

Casebook

EARN 3
CPD ETHICS
POINTS THIS
ISSUE!
SEE PAGE 27

YOUR LEADING MEDICOLEGAL JOURNAL

MPS



Counting the cost

THE EVER-INCREASING
PRICE OF LITIGATION

PAGE 9

Psychology: treating children

CONFIDENTIALITY ISSUES IN
OUR SPECIALTY FEATURE

Improving communication

CUT RISK BY STRENGTHENING
YOUR SKILLS

News: fraudulent doctors at large

HPCSA REVEALS FIGURES
FROM PRETORIA HOSPITALS

CASE
REPORTS
PAGE 13

Secure your spot at

MPS 2012

A new
international
conference
focusing on

**Quality and
Safety in
Healthcare:
Making a
Difference**

**A conference addressing
quality, patient experience,
safety culture, cost and
professionalism**

**Thursday 15 November and
Friday 16 November 2012**

Church House • London • United Kingdom

**Register
before
30 June
2012 for
discounts!**

Secure your spot and find out more at:
www.mpsinternationalconference.org

MPS



ON THE COVER

9 Counting the cost

The value and frequency of claims continues to soar in South Africa. Dr Stephanie Bown, describes an unsustainable situation.

7 Improving communication

Dr Jagdeesh Singh Dhaliwal, of MPS Educational Services, outlines why good communication is important for patients and colleagues alike.

11 Specialty focus: Psychology

Attorney Stephanie Esterhuyse looks at confidentiality in psychology.

27 Questions for CPD

Earn three CPD ethics points by answering 20 medicolegal questions.



ALSO THIS ISSUE

4 Your MPS

In addition to MPS Medical Director Dr Priya Singh's regular column, you can also read about the latest offerings from Educational Services and find out what MPS has been up to in YOUR part of the world.

6 Headlines and deadlines

The latest news on legislation, events and open consultations in Africa.

13 On the case

Dr Graham Howarth, MPS Head of Medical Services (Africa), introduces this issue's selection of case reports.

14 Case reports

- 14 Too quick to clear the spine
- 15 Too many records spoil the notes
- 16 Ignoring the cold foot
- 17 Right patient – wrong sample
- 18 More than a bruise
- 19 "Just a quick look" can be costly
- 20 Double problem, double risk
- 21 An unfortunate prescription
- 22 Symptoms that don't add up
- 23 Your patient, your responsibility

24 Over to you

A sounding board for you, the reader – what do you think about the last issue of *Casebook*? All comments and suggestions welcome.

26 Reviews

This issue, Philippa Pigache reviews *Zero Degrees of Empathy: A New Theory of Human Cruelty*, by Simon Baron Cohen, while Wendy Moore reviews *Great Discoveries in Medicine*, by William and Helen Bynum.



GET THE MOST FROM YOUR MEMBERSHIP



Visit our website for further *Casebook* issues, a wealth of publications, news, events and other information:
www.medicalprotection.org



Opinions expressed herein are those of the authors. Pictures should not be relied upon as accurate representations of clinical situations. © The Medical Protection Society Limited 2012. All rights are reserved.

ISSN 1740 0090

Casebook is designed and produced three times a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

GLOBE (logo) (series of 6)® is a registered UK trade mark in the name of The Medical Protection Society Limited.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary, as set out in the Memorandum and Articles of Association.



Cover: © Lise Gagne/iStockphoto.com

Welcome



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

The impact of the global recession continues to be felt in many jurisdictions where MPS operates and the consequences of rising costs in clinical negligence claims will be felt ever more keenly.

Although the medical profession can offer a financially rewarding career, no-one is immune to the kind of cost increases that cause a health practitioner to question the affordability of their medical indemnity. But increases in claims costs, together with an increase in the number of claims – which are continuing seemingly unabated, particularly in the UK, South Africa and Ireland – make this scenario more realistic.

Many members contact us in dismay that they seem to be feeling the hand of the regulator more often than ever before. We have attempted to identify the reasons why claims and complaints are on the rise – depersonalisation of the doctor-patient relationship, higher patient expectations, errors from working in high stress environments with stretched resources; these are all real issues that face each of you every day.

This is where we hope that *Casebook* has a part to play. No-one can stop all claims from occurring but we can help to highlight what you can do to ensure that you have a robust defence at your disposal.

I do hope that you find *Casebook*, and the other range of medicolegal publications that MPS produces, to be sufficiently supportive in these trying times. Please get in touch with any comments or suggestions; it is really helpful to receive your feedback.

Stephanie Bown

CONTRIBUTORS

Dr Stephanie Bown
Editor-in-chief



Gareth Gillespie
Editor



Sara Williams
Assistant editor and senior writer



Sarah Whitehouse
Assistant editor and writer



Dr Monica Lalanda
Medical writer



EDITORIAL BOARD

Dr Tina Ambury, Dr Nick Clements, Dr Marika Davies, Dr Lyn Griffiths, Dr Graham Howarth, Dr Jonathan Jones, Dr Su Jones, Dr Sonya McCullough, Dr Jayne Molodynski, Rachel Morris, Dr Amanda Platts, Dr Ming-Keng Teoh

PRODUCTION

Production manager – Philip Walker
Design – Jayne Perfect
Print – HMPG

CASE REPORT WRITERS



Dr Sara Chambers



Dr Sam Dresner



Dr Anna Fox



Dr Anusha Kailasanathan



Dr Monica Lalanda



Dr Gurinder Matharu



Dr Sally Stucke



Dr Ellen Welch



Dr Jonathan Wild

PLEASE ADDRESS CORRESPONDENCE TO
Casebook Editor, Medical Protection Society,
Granary Wharf House, Leeds LS11 5PY, UK.
casebook@mps.org.uk

Fighting back against online attacks

MPS Medical Director *Dr Priya Singh* calls for global action against internet defamation



Members are increasingly facing the very distressing situation of material having been posted about them on the internet. This can take a number of forms, such as discussion forums, other websites containing a feedback element, or as a result of individual campaigns by patients dissatisfied with care received.

Whether the content is written by members of the public posting anonymously or by identifiable individuals, it is rare that the circumstances offer the subject of the material a right of reply.

Whilst MPS would not wish to restrict freedom of expression and fair comment, we do feel that members in these circumstances deserve a right of reply and/or redress, and it is therefore important that new legal frameworks around the world are created to reflect this.

This is less problematic in instances

where the website host properly moderates the content available on their website or is able to offer a right of reply. Increasingly the process is more difficult and may even lead to a situation where there is no mechanism for challenging false or defamatory material. It is therefore of importance that website hosts continue to have liability for the content they publish.

We are seeing the courts beginning to recognise the impact and importance of these issues. As an example, where an internet campaign was a part of a wide range of harassment suffered by a member, we have been successful in obtaining an order prohibiting such internet attacks. These successes help us to continue to make strong representations on behalf of members, to ensure that legislators understand the devastation that such campaigns can cause.

Education update: handling difficult interactions

Dealing with difficult interactions with patients can be a significant cause of stress for doctors, yet the nature of most clinical jobs makes these encounters unavoidable. Approximately 15% of clinical interactions are classified by doctors as “difficult” (Hahn et al 1994, Jackson and Kroenke 1999). These types of interactions can induce a range of distressing emotions in both doctors and patients. They can also often lead to increased medicolegal risk.

To assist you in handling difficult interactions and avoiding the negative outcomes that may result, MPS will be launching Mastering Difficult Interactions with Patients, the latest in MPS’s “Mastering” series of communication skills workshops.

Mastering Difficult Interactions with

Patients explores the causes of difficult interactions and provides techniques to handle these situations effectively. Workshops will be available in South Africa in the second half of 2012. As an MPS member you will be able to attend free of charge as a benefit of your membership.

The following workshops are also available in the series:

- Mastering Your Risk
- Mastering Adverse Outcomes
- Mastering Professional Interactions

All of the workshops in the “Mastering” series are focused on minimising your risk of complaint and litigation through effective communication.

For further information, please visit www.medicalprotection.org/southafrica/education.

Visit www.medicalprotection.org/southafrica/education-publications for details of MPS events, courses and workshops in your area

EVENT FOCUS – IRELAND

Unravelling the myths of the consultant post

Fifty delegates attended the second Making the Most of Your Consultant Post conference for members in Ireland in November.

Held at Croke Park Stadium, Dublin, the event armed specialist registrars and newly-qualified consultants with the information they need to succeed in their current or future roles.

The day started with the presentation: "What to expect when you're a consultant – everything you wanted to know, but were too afraid to ask" and included topics on the importance of open communication, human factors and

system errors, and protecting your reputation – the MPS approach.

Professor James Lucey, Medical Director at St Patricks University Hospital and Clinical Professor of Psychiatry at Trinity College, Dublin, spoke on mental health and burn out in medical professionals.

Case studies and ethical dilemmas from the MPS caseload were studied as part of a round-table discussion, with feedback from an expert panel.

The day had some excellent feedback and we look forward to organising similar events for members in Ireland in 2012.



COUNTRY FOCUS – HONG KONG

HKAM – MPS Award for Patient Safety



Dr Alexander Chiu has been named as the winner of the 2011 MPS – Hong Kong Academy of Medicine (HKAM) Award for Patient Safety.

His paper, "Root Cause

Analysis Improves Patient Safety: A descriptive study of Root Cause Analysis Framework applied to clinical incident investigation in a University Affiliated Hospital", was awarded the highest total score by the judges. Dr Chiu was presented with a plaque and a cheque for HK\$20,000.

The award aims to encourage medical professionals to promote patient safety and risk reduction.

Dr Chiu presented his winning paper at the HKAM – MPS Seminar on Patient Safety on Friday 2 December.

News near you...

CARIBBEAN AND BERMUDA

MPS's Dr Nancy Boodhoo and Al Neaber visited five countries in the region in October to meet with representatives of medical and dental associations, hospital boards and health services authorities.

In November, MPS Senior Consultant Dr Paul Nisselle presented risk management workshops focused on effective communication in conjunction with Cayman Islands Health Services Authority and the South Eastern and Western Regional Health Authorities in Jamaica.

SOUTH AFRICA

Chaired by MPS medicolegal consultants Dr Tony Behrman and Dr Liz Meyer, "Ethics for All", the annual MPS ethics evening, was held in Pretoria (400 attendees) on Monday 21 November and in Cape Town (1,500 attendees) on Wednesday 30 November.

SINGAPORE

More than 150 doctors attended a lunchtime seminar on consent at Gleneagles Hospital in September. MPS Head of Medical Services (Asia) Dr Ming-Keng Teoh spoke on "Ethical and legal principles", Edwin Tong from Allen & Gledhill spoke on "Recent SMC and High Court decisions" and MPS Medicolegal Adviser Dr Janet Page spoke on "Where to from here?"

Dr Teoh and Dr Page met with the new SMC President, Prof Tan Ser Kiat, to discuss recent SMC decisions on consent and better ways of working together.

UK

In September, MPS held the Making it Safer: Out of Hours and Unscheduled Primary Care conference, in Westminster, London. The conference attracted nearly 200 medical and clinical directors, chief executive officers, general practitioners, commissioners of out-of-hours (OOH) services and nurses. The packed programme included talks on: the role of the nurse practitioner; top tips on registering with the CQC; telephone triage; vicarious liability; and learning from adverse events.

HONG KONG

The second Hong Kong Expert Witness Training Programme, co-organised by MPS and HKMA, and supported by the HK Academy of Medicine, was held in September. The event was heavily oversubscribed, with more than 200 applications for 75 places. Topics included: the litigation process, clinical negligence, how to write a report, MPS claims handling ethos and what the courts wants from experts.

MALAYSIA

In November, Dr Ming-Keng Teoh delivered a lecture on medical protection and litigation in Penang. Dr Teoh spoke at the King Edward VII College of Medicine, University of Malaya's annual alumni reunion.

MPS meets with specialty groups to discuss rising cost of claims

ALEX SLOBODKIN/ISTOCKPHOTO.COM



In October, MPS hosted a round-table discussion in Johannesburg for key representatives of high risk specialty groups within the medical profession, to discuss the rising cost and frequency of clinical negligence claims in South Africa. The group explored how they could work collaboratively to positively influence the current and future claims environment, and how issues such as high quality communication could help improve the patient experience and minimise claims. The meeting followed discussions MPS had earlier in the year with the Health Minister Dr Aaron Motsoaledi, who has recently indicated

he will set up a taskforce to investigate the rise in claims costs and incidence.

The cost of clinical negligence is rising steeply. In the last two years MPS has seen the cost of reported claims more than double – specifically an increase of more than 132%. Media coverage, reports from individual provinces and views recently expressed by Dr Motsoaledi demonstrate that the cost of clinical negligence is also a significant problem in the state sector. Dr Motsoaledi has set up a task force to look into the scale of the problem, contributory factors and to consider possible solutions.

New factsheets for South Africa

MPS has recently published three new factsheets for members in South Africa on chaperones, circumcision and retention of medical records.

Acting as a chaperone can raise many medicolegal dilemmas for doctors. The *Chaperones* factsheet draws upon guidance and regulations to outline how you can perform effective patient examinations while safeguarding your professional reputation.

The factsheet on *Retention of Medical Records*

outlines how doctors should manage medical records and know when it is permissible to dispose of them.

The *MPS Policy on Circumcision* factsheet outlines our position on assisting doctors who conduct circumcisions, and considers the ethical considerations and potential difficulties that can be involved.



MPS POSITION STATEMENT: TELERADIOLOGY

Teleradiology is the process whereby an image is taken in one location and then transmitted to another for reading, analysis, interpretation and provision of a report by the radiologist at the other location.

Members are expected to advise MPS if they are participating in teleradiology and restrict the practice to their respective local jurisdiction. If an indemnity risk arises from that practice then the appropriate grade for that jurisdiction will be charged.

Members who wish to practise teleradiology in circumstances where the image is taken in another jurisdiction must both be appropriately registered and have professional indemnity cover in the jurisdiction where the image is taken. MPS may be able to offer benefits of membership in these circumstances and members should contact MPS for advice. Members should not assume that their current MPS membership will offer such an indemnity.

FRAUDULENT PERSONNEL WORKING IN EMERGENCY DEPARTMENTS

The Health Professions Council of South Africa (HPCSA) has revealed that thousands of personnel have been practising in Pretoria's emergency care services with fraudulent certificates.

Since making the discovery in August 2011, more than 1,400 individuals have been removed from the medical register by the Professional Board for Emergency Care (PBEC).

The PBEC conducted a thorough investigation into the quality of training provided by the Limpopo Ambulance Training Academy (LATA).

The Chairman of PBEC said the public were being placed "at risk" when coming into contact with these individuals who had been issued fraudulent certificates from the LATA. He also issued a warning to "any registered member who is involved in any criminal, unprofessional and unethical conduct to stop immediately".

The HPCSA has reminded all institutions offering emergency care training to ensure they are accredited and operating in compliance with the education and training standards as laid out by the PBEC. The council is calling on all employers to ensure any emergency care staff who obtained certificates from LATA, and who are registered with the HPCSA, have legitimate qualifications.

The PBEC also advises medical students to contact the HPCSA to check the training centres they are attending are accredited institutions.

Following on from the investigation, the PBEC also raised separate concerns about:

- The quality case provided by ambulance crews
 - Submission of fictitious claims
 - Practitioners practising outside their scope of practice
 - Photographs being taken at accident scenes and distributed across social media websites
 - Strike action, which is strictly prohibited for emergency care workers.
- www.hpcsa.co.za



Improving communication, cutting risk

Why is effective communication with patients and colleagues so essential to managing risk for doctors? **Dr Jagdeesh Singh Dhaliwal**, MPS Manager and Senior Medical Educator for the Asia-Pacific region, offers some thoughts

Casebook readers who have never attended any of our risk management workshops and master classes might ask themselves why MPS's educational programmes focus so heavily on communication.

As doctors, we spend our professional lives seeking to finesse our clinical knowledge and our clinical skills. Fear of becoming "an out-of-date doctor", coupled with a desire for excellence, probably sums up the strong psychological drivers for study and improvement shared by most members of our profession.

Thinking back to our experiences at medical school, many of us will no doubt remember how difficult it felt to be able to converse with patients and elicit a complete history during the early clinical years.

However, we persist and follow through and as our knowledge and practical skills grow, so does our history-taking ability – and we start to become competent

and confident as diagnosticians.

It can be a rude shock, therefore, to find oneself in a situation where a patient is unhappy despite an objectively correct diagnosis and an excellently executed surgical or medical management plan. "Why are they unhappy with me, when I did everything correctly?" "How dare they complain..." "I would understand if I had done something wrong... but a complaint when I did everything right is very unfair..."

A negative spiral can ensue where we either get angry at the patient and the family or sad or upset about the unfairness of a complaint that was not the result of a clinical mistake.

MPS's claims data and international research consistently demonstrates the following: it is patient dissatisfaction with communication by their doctor that fuels the majority of complaints.

Recently, for example, Moore et al's¹ study into

hospital complaints in Chile has demonstrated that patient dissatisfaction with communication with the doctor is the largest contributing factor leading to a complaint. From the other end of the globe, Hamasaki et al² have explored the increasing trend of doctors' explanations forming a pivotal point of medical malpractice litigation by patients in Japan. These studies build on earlier research from around the world, which emphasises the role of problematic communication as a key reason patients decide to sue following an adverse outcome.^{3,4,5,6}

And specifically, it is a failure on the part of doctors to communicate caring that lies at the heart of most patient dissatisfaction with their doctors.

For instance, Ambady et al's⁷ interesting study found that (controlling for content), surgeons' audiotaped voices that were independently assessed by two patients as demonstrating "high dominance



MPS's claims data and international research consistently demonstrates the following: it is patient dissatisfaction with communication by their doctor that fuels the majority of complaints

over the patient" and "low concern/anxiety for the patient" correlated significantly with those surgeons who had previous claims. Beckman et al's⁸ seminal paper looking at plaintiff depositions demonstrated an association between "perceived lack of caring and or collaboration" and patients' decisions to litigate against their doctor. Chiu et al⁹ in Taiwan have found that a driving motivation for patients and their families for litigating is the emotional desire to achieve comfort or, in other words, a sense of "being cared for".

Certainly, it seems, the research would point to poor communication and a lack of caring being instrumental in patients' decisions to sue. But is the converse true? Is being a good communicator and demonstrating caring associated with less risk of sustaining patient complaints?

Amongst other studies, Moore et al¹⁰ have found that positive doctor communication behaviours increase patients' perceptions of the competence of that doctor and decreases their intention to sue either the doctor or his or her hospital in the event of an adverse outcome. And a very interesting study by Hagihara et al¹¹ has found that physician explanatory behaviours, including explaining and listening to

families, is associated with a markedly lower probability of a court decision of negligent care by judges in Japan.

What might this mean for us as doctors? Perhaps this.

That, as well as continuously perfecting our technical expertise in our particular specialty, continuously perfecting our communication and empathy skills is essential to cutting our risk. It is this combination of both technical and emotional performance that appears to single out the route to ongoing overall excellence as a doctor.

Communication skills workshops

MPS has developed a series of communication skills workshops. The following workshops are available in South Africa:

- Mastering Your Risk
- Mastering Adverse Outcomes
- Mastering Professional Interactions

As an MPS member you can attend these workshops free of charge as a benefit of your membership. For more information, including forthcoming dates, locations and online booking, please visit: www.medicalprotection.org/southafrica/education.

A new workshop, Mastering Difficult Interactions with Patients, will be available in the second half of 2012.

REFERENCES

1. Moore P et al, A Study of Hospital Complaints and the Role of the Doctor-patient Communication, *Revista Medica De Chile* 139(7): p880-885 (2011)
2. Hamasaki T, Takehara T and Hagihara A, Physicians' Communication Skills with Patients and Legal Liability in Decided Medical Malpractice Litigation Cases in Japan, *BMC Family Practice* 9: p43 (2008)
3. Vincent C, Young M and Phillips A, Why do People Sue Doctors – a Study of Patients and Relatives Taking Legal Action, *Lancet* 343(8913): p1609-1613 (1994)
4. Krause HR, Bremerich A and Rustemeyer J, Reasons for Patients' Discontent and Litigation, *J Craniomaxillofac Surg* 29(3): p181-3 (2001)
5. Lester GW and Smith SG, Listening and Talking to Patients – a Remedy for Malpractice Suits, *Western Journal of Medicine* 158(3): p268-272 (1993)
6. Asnani MR, Patient-Physician Communication, *West Indian Medical Journal* 58(4): p357-361 (2009)
7. Ambady N et al, Surgeons' Tone of Voice: a Clue to Malpractice History, *Surgery* 132(1): p5-9 (2002)
8. Beckman HB et al, The Doctor-patient Relationship and Malpractice. Lessons from Plaintiff Depositions, *Arch Intern Med* 154(12): p1365-70 (1994)
9. Chiu YC, What Drives Patients to Sue Doctors? The Role of Cultural Factors in the Pursuit of Malpractice Claims in Taiwan, *Social Science & Medicine* 71(4): p702-707 (2010)
10. Moore PJ, Adler NE and Robertson PA, Medical Malpractice: the Effect of Doctor-patient Relations on Medical Patient Perceptions and Malpractice Intentions, *Western Journal of Medicine* 173(4): p244-250 (2000)
11. Hagihara A and Tarumi K, Association between Physicians' Communicative Behaviors and Judges' Decisions in Lawsuits on Negligent Care, *Health Policy* 83(2-3): p213-222 (2007)

Counting the cost of litigation

The cost of claims in South Africa is escalating at an accelerating rate. **Dr Stephanie Bown**, MPS director of policy and communications, outlines the stark reality of a growing problem

Over the past five years, MPS's claims experience in South Africa has shown an alarming deterioration that has been gathering pace – so much so that over the past two years alone, the value of reported claims has more than doubled: an increase of 132%.

If you are a claimant lawyer, you are no doubt rubbing your hands together in glee at this news. And claimant lawyers appear to be doing just that – a Google search using the terms “doctor” and “litigation” produces in the sponsored adverts section a collection of law firms claiming to specialise in medical negligence cases, suggesting that claimant lawyers – perhaps disgruntled at changes to the Road Accident Fund that capped the fees they can charge – have wised up to the opportunities on offer, and have stepped up their advertising.

Value and frequency

This year, MPS settled our highest claim yet in South Africa, paying out almost R24 million on behalf of a member. The value of settling our five highest claims between 2006 and 2010 was more than twice the value of settling our five highest claims between 2001 and 2005. One of the key factors behind this growth in value is the increased size of awards for catastrophic neurological damage; technological advances and improved life expectancy has meant that the cost of care for affected patients has escalated, in turn increasing the financial awards in negligence cases.

Large claims are just part of the problem. The overall number of claims against members in

South Africa has also increased, with the number reported to MPS in 2010 30% higher than the number reported in 2006, just four years previously.

If this trend is to continue unchecked, the grim, blunt reality is that private practice in the highest risk specialties may diminish or even disappear altogether, due to the level of income generated from practice no longer being sufficient to meet the increased cost of indemnity.

The highest membership subscription paid by MPS members in South Africa is typically in the category of obstetricians. The anxiety over affordability of professional indemnity is heightened within this specialty, as the largest element of claims values arises from claims brought on behalf of children catastrophically injured during birth. Bearing in mind that such claims can be brought many years after the birth, when general claims inflation and changes to the amount of future care to be provided come into play, the cost of settling a claim can increase enormously.

Cause and effect

There is no definitive answer to what is causing this sharp rise in claims frequency and value, but there are probably a number of contributory factors.

As already mentioned, the reaction of lawyers to the Road Accident Fund Amendment Act, which capped the amount of compensation payable to road accident victims, and lawyers' more extensive advertising, is likely to have had an effect. In addition, as Dr Graham Howarth, MPS Head of Medical Services (Africa), told *SAMJ*, a developing country like South Africa was always likely to see patient awareness of their constitutional rights grow, making them more likely to make a medical negligence claim.¹

Something that is definitely on the radar of Health Minister Dr Aaron Motsoaledi is the “no win, no fee” system promulgated by the Contingency Fees Act 1997. The system allows prosecuting lawyers to take a significant cut of any payout – doubling their hourly rate to take up to a maximum of 25% of the payout – when they win their case. Dr Motsoaledi told the *Medical Chronicle*: “I want a system that will put doctors back in hospitals and lawyers in courts – not the other way around as we are now seeing. Medical litigation and the practice of defensive medicine are the main contributing factors to the outrageous cost of healthcare in the USA because, there, doctors don't just treat patients – they

also have to treat the lawyer behind the patients and we can't allow this to happen in SA."²

Another possible factor is the increasingly stressful environment in which healthcare professionals are working. Higher patient expectations and the fear of the consequences of making an error can, paradoxically, lead to more errors occurring. An overly stressed doctor is not at their most effective, and MPS sees no evidence that the profession is intentionally letting its standards slip; the commitment to providing safe care to patients remains as strong as ever.

Stress within the medical profession has arguably never been higher; in 2009, MPS introduced a counselling service for members in South Africa to address anxiety that results from facing a complaint or claim.³ In 2010, Dr Tim Hegan, Director of International Operations at MPS, told *SAMJ* that many private doctors cited high patient demands and the fear of being reported to the authorities as their main stressors.⁴

In 2006, a study by Thomas and Valli on stress levels in a public sector hospital found higher levels of occupational stress compared to the average working population.⁵ The main sources of pressure included understaffing, lack of resources, lack of control, difficult work schedules, inadequate security, and poor career advancement and salaries.

Finding a solution

It is interesting to look at the experiences of other countries that have experienced similar challenges in the claims environment, even though different socio-economic conditions across the world mean the comparison is flawed by not being like-for-like. However, the example of Australia, and the tort reforms that took place following the Ipp Report in 2002, is a notable one. By 2002, insurance premiums and damages awards for personal injuries through the fault of another were becoming "unaffordable".⁶

The reforms wiped out small claims, by setting minimum thresholds under which no claim

could be made for damages. The threshold in New South Wales, for example, is 15% of the worst case of impairment, such as paraplegia, which is approximately \$400,000. So claims cannot be made of less than roughly \$60,000. Medical indemnity organisations in Australia say these reforms have been critical – one said that the cost of claims has been reduced by 10-15%.⁷

In New Zealand, there is a completely different system for ensuring victims of clinical negligence are compensated. The "no-fault" system means compensation is paid out to patients from the Accident Compensation Corporation, with no liability attached to the party who is at fault.

A parallel approach – not an alternative, but in addition to the systems described above – is to ensure the medical profession does all it can to ensure learning from adverse events takes place, with a focus on quality improvement as an outcome, rather than castigation.

MPS is already leading on the promotion of this approach. Our Educational Services department offers a series of workshops across South Africa that are free as a benefit of MPS membership. Mastering Adverse Outcomes, in particular, gives practical training in effective management of patient care following an adverse outcome; Mastering your Risk and Mastering Professional Interactions are two other workshops that focus on risk management and strengthening doctor-patient communication respectively. You can read more about these courses here: www.medicalprotection.org/southafrica/risk-management-workshops.

Setting subscriptions fairly

The rising cost of claims in South Africa has made increases in subscription rates unavoidable –



We believe that the escalating cost of claims across both state and private sectors is detrimental to the wider healthcare economy and will have adverse consequences for patients, the public and those delivering care in increasingly challenging circumstances

a consequence that we know is unwelcome. As a not-for-profit, mutual organisation, we always try to ensure that subscription rates are fair. We have no motivation other than to ensure that members' needs are met.

The cost of clinical negligence claims is the largest element of MPS costs, so we begin by looking at recent claims experience and then try to predict the future trends, with independent specialist actuarial advice. This is no easy task; we have to collect enough money in any year to pay for the consequences of adverse incidents that occur from members' clinical practice in that year – even though claims arising from those incidents may not be reported for many years. MPS needs to ensure that sufficient funds are available to deal with consequences of all adverse incidents – consequences that may take many years to come to light.

We believe that the escalating cost of claims across both state and private sectors is detrimental to the wider healthcare economy and will have adverse consequences for patients, the public and those delivering care in increasingly challenging circumstances. We will continue to work in collaboration with members and engage with government to try to find a workable solution.

Additional reporting by Gareth Gillespie and Dr Graham Howarth

REFERENCES

1. Bateman C, Medical negligence pay-outs soar by 132% – subs follow, *S Afr Med J* 101:216-218 (2011)
2. www.medicalchronicle.co.za/motsoaledi-wages-war-against-lawyers (accessed 29 November 2011)
3. Gillespie G, Putting the stress on anxiety, *Casebook* 17(2):7 (2009)
4. Bateman C, Stressed doctors thrown an MPS lifeline, *S Afr Med J* 100:11-13 (2010)
5. Thomas LS and Valli A, Levels of occupational stress in doctors working in a South African public sector hospital, *S Afr Med J* 96:1162-1168 (2006)
6. www.onlineopinion.com.au/view.asp?article=1900 (accessed 28 October 2011)
7. www.australiandoctor.com.au/news/c8/0c06b9c8.asp (accessed 28 October 2011)

Specialty focus: Psychology – treating children

From time to time, *Casebook* focuses on issues pertinent to particular specialties. Here, attorney **Stephanie Esterhuyse** looks at the confidentiality issues facing psychologists who are treating children

Although this article relates to the specialty of psychology, it covers the general principles of confidentiality, many of which are the same across the healthcare profession

There can be no doubt that all psychologists have a duty of confidentiality in relation to all information disclosed to them during the course of therapy. Confidentiality is also the cornerstone of the trust between therapist and patient. Having said this, a patient's right to confidentiality is not absolute, as circumstances may arise where a psychologist may lawfully or alternatively be obliged to disclose confidential information.

The law

Regulation 27(1) of the *Rules of Conduct Pertaining Specifically to the Profession of Psychology* (as set out in Annexure 12 of the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act and published in *Government Gazette* No. 29079 of 4 August 2006), sets out certain prescribed circumstances when a psychologist may disclose confidential information:

"A psychologist may disclose confidential information in the following circumstances:

- (a) with the permission of the client concerned;
- (b) when permitted by law to do so for legitimate purpose, such as providing a client with the professional services required;
- (c) to appropriate professionals and then for strictly professional purposes only;
- (d) to protect a client or other persons from harm; or
- (e) to obtain payment for a psychological service, in which instance disclosure is limited to the minimum necessary to achieve that purpose."

In terms of Regulation 27(2), a psychologist may also disclose confidential information when required to do so by a court of law.

Regulation 30 then deals with two scenarios where a psychologist may be compelled to release confidential information, and reads as follows:

"A psychologist shall release confidential information when ordered to do so by a court of law or when required to do so by law or when authorised to do so in writing by the client concerned or the parent or legal guardian of the minor client."

In relation to a court order, the disclosure will necessarily be lawful.

In practice

The question to be posed is in relation to the second scenario, where a psychologist receives written authorisation from the child's parent for the release of confidential information disclosed by the child during the course of therapy. Must the information be disclosed? Can the psychologist refuse to disclose the information?

These questions were recently debated in a matter before the HPCSA.

In this matter, Mr F lodged a complaint of unprofessional conduct against Ms V, a psychologist and his seven-year-old daughter's therapist. He alleged that she had conducted herself in an unprofessional manner in as far as she had



Confidentiality is also the cornerstone of the trust between therapist and patient

CONFIDENTIAL

failed to provide him with information or a report following a consultation that she had had with his daughter. He alleged that he was entitled to the information disclosed during the course of the therapeutic consultation, as he was the father and had paid for the consultation.

Mr F had initially telephoned Ms V with a request for information. This was then followed by a letter from his attorney. Ms V addressed a letter to Mr F's attorney in reply and she indicated that the information requested was confidential and, as she did not have the child's consent to the disclosure thereof, she was unable to give him the information requested.

In her consideration as to whether the information should be disclosed to the child's father, Ms V also had regard to the paramourcy rule – in terms of which she was of the opinion that it was not in the child's best interest to disclose any information.

The matter was then considered by the Professional Board of Psychology's Committee of Preliminary Inquiry, which is a deliberating body comprised of psychologists. In their opinion, Ms V had acted unprofessionally in as far as she had failed to provide Mr F with the information requested. At the hearing of the matter before a Professional Conduct Committee, which consists of three psychologists, Ms V was then found guilty of unprofessional conduct.

The matter was then heard by an Appeal Committee of the HPCSA. This Committee comprised a lawyer as chairperson, two psychologists and a community representative. The judgment of the Professional Conduct Committee was set aside and Ms V was found not guilty of unprofessional conduct. It is this judgment handed down by the Appeal Committee that provides us clarity in relation to the disclosure to a parent of confidential information in relation to a child/minor.

Whilst the Appeal Committee in its judgment did not deal specifically with Regulation 30, it clarified a psychologist's duties when confronted with a request



CHRIS SCHMIDT



The Appeal Committee also criticised the Professional Conduct Committee for failing to accept the evidence of the expert clinical psychologist called by Ms V in her defence of the charge against her

from a parent for information disclosed during the course of therapy. The Appeal Committee in its judgment criticised the Professional Conduct Committee for failing to appreciate the importance, implications and the effect of the paramourcy rule.

The Appeal Committee went on to point out that the paramourcy rule was not only contained in the *Rules of Conduct* pertaining specifically to the profession of psychology, but also in the Children's Act (Act 38 of 2005); and most importantly it is also enshrined in the Bill of Rights (Chapter 2 of the Constitution of the Republic of South Africa, Act 108 of 1996). Section 28(2) reads as follows:

"A child's best interests are of paramount importance in any matter concerning a child."

The Professional Conduct Committee had therefore erred in rejecting Ms V's evidence that she had acted in the child's best interests in discharge of her ethical duty to the child.

The Appeal Committee also criticised the Professional Conduct Committee for failing to accept the evidence of the expert clinical psychologist called by Ms V in her defence of the charge

against her. He had testified that the *Rules of Conduct* are there to protect and promote the best interests of a child and that, in a situation of risk, a psychologist should err on the side of caution to protect a child.

Regulation 30 must accordingly be read within the context of the *Rules of Conduct Pertaining Specifically to the Profession of Psychology*, the Children's Act and the Constitution of the Republic of South Africa. In doing so, the application of Rule 30 will not result in a child's right to confidentiality being undermined.

Therefore, on a critical analysis of the *Rules of Conduct Pertaining Specifically to the Profession of Psychologists*, it could not have been the intention of its authors to give a parent the right to information disclosed during the course of therapy; but rather to provide for the lawful disclosure of confidential information by a psychologist to a third party. An example would be where the psychologist obtains the written authorisation from the parent to discuss information disclosed during the course of therapy with another therapist/healthcare professional.

Stephanie Esterhuyse is a director at Bowman Gilfillan, Cape Town

On the case

Dr Graham Howarth, Head of Medical Services (Africa), introduces this issue's round-up of case reports

In "Too quick to clear the spine" on page 14, the multiple injuries Miss T suffered in a road traffic accident made it difficult to localise the pain to her neck. As a result of the other distracting injuries, ED consultant Dr W missed the C6 fracture and removed Miss T's spinal collar. A detailed record of the severity of the accident might have alerted Dr W to the potential for severe spinal injury. In this case, the two junior orthopaedic doctors did not challenge Dr W's diagnosis that Miss T's c-spine had been cleared, despite the paraesthesia in all her limbs. Where necessary, previous clinical decisions should be challenged, even those of senior colleagues.

Similarly, you should always be prepared to revisit your own diagnosis, should symptoms persist. Dr G, in "Double problem, double risk" on page 20, was distracted by Mr E's multiple complaints and did not reconsider his initial diagnosis. The five-month delay in the diagnosis of squamous cell carcinoma of the tonsil meant that the case could not be defended. In "Too many records spoil the notes" on page 15, ophthalmology consultant

Dr C failed to diagnose Mr M's glaucoma, despite there being recurrent abnormalities in his vision and a family history of glaucoma. Listening to the patient is imperative; have an open, unbiased mind at each consultation and consider a second opinion if you are unable to account for a patient's symptoms or clinical signs. Inaccurate record-keeping and retrospective amendments to the patient's records made this case indefensible.

Conversely, accurate record-keeping can help to build a successful defence against a claim. We often receive feedback from members asking us to feature more successfully defended case reports; "Right patient, wrong sample" on page 17 and "More than a bruise" on page 18 are such examples. In "More than a bruise", none of the doctors involved were found to be in breach of their duties, despite Mr U's sudden and unexpected death. Records clearly showed the careful management of his condition, examination and documentation of symptoms. Had the records not been comprehensive, there could have been reasonable doubt that there were missed symptoms or signs.



CASE REPORTS

Casebook publishes medicolegal reports as an educational aid to MPS members and to act as a risk management tool. The reports are based on issues arising in MPS cases from around the world. Unless otherwise stated, facts have been altered to preserve confidentiality.

CASE REPORT INDEX

PAGE	TITLE	SPECIALTY	SUBJECT AREA
14	Too quick to clear the spine	EMERGENCY MEDICINE AND ICU ORTHOPAEDICS	DIAGNOSIS/INVESTIGATIONS
15	Too many records spoil the notes	OPHTHALMOLOGY	DIAGNOSIS/RECORD-KEEPING
16	Ignoring the cold foot	PAEDIATRICS	INTERVENTION AND MANAGEMENT/RECORD-KEEPING
17	Right patient – wrong sample	HISTOPATHOLOGY AND GASTROENTEROLOGY	SUCCESSFUL DEFENCE
18	More than a bruise	GENERAL PRACTICE/EMERGENCY MEDICINE	SUCCESSFUL DEFENCE
19	"Just a quick look" can be costly	VASCULAR SURGERY/ORTHOPAEDIC SURGERY	DIAGNOSIS/INVESTIGATIONS
20	Double problem, double risk	GENERAL PRACTICE/ENT	DIAGNOSIS
21	An unfortunate prescription	GENERAL PRACTICE	NOTEKEEPING/PRESCRIBING
22	Symptoms that don't add up	GENERAL PRACTICE	DIAGNOSIS
23	Your patient, your responsibility	OBS&GYNAE	NOTEKEEPING/INTERVENTION AND MANAGEMENT

WHAT'S IT WORTH?

Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant's job or the number of children they have) this figure can sometimes be misleading. For case reports in *Casebook*, we simply give a broad indication of the settlement figure, based on the following scale:

High R15,000,000+
 Substantial R1,500,000+
 Moderate R150,000+
 Low R15,000+
 Negligible <R15,000





ELVIRA BUTLER/ISTOCKPHOTO.COM

Too quick to clear the spine

Twenty-eight-year-old Miss T was a pillion passenger on her boyfriend's motorbike going at high speed on a motorway. He lost control of the vehicle and tried to regain it by braking, which threw them both over the handles, landing some distance away. Unfortunately, Miss T's boyfriend was certified dead at the scene of the accident.

The paramedics who dealt with Miss T removed her helmet, following appropriate guidelines, and then immobilised her neck with a rigid collar and head blocks. She was then moved on a long spinal board and rushed to the local emergency department (ED).

Dr W was the consultant in charge and was already expecting Miss T in the resuscitation room, where he took a brief handover from the ambulance

crew. Miss T was fully conscious on arrival with a GCS of 15/15 and was hemodynamically stable. Dr W performed a primary survey and then requested a series of trauma x-rays, including c-spine, pelvis and thorax. On a full secondary survey, Dr W suspected fractures of left clavicle, left wrist, right hand and left tibia and fibula, which were all confirmed soon after by x-rays.

Dr W removed the collar and felt for tenderness in Miss T's cervical spine processes, but Miss T said that it was not painful; neurological examination was also normal. The cervical spine x-ray only showed down to the top of C6 but didn't show any fractures so Dr W removed the collar and wrote in his notes: "C-spine cleared".

The orthopaedic team took over Miss T's care and she

was then moved to theatre for surgical management of her fractured tibia and manipulation of her wrist. When she was still in the recovery room following surgery, Miss T mentioned that she had some tingling in her legs and that her legs felt heavy and weak. This was documented in the nursing notes but was not acted upon.

Once she was moved to the orthopaedic ward, Miss T continued to complain about paraesthesias in all her limbs; she also mentioned that her head felt unstable as if "it was falling backwards". She also had a long episode of hypotension that did not respond to fluids. Two different orthopaedic junior doctors made entries in her clinical notes about this and they both commented that Miss T's c-spine had been cleared earlier on by the ED consultant. They

both felt that the symptoms could be related to the multiple limb fractures.

Three days after the accident, the orthopaedic consultant in charge requested a c-spine CT during the ward round since Miss T continued to mention that her limbs felt weak and numb. The CT was done but it was not reviewed by the radiologist until the following morning, when he immediately acted upon it and contacted the orthopaedic team; it was finally confirmed that Miss T had a displaced fracture of C6. Unfortunately, the final outcome was not good and Miss T was left tetraplegic. She made a claim against all the doctors involved in her care and following expert review it became obvious that the case could not be defended. The case was settled for a high sum.

ML

LEARNING POINTS

- In severe trauma cases, getting a detailed history and an accurate description from the paramedics is always a good start. The presence of fatally injured victims in the same accident is an indicator of the severity of the trauma sustained by survivors. The kind of vehicles involved, approximate speed, description of surroundings, distance between motorbike and victims, description of witnesses and so on will give you invaluable information.
- Distracting injuries make clinical evaluation of the cervical spine less useful and sometimes completely unreliable. Localising the pain to the neck becomes far more difficult when there is severe pain in other areas of the body, particularly the torso. In most cases of major trauma an adequate three view cervical spine plain film series will be necessary. When clinical assessment is complicated by multiple injuries or mental obtundation, or the plain films are inadequate, further imaging should be considered.
- Most trauma centres would consider doing a full trauma CT scan from the head to pelvis. You should check the adequacy of cervical spine x-rays and make sure that they are reliable; in this case you should ensure that the cervical spine down to C7 has been visualised.
- Relying on the diagnosis of other colleagues when there are worrying symptoms could result in a missed or delayed diagnosis. Diagnosis is a dynamic process and, when necessary, previous clinical impressions by other colleagues need to be challenged, even those of senior colleagues by more junior doctors.
- When patients do not respond as expected, the situation needs reviewing. A hypotensive trauma patient not responding to fluids might be suffering with neurogenic shock, secondary to spinal injury, but unless it is thought about, the diagnosis will remain missed.
- It is important to ensure that all investigations are followed up – remember your responsibilities when you are part of a multidisciplinary team. Ensure that there is continuity of care.



Too many records spoil the notes

Mr M, a 51-year-old primary school teacher, was referred to ophthalmologist Dr C, following a letter sent by an optometrist to his GP. The optometrist had found Mr M to have an abnormal right optic disc, slightly raised intraocular pressures and significant defects in the visual fields of his right eye with suspected glaucoma. Dr C reassured the patient that the static visual field defect in the right eye was as a result of an optic disc pit and that there were no signs indicating glaucoma at that time.

Mr M then became a patient of Dr C when he noted a deterioration in his vision. She followed him up for five years. During this period, Mr M consulted Dr C regularly. She examined him clinically,

took intraocular pressure measurements, made optic disc assessments and performed a number of investigations including serial automated visual fields tests. Mr M expressed concern about the progressive deterioration of his vision. His paternal grandmother went blind due to glaucoma and his father was on treatment for glaucoma. Dr C did not offer an explanation for the progressive deterioration of his sight. She did not offer a referral for a second opinion or referral to a specialist. Mr M relocated to a new town with his job and was seen by a different ophthalmologist, who found abnormalities consistent with advanced glaucoma in both eyes and significant visual field loss. Mr M was registered partially sighted and lost his driving licence. He underwent

rehabilitation at work and was unable to work without the use of low vision aids.

Mr M made a claim against Dr C. The case notes submitted by Dr C had recorded normal examinations, which included normal pressures and normal optic discs. However, during the investigation of the case, it transpired that the documentation presented by Dr C as her clinical notes regarding her patient were actually retyped "summaries" of the original notes. It was found that the original notes recorded the finding of physiological disc cupping with no mention of a disc pit – yet Dr C had failed to record the cup-disc ratios, which could have helped to monitor deterioration in the health of the discs and to ultimately diagnose Mr M's glaucoma.

It was obvious that the reproduced "summaries" – which neglected to mention the finding of physiological cupping – was an attempt to disguise the original failure to diagnose.

Expert opinion concluded that the vast majority of peers would agree that Mr M was at risk of glaucoma and that he needed to be carefully monitored with detailed recording of the state of the optic discs, and that he had signs consistent with glaucoma when he was first referred to Dr C. They would have offered treatment for glaucoma and a referral to a glaucoma specialist for further care.

The case was settled for a high sum considering the permanent and severe nature of the damage to vision.

AK

LEARNING POINTS

- Doctors failing to make the care of the patient their first concern put themselves at the risk of both disciplinary action and medicolegal claims.
- Early glaucoma is, unfortunately, a diagnosis that is frequently missed. All doctors are responsible for keeping up-to-date with professional knowledge, knowing their limitations and working with colleagues to provide the best level of care for their patients.
- Listening to the patient and

responding to their concerns is vital, not just for making an accurate diagnosis but also for establishing rapport and trust. Be prepared to reconsider a diagnosis that was eliminated on an earlier visit by having an open, unbiased mind at each consultation. Consider getting a second opinion if you are unable to account for a patient's symptoms or clinical signs.

- Medical notes have to be considered not only as medical documents but also as legal documents.

Passing off rewritten records as contemporaneous is a criminal offence and any retrospective change has to be clearly marked, dated and signed, and a reason for the change should be documented. Altering existing medical records, removing records, or adding false records puts a doctor at the risk of referral to a regulatory body for dishonesty.

- Disclosure of authentic, original clinical notes is essential when a claim is brought. Failure to do so can make a claim indefensible.



Ignoring the cold foot

Mrs T, a 40-year-old secretary, was overjoyed to find herself pregnant for the first time. Unfortunately, a detailed antenatal congenital anomaly scan identified that her baby had a severe congenital heart defect. The pregnancy was closely monitored by the regional cardiology team. Baby T was born in the regional teaching hospital, and first stage cardiac surgery was carried out in the first week of life.

Baby T recovered well from this initial surgery. Despite very slow weight gain and some feeding difficulties, she made good developmental progress. Her cardiac function was closely monitored, and definitive surgery was planned for 18 months of age.

One Friday just before her first birthday, baby T became increasingly breathless. She was admitted to her local hospital, where she was found to have heart failure thought to be secondary to a dysrhythmia. Baby T was started on oral medication, but she deteriorated acutely, and the decision was made to transfer her to the regional Paediatric Intensive Care Unit (PICU).

On arrival at the PICU, baby T was assessed by Dr Q, a newly-appointed consultant. He noted her to be acutely unwell,

breathless and hypotensive. Dr Q electively intubated her and proceeded to insert a right femoral catheter to enable intra-arterial blood pressure monitoring.

Two hours later, Dr Q reviewed baby T. He noted that the right foot was cold and poorly perfused. Dr Q elected to remove the right femoral artery catheter. Invasive blood pressure monitoring was still clinically indicated, and he therefore sited a catheter in the left posterior tibial artery. Dr Q recorded in the infant's notes that the right foot was "slightly warmer but the general perfusion still poor". Before leaving the unit for the weekend Dr Q asked the nurse looking after baby T to "keep an eye on that leg".

Over the next 24 hours,

baby T responded to medical management of her dysrhythmia. However, on the Sunday morning ward round, she was fully examined for the first time since admission. Her right foot was noticed to be mottled and very cold. An urgent ultrasound demonstrated thrombosis of the right femoral artery. The vascular team was contacted. Due to the delay in presentation, medical management with thrombolytics was deemed to be inappropriate. An embolectomy and fasciotomy were performed urgently but unfortunately were not successful. The limb was non-viable, and baby T required a below knee right leg amputation.

On reviewing the records, it became apparent that

while nursing observations had recorded the look and temperature of the left leg throughout her stay on the PICU, no observations had been made on the right leg for over 24 hours. The medical records did not indicate that any specific examination of the right leg had been made by the junior doctor covering the unit for the weekend. There was no record of a formal handover from Dr Q to his consultant colleague covering the unit for the weekend.

A claim was made against Dr Q. Expert opinion was that Dr Q should have left specific instructions for the nursing staff to check on the right leg in addition to the left. The claim was settled for a high sum.

SS

LEARNING POINTS

- Iatrogenic vascular thrombosis is a well-recognised complication of arterial catheterisation. The risk is particularly high in infants below two years of age. Where intra-arterial catheters are used for blood pressure monitoring, clear local guidelines should be in place for monitoring the insertion site and the limb distal to the insertion of the catheter for signs of potential vascular compromise. This includes a cold, pale limb with a prolonged capillary refill time and reduced or absent pulses. Arterial occlusion can quickly progress to gangrene.
- When delegating to a colleague you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved.
- It is inappropriate to assume that nurses will anticipate complications of a medical procedure, or to understand the significance of a clinical sign. Where any additional nursing observations are to be undertaken, this should be clearly and explicitly stated. Clear instructions and a good handover are essential.
- In relation to medical negligence claims, good documentation makes the difference. "If it's not in the notes it didn't happen" is an aphorism worth remembering.



Right patient – wrong sample

Mr Q, a 23-year-old student, was admitted to hospital as a surgical emergency with an acute abdomen. A provisional diagnosis of acute appendicitis was made and Dr S, consultant surgeon, performed a laparoscopic procedure. The findings at the time of surgery revealed a normal appendix, which was removed. Dr S undertook a thorough inspection of the rest of the abdominal contents and discovered a small perforation of the body of the stomach with thickening of the surrounding tissue and localised contamination. A biopsy of the perforation site was taken and sent to the pathology laboratory for frozen section analysis by consultant pathologist Dr F.

Dr F called the operating theatre a short time later to discuss the biopsy result, which appeared to demonstrate an undifferentiated malignant tumour. Both Dr S and Dr F considered this to be highly unusual, particularly in view of Mr Q's age. Dr F was confident in the accuracy of his initial assessment of the specimen, but felt that further histopathological analysis and stains together with a second opinion from colleagues in his department would be helpful. Following this discussion, Dr S decided at this point simply to

close the perforation with an omental patch, wash out the contaminated fluid and await further assessment of the biopsy.

Postoperatively, Mr Q made a straightforward recovery. Dr S requested a CT scan that did not reveal any other disease and only demonstrated some gastric wall thickening at the site of the perforation. After further histopathology tests, the final opinion of Dr F and his colleagues was that the initial diagnosis of an undifferentiated malignant tumour was correct. Following careful discussion between Dr S and the patient, Mr Q underwent a

total gastrectomy three days after the initial biopsy. Again, Mr Q made an uneventful recovery. The final pathology report from the resected specimen proved to be a normal stomach with no features of malignancy.

On the grounds that his major surgery had been unnecessary, Mr Q made a claim against the doctors involved in his care. The hospital initiated an internal investigation and it became apparent that there had been an error in the pathology laboratory. The frozen section sample taken from Mr Q had been mislabelled in the pathology department and actually

belonged to another patient who had had surgery some hours earlier. The correct specimen taken from Mr Q was entirely benign.

The case was defended successfully on behalf of the member, Dr S. An investigation by the regulatory body (to whom the clinicians involved had been reported) also exonerated Dr S and Dr F. A separate claim against the hospital did, however, result in a substantial settlement for the claimant on the basis of errors in the pathology labelling processes.

This is a genuine case and was reported in the media.

SD

LEARNING POINTS

- Many doctors will have a claim made against them during their professional lives. Even when some mistakes occur because of system failures, it is the doctors who may initially be investigated. In this situation the clinicians did go to extra lengths to check the veracity of the pathology report before acting upon it, but were ultimately let down by problems with the hospital's systems for labelling pathology specimens.
- Misidentification of pathology specimens occurs every year in even the most developed healthcare systems. This can potentially lead to both inappropriate treatment and also delays or false reassurance in the management of unreported

conditions. Despite technological advances and improvements in quality control of system processes, clinicians should always be alert to the possibility of a misidentification error when an unexpected result appears.

- Additional opinions from colleagues and further biopsy material can help confirm or refute an unexpected pathology result and prompt investigation into any mistakes in labelling or specimen identification that may have occurred.
- In the case described, it is likely that a wider group of clinicians would have suggested additional biopsy material from an endoscopy and a laboratory check on the identity of the specimen, prior to proceeding with such radical treatment in a very young man.



WIKIPEDIA.ORG/STEVENFRUITSMARK

More than a bruise

Mr U, a healthy 30-year-old taxi driver, was on duty when he suffered a minor road traffic accident. He was sitting at the wheel of his car at a red light, when a car hit him from behind. Mr U was wearing his seat belt, and the collision caused the seat belt to impact on his chest, which caused an abrasion and bruising. There was no damage to the other cars involved and Mr U felt no subsequent pain so, after exchanging insurance details, he continued his day as usual.

The following day, Mr U awoke with pains in his shoulder and the upper part of his chest, where the seat belt had restrained him. The pain did not have any worrying features and was very non-specific, but his wife prompted him to visit the local emergency department (ED).

On arrival Mr U had his heart rate and blood pressure checked. They were within normal limits; he was then examined fully by Dr F, a junior doctor. Dr F documented that there were no obvious abnormalities, and the chest examination was normal. As the pain seemed severe, he requested a chest x-ray, and no abnormalities were detected. Dr F reassured Mr U that he had a minor chest contusion, probably caused by the seat belt, and

that it would settle down without any further problems. He also advised Mr U to take ibuprofen regularly for the next couple of days.

During the next five days, Mr U attended his GP surgery with increasing pain to the traumatised area. Mr U was seen by three different doctors. At every visit he was fully examined and his temperature, oxygen saturation and HR/BP were recorded. In spite of the severe pain, there appeared to be no change in Mr U's condition. There were no bruises, no crepitus and the breath sounds were normal. The entries on Mr U's records by all the doctors involved were clear and detailed. Each doctor added

a painkiller of increased strength in an attempt to make him more comfortable. All doctors agreed that it was a musculoskeletal pain caused by the contusion.

Six days after the accident, Mr U felt dizzy and looked very unwell. His wife drove him to the ED. On arrival he was hypotensive and tachycardic, his oxygen saturation was low and he was feverish. Mr U was seen again by Dr F, who found on examination a large bruise on his chest. Dr F immediately started treatment with fluids and antibiotics, but as he was waiting for the blood results the bruised area seemed to grow larger than an hour earlier. Suspecting necrotising

fasciitis, he called the ICU team, where Mr U was admitted. Mr U was taken to theatre for debridement, but unfortunately he rapidly deteriorated and died from the necrotising fasciitis two days later.

Mr U's widow made a claim against all the doctors who saw her husband following the accident. The experts reviewed all the medical records and gave supportive evidence, so the decision was made to defend the case, since it was felt that the management had been correct and none of the doctors were in breach of their duties. The case was successfully defended.

ML

LEARNING POINTS

- Sudden and unexpected death will leave questions behind that may affect the perceptions of the bereaved. Good quality records are invaluable in demonstrating that care was of the appropriate standard and reasonable in the circumstances.
- Claims and complaints can and will happen in spite of doctors doing their jobs properly.
- It is always safe practice to treat each patient as if they are being seen for the first time. Diagnoses made by colleagues can lead to a false sense of security and a repeat of the wrong diagnosis.
- In this particular case, each doctor examined the patient and documented it; had this not been the case, there could have been reasonable doubt that there were symptoms or signs missed.
- Beware of pain that is out of keeping with the clinical findings.
- Do not be afraid to go back and rethink the initial diagnosis (whether made by you or somebody else), in light of any new evidence or if the condition is not resolving or behaving in the way you thought it would.
- Necrotising fasciitis is not a common condition, but is still a life threatening one. Useful advice can be found at: <http://emedicine.medscape.com/article/1348047-overview#aw2aab6b3>; Dr S Hasham, Necrotising fasciitis, *BMJ* (2005; 330:1143) – www.bmj.com/content/330/7495/830.full



“Just a quick look” can be costly

Mrs W, a 42-year-old staff nurse, had long-standing poorly-controlled diabetes. While shopping at the weekend, she twisted her right ankle stepping off a kerb to avoid a push chair, and it became swollen and mildly painful.

The following Monday, she asked one of the doctors on the ward where she worked to “have a quick look at it”. Dr J examined the ankle in the ward office and diagnosed sprained ligaments. Dr J did not document this brief consultation.

Forty-eight hours later, the swelling had not improved so Mrs W asked Dr J to have another look at her ankle and he sent for a plain ankle x-ray. Dr J reviewed the film and reassured Mrs W that there was no fracture, insisting on the sprain diagnosis.

One month after the injury, with persistent swelling

and redness, Mrs W went to see her GP, Dr Y, with a self-diagnosis of cellulitis. During the consultation she mentioned the normal x-ray organised by Dr J. Dr Y prescribed amoxicillin to treat the suspected cellulitis.

The following week, Dr Y saw Mrs W again, and was unable to palpate peripheral pulses bilaterally. Dr Y queried the initial diagnosis of cellulitis and sought urgent telephone advice from Dr N, a vascular surgeon. With no evidence of acute ischaemia, Dr N was not concerned and advised that Mrs W should continue the oral antibiotics and suggested she attend a routine outpatient appointment.

Three weeks later, Dr N assessed Mrs W in an outpatient clinic, studied her x-ray, and sent her for ankle-brachial pressure indices (ABPIs) and an arterial duplex ultrasound of the lower limbs. Following

a further appointment, with the investigations not revealing any significant macrovascular insufficiency, Dr N then referred Mrs W for an outpatient orthopaedic opinion. Almost three months following the initial injury, Mrs W was assessed by Dr B, an orthopaedic surgeon, who diagnosed a total midtarsal and hind-foot Charcot collapse with poor prognosis.

Mrs W made a complaint against all the doctors involved. On examination of the case, there was no documentation from Dr J’s initial consultations and it transpired that Dr J did not even know that Mrs W was diabetic. The plain x-ray requested by Dr J did reveal features of established neuropathic osteoarthropathy of the midtarsal joint of the right foot, which was missed by both Dr J and Dr N.

Having been reassured that there was no significant

injury, Mrs W had continued to work and weight-bear through the affected foot until the correct diagnosis was finally made. The repeated misdiagnosis had resulted in a delay and failure to initiate potentially effective early treatment.

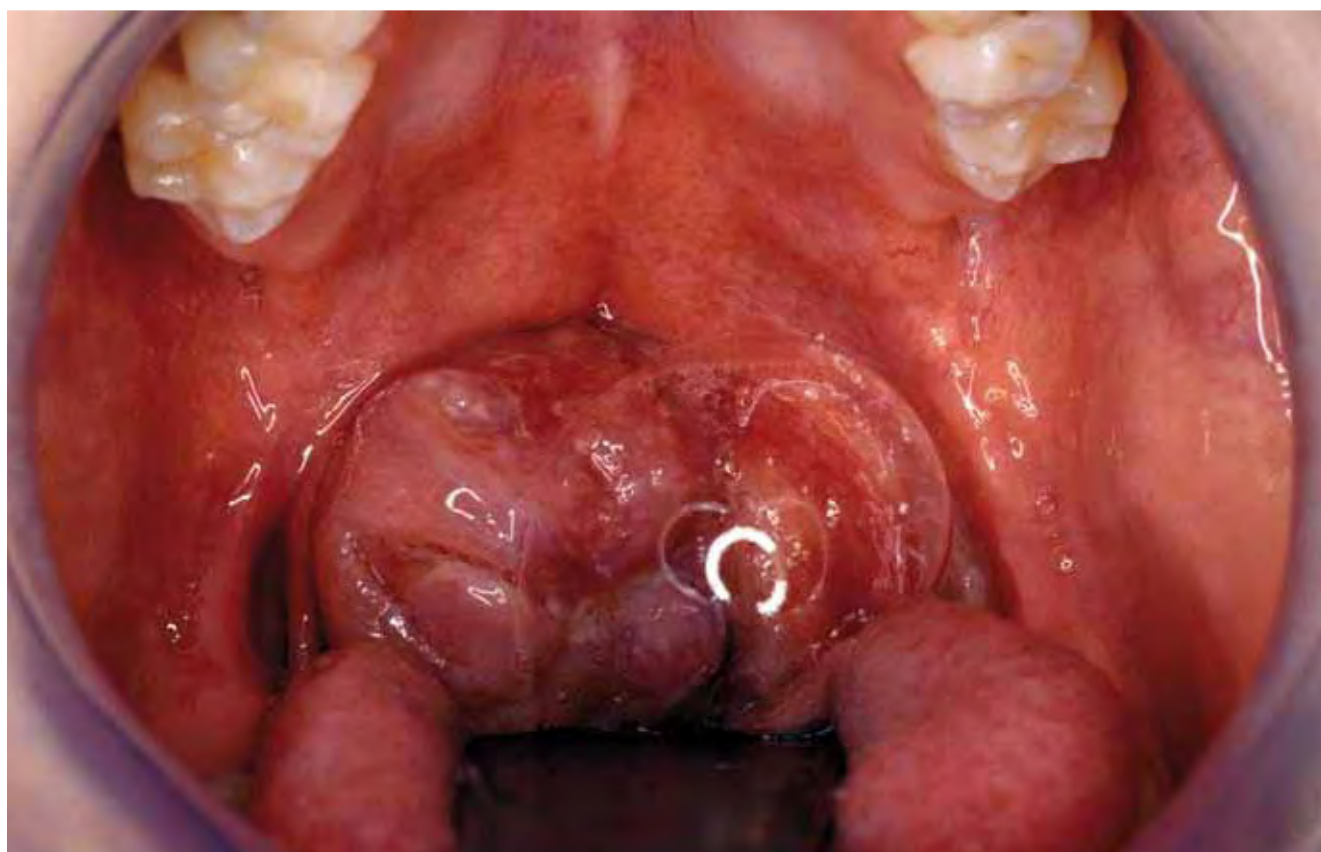
The experts, although not critical of Dr Y or Dr B, were critical of Dr J and Dr N. Despite two separate consultations and further investigation, the failure of Dr J to document his interactions with Mrs W was criticised. The experts were critical of Dr N’s management, believing it fell below the acceptable standard in that he failed to correctly interpret the history and findings on examination, which contributed to a delay in reaching the correct diagnosis and a poor prognosis for Mrs W.

The case could not be defended and was settled for a moderate sum.

JW

LEARNING POINTS

- Having a member of staff ask for an informal medical opinion is a common event for most doctors. Doing things in a by-the-by way often means not taking a history, or documenting and even dealing with medical problems that are beyond our expertise. However, the medical responsibility remains the same.
- Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal or working relationship.
- Knowing the relevant past medical history of any patient is always useful, even for apparently minor injuries.
- When looking at an x-ray, it is always useful to have a global look at it rather than exclude a diagnosis. The fact that in this case there was no new fracture did not make the x-ray “normal”.
- Severe injury associated with Charcot osteoarthropathy may occur following minimal or unperceived trauma.
- Non-weight-bearing immobilisation in the acute inflammatory stage is crucial to a successful treatment outcome.
- Any patient with peripheral neuropathy who presents with a hot swollen foot should be regarded as having an acute neuropathic osteoarthropathy until proven otherwise. Guidance can be found here – TS Roukis, T Zgonis, The Management of Acute Charcot Fracture-dislocations with the Taylor’s Spatial External Fixation System, *Clin Podiatr Med Surg* (2006 Apr; 2)



Double problem, double risk

Mr E, a 52-year-old truck driver, visited his GP Dr G, complaining of a tight chest. Mr E had no significant co-morbidities, but had been suffering with coryzal symptoms for more than a week, which were starting to affect his breathing. He had wanted to attend sooner, but due to his job he had not been able to attend the surgery earlier. During the consultation Mr E mentioned that his throat has been bothering him for a couple of weeks, so he had started to cut down on his usual 20 cigarettes a day.

After examining Mr E's chest, Dr G was quite concerned about his widespread wheeze. He administered a nebuliser in the surgery, and gave him some smoking cessation advice, but did not investigate Mr E's throat.

A few weeks later Mr E reattended with similar symptoms of wheeziness and a cough, which again required another nebuliser.

He mentioned that one side of his throat was painful and this was documented in the notes, but his throat was not examined.

During the following month, Mr E saw an ENT specialist Dr W, for a previously organised appointment to discuss a "recurrent sinusitis problem". While he was at the hospital, Mr E mentioned his ongoing

right-sided sore throat to Dr W. Dr W suggested that Mr E "tell his GP to check it".

A month later at a follow-up appointment to see another ENT specialist, Mr E saw Dr S, who immediately examined his throat. It became clear that there was an abnormal mass in his right tonsil and further tests confirmed squamous

cell carcinoma of the tonsil with neck nodes. There was a five-month delay in the diagnosis, which required more aggressive treatment and left a poorer prognosis.

The experts were critical of the management of Mr E by both Dr G and Dr W, so the claim was settled for a moderate amount.

EW

LEARNING POINTS

- Patients who present with more than one complaint can easily distract a doctor's attention, particularly if the patient is unwell and the added complaint seems insignificant in comparison. If there is not sufficient time during a consultation to address multiple problems, a record should be made and a follow-up appointment arranged.
- A flexible and open approach can avoid situations like the one in this particular case. Sending a patient to see his GP because the new complaint is not related to the reason for the appointment can leave a patient vulnerable.
- Head and neck cancers are relatively rare, especially those arising from the tonsils. It is important to be aware of national guidance that advises referral for persistent, particularly unilateral discomfort in the throat, for more than four weeks.
- The most common presenting symptoms of head and neck cancers are also common symptoms of infection, so can be easily dismissed. The key difference is that these symptoms tend to persist; therefore, a patient with unexplained symptoms, who fails to respond to conservative treatment, should be referred for further investigation.



An unfortunate prescription

Mrs H was a 35-year-old teaching assistant who also had two school-aged children. She was obese with a BMI of 40. In 2006, she had seen Dr G with left knee pain. Dr G recorded that on examination her knee was tender over her medial joint line but was otherwise stable. He initially prescribed diclofenac and advised her to lose weight.

Shortly after, Mrs H returned to see Dr G. She still had knee pain but had also developed epigastric pain. Dr G noted her recent diclofenac use, realised the link and advised her to stop taking it immediately and return in a week if her epigastric pain was not settling. Dr G recorded in the free text of her consultation notes that Mrs H had probably had gastrointestinal side effects to a NSAID but he did not code this as an adverse reaction on her problem list.

Mrs H's epigastric pain did settle and it was seven months before she was next seen with ongoing aching in her left knee, which was giving her sharp pains when she bent down to talk to the children at school. Her weight was once again discussed and she was referred for physiotherapy.

Mrs H was next seen by Dr J, a locum, with depressive symptoms in

late 2009. Fluoxetine was prescribed along with a referral for cognitive behavioural therapy. Mrs H felt better as the weeks and months passed but then her mother died and she became wary of stopping her fluoxetine, fearing a relapse of her depressive symptoms.

She remained on fluoxetine with two monthly reviews by Dr G. The fluoxetine was issued on each occasion as an acute prescription for two months and did not appear on her repeat medication screen on the practice computer system.

In January 2011, Mrs H injured her back while leaning forward to help a child put on a coat at school. After one week of severe pain, she consulted Dr W, a locum GP. Dr W noted that Mrs H was in distress with pain, was not able to work or sleep and was having difficulty caring for her children. He recorded that she was not responding to over-the-counter painkillers. Dr W checked her problem list and repeat medication screen, both of which were empty, and concluded that other than obesity, she was an otherwise fit 35-year-old. Dr W prescribed naproxen with co-codamol, referred Mrs H for physiotherapy and signed her off work for two weeks. He failed to note past

history of dyspepsia and did not document any warnings.

Mrs H saw Dr G ten days later. Her back pain was improving but she was not yet ready to return to work, was still requiring analgesia and was running out of medication. Dr G advised her to stay off work and issued more naproxen and co-codamol.

Four days later Mrs H was admitted with epigastric pain, coffee ground vomiting, and melaena. While in the emergency department waiting to be seen by the medical on-call team, she had a large haematemesis and was taken for urgent endoscopy. Endoscopy revealed a large gastric ulcer but endoscopic intervention failed to control the bleeding and she required emergency laparotomy and

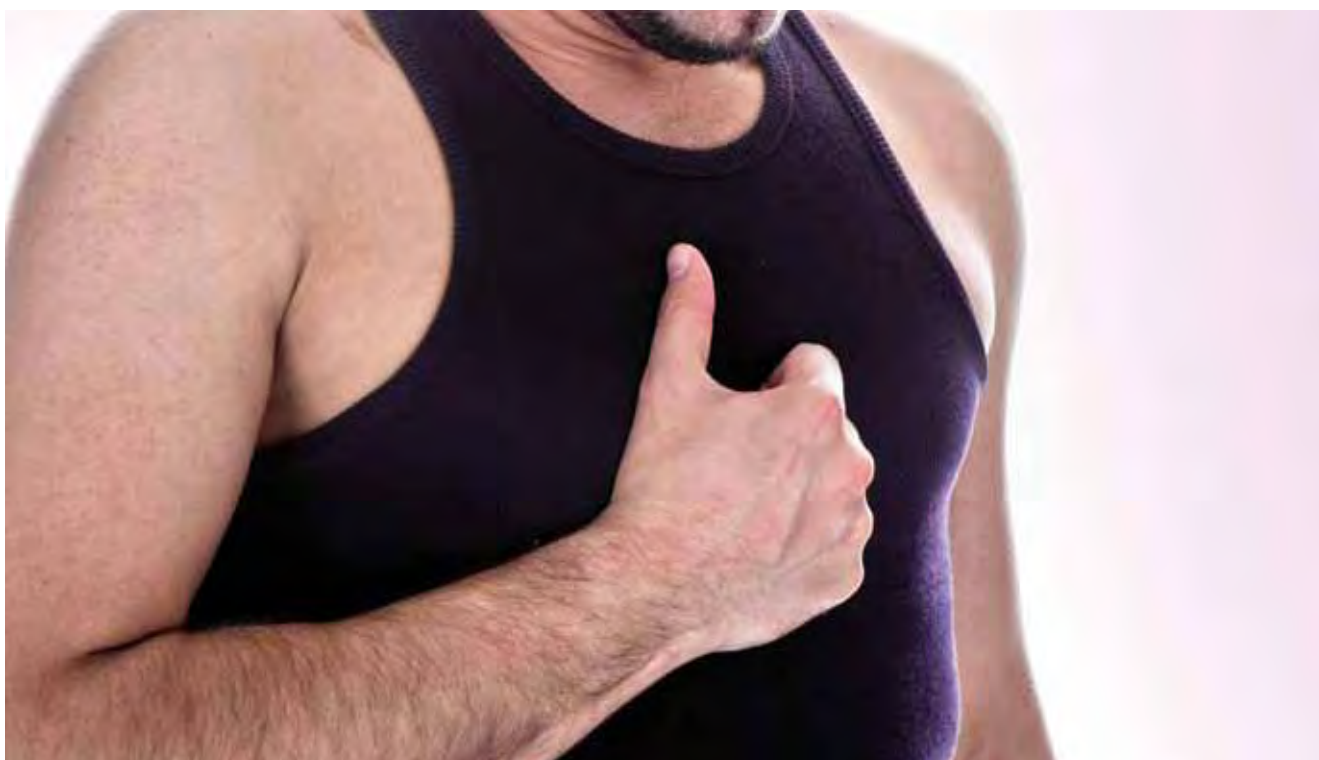
a transfusion of five units of blood. Postoperatively she was very unwell and was returned to theatre with recurrent bleeding. She then spent two weeks on ITU. Unfortunately, her recovery was further complicated by a severe wound infection and she spent another three weeks in hospital. It was a further four months before she felt fully fit and able to return to work and fully care for her children without extensive family support.

The large ulcer was attributed to NSAID use in a patient who had previously experienced dyspepsia whilst on NSAIDs, her risk being further increased by concurrent use of an SSRI. She made a claim against Dr G and Dr W. The case was settled for a moderate sum.

SC

LEARNING POINTS

- It is important to keep in mind that all drugs, even those we prescribe regularly, might be dangerous to certain patients.
- When repeating prescriptions by a previous doctor, it is important to review indications, interactions with other medications and most importantly contraindications.
- It is important to record adverse medication reactions in a way that will be easily displayed for future reference. In this case, the adverse reaction was buried away in a consultation note from five years previously but had not been coded as a problem that would be prominently displayed on the patient's problem list or prescribing notes.



Symptoms that don't add up

Mr B was a 30-year-old garage manager who had just returned from a long trip abroad with his wife. After the flight he developed some chest tightness. This showed no signs of improvement after ten days so Mr B made an appointment with his GP, Dr W. Dr W took a brief history and documented only that he had no cough or sputum. He did not ask about the character, site or radiation of the chest pain, or ask about recent long flights or family history of thrombosis. Despite documenting "no cough, sputum and examination of the chest normal", he diagnosed a chest infection but also documented that he had queried asthma. Dr W prescribed seven days of amoxicillin and arranged a chest x-ray and an ECG.

Over the next few days Mr B's chest pain persisted. It was retrosternal and he found himself taking shallow breaths because the pain was worse on inspiration. He walked down to the GP surgery and was quite short

of breath just walking down the road. Dr W reviewed him the same day and his examination notes stated "no pain or swelling in the legs". He looked at the chest x-ray report and the ECG and noted them to be normal, although the ECG had showed a sinus tachycardia. Again there was no record of him taking a detailed history of the chest pain or breathlessness. Dr W changed the antibiotics to erythromycin and added in gaviscon to ease the retrosternal chest pain, which he thought was dyspeptic in nature.

The next day, Mr B became very anxious because he was now breathless just walking around at home. His wife was worried so made him another appointment to see his GP. Dr W documented that he was anxious but that examination was normal other than a slightly raised blood pressure and heart rate, which he put down to anxiety. He prescribed some diazepam for his "nerves".

Almost three weeks after the chest tightness started,

Mr B became acutely short of breath and dizzy, then collapsed at home. His wife called emergency services but despite all attempts by the paramedics he was pronounced dead on arrival at hospital. The postmortem

showed bilateral pulmonary thromboemboli.

Mr B's wife was devastated and made a claim against Dr W. The case was settled for a substantial sum.

AF

LEARNING POINTS

- For patients who keep coming back with the same complaint, it is always wise to review the initial diagnosis. A patient who is not responding to treatment as expected might need to have the whole picture revisited with a fresh pair of eyes. See the article "Tunnel vision", in *Casebook* 19(2).
- It is important to consider more unusual diagnoses. Although a pulmonary thromboembolus is a relatively rare diagnosis in a healthy young man, it does happen. Unless you think about it you'll miss it.
- It should be remembered that not all pulmonary emboli are preceded by signs of a clear DVT.
- When considering the differential diagnosis of breathlessness, it is useful to consider whether it is acute or chronic and to decide whether it is pulmonary, cardiac or physiological in nature.
- Great care must be taken when diagnosing anxiety, especially in someone presenting with physical symptoms. Mr B had presented with chest tightness and dyspnoea and had been found to have a tachycardia and an elevated blood pressure. All these symptoms can be attributed to anxiety but this should have only been diagnosed after excluding other causes.



Your patient, your responsibility

Forty-five-year-old hairdresser Mrs T was diagnosed with an 8cm complex left ovarian mass following some months of left iliac fossa pain. Mrs T had had two previous laparotomies, one for a right oophorectomy and latterly a hysterectomy. The right oophorectomy had been for a dermoid cyst and the hysterectomy for menorrhagia. Mrs T attended the clinic where she saw Dr D, gynaecology consultant, who advised her to have surgery to remove the ovarian mass.

The surgery was complicated due to the presence of considerable adhesions involving the ovarian mass, large bowel and pelvic side-wall. The left ureter was identified and mobilised clear of the left ovarian mass, which was excised as planned.

Some hours after the surgery, Dr D had a family emergency and he had to leave the country for a few days. He asked his colleague Dr G to keep an eye on his patients while he was away.

The first 72 hours after surgery were uneventful, although Mrs T was making slow progress. She was drinking but did not have much of an appetite. She felt bloated and had not passed much flatus nor had she opened her bowels. Indeed, Mrs T's abdomen was

distended and her abdominal wound was beginning to discharge offensive material. The nurses tried unsuccessfully to contact Dr D. Dr G reviewed Mrs T a few times and also checked Dr D's surgical notes. The documentation was scarce and there was no mention of adhesions or any difficulty encountered during surgery. Dr G decided to adopt a conservative approach as Mrs T's general condition remained stable, even though the wound continued to discharge. He mentioned

to other colleagues that he felt it was difficult to interfere with the care of a senior colleague's patient as he felt intimidated by Dr D. As a precaution, Mrs T was prescribed broad-spectrum antibiotics.

A week after the initial surgery, Mrs T's condition deteriorated and she developed an acute abdomen. She had generalised abdominal pain and vomiting, along with a fever and a raised white cell count. Dr G took her to theatre for an emergency

laparotomy to find faecal peritonitis and a loculated pelvic collection. There were several perforations of the sigmoid colon which necessitated partial bowel resection and a colostomy. Further surgery was required before Mrs T was finally discharged home two months later.

The case was settled for a moderate sum. Allegations of negligence were in relation to bowel perforation, delay in diagnosis and poor postoperative care.

GM

LEARNING POINTS

- An operative note is for the benefit of all personnel looking after a patient. The record should not only give an account of the operation performed, but it should also accurately reflect any degree of difficulty of the procedure or deviation from the norm. Dr D failed to do this.
- Good surgical documentation can alert colleagues to an ensuing postoperative complication and may facilitate early intervention and treatment.
- It is important to ensure appropriate arrangements are in place when leaving patients in someone else's care. Dr D did in fact do this by informing his colleague Dr G, but it seems he did not inform the ward nursing staff. It is good practice to advise the nursing staff which doctor will be responsible for your patients in your absence. Not only did Dr D fail to write comprehensive surgical notes, but also he should
- have conveyed the intraoperative difficulties he had to Dr G.
- If you are covering for a colleague, you must take full responsibility for those patients. A patient's care should not be compromised for fear of offending a colleague. Dr G's remark that he found it difficult to interfere with a colleague's patient is difficult to accept, given that Dr D had asked Dr G to look after his patients. If there is uncertainty over how a patient should be managed, you should consider asking the opinion of a colleague.
- A wound that is discharging offensive material following intraperitoneal surgery should be investigated promptly. You need to consider the possibility of bowel injury. In this case, the use of radiological imaging may have helped confirm a significant complication and facilitated earlier intervention.

Over to you . . .

We welcome all contributions to *Over to you*. We reserve the right to edit submissions. Please address correspondence to: Casebook, MPS, Granary Wharf House, Leeds LS11 5PY, UK Email: casebook@mps.org.uk

Right level, wrong site (1)

I READ THE September 2011 *Casebook* with interest, specifically the report on "Right level, wrong site" (p21). I know of more than one surgeon who believes that all lumbar disc lesions can be approached surgically from the midline! That is unequivocally untrue as your expert so rightly pointed out.

One of my points comes from your section on learning points in relation to the management of acute lumbar disc lesions. In the lumbar spine the spontaneous resolution rate for acute disc protrusions is closer to 100% than 80%, but specifically time-related. Sadly the world literature is badly biased by the fact that surgeons tend to advocate surgery and it is not in their interest to be promoting conservative management: a cynical but truthful observation. Patients should be advised that the outcome of conservative versus operative treatment is little if no different at 12 to 18 months. Surgery offers the advantage of a short cut but risks not insignificant complications; conservative management has minimal risk but often a drawn-out recovery. Extraordinarily I have read notes that record that patients with lumbar disc lesions will not get better without surgery!

In relation to the time allowed for spontaneous resolution of these lumbar disc lesions, four to six weeks is, I have to say, an exceptionally short period of time to suggest before considering surgery. Certainly there will be occasions, short of cauda equina compression, where

in special circumstances early surgery may be considered – but the message that MPS supports such early surgery may not be a good one to be promulgating. I know that the difference between private and public treatment standards in respect of surgical advice exists and I am pleased that you raised that, to try to keep practitioners honest in that respect.

Another interesting point arises in relation to communication. Doctors (surgeons) can be quite foolish on occasions by telling patients that a particular treatment previously given to their patient was wrong simply because it was not their own practice. This is particularly important now that the 'school of opinion' defence has been challenged. Doctors should be taught and reminded that they must resist the temptation to portray themselves as the saviour of a situation by denigrating previous unsuccessful but perfectly proper treatment.

As an orthopaedic spinal who performed more than 7,000 open spinal operations, I do speak from a depth of experience.

One final point in the form of a question. Are surgical trainees and newly-appointed consultant surgeons being formally and appropriately (not voluntarily) appraised of their responsibilities in relation to medical insurance? It would be difficult if not impossible to argue against mandatory malpractice education as a requirement for medical insurance!

Name and address supplied

Right level, wrong site (2)

REF "RIGHT LEVEL, wrong site" (*Casebook* 19(3), p21). An interesting case with possible implications wider than the ones you mentioned. Was there a governance structure in place in this doctor's organisation that reviewed his previous operations to see if he had inappropriately operated on other patients? Do doctors in MPS have an obligation to inform the Medical Council about the possible concerns about this doctor?

Paul Scott, GP, UK

Response

I should reiterate the comment we make in "On the case", that reports are based on issues arising in MPS cases from around the world, but facts are altered to preserve confidentiality. To that extent the reports are not factual iterations of individual cases. The issue you raise is one MPS takes seriously and during the course of every case we seek to work with the member to identify any risk management issues that could bear on future practice.

Mother knows best (1)

I READ WITH great interest the case "Mother knows best" in the last issue of *Casebook*, 19 (3).

Whilst we continually strive for excellence and perfection, it is impossible for doctors to make accurate diagnoses on every occasion. The difficulty is highlighted in this case where the initial presentation of intermittent twitching without any other symptoms is rather atypical for bacterial meningitis. This can be easily missed.

Therefore, the learning points in the article are

absolutely valid and correctly emphasised. Parent concerns should always be considered and a high index of suspicion is required to avoid misdiagnosis.

More importantly, it is imperative that junior doctors on-call should always discuss the working diagnosis with a senior colleague in spite of how confident he/she feels or how cumbersome this may seem. Occasionally, patients may re-present 24-48 hours following the first presentation to hospital with worsening or persisting symptoms. It is vital that the patient is seen by a middle grade doctor or above at this stage. Had this been applied to the baby in the above-mentioned case, the outcome might have been very different.

I believe that the learning points from the article apply to all junior doctors regardless of their speciality rotations. Not least will this exercise be life saving, it could also potentially save a budding career.

Billy LK Wong, junior doctor, UK

Avoiding dosing disasters

DAVID MITCHELL'S PROFESSOR is correct (*Over to You*, *Casebook* 19(3)). Drug charts should be reviewed on all patients at every ward round, and ideally every day. This ensures that prescriptions have not been made overnight that clash with those drugs already prescribed, that initial prescriptions are reviewed regularly and that drugs no longer needed are stopped. I work in critical care and it is our practice to review the drug chart daily, looking for issues before it is reviewed again by the



Mother knows best (2)

I REMINISCE TO my Foundation Year 2 days in the emergency department. I found dealing with children and particularly neonates to be the most challenging part of my medical career so far. From this stems the utmost respect and admiration for all qualified and aspiring paediatricians.

To get back to the subject matter, I do remember taking two lessons away from my brief period spent in the department. The first one relates to history. We are indoctrinated from our earliest days in medical school that over three quarters of the information you need to make a diagnosis or at least decide on the next course

of action is in the history. In the case of the young ones still lacking language skills, we can only rely on the mother's history, even when this is sometimes limited to a story.

I always felt that a mother's concern was enough to take things forward, especially if a little reassurance was not adequate. There is no substitute for a mother's sixth sense of something being amiss. None other than she would be able to discern the smallest changes and nuances in the behaviour and hence the overall condition of her baby, and this is proof enough of her worry. There is no way that you could confidently fully discern normality in

the short period of contact you have with the child in the department.

The second lesson is if there is a reattendance within the last 24 hours; an expert consult needs to be sought, even if it is to reassure all parties concerned of the benign nature of the presentation. The worst thing that could happen with getting a second opinion is another medical professional doing what he was trained and is paid to do: his job!

With these two skills in hand, it should not be too difficult to navigate the delicate waters of the paediatric department in accident and emergency.

Ali Abdool, registrar in cardiology, UK

critical care consultant on the ward round.

Drugs are stopped, doses altered in light of altered renal function and other drugs started if they have been omitted or forgotten. Every day we check if thromboprophylaxis has been prescribed or considered contraindicated, if gastroprophylaxis has been instituted and that appropriate nutrition and anti-pneumonia measures are in place. Analgesics,

sedatives, inotropes and vasopressors are reviewed, and antibiotics and steroids stopped if they have run their course.

I strongly agree that focusing solely on the initial prescriber is wrong. The inpatient care of a patient is the responsibility of all of us involved in their care. We should all be reviewing drug charts regularly to minimise prescription errors. Chris Smith, specialty registrar, Anaesthesia, UK

Casebook and other publications from MPS are also available to download in digital format from our website at:

www.medicalprotection.org



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

Reviews



Great Discoveries in Medicine

Edited by William and Helen Bynum (Thames & Hudson, 2011)

Reviewed by Wendy Moore, author and journalist, UK. She can be contacted through her website: www.wendymoore.org.

Both marvellously illuminating and beautifully illuminated, *Great Discoveries in Medicine* is a perfect marriage of simple, clear text and spellbinding pictures. Editors Helen and William Bynum have amassed a team of experts in their fields to provide a breathtaking journey through the story of human efforts to fight illness and disease from ancient Egypt to the modern day. The book is logically organised into seven sections exploring themes; within each section, academic experts offer snapshots on

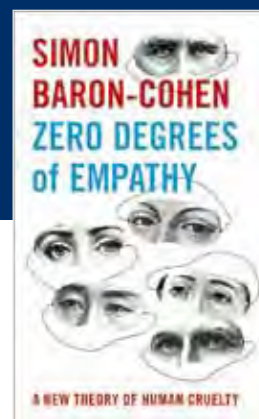
topics as diverse as bubonic plague and beta-blockers.

Inevitably, given the title, this compendium is chiefly – and unusually for some contemporary medical historians – a celebration of medical achievement, just as it should be. Here are all the familiar heroes and triumphs, like Harvey, Pasteur, Snow and Lister, and their extraordinary stories of dogged determination and maverick insights. Yet there are some extraordinary new stories too, along with welcome spotlights on insufficiently hymned figures.

Among the most fascinating of the less well-known innovations is the story of the incubator. Darwinist ideas discouraged doctors in Britain and the US from attempting to save premature babies,



explains Jeffrey Baker. But French obstetrician Stéphane Tarnier (1828-1927) noticed chicken incubators on a trip to a Paris zoo and promptly installed similar devices in his hospital ward. Mortality for underweight babies fell by nearly half. Before long, 'incubator baby' shows were popping up as exhibits in shop windows and world fairs. The invention of the defibrillator is another vastly significant yet unfamiliar tale, although the book's account inexplicably omits the first established case of reviving a patient with electric shocks, in London in 1774,



when a three-year-old girl was reportedly resuscitated after falling from a window.

But the real stars in the sparkling firmament of this scintillating book are without doubt the illustrations. Ranging from exquisite anatomical drawings to public health posters, from Islamic tapestries to CT images, these expertly chosen and beautifully reproduced images offer us the best understanding of changing attitudes towards health and disease. Together these wise words and stunning pictures offer a humbling story and a visual feast.

Zero Degrees of Empathy: A New Theory of Human Cruelty

By Simon Baron Cohen

(Allen Lane, 2011) Reviewed by Philippa Pigache, honorary secretary of the Medical Journalists Association in the UK

Simon Baron Cohen is Jewish and grew up hearing stories of the unbelievable cruelty shown to the Jewish population by the Nazis in World War 2. It was this that prompted him to use his book to ask the question: what is the cause of human cruelty? He considers that to attribute it to "evil", as some do, is a cop-out, for it explains nothing. Why should some people, in otherwise just and caring societies, carry out aberrantly vicious acts? His hypothesis is that underlying such acts is a total inability to put yourself in another person's shoes, to feel what they feel and act accordingly; a lack of what is called empathy – this he calls "zero degrees of empathy".

Baron Cohen is a professor of developmental psychopathology at the University of Cambridge, and one of the foremost names in the study of autism and Asperger's syndrome. He has blurred the boundaries between such

extreme mental health conditions and the normal human brain, developing the concept of the autism spectrum and the "extreme male brain".

He finds support for his hypothesis in neurology and psychology, and demonstrates, with studies using questionnaires, twins and functional magnetic resonance (fMRI), that human beings fall along a spectrum in their capacity for empathy. This empathy spectrum forms a normal distribution curve, where most people cluster in the middle and a few at the extreme ends. At one extreme are those who commit, or perhaps have the capacity to commit, extreme acts of thoughtlessness or cruelty (not necessarily physical), and at the other, those exceptional individuals who devote their lives to caring for others. In the middle are you, me and Joe Public; some are more empathic than others. Interestingly, more men than women fall into the low-average level and more women than men into the high-average group.

Baron Cohen goes on to look at possible explanations for the empathy spectrum and he finds

them in childhood experiences, eg, low levels of empathy are associated with childhood abuse, neglect or disturbance, characteristic electrical patterns in the brain and their effect on key neurotransmitters, like serotonin, and in distinct genetic variations, though not upon a single gene. The evidence he cites is inevitably drawn from studies of either mental health patients, or those in conflict with the law in either Europe or the United States.

Does he satisfactorily explain Nazi cruelty? I am not sure he does. I think he explains the behaviour of misfits – mental or penal – in essentially just, caring 21st century societies, but he ignores societal norms. What is regarded as cruel depends on social context. Stoning was not considered cruel 2,000 years ago – such barbaric cruelty was the norm – a mere 100 years ago, callous, insensitive treatment of children was routine and it took exceptional free-thinkers to challenge it. But we still await an explanation for how, in the first half of the 20th century, Nazi doctors treated Jewish people no better than laboratory mice.

CPD Questionnaire

CPD questionnaires must be completed online via www.cpdjournals.co.za. After submission you can check the answers and print your certificate.

Instructions:

1. Read *Casebook*: all the answers will be found there.
2. Go to www.cpdjournals.co.za to answer the questions.

Accreditation number: **MDB001/034/10/2011**

- 1. Approximately what percentage of consultations are classified by doctors as difficult?**

1%, 10%, 15%, 20%, > 25%.

- 2. Dysfunctional consultations increase one's medicolegal risk.**

True / False.

- 3. Dissatisfaction with a doctor's communication often fuels complaints.**

True / False.

- 4. Patients often tend to assess a doctor's competence on the doctor's communication skills.**

True / False

- 5. MPS's claims values have increased by what percentage over the last two years?**

5%, 25%, 75%, 100%, > 100%.

- 6. The highest claim yet settled in South Africa by MPS was for R 24 million.**

True / False

- 7. Catastrophic neurological damage plays a major role in the size of awards.**

True / False

- 8. Subscription inflation plays no role in the ongoing viability of high-risk specialties in private practice.**

True / False

- 9. The number of claims reported to MPS over the last few years has increased by what percentage?**

10%, 20%, 30%, 40%, 50%

- 10. The increasing litigation in private practice is probably as a result of deteriorating standards of care.**

True / False

- 11. A patient's right to confidentiality is absolute and may never be breached.**

True False

- 12. There is an important distinction between when a health professional may and when they must disclose confidential information.**

True / False

- 13. In cases concerning a child, the child's best interests are of paramount importance in South African law.**

True / False

- 14. A parent is entitled to disclosure of information about their child by a healthcare professional.**

True / False

- 15. Medical notes are not potentially legal documents.**

True / False

- 16. Doctors may not delegate responsibility to colleagues.**

True / False

- 17. In medical litigation, good contemporaneous documentation can make a difference in a medical negligence claim.**

True / False

- 18. It is appropriate to assume that nurses will anticipate complications of a medical procedure, or to understand the significance of a clinical sign.**

True / False

- 19. Claims and complaints only follow poor medical care.**

True / False

- 20. Given the sophisticated equipment available nowadays, experience indicates that the medical history seldom plays an important role in contemporary medical care.**

True / False

How to contact us

THE MEDICAL PROTECTION SOCIETY

33 Cavendish Square
London, W1G 0PS
United Kingdom

www.medicalprotection.org
www.dentalprotection.org

General enquiries (UK)

Tel +44 113 243 6436
Fax +44 113 241 0500
Email info@mps.org.uk

MPS EDUCATION AND RISK MANAGEMENT

MPS Education and Risk Management is a dedicated division providing risk management education, training and consultancy.

Tel +44 113 241 0696
Fax +44 113 241 0710
Email education@mps.org.uk

Please direct all comments, questions or suggestions about MPS service, policy and operations to:

Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

chief.executive@mps.org.uk

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

Africa medicolegal advice

South Africa, Botswana, Lesotho, Namibia, Swaziland and Zimbabwe

Dr Tony Behrman, Cape Town
Tel +27 083 270 7439 (cell phone)
Email tony.mps@currantxpress.co.za

Dr Liz Meyer, Pretoria
Tel +27 082 653 5755 (cell phone)
Email lmeyer@connectit.co.za

Africa membership enquiries

South Africa, Botswana, Lesotho, Namibia, Swaziland and Zimbabwe

South African Medical Association
Tel 0800 225 677 (toll-free within South Africa)
Tel +27 (0)12 481 2070 (calls outside South Africa)

South Africa

Membership and Marketing Agents
Tel 0800 118 771 (toll-free within South Africa)
Tel +27 (0)11 887 0197 (calls outside South Africa)

Ian Middleton
Email medprotection@global.co.za

Alika Maharaj
Email mps@iburst.co.za

Kenya

Jacky Keith
Tel +254 (0)20 243 0371 or +254 (0)20 351 2928
Mobile +254 (0)722 736470
Email mps@africaonline.co.ke

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

The Medical Protection Society Limited. A company limited by guarantee.
Registered in England No. 36142 at 33 Cavendish Square, London, W1G 0PS