DIVERTED BY THE DIAGNOSIS
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ASPECTS OF CONFIDENTIALITY

One of the most commonly recurring issues that features on the MPS advice line is confidentiality. In each edition of Casebook we will highlight an unusual scenario, at the heart of which lies a difficult dilemma around confidentiality.

The use of ‘family files’—where the notes of members of one family are kept together in one file—is quite common across general practice in South Africa.

The recent MPS caseload has demonstrated that there are significant risks attached to the use of family files, and as a result MPS advises against their continued use. Although there are no official guidelines against their use, the potential problems are fairly self-evident and include an increased risk of one family member having access to the records of another—the therefore breaching confidentiality—and difficulty in proving records of only one family member when these are requested, for example by a solicitor when preparing a clinical negligence claim.

Family files can take on various appearances. Sometimes separate records are kept for each family member but these are all kept in one physical folder, often in the name of the primary member of the medical aid scheme concerned. Other times the clinical notes are entered chronologically on the same card or piece of paper, irrespective of which family member they relate to. Both approaches are examples of potentially risky record-keeping.

CLAIM CONFUSION

A man made a claim against his GP for a missed diagnosis. An expert witness was instructed to provide advice on the case, and in keeping with normal practice she was supplied with the notes of the claimant—only the notes were mixed in with other family members, and the expert attributed some of the notes of the claimant’s son to the claimant himself.

In what was a related issue, the wife complained that she should have been informed of her husband’s HIV diagnosis, as she would have taken the necessary precautions to protect herself. MPS advised Dr F that at the time of the HIV diagnosis, he should have counselled the husband on disclosing his status to his wife, who should then have been offered testing (with the necessary counselling). If he refused to disclose his status to her, consideration should have been given to this being disclosed to the wife by Dr F, after having warned the husband that this would be done.

Although it is a breach of patient confidentiality, such a disclosure is justified if somebody else’s (the wife’s) health (and life) is at risk. See the MPS factsheet on “Disclosures without consent.”

EXAMPLE CASES

HIV DIAGNOSIS

A female patient at a medical centre consulted GP Dr F and was subsequently sent for further treatment at another department within the building. Dr F supplied the patient with her medical notes, to be passed on at her next consultation. The notes were contained in a ‘family file’ and the patient flicked through it with curiosity. She discovered her husband’s notes and a diagnosis—three years earlier, and unknown to her—that he was HIV positive.

The husband complained to the medical centre about the violation of his patient confidentiality. He also sent a complaint to the HPCSA, who strongly criticised Dr F over his practice of keeping ‘family files’.

Advice

It is not good practice to have ‘family files’. Each family member should have their own file, which will assist in preventing accidental disclosures of one family member’s details to another family member.

It also means that when faced with a request for copies of any individual family member’s records—for example, if someone changes practitioners, or requires his/her records for medicolegal purposes—doctors may supply these without compromising the other family members’ confidentiality.
A MATTER OF LIFE AND DEATH

FEATURE

Suzette van der Merwe, director at MacRobert Attorneys, looks at the ethical and legal considerations facing doctors when deciding to withdraw a patient’s treatment.

The quality of life that a patient will have following life-prolonging treatment is paramount in these decisions, and this will differ from individual to individual.

A patient has the right to refuse life-saving medical treatment even though this may hasten death. Our courts have given unambiguous recognition and acceptance to the right of a patient to refuse a life-saving medical intervention.1 This is an explicit rejection of medical paternalism and an endorsement of patient autonomy as a fundamental right.

A PATIENT WITH DECISIONAL CAPACITY

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A PATIENT WHO LACKS DECISIONAL CAPACITY

Here difficult questions may arise with regard to the withholding of treatment, particularly where the patient’s family members are not in all agreement about what they believe should happen next.

• Living wills

A living will is a written advance directive given by a patient at an earlier stage, when he or she was of sound mind and had decisional capacity. This contains his or her wishes in the event of facing an incurable disease, or becoming so ill that prospects of recovery are slim and they are no longer in the position to consent to the withholding of treatment.

Although it has not yet been recognised in terms of South African legislation and is still being considered by government, it may be considered to be legally binding and allows a healthcare practitioner insight into the previously expressed views, feelings and wishes of a patient when having to make decisions about their continued medical care.

Some of the criticisms of living wills include that these are often not individualised and may not be applicable to the current situation, meaning that they are then open to misinterpretation. Sometimes the wording is too general, so the will is of little help in determining what the patient would have wanted. However, when the patient is properly worded and recent, a living will can be helpful to a practitioner when considering what the patient is likely to have wanted, and can assist in making decisions about the withholding of treatment.

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The proxy decision-maker

The National Health Act, Act 61 of 2003, also provides for patients mandating another to act on their behalf when they are no longer able to do so. The patient’s selected ‘proxy decision-maker’ may, in the absence of a living will or advance directive, give instructions to practitioners to withhold or withdraw life-prolonging treatment to the terminally ill patient when there is no reasonable prospect of recovery.

• Other considerations

The quality of life that a patient will have following life-prolonging treatment is paramount in these decisions, and this will differ from individual to individual.

A practitioner has to give careful consideration to the patient’s previously expressed wishes, sometimes initially if it is a longstanding doctor-patient relationship, or in a living will, or as conveyed to him by family members.

The wishes of the family also need to be taken into account, but ultimately it is the practitioner’s decision whether to be aggressive with therapy, for example by ventilating a patient, inserting dialysis, inserting a pacemaker, chest drain or to conduct surgery, or to withhold these measures and continue only with the giving of pain medication, fluids and nutrition, and, if appropriate, antibiotics.

THE LEGAL VIEW

Our courts have held that the withdrawal of treatment in circumstances where the patient’s condition is terminal and the prognosis hopeless, does not amount to a new intervention acting between the underlying cause of death and the withdrawal of treatment – and is therefore lawful.2

Our courts have also held that the maintenance of biological life, such as heartbeat and respiration uncompromised by any function of the brain, cannot be equated with living in the human context.3 In this case, the patient had been in a permanent vegetative state for five years and was fed by means of a nasogastric feeding tube. The court, having also considered evidence of the patient’s strong views on voluntary euthanasia and who had signed a living will, ruled that judging by society’s bona fides (or moral yardsticks), the artificial feeding of the patient may be discontinued.

In the National Health Act, death is described as “brain death”. Treatment that is withdrawn or withheld when a patient is kept artificially alive but is technically brain dead at the time, is not considered unlawful. Similarly, giving a DNR order in such circumstances will also be acceptable.

We have expressed the view that in the case of omission or discontinuance of life-sustaining procedures, legal liability would depend on whether there was a duty to institute such procedures or continue with such procedures.4 Where the institution of life-sustaining procedures were not unsuccessful in sustaining cortical and cerebral functions but simply biological functions (heartbeat, respiration, digestion and blood circulation) then the resuscitative measures cannot be considered to have been successful and as such no duty to continue with these arose.

As indicated above, the practical difficulty for medical practitioners lies in deciding whether there are reasonable prospects of recovery and if so, what the patient’s quality of life will probably be afterward and whether it will be in the patient’s best interests to introduce or continue with treatment that prolongs his or her life.

If you have consulted with family members and other healthcare practitioners over the withdrawing of treatment, and no consensus can be reached, you should contact MPS for advice. Practitioners are advised to fully and clearly document any decisions in patients’ notes explaining the reasoning behind these decisions and the procedure adopted in the decision-making process.

The HPCSA provides Guidelines for the Withholding and Withdrawing of Treatment in booklet 12 (May 2008), available on their website.5

REFERENCES

1. Carleton Ci Cerffrigion (1994) LA 59 (A 133 (D)).
2. By Williams (1945) LA 69 (A 133 (D)).
3. Clarke v Whyte and Others 1994 (3) SA 430 (D).
4. Carleton Ci Cerffrigion (1996) LA 67 (A 133 (D)).

CASE STUDIES

CASE 1

Patient A, a 57-year-old man, was admitted to the ICU of a private hospital with kidney and liver failure, and in a coma. There was no reasonable prospect of recovery.

Dr X conducted a physical examination and blood tests. He formed the opinion that although A was extremely ill, he had a reasonable prospect of recovery should he be ventilated and receive dialysis. The family members disagreed with Dr X’s proposed management and requested that only fluids and pain medication be administered, and that he be allowed to die. Dr X advised the family that although there was liver damage, there was a reasonable prospect of A making a recovery with a reasonable quality of life.

Dr X advised the family that he had ethical codes to uphold and that, legally, it was not appropriate at that time to withdraw A’s treatment. Dr X made the correct decision but if the family disagreed, they had the option of obtaining a second opinion from another practitioner or apply for a court order.

CASE 2

Patient B, a 70-year-old female, with a history of dementia, stroke and pneumonia, was admitted to the emergency room of a private hospital in a coma. She had advanced lung cancer and was well-known to the physician, Dr Y, who was called to see her. There was no liver failure but, in the past, B informed Dr Y during a consultation that should she be ventilated she would not want aggressive treatment and that this should be actively withheld.

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MEDICAL CERTIFICATES: AVOIDING THE PITFALLS

Hanneke Verwey, candidate attorney at MacRobert Attorneys, warns of the rising abuse of sick leave and medical certificates, and provides advice and guidance on best practice.

According to Occupational Care South Africa (OCSA) and Statistics South Africa, the abuse of sick leave is costing the South African economy between R12 billion to R16 billion a year. OCSA estimates that there is an average of 15% of staff absent on any given day and that only one in three absentees is genuinely physically ill.

What is concerning is the fact that a great deal of poor medical certificate practice has been seen, and forgeries by patients (not the fault of the medical practitioner) have been seen, and forgeries by patients (not genuinely physically ill.

SICK LEAVE – MANAGING THE ABUSE

This rise in sick leave abuse by employees means it has become increasingly common for disgruntled employers not only to institute disciplinary action, but also to lodge complaints with the HPCSA against medical practitioners for issuing medical certificates that do not strictly comply with the provisions of the HPCSA’s Ethical Rules of Conduct and/or being too generous in issuing medical certificates.

Since 2007, there have been several dozen instances of medical practitioners being charged and found guilty of unprofessional conduct related to poor medical certificate practice. The reported penalties imposed by the HPCSA have ranged from caution and reprimand to fines not exceeding R15,000.

Clinicians should be familiar with the relevant statutory and ethical guidelines and requirements in respect of the issuing of valid medical certificates. This includes the provisions of section 23 of the Basic Conditions of Employment Act (Act No 75 of 1997), as well as the Rule 16 of the HPCSA’s Ethical Rules of Conduct.

THE BASIC CONDITIONS OF EMPLOYMENT ACT

In terms of section 29(4) of the Basic Conditions of Employment Act, an employee is obliged to furnish a legitimate medical certificate if the employee is absent from work for more than two consecutive days or on more than two occasions during an eight-week period. Section 23 of the Act deals with proof of incapacity and outlines the requirements for legitimate and acceptable medical certificates qualifying an employee to be paid statutory sick leave.

In short, the medical certificate must state that the employee was unable to perform his or her normal duties because of illness (or an injury), and that this diagnosis is based on the professional opinion of the medical practitioner.

The medical certificate must be issued and signed by a medical practitioner or any other person who is certified to diagnose and treat patients, and who is registered with a professional council established by an act of parliament.

ETHICAL RULES OF CONDUCT – THE HPCSA

Further guidelines relating to the issuing of valid medical certificates as contemplated in section 23 of the Basic Conditions of Employment Act can be found in Rule 16 of the HPCSA’s Ethical Rules of Conduct.

In terms of Rule 16(1), a medical practitioner shall grant a medical certificate only if it contains the following information:

- the name, address and qualification of such practitioner
- the name of the patient
- the employment number of the patient (if applicable)
- the date and time of the examination e. whether the certificate is being issued as a result of personal observations by such practitioner during an examination, or as a result of information which has been received from the patient and which is based on acceptable medical grounds.

f. a description of the illness, disorder or malady in layman’s terminology with the informed consent of the patient provided that if such patient is not prepared to give such consent, the practitioner shall merely specify that, in his or her opinion based on an examination of such patient, such patient is unfit to work g. whether the patient is physically indisposed for duty or whether such patient is able to perform less strenuous duties in the work situation

The medical certificate must be issued and signed by a medical practitioner or any other person who is certified to diagnose and treat patients, and who is registered with a professional council established by an act of parliament.

CERTIFICATES OF MEDICAL ATTENDANCE

A distinction should be drawn between medical certificates that recommend a period of sick leave, and certificates of medical attendance. A certificate of medical attendance merely serves as a confirmation that the practitioner saw the patient or was informed by the patient that the patient was ill – it is not considered to be a valid medical certificate.

EXTENDING SICK LEAVE

In the event that a patient requests an extension to the originally allocated sick leave, the medical practitioner should insist on conducting a follow-up consultation with the patient and should issue an additional medical certificate. A medical practitioner may not extend the initial period of sick leave and issue an additional medical certificate without having consulted with and physically examined the patient.

The medical certificate must be an original document. Existing sick leave telephonically, having the patient amend the original medical certificate, or faxing or emailing medical certificates is unethical and unprofessional conduct.

Rule 16(3)(f) states that the medical practitioner should give a description of the illness, subject to the patient giving his or her informed consent to the disclosure. In terms of the Guidelines of Good Practice issued by the HPCSA relating to patient confidentiality, medical practitioners must not express verbal or written consent where patients may be personally affected by the disclosure.

It is important to always obtain the patient’s express informed consent before disclosing the diagnosis in a medical certificate, particularly so if the nature of the diagnosis could embarrass or prejudice the patient. If the patient is not prepared to give such consent, the medical practitioner shall merely specify that, in his or her opinion based on an examination of such patient, such patient is totally indisposed for duty or is able to perform less strenuous duties in the work situation.

CONFIDENTIALITY – THE EMPLOYER’S RIGHTS

With regard to patient confidentiality, a general misconception exists that an employer may not contact a medical practitioner to validate a medical certificate, as this would constitute a breach of patient confidentiality. This is not the case.

Although a medical practitioner is prohibited from disclosing any confidential information regarding the patient’s medical condition without their specific consent, a medical certificate would not constitute privileged information should the patient submit it as proof of their absence due to illness. The employer, therefore, has a right to investigate the validity of the certificate and to confirm the facts stated on the certificate, as well as to confirm the actual dates booked off.

STAYING SAFE

In view of the widespread fraud involving medical certificates, medical practitioners should take reasonable steps in order to keep their certificates in a safe place. Should it be found that a patient misappropriated a past medical certificates left lying around in the practice, it is advisable to report the matter to the South African Police Services.

A medical certificate may only be issued if the patient is truly medically unfit to perform his or her normal duties: they may not be issued for routine check-ups, examinations, tests, collecting medicine from the pharmacy, or visits to specialist medical practitioners.

Medical practitioners often come under considerable pressure from patients, especially those who have been patients of a particular practitioner for many years, to issue medical certificates when it is not strictly indicated. Medical practitioners should resist these pressures and issue medical certificates strictly on merit at all times. Although not specifically mentioned in the Ethical Rules of Conduct, medical practitioners should also be careful not to issue medical certificates in respect of medical conditions that fall outside their scope of practice and expertise.
What’s it worth?

Since precise settlement figures can be affected by issues that are not necessarily 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 $15,000,000+
- SUBSTANTIAL $1,500,000+
- MODERATE $150,000+
- LOW $15,000+
- NEGLIGIBLE $15,000+

CASE REPORTS

SPECIALTY: ANAESTHETICS

THEME: INTERVENTION AND MANAGEMENT

MR J was a 32-year-old female patient who arrived at the emergency department with a history of neck pain following a road traffic accident. The pain was localised to the left shoulder and neck area, and she reported that the injury was caused by an avoidable harm because of a failure of the doctor, which has led to cumulative errors and a chain of events from a very different perspective.

When a claim appears before a judge, they see the whole picture with all the missing pieces and an adverse outcome. A judge will use the experts to inform them on medical issues, but will apply legal tests and a layman’s view of common sense. With that in mind, you will see how easy it is for them to form a view that if someone had stood back and looked at all that had gone before, and assessed the issues objectively, the chain of events could have been stopped.

Interestingly, having had the opportunity to discuss this with my colleagues who deal with matters before the regulator, ‘reflection’ and ‘insight’ are words that are used repeatedly in that arena. Again, reflection can be the key to a successful outcome.

As a final thought, I can see how some may wonder why compensation is still paid even though there was an adverse outcome. For the purpose of the adverse event: “What has been caused?” you may ask. Legal causation is any pain and suffering that flows from an error, and which is irrespective of the adverse event: “What has been caused?”

The next morning Mrs. J was no better. She felt unsteady on her feet and complained of a burning sensation in her right leg, as well as weakness and shooting pains in her left arm. Dr M decided that a second opinion was required and referred Mrs. J to a neurological colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved but Mrs. J continued to suffer from terrible neuropathic pain. It affected many aspects of daily life and she found it difficult to return to work as she was not able to sit for any length of time. A spinal cord stimulator was inserted by another pain specialist to try and help with the pain, but this was largely unsuccessful and was later removed.

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

EXPERT OPINION

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

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

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

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

The case was considered indefensible and was settled for a high sum.
Mr S was a 60-year-old lorry driver. He was overweight and smoked, and could not walk because he suffered with pain in his calves.

During a long drive he became aware of pain in his right calf and foot. This became so severe that he attended the out-of-hours service that evening. The GP measured both calves and found them to be the same. A history of foot pain but no calf tenderness was noted and a DVT was excluded. He told Mr S that he likely had a problem with his circulation. Mr S was prescribed aspirin and advised to consult with his own GP for further follow-up.

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

Mr S’s Doppler scan was arranged for the following week but he rang his GP surgery three days later because the pain in his foot and leg had become more severe. He had to hang his foot over the edge of the bed to get relief from it. Dr A advised him to go straight to the Emergency Department (ED). The ED doctor sent him home despite documenting limb pain at rest and a cool, pale right foot with weak pulses. The diagnosis of arterial insufficiency rather than acute limb ischaemia became more severe. He was advised to stop smoking and to attend his Doppler assessment in four days’ time.

Mr S called, but Dr A reassured him because he had been discharged home and was becoming swollen. Dr A reassured him that being reassured in the ED. He rang his GP to stop smoking and to attend his Doppler assessment in four days’ time. Mr S was advised of acute ischaemia was made. Mr S was advised of the diagnosis of acute ischaemia in the description of rest pain at right coupled with an alteration in colour and temperature of the foot. She said that this required urgent same-day surgical assessment. She felt that there was no clinical indication for quinine sulphate and the decision to request a Doppler scan, which was clearly not performed with any degree of urgency, was insufficient in the light of the history and clinical findings.

The opion of a professor in vascular surgery was also gained. He considered that Mr S’s foot was obviously ischaemic when he presented to his GP. He thought that an amputation may well have been avoided if Mr S had been examined earlier.

The case was settled for a high amount against both the hospital and the GP.

Mr S, 34, presented to the delivery suite at 12.45pm, 38 weeks into her first pregnancy. She had been admitted earlier.

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

At 3.30pm she was re-examined and found to be 3cm dilated and was given 100mg pethidine IM.

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

At 10pm, she was found to be 3cm dilated and the "membranes were still intact" despite still having regular contractions of three every ten minutes. No artificial membrane rupture was carried out, however, Mrs G was started on a syntocinon regime by the midwife. There was no documentation as to whether this was carried out. After verbal advice from the doctor but not, no written prescription could be found on the drug chart, when the notes were reviewed retrospectively.

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

The claim was settled for a substantial sum.
A baby was born by caesarean section at 27 weeks gestation with a birth weight of 980 grams. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first four hours of life, the baby’s oxygen saturations were recorded as ranging between 96-97%. A blood gas taken five hours after delivery showed a pH of 7.88 (normal 7.3-7.4), a PaO2 of 35.8kPa (normal 8-10 kPa), a PaCO2 of 38.4 kPa (normal 5-8 kPa) and a bicarbonate level of 24.6 mmol/l (normal 18-24). This showed the baby was being over-ventilated.

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

The baby was not referred at four to six weeks of age for retinopathy of prematurity (ROP) screening, and was not referred at four to six weeks of age. The baby’s care was not adequately assessed by the nursing staff indicating that the nursing staff had no protocol for weaning of oxygen according to oxygen saturation.

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

There was negligence on the part of the paediatrician and nursing, in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a four-day period, and this led to blindness in the baby.

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

**EXPERT OPINION**

The baby had inappropriately high transcutaneous oxygen saturation levels and PaO2 levels for a period of 204 hours. During oxygen administration to premature infants, very high blood oxygen levels can develop if saturation levels rise above 96%. Weaning of the Fraction of Inspired Oxygen (FiO2) seldom occurred despite oxygen saturation levels of between 96% and 100%, indicating that the nursing staff had no protocol for weaning of oxygen according to oxygen saturation.

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

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

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

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

Mr S had a proctoscopy and the histological diagnosis was of two synchronous rectal carcinomas. Duke stage C1. Multiple adenomas were found, some with high grade dysplasia, and it was considered that Mr S had Attenuated Polyposis Syndrome. Mr S’s family were very devastated. He struggled through chemotherapy and radiotherapy. He was told that it was not possible to reverse his illness and that his five-year survival rate was 45-55%. He was very angry and made a claim against Dr A for not referring him earlier or taking notice of the overseas health clinic’s recommendations.

**EXPERT OPINION**

Mr S’s GP argued that he had followed the guidelines and referred Mr S to the colorectal clinic. Considering the risks of rectal bleeding in a 35 year old, he followed national guidelines for referring suspected cancer cases.

The expert GP was critical of Dr B and the colorectal surgeon. He felt that Dr A would not have avoided a rectal examination at Mr S’s first presentation he would have been able to palpate the polypoid lesion in the lower rectum. This should have raised suspicions such that he would have had a digital rectal examination at Mr S’s first presentation.

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**Learning points**

- Be prepared to reassess patients if their symptoms are not resolving by taking a detailed history and conducting a thorough examination.
- A diagnosis may need to be revisited on subsequent consultations rather than relying solely on former colleagues’ decisions.
- Regardless of the fact someone has a consultation overseas out of context, it is never safe to ignore the findings of those consultations.
- It is always reasonable to take a full history and clinical examination as soon as possible for all rectal bleeding episodes as this may be a sign of occult rectal bleeding.
- If you receive a referral from overseas, always take a detailed history and examination as you might need to correct any missed points from your overseas colleagues.

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Miss A, a 40-year-old IT consultant, was talking to a colleague at work when she developed a headache, along with blurred vision and nausea. Her symptoms worsened as an ambulance was called. In the Emergency Department (ED), Miss A was triaged as moderate urgency and examined by Dr X who recorded that her head felt “heavy” at work and she felt herself breaking out in a cold sweat, with a throbbing frontal headache radiating to each temple.

The notes describe Miss A lying on a trolley covering her eyes with her hands, with temperature of 35.4, blood pressure 152/96, pulse rate 58/min, and tenderness over her temporal muscles. Her neurological examination was essentially normal. Kernig’s sign was negative and she had no sinus tenderness or neck stiffness. There was no past medical history of migraine or family history of note. She was given IM metoclopramide and diclofenac.

A record followed of a telephone discussion with another doctor, who requested that Miss A have hourly neurological observations; be reviewed in the emergency observation unit. Miss A received intravenous fluid and analgesia. She had a normal full blood count, electrolytes, liver function tests, bone profile and c-reactive protein. ESR was mildly raised at 30mm/hr. Two hours later, Miss A was assessed and, although the headache was still present, she was feeling better and the blurred vision and dizziness had resolved. The raised ESR was noted with a comment that it was unlikely to represent giant cell arteritis. Following investigations, he’d made an unreasonable diagnosis of migraine with respect to Miss A’s age and symptoms. He’d instructed her to return if the headache did not settle or suggest that there might be anything more serious causing it.

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

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

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

Two days later, Miss A returned to work, though she still had the headache and preferred to be in a dark room. The following day, Miss A phoned to report that her headache was much better. Dr X recorded a discussion about a possible ophthalmological opinion and follow up.

The following day, Miss A phoned to report that her headache was much better. Dr X recorded a discussion about a possible ophthalmological opinion and follow up. Miss A had work stress, which may have precipitated a migraine and reinforced the diagnosis. Migraines usually present as unilateral headaches, but bilateral headaches can also occur. Miss A’s headache was frontal to begin with and then bi-temporal when she’d attended Dr X. Although she had no history of aura, migraines without aura are more common. In Dr X’s opinion, it did not matter that Miss A had no past history of migraine – not all patients are aware they may have experienced migraines in the past.

The claim was settled against both Dr X and the hospital for a moderate sum.
Mr M, a 44-year-old architect, attended his GP, Dr C, for a skin check. Dr C diagnosed a seborrhoeic wart on his right chest wall as well as a seborrhoeic keratosis skin lesion of the upper left arm. A brief record was made in the notes, but there was no detailed description of how the lesion looked and no action was taken.

Five months later, Mr M was seen by another member of the practice, Dr B, for heartburn symptoms and Mr M also mentioned the skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large crusted seborrhoeic wart with almost black skin lesion on his left arm. Dr B noted a “large (cont...)
He described two months of symptoms, occurring up to six times per week, mainly in the mornings and with associated nausea. Dr P took a thorough history and neurological examination, including fundoscopy. He excluded alcohol, stress or cardiac monoxide poisoning as potential precipitants, and found no other ‘red flag’ symptoms. Mr H mentioned that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded and referred him for an early neurological opinion.

As part of his examination, Dr P checked the patient’s blood pressure and found it to be elevated. Dr P arranged an MRI scan which was normal and Dr B advised Mr H that his headaches were likely to be related to muscle tension. Mr H didn’t see Dr P again for another two years. When he re-presented to Dr P, it was more difficult to discuss his symptoms as he had been arranged with the practice nurse for a couple of months. Mr H was not followed up until seven months later when he was called in for some routine blood tests. His renal function was notably impaired with a serum creatinine of 262 umol/l, an eGFR of 20 ml/min and a urea of 17.3 mmol/l. Investigations were initiated (renal USS was normal) and he was reviewed by consultant nephrologist Dr C. Dr C made note of recurrent LFTs during Mr H’s childhood and his hypertension, and concluded that renal nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly.

Mr H subsequently discontinued his claim.

Mr H was seen by nephrologist Dr B some six months after his initial GP presentation, and underwent an MRI scan. The scan was normal and Dr B advised Mr H that his headaches were likely to be related to muscle tension. Mr H didn’t see Dr P again for another two years. When he re-presented to Dr P, it was more difficult to discuss his symptoms as he had been arranged with the practice nurse for a couple of months. Mr H was not followed up until seven months later when he was called in for some routine blood tests. His renal function was notably impaired with a serum creatinine of 262 umol/l, an eGFR of 20 ml/min and a urea of 17.3 mmol/l. Investigations were initiated (renal USS was normal) and he was reviewed by consultant nephrologist Dr C. Dr C made note of recurrent LFTs during Mr H’s childhood and his hypertension, and concluded that renal nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly.

Mr H subsequently discontinued his claim.

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

Learning points

• When starting new drugs or medications, it is important to have a baseline measurement of renal function, and ongoing monitoring of renal function thereafter. The NICE guidelines on Clinical Management of Primary Hypertension in Adults: https://www.nice.org.uk/guidance/ng177 (https://www.nice.org.uk/guidance/ng177). It is important to have a baseline measurement of renal function, and ongoing monitoring of renal function thereafter. The NICE guidelines on Clinical Management of Primary Hypertension in Adults: https://www.nice.org.uk/guidance/ng177 (https://www.nice.org.uk/guidance/ng177). It is important to have a baseline measurement of renal function, and ongoing monitoring of renal function thereafter. The NICE guidelines on Clinical Management of Primary Hypertension in Adults: https://www.nice.org.uk/guidance/ng177 (https://www.nice.org.uk/guidance/ng177).

• Consider the presence of a joint effusion with non-specific tissue reaction and take biopsies for histology.

• Interpretation of the histology proved extremely challenging and the specialists were a sentiment to an eminent expert to discuss the matter. The consensus was that this was a high grade, undifferentiated soft tissue sarcoma, although malignant pigmented villonodular synovitis (PVNS) could not be entirely excluded.

A further MRI scan was carried out, which identified a residual soft tissue mass that was also biopsied and confirmed to be consistent with the initial histology. Ms M underwent an above knee amputation followed by chemotherapy.

She subsequently made a claim against Dr A for alleged failure to properly interpret and report on the original MRI scan, thus leading to a delay in diagnosis of synovial sarcoma, which necessitated an above knee amputation.

In the opinion of the MPS radiology expert, Dr J, Dr A had underreported the MRI scans in that he had failed to mention the presence of a joint effusion with non-specific tissue in the supra-patellar pouch. In his opinion, however, it would have been inappropriate on this evidence to consider a sarcoma in the differential diagnosis. In the context of a recurrent acute episode these findings were likely to represent breakdown products of blood.

Further investigation would have been dictated by the subsequent clinical course of events, albeit that this may have been influenced by the MRI findings. Mr K, the orthopaedic expert, agreed with Dr J that the MRI findings were non-specific and not indicative of malignancy. Had the MRI been reported in the terms suggested by Dr J, Mr K considered it likely that the GP would have reassured Ms B and treated her conservatively with physiotherapy, which was, in fact, what happened.

Had Ms B’s symptoms not settled down following the first MRI scan it is likely the GP would have referred Ms B to an orthopaedic surgeon who would probably have arranged an arthroscopy, and biopsied the lesion. This would have resulted in the same course of action and outcome as that which subsequently transpired. The treatment options that would have been offered would have been above knee amputation or tumour resection followed by radiotherapy. The prospects of success for the latter option would have been low, with a high risk of recurrence. In Mr K’s opinion, the only safe option was above knee amputation. He disagreed with the claimant’s expert, Mr C, that amputation would have been avoided had the diagnosis been made 14 months earlier.

The presence of an effusion and soft tissue within the knee joint, this would not have altered the outcome. Had Dr A reported the MRI scan correctly, management would have been dictated by the subsequent clinical course and would most likely have been conservative in the first instance. From the outset, above knee amputation would have remained the only curative treatment option, and hence the amputation could not be attributed to any failure on Dr A’s part to report the abnormalities on the original MRI scan and so causation could not be established.

Although the claimant could not be persuaded to discontinue on the causation defence alone, it enabled MPS to settle the case for a reduced amount, based on the patient’s additional pain and suffering.

Learning points

• A poor outcome does not necessarily mean negligence.

• In radiology, failure of interpretation or misinterpretation that lead to a failure to report or recommend further investigation may constitute a breach of duty even if the radiologist was unaware that the diagnosis is made from the presenting features. The same principle also applies to failure to elicit or correctly interpret clinical signs and symptoms.

• Breach of duty alone is insufficient to establish negligence. The defendant must prove a causal link between the breach and the subsequent injury or harm suffered.
**STROKE AFTER CAROTID SURGERY**

**SPECIALTY GENERAL SURGERY**

**THEME CONSENT**

**HIGH-RISK: £500,000+**

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

During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 1,100mls. Professor A felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have prevented thrombus formation, such a high risk of major haemorrhage and was contraindicated.

Postoperatively, Miss C initially appeared drowsy, but had no obvious neurological signs. He explained that the process of informed consent had been discussed and Professor A accepted the risks in advance and this discussion is recorded.

Expert opinion

Agreed that arterial bleeding from excision of a carotid body tumour is a well-recognised and inherent potential risk of such surgery and Professor A handled this complication in an appropriate and timely manner. Although questioning the need for three periods of carotid clamping, it was felt that the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks.

Postoperatively, Miss C actually appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have prevented thrombus formation, such a high risk of major haemorrhage and was contraindicated.

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

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

Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

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

**Learning points**

- Effective communication and documentation are essential in the process of consent. Patients must be made aware of the risks of surgery and their implications. This includes common complications, as well as any serious adverse outcomes, including thromboembolic complications, which may result in permanent disability or death. Patients need to be able to weigh up the benefits and risks and make an informed decision as to whether they want to proceed.

- Consent can be given and withdrawn at any time and it is necessary to get a signed consent.

- Litigation can be avoided successfully. If patients are repeatedly asked about the risks in advance and this information is recorded.

**THE STORY OF BETH BOWEN**

Casebook 22(3), September 2014

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

The two letters below capture many common themes: respect and admiration for Clare Bowen in speaking openly about her daughter’s loss and anger and disableli at Mr’s Bowen’s struggle to obtain answers and information.

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

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

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

John SM Leung, FRCSEd, Hong Kong

**Responses**

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

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

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

Dr Rachel Jones, GP, Auckland, New Zealand

I read with much sadness the story of Beth Bowen as narrated by her mother in Casebook (2014); 22:3, pp 10-11. I wish to express my deepest sympathy to the Bowen family and concur with Ms Bowen that the medical profession fell short of expectations in this case and much needs to be done.

John SM Leung, FRCSEd, Hong Kong

I completely agree with the point you make regarding cross-examination in the context of formal legal proceedings. The article was intended to apply more widely to expert reports in general, many of which are written for purposes other than litigation. The role of an expert in the litigation process (including cross-examination) can be considerably wider and may involve attendance at conferences, provision of support at disciplinary proceedings and meeting the expert for the other side with a view to reaching an agreed, joint position.

I will ask the author of the original piece to see whether a follow-up article, dealing with some of these other issues, might be helpful.

Thank you once again for your comments.
MISS CAUDA EQUINA

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

I recently saw a previously completely healthy middle-aged businesswoman who had weak legs and disabling and permanent urinary and faecal incontinence immediately postoperatively, after she had “soft” catheter cauda equina anaesthesia. Various alternative explanations were given but the timing of her signs and symptoms were indisputable and occurred immediately after surgery.

Other neurological colleagues I have discussed this with have had similar experiences. I suggest that spinal catheters should be avoided whenever possible.

John W Norris, Emeritus Professor, Clinical Neurosciences, St George’s Medical School, London

Response
Thank you for your letter.

Our case report was, as you point out, our case report was a summation of the actual case, where the documents often run into many hundreds of pages. This does mean that we are only able to focus on the most salient features of the case from a medico-legal perspective. In this particular case, even after the involvement of a number of specialists, the diagnosis was not completely certain. The claimant alleged a failure to make the diagnosis (probably a variant of chronic fatigue syndrome), as well as a failure to arrange vestibular rehabilitation. This will have been based on the advice of his solicitors and, in all probability, an expert opinion.

However, the expert opinion obtained by MPS on behalf of our member was supportive, as explained at the end of the article. It is important to bear in mind that the standard to be applied here is that of a reasonable body of general practitioners, and not any higher or different standard. It is also the case that where there might be more than one school of thought on a particular issue, a doctor will not be negligent for being the minority opinion. We appreciate that this scenario may well be unlikely, but our view would still stand in those cases where the advanced directive containing the refusal does not also appoint a healthcare agent.

John W Norris
Emeritus Professor, Clinical Neurosciences
St George’s Medical School, London

HIGH EXPECTATIONS

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

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

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

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

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

By necessity, our case reports are a summation of the actual case, where the documents often run into many hundreds of pages. This does mean that we are only able to focus on the most salient features of the case from a medico-legal perspective.

In this particular case, even after the involvement of a number of specialists, the diagnosis was not completely certain. The claimant alleged a failure to make the diagnosis (probably a variant of chronic fatigue syndrome), as well as a failure to arrange vestibular rehabilitation. This will have been based on the advice of his solicitors and, in all probability, an expert opinion.

However, the expert opinion obtained by MPS on behalf of our member was supportive, as explained at the end of the article. It is important to bear in mind that the standard to be applied here is that of a reasonable body of general practitioners, and not any higher or different standard. It is also the case that where there might be more than one school of thought on a particular issue, a doctor will not be negligent for being the minority opinion.

In this case, the claimant withdrew their claim before the matter came to court, which generally indicates that their solicitor (with the help of their expert) has advised them that their case is unlikely to succeed. Of course, medicine is constantly changing and advancing, and what would have been acceptable practice five years ago may no longer be supportive. In the context of medical negligence litigation, the standard which applies is, of course, that which applied at the time in question.

Thank you once again for your comments.

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The Challenges of Treating Jehovah’s Witnesses, Casebook 22(2), May 2014

Following publication of the above article, we received some correspondence in relation to the following: “Even if an “advance directive” has been given by the patient, it is still advisable to obtain proxy consent/refusal from the patient’s spouse or partner, a parent, a grandparent, an adult child or a brother or sister (in this specific order). If this person consents to a blood transfusion (in contravention of the patient’s directive), it is advisable to obtain a court order before administering the blood transfusion.”

We are happy to provide this clarification:

The premise of our article was that not all advanced directives necessarily mandate someone else to consent/refuse treatment. If the advanced directive does address both the patient’s unequivocal refusal of blood transfusions as well as the appointment of healthcare agents mandated to consent or refuse treatment during the patient’s incapacity, then it would be correct to say that medical practitioners would be ill-advised to seek “proxy consent” from family members or friends.
Being Mortal
Atul Gawande
Review by Dr Sam Dawson
(Speciality trainee, anaesthetics, Northern Ireland)

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

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

Gawande does this by telling the stories of his patients facing cancer, of his neighbours and most movingly, of his own family as they face old age, decline and death. He weaves together his research, philosophy, historical study and personal anecdotes to show that many of us are nêing living well in our last days nor dying the way we want.

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

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

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

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

An employee is obliged to furnish a legitimate medical certificate if the employee is absent from work for more than two consecutive days or on more than two occasions during an eight-week period. True/False

Communication and documentation are essential elements of the process of consent. True/False

Patients must only be made aware of the risks of surgery but also their implications. True/False

Patients who select a proxy decision-maker may, in the absence of a living will or advanced directive, give instructions to practitioners to withhold life-prolonging treatment to a terminally patient when there is no reasonable prospect of recovery. True/False

A poorly-completed medical certificate may lead to censure by the HPCSA. True/False

The HPCSA does not have specific rules with respect to sick certification. True/False
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