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CASE REPORTS

In a number of areas. Find out how this compares with services available to doctors who practise privately.

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Aspects of confidentiality:

One of the most commonly recurring issues that feature on the MPS advice line is confidentiality. In each edition of Casebook we will highlight an unusual scenario around confidentiality.

Public and media interest in the health and wellbeing of high-profile figures is not surprising. In this article we look at the contrasting experiences of two South African health ministers when it came to the confidentiality of their medical conditions. In 2007, the late health minister Dr Manto Tshabalala-Msimang was admitted to the Johannesburg Hospital, suffering from anaemia and pleural effusion. Dr Tshabalala-Msimang later underwent a liver transplant. The stated cause was autoimmune hepatitis with portal hypertension, but the transplant was surrounded by accusations of heavy drinking. That these details made it into the public domain meant Dr Tshabalala-Msimang’s right to confidentiality had been breached.

Fast forward to August 2013. Current health minister Dr Aaron Motsoaledi was admitted to Steve Biko Academic Hospital, Pretoria, for an undisclosed procedure. His spokesperson confirmed to the media that Dr Motsoaledi had been admitted, but declined to give the reason – citing doctor–patient confidentiality.

In the United States, the Hollywood actor George Clooney was admitted to the Palmsdes Medical Center following a motorcycle accident. Subsequent to this, 27 staff who were not involved in his care were suspended without pay for accessing his medical records.2

In New Zealand, Auckland District Health Board fired one employee and disciplined 20 others “for examining the private medical records of celebrities”. The hospital routinely runs electronic audits after a celebrity has stayed in the hospital.3

What the law says

Patient confidentiality is enshrined in law – the National Health Act 2003 makes it an offence to disclose patients’ information without their consent, except in certain circumstances. Sections 14, 15 and 16 of the Act are pertinent where such access or disclosure is in the interests of the user.4

It is not just in law that confidentiality is delineated; the HPCSA views it as central to the doctor–patient relationship and a core aspect of the trust that holds the relationship together. The HPCSA’s official guidance, Confidentiality: Protecting and Providing Information (2008), lists the key principles:

1. Patients have a right to expect that information about them will be held in confidence by health care practitioners.
2. Where health care practitioners are asked to provide information about patients, they should:
   • Seek the consent of patients to disclosure of information whenever possible, whether or not the patients can be identified from the disclosure; Comprehensive information must be made available to patients with regard to the potential for a breach of confidentiality with ICD10 coding.
   • Anonymise data to where unidentifiable data will serve the purpose;
   • Keep disclosures to the minimum necessary.
3. Health care practitioners must always be prepared to justify their decisions in accordance with these guidelines.5

An embedded problem

In Current Allergy & Clinical Immunology, the official journal of the Allergy Society of South Africa, Dr Sharon King writes: “Famously, medical information about the late Minister of Health, Dr Manto Tshabalala-Msimang, was leaked to the press. The perception is that public figures are not entitled to the same confidentiality and privacy rights that accrue to others.”

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High-profile patients

In academic teaching hospitals, the hospital folder is generally available to numerous staff and students, and discussions on ward rounds may inadvertently disclose confidential information in the presence of patients other than those being discussed. “Computerisation of laboratory and radiological investigations makes confidential information easily available, even to healthcare professionals not directly involved with the particular patient’s care. In private hospitals I have personally witnessed patient confidentiality being violated by both nursing and medical staff.”

There are numerous situations where a doctor is permitted to disclose confidential patient data – many of which have been outlined in a previous Casebook article6 but the public profile of the patient is not one; hospital staff – both clinical and administrative – should be appropriately warned of their responsibility.
Public or private – know your service

The range of assistance on offer from MPS varies according to your role as either a state or private doctor. Gareth Gillespie clarifies the difference.

Differences in MPS subscription rates paid by state-employed doctors and private practitioners in South Africa have led to occasional queries – and reasonable misconceptions – about exactly what members are getting for their money.

Although a number of factors influence the setting of subscription rates – the level of risk carried by a member’s specialty being one obvious example – they are also affected by the range of services that the member can request of MPS. The only difference between what MPS can do for doctors working in the public sector and for those working privately is in handling claims for clinical negligence.

MPS members who practise privately are entitled to request assistance on all aspects of a claim, meaning MPS can manage it from first notification to conclusion, and can take care of all the legal costs and compensation payments. For members working in the public sector, this is handled by the relevant hospital – with Dr S as a named defendant, if necessary.

Unfortunately a patient had died and Dr S was concerned that her involvement in the care of the patient was open to criticism. It was clear to the medicolegal adviser who spoke to Dr S that the member was extremely concerned and, under the circumstances, Dr S was referred to the MPS counselling service for support.

Based on the details of the case and the likelihood of the matter progressing, MPS assisted in drafting a report of events and forward them to the local solicitors, when they contacted her. Dr S also made a copy of the salient clinical notes. As predicted, an inquest followed and the family subsequently complained to the HPCSA.

The unique benefits of MPS assisting public sector doctors in these different areas are:

■ HPCSA referrals – sometimes it is the state that handles complaints about clinical care and, essentially, this response is on behalf of the state. MPS is here to defend the interests of members, and one aspect of assisting with complaints responses is to ensure the blame isn’t shifted on to the doctor.

■ Inquests – conflicts of interest may arise between the state and a doctor during an inquest and, because of this, it may be in a member’s best interests to rely solely on the representation of a state attorney. Conversely it may not be in the member’s best interests to be separated out from the rest of the staff involved. MPS can advise on the best approach in any given situation.

■ Claims – as already discussed, MPS do not handle clinical negligence claims on behalf of state doctors – but we can assist in some areas, such as writing reports. As seen in the case above, we can intervene to speed up certain aspects of the proceedings, such as ensuring the state swiftly arranges representation for the doctor.

The following case, taken from MPS files, outlines how a single situation can lead a doctor through numerous lines of enquiry – and MPS can help at each stage.

The case

Dr S, a community service doctor, informed MPS of an adverse incident and sought advice on how to manage the fall-out of a case she had been involved in.

Unfortunately a patient had died and Dr S was concerned that her involvement in the care of the patient was open to criticism. It was clear to the medicolegal adviser who spoke to Dr S that the member was extremely concerned and, under the circumstances, Dr S was referred to the MPS counselling service for support.

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The only difference between what MPS can do for doctors working in the public sector and medical negligence claims against state doctors may be handled by the province, but there are still many forms of MPS assistance on offer to public sector doctors.

The range of services described above, and the unique benefits that assistance can be requested for a wide range of difficult scenarios.
How reliable is healthcare?

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

The healthcare industry is defined by continuous change, but continuous change does not necessarily mean continuous improvement. Emerging technologies may provide great promise for advancing our diagnostic and therapeutic options – but with the increasing frequency and complexity of healthcare interventions, so increases the risk of system or personal failures that can harm patients. Through litigation, these failures can harm institutions and careers. It is highly important that healthcare professionals recognise the hazards associated with providing healthcare services and confront the very real challenge of complacency. Whereas we may see harm when it occurs, more often than not we do not see the “near misses” – and because we do not, this feeds our complacency. We are not truly aware of how often something goes amiss!

Managing danger

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

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

A natural fit?

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

Healthcare professionals are not engineers or pilots and our way of doing business is fraught with uncertainty and variability. Many of our diagnostic and therapeutic interventions are based on insufficient evidence and are over-utilised, thus increasing risks and the potential for harm. Most importantly, patients are not aeroplanes. They are far more complex than aeroplanes. They have mobilities and constraints, genetic predispositions, fears, belief systems, social and economic confounders, intellectual and cognitive challenges, and language and fluency issues.

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

Dr Dan Cohen
International Medical Director at Datix Inc. In whose case study, thought leaders and speaks at conferences worldwide on improving patient outcomes.

A case study

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

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

- My leg was not placed correctly on the stretcher, increasing my risk of a fall at home.
- The x-ray CT scan technician did not offer me any gonadal shielding, even though he was scanning my entire right leg, and I did not think to ask.
- When I was admitted, unable to ambulate without assistance, I was not provided with a walkie-talkie for wall-to-wall communication. The wristband was clearly visible and was not adapted to my situation.
- I was misidentified and given another patient’s insurance details to the ED (Emergency Department) admissions clerk. The wristband did not include information that would enable me to identify this discrepancy, and only when a nurse tried to enter orders into the system was the discrepancy detected. This was not corrected for 30 minutes, delaying my evaluation even as my leg was becoming increasingly numb and purple. I was pointing this out to the nurse; there was urgency here, but...
- I was seen by several different nurses, technicians, and physicians, and it was the exception rather than the rule that these individuals washed their hands before touching me or touching equipment in the room, even after I jokingly pointed this out.
- The x-ray CT scan technician did not offer me any gonadal shielding, even though he was scanning my entire right leg, and I did not think to ask.
- When I was admitted, unable to ambulate without assistance, I was not provided with a walkie-talkie for wall-to-wall communication. The wristband was clearly visible and was not adapted to my situation.
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- The x-ray CT scan technician did not offer me any gonadal shielding, even though he was scanning my entire right leg, and I did not think to ask.
Mr P made a clinical negligence claim against Drs A, B, and C. He alleged that all three doctors failed to suspect a spinal infection and refer Mr P to an orthopaedic surgeon, who would have referred him for an MRI scan. It was alleged that the MRI scan would have identified infective discitis, which would have led to hospital admission and antibiotic therapy, avoiding Mr P’s paraplegia.

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

**THE EVIDENCE**

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

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

Mr P served evidence on breach of duty from a GP (Dr I) and causation evidence from a consultant neurological and spinal surgeon (Mr J), and a consultant microbiologist (Dr K). Mr P was not relying on Mr P’s contemporaneous GP notes. Indeed Dr A was heavily reliant on Dr C’s very detailed consultation notes to assist him in defending his assessment of Mr P on 4 August. Mr P made a note of a detailed examination in Mr P’s records. He concluded Mr P was suffering from muscular back pain, and recommended pain relief and a return visit to Dr A in two weeks’ time.

Two weeks later, on 4 August, Mr P reattended the surgery. Dr A noted some chest discomfort and made a referral to physiotherapy for the back pain, which took place five days later. The day after that, Mr P felt unwell and collapsed due to a loss of sensation in his legs. He was admitted to hospital.

At the recommendation of the hospital consultant microbiologist, Mr P’s antibiotics were withheld and the following day he was transferred to another hospital, where an MRI scan was performed. This revealed infective discitis at T6/7. Mr P underwent an emergency laminectomy with open biopsy, where a soft tissue mass was submitted for histology investigations; once the biopsy samples were obtained antibiotics were recommended. Further surgery was carried out the same day and antibiotics (a combination of ceftriaxone and vancomycin) were administered.

Following surgery, Mr P was left with T4 ASIA A paraplegia. He underwent rehabilitation at a spinal injury centre.

**THE CLAIM**

Mr P was a high-earning, self-employed management consultant, attended his GP surgery on 10 July 2010 with flu-like symptoms and saw Dr A. He diagnosed a chest infection and prescribed antibiotics; on 15 July Mr P returned with similar symptoms – Dr A referred Mr P for a chest x-ray and prescribed further antibiotics. The x-ray was carried out the next day, after which another GP at the surgery, Dr B, advised Mr P that the x-ray was clear and that he could continue to work.

Mr P felt unwell and collapsed due to a loss of sensation five days later. The day after that, Mr P reattended the surgery. Dr A noted some back pain, recommended pain relief and a return visit to Dr A in two weeks’ time.

Two weeks later, on 4 August, Mr P was not displaying any symptoms or signs that would have alerted a GP to possible infective discitis developing. He considered referral within one to two weeks – either for an MRI scan or “more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan”.

**BREACH**

Consultation: 15 July

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

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

**THE LIABILITY**

On Mr P’s assessment, Drs B and C had no culpability. Dr B simply reported the chest x-ray was clear. Dr C undertook a very detailed and thorough assessment and this was recorded in Mr P’s contemporaneous GP notes. Indeed Dr A was heavily reliant on Dr C’s very detailed consultation notes to assist him in defending his assessment of Mr P on 4 August.

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

Mr P alleged Dr A was in breach of duty for failing on 15 July to arrange blood tests and failing on 4 August to suspect infective spinal pathology and arrange a “very urgent orthopaedic investigation”.

Mr P placed heavy reliance on his assertion that he had made sufficient complaint of back pain on each occasion to prompt suspicion of an infected spinal pathology.
THE TRIAL

Dr P alleged that had he undergone blood tests following all consultations, the results would have been consistent with bacterial infection. This would have led to further investigations, prompting referral for orthopaedic investigation suspecting infected spinal pathology, including an MRI scan. A diagnosis would have been made, Mr P would have been admitted to hospital and treated with intravenous antibiotics, making a complete recovery.

Dr E maintained Mr P would have had to receive antibiotics for a period of 48 hours to have avoided all neurological sequelae, without surgery. Dr K considered antibiotics 24 hours earlier would have avoided onset of neurologic deficit.

Dr K, crucially, accepted at the experts’ meeting that Mr P’s white cell count and temperature would have been within normal range for each consultation. The neurosurgeons agreed Mr P would have displayed no neurological sequelae at any consultation.

It was accepted that if blood tests had been undertaken on 4 August they would have altered the outcome. For Dr A to succeed at trial on causation in relation to the 4 August consultation, the court had to accept:

- Referral to orthopaedic surgeon was reasonable on a ‘non-urgent’ basis was reasonable, based on Mr P’s factual evidence.
- Even if the court did not accept referral on a ‘non-urgent’ basis to an orthopaedic surgeon was reasonable, Mr P needed to establish that referral and appropriate treatment within a five-day window of opportunity (4-9 August) should include referral to an orthopaedic surgeon, MRI scan, blood tests.
- Dr A did not assess Mr P until 5.30pm on 4 August. Accordingly, the earliest that blood tests could have been undertaken, based on a fasting sample, was 5 August, with the results available that afternoon. The earliest an MRI scan could have been arranged is 7 August. The earliest the results could have been available is that same day, with admission to hospital that evening. Mr P was asymptomatic and the appropriate action would have been to undertake a biopsy to identify the pathogen so the appropriate treatment within a five-day window of opportunity would have led to further investigations, prompting referral for orthopaedic investigation suspecting infected spinal pathology, including an MRI scan.

THE OUTCOME

Mr P abandoned his claim and discontinued proceedings after the conclusion of day 3 of the trial. By that stage all witnesses and experts, save the microbiologists, had given their evidence. For Dr A to succeed at trial on causation in relation to the 4 August consultation, the court had to accept:

- Referral to orthopaedic surgeon was reasonable on a ‘non-urgent’ basis was reasonable, based on Mr P’s factual evidence.
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This was a significant and by no means straightforward claim to defend. The value of the claim was in excess of £5 million, with Mr P’s legal costs alone estimated to be an additional £1.5m.
Common can be complicated

Miss G, 11 years old, was taken by her mother to see GP Dr A with corneal symptoms and a discharging right eye. She appeared quite well during the consultation, so Dr A advised her to control symptoms with antibiotic drops and return for review in a week. A week later, the patient was feeling worse, complaining of ear ache and neck stiffness and a poor appetite. Dr A reviewed her as planned and documented a negative Kernig’s sign with no evidence of photophobia or rash. He prescribed antibiotics and reassured her that she should recover soon – but that she should return again if she became any worse. Miss G continued to deteriorate over the next few days, prompting her mother to call the surgery. She spoke with a locum, and reassured her that these symptoms should be reasessed by a diagnostic ultrasound test on the following afternoon. She appeared quite well during the second consultation. They asserted that neither of these telephone consultations would hinder future employment or result in a reduced visual acuity or frequent headaches.

Both of these telephone consultations were made late in the afternoon, on a false premise. She alleged that she would not have suffered from reduced visual acuity or frequent headaches had she been seen in person, which can lead to a deteriorating clinical condition.

Miss G’s symptoms persisted after a week. Four days later, her emergency appointment with Dr A was transferred for appropriate specialist care for a possible tonsillectomy or investigation of multiple adhesions from her prior surgery. The family lodged a negligence claim against Dr A, stating that he failed to refer for urgent investigation following the second consultation. The review notes made by the hospital regarding the onset of visual symptoms, he performed an appropriate examination and provided a reasonable standard of care during his second consultation. However, it was evident from the course of events that Miss G did deteriorate and the emerging visual symptoms allegedly reported to the locum did demand an urgent assessment. Failure to arrange immediate review fell below a reasonable standard of care and Dr A and his practice carried vicarious liability for this error.

Miss G’s family alleged she was unable to use public transport unaccompanied due to her persistent symptoms, which would hinder future employment prospects. MPS’s legal team made use of video surveillance in this case, which provided evidence that Miss G appeared very comfortable using public transport independently. This reduced the final settlement offer significantly, although the case was still settled for a substantial amount.

Learning points

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

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

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

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

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

■ Mastoidsitis is now relatively rare. The incidence of the condition following acute otitis media reduced from 50% to 0.4% following the introduction of antibiotics. Prior to this, mortality rates were 1 per 100,000 compared to <0.01 per 100,000 now.

■ Communication and documentation is vital. Had the specific purpose and limitations of the biopsy been explained clearly to Mrs S at the outset, and the options for further management discussed thoroughly, she might not have brought the claim. With as many claims, the claintant did not base on the outcome of the surgery but rather because of lack of communication and correct information.1 All medical practitioners must have time to make sure their patients fully understand all aspects of their management.

REFERENCES


Patient confusion: patient claim

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

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

Dr F proceeded with left radical nephro-ureterectomy; a decision supported by the local multidisciplinary meeting. During surgery, Mrs S was found to have a 5cm tumour and a sigmoid colon adherent to the pelvic side wall due to multiple adhesions from her prior surgery. The histology of the nephro-ureterectomy specimen showed no evidence of malignancy with endometriosis in the ureteral wall and lumen. This was communicated to Mrs S who felt that she had been misinformed as to the purpose of the surgery (as she had never had cancer).

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

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

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

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

REFERENCES


The twisted knee

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

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

Ten days later Ms C reattended her local surgery. It was noted that an effusion had developed in the left meniscus and the range of flexion had decreased. Physiotherapy was advised. A week later, Ms C presented to the local Emergency Department (ED) with persistent pain, at which point an x-ray excluded any gross bony injury, a splint was provided and she was re-referred to her GP. Her GP duly sought advice from the local orthopaedic surgeon.

A month after the fall, Ms C attended a follow-up consultation with Dr A, another consultant orthopaedic surgeon. The MRI had yet to be performed. Dr A noted that Ms C had sustained a significant injury to the left knee and that she was limping heavily. Moreover, she was unable to fully extend the knee and could not flex beyond 90° without severe medial joint line pain.

Concerned about a significant disruption of the meniscal meniscus with or without an associated injury to the anterior cruciate, Dr A advised Ms C that MS MRI imaging was likely to be academic and that urgent and more appropriate management was more appropriate.

Arrangement was made a week later and the patient consented for an arthroscopy. The arthroscopy demonstrated a large injury to the medial meniscal coroideal was observed but the meniscus were not torn – Ms C was advised that healing would occur with time. After a brief overnight admission due to pain, Ms C was discharged.

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

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

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

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

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

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

If the claim had proceeded, MPS’s legal team would have considered commissioning expert evidence from a vascular surgeon to consider the cause of the PE. However, in light of the supportive expert evidence, liability was denied and the claim was subsequently discontinued; no damages or claimant costs were paid. OM.

Learning points

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

An unexpected pregnancy

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

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

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

Two years later, Mrs B brought a claim against the local GP, alleging that he had negligently prescribed the POP. The original consultation, when she was prescribed the POP, was in October 2003 after the birth of her first child. The notes read “16 days post D&V. Wants contraception. Discussed and start norethisterone.”

Over the next four years there were a dozen clinical encounters. Three of these were pill checks with a locum. A typical entry noted “No pills missed, occasional headaches [BP normal].”

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

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

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

The expert felt that part of this could have been achieved by advising the patient to read the product insert. In this case the expert felt that it was reasonable not to prescribe the COCP due to the family history of DVT (and also the relative contraindication of the varicose veins). A defence denying liability was served.

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

AK.

Learning points

- It is striking that despite so many clinical encounters over many years and her own prolonged use, Mrs B still alleged that she was unaware of key issues with the POP and COCP, including the three-hour window in which to take the POP. It is a timely reminder that giving information is important, but checking that the patient has understood the information is vital. This forms the basis of valid consent to treatment. In this case it would have been all too easy to view the ‘pill check’ as a routine encounter, make assumptions and be less rigorous in documentation.
- A number of the prescriptions were issued as repeats by the administration team in the practice. When devolving responsibility it is important to ensure that there is a clear practice policy on what is expected of staff and that this protocol is thought through, written down and rigorously in documentation.

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M is a 58-year-old woman, saw Dr A, a consultant orthopaedic surgeon, with a history of left-sided knee pain. She had seen him several years previously with a similar complaint – at that time, an arthroscopy had demonstrated degenerative change in both medial and lateral compartments of the knee. Upon being re-evaluated, Dr A performed a second arthroscopy – severe degenerative changes and bone-on-bone contact were observed. Ms M was duly listed for a left-sided total knee replacement, which was performed three months later.

When undertaking the consent procedure Dr A indicated that he would be performing a left total knee replacement, that the indications for surgery were pain relief and improved mobility, and that the serious and frequently occurring risks had been fully discussed.

The procedure was performed through a midline incision. The finding, as anticipated, was gross tri-compartmental osteoarthritis. The prosthesis was inserted, the patellar osteotries were trimmed but the patella was not resurfaced. The operating note does not record any untoward intraoperative events. Routine antibiotics and thromboprophylaxis were prescribed.

The following day an x-ray was performed. This showed that the tibial component of the prosthesis had been sited in a suboptimal position. Over the course of a week, the nursing notes consistently commented that it was very painful for Ms M to move her leg, that she was profoundly immobile and that physiotherapy was almost impossible. Dr A repeatedly suggested that Ms M should be mobilised – unheary with this advice, Ms M pursued a second opinion. This was provided by Dr B.

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

Three days after the correspondence and ten days after the original operation, revision surgery was undertaken by Dr B. The operating note described the suboptimal position of the tibial component and recorded a fracture of the medial tibial plateau. The component was replaced and the patella resurfaced. A swab taken at the time of revision grew a coagulase negative Staphylococcus and this was thought to be a contaminant. The claimant made a reasonable recovery and was duly discharged four days later.

Follow-up was arranged by Dr B and Ms M was seen six weeks later. At that time, the wound had healed and Ms M was walking with a stick. The knee was a little stiff but physiotherapy was ongoing. At this point a second issue supervened. Ms M complained of severe lower back pain and left-sided sciatica – an MRI scan of the lumbar spine demonstrated an L4/L5 disc protrusion. A concurrent CRP of 35 and ESR of 31 were felt to be of questionable relevance and were attributed to delayed wound healing and the MRI finding. Further follow-up, six months later, found that Ms M was walking without the aid of a stick. The knee was a little warm. The range of movement was 9° to 110° and it was considered that the knee was improving.

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

Six months later Ms M made a claim against Dr A. It alleged that Dr A had been negligent on multiple counts, in that he had fractured the tibial plateau at the time of the original surgery, failed to identify the fracture during surgery and then failed to take remedial action intraoperatively. Moreover, it alleged that Dr A had been negligent in failing to proceed urgently to revision surgery and in persistently advising Ms M to mobilise, despite her severe pain, the concerns expressed at multidisciplinary team meetings and all the clinical and radiological indications that the knee joint was mal-aligned.

Ms M also claimed that were it not for Dr A’s negligence, the total knee replacement would have been successful and she would have recovered swiftly following surgery. Furthermore, Ms M alleged that she would have been relieved of her preoperative symptoms and would not have required a further revision for approximately two decades. It was also suggested that the initial revision, the ensuing septic arthritis, the subsequent arthroscopy and the final two-stage revision were all consequent to Dr A’s negligence.

Expert evidence was sought from Dr D, a consultant orthopaedic surgeon, with regards to breach of duty and causation. Although Dr D acknowledged that Dr A was not aware of any adverse event occurring during the original operation, he was highly critical of Dr A for failing to act on the immediate postoperative x-rays, failing to proceed urgently to revision surgery and for repeatedly advising Ms M to mobilise, despite her severe pain, the concerns expressed at multidisciplinary team meetings and all the clinical and radiological indications that the knee joint was mal-aligned. Ms M against an early revision.

He was also critical of the persistent advice to mobilise and acknowledged that, in his opinion, this was one of the worst total knee replacements he had seen. Moreover, Dr D felt that the subsequent operations Ms M underwent were a result of Dr A’s breach of duty during the index operation. In terms of breach of duty, Dr A made the tibial cut in the wrong direction. This led to poor placement of the tibial component with fracture of the posterior tibial cortex, which is surgery that falls below an acceptable standard of care. The claim was settled for a substantial sum.

Learning points

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

- In this instance, the highly critical expert evidence required swift action to control costs – in cases such as this, prompt settlement was appropriate. Strong expert opinion guides the approach of both MPS and the members involved.
Cutting corners

Learning points

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

A restoration problem

Mr A, a 46-year-old accountant, had a long history of biopsy-confirmed ulcerative colitis. Because of escalating medication, he was referred by his gastroenterologist for consideration of surgery after repeated exacerbations. He saw Dr C, a colorectal surgeon, who discussed the options available. Mr A had been unable to work for several months. He had done some independent research on the internet and concluded that he wished to undergo a restorative proctocolectomy to avoid a permanent stoma. Dr C documented the risks of this complex procedure and warned Mr A of possible leaks, pelvic sepsis and possible future pouchitis. He planned to perform the operation laparoscopically, which would carry the advantages of a quicker recovery, fewer adhesions and minimal scarring. Mr A underwent a laparoscopic proctocolectomy with complete intra-corporeal ileo-anal pouch formation and a covering loop ileostomy. He made a slow but straightforward recovery and was discharged home the day after surgery. The relationship between patient and surgeon was well-acquainted and on first-name terms. Mr A was desperate for his ileostomy to be closed so he could return to work and, following a normal water soluble enema, Dr C decided to close the loop ileostomy. Preoperatively he documented the "high risk of pelvic sepsis if there is a persistent anastomotic dehiscence". Before surgery Dr C performed an examination under anaesthesia, which showed a very small leakage at the anastomosis. Nevertheless, Dr C proceeded with closure of the ileostomy, in the hope that this would ultimately heal. Mr A then suffered a recurrence of his previous problems with urinary retention, pelvic pain and sepsis. A further 12-month period of repeated hospital admissions ensued, with radiologically-guided drainage of the pelvic collections and treatment with antibiotics. The relationship between surgeon and patient gradually broke down and Mr A referred to Professor X, who undertook a revision open procedure to refashion the pouch, which eventually produced a satisfactory outcome.

Mr A initiated a claim against Dr C, citing that he had insufficient experience in undertaking laparoscopic proctocolectomy and ileostomy. Mr A’s anaesthetist should instead have undertaken an open procedure. He also complained that he provided negligent postoperative care, performing a closure of ileostomy whilst an anastomatic defect remained.

Expert opinion agreed that the decision to perform a restorative procedure was correct and Dr C had sufficient experience and training to undertake the procedure laparoscopically. They were, however, in agreement that closure of the covering ileostomy – despite the operative finding of a persistent anastomotic defect – was not defensible. Dr C accepted the criticism, but noted that on a personal basis he felt responsible for the patient’s complications, and had been influenced by a desire to help the patient back to a normal life as rapidly as possible.

The case was settled for a substantial sum.
Learning points

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

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

Response

In this case, the claimant had a valid claim, and was entitled to the amount of compensation which was ultimately paid to her. However, she pleaded exaggerated damages, which led MPS to dispute the claim. The arguments that the claimant’s legal costs were being paid for by public funds and this was withdrawn after surveillance showed she was clearly lying regarding her disabilities. Surely she was attempting to avoid paying a ‘potentially claim’ and should be dealt with accordingly – was there any prosecution for this offence?

Has she also committed a fraud by receiving taxpayer funding for her legal action to gain money by deception? If legally possible, MPS should push hard for prosecution in cases such as these to reduce and deter unwarranted compensation payments.

Dr Chris Fox, Consultant Physician, East Kent Hospitals NHS Trust

A confidential issue?

Response

In this scenario, the GP had wrongly assumed that the patient was content for her daughter to know confidential information regarding her HV status. The patient, in making her complaint, had not expected that information to be divulged, and the case illustrates the dangers of making assumptions. Fortunately, although the GP had to endure the stress of a complaint to the Medical Council, the case did not proceed to a hearing.

Poor notes: why?

Response

You are quite correct that an otherwise potentially defensible claim is often rendered indefensible if the practitioner’s recollection of events is not reflected in the records. You raise an interesting point in trying to understand why this happens. I am not sure how we could study this in a scientifically robust way, but perhaps there are analogues from other daily activities. When learning to drive, we are meticulous in following our instructor’s directions; look in the mirror, indicate and so on, and concentrate on when to depress the clutch, change gears, avoid obstacles. As we become more experienced, not only does the process become easier and a subconscious skill, we also sometimes cut corners and don’t concentrate on following all the rules we were taught at the outset.

What is important is to continually remind ourselves how important good records are, for continuity of patient care, as an indicator of the standard of our practice, and ultimately to enable unmeritorious claims to be defended. So it is no surprise that this is the topic in so many of our articles, features and case reports, as well as workshops and seminars.

If you have any ideas about more that MPS could do, I would welcome hearing from you.

Stumbling block

Response

Thank you for highlighting the important case of a nerve injury following a femoral nerve block.

“Stumbling block”, Casebook 21 [3]. However, I would dispute your statement that use of ultrasound has revolutionised the safety and efficacy of regional anaesthesia. Published works show a rate of nerve injury whilst using ultrasound to be similar to traditional techniques.1 Surely the key factors in this case were the use of an unsafe nerve block technique, as well as severe deficiencies in consent and communication. From the details published the decision to use a regional block at all might seem questionable, regardless of technique. The presence of an ultrasound machine would not have made any difference to these factors.

Dr Vishal Naidoo, Portfolio GP, UK

REFERENCES

1 Fredickson MJ, Kilfoyle DH, Neurological complications analysis of 1,000 ultrasound-guided peripheral nerve blocks for elective orthopaedic surgery: a prospective study. Anaesthesia 2012

An unavoidable amputation

Response

Re: “An unavoidable amputation”, Casebook 21 [8]. Thank you for your interesting case reports, which I always read.

I was trying to gain a better understanding as to why the patient, Mrs N, did not make a claim against Dr B, the initial clinician, or at least Dr G, who was involved in the consent and communication. From the record, it seemed her focus was on one doctor rather than the other.

This is relevant to my local GP work.

Dr Vahid Niazi, Portfolio GP, UK

Hospital managers: support needed

Response

Dr Rob Hendry makes a very valid point in his article (“Under the influence”) on page 4 of the latest edition (Vol 21 No 3, September 2013) of Casebook about failing teams being at the root of much of the problems in failing hospitals. He is not precise about which teams he has in mind but the point is valid in all contexts, perhaps in failing hospitals it is the management team that needs most help.

There can be considerable antipathy, as well as inability to understand the other’s point of view when managers and doctors meet.

This may not be all that surprising when such are very different goals. People who just cannot get on need outside help. Dr Hendry might like to follow up his comments with a note about where one should turn. I felt this was a lack in the article. His concluding comment was too vague. One needs to be aware of which of one’s actions one needs to “take responsibility for”, and how to do that.

Illegibilities that impact negatively are compounded by communication failures, and some may find it helpful to read something on the subject. I would recommend a book by three American authors, which of the hundreds available and several I have read is really outstanding. Though I have not read the latest edition of 2012 there is every reason to believe it will be as good as earlier ones.

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

Dr Howard Bliit in, retired consultant paediatrician, Tewkesbury, UK


Casebook and other publications from MPS are also available to download in digital format from our website at: www.medicalprotection.org
Common Neuro-Ophthalmic Pitfalls: Case-Based Teaching

By Valerie A Purvin and Aki Kawasaki

This book is part of a series of similar case-based books on different specialties, and is enjoyable and well written. If you are tired of didactic reference textbooks that serve up boring writing on layers of judgemental tedious lists and tables, like sawdust on bread and crackers, then this will be the cheese and grapes that render neuro-ophthalmology not just palatable but moreish. If you are honest most of us non-neuro-ophthalmic specialists shy away from this subject and typically venture down the nearest exit or jump through when a patient presents with double vision and headaches. Patients almost never present with textbook findings and almost always have confusing, subtle and variable symptoms or signs. This makes for a long cornor of bear traps, at the end of which awaits your own headache and diplopia if you are not careful.

The authors have nicely addressed the main subjects that cause anxiety amongst clinicians in neuro-ophthalmology and use real cases with relevant pictures and simple tables. There are 12 chapters:

1. When ocular disease is mistaken for neurological disease
2. When orbital disease is mistaken for neurological disease
3. Muting congenital anomalies for acquired disease
4. Radiographic errors
5. Incidental findings (seeing but not believing)
6. Failure of pattern recognition
7. Clinical findings that are not there
8. Misinterpretation of visual fields
10. Over-reliance on negative test results
11. Over-ordering tests
12. Management misadventures.

The style feels like a rewarding one-on-one tutorial and makes you feel like you may actually be able to deal with similar cases in future. You can dip into it like a textbook or enjoy reading it straight through from start to finish – there are many interesting and surprising facts that I have not found in other textbooks.

This book will help you better understand subjects you thought you knew and those you know you didn’t know. Neuro-ophthalmologists will find this book serves as a good tune-up on their knowledge; non-neuro-ophthalmologists may benefit from the insights, like a full service on the rusting remains of their faded membership memories. It is satisfyingly clinically relevant and not just another book for membership examinations. Overall the book deserves the honour of being well-thumbed and to stand battered and frayed from much use amongst the shiny, thick tables of untouched neuro-ophthalmic monoliths in your, or your institution’s, library.

Errornomics: Why We Make Mistakes and What We Can Do To Avoid Them

By Joseph T Hallinan

Reviewed by Dr Matthew Sargeant, consultant psychiatrist and clinical human factors group member

I learnt so much from this easy-to-read, enjoyable little book. Why We Make Mistakes is available as paper book, eBook or audio book. How we look at things without seeing, forget things in seconds, and are all pretty sure we are way above average are the themes. Such themes are of immediate contemporary clinical relevance to practice and comprehensively described. This book is good for everyone, whether on a course on clinical human factors or not. For more than 20 years Hallinan, a journalist, collected many errors and obtained comments from academics who study various aspects of human performance and psychology related to human error making. There are many helpful references, a guide to chapters and footnotes. The book is an invaluable primer for academic literature for human factors/ergonomics terminology. Grouped deceptively simply under 13 chapters, we are told making fewer mistakes is not easy, especially if the reader merely desires to do so without reflection. Hallinan urges, put effort into thinking of the small things we do and do not do, for the consequences are big. To improve patient safety with the very next patient you manage, read the book. The book advises team members to work together, to have a supportive and accessible attitude to reduce error in team members. Clinicians are also advised to look up at organisation they are working in for the sources of errors, as well as down at what they are doing. Clinicians are also told to avoid multitasking. The book implies that designing, investigating, delivering and managing clinical care are onerous responsibilities to promote patient safety. The book is a lifeline for all medical students and doctors who make medical errors. It is important that the reader review the book promptly and act upon accordingly.

Reviews

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

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1. One of the steps that a claimant has to prove to be successful in a medical negligence claim is that there was a breach of duty of care – in other words the care given was not up to acceptable standards.

True/False

2. Unless a claimant in a medical negligence claim can prove that any substandard care caused or contributed to injury, loss or damage suffered, the claim will be unsuccessful.

True/False

3. If, during a telephone conversation, there are concerns regarding a patient’s clinical condition, there should be a face-to-face review if possible.

True/False

4. If a patient develops new symptoms they should be reassessed and the diagnosis reviewed.

True/False

5. If a patient telephones and speaks to you about a clinical issue, it is important to make (and then retain) a contemporaneous record of the telephone conversation.

True/False

6. When performing a special investigation, it is important that the specific purpose and the limitations of the investigation are clearly explained to the patient.

True/False

7. It is important to recognise that a complication does not amount to negligence.

True/False

8. Experts play an important role in evaluating and subsequently defending claims.

True/False

9. While giving information during the consent process, it is equally important to ensure that the patient understands the information.

True/False

10. Fatigue is a powerful cause of reduced vigilance and can be used, often successfully, as a defence.

True/False

11. Distraction in theatre, including portable electronic devices that can distract healthcare professionals with text messages and emails, are more common than they used to be.

True/False

12. A doctor should always maintain objectivity in the advice given to a patient.

True/False

13. When taking consent for a procedure, it is important to contemporaneously document not only the serious but also the common complications that were discussed.

True/False

14. Patients often equate a complication with negligence, and claims may be averted if a patient is warned of the possibility of a complication prior to a procedure and then, if the complication occurs, they are given a clear explanation as to why it occurred.

True/False

15. If you are going to carry out a special investigation it is important that the results are reviewed promptly and acted upon accordingly.

True/False

16. Accurate and legible entries in the notes are the cornerstone to any medicolegal defence.

True/False

17. Patient confidentiality is not legally enshrined.

True/False

18. The HPCSA uses confidentiality as central to the doctor–patient relationship and a core aspect of the trust that holds the relationship together.

True/False

19. The state is vicariously liable for the acts or omissions of state employees; MPS membership does not extend to defending state employees.

True/False

20. The healthcare industry is defined by continuous change – and this continuous change necessarily means continuous improvement.

True/False
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