This issue...

FROM THE CASE FILES
Our latest collection of case reports

CHILDREN AND CONSENT
What you need to know

TERMINATING A DOCTOR-PATIENT RELATIONSHIP
What are your obligations?

CHALLENGING INTERACTIONS WITH COLLEAGUES
HOW TO MAINTAIN RELATIONSHIPS AND COMMUNICATE EFFECTIVELY WITH COLLEAGUES

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In this edition of Casebook we have a particular focus on difficult interactions, whether that is with a patient or with a colleague. In our experience, poor communication between doctor and patient, or doctor and colleague, is the root cause of many of the complaints, claims and disciplinary actions we see.

On page 10 our director of education, Dr Mark Dinwoodie, takes a look at challenging interactions with colleagues. He provides practical tips, based on those in our Mastering Professional Interactions workshop, to help you through these difficult situations.

On page 8 we examine similar issues with patients and consider when it is reasonable to terminate the doctor-patient relationship. This is not something to be done lightly, and there is much to consider before taking the decision, not least of which is the continued care of the patient. Medicolegal assistant Ralitsa Sahatchieva breaks down the issue.

The case reports in this issue demonstrate yet again the importance of good history taking, performing appropriate examinations, communicating well with colleagues and keeping full and complete clinical records. These themes are almost a permanent feature of our case reports, but this is because every day we see cases where a failure to do one or all of these has made it difficult for us to defend a claim brought against a member.

I hope you enjoy this edition. We welcome all feedback, so please do contact us with your comments or any ideas for topics you’d like us to cover.

Dr Marika Davies
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ractitioners are faced with numerous scenarios on a daily basis that require them to obtain informed consent from their patient. In general, informed consent is governed by the National Health Act, No. 61 of 2003.

The Act states the healthcare provider must inform the patient of:

- his or her health status (except in circumstances where there is substantial evidence that such disclosure would be contrary to the best interests of the patient)
- the range of diagnostic procedures and treatment options available to the patient
- the benefits, risks, costs and consequences associated with each option, as well as the patient’s right to refuse health services and the implications, risks and obligations of refusal.

This information must be conveyed to the patient in a language that the patient understands, and in a manner which takes into account the patient’s level of literacy.

Many practitioners, be they general practitioners or specialists, are confronted by child patients routinely. Every practitioner therefore has to be well informed of the legislative framework relevant to children’s consent. This can be particularly challenging as the practitioner will have to find a balance between the clinical condition and its severity, the various treatment options and the child’s maturity and understanding, as well as the parental expectations.

The Children’s Act, No. 38 of 2005, states that for surgical treatment the age of consent is 12 years. To give valid consent the child must also have sufficient maturity and mental capacity to understand the benefits, risks and social implications of the operation; in addition, the child must be duly assisted by his or her parent or guardian. The same guidelines apply for medical treatment, except that the child does not need to be duly assisted by his or her parent or guardian.

For children under 12 years, or children over 12 years but with insufficient maturity to consent, the parent, guardian or caregiver must consent on the child’s behalf. Before the parent or guardian consents to surgery or medical treatment on behalf of the child, the views of the child must be considered, depending on the age and stage of development of the child.

A child that has attained the relevant age of consent, and is mature enough to understand the risks and consequences of refusing surgical or medical treatment, can validly exercise his or her right to refuse treatment. However, if the child unreasonably refuses to give consent, the Minister of Social Development can consent to treatment on behalf of the child.

It is always good practice to include children, whether or not they have adequate decisional capacity to give consent, in the decision-making process. You should tailor your conversation to the child’s mental capacity and engage them in relevant decisions.

CHILDREN AND CONSENT

Obtaining consent from children can be challenging even to the most experienced practitioner. Dr Volker Hitzeroth, Medicolegal Adviser, investigates current legislation.
MANAGING CONFLICT
You may be faced with a situation where parents disagree with the proposed treatment or management of certain conditions. This is one of the most difficult situations you can face. If you feel that a parent’s refusal to consent to treatment for their child is likely to lead to further suffering or put the child at risk, you should discuss the situation with a senior colleague, consult your hospital’s legal department and contact Medical Protection for advice.

You may also need to report the matter to a social worker or the provincial Department of Social Development.

EMERGENCY TREATMENT
If the adults with parental responsibility are unable to provide consent for emergency treatment, for example if they are unavailable, the treatment can continue if in the child’s best interests, provided it is limited to treatment that is reasonably required in that emergency.

For similar emergencies in state hospitals, the HPCSA states that the relevant “clinical manager” should be the one to take the decision on consent to treatment. In non-urgent situations, an application should be made to the Minister of Social Development, who is empowered to give consent in lieu of the child’s parent or guardian.

In these situations record keeping becomes even more important as this will provide the primary evidence of your clinical decision making.

PARENTAL RESPONSIBILITY
The Children’s Act defines parental responsibilities as the rights and responsibilities a person may have in respect of a child. These include all or some of the elements of guardianship, care, contact and maintenance.

A holder of full parental rights and responsibilities has the right and responsibility to:
- care for the child
- maintain contact with the child
- act as the guardian of the child
- contribute to the maintenance of the child.

CASE REPORT
Baby S was born with a very large umbilical hernia. Her specialist paediatrician remarked that it was the largest he had ever seen, and asked a surgical colleague, Dr A, to advise. Dr A told Baby S’s mother that the hernia needed surgery, as it would be unlikely to reduce spontaneously. Baby S’s parents gave their consent for the operation.

The surgery was carried out when Baby S was two months old and Dr A excised the large pouch of redundant skin which had contained the hernia.

When the dressings were removed, Baby S’s parents were not happy to find that their daughter no longer had a navel. They went back to see Dr A and complained. He sent Baby S to a plastic surgeon who fashioned a new umbilicus.

The parents sued, alleging that they hadn’t been warned that this could happen. They claimed that the excision of the umbilicus was unwise and contrary to proper surgical procedure, and that at the age of two months, surgery for umbilical hernia was not indicated in the first instance.

Dr A could give no justification, other than the size of the hernia, for performing surgery for a condition that is normally left alone until the child is a few years old to see if it would reduce spontaneously.

In terms of consent for the procedure, Dr A hadn’t documented any preoperative discussion of the risks of surgery with Baby S’s parents. The consent form that should have been in the notes was missing. Dr A agreed that the case should not go to court, and so Medical Protection settled on his behalf for a moderate sum.

LEARNING POINTS
Consent – Parents must be provided with all relevant information that any normally prudent person would need before making a decision. Deformation of the natural appearance of a newborn baby would fall into this category, even if the particular outcome may seem of no major significance to a practitioner.

FOR CONSENT TO BE VALID:
- The patient must be competent.
- The patient must have sufficient information to make a choice.

Assessment of a person’s capacity should be based on his/her ability to understand, retain and balance the information relevant to a particular decision.

Pressuring patients into consenting to treatment invalidates the consent. Be aware, too, that patients’ friends and relatives may also try to exert their influence and that this can be subtle but nevertheless powerful.

Any failure to respect these rights of the patient could be met with either a complaint to the HPCSA, civil or criminal proceedings for assault or a negligence claim.

FURTHER READING
1. Children’s Act, No. 38 of 2005
2. National Health Act, No. 61 of 2003
3. Choice on Termination of Pregnancy Act, No. 92 of 1996
4. Mahery P and Proudlock P, Legal Guide to Age Thresholds for Children and Young People (5th edn), Children’s Institute, University of Cape Town (2011)
Male circumcision can be a difficult area for doctors to navigate, especially when dealing with the large portion of the population who value the procedure as part of their cultural heritage. However, when dealing with these requests a doctor needs to balance the wishes of the patient with what is in his best interest, and also consider a doctor’s responsibilities under the law.

The law regarding male circumcision is laid out in The Children’s Act No. 38 of 2005 and the General Children’s Regulations.

CHILDREN UNDER THE AGE OF 16 YEARS
A doctor may perform circumcisions for religious or medical reasons on any male under the age of 16 provided appropriate consent has been obtained (for more on children’s consent see our article on page 5). The Act states that the circumcision of male children under the age of 16 years is prohibited except when:

- circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed
- circumcision is performed for medical reasons on the recommendation of a medical practitioner.

Notably, the Act makes no provision for circumcisions due to cultural or social reasons for boys under the age of 16 years. The law does not permit boys under 16 years to be circumcised simply because the parents request it, citing cultural or social reasons.

CHILDREN FROM 16-18 YEARS
The Act states that the circumcision of male children older than 16 years may only be performed:

- if the child has given consent to the circumcision in the prescribed manner
- after proper counselling of the child
- in the manner prescribed.

The Act states that every male child, depending on the child’s age, maturity, and stage of development, has the right to refuse circumcision.

In addition, it provides that every child has the right not to be subjected to social, cultural and religious practices which are detrimental to his or her well-being.

RELIGIOUS REASONS
Circumcisions performed for religious purposes must be in keeping with the practices of the religion concerned and in the manner prescribed. The General Children’s Regulations state that the circumcision must be consented to by both parents using Form 3. The circumcision must be performed by a medical practitioner or a person from that religion who has been trained to perform circumcisions.

MEDICAL REASONS
Circumcisions performed for medical reasons must be performed on the recommendation of a medical practitioner. Medical reasons are not defined in the Act or the Regulations and neither clarifies the consent issues. A practitioner is therefore left to follow the general consent guidance in the Act. Finally, unlike circumcisions for religious reasons, no specific form requires completion.

SOCIAL OR CULTURAL REASONS
Circumcisions performed for social or cultural reasons must be in accordance with the social or cultural practice concerned and in the manner prescribed. Circumcisions for these reasons can only be carried out after the child has been appropriately counselled, informed consent has been confirmed from the child and Form 2 has been completed. The procedure may only be performed by a medical practitioner or person who has knowledge of the relevant social or cultural tradition and who has been trained to perform such procedures.

Anyone carrying out the operation should ensure they have the necessary skills and experience to do so, and that the procedure is carried out using the prescribed equipment and with adequate sterilisation and universal infection control procedures. The medical practitioner or person performing the circumcision must ensure that:

- sterile surgical gloves are worn and that they are disposed of after each circumcision
- any instrument used must be disposed of after each circumcision or appropriately sterilised in accordance with the medical standard for the sterilisation of surgical instruments
- no person involved in the procedure should have direct contact with any blood, bodily fluid or foreign substance
- the disposal of any instruments, including human tissue, must take place in accordance with the relevant medical standard for the disposal of surgical instruments and human tissue.

To read our factsheet on this topic, visit medicalprotection.org and click on the ‘Casebook and Resources’ link.

If you need medicolegal advice, contact a medicolegal adviser at medical.rsa@medicalprotection.org or 0800 982 766.

FURTHER READING
1. Children’s Act, No. 38 2005
2. General Children’s Regulations Regarding Children, no. R261 of the Children’s Act 2005
Once a doctor-patient relationship is established, it creates various obligations on the doctor relating to the duty of care that they provide. All healthcare practitioners should always regard a patient’s well-being as their primary concern and ensure continuity of care. However, it is inevitable that some relationships will break down. In these instances, you might need to know when it is appropriate to end the relationship and what steps you need to take to ensure that no harm will be caused to the patient.

You are legally within your rights to refuse to treat a patient, except in an emergency. Below is a summary on how to terminate a doctor-patient relationship, while ensuring the patient’s well-being and best interests are protected at all times.

**MAKING THE DECISION**

A decision to terminate a doctor-patient relationship should be taken with great caution and due consideration.

It is imperative that you:

• reach this decision once all other means of resolving the problems have been explored and there is no other alternative

• can justify the decision to end the relationship and that the decision was reached for the correct reasons, impartially and objectively

• ensure the termination is performed in an appropriate manner so that there is continuity in the care and treatment of the patient

• only decline to provide care if alternative care is made available to the patient, for example by referral to a public health facility or another practitioner.

It is also crucial that the patient is:

• given reasonable notice of when the termination of the relationship will become effective

• made aware of the process to avoid any expectations of continuing care.
**CASE STUDY 1**

Mrs F saw Dr B with an infected ingrown toenail. However, at the end of the initial consultation, the patient became aggressive and violent. The patient continued to be hostile at the next consultation and was offensive towards Dr B and her staff. Dr B tried to investigate possible underlying causes for the patient’s distress, for example fear or pain. She attempted to resolve the behavioural problems but was unable to do so. Subsequently, she contacted Medical Protection for advice on whether she could terminate the doctor-patient relationship on this occasion.

**ADVICE**

Dr B was advised that ending a doctor-patient relationship should only be used as a last resort. However, if a patient has been violent to any members of staff, or has been threatening to the point where there have been fears for personal safety, it may be reasonable to take steps to end the relationship. Dr B was advised to inform the patient of the reasons leading to the termination, and to document carefully the circumstances leading to her decision. She was advised she would need to make arrangements for the patient’s ongoing care, and if transferring care to a colleague would be harmful to the patient, then she would have a responsibility to continue treating the patient, until such time that the transfer of care would not cause harm.

**CASE STUDY 2**

Dr A had been treating Mrs U for a couple of months and she had recently started attending consultations with her husband. Dr A was not happy about this as the husband had a history of being verbally abusive towards his wife; however, the patient consented and Dr A honoured her wishes. During the first consultation the patient’s husband was offensive to Dr A, who had no choice but to ask him to leave the practice. Dr A felt very distressed and disheartened by this event and was concerned about continuing to treat the patient. He sought advice from Medical Protection on how to proceed.

**ADVICE**

Dr A was advised that he would need to act in the best interests of his patient with regard to her care and treatment. The adviser suggested he ask to see the patient alone, and if this was not possible, explain to both the patient and her husband that abusive behaviour to staff was unacceptable and would not be tolerated. Terminating the doctor-patient relationship should only be considered if all reasonable measures have been taken to resolve the situation, and if there was an irretrievable breakdown in the doctor-patient relationship. It should not be done because a patient (or their relative) complains or is critical or highly demanding, as this could result in a complaint from the patient or criticism by the regulator.

**CONCLUSION**

Terminating a doctor-patient relationship can be challenging, however, if you choose to do this, ensure that:

- clear reasons are identified
- attempts have been made to address underlying causes with the patient concerned
- viable alternatives have been acknowledged, and either tried or rejected by the patient
- no overriding reason to continue has been identified; for example, an emergency situation or a risk of interruption in necessary treatment.

**WHAT DO YOU THINK?**

We want to hear from you. Send your comments to: casebook@medicalprotection.org
Interactions with colleagues can be one of the most challenging aspects of medicine. The people you work with have a profound effect on how you practise—colleague interactions can lighten the burden, or make it infinitely heavier.

Our experience is that poor communication between two or more doctors providing care to patients lies at the heart of many complaints, claims and disciplinary actions.

It is inevitable at some point throughout your career as a doctor that you will come across at least one colleague with whom you have issues working. It is therefore important to be aware of different strategies and techniques you can use to deal with this situation.

**IDENTIFYING RISKS**

There are many reasons why doctors may not communicate sufficient clinical information to their colleagues about patients under their care. These can include pressures of time, difficulty in accessing colleagues, and difficult relationships with them.

Changes in working patterns and the resultant increase in shift work and cross cover mean that more doctors may be involved in a patient’s care. This has increased the risk of failures in communication because passing care between doctors (in a referral or a handover) increases the possibility that patient information will not be shared optimally. As a result, abnormal investigation results may be missed, treatments may be monitored inadequately or important comorbidities may not be taken into account, which all put the patient at risk of harm.

So what can you do to reduce the risk around interactions with difficult colleagues?

**PICK YOUR BATTLES**

Use your energy wisely—you might have several issues with colleagues but some will generate more risk to patients and yourself than others. It is wise to concentrate your efforts and energy on high risk areas, with the best interests of the patient at the centre of discussions.

**STOP RISKY ASSUMPTIONS**

Assumptions are a common human error that we all make. They are especially prevalent when dealing with colleagues we dislike or find challenging. We can be more likely to make an assumption relating to clinical communication rather than check with that colleague. This generates a variety of risks that can lead to catastrophic outcomes.

Checklists can reduce this type of risk. They are a useful method of ensuring completeness of communication when referring a patient, and they can be used as memory aids or integrated into the records or correspondence. They also enable doctors to focus on more complex tasks by reducing the amount of information they need to remember and process at one time.

**HANDBACK**

Where all responsibility for patient care is being handed over—for example, to the hospital night team or to a GP colleague when going on leave—a handover model such as SBAR (situation, background, assessment, recommendation) or the Medical Protection SHIFT™ model (status of patient, history, investigations pending, fears of what may unfold, treatment planned) can be used to ensure all relevant information is passed on and recorded. It can be useful to ask the recipient to repeat back a summary of what they have understood to confirm the accuracy of information transfer.

Other ways to reduce risk when passing care to a colleague include the use of information technology systems to automate information transfer, as well as tracking systems for referrals, investigations and follow-up, to ensure safe completion of processes. Patients may also be recruited to “check” the communication between colleagues—for example, a referral letter can be dictated in their presence or they can be given a copy of their discharge summary or clinic letter. Doctors should take action if the communication they receive about a patient is inadequate.
ACTIVELY MANAGE DISAGREEMENTS

Differences of opinion between doctors also pose a risk. Disagreements may arise over diagnosis, treatment, and management, as well as interpretation of investigations, resource allocation and end of life issues. The breakdown of a working relationship between doctors can have a detrimental effect on colleagues and patient care. When raising concerns with colleagues over disagreement about patient care, you should emphasise the importance of achieving the best outcome for the patient, while maintaining dignity and respect for your colleague, and attempt to negotiate a mutually agreeable resolution.

If you think that a colleague is routinely putting you or your patient at risk through inadequate communication, and your attempts to give subtle feedback have not been effective, you should raise your concerns with the colleague directly, making suggestions for improvements to enhance clinical communication and framing the conversation in terms of the risk to everyone concerned. You should emphasise that you are committed to taking action, document your concerns, and explain what you have done to tackle them. If that does not work, you should discuss the matter with your clinical lead or defence organisation for support and advice on what to do next.

LEARNING POINTS

• Effective clinical communication between healthcare professionals is essential for safe patient care. In the context of an operating theatre, where there are anaesthetic factors that may have an impact on the surgical outcome (and vice versa), it is vital that this information is shared.

• Unresolved personal or professional disagreements between healthcare professionals who share responsibility for patients is potentially prejudicial to patient care. It is the responsibility of all who work in the clinical team, and those who manage them, to make sure that patients are protected from any adverse outcome that results from doctors not working together properly. The wellbeing of patients must always significantly outweigh the personal disagreements of doctors.

• The rights and wrongs of any argument come second to their conduct. Both individuals could find themselves the subject of investigation by the regulatory authorities.

• Independent, external professional assistance with conflict resolution may sometimes be necessary and can be extremely effective.

Medical Protection has a series of online learning modules on a range of topics including communication and interpersonal skills. To find out more visit medicalprotection.org and click on the ‘Education and Events’ link.

CASE REPORT

WE DON’T TALK ANYMORE

Mr Y, a 35-year-old marine engineer, was undergoing surgery to treat a congenital vascular lesion in the posterior compartment of the thigh. Mr O, consultant vascular surgeon, was carrying out the procedure. The lesion was closely related to the sciatic nerve and some of its branches, and Mr O was aware of the risk of damaging the sciatic bundle.

The anaesthetic was given by Dr A, consultant anaesthetist. During the induction phase Mr Y had suffered repeated generalised muscular spasms, so Dr A had given a muscle relaxant to prevent intraoperative movement of the surgical field.

Intraoperatively, Mr O used tactile stimulation to ascertain if a nerve that was likely to be compromised by his surgical approach was the sciatic nerve, or a branch of the peroneal nerve. Reassured by a lack of contraction of relevant muscle groups, he continued to operate under the impression that the structure about which he was concerned was not the sciatic nerve.

Unfortunately, in the context of neuromuscular blockade, there was no rationale for this approach. It transpired that Mr Y suffered severe foot drop as a result of extensive damage to the sciatic nerve. Mr Y sued Mr O as a result of his injuries.

The case hinged on whether Mr O had taken sufficient care in establishing the relevant anatomy during surgery. Dr A had documented in the anaesthetic record that he had given the muscle relaxant, and was adamant that he had told Mr O this fact. Mr O, however, was insistent that Dr A had not informed him about the administration of the drug, and so had left him open to the error that he made.

During an investigation of events surrounding the case it emerged there were unresolved investigations into allegations of bullying and harassment between Mr O and Dr A. In the context of how Mr Y suffered his injury, and the clinicians’ apparent failure to communicate, it was impossible to defend the case, which was settled for a moderate sum with liability shared equally between the two doctors.
Healthcare practitioners should adopt a cautious approach when advertising their medical services, says Medicolegal Assistant Ralitsa Sahatchieva

During the course of your career there will come a time when you wish to advertise your services as a medical practitioner. Whether you are at the beginning of your career, opening a new private practice or relocating to another area, advertising your medical services will have to be in compliance with the relevant HPCSA regulations and the Advertising Code of Practice.

HPCSA GUIDELINES
Booklet 2 on the Ethical and Professional Rules of the HPCSA Guidelines for Good Practice in the Health Care Professions1 provides healthcare professionals with guidance on advertising and touting. It states that:

1. “A practitioner shall be allowed to advertise his or her services or permit, sanction or acquiesce to such advertisements provided that the advertisement is not unprofessional, untruthful, deceptive or misleading or causes consumers unwarranted anxiety that they may be suffering from any health condition.”

2. “A practitioner shall not canvas or tout or allow canvassing or touting to be done for patients on his behalf.”

The HPCSA defines canvassing as “conduct which draws attention, either verbally or by means of printed or electronic media, to one’s personal qualities, superior knowledge, quality of service, professional guarantees or best practice”.2

Touting is defined as “conduct which draws attention, either verbally or by means of printed or electronic media, to one’s offers, guarantees or material benefits that do not fall in the categories of professional services or items, but are linked to the rendering of a professional service or designed to entice the public to the professional practice.”3

ADVERTISING CODE OF PRACTICE
In addition to HPCSA guidelines, you will need to consider the Advertising Code of Practice4 when creating any advertisement. The Code is the official guiding document of The Advertising Standards of South Africa (ASA). It stipulates that “all advertising should be legal, decent, honest and truthful, and be prepared with a sense of responsibility to the consumer”.

It also specifies that:

1. Advertisements should not describe products as “free” if there is any cost payable by a consumer except for delivery or postage costs.

2. Advertisements should be honest and not abuse consumer’s trust or lack of knowledge.

3. Advertisements should not contain any statements or visual presentations, which, directly or by implication, omission, ambiguity or exaggeration, is likely to mislead consumers.

4. Advertisers should have available acceptable proof of all factual claims made in advertising.

CASE STUDY
Dr A wants to advertise her medical services in a local newspaper as she has recently relocated to a new area and opened a new private practice. She would like the advertisement to include an offer of a free medical examination to any patients who join the practice, as part of their first consultation. Before placing the advert Dr A contacted Medical Protection to ensure this would be in compliance with the HPCSA guidelines.

ADVICE
In such matters Medical Protection can only provide advice on the medicolegal aspects, as advertising is a business matter and as such falls outside the scope of assistance offered as a benefit of membership. In this instance a medicolegal adviser recommended that Dr A adopt a cautious approach and only include factual information as part of the advertisement, in order to ensure compliance with both HPCSA guidelines and the Advertising Code of Practice. Dr A was told that the offer of a free medical examination as an incentive to attract new patients could be interpreted as touting, and could be in breach of the HPCSA guidelines.

WHAT DO YOU THINK?
We would like to hear from you. Send your comments to casebook@medicalprotection.org.

REFERENCES
1. HPCSA, General Ethical Guidelines for the Health Care Professions, Booklet 2 (2008)
2. Ibid
3. Ibid

The case mentioned in this article is fictional and is used purely for illustrative purposes.
n a world in which technological advances and medical innovation abound, it is very easy to overlook the importance of the fundamental clinical skills of history taking and clinical examination. Yet, as some of the cases you will be reading about in this edition illustrate, a few extra minutes taken to ask pertinent questions and perform relevant clinical examinations pays dividends. Not only may it result in an earlier diagnosis and improved outcome for the patient, but it could also reduce the risk of a clinical negligence claim.

In ‘Tunnel vision’, having failed to take a proper history at the first consultation, Mrs O’s doctors fell into the trap of accepting the earlier presumptive diagnosis. Despite repeated attendances by the patient with worsening symptoms, no further history was elicited and no examination undertaken. The correct diagnosis was ultimately made when Mrs O collapsed resulting in an emergency admission to the local hospital.

In ‘Tripped up’, Master Y was reviewed twice by his GPs, Dr E and Dr B, three and seven weeks after his fall when he was still complaining of unremitting pain, but despite this there was no attempt to revisit the history and review the original diagnosis. It was only by chance that an unrelated abnormality on a knee x-ray prompted an orthopaedic referral which led to the correct diagnosis being made.

Making a diagnosis is particularly challenging for patients with more than one co-existing condition, as illustrated in ‘Back to front’. In this case, a careful review of the character of Mr W’s pain after he failed to respond to treatment may have prompted consideration of alternative diagnoses.

Communication and process errors are other themes emerging from this edition’s case reports. In Mr T’s case, an abnormal MSU result was marked as “normal” and filed in the records without action. Notwithstanding that Dr W had no record of having received the health-screener’s letter, the practice’s failure to communicate the abnormal result to the patient, or to flag it up in the records led to further actions which compounded the problem, and was indefensible. ‘Turning a blind eye’ is another example of how a failure to communicate an abnormal result to a patient can have devastating consequences. In this case Dr L, in his desire not to alarm the patient or to disclose sensitive information in a letter, failed to convey to Mrs R the urgency of his request such that she chose to ignore it. In such circumstances it is imperative that the request is followed up if the patient fails to attend within the anticipated timeframe.

Poor communication between healthcare providers can also lead to problems, as illustrated by ‘A risk of harm’ and ‘Paediatric brain injury’. In both cases the failure to give clear, explicit and documented instructions to nursing staff led to a misunderstanding as to the level of observation required, which contributed to a delay in treatment of a postoperative complication in BC’s case and to Miss A suffering serious harm.

Finally, time and time again, we see the impact of poor record keeping on our ability to defend our members’ actions, particularly when it comes to issues of consent and providing evidence of discussions of risks and complications. The case of Mrs W and Dr D is no exception. Master Y’s doctors, Dr E and Dr B, are also criticised for their poor record keeping. Our GP expert in that case remarks on the discrepancy between their described usual practice and the paucity of the records. Today’s doctors are practising in an increasingly pressured and challenging environment in which the temptation to take shortcuts is a strong one. By continuing to practise those core skills of history-taking, clinical examination and communication, doctors can reduce substantially the risk of a successful claim of clinical negligence being brought against them.

At Medical Protection we are proud to say that we were able to successfully defend 74% of medical claims (and potential claims) worldwide between 2011 and 2015. We believe that through our risk management advice, and the learning taken from case reports such as these we can help members lower their risk, and improve that figure even further.

What’s it worth?

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

- HIGH R15,000,000+
- SUBSTANTIAL R1,500,000+
- MODERATE R150,000+
- LOW R15,000+
- NEGLIGIBLE <$15,000
Mr T, a 40-year-old accountant, attended a private health check under his employer's healthcare screening. Blood and protein were noted on urinalysis and his eGFR was found to be 45 ml/min/1.73 m². He was asked to make an appointment with his GP and was given a letter highlighting the abnormal results to take with him.

Mr T saw his GP, Dr W, shortly after and told her that blood had been found in his urine on dip testing during a health screening. Dr W arranged for an MSU to be sent to the laboratory. The MSU showed no infection or raised white cells but did confirm the presence of red blood cells. Unfortunately the result was marked as "normal" and filed in the notes without any action.

A year later Mr T saw Dr W again, this time with a painful neck following a road traffic accident. Dr W prescribed diclofenac tablets to help with the discomfort. A week later Mr T booked an urgent GP appointment because he had developed a severe headache and felt very lethargic and breathless. He was seen by Dr A, who diagnosed a chest infection and prescribed a course of amoxicillin.

Mr T went home but was taken to hospital later the same day following a fit. He was subsequently diagnosed with malignant hypertension and severe renal failure with pulmonary oedema. Again, blood and protein were found in his urine, but this time his eGFR was 12 ml/min/1.73 m². Mr T stabilised but needed assessment for possible kidney transplantation.

Mr T was angry and upset about the care he had received from his GP. He alleged that he had given Dr W a letter from the health screening assessment when he consulted with her and that she had failed to act on it. He also alleged that Dr W had failed to diagnose his renal disease or refer him to the renal team. He claimed that this delay had resulted in progression of his condition to end-stage renal failure.

EXPERT OPINION

Medical Protection sought the advice of a consultant nephrologist, Dr B. Dr B was of the opinion that Mr T's renal impairment was probably due to glomerulosclerotic disease, rather than hypertension, at the time of the health check. He felt that the diclofenac prescribed caused the clinical situation to deteriorate, leading to the acute presentation of severe hypertension and renal failure. He advised that if Mr T's condition had been diagnosed earlier, this would have allowed monitoring and control of his blood pressure. It would also have been unlikely that NSAIDs would have been prescribed, thus avoiding the acute presentation. It was Dr B's opinion that earlier diagnosis and treatment would have delayed the need for renal transplant by a period of between two to four years.

Dr W specifically denied that she had been given the letter from the private health screening and, indeed, there was no evidence of it within the GP records. She did however accept that she had erroneously marked the MSU result as normal and had thus not taken any action. In view of this, it was agreed that Dr W was vulnerable in this matter and the case was settled for a high sum.

Learning points

- This case raises issues about communication between healthcare providers. Doctors need to consider whether their systems for receiving and recording information, written or verbal, from other healthcare providers are sufficiently robust.
- Mistakes can be easily made when working under stress with high workloads. It is important, however, to be thorough and to ensure that all elements of a test result are reviewed before marking the result as normal.

AF
P was a 32-year-old runner. He had a skin tag on his back that kept catching on his clothes when he ran. It had become quite sore on a few occasions and he was keen to have it removed. He saw his GP, Dr N, who offered to remove the skin tag in one of his minor surgery sessions.

The following week, Mr P attended the minor surgery clinic at his GP practice. Dr N explained that he was going to use diathermy to remove the skin tag and Mr P signed a consent form.

Mr P lay on the couch and a sterile paper sheet was tucked under him. The assisting nurse sprayed his skin with a topical cryo-analgesic. The spray pooled on his back and soaked into the paper sheet. No time was left for the alcohol-based spray to evaporate. Mr P’s back was still wet when Dr N began the diathermy to remove the skin tag. Unfortunately the paper sheet caught fire along with the pooled spray on his back. Mr P suffered a superficial burn. Dr N and the nurse apologised immediately and applied wet towels and an ice pack. The burn area was treated with Flamazine cream and dressings. Mr P was left with a burn the size of a palm on his back which took two months to heal fully.

Mr P made a claim against Dr N, alleging that his painful burn had been the result of medical negligence. It is well known that alcohol-based solutions pose a risk of fire when diathermy is used, and in failing to ensure the area was dry before applying the diathermy Dr N was clearly in breach of his duty of care. Medical Protection was able to settle the claim quickly, thus avoiding unnecessary escalation of legal costs.

Learning Points

- Flammable skin preparation fluids must be used with caution. GPs should refer to safety data sheets before using these products. The data sheet for the topical cryo-analgesic states that it “may form flammable/explosive vapour-air mixture” and that one should “ensure good ventilation and avoid any kind of ignition source”.

- The fire triangle is a simple model illustrating the three necessary ingredients for most fires to ignite: heat, fuel and oxygen. In clinical situations such as the one described above, diathermy provides the heat and the skin preparation fluids provide the fuel.

REFERENCES

A delay in sharing an urgent result with a patient results in a loss of vision

Mrs R, a 56-year-old freelance journalist, became aware she had reduced vision in her right eye. She saw her optician who noted that her visual acuity was 6/18 in the right eye and 6/6 in the left eye. Examination confirmed a nasal visual field defect in the right eye with a normal visual field in the left eye. The right optic disc was atrophic but the left appeared normal. Mrs R’s optician referred her to an ophthalmologist at her local emergency unit, where Dr S confirmed his findings and also detected a right afferent pupillary defect and reduced colour vision in the right eye. He made a diagnosis of right optic atrophy and arranged blood tests to investigate this further.

Two weeks later Dr S received a telephone call from the microbiology department informing him that Mrs R had tested positive for syphilis. Dr S immediately contacted Mrs R’s GP, Dr L, informing him of the result and the need for urgent treatment.

On the same day, Dr L wrote a letter to Mrs R asking her to book an appointment. His letter said: “Please be advised that this is a routine appointment, and there is no need for you to be alarmed.”

Mrs R did not take this letter seriously and no appointment was made. Dr L did not pursue the matter.

Seven months later, Mrs R was referred to Dr D in the neuro-ophthalmology clinic for deteriorating vision affecting both eyes. Dr D diagnosed bilateral optic atrophy and repeated the blood tests for syphilis. He arranged for Mrs R to be admitted to hospital, where lumbar puncture and examination of the cerebrospinal fluid confirmed the diagnosis of neuro-syphilis.

Mrs R brought a case against her GP alleging that the delay in treatment led to her losing her sight. Due to this she had lost her driving licence, which had substantially reduced her earning capacity.

EXPERT OPINION
A GP expert considered that in failing to follow-up on an important laboratory result, Dr L was in breach of his duty of care. Ophthalmology expert opinion concluded that the delay in treatment resulted in loss of the remaining 50% of vision in the right eye and 80% of vision in the left eye. The loss of sight impacted substantially on Mrs R’s lifestyle and earning capacity. Both the microbiology department and the ophthalmologist were deemed to have acted appropriately and promptly.

The case was settled for a substantial sum on behalf of Dr L.

Learning points

• When faced with a serious condition requiring urgent treatment you should be diligent in your attempts to communicate this to the patient promptly and sensitively.
• When communicating urgent information to colleagues, direct conversations are the most effective. It may be useful to follow a conversation with a letter as this may reinforce a point and prompt further action. A letter on its own may be insufficient in that it may be mislaid, misfiled or the importance not understood.
• When communicating sensitive information to patients a face-to-face consultation is most appropriate. Communicating such information in writing could lead to misunderstanding, a breach of confidentiality or may downplay the urgency of the matter.
• Be aware of local practice: the management of neuro-syphilis is often initiated through neurology or medical teams and the ophthalmologist should consider direct referral when the condition is sight threatening. Ophthalmologists should also be prepared to discuss laboratory results with patients and, where appropriate, emphasise the need for prompt treatment.

AK
A child is unable to weight bear after a fall

Master Y, aged nine, was walking home from school when he tripped over and fell. He was usually very stoical but after the fall he cried with pain when he tried to stand on his right leg. His mother took him into the local Emergency Department (ED) where, after a brief examination, he was discharged home with a diagnosis of a torn quadriceps muscle. No x-rays were taken. He was advised to avoid weight bearing for two weeks.

Master Y was no better three weeks later. His mother rang their GP, Dr E, who saw him the same day. Dr E noted the history of a fall and recorded only “tenderness” and “advised NSAID gel and paracetamol”.

Master Y continued to complain of pain in his thigh and also his knee. A month later, he saw another GP, Dr B, who assessed him and diagnosed “musculoskeletal pain”. There was no record of any examination. Master Y’s knee pain continued over the next month. Dr B reviewed him and arranged an x-ray of his knee. The only entry on the records was “pain and swelling right knee”.

The x-ray showed signs of osteoporosis and features consistent with possible traumatic injury to the right proximal tibial growth plate. The report advised an urgent orthopaedic opinion, which Dr B arranged.

The orthopaedic surgeon noted an externally rotated and shortened right leg. An urgent MRI revealed a right-sided slipped upper femoral epiphysis, and Master Y underwent surgery to stabilise it. The displacement was such that an osteotomy was required later to address residual deformity.

Despite extensive surgery Master Y was left with a short-legged gait and by the age of 16 he was increasingly incapacitated by pain in his right hip. Surgeons considered that he would need a total hip replacement within ten years, and that a revision procedure would almost certainly be required approximately 20 years after that.

A claim was brought against GPs Dr E and Dr B, and the ED doctor, for failing to diagnose the slipped upper femoral epiphysis. It was alleged that they failed to conduct sufficiently thorough examinations, arrange imaging and refer for timely orthopaedic assessment.

EXPERT OPINION

Medical Protection instructed a GP expert who was critical of both GPs’ unacceptably brief documentation. He noted the discrepancy between what was actually written down by the GPs in the contemporaneous records and their subsequent recollection of their normal practice. The expert felt that their care fell below a reasonable standard.

Medical Protection also obtained an opinion from a consultant orthopaedic surgeon. The expert was critical of the assessment undertaken in the ED and advised that knee pain can be a feature of slipped upper femoral epiphysis. The expert considered that the fall caused a minor slippage of the right upper femoral epiphysis, which was a surgical emergency, and the appropriate management would have been admission for pinning of the epiphysis in situ. In the presence of a slight slip and subsequent fusion of the epiphysis, recovery without functional disability would have been expected. As a consequence of failure to diagnose an early slip, Master Y lost the chance of early correction. Instead, he developed a chronic slippage with associated disability, necessitating osteotomy.

The case was settled for a high sum, with a contribution from the doctor who saw Master Y in the ED.

Learning points

- Slipped upper femoral epiphysis is a rare condition in general practice. It usually occurs between the ages of eight and 15 and is more common in obese pain in this age group.
- Because patients often present with poorly localised pain in the hip, groin, thigh or knee, it is one of the most commonly missed diagnoses in children. Pain can cause diagnostic error and orthopaedic examination should include examination of the joints above and below the symptomatic joint.
- The medical records were inconsistent with the GPs’ accounts. When records are poor it is very difficult to successfully defend a doctor’s care. The HPCSA require doctors to ensure consultations are recorded in “complete, concise and consistent” notes.
- Safety-netting is important and follow up should be arranged if patients are not improving or responding to treatment. This should prompt a thorough review and reconsideration of the original diagnosis.

REFERENCES

Case Reports

Tunnel Vision

A patient presents several times with a worrying vaginal discharge

Mrs O, a 34-year-old mother of three, visited her GP with a two-month history of worsening vaginal discharge, which had recently become malodorous. Her husband had urged her to see the doctor as he was particularly concerned when she had admitted to the discharge being blood stained.

The first GP she saw, Dr A, took a cursory history and simply suggested she should make an appointment with the local sexual health clinic. Of note, Dr A didn’t enquire about the nature of the discharge, associated symptoms or note that she had not attended for a smear for over five years, despite invitations to do so. Dr A did not examine Mrs O, nor did he arrange investigations or appropriate follow-up. Mrs O was deeply offended that Dr A had implied the discharge was likely to be secondary to a sexually transmitted infection and did not feel the need to attend a sexual health clinic.

She re-presented to another GP, Dr B, several months later, complaining that her discharge had worsened. Dr B reviewed the previous notes and encouraged her to make an appointment with the sexual health clinic as previously recommended by Dr A. There was no evidence from the notes that a fresh review of the history had been undertaken. No examination was performed, and Dr B did not arrange for vaginal swabs or scans despite Mrs O’s continued discharge.

A week later, Mrs O re-attended the surgery, where Dr B agreed to try empirical clotrimazole on the premise she may be suffering from thrush. Again, no examination or investigations were discussed, and there was no evidence of safety-netting advice documented in the records.

Two months later, Mrs O saw a third GP, Dr C, as the clotrimazole had failed to resolve her worsening symptoms. By now she had started to lose weight, had developed urinary symptoms and her bloody vaginal discharge had worsened. Despite her malaise and pallor, Dr C again failed to take an adequate history or examine Mrs O, and further reinforced the original advice that Mrs O attend the sexual health clinic.

Mrs O collapsed later that week and was taken by ambulance to the Emergency Department (ED) of her local hospital. She was found to have urosepsis and was profoundly anaemic with a haemoglobin of 60 gm%. Examination by the ED team revealed a hard irregular malignant-looking cervix and a large pelvic mass. She was admitted under the gynaecology team who arranged for an urgent scan. The scan revealed an advanced cervical cancer, with significant pelvic spread and bulky lymphadenopathy.

After a multidisciplinary team meeting and a long discussion with her oncologist, Mrs O and her husband elected to try a course of neoadjuvant chemotherapy and debulking surgery. Unfortunately, prior to surgery, she experienced severe pleuritic chest pain, and a working diagnosis of pulmonary embolism was made. Further investigations excluded embolic disease but confirmed tumour deposits in the lung and liver.

It was agreed she should forego chemotherapy, and Mrs O was referred to the palliative care team. Her symptoms were managed in the community until her death at home two months later.

Learning points

- Failure to take an adequate history and examination will make any case difficult to defend.
- It is not advisable to reinforce a colleague’s diagnosis or management advice without first conducting your own assessment of the patient’s symptoms.
- Alarm bells should ring if patients return multiple times for the same problem.
- Where clinically relevant, screening tests should be offered opportunistically to patients who fail to respond to routine invitations.

Expert Opinion

A claim was brought against all three GPs for failure to take adequate histories, failure to examine, failure to accurately diagnose and failure to safety net. An expert witness was highly critical of the care Mrs O received from all the GPs involved, and advised that her death was potentially avoidable with better care and a more robust smear recall system. Breach of duty and causation were admitted and the family’s claim was settled for a high amount.
A 34-year-old lady, Mrs C, consulted a plastic surgeon, Dr Q, about her lax abdominal skin. Nine days later, she was admitted under his care for an abdominoplasty procedure (tummy tuck). The procedure was uneventful and the patient was discharged after 24-hours.

A fortnight later, at the postoperative wound care, Mrs C complained of lower abdominal swelling. This was identified as a seroma and she was briefly admitted for aspiration by Dr Q.

Three months later she was seen again at a nurse-led clinic, on this occasion complaining of peri-umbilical pain. She was reviewed two days later by Dr Q himself, whose examination noted nothing amiss. Her symptoms continued and four months later her GP referred her to an orthopaedic surgeon, raising the possibility of an incisional hernia. Dr Q was contacted by the hospital and reviewed Mrs C again. He offered to perform a scar revision and to waive his fee.

Three months after this revision surgery was performed, Mrs C had further problems around the scar site, this time manifesting as an infection, which developed into an abscess. Initially her GP treated this with antibiotics and dressings. However, despite this intervention, she was seen again by Dr Q, who re-admitted Mrs C for drainage of the abscess. She was briefly admitted for aspiration by Dr Q.

Mrs C was unhappy with the cosmetic result and, after her discharge from hospital, Dr Q referred her to a colleague, Dr H, for a further opinion. Dr H reviewed Mrs C and replied that in his view the umbilicus and the horizontal scar were placed too high, and some technical aspects of Dr Q’s wound closure methods.

Mr C was critical of a number of aspects of Dr Q’s management, including the positioning of the incision line, consent issues around scarring, and some technical aspects of Dr Q’s management, including the positioning of the incision line, consent issues around scarring, and some technical aspects of Dr Q’s wound closure methods.

In the light of the expert’s comments the case was settled for a moderate amount.

**Learning points**

A patient’s decision to make a claim against his or her clinician often reflects more than one point of dissatisfaction or poor performance. Some of the important points in this case include:

- The interval between Mrs C having her first consultation with her surgeon and the subsequent operation was just nine days. When cosmetic surgery is being considered it is good practice to allow a cooling-off period of at least two weeks before the surgery. The patient should be provided with, or directed to, sources of information about the proposed procedure. It is also best practice to offer patients a second consultation, which allows the patient to discuss any doubts or questions which may have arisen. Patients should be under no pressure to proceed with aesthetic surgery.

- Complications can occur after any surgery. In abdominoplasty, issues of scarring and the formation of seromas can occur. It is vital that these possibilities are discussed during the pre-procedure consultations. It is insufficient to simply list them on a consent form, signed in a rush on the morning of operation by a nervous patient.

- Being asked to provide a second opinion can be an extremely challenging task, particularly when you do not agree with the opinion of the original doctor. In this case, Dr H was critical of the repeat surgery carried out by Dr Q. Doctors should always convey their honest opinion to patients. However, you should consider the effect that the manner you express an opinion can have. Excessive or derogatory comments to a patient are unlikely to be helpful and may encourage a patient to complain or pursue a claim.
A RISK OF HARM

A psychiatric patient is placed under close observation

Miss A, a 30-year-old teacher, saw Dr W, a consultant psychiatrist, in the outpatient clinic. Dr W noted Miss A’s diagnosis of bipolar affective disorder, her previous hospital admission for depression and her history of a significant overdose of antidepressant medication. Dr W found Miss A to be severely depressed, with psychotic symptoms. Miss A reported thoughts of taking a further overdose, and Dr W arranged her admission to hospital.

During Miss A’s admission Dr W stopped her antidepressant medication, allowing a wash-out period before commencing a new antidepressant and titrating up the dose. He increased Miss A’s antipsychotic medication and recommended she be placed under close observation due to continued expression of suicidal ideation. He documented that Miss A appeared guarded and perplexed, did not interact with staff or other patients on the ward and spent long periods in her nightwear, lying on her bed. He did not document the content of her suicidal thoughts. Dr W reiterated to nursing staff that close observations should continue.

During the third week of her admission, Miss A asked to go home. Miss A’s nurse left Miss A alone to contact the doctor to ask whether Miss A required assessment. While alone in her room, Miss A set fire to her night clothes with a cigarette lighter and sustained burns to her neck, chest and abdomen. She was transferred to the Emergency Department and then to the plastic surgical team. She remained an inpatient on the burns unit for three months, requiring skin grafts to 20% of her body.

Miss A made a good recovery from this incident and subsequently brought a claim against Dr W and the hospital. She alleged Dr W had failed to prescribe adequate doses of medication to ensure the optimal level of improvement in her mental health symptoms, failed to adequately assess the level of risk she posed and failed to ensure constant specialist nursing care was provided to supervise her adequately during her hospital stay. She also alleged the hospital had failed to ensure she did not have access to a cigarette lighter. Miss A claimed that she would not have suffered the severe burns and subsequent post-traumatic stress disorder if not for these failings.

EXPERT OPINION

An expert opinion was sought from a psychiatrist. The expert made no criticism of the medication regimen or changes to it, but was critical of the communication between Dr W and nursing staff over the meaning of the words “close observation”, and the lack of a policy setting this out. She was also of the view that additional nursing staff should have been requested to ensure one-to-one nursing of the patient during her admission. She was critical of the hospital for allowing the patient access to a lighter on the ward, and concluded that the incident could have been avoided if these failures had not occurred.

Dr W acknowledged Miss A had been the most unwell patient on the ward at the time and, in hindsight, agreed that additional nursing staff should have been requested. Dr W highlighted that there was pressure due to cost implications. He also acknowledged that by “close observations” he had expected the patient to be within sight of a member of nursing staff at all times but had not ever communicated this specifically to the ward staff.

The claim was settled for a substantial sum, with the hospital contributing to the settlement.

Learning points

- Mental health units should have clear policies regarding observation levels and all staff should be aware of these. The observation level deemed appropriate for each patient should be clearly discussed with ward staff and documented within the notes, both on admission and whenever changes are made. The justification for any changes in the level of observation should be clearly documented.
- Robust risk assessment is always important. Risk assessment tools are available, and you should be familiar with any relevant local policies regarding these. Decisions made about the risk posed by a patient to themselves or others should be clearly documented and communicated.
- Mental health units should also have policies surrounding the requirement to check patients’ belongings when they are admitted and for removing any items that may pose a risk, including lighters and any sharp implements.
- If a lack of resources results in patient safety concerns, these should be raised by the clinician involved. Discuss your concerns with a senior colleague or seek advice from Medical Protection. Any concerns and discussion of them should be documented.

CNR

Further Reading

Royal College of Psychiatrists, Self-harm, Suicide and Risk: a Summary (2010)
rcpsych.ac.uk/pdf/ps03-2010x.pdf
A three year old child, BC, was admitted to hospital for investigation following an epileptic fit. A CT scan demonstrated a left-sided Sylvian fissure arachnoid cyst with bulging of the overlying temporal bone (but no midline shift).

BC underwent cyst drainage with insertion of a shunt under the care of Dr S, a consultant paediatric neurosurgeon, but it was complicated by an intracranial bleed. Intraoperative exploration revealed that there had been an injury to the temporal lobe that was likely to have been associated with the insertion of the ventricular catheter (which was not inserted entirely under direct vision). The haemorrhage was under control when the operation was concluded.

Following the surgery, BC was transferred to the paediatric ward as a high care patient. Dr S left the hospital having handed over care to Dr K, a consultant paediatrician, and Dr P, a consultant neurosurgeon. Dr S explained that BC had had an intraoperative bleed, that a clotting screen should be checked (to exclude an underlying bleeding disorder) and that regular neurological observations should be undertaken. Unfortunately the handover discussions were not documented in the records.

BC remained stable until early evening, when Dr K was asked by the nursing staff to review her because she had started to vomit and had developed a dilated left pupil. A repeat scan demonstrated a haematoma in the Sylvian fissure with consequent displacement of the shunt, impingement of both the temporal and parietal lobes, together with a midline shift. Dr P was called and immediately returned BC to theatre to evacuate the haematoma.

Unfortunately BC sustained a neurological injury, which left her with a right-sided hemiparesis, cognitive difficulties and ongoing epilepsy.

The parents pursued a claim, alleging:
- the original procedure was not indicated (and that non-surgical approaches were not considered)
- the shunt was negligently inserted, which led to the bleeding and associated brain injury
- the bleeding was not adequately controlled in the context of the first procedure
- BC should have been transferred to a paediatric intensive care facility so that her neurological condition could have been monitored intensively

EXPERT OPINION
Medical Protection sought an expert opinion from a consultant paediatric neurosurgeon, who was not critical of Dr S’ decision to drain the cyst and insert a shunt. However, concerns were raised in relation to the operative technique which, the expert said, was not according to standard practice. The expert indicated that the preferred approach would be to insert the ventricular catheter under direct vision and postulated that there may have been damage to one of the branches of the middle cerebral artery.

The expert was not critical of the decision to transfer BC to a paediatric ward (on the basis that she did not require ventilation and that the monitoring facilities on the ward were appropriate) but was concerned about the lack of written and verbal instructions (particularly directed towards the nursing staff) relating to postoperative care and neurological observations. In addition, the expert was of the opinion Dr S should have reviewed BC on the ward, given that he had performed a surgical procedure on her that had been complicated by bleeding.

In light of the vulnerabilities highlighted by the expert, the claim was resolved by way of a negotiated settlement.

Learning points
- The allegations were wide-ranging and although the expert was supportive of some aspects of Dr S’ involvement in BC’s care, the concerns in relation to the operative technique and handover meant that there was no realistic prospect of successfully defending the case.
- The case emphasises the importance of communication and record keeping, particularly with reference to providing clear verbal and written handover to all relevant staff.
- It may be entirely appropriate to leave the care of a patient in the hands of colleagues at the end of a shift but it would have assisted Dr S’ defence if he had reviewed BC on the ward postoperatively in light of the fact that the neurosurgical procedure had been complicated by bleeding.
Mr W was a 55-year-old diabetic who worked in a warehouse. He began to get pain across his shoulders when he was lifting boxes and walking home. He saw his GP, Dr I, who noted a nine-month history of pain in his upper back and around his chest on certain movements. She documented that the pain came on after walking and was relieved by rest. Her examination found tenderness in the mid-thoracic spine area. Dr I considered that the pain was musculoskeletal in nature and advised anti-inflammatory medication and a week off work.

Two weeks later Mr W returned to his GP because the pain had not improved. This time Dr I referred him to physiotherapy. Mr W did not find the physiotherapy helpful and four months later saw another GP, Dr J, who diagnosed thoracic root pain and prescribed dothiepin. He also requested an x-ray of his spine, which was normal, and referred him to a specialist. The referral letter described pain worse on the left side that was brought on by physical activity and stress.

The specialist documented a two-year history of pain between the shoulder blades. The examination notes stated that direct pressure to a point lateral to the thoracic spine at T6 could produce most of the pain. Myofascial pain was diagnosed, and trigger point injections were carried out.

Three months later Mr W was still struggling with intermittent pain in his upper back. He went back to see Dr J who referred him to orthopaedics. His referral letter described pain in the upper thoracic region with radiation to the left side, aggravated by strenuous activity and stress. Again, it was recorded that the pain was reproduced by pressure to the left thoracic soft tissues.

Two months later Mr W was assessed by an orthopaedic surgeon who diagnosed ligamentous laxity and offered him sclerosant injections.

Mr W took on a less physically demanding role and the pain came on less often. After a year, however, his discomfort increased and his GP referred him back to the orthopaedic team.

A consultant orthopaedic surgeon found nothing of concern in his musculoskeletal or neurological examination. X-rays were repeated and reported as normal. It was thought that his symptoms were psychosomatic and he was discharged.

Six months later, Mr W was struggling to work at all. He rang his GP surgery and was given an appointment with a locum GP, Dr R. Her notes detailed a several-year history of chest and back pain on lifting and exercise that had worsened recently. Pain was recorded as occurring every day and being “tight” in character. It was also noted that he was diabetic, smoked heavily and that his mother had died of a myocardial infarction at the age of 58. Dr R referred him to the rapid access chest pain clinic.

Angina pectoris was diagnosed and an ECG indicated a previous inferior myocardial infarction. Mr W was found to have severe three-vessel disease and underwent coronary artery bypass grafting, from which he made an uncomplicated recovery. He was followed up in the cardiology clinic and continued to be troubled by some back pain.

Mr W brought a claim against GPs Dr I and Dr J for the delay in diagnosis of his angina pectoris.

CASE REPORTS

BACK TO FRONT

An unusual presentation masks a significant underlying diagnosis
Learning points

- Pain that is precipitated by exertion should always raise suspicion of angina.
- The National Institute for Health and Care Excellence (NICE)1 in the UK defines stable angina symptoms as being:
  - constricting discomfort in the front of the chest, in the neck, shoulders, jaw or arms;
  - precipitated by physical exertion; and
  - relieved by rest or glyceryl trinitrate within about five minutes.
- People with typical angina have all three of the above features. People with atypical angina have two of the above features.
- Angina can present in uncharacteristic ways. There can be vague chest discomfort or pain not located in the chest (including the neck, back, arms, epigastrium or shoulder), shortness of breath, fatigue, nausea, or indigestion-like symptoms. Atypical presentations are more frequently seen in women, older patients and diabetics.2
- Multiple conditions can run alongside each other, and we must try to untangle them by careful questioning and listening. Stepping back and looking at the bigger picture can help if patients' symptoms are persistent.
- Confirmation bias can lead to medical error. The interpretation of information acquired later in a medical work-up might be biased by earlier judgments. When we take medical histories it can be tempting to ask questions that seek information confirming earlier judgements, thus failing to discover key facts. We also can stop asking questions because we have reached an early conclusion. The BMJ published an article about the cognitive processes involved in decision making and the pitfalls that can lead to medical error.3

REFERENCES

1. National Institute for Health and Care Excellence, Chest Pain of Recent Onset: Assessment and Diagnosis of Recent-Onset Chest Pain or Discomfort of Suspected Cardiac Origin, Clinical guideline 95 (2010)
Mrs W, a 58-year-old business manager consulted Dr D, an orthopaedic surgeon, with exacerbation of her chronic back pain. She had a history of abnormal clotting and had declined surgery three years earlier because of the attendant risks. An MRI scan confirmed degenerative spinal stenosis for which Dr D recommended an undercutting facetectomy, to decompress the spinal canal, while preserving stability. On this occasion, Mrs W agreed to the proposed procedure. Surgery was uneventful, and she was discharged home on the fourth postoperative day.

At her outpatient review 11 days later, Mrs W complained that she had been unable to open her bowels and that she had also developed a swelling at the wound site, from which Dr D aspirated “turbid reddish fluid”. Suspecting a dural leak, Dr D undertook a wound exploration, which confirmed that the dura was intact. At the same time, a sacral haematoma was evacuated. In the two years following surgery, Mrs W was seen by Dr D and a number of other specialists complaining of ongoing constipation, urinary incontinence and reduced mobility, which, although atypical, was thought to be due to cauda equina syndrome.

Mrs W brought a claim against Dr D, alleging that she had not been advised of the risks of the surgery and that no alternative options were offered to her. Furthermore, she claimed that had she been properly advised, she would have declined surgery, as indeed she had done in the past. She also alleged that Dr D failed to arrange appropriate postoperative monitoring such that her developing neurological symptoms were not acted on, and that she should have undergone an urgent MRI, which would have revealed a sacral haematoma requiring immediate evacuation.

EXPERT OPINION

An orthopaedic expert instructed by Medical Protection made no criticism of the conduct of the surgery, but was very critical of the poor quality of Dr D’s clinical records. Although Dr D was adamant that the risks of surgery and alternative treatment options were discussed with Mrs W, he made no note of this in the patient’s records nor did he make reference to any such discussions in his letter to the GP. Furthermore, despite Dr D’s assertions that he reviewed Mrs W every day postoperatively prior to her discharge, he made no entries in the records to this effect stating that he had relied on the nurses to do so. The nursing records did not corroborate this.

The claim was predicated on the basis that Mrs W suffered from cauda equina syndrome and that earlier intervention to evacuate the haematoma would have improved the outcome. In the expert’s opinion, there was insufficient evidence to support a diagnosis of cauda equina syndrome, and hence it was unlikely that earlier decompression would have made a difference. However, the absence of documentary evidence of her postoperative condition made it very difficult, if not impossible, to rebut this claim.

In any event, Mrs W would have been successful in her claim if she could establish that she was not properly advised of the risks and alternative options, and that if she had been so advised she would have not proceeded with the surgery. This is because, on the balance of probabilities, the complications she suffered would not have occurred had she been properly counselled. The absence of any record of the advice given, coupled with the documented reasons for her earlier refusal of surgery, lent significant weight to Mrs W’s claim.

On the basis of the critical expert report the claim was settled for a substantial sum.
Thank you for pointing out the two errors in the case report from the last edition. You are correct that it should have been the CRB65 algorithm and the Abbreviated Mental Test Score that were referred to. We regret that these were not picked up on clinical review and we apologise for any confusion caused.

Dr Brian Murray

Response

Thank you for pointing out the two errors in the case report from the last edition. You are correct that it should have been the CRB65 algorithm and the Abbreviated Mental Test Score that were referred to. We regret that these were not picked up on clinical review and we apologise for any confusion caused.

Dr Brian Murray

Finally, the decision-making capacity of the doctor will be impaired if in an unfamiliar location and stressed by congestion and route finding whilst travelling to a patient’s home, as well as consulting without immediate access to the full medical record.

Dr Douglas Salmon

A FAMILY MATTER

I read the case study regarding the doctor prescribing an antibiotic for her daughter. Having retired recently after 25 years as a GP partner it surprises me that common sense is not applied by the GMC in such circumstances.

How this can ever be considered a serious complaint baffles me. Being a GP is stressful enough, and cases like these make me angry that as a profession we have to suffer such indignity when we can’t be trusted to treat our families for minor illnesses.

Dr M Shah

PROBLEMATIC ANAESTHETIC

I read with interest the unfortunate case of neurological injury following attempted paravertebral blockade.

What the learning points do not mention is the expert opinion that this procedure should have been performed awake or under light sedation. Many anaesthetists perform this procedure under anaesthesia with exemplary results, but I have to agree with the expert opinion. When struggling with a procedure we can sometimes get too preoccupied with succeeding. Awake patients do not like needles in places where they should not be and this helps prevent multiple attempts by the operator. In this case it may have led to the doctor abandoning this unnecessary procedure.

Dr Mohammed Akuji

REFERENCES


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

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OMNIFOCUS (IOS, MAC)
OMNI GROUP
omnigroup.com/omnifocus

Review by: Dr Jennifer Munroe-Birt

The Omnifocus app can’t technically grant you the extra ten hours a day that everyone wishes they had, but what it can do is focus you, organise you, and maximise your productivity so you do in fact seem to end up with more time. At first glance it doesn’t seem much of an upgrade on a to-do list – albeit a rather expensive one – but further inspection reveals an intuitive, multi-level application that will afford you levels of organisation you always assumed were beyond you.

For doctors, the app is useful to arrange and categorise the abundance of tasks at hand (projects, meetings, CV, CPD). You can easily categorise individual tasks into bigger projects (holiday, that audit you’ve been meaning to finish all year) and assign deadlines to each task. Being able to break each ‘project’ into smaller, more manageable chunks will appeal to anyone who has sat down to start a big piece of work and found themselves still on Facebook half an hour later because they are too daunted to take the first step.

Each project can be contextualised to various aspects of your life, and each ‘context’ can be location-based using GPS. This way Omnifocus knows when you’re at home (‘paint shelves’), when you’re at work (‘arrange educational supervisor meeting’), or even when you’re walking past the supermarket (‘buy mustard’).

One of my favourite features is the ability to defer certain tasks once they are out of your control (for example, if you’ve sent an email and are waiting for a reply) and bring them back into view again once you’re required to respond. It seems obvious, but this minor tweak to the interface saves you scrolling through irrelevant tasks, making you feel more motivated and focused on the things that you are able to control.

Currently the app is limited in a clinical setting primarily due to confidentiality issues. Perhaps one day our archaic bleeps will be replaced with hospital-issue encrypted smartphones with apps such as Omnifocus to help co-ordinate tasks...but I won’t hold my breath.

RISE
By Sian Williams

Review by: Rosie Wilson

Rise describes itself as a “psychological first aid kit” and it’s easy to see how – to a certain reader – it could serve as just that. The autobiographical book follows BBC newsreader Sian Williams’ journey through the treatment of, and recovery from, breast cancer.

From a doctor’s perspective, it is interesting to see the patient’s perception of her medical journey. The book includes a lot of medical jargon, records of what was told to Williams, followed immediately by her confessions of feeling confused and overwhelmed. It can be easy to forget how alien all the information about a disease or condition is to a patient when you’ve been immersed in it for years.

Treat Rise almost as a manual, then; Williams talks in detail about the doctors she liked – and the ones she didn’t – and the differences in their treatment of her. Compassionate, matter-of-fact and not at all pandering, Williams’ accolades for her favourite doctors reflect the sort of praise we might want to hear about ourselves professionally.

From a general human perspective though, the reader is struck by the emotion and candour of the book. Williams’ interactions she has with her young children as they struggle to understand the situation. After all, medical professional or not, all of us have experienced – or will experience – cancer on a personal level at some point in our lifetimes, and it’s the relatability that makes the book so hard to put down.

Thanks to her background as a journalist, Williams understands the balance between facts and feeling. The book is an insight into the typical everyday thoughts of a patient going through long-term treatment – not just for cancer, but for anything that has an impact on day-to-day living.
Which one of the following is NOT part of the fire triangle:

a) Oxygen  
b) Carbon dioxide  
c) Heat  
d) Fuel  

What effect did the NSAID (diclofenac) prescribing have on Mr T’s renal condition?

a) It improved it directly  
b) It worsened it  
c) It had no effect  
d) Its drug to drug interactions improved it indirectly  

Atypical presentations of angina can occur more often in which one of the following groups

a) Younger people  
b) People with a family history of ischaemic heart disease  
c) Diabetics  
d) Men  

Regarding communication with patients which one of the statements reflects best practice

a) Face to face consultations are the best way of discussing sensitive information  
b) Written communication is always required when inviting patients for a consultation  
c) Do not highlight the importance of a matter in written communication  
d) Post results of blood tests to patients if they do not attend clinic appointments  

Which one of the following is the most accurate statement with regards to syphilitic eye disease

a) Syphilitic optic neuropathy occurs in 1/20 patients with decreased visual acuity  
b) Blood tests are adequate to diagnose neuro-syphilis  
c) Syphilitic optic neuropathy will lead to blindness even if adequate treatment is given  
d) Penicillin is the standard antibiotic used for the treatment of syphilitic optic neuropathy  

Slipped upper femoral epiphysis is most common in which age group?

a) 8-15 years  
b) 2-6 years  
c) 60-75 years  
d) 35-40 years  

Bearing in mind that BC did not have the requisite capacity to provide consent herself, the doctor (Mr C) required consent from BC’s parents prior to the original procedure. Which one of the following statements best describes the risks that Mr C would need to discuss with BC’s parents during the consent process

a) Minor risks only as providing information about the more serious risks may prevent BC’s parents from providing their consent  
b) The common risks  
c) The risks that Mr S felt to be important  
d) The risks that BC’s parents specifically asked about  
e) All the risks (whether minor or serious, common or rare) that would be relevant to BC’s parents in making their decision (whether or not they specifically asked about them)  

Which one of the following statements best reflects the preferred approach when handing-over the care of a complex patient at the end of the shift

a) Provide verbal and written instructions to all relevant staff in accordance with an agreed hospital handover protocol  
b) There is no requirement for any formal handover as this will impair the ability of staff to make an independent assessment of the patient’s condition and/or care requirements  
c) To provide a verbal handover to a single member of staff and allow them to disseminate any relevant instructions  
d) To provide a brief written summary of any relevant instructions in the patient’s records  
e) To delegate the task of handover to a junior colleague  

Which one of the following statements does NOT form part of the consent process?

a) An explanation of the proposed treatment  
b) A warning of the potential risks and complications  
c) A discussion of past surgical history  
d) A discussion of alternative treatment options.  

Which one of the following statements is true concerning documentation?

a) When recording a clinical examination, relevant negative findings do not need to be written down  
b) All entries should be dated, timed and the name of the author clearly documented.  
c) It is not necessary to make a separate note in the medical records where there are nursing records available.  
d) A signed consent form is sufficient evidence that valid consent has been obtained.
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