history including possible alteration in bowel habit, weight loss and abdominal pain. He felt that choosing to ignore the recommendations of the overseas clinic without making any attempt to reach his own diagnosis to explain the rectal bleeding failed to provide a reasonable standard of care. He commented that haemorrhoids are a common cause of rectal bleeding in a 35-year-old but the decision to dismiss the clinic’s advice without adequately assessing the patient could not be defended.

The expert GP was also critical of Dr B. The notes from his two consultations gave no indication that any further history was taken. He felt that he should have conducted a digital rectal examination rather than just an external inspection and that this represented an unreasonable standard of care. He felt that a digital rectal examination would have revealed the polyps and thus a more timely referral.

The opinion of a professor in colorectal surgery was sought. He considered that if Dr A had performed a digital rectal examination at Mr S’s first presentation he would have been able to palpate the polypoid lesion in the lower rectum. This should have raised suspicions such that he would have made the referral for colonoscopy. He felt that Mr S would not have avoided a panproctocolectomy because he had multiple other polyps in his colon and was thought to have Attenuated Polyposis Syndrome. He did state that if the ressection had been done closer to presentation, the tumour would have been more likely to be a Dukes A or B and he would have had a five-year survival rate of 70-95%.

The case went to court and was settled for a high amount.

• Common, normally benign symptoms can on occasion be more serious.
• Be prepared to reassess patients if their symptoms are not improving for taking a detailed history and conducting a thorough examination.
• A diagnosis may need to be revisited on subsequent consultations rather than relying solely on former colleagues’ decisions.
• Regardless of where someone has a consultation overseas or out of country, it is never safe to ignore findings of those investigations without properly ruling them out first.

In the UK the National Institute for Clinical Excellence (NICE) has produced guidelines, NICE guideline 59: Chapter 2.
Miss A, a 40-year-old IT consultant, was talking to a colleague at work when she developed a headache, along with blurred vision and nausea. Her symptoms worsened as an ambulance was called. In the Emergency Department (ED), Miss A was triaged as moderate urgency and examined by Dr X who recorded that her headache was “heavy” at work and she’d felt herself breaking out in a cold sweat, with a throbbing frontal headache radiating to each temple.

The notes describe Miss A lying on a trolley covering her eyes with her hands, with temperature of 35.4, blood pressure 133/96, pulse rate 68/min, and tenderness over her temporal muscles. Her neurological examination was essentially normal. Kernig’s sign was negative and she had no sinus tenderness or neck stiffness. There was no past medical history of migraine or family history of note. She was given IM metoclopramide and diclofenac.

A record followed of a telephone discussion with another doctor, who requested that Miss A have thoroughly neurological observations, be given analgesia and reviewed in the emergency observation unit. Miss A received intravenous fluid and analgesia. She had a normal flat blood count, electrolytes, liver function tests, bone profile and C-reactive protein. ESR was mildly raised at 30mm/hr. Two hours later, Miss A was assessed and, although the headache was still present, she was feeling better and the blurred vision and dizziness had resolved. The raised ESR was noted with a comment that it was unlikely to represent giant cell arteritis. Following investigations, Miss A phoned to report that her headache was much better. Dr X recorded a discussion about a possible ophthalmology opinion and follow-up.

Over the next three weeks, Miss A continued to have a headache, which varied in severity. She didn’t seek further medical advice because she expected the headache to pass, after being investigated at hospital and attending her GP. Her partner said later she had no reason to doubt the advice she had been given.

One month after the headache started, Miss A left work early because of another severe headache. While brushing her teeth, she lost consciousness and collapsed. She vomited twice before an ambulance took her to the ED where, on arrival, her GCS was 12/15. Resuscitation was attempted but following a CT scan of her brain, she died. The scan confirmed a large subarachnoid haemorrhage involving the 3rd and 4th ventricles on the left side and a frontal intracerebral haemorrhage.

A claim was made, alleging delay in referring Miss A to a vascular event as a cause of the headache. However, had planned to wait and arrange an MRI scan if the headache did not settle with treatment. In this case, Dr C, an expert GP instructed by MPS, said it was unreasonable for GPs to rely on the reported pulsating headache to pass, after being investigated at hospital and attending her GP. The claim was settled against both Dr X and the hospital for a moderate €15,000+.

Expert opinion

Expert opinion found that it is reasonable for GPs to rely on diagnoses made at hospital after a period of inpatient observation and investigation. In this case, however, the patient’s presentation to Dr X was so suggestive of a subarachnoid haemorrhage, that hospital admission was essential that day to exclude a diagnosis.

Dr X had based his own diagnosis on the reported pulsating headache lasting 4–72 hours of moderate to severe intensity, aggravated by routine exertion and associated photophobia. Miss A had work stress, which may have precipitated a migraine and reinforced the diagnosis. Migraines usually present as unilateral headaches, but bilateral headaches can also occur. Miss A’s headache was frontal to begin with and then bi-temporal when she’d attended Dr X. Although she had no history of aura, migraines without aura are more common. In Dr X’s opinion, it did not matter that Miss A had no past history of migraine – not all patients are aware they may have experienced migraines in the past.

Dr X attributed Miss A’s symptoms to stress at work – although stress and anxiety can cause physical symptoms, you must ensure you have excluded any serious physical causes first.

GMcK
**CASE REPORTS**

**A MALIGNANT LESION**

SPECIALTY: GENERAL PRACTICE

**THEME:** SUCCESSFUL DEFENCE

Mr M, a 44-year-old architect, attended his GP Dr C for a skin check. Dr C diagnosed a papilloma on his right chest wall as well as a seborrheic keratosis skin lesion of the upper left arm. A brief record was made in the notes, but there was no detailed description of how the lesion looked and no action was taken.

Five months later, Mr M was seen by another member of the practice, Dr B, for heartburn symptoms and Mr M also mentioned the skin lesion on his left arm. Dr B noted a “large crusty seborrheic keratosis with exudative hard surface and red flare around with warty texture”. There was no clipping or bleeding. Dr B discussed removal with Mr M only if “it was a melanoma”.

The following month, a third doctor in the practice, Dr A, saw Mr M and referred him to the practice’s minor surgery clinic for removal of the lesion.

A month later, Mr M returned to the GP practice about the skin lesion – it had increased in size and was bleeding. Dr A prescribed flucloxacin as he felt the lesion was infected. Mr M was referred urgently to a dermatologist. In the referral letter, Dr A wrote: “Pigmented lesion that he claims he has always had, although it was quite small. Over the recent months it has increased in size and is now bleeding on occasions. It may be a malignant melanoma or squamous cell carcinoma. Can you see him as a matter of urgency?”

The day after the urgent referral was made, Mr M presented for minor surgery at his practice, for the appointment that Mr M had attended the previous day. Dr B discussed removal with Mr M only “if it was a melanoma”.

Mr M’s widow made a claim against the doctors at the practice for failing to diagnose the lesion as malignant sooner.

**EXPERT OPINION**

Claimant expert opinion was critical of the standard of care provided. Dr A wrote: “Pigmented lesion that he claims he has always had, although it was quite small. Over the recent months it has increased in size and is now bleeding on occasions. It may be a malignant melanoma or squamous cell carcinoma. Can you see him as a matter of urgency?”

Mr M’s widow made a claim against the doctors at the practice for failing to diagnose the lesion as malignant sooner.

**Learning Points**

- Whenever a patient presents with a skin lesion, please appropriate guidance such as NICE skin point checklist: http://www.nice.org.uk/nice-guidance/CG122
- Always ensure that the patient understands the purpose of the referral and what they are expected to do.
- When referred for skin surgery, the patient should have been investigated further and a full history documented.
- Meticulous record keeping is important, especially in relation to lesions and whether they are growing or changing in appearance. When referring skin, it helps to detail how the lesion looks in terms of size, colour and shape, rather than simply making a diagnosis.

Mrs J, a 62-year-old housewife, did not visit her GP often; however, she consulted Dr A with a two-week history of corneal symptoms. Apart from hypothyroidism, she was otherwise fit and well, but for the previous fortnight she reported lethargy, body aches and a cough productive of green sputum. Dr R recorded a temperature of 40°C with a pulse of 102, respiratory rate of 24 and oxygen saturation levels of 95%. Despite a lack of chest signs on auscultation, he commenced treatment for a lower respiratory tract infection, prescribing co-amoxiclav and clarithromycin, which the patient had taken in the past without problems.

The following day Mrs J felt worse rather than better and her husband requested a visit at home. This time she was seen by Dr A, who found her to be in a very sick state and had hallucinations. Dr A measured her temperature at 40.5°C and found her throat to be red and swollen with bilateral exudates. He documented a blanching rash on her chest and back, which appeared to be erythema multiforme. He also noted bilateral conjunctivitis, for which he started chloramphenicol. Since she also complained of thrush, Dr A added canesten to his script and advised Mrs J to give the antibiotics longer to work, and to take paracetamol, ibuprofen and fluids to control her fever.

Mrs J continued to deteriorate and the following morning she called the surgery again, to speak to Dr C. Dr C explained that she was unable to swallow any medication due to her sore throat. The rash and fever were ongoing. Dr C converted the paracetamol and antibiotics to a dispersible form and advised she crush the clarithromycin. She advised the patient to seek medical attention if the fever persisted once she managed to swallow her medications.

Later that day, Mrs J deteriorated further and her husband called the surgery, this time she was unresponsive. She was now unable to swallow fluids at all. Dr R advised she would need iv treatment and told them to go urgently to the Emergency Department. The ambulance transferred them to hospital within 30 minutes. On arrival in the ED a temperature of 29°C was recorded. Mrs J was noted to have macules and papules with urticarial plaques and bullous erythema multiforme over her face, scalp and neck as well as her trunk (10% of her body). Oral ulceration and conjunctivitis was present.

A diagnosis of Stevens-Johnson syndrome was made, presumed secondary to penicillin or mycoplasma pneumonia, and she was transferred to the ICU where she remained for over a month. CMV showed a left lower zone consolidation and skin swabs detected herpes simplex virus, which was treated with aciclovir. By the time of Mrs J’s discharge from ICU her skin had greatly improved, but she became colonised with pseudomonas and suffered with recurrent chest infections. She had significant muscle loss, which required intensive physiotherapy.

Another month after being discharged to the ward, Mrs J’s breathing began to deteriorate and she was transferred back to ICU with severe type 2 respiratory failure attributed to toxic epidermal necrolysis (TEN) and associated bronchiolitis obliterans. She was intubated, ventilated and treated with methylprednisolone, cyclophosphamide and IV immunoglobulin. Despite this, Mrs J’s outcome continued to deteriorate and died.

**EXPERT OPINION**

Experts reviewing the case were critical of Dr A and considered she had breached her duty of care in this case. When she visited Mrs J, there was a clear deterioration in her condition. She was febrile, hallucinating and had a widespread rash. Dr A maintained that she had been concerned about the patient but felt that hospital admission would not have changed the patient’s treatment at this point. It was unclear whether the Stevens-Johnson syndrome was drug induced and expert opinion agreed that it was reasonable for Dr A to have commenced antibiotics in a patient with no history of drug allergy, who had been given both of the medications in the past without problems. It proved difficult to speculate on whether or not earlier withdrawal of these medications would have affected Mrs J’s outcome.

MPS served a detailed letter of response, defending the claim on a causation basis. As a result, the case was discontinued.
Mr H, a 45-year-old solicitor and father of three, visited his GP, Dr P, with a persistent headache. He described two months of symptoms, occurring up to six times per week, mainly in the mornings and with associated nausea. Dr P took a thorough history and neurological examination, including fundoscopy. He excluded alcohol, stress or carbon monoxide poisoning as potential precipitants, and found no other ‘red flag’ symptoms. Mr H mentioned that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded and referred him for an early neurological opinion.

As part of his examination, Dr P checked the patient’s blood pressure and found it to be elevated at 164/89. A follow-up visit was arranged with the practice nurse a few days later and this had reduced to 132/72. No further action was taken.

Mr H was seen by neurologist Dr B some six months after his initial GP presentation, and underwent an MRA scan. The scan was normal and Dr B advised Mr H that his headaches were likely to be related to muscle tension.

Mr H didn’t see Dr P again for another two years. When he re-presented to Dr P, it was more intensely when he was walking. He mentioned that the headaches had been ongoing for two years and were still being treated with an OTC medication for an MSU and bloods to be taken (CRP, LFTs, PV and PSA) and commencement of simvastatin to help with his blood pressure.

This was arranged, along with pain clinic review, and the patient was not seen by Dr P for another six months, until he presented with a presumed sinus infection. His blood pressure was recorded as 180/100 on this occasion, and when repeated a week later was still elevated at 165/120. Lisinopril was started at 1mg once daily. This was continued until he saw Dr P again four months later with symptoms of a UTI. Blood pressure was documented as 150/96 and lisinopril was doubled to a dose of 10mg daily.

Time went on, and apart from a blood pressure check with the practice nurse every couple of months, Mr H was not followed up until seven months later when he was called in for some routine blood tests. His renal function was notably impaired with a serum creatinine of 2.6 mg/dl, an eGFR of 20 ml/min and a urine of 17.3 mg/100ml. Investigations were initiated (renal USS was normal) and he was reviewed by a consultant nephrologist Dr C. Dr C made note of recurrent LFTs during Mr H’s childhood and his hypertension, and concluded that reflux nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly.

He further noted that the main tool available to delay renal deterioration is optimal control of blood pressure, using renal protective drugs like the lisinopril Mr H was given.

Mr H made a claim against Dr P for alleged breach of duty – stating that renal function could have been tested on several occasions. Mr H also claimed for causation, stating that if renal function had been tested when he first presented with headaches, then he would have been diagnosed as a far stage earlier, which would have allowed him to retain his renal function by a judicious use of medication and diet.

Mr H subsequently discontinued his claim.

**Learning points**

- When starting new medication it is important to have baseline measurements of renal function, and ongoing monitoring of renal function and ongoing monitoring of renal function and ongoing monitoring of renal function and ongoing monitoring of renal function.

**Expert opinion**

Expert opinion was supportive of Dr P’s initial management. When Mr H first presented with headaches he had a single mildly elevated blood pressure reading following two normal results, which would not be consistent with a headache secondary to malignant hypertension or renal disease. Although outside his area of expertise to comment on a GP’s standard of care, he did comment on Dr P’s failure to follow up Mr H more intensively once his hypertension was diagnosed and for failing to assess baseline renal function in conjunction with starting lisinopril. However, since the treatment to delay renal deterioration is to use an ACE inhibitor, experts agreed that on the balance of probabilities, earlier intervention is unlikely to have significantly affected Mr H’s long-term renal prognosis.

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Mr H subsequently discontinued his claim.
Miss C, a 30-year-old accountant, developed an asymptomatic left sided neck lump. A scan revealed a 23 x 17 x 27mm mass at the carotid bifurcation consistent with a carotid body tumour. Miss C was referred to Professor A, a vascular surgeon, who noted there was no significant medical or family history and confirmed that she was normotensive with no neurological signs. He explained that this was a rare tumour with the potential for malignancy and recommended surgical excision, which he undertook the following day. Miss C signed a consent form completed by Professor A for medical excision of left carotid body tumour.

During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 3.100mls. Professor A recorded that the bleeding was controlled by clamping the common carotid artery three times for a total of 16 minutes. The injury was repaired “with difficulty” using a 5/0 prolene suture and at the end of the procedure there was good flow in the internal carotid artery.

Postoperatively, Miss C was transferred to the ICU where she was extubated and initially appeared drowsy, but had no obvious neurological deficit. She remained stable overnight but the following morning appeared drowsier and was noted by the nursing staff to have profound right-sided weakness. Dr B, ICU anaesthetist, reviewed Miss C and attributed her drowsiness to opiate toxicity. It was speculated that the process of informed consent had been inadequate.

The case was settled for a high sum, reflecting the severe neurological outcome and the need for continuous care.

**EXPERT OPINION**

Miss C’s family felt the process had been rushed and that she had not fully understood the magnitude of the risks of surgery. Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

**Learning points**

- **Communicating within the team** is important – the nursing staff should inform the medical team of the patient’s deteriorating condition in a timely manner.
- **Good communication and documentation** are essential in the process of consent. Patients must be made aware of the risks of surgery and their implications. This should include common complications as well as any serious adverse outcomes, including complications in which they may result in a permanent disability or death. Patients need to be able to weigh the benefits and risks of an intervention so that they can make an informed decision as to whether they want to proceed.
- **Consent can be given at any time and are not necessarily a sign of negligence.**
- **Litigation can be prevented if patients are informed about the risks in advance and this discussion is recorded.**

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to opiate toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C’s stroke may have led to a worse neurological outcome.

However, the main focus of criticism centred on the consent process. Experts expressed the view that Professor A carried out surgery the day after the initial consultation, given the slow growing nature of carotid body tumours. Miss C’s family felt the process had been rushed and that she had not fully understood the magnitude of the risks of surgery.

**THE STORY OF BETH BOWEN**

**Casebook 22/3, September 2014**

Our cover story in the previous edition of Casebook, “The Story of Beth Bowen”, drew a powerful and emotional response from many readers – indeed your letters were so numerous that we can only print a small selection in this edition.

The two letters below capture many common themes: respect and admiration for Clare Bowen in speaking openly about her diagnosis, loss and anger and disable at Mr Bowens struggle to obtain answers and information.

Although mistakes in medicine are unavoidable, many issues in this case combined to contribute to the tragedy and its aftermath: from the surgical team’s misplaced confidence (in terms of the equipment used), to the lack of an appropriate and valid consent process. This was only exacerbated by the institutional behaviour of the hospital, which made it so difficult for the Bowen family to get the explanations and apologies that were their basic right.

MPS has long campaigned for greater openness in healthcare, particularly when things go wrong. This is a challenging and difficult process, which needs the support of culture, colleagues and organisations. The story of Beth Bowen as narrated by her mother in Casebook (2014: 22:3, pp 10–11) I wish to express my deepest sympathy to the Bowen family and concur with Mr Bowen that the medical profession fell short of expectations in this case and much needs to be done.

The irony was that the child would not have died 30 years ago, before the widespread introduction of laparoscopic surgery. If he had opted for laparoscopy, a properly qualified surgeon could have completed the operation with minimal risk. Even if a major blood vessel is torn, it could have been handled without delay. Laparoscopic surgery does not require the important faculty of tactile sensation and stereoscopic vision. It also denies the surgeon rapid response to accidental tear of major blood vessels and organs as illustrated in this case. Worst of all, it opens a floodgate and permits the introduction of high risk-instruments like the morcellator, which has killed other patients, including adults. And it is not young surgeons that are dangerous; senior surgeons trained in the open classical procedures are even more dangerous if they have their hands on laparoscopic procedure without proper retraining.

I completely agree with the point you make regarding cross-examination in the context of formal legal proceedings. The article was intended to apply more widely to expert reports in general, many of which are written for purposes other than litigation. The role of an expert in the litigation process is different to that they experience in putting forward their case and much needs to be done. This may include but not be limited to questioning the expert’s qualifications, impartiality, experience, opinions and conclusions.

A cross-examination, particularly one from an experienced, clever and sometimes intimidating barrister, is rarely an enjoyable experience but one that an expert should expect to undergo from time to time.

Writing a report is one thing. Standing over it in a court of law is a part of the totality of being an expert and should, I feel, have received at least a mention in an otherwise excellent article.

**Dr Stephen Murphy, The Park Clinic, Dublin**
MISSED CAUDA EQUINA

You report a case of a GP missing a cauda equina syndrome in a patient with a slipped disc (page 17, Casebook September 2014). I do not believe this is within the expertise of a GP and is not even within the expertise of many specialists. I have seen several of these cases not from slipped disc but from anaesthesia either by inserting a needle into the lumbar spine or from the insertion of a plastic catheter to anaesthetise the abdomen or legs. Most anaesthetists claim the procedure is harmless and that “soft” catheters can’t harm. It may be rare but it is completely false to argue it is harmless.

HIGH EXPECTATIONS

I am rather puzzled by “High Expectations”, on pages 22 to 23 of the September 2014 issue. From the description of the case, it sounds very likely that this was indeed a case of post viral fatigue syndrome (also known as Myalgic Encephalomyelitis or chronic fatigue syndrome). No diagnosis is given or even the most probable possible diagnosis of chronic fatigue or what management was given for this condition.

Post viral fatigue syndrome is a common condition probably affecting about 1% of the population. It is not difficult to diagnose as there are clear diagnostic criteria available today and it would be interesting to know whether this patient fitted the diagnostic criteria or not. They did seem so bizarre to doctors that if a misdiagnosis would be unlikely if the criteria were properly used. In addition, in the following paragraph it is stated that the patient “… was convinced that there was a physical cause for his symptoms…” as if this rebutted the specialist opinion. However, it is well-known today that chronic fatigue is indeed an organically-based physical condition. The was clearly shown at the last conference of 2014 in the United States and it is no longer considered acceptable to consider a non-organic cause for such a condition. It is probably a chronic encephalitis but this has not been definitely proven. There is management available for chronic fatigue syndrome.

In my opinion, it is indeed negligent to miss this diagnosis in a patient who fits the criteria for it (e.g. Carruthers et al 2003 and 2011 – these are the criteria used). In addition the patient’s prognosis can be adversely affected if proper management including management of activity scheduling is not instituted as soon as possible.

Unfortunately, at least in South Africa, this disease now occupies the same space as mental illnesses did in the dark ages and as multiple sclerosis did at the turn of the last century ("Faker’s Disease"). Patients generally do not have the energy or financial means to pursue their cases against doctors regarding diagnostic failure but in my opinion it certainly should be a source of litigation because of the poor diagnostic skills of most practitioners. In regard to the ignorance about management and the stigma which doctors attach to this disease, greatly increasing the significant suffering of patients.

Dr Elizabeth Murray, Rondelsbeke Medical Centre, Mediclinic Constantiaberg, UCT Private Academic Hospital, South Africa

The paper was not accepted for publication as it was felt that the association with balanoposthitis and diabetes was well-known, although interestingly the 40 and 51-year-old had been advised to attend our department by their GPs and at least two were prescribed metformin.

These patients all presented with balanoposthitis and at some stage appeared to have associated phimosis. It has been previously suggested that the sudden appearance of these symptoms in a patient without a prior history justifies investigating such patients for possible diabetes.

The Chrome of the symptoms relating to the skin in this case was a sore scratch to the penis (possibly infected) in June 2006, and of a rash on the hand and penis eight months later, in February 2007.

Whether a doctor would be considered negligent in not considering diabetes in such circumstances revolves around whether their actions would be supported by a responsible body of medical opinion, skilled in the relevant specialty. In this case, this relevant specialty is general practice, and the GP expert instructed by MPS was supportive of our member’s actions.

It is important to realise that where there might be differing views as to the appropriate steps to take in an individual case, a doctor is not negligent for choosing one option over another, as long as he or she chooses would be supported by a responsible body of opinion.

It was on the basis of the supportive opinion that MPS decided to defend the case.

Subsequently, the claimant discontinued his case, presumably on the advice of his solicitors and any expert opinions they had obtained.

CORRECTION

The following correction relates to a photo accompanying the case “A cannuila complication” in the previous issue of Casebook. Our photographs are taken from stock image libraries and are chosen to reflect the general theme of an article or case. Here, the case related to the potential risks associated with cannulation, specifically neurogenic damage to the radial nerve, and the image was chosen to reflect that theme. In this case a picture of venous cannulation would have been better, and we apologise for any confusion caused by this error.

OVER TO YOU
BEING MORTAL
Atul Gawande

Review by Dr Sam Dawson
(Specialty trainer, anaesthetics, Northern Ireland)

Atul Gawande barely needs an introduction. He is the author of three bestselling books, winner of multiple awards for writing and Professor at Harvard Medical School. He was also a key figure in the implementation of the WHO checklist revolution.

His new book Being Mortal is a compassionate yet unfurting look at what mortality means in the 21st century. In it he explores the way in which modern medicine is letting our patients down at the ends of their lives whether in nursing homes, hospitals or hospices. At the same time, he reveals the people and institutions redeeming the situation with unparalleled passion and creativity.

Gawande does this by telling the stories of his patients facing cancer, of his neighbours and, most movingly, of his own family as they face old age, decline and death. He weaves together research, philosophy, historical study and personal anecdotes to show that many of us are neither living well in our last days nor dying the way we want.

Most damning of all, however, is the realisation that the medical profession is not only hapless in the face of this suffering but acting harmfully as a result of paternalism, lack of imagination and fear. Gawande’s previous book The Checklist Manifesto ushered in a new global paradigm of perioperative safety with a simple, yet radical, idea. Being Mortal could do the same for end-of-life care.

I read most of this book in my on-call room, pausing to attend the critically ill in the wards, theatre and emergency department in which I work. This added extra poignancy to what is already an emotional, compelling and challenging book. It isn’t perfect – at times the interlinking of stories is disjointing and the section on assisted dying appears somewhat tacked on. However, this book is for anyone who has ever stared speechlessly into the eyes of someone who knows they are dying, or who has had the difficult task of counselling their relatives. In fact, it is for anyone who wants to live well, help others live well and, in the end, die as well as they can.

What would a new era of ingenuity, empathy and dignity look like for our patients as they approach the end of their lives? It is obvious Gawande is not entirely sure, but in Being Mortal he is asking the right questions and exploring novel solutions to a situation we desperately need to improve.

POSTMORTEM: THE DOCTOR WHO WALKED AWAY
Maria Phalime

Review by Dr Anand Narabhai
(Intern at New Somerset Hospital, Western Cape, South Africa)

After practising clinical medicine for four years, Maria Phalime decided to stop. Postmortem: The Doctor Who Walked Away tells the story of her search for an explanation and provides a useful perspective on her own story.

I found reading the first part of the book laborious, although I was interested in her childhood and high school years. From then on the clichés and anecdotes were unoriginal to my ears, although these do provide, for the general public, one account of what practising medicine in the public sector can be like.

Phalime’s decision to leave was multifaceted. She relates: “It was tough, it was sad, and I left, that’s all.” She practised medicine during the dark age of HIV denialism, and in the often frustrating, pressured and disheartening South African public health sector.

There is a bigger lesson in the book: in an interview with Stellenbosch University Dean of Health Sciences, Professor Jimmy Volmink, Phalime is told: “We are all on a journey, and sometimes that journey takes us overseas, into the private sector, or even out of the profession altogether. People have got to be allowed to take that journey.” Phalime is on her journey, each of us is on our own, and for our patients, maybe the point of what we do by caring for their health, is to give them an opportunity to take their own journey.
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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

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