DIVERTED BY THE DIAGNOSIS
HOW A HOSPITAL ASSESSMENT MISLED A GP – PAGE 16

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Avoid a referral to the HDC by following our advice on managing your patients’ test results

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FEATURE

HANDLING TEST RESULTS

MPS sees many cases where doctors have been referred to the HDC for mismanaging the test results of patients. Medical Adviser Dr Sam King shares some case scenarios and best practice advice.

A RECENT CASE

A recent case that came before the HDC has highlighted the importance of communicating and acting on abnormal results. In this case a general practitioner removed a mole from a patient’s right thigh. The histology showed melanoma in situ with adequate margins showing excision was complete. There is no documentation that the patient was informed of the histology result and the patient assumed that the result was normal because he was not contacted by the surgery.

The patient returned with a lump in the right groin two years later. An ultrasound was requested by the GP and reported as most likely a reactive lymph node; recommended was either fine needle aspiration (FNA) or repeat ultrasound in four weeks with FNA if this further scan was abnormal. The patient was advised that the lump was benign but not advised of the follow-up recommendations of the radiologist. No follow-up scan or FNA was ordered.

Several months later the lump had increased in size and the patient saw a different GP. The patient was found to have metastatic melanoma and sadly died the following year. The HDC found the first GP to be in breach of the Code of Patient Rights for not informing the patient of the abnormal ultrasound and not following up the recommendations of the radiologist.

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MPS's experience common themes include failing to:

• ensure that an abnormal result is recognised and acted on
• bring a significant result to the attention of the appropriate clinician
• notify a patient of the result and the need for follow-up

This article seeks to explain basic principles for managing patient results that will help to minimise the risk of adverse outcomes for patients and subsequent complaints.

Dr Mike Greenberg
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M

Medical 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 result.

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. This includes an extensive range of educational products such as online learning, workshops and seminars, as well as 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 in September, regarding our cover story on the case of Beth Bowen. 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 openness and consent. Anger at the treatment of the Bowen family was palpable in some of your letters, and if openness and consent...
MANAGING INVESTIGATIONS

The management of clinical investigations is a contentious issue in New Zealand practice.1 The Medical Council of New Zealand has no guideline or statement on this issue, which perhaps reflects the diversity of opinion within the profession. Coles does suggest that there are common principles that most parties can agree on, which clinicians should consider following to ensure patient health and safety.2

When patients or their family are unhappy with the care they have received they will often complain to the HDC. The main role of the HDC is to ensure that the rights of health consumers are upheld. Rights 4 and 6 refer to the clinician’s responsibility in the ordering and follow-up of investigations.

RIGHT 4 Right to Services of an Appropriate Standard

(2) Every consumer has the right to have services provided with reasonable care and skill.

(3) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

(4) Every consumer has the right to co-operation among providers to ensure quality and continuity of service.

RIGHT 6 Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, including – (f) The results of tests

With regard to the management of investigation results, the previous Commissioner’s view of key principles in managing clinical investigations is listed in panel 1:

ORDERING INVESTIGATIONS

When ordering tests, clinicians are expected to explain to patients why a test is being requested and when and how the results will be communicated to them. It is common practice to only contact patients if results are abnormal. However, patients should also be made aware of their right to request their results if they wish, and told how they can do so.

Patient online portals that are currently being introduced into general practice allow patients direct access to their own test results once the clinician has filed them. This will allow patients easier access to their health information.

It is important to note that even with the introduction of patient portals, the HDC considers that responsibility to follow-up test results remains with the referring practitioners, not the patient.4

It is not uncommon for patients to delay or decide not to have the investigations recommended by their health practitioner. It is difficult for a clinician to track every investigation requested – however, where significant pathology is suspected, it is prudent for clinicians to track results to ensure that they are received and dealt with in a timely manner.5

MPS does see a significant number of cases where opportunities for early diagnosis of a life-threatening disease, eg, cancer, are missed, with a tragic outcome. Of particular note, due to resource limitations in the public health system, investigations requested by practitioners may be delayed. If significant pathology is suspected, clinicians should ensure that patients are kept informed about the reason for the investigation and the timeframe in which you anticipate they will be seen. Asking the patient to then make contact if this does not occur provides an additional safety net.

Panel 1

1. At the time any test is proposed, patients have a right to be told by their doctor why the test is recommended and when and how they will be informed of the results.
2. If a doctor or medical centre has a standard practice of not notifying normal test results, patients must be informed and their consent obtained to not notifying in such circumstances.
3. It must be made clear to patients that they are entitled to be notified of all test results, and, even if they agree to be notified only of abnormal test results, they are welcome to call the medical centre and check whether their results have been received and what they are.
4. In the absence of any other such arrangement being made, when results are received by a medical centre, the patient must be informed. This is especially important if the results raise a clinical concern and need follow up.
5. A doctor is responsible for having an efficient system for identifying and following up overdue test results.

TIMELY REVIEW AND MANAGEMENT OF RESULTS

A case recently published by the HDC involved an 87-year-old man admitted to hospital with gallstone ileus. He had multiple co-morbidities and was considered to have a high risk of dying from surgery. Immediately following surgery the patient had a central line inserted under US guidance in theatre. He was then admitted to ICU.

During handover to ICU the staff were advised that a chest x-ray was required to ensure correct placement of the central line. This was done later that night.

The ICU registrar was unaware that the x-ray had been taken and no clinician reviewed the films until over 24 hours later. The man deteriorated in ICU with what was thought to be aspiration pneumonia and died. Upon review of the case in the hours after his death it was then found that the chest x-ray showed a tension pneumothorax.

The HDC held that this was predominantly a systems failure and found the DHB in breach of Right 4(1) and (5) of the Code of Patient Rights.

A clear policy outlining the system for reviewing and management of results will help individual practitioners and organisations to ensure that results are seen in a timely manner. Particular attention should be given to the process in place when the requesting clinician is on leave or has moved to another location or, as in this case, gone off duty. It is essential that the clinician assuming responsibility is identified in the policy to ensure that results are managed appropriately.

In a busy schedule it is easy to see how a significantly abnormal result can be overlooked. Many clinician’s work part-time, which can make review of results more difficult. To ensure patient safety, clinicians and organisations must remain especially vigilant when managing abnormal test results. To minimise the risk of human error it is prudent for clinicians to utilise methods available to them – for example, a computer task manager.

HANOVER

Right 5 of the Code of Patient Rights requires co-operation among providers to ensure quality and continuity of services. With regards to investigation results, when care of a patient is handed over from one clinician to another, for example between different departments within a DHB or from general practice to a specialist service, the HDC considers both clinicians to have responsibilities regarding following up investigation results – the clinician who hands a patient over is expected to review all test results to hand, document tests ordered and notify the accepting doctor of any pending test results as well as the results already to hand.2 A clinician who accepts care of a patient is expected to actively review results of tests already performed.10

TESTS ORDERED BY ANOTHER CLINICIAN

MPS is commonly avoided by members if they are responsible for tests they did not order. The primary responsibility for following up abnormal results rests with the clinician who ordered the tests.11 However, the HDC has an expectation that an abnormal result will be followed up by a treating doctor regardless of who ordered the test to avoid patients “falling through the cracks”. Follow-up may involve tasking another member of the team (perhaps a nurse or junior doctor) to ensure that the result has been received and appropriately managed. Supervising consultants are expected to review all investigation results when they review a patient.12 This also applies to GPs, who may be only one of a number of clinicians to consult with a patient concerning a health problem.

CONCLUSION

Most clinicians order and review a vast number of tests on a day to day basis. Many difficulties can arise when the process of ordering and managing results is not done in a timely and appropriate manner. Implementing a clear policy will help to minimise poor outcomes for patients.

The default position is that patients must be informed of all significant test results – it is the clinician’s, not the patient’s, responsibility to ensure that this happens. The onus for follow-up of abnormal results lies with the clinician ordering the test but also with those who have responsibility for overall care of the patient.

REFERENCES

1. 8. 05HDC11908
2. 26-George IM 2013. The management of clinical investigations. Chapter 4 in St George IM (9ed.). Cole’s Medical Practice in New Zealand, Wellington at p133
3. 26-George IM 2013. The management of clinical investigations. Chapter 14 in St George IM (9ed.). Cole’s Medical Practice in New Zealand, Wellington at p129
4. 05HDC11908
5. 12. 05HDC11908
6. 10HDC01419
7. 10HDC01419
8. 10HDC01419
9. 10HDC01419
10. 10HDC01419
11. 11HDC01419-11HDC01419
12. 11HDC01419
13. 11HDC01419-11HDC01419
14. 2013-11HDC01419
15. Chapter 1 in: George IM 2013. The management of clinical investigations. Chapter 14 in St George IM (9ed.). Cole’s Medical Practice in New Zealand, Wellington at p129

Medical Centres have a responsibility to have good systems in place to ensure patients receive good quality care. In particular, they are responsible for having effective policies for the handling of incoming results and patient follow-up.2
FEATURE

CONNECTED FOR HEALTH: THE RISKS AND BENEFITS OF TELEHEALTH

Dr John Garrett, paediatrician and telehealth clinical leader at Canterbury and West Coast DHBs and Chair of the New Zealand Telehealth Forum, and Gareth Gillespie look at the pros and cons of telehealth

As technology advances, the modern world needs a new healthcare system – and telehealth is one such innovation that continues to divide opinion among policy-makers, clinicians and patients worldwide.

Telehealth – which can be defined as the delivery of healthcare at a distance using some form of digital information technology – is a way of delivering a service rather than a service itself. And like any service in the healthcare sector, it comes with its share of risks and benefits.

THE GOOD, THE BAD...

Telehealth has an important role in modern medicine as it can overcome inequity of delivery of healthcare at a distance using some form of digital information transfer – is an easily recognisable form of digital information transfer – is an easily recognisable form of digital information transfer – is an easily recognisable form of digital information transfer. An effectively used system – and telehealth is one such technology – and telehealth is one such technology – and telehealth is one such technology.

With videoconferencing though there are disadvantages, and the obvious one to mention is that it is not possible to physically examine the patient. Warning signs about a patient’s condition that are missed through a lack of face-to-face interaction will leave a doctor vulnerable if an adverse outcome follows. To avoid this there are three actions to take, starting with making every first assessment a face-to-face consultation. Then, for subsequent consultations, consider whether the patient needs to be examined to make a safe treatment decision, and if the answer is ‘yes’, organise an in-person assessment. Lastly, where an examination is required consider the option of having a clinician with the patient relay examination findings to the remote clinician.

When videoconferencing is used in the acute setting there will usually be a clinician with the patient who is seeking the advice and support of a remote clinician, and the question can arise as to who is then responsible for the care of the patient. The answer will depend very much on the situation, and the best approach is for the clinicians involved to recognise that they have an individual responsibility to contribute to a joint decision-making process. A very useful discussion of interdisciplinary collaboration, of which teleacute telehealth is an example, can be found in Chapter 16 of Coles’ Medical Practice in New Zealand.

Given that there is a wide range of options available in terms of videoconference technology and quality, it is important to be sure that what is used is up to the job. Any perceived shortcomings with the technology itself – or with equipment associated with the consultation, such as a webcam or laptop computer – will not be a defence in the event of an error in diagnosis or treatment occurring. A practitioner remains personally responsible for their diagnosis, irrespective of what facilities were relied upon to provide aid in that regard.

OFFICIAL GUIDANCE

The Medical Council of New Zealand (MCNZ) issued its Statement on Telehealth in June 2013. Paragraphs 8-9 state: “It is because of the limits of technology, you are unable to provide a service to the same standard as a face to face consultation then you must advise the patient of this. It is particularly important that you consider whether a physical examination would add critical information before providing treatment to a patient. If a physical examination might add critical information then you should not proceed until a physical examination can be arranged. In some circumstances it may be reasonable to ask another practitioner in the patient’s location to conduct a physical examination on your behalf.”

PRESCRIBING

Prescribing via a telehealth consultation is restricted by the requirements of the Medicines Regulations 1984. Clause 39 (ii) states: “An authorised prescriber (including a designated prescriber) may only prescribe a prescription medicine if the authorised prescriber –

(i) is prescribing the prescription medicine –

• for the treatment of a patient under the authorised prescriber’s care,

(ii) within, and in accordance with all conditions (if any) stated in, the authorised prescriber’s scope of practice, as determined by an authorisation granted under section 21 of the Health Practitioners Competence Assurance Act 2003 by the authority responsible for the registration of the authorised prescriber.”

The MCNZ’s Statement on Telehealth expands on these points, in particular clarifying the absence of a face-to-face consultation are covered in the following (paragraph 14):

“Before issuing a prescription for any medicine you should have a face-to-face consultation with the patient or, in the absence of a face-to-face consultation, discuss the patient’s treatment with another New Zealand registered health practitioner who can verify the patient’s physical data and identity. Where neither of these options is possible or practical, it may be reasonable practice to –

• complete a prescription for a patient if you are providing cover for an absent colleague or are discharging a patient from hospital and review the patient’s notes subsequently:

• renew a prescription of a patient you, or a colleague in the same practice, have seen previously, following a review of its appropriateness for the patient. When the prescription has potentially serious side effects, you should regularly assess the patient

• complete a prescription when you have a relevant history and there is an urgent clinical need to prescribe, provided that you inform the patient’s regular doctor as soon as possible.”

THE GREAT DIVIDE

By its very nature, telehealth offers opportunities to consult patients overseas. It is important to be aware that clinicians who do so are subject to New Zealand law and may also be subject to other legal obligations, requirements or liabilities in the patient’s location.

The MCNZ adds (paragraph 16): “You are also subject to the jurisdiction of authorities in the patient’s home country, and may be liable if you assist patients to contravene that country’s laws or regulations, for example, any importation and possession requirements. You should seek legal advice in that country if necessary.”

If you intend to carry out video consultations with patients who are not in New Zealand you should take advice from your MII on the indemnity position.

FINAL WORDS

In February, the MCNZ issued a statement that reiterated its previous stance by advising caution among patients and doctors, with regards to telehealth.

In the statement, MCNZ chairman Andrew Connolly said: “The concept of telemedicine is a fantastic one that potentially offers benefits to both patients and doctors alike. But it is important that both patients and doctors are aware of the pitfalls of undertaking consultations on the internet, for example, a diagnosis made purely online, without a physical examination has the very real potential to be wrong.”

If you propose to offer video consultations, you should inform your medical defence organisation, such as MPS, to discuss this potential adjustment in your working practice.

Cases identified by the MCNZ demonstrate the consequences of irresponsible prescribing via telehealth consultations.

CASE 1

In 2001, the Auckland District Court convicted a doctor who had been involved in the internet sale of prescription medications and sentenced him to a term of imprisonment for the following offences under the Medicines Act 1983 (Police v Roy Christopher Simpson, Auckland District Court, 17 October 2001):

• Selling by retail a prescription medicine other than under a prescription given by a medical practitioner or designated prescriber.

• Selling by retail a prescription medicine without being a pharmacist or other authorised person.

• Publishing or causing to be published a medical advertisement that was likely to mislead any person with regard to the use and/or effect of that medicine and which failed to give sufficient information on precautions, contraindications and side effects required by Regulation II of the Medicines Regulations 1984.

• Publishing or causing to be published a medical advertisement that failed to make statements required by Regulation III of the Medicines Regulations 1984 to be made in an advertisement relating to medicines of that description, kind or class.

In 2003 of violating the Medicines Act for supplying medicines over the internet. The pharmacy was found guilty of selling a prescription medicine without a prescription, selling medicines by wholesale transaction without holding a wholesale licence, selling unregistered medicines, unlawful possession of medicines and breaching advertising restrictions.

The company had advertised medicines without providing legally required information, such as potential adverse effects, warnings, precautions and notification of the classification of the medicine.

A finding of the Hamilton District Court and affirmed in the High Court (Ministry of Health v Ink Electronic Media Ltd and others, Hamilton District Court 12 December 2003) and Ministry of Health v Ink Electronic Media Ltd and others (High Court, 11 August 2004) considered the meaning of ‘under his or her care’ in section 39 of the Medicines Regulations. The Court held that as a minimum there must be:

• Some information given about the patient to the doctor.

• An acknowledgement by the patient that the doctor is his or her medical adviser for this purpose.

• The doctor accepts responsibility for treating the patient for the condition referred to.

REFERENCES


2. Ministry of Health of New Zealand, Statement on Telehealth (June 2013)
am pleased for this opportunity to review the cases in this edition of the 
Casebook and to add my comments to the learning points of the cases. I think 
this was because I was seeing them as a lawyer: seeing the whole scenario unfold 
and not just seeing a snapshot in time. This is exactly how a judge would see a case and I 
think that is worth reflecting on.

As a doctor you are often dealing with a snapshot in time, and often under significant 
time pressure. However, it is always worth taking time to consider the whole picture and 
taking a longer view. The patient’s story will often be relevant to the outcome of the case, 
and looking at the whole picture can be helpful in understanding the context of the events that 
led to the adverse outcome.

What's it worth?

Since precise settlement figures can be affected by issues that are not readily apparent to the

Learning points

- Although it is commonplace for a doctor to advance a defence or resist a claim, the expert’s 
  report must be relevant to the matter in issue and capable of allowing the fora
  to decide the matter. The conclusion reached is not necessarily evidence 
  that an expert’s report is not a relevant factor in the matter in issue. 
- Although Dr H's report did not refer to the possibility of nerve damage, this is not necessarily 
  evidence that the expert’s report is not a relevant factor in the matter in issue. 
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CASE REPORTS

PULLED IN ALL DIRECTIONS

SPECIALTY ANAESTHETICS

THEME INTERVENTION AND MANAGEMENT

HIGH NZ$1,000,000+

SUBSTANTIAL NZ$10,000+

MODERATE NZ$1,000+

LOW NZ$100+

NEGILIGIBLE NZ$0

RSJ was a 32-year-old female patient who was a notorious head-case when 
receiving any sort of medical attention. She was always MR, and she 
wanted to make a complaint about everything. This led Dr M to 
suspect a trial lawyer, and he wanted to ensure that the case was settled 
for a high sum.

MRS J was referred to Dr M, a pain consultant, and Dr M noted a minor shoulder 
and neck movement on the affected side and indicated tenderness over the left C5/6 and C6/7 facet joints. The patient complained that there was pain on getting up after the procedure and difficulty in moving her neck, arms, and shoulders.

Dr M decided to settle the claim for NZ$100,000.

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Mr S was 60-year-old lorry driver. He was overweight and smoked, and could not walk because he suffered with pain in his calves. During a long drive he became aware of pain in his right calf and foot. This became so severe that he attended the out-of-hours service that evening. The GP measured both calves and found them to be the same. A history of foot pain but no calf tenderness was noted and a DVT was excluded. He told Mr S it was likely he had a problem with his circulation. Mr S was prescribed aspirin and advised to consult his own GP for further follow-up.

Mr S struggled to sleep for the next two nights because he had a burning sensation in his right foot and lower leg, which felt cold and numb. He had to get up to relieve the pain. He made an appointment with his own GP, Dr A, the next day. Dr A noted the history of numbness and rest pain. He documented that his right foot was pale and felt cold. He requested a non-urgent Doppler assessment because he could not detect any pulses in his right foot and prescribed quinine sulphate.

Mr S’s Doppler scan was arranged for the following week but he rang his GP surgery three days later because the pain in his foot had become more severe. He had to hang his foot over the edge of the bed to get relief from it. Dr A advised him to go straight to the Emergency Department (ED).

The ED doctor sent him home despite doing a Doppler scan and a cool, pale right foot with weak pulses. The diagnosis of arterial insufficiency rather than acute ischaemia was made. Mr S was told to stop smoking and to attend his Doppler assessment in four days’ time.

Mr S was seriously worried about his leg despite being reassured by his GP. It was alleged that Dr A had not appropriately acted upon his symptoms of rest pain or made the correct diagnosis of critical limb ischaemia. It was claimed that Dr A had failed to refer him for urgent surgical review and that he had wrongly asked him to wait for a week for a Doppler scan.

Mr S was admitted urgently from the ED, advised him to come for an acute ischaemia assessment in four days’ time.

Mr S’s Doppler scan was arranged for the following day. When he attended the operator was unable to get a result due to swelling and pain but noted that his foot pulses were difficult to detect. Mr S was given an appointment with Dr A the next day to discuss the results.

Dr A discussed the Doppler results and documented that his right foot was cold. He made the diagnosis of ‘worsening peripheral vascular disease’ and arranged for Mr S to attend the surgical assessment unit the following day.

Mr S was admitted urgently from the surgical assessment unit with a diagnosis of acute ischaemia. He was noted to have rest pain at night coupled with complaints of rest pain at rest. He was given an appointment with Dr A the next day to discuss the results.

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The baby was born by caesarean section at 27 weeks gestation with a birth weight of 980 grams. 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 99-97%. A blood gas taken five hours after delivery showed a pH of 7.46 (normal 7.3-7.4), a PaCO2 of 35.8kPa (normal 4.6-6.0), a PaO2 of 35.8kPa (normal 5-6) and a bicarbonate level of 4.6mmol/l (normal 18-24). This demonstrated the baby was 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. Overall, the baby received 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 irreparable Scarlet 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 a panproctocolectomy and the histological diagnosis was of two synchronous rectal carcinomas, Duke’s stage C1. Multiple adenomas were found, some with high grade dysplasia, and it was considered that Mr S had Attenuated Polyposis Syndrome.

Mr S’s family were devastated. He struggled through chemotherapy and radiotherapy. He was told that it was not possible to reverse his illocity 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.

Dr A advised Mr S to avoid cannulation 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 simple haemorrhoids. He noted that Mr S was not keen on medication so advised him to drink more fluids and increase his fibre intake. 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, 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 an overlap 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 suspicious 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.

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 Dr A. Dr A gave Dr A a letter from the overseas health clinic and explained that he had noticed occasional rectal bleeding. He advised that he had seen one of his colleagues a month before who had seen external haemorrhoids that were bleeding slightly. Dr A advised Mr S to avoid cannulation to help with his haemorrhoids. He filed the letter from the health clinic but did not act on it.

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 polyoid 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 rectoscopy 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.
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 so 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 head felt “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 135/80, pulse rate 58/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 hourly neurological observations, be reviewed in the emergency observation unit. Miss A received intravenous fluid and analgesia. She had a normal full 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 a diagnosis of migraine headache, she was discharged with analgesia and advised to return if the symptoms worsened.

Two days later, Miss A returned to work, though she still had the headache and preferred to be in a dark room. The next week she attended her GP, Dr X, who listened to her history and read the hospital letter, noting that her head felt “heavy” at work and she’d felt herself breaking out in a cold sweat, with a throbbing frontal headache radiating to each temple.

The following day, 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. Transfusion was attempted but following a CT scan of her brain, she died. The scan confirmed a large subarachnoid haemorrhage involving the 3rd and 4th ventricle on the left side and a frontal intracerebral haemorrhage.

A claim was made, alleging delay in referring Miss A, resulting in late diagnosis of subarachnoid haemorrhage from which she died. Allegedly, Dr X had failed to notice the ED records, which showed a history of sudden onset headache. He did not act cautiously and refer Miss A for investigations for suspected SAH. After considering the possibility of a vascular anomaly, he did not act and hadn’t arranged an urgent hospital admission and investigations. He’d made an unreasonable diagnosis of migraine with respect to Miss A’s age and symptoms.

The claim also alleged that the hospital had failed to establish Miss A’s subarachnoid haemorrhage and hadn’t reviewed her appropriately in the ED.

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 reasonably considered a vascular event as a cause of the headache. However, he’d 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 not reasonable to wait before arranging referral for investigations.

Dr X felt his actions were defensible. After their consultation, Miss A had his telephone number so could have phoned him at any stage. He’d instructed her to return if her condition deteriorated. He’d acted cautiously and responsibly – the patient declined medical follow-up and specialist referral the next day. She’d been investigated at ED before attending him and the diagnosis had been migraine.

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.

The claim was settled against both Dr X and the hospital for a moderate sum.
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 seborrhoeic keratosis 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 seborrhoeic wart’ on a hard surface and red flare around with warty texture. There was no catching or bleeding and Dr B discussed removal with Mr M only ‘if it was a malignancy’.

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 flucloxacillin 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 general practice, for the appointment that had been arranged by Dr A a month earlier. Only the crust of the lesion was removed as the doctor noted the possibility of squamous cell or ‘more likely a malignant melanoma’. The practice arranged for Mr M to be seen urgently by the dermatologist within two days. There were now palpable axillary nodes and melanoma seemed likely.

One month later, in March, Mr M underwent wide excision and axillary dissection, but his condition deteriorated. Unfortunately, he had developed brain metastasis by April and stage 4 malignant melanoma. He died in July of progressive metastatic disease, despite chemotherapy and raditherapy.

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 and felt that Mr M should have been referred straight away, rather than three months after the initial presentation. They also felt that the earlier description of the lesion was not adequate or detailed enough, quoting NICE guidelines. Lifting the crust off the top of the lesion was criticised. However, expert opinion instructed by MPS felt that the overall outcome would not have been affected by a referral after the second GP consultation, given the rate and rapid progression of the disease by the time Mr M was first seen by the dermatologist.

In summary, the practice had been in breach of duty, but this breach was not the cause of death. The case was successfully defended.

The ambulance transferred them to hospital within 30 minutes. On arrival in the ED a temperature of 39°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 (30% 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. CLOF 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 intravenous immunoglobulins. Despite this, Mrs J 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 D 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 is 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 165/110 mmHg. His urine 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 neuropathologist Dr B some six months after his initial GP presentation, and underwent an MRI 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 noted to be his usual practice to measure his blood pressure. He mentioned that the headaches had been ongoing for two years and were still associated with fatigue and认知 impairment as well as an MSU and bloods to be taken (CRP, LFTs, PV and PSA) and commenced sumatriptan to have a trial of sumatriptan for his MSU and bloods, and was reassured that the headaches were likely to be tension headaches. Blood pressure was not checked. Mr H was reviewed the following week and investigations were all normal. His headache also appeared to have improved.

Three months later, Mr H returned about his headaches again. He felt sumatriptan was no longer effective and requested a trial of anti-hypertensive medication. 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. Lsinopril 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 262 umol/l, an eGFR of 20 ml/min and a urine of 173 mmol/l. Investigations were initiated (renal USS was normal) and he was reviewed by a consultant nephrologist. Dr C. Dr C made note of recurrent UTIs during Mr H’s childhood and his hypertension, and concluded that reflex 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 tools available to delay renal deterioration is optimal control of blood pressure, using reninal 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 had renal function been tested when he first presented with headaches, then he would have been diagnosed as a far earlier stage, which would have allowed him to retain his renal function by a judicious use of medication and diet.

**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 malignan 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.

Mr H subsequently discontinued his claim.

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Mr H subsequently discontinued his claim.
Critical of numerous aspects of their care. The family of Miss C initiated proceedings by the ICU team and neurosurgeons, Miss C’s carotid arteries. Despite further intervention common carotid, internal carotid, external occlusion of the entire extra-cranial left demonstrated a large left middle cerebral did not improve and when Professor A saw attributed her drowsiness to opiate toxicity to have profound right-sided weakness. Dr was damaged, resulting in rapid blood loss by Professor A for “radical excision of left day. Miss C signed a consent form completed for malignancy and recommended surgical this was a rare tumour with the potential outcome. The experts raised concerns regarding bleeding may have prevented thrombus formation at the site of cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks. Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have surgery and their implications. This should permanent disability or death. Patients need surgery and their implications. This should include any serious adverse outcomes, including complications, which may result in permanent disability or death. Patients need to be aware of the benefits and risks make an informed decision as to whether they want to proceed. Communication can be difficult and are not necessarily a sign of negligence. Litigation can be expensive and is usually avoided if patients are satisfied about the risks in advance and this discussion is recorded.

**Learning points**

- Communicating within the team is important – the nursing staff s surgical procedure was marked 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 brain-damaged, but had no obvious neurological deficit. She remained stable overnight but the following morning appeared drowsy and was noted by the nursing staff to have a persistent left hemiparesis. Dr B, ICU anaesthetist, reviewed and Miss C and attributed her drowsiness to opiate toxicity and suspected vasovagal reaction did not improve and when Professor A saw her, he arranged an urgent MRI scan. This demonstrated a middle cerebral artery territory infarction with complete occlusion of the entire extra-cranial left common carotid arteries. Despite further intervention by the ICU team and neurosurgeons, Miss C suffered permanent brain damage with severe hemiplegia and cognitive impairment requiring continuous nursing care. The family of Miss C initiated proceedings against Professor A and Dr B, as they were critical of numerous aspects of their care. EXPERT OPINION Expert opinion agreed that arterial bleeding from excess of a carotid body tumour is a well-recognised and inherent potential risk of such surgery and Professor A handled this complication in an appropriate and timely manner. Although questioning the need for three periods of carotid clamping it was felt that the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks.

**OVER TO YOU**

We welcome all contributions to Over to you. We reserve the right to edit submissions. Please address correspondence to Casebook, MPS, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK. Email: casebook@medicalprotection.org

**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 issue.

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 Ms Bowen’s 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. Her words are humbling and a timely reminder for doctors regarding the privileged positions of trust and responsibility that we hold. I wish this article will provide food for thought amongst our profession and for the institutions that we work within.

Dr Rachel Jones, G.P., Auckland, New Zealand

I read with much sadness 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 MPS that the medical profession fell short of expectations in this case and much needs to be done.

Dr. Stephen Murphy, The Park Clinic, Dublin

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 (independent of any personal conflict) can be considerably wider and may involve attendance at conferences, provision of supplementary reports and opinions, and attendance at conferences, provision of supplementary reports and opinions, and meeting the expert for the other side with a view to reaching an agreed, joint position, 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 try their hands on laparoscopic procedure without proper retraining. This is important to have a small scar that we should compromise safety standards?

John SM Leung, FRCSd, Hong Kong

I am emailing to say thank you for publishing the heart-wrenching story of little Beth Bowen in the September edition of Casebook.

Her mother Clare has shown much courage and strength of character in standing up and speaking out about these harrowing events. One can but only begin to imagine the devastation of losing a daughter and subsequently a husband under such devastating circumstances.

I wish this article will provide food for thought amongst our profession and for the institutions that we work within.

Dr Rachel Jones, GP, Auckland, New Zealand

I read with much sadness 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 Mrs 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 she had open laparotomy, a properly qualified surgeon could have completed the operation with minimal risk. Even if a major blood vessel is torn, it could have been controlled without delay. Laparoscopic surgery denies the surgeon 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 try their hands on laparoscopic procedure without proper retraining. This is important to have a small scar that we should compromise safety standards?
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 assume 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 in the article although there are several possible diagnoses of chronic fatigue or what management was given for the 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 I feel 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 this is no longer considered acceptable to consider a non-organic basis for the disease. It is probably a chronic encephalitis but this has not been definitively 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. Caruthers 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 diagnosis but in my opinion it certainly should be a source of litigation because of the poor diagnostic skills of most practitioners. In regard, the ignorance about management and the stigma which doctors attach to this disease, greatly increasing the significant suffering of patients.

Dr Elizabeth Murray, Rondhoushe Medical centre, Mediclinic Constantiaberg, UCT Private Academic Hospital, South Africa

Response

Thank you for your letter of 21 September, regarding the case report “High Expectations”.

By necessity, our case reports are a summarisation of the actual case, where there is no confusion caused by this error. I do not believe the timing of her signs and symptoms, and consequently failing to take appropriate timely action.

Being negligent to fail to escalate 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 this is no longer considered acceptable to consider a non-organic basis for the disease. It is probably a chronic encephalitis but this has not been definitively proven. There is management available for chronic fatigue syndrome.

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Dr Elizabeth Murray, Rondhoushe Medical centre, Mediclinic Constantiaberg, UCT Private Academic Hospital, South Africa

THE ELUSIVE DIAGNOSIS

Re: “The elusive diagnosis”, Casebook September 2014. I am very surprised from the evidence given that the claim for late diagnosis of diabetes (presumably mellitus) was successfully defended. The failure to test the plaintiffs urine is inexcusable.

Many years later the late Professor Jackson estimated that in Cape Town there were an estimated 20,000 asymptomatic people with undiagnosed diabetes mellitus. Since then the provincial facility at which I used to practise has tested the urine of every new and returning patient for glucose etc. We were newly diagnosing two to three diabetes mellitus patients every week.

Dr Stephen A Crawen, Hon Lecturer in Family Medicine, University of Cape Town, South Africa

Response (to both letters):

Thank you for your correspondence about this case.

The chronology 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 his actions would be supported by a responsible body of medical opinion, skilled in the relevant specialty. In this case, the 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 his/her options 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 necrotic 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.

REFERENCES

BEING MORTAL

Atul Gawande

Review by Dr Sam Dawson
(Specialty trainee, 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 unflinching 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 helplessly 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 disorientating 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 Narainbhial
(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 commentary on the profession.

The book is divided into two parts. In the first part, Phalime searches within herself for reasons why she left. She tells of her life growing up in Soweto and Wonderboom and then studying medicine at the University of Cape Town. She also documents her experiences as an intern in the South African public health sector. This second part of the book highlighted common but often barely accepted issues that we face in the medical profession.

In the end, Phalime’s decision to leave is multifaceted. She concludes: “It was tough, it was sad, and I left, that’s all.” She practised medicine during the dark age of HIV/AIDS, 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.
How to contact us

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