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EARN 3 CPD ETHICS POINTS THIS ISSUE! SEE PAGE 27
The annual MPS ethics event

Due to popular demand, MPS will be running three Ethics 4 All events in 2012. Don’t miss out on the chance to earn your entire ethics points for the year from these events.

**DURBAN**

**Sunday 4 November 2012**

**Venue:** Elangeni Hotel

**Time:** Registration from 8.30am for a 9.45am start – 12.30pm

In association with:

**KZNMC**

**PRETORIA**

**Monday 5 November 2012**

**Venue:** CSIR International Conference Centre

**Time:** Registration from 6.00pm for a 7.15pm start – 10.00pm

In association with:

**AMPATH**

**CAPE TOWN**

**Thursday 8 November 2012**

**Venue:** Cape Town International Convention Centre (CTICC)

**Time:** Registration from 6.00pm for a 7.15pm start – 10.00pm

In association with:

**Pathcare**

Why attend?

MPS is dedicated to keeping you up to date with your CPD/CME Medical Ethics, Medical Law and Human Rights points. You need to earn five points per year. Attending one of our events will earn your entire annual ethics points in one go.

**Cost:** These events are provided at no charge to MPS members

For more information and to register visit:

[www.medicalprotection.org/southafrica/events-and-workshops](http://www.medicalprotection.org/southafrica/events-and-workshops)
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GET THE MOST FROM YOUR MEMBERSHIP

MPS

Visit our website for further Casebook issues, a wealth of publications, news, events and other information:

www.medicalprotection.org

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Welcome

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

The level of performance a person is capable of attaining is dependent on finding the right balance between tension and support. Nowhere is this truer than in medicine, where high performance is expected and can literally be the difference between life and death.

No tension with no support creates a sense of apathy; excessive support alone can create complacency. Without urgency, determination and drive – why get out of bed in the morning?

On the other hand, high tension without adequate support creates high levels of stress, which we know can compromise performance.

In today’s environment, tension is on the rise: most doctors are working in increasingly challenging environments and few experience a proportionate increase in support. But access to support that matches the level of stress in the job is what is needed if we, as doctors, are to maximise our potential and do the best we can for patients.

A year ago we wrote in Casebook about the cause and effect of stress in medicine (“The pressure point”, Casebook 19(3)). The evidence is there to show that being involved in an adverse event, being sued for negligence, or having your professional conduct or competence brought into question is a source of the most severe tension for healthcare professionals. It is also associated with an increased risk of a second or third event. This issue of Casebook features many case reports that reflect these stressful situations.

At MPS we understand how important it is that the support we provide matches the tension caused by these events – it is at the core of what we do.
Providing a global perspective

MPS Medical Director Dr Priya Singh on MPS’s landmark conference

This November sees MPS host its two-day international conference on patient safety and risk – the first time we have held such an event for speakers and audiences from around the world.

A key part of MPS’s work, as the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and healthcare professionals, is informing and influencing the statutory and regulatory framework in which clinicians practise. Our aim in hosting the conference is to provide a platform to discuss international experience of how best to respond to the changing expectations surrounding healthcare.

The conference, Quality and Safety in Healthcare: Making a Difference, focuses on quality, safety culture, professionalism, cost and the patient experience. The latter is particularly pertinent in today’s climate as patient expectations continue to rise. There is perhaps no place where this has been more clearly demonstrated than in the increasing frequency, and associated cost, of clinical negligence claims.

We are delighted to welcome international experts in quality and safety from medicine and from other disciplines. The programme spans the breadth of policy and practical considerations, from questions such as what does quality mean, and is it affordable, to the implementation of tort reform and the management of adverse outcomes.

Speakers include Dr Lucian Leape, from the Harvard School of Public Health, who many will know and recognise as a leader of the patient safety movement. In particular, Dr Leape has been an outspoken advocate of the non-punitive systems approach to the prevention of error. We hope the conference will help to identify and share ways in which all in healthcare can be supported in achieving open and effective communication, even in the most challenging and stressful of circumstances in which we frequently practise.

A global perspective on safety and risk in healthcare gives us the best opportunity to pool learning and experience and to accelerate our progress. The first conference will be held in London on 15 and 16 November 2012, and we will look forward to hosting events around the world in the future, so if you have suggestions for conference content do please let us know.

To find out more about Quality and Safety in Healthcare: Making a Difference, and to book your place, visit http://mpsinternationalconference.org

IMPORTANT NEWS

Compounded life membership

In September last year, MPS’s previous Chief Executive, Tony Mason, announced a decision by MPS Council to discontinue Compounded Life Membership (CLM), in the interests of fairness to the wider membership.

This is a reminder that CLM will cease on 1 January 2014. Anyone who is a CLM member and still practising on 31 December 2013 will be required to pay the subscription appropriate for their grade and specialty to receive the benefits of MPS membership after that date.

CLM has been offered to members who have completed 40 years of paying membership, providing a waiver of the annual subscription for those still in practice. The decision to withdraw CLM was taken due to increased longevity and people working longer, therefore placing an unfair burden on paying members.

NEW COUNCIL CHAIR

Kay-Tee Khaw has been appointed the new Chair of the MPS Council. Kay-Tee has served on the Council since June 2011 and has a long and distinguished career. Visit the MPS website and click on “About MPS” for more information on Kay-Tee.
New contact details for South Africa

MPS members in South Africa can now access medicolegal advice direct from the central MPS advice centre, following some changes we have made to our services.

There is now a toll-free central advice line – 0800 982 766 – and a central email address – medical.rsa@mps-group.org – to which you can direct any request for medicolegal assistance.

This new direct access will be underpinned by our established panel of local expert lawyers and experienced medicolegal advisers. We have also developed an online form on our website, for members to complete with details of their medicolegal query. More information on this form can be found on the advert on page 23.

Membership of MPS continues to grow and, with more than 29,000 healthcare professionals in South Africa now subscribing to MPS’s services, these new methods of requesting support and advice will help us deliver on our commitments.

Membership advice
The contact details for obtaining information about your MPS membership remain unchanged – you can continue to call 0800 225 677 or email your query to mps@samedical.org.

Service
Your views are important to MPS. If you would like to provide any feedback about the new centralised contact points for medicolegal advice or make suggestions about improving the service and support we offer, please contact us on either of the numbers or email addresses above.

HPCSA campaign on patients’ rights

The HPCSA launched a campaign earlier this year to raise awareness of patients’ rights. The acting registrar of the HPCSA at the time, Dr Kgosi Letlape, gave a series of interviews in which he claimed that there had been a “decline” and “decay” in standards of ethics and professionalism.

MPS responded in a number of ways:

- Dr Graham Howarth, MPS Head of Medical Services (Africa), had a letter published in Business Day that responded to an interview that Dr Letlape made (this was featured in the May 2012 edition of Casebook)
- Dr Howarth met with Dr Letlape informally and had the opportunity to express his concerns in person
- A number of MPS members wrote to Dr Howarth expressing concerns – we wrote back reiterating our position.

MPS engages with the HPCSA on behalf of members. We will continue to do so with the new CEO and Registrar Dr Buyiswa Mjamba-Matshoba.

Legal Practices Bill

The Bill has been 15 years in the making. It seeks to unify and update the practices governing the legal fraternity, make the profession more representative of the country’s demographics and make legal services more accessible to ordinary people by capping legal fees.

It was tabled in Parliament at the end of May and the Department for Justice and Constitutional Development briefed the Portfolio Committee in early June.

Given the rise in clinical negligence costs in South Africa and the part that legal fees play in this, the Bill will be of interest. However, it is too early to tell what impact that this could have – but we will continue to monitor the Bill.

National Health Amendment Bill

The long-running Bill proposes to amend the National Health Act 2003 and seeks to empower the Minister to establish the Office of Health Standards Compliance (OHSC). This will be an independent body that will advise the Minister on the development and implementation of enforceable norms and standards for quality and safety of the entire health system.

MPS took part in a consultation on the Bill in 2011 and called for greater clarity on how the norms and standards that the OHSC are to implement are defined and how extensive they will be.

Public hearings on the Bill took place during this spring and the Bill is now being redrafted. MPS will continue to monitor the progress of the Bill.

Ethics 4 All events continue

Given the continuing rise in clinical negligence claims and the potential rise in complaints to the regulator, it is important that doctors receive straightforward and effective advice on how to avoid adverse outcomes.

MPS will host the hugely successful Ethics 4 All conferences in November. It will be its fifth year and for the first time they will be held over three sites (Cape Town, Pretoria and Durban). www.medicalprotection.org/southafrica/events-and-conferences
Disclosing patient records

Confidentiality is a fundamental right of all patients, but access to their medical records can be granted – for appropriate reasons. **Gareth Gillespie** looks at the issues involved

A common source of queries from MPS members in South Africa is uncertainty over when to disclose confidential patient information held within medical records. In a follow-up article to last issue’s feature on maintaining good patient records, we now look at the law surrounding confidentiality in records, and also consider the situations where you can disclose without patient consent.

Confidentiality

Patient confidentiality is enshrined in law – the National Health Act 2003 makes it an offence to disclose patients’ information without their consent, except in certain circumstances. These will be discussed later in the article. This right to confidentiality means more than simply refraining from divulging information – you are also responsible for ensuring that all records containing patient information are kept securely.

Sections 14, 15 and 16 of the Act are pertinent with regards to confidentiality. In particular, sections 15 and 16 describe how patient information may be disclosed by a healthcare worker “for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user”.

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

1. Patients have a right to expect that information about them will be held in confidence by health care practitioners. Confidentiality is central to trust between practitioners and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide good care.
2. Where health care practitioners are asked to provide information about patients, they should: 2.1 Seek the consent of patients to disclosure of information wherever possible, whether or not the patients can be identified from the disclosure; 2.2 Anonymise data where unidentifiable data will serve the purpose; 2.3 Keep disclosures to the minimum necessary.
3. Health care practitioners must always be prepared to justify their decisions in accordance with these guidelines.

Disclosures

There are circumstances – including a statutory duty to share certain information, such as reporting notifiable diseases – when you may have to disclose or allow access to information within a patient’s medical record. Not all these circumstances require you to obtain the patient’s consent. Examples are listed in this article but each situation must be assessed on an individual basis – and you must also document your actions and the reasons for doing so, whether you decide to disclose the information or not.

Consent must be obtained from the patient if access to their record has been requested by the HPCSA, an insurance company, employer or people involved in legal proceedings. If no such authority is forthcoming from the patient, no disclosure can be made.

Sharing of information within the healthcare team is usually assumed if the patient, for example, has agreed to being referred to a specialist. In this case, such sharing should be limited to a need-to-know requirement. Patients do have the right to request that certain information be withheld from a team, but many are unaware of this right – they should be made aware through leaflets, notices or verbal means.

HIV

Your record-keeping system should have a way of limiting access to information regarding the status of HIV-positive patients. The HPCSA says such information should be treated as highly confidential and specific consideration should be given to sharing this information with other professionals involved in the patient’s care.

Disclosures without consent

It is possible to disclose confidential information about a patient without their consent, if there is a sufficient risk to public health. The HPCSA says the risk of harm must be serious enough to outweigh the patient’s right to confidentiality. You should always try to obtain the consent of the patient first, but disclose...
Anyway if consent is not forthcoming. Again, your reasons for disclosing this information must be documented. The same applies in cases where you suspect a vulnerable patient – such as a child or adult lacking capacity – is at risk of abuse or neglect. The patient’s best interests are the overriding factor in such situations, and any concerns must be reported to the relevant person or agency.

**Access to records**
The Promotion of Access to Information Act 2000 gives everyone the right of access to records held by public or private bodies, provided it is for legitimate reasons. This includes health records. Either the patient or someone authorised to act on the patient’s behalf can request access, and the request must be responded to in 30 calendar days. The Act says that the request should be refused if the disclosure to “the relevant person might cause serious harm to his or her physical or mental health, or well-being”. Relatives other than parents have no automatic right of access and any requests for information should only be granted with the consent of the patient.

Parents and guardians of children aged under 12 can gain access to their child’s medical records if they request it. An exception is if the child has had a termination of pregnancy, which should remain confidential unless the child consents to its disclosure. Children aged 12 or over, and who have the maturity to understand the consequences of disclosure, must give their consent to the disclosure of their medical records.

The police have no special right to access clinical records. However, they can be granted access if the patient consents to the disclosure; if the information has been requested by a court order; or if – as with risks to public health – the public interest outweighs the patient’s right to confidentiality.

Solicitors may also request access to a patient’s medical records, in situations where they are handling a claim – again, the consent of the patient is needed before any disclosure. If the solicitor is acting on behalf of the patient, it is safe to assume that the request is being made on the instructions of the patient – although a signed consent form clarifying this is preferable.

**Conclusion**
While the importance of confidentiality in the doctor–patient relationship cannot be underestimated, it is equally important to be aware of the range of circumstances where you may be asked to disclose confidential information from or provide access to your patients’ medical records. That said, it is not possible to cover every unique scenario and while there are sometimes definitive rules you must adhere to, in some cases your course of action is not so crystal clear. You should remember to contact MPS for specific advice if you are faced with such a dilemma.

**REFERENCES**
2. HPCSA, Ethical Guidelines for Good Practice with Regard to HIV (2008), para 5.
3. Promotion of Access to Information Act 2 of 2000, section 61(1)

The police have no special right to access clinical records. However, they can be granted access if the patient consents to the disclosure.
If you are a member who has had few, if any, cases in the past, you might look at your subscriptions increasing and find yourself asking: “Am I subsidising colleagues who need MPS’s services disproportionately?” Such a reaction is understandable.

Why do some doctors experience more claims than others?

There can be many reasons why doctors have a higher-than-average number of cases. Some doctors face additional problems largely because of where they practise, the patients they treat, or the specialty in which they work. Some doctors go through periods in their career where additional pressures are created by health problems, social or domestic upheavals, financial difficulties or other factors. Others, however, do need help to improve poor practice.

As a mutual organisation, our first instinct is to help and support members through such difficult times. We all appreciate how stressful it is to have even a single complaint and for those who are experiencing a lot of problems, we find that the impact on them is greater than just in their professional lives.

However, it makes little sense to wait until something bad happens and needs to be paid for – and more sense to invest in the prevention of problems in the first place. As a responsible organisation, with a duty not only to an individual member but also the membership as a whole, we must be responsible in using the subscriptions paid by members. For this reason, MPS has developed educational programmes based on more than 100 years’ experience in this field, aimed both at helping all members and at providing that extra help that a small proportion of members will need.

Helping those in need

As part of our service, our medicolegal staff review every case and we aim to provide guidance to members if lessons can be learned from what has happened. If there are a number of repeat cases with a similar theme, we may recommend specific types of learning or training courses, which we believe will be of assistance to members in avoiding problems in the future.

In addition, there are a very small number of members who we invite to enter our Membership Governance Programme. These are members who have a significant adverse risk profile particularly in relation to claims. We aim to work with them to try to reduce the likelihood of future claims or complaints arising. Depending on an assessment of their individual needs, we may require compulsory attendance on an intensive course, or we may place some restrictions on their benefits of membership in order that they can remain in MPS membership. Those in Membership Governance also pay an enhanced subscription, reviewed annually as part of continuing risk assessment. We believe that as these members are more likely to be at greater risk of future claims, they should contribute more to the mutual fund.

Through working with individuals on the Membership Governance Programme, we can try to mitigate risk for the whole of our membership. Those who refuse to accept the help offered will not be able to remain members of MPS. We expect that individual members experiencing difficulties should be prepared to take reasonable steps to work with MPS to help themselves. As in all walks of life, there will be a very small number of members who cannot, or will not, change their risk profile and in such circumstances may be unable to continue in MPS membership.

The overall aim of Membership Governance is to help the individual member suffering more problems than their colleagues, and to protect the assets of the mutual fund for which MPS is a custodian, so that members are not subsidising colleagues who need MPS’s services disproportionately.
An example of the type of course which a member may be asked to attend as part of the Membership Governance Programme is the three-day Clinical Communication Programme (CCP) workshop created by MPS Educational Services. The workshop focuses on improving communication skills and is followed-up with a six-month period of educational support.

Members who have attended the CCP have been encouragingly positive about the value of its content. Dr A said: “It made a real impression on me and made me aware of my shortcomings,” and surgeon Dr M said: “The CCP was very helpful; it points out the difference between real and perceived communication skills.” Other members revealed that the changes they have been able to implement in their communication with patients since attending the programme included moves to: “listen more”, “discuss various treatment options”, and “repeat, summarise, and question the patient to help with decision-making”.

Often, there may be a degree of anxiety, even resistance, amongst some members about being entered into the Membership Governance Programme. However, the intention of the programme is to work with members to mitigate potential future risk. Every member who is experiencing problems is encouraged to call and speak to our team about their cases and about any special circumstances which may have given rise to them.

When providing feedback, one member was very honest about their initial – negative – response to the programme, which makes their eventual appreciation all the more positive: “I am sure I had the typical response and resistance to the programme. It is without doubt one of the most invaluable courses I have done that has probably had more impact on my practice than any other. In hindsight (the best sight), I am grateful for being awarded the opportunity to do the CCP.” The impact of the CCP is improved communications, a better identification of high-risk areas in clinical practice and, most importantly, an improved doctor–patient relationship.

GPs or others with an increased risk profile may be recommended to undergo a Member Risk Assessment, provided by MPS Educational Services. Here, the purpose is to assist in identifying existing and potential risks in their medical practice and throughout the surgery as a whole, and to make recommendations for change in line with national guidance and good practice.

Following a recent Member Risk Assessment, where the test results system was found to be unsafe, recommendations were made, and the member wrote to inform MPS that their practice now had a computerised “tracking system” to ensure that patients do not get lost in the system and there is adequate follow-up.

For more detailed information on how the Membership Governance Programme works, see the article “Introducing Membership Governance” in Casebook (Vol 19 no 1 – January 2011):

www.medicalprotection.org/southafrica/casebook-january-2011/introducing-membership-governance
Nasogastric tube errors

Nasogastric tubes are widely used in the world’s hospitals, yet in spite of fierce campaigning to expose the dangers, patients are still dying from the complications of wrongful insertion. Sara Williams and MPS medicolegal adviser Dr Gordon McDavid explore how to avoid these risks.

In 2010 75-year-old Maurice Murphy died in hospital as a result of a misplaced nasogastric tube. He was being treated for liver failure and required a nasogastric (NG) tube to be inserted. Unfortunately this ended up in his right lung instead of his stomach and feeding commenced, resulting in fatal pneumonia.

At the inquest it emerged that a junior doctor was challenged by a nurse to confirm that the tube was in the right place. The doctor in question overruled her, saying: “You don’t have a brain to remember that I told you to start the feed as the tube is in the right position.” It also emerged that there was an x-ray flagging the error.

So why hadn’t anyone seen it?

It would appear that a combination of factors led to the death of Mr Murphy – the misplaced confidence of the junior doctor, the fact the standardised procedure for inserting a tube was not followed, and that the x-ray was not reviewed.

NG tubes are commonly used across the world to treat stroke patients with dysphagia or those on ventilators, and are generally accepted as being safe pieces of equipment. They are used in the short to medium term (six weeks); longer term feeding usually requires insertion of gastrostomy or jejunostomy tubes (PEG or PEJ). Although feeding by NG tubes is not routinely captured in activity data, in the UK alone around 170,000 tubes are supplied to the NHS each year.

Many practitioners may not have considered the real potential for harm that these innocent-looking plastic tubes may present, particularly if they are misplaced in the patient’s oesophagus or, worse, a bronchus.

NG tubes are inadvertently caused a pneumothorax using an NG tube while working in a busy teaching hospital. “I was bleeped just before my shift ended and asked to check the position of an NG tube my consultant had inserted into a female patient who was nil by mouth due to an unsafe swallow post-stroke. The CXR showed that the tube was in the left bronchus. “Unfortunately, I had to free the tube from the bridle it had been attached to before removing it. To reinset the tube I couldn’t use the standard technique of having the patient swallow and so went blindly. The first time it coiled in her mouth, the second time it inserted smoothly without any resistance. As we were unable to aspirate any contents she went for a further chest x-ray to confirm the position.

“I came in after the weekend to find that I had unwittingly caused a pneumothorax and still have no idea how. Fortunately the patient received no lasting damage.”

RISKS OF NASOGASTRIC TUBES

The ‘whoosh’ or ‘blow’ test

The UK’s National Patient Safety Agency (NPSA) issued guidance in 2005 highlighting the unreliability of certain tests to detect the placement of NG tubes, such as the ‘whoosh’ test (listening for bubbling sounds after blowing air through the NG tube with a syringe) and pH testing by non-quantitative, coloured litmus paper. The NPSA recommend pH testing using pH indicator paper as a first-line check – pH levels between 1 and 5.5 are safe.

Misinterpretation of x-rays

Between 2005 and March 2011 the NPSA was notified of 21 deaths and 79 cases of harm due to misplaced NG tubes. The single greatest cause of harm was due to misinterpretation of x-rays, accounting for about half of all incidents and deaths.

A chest x-ray is required if the first-line check fails to prove the NG tube is safe for use.

Flushing nasogastric tubes

The NPSA recently highlighted the deaths of two patients, where staff had flushed NG tubes with water before the initial placement. The mix of water and
Between 2005 and March 2011 the NPSA was notified of 21 deaths and 79 cases of harm due to misplaced NG tubes

Recurring problems
According to Sir Liam Donaldson, Patient Safety Envoy for the World Health Organisation, recent findings indicate that NPSA guidance is not being heeded, such as feeding despite obtaining nasogastric aspirates with pH between 6 and 8, instilling water down the tube before obtaining an aspirate, not checking tube placement or not recording written confirmation of such checks.

Sir Liam said: “An NPSA audit suggested great variation among 166 junior doctors at five pilot hospital sites in England and Wales, with low awareness of harm and continued use of checks, such as the ‘whoosh test’ or blue litmus paper, as bad practice. Fewer than a quarter were aware of existing guidance and less than a third of the junior staff had received formal training on x-ray interpretation.

“Because of the preventable nature of this harm, last year misplaced nasogastric tubes were confirmed by the Department of Health in England as a ‘never event’, one of a restricted list of serious avoidable events that could incur financial penalties for providers.”

England and Wales are not alone; other countries such as Malaysia routinely use the ‘whoosh test’ to detect the placement of NG tubes.

CASE REPORT

Think before you sleep

Mr S was a 70-year-old librarian who had a long history of recurrent colitis due to Crohn’s disease. Despite maximal medical treatment, he experienced recurring symptoms of severe abdominal pain and rectal bleeding, so was admitted to hospital. Following a period of parenteral steroid therapy, Mr S’s bleeding continued and he required an exploratory laparotomy. Prior to surgery a barium enema revealed a discrete area of abnormal bowel, which was felt to be responsible for his symptoms. It was hoped that the inflamed section of bowel could be surgically resected. Mr S underwent a pre-op assessment by anaesthetist, Dr P. He was noted to have a history of angina and COPD, but these chronic conditions were stable.

On the day of surgery, the operation took place without complication and Dr P inserted a NG tube. As Mr S was intubated, Dr P used a laryngoscope and Magill’s forceps to insert the NG tube. Dr P had performed this procedure many times before and felt confident to do it independently. During the insertion, Dr P found it difficult to visualise the proximal end of the oesophagus, but based on the smooth insertion assumed the NG tube was in place.

On arrival in ICU, Dr P still needed to confirm the position of the NG tube. Unable to aspirate fluid, he wanted to auscultate the stomach while instilling air through the NG tube (the ‘whoosh’ or ‘blow’ test) – this was in line with the local protocols at the time. As Mr S had had a laparotomy, Dr P was unable to access the epigastrium to carry out this manoeuvre due to a large wound pad covering the area. Dr P decided to arrange a chest x-ray. Due to a backlog in the radiology department, the x-ray was not carried out before the end of Dr P’s shift. Dr P handed over the task of reviewing the film to the nightshift trainee, Dr A. Unfortunately, Dr P failed to inform Dr A that the x-ray was to check the position of the NG tube. Dr P had not documented the NG tube insertion.

Following the handover, Dr A noticed a leak from Mr S’s endotracheal tube and injected approximately 1ml of air into the tube’s cuff. Dr A was called away to an emergency, but instructed one of the nurses to observe Mr S. The results of Mr S’s chest x-ray arrived, but Dr A was very busy. She glanced at the x-ray, verbally informing the nurses that it “looked ok”, referring to the ET position as “satisfactory” and the lungs looking “grossly normal”. She did not document this in the notes.

Unfortunately, Mr S had to return to theatre for an anastomotic leak repair and subsequently required prolonged intubation, blood transfusions, IV fluids and inotropic support after the second surgery. With treatment Mr S’s haemodynamic parameters stabilised although he began to develop renal failure. Consultant anaesthetist Dr W took the decision to begin feeding. During this time, the original NG tube remained in-situ and no-one realised the initial chest x-ray had not been formally reviewed.

About 12 hours later, Mr S’s nurse aspirated feed-like material from his ET tube and feeding was immediately stopped. Dr A was asked to review the patient. Radiology then phoned to advise that the chest x-ray taken before the weekend showed the NG tube was positioned incorrectly. Despite aggressive treatment for aspiration pneumonitis, unfortunately Mr S died two days later.

The outcome
The postmortem outlined the cause of death as aspiration pneumonia due to a misplaced nasogastric tube in right main bronchus, left hemicolectomy for intestinal haemorrhage, ischemic heart disease and chronic obstructive airways disease. Dr P and the nurses involved were interviewed by the police under caution, but following an investigation it was agreed that the level of care, although suboptimal, did not meet the necessary criteria for a criminal offence.

Two years later, the practitioners involved were called to an inquest and MPS arranged legal representation for Dr P. Dr P accepted that it was his omission not to have specifically recorded the NG insertion in the notes. The magistrate took no further action, as she was satisfied that preventative systems had been implemented by the hospital. Mr S’s wife subsequently launched a claim against the hospital, which was settled for a moderate sum.
MPS strongly advocates mandatory documentation of the method by which the NG tube’s position is confirmed.

AVOIDING THE RISKS

Individual clinicians should consider the following:

■ Is nasogastric feeding right for this patient? – Seek specialist advice if the patient has a high risk of aspiration or any deviation to normal anatomy, such as pharyngeal pouch, strictures or facial trauma, in which cases fluoroscopic guidance can often be used. The decision to feed should be agreed by two competent professionals and recorded.

■ Does this need to be done now? – Risks are greater during the night.

■ Am I competent to do this? – Ensure you have had training in safe insertion and checking, including interpretation of x-rays.

■ How can I check the right amount of tube has been inserted? – Use “NEX” measurement (by placing exit port of tube at tip of Nose, stretching to Earlobe and then down to Xiphisternum) to guide insertion. The tube length should be confirmed and recorded before each feed to check it has not moved.

■ Do I know how to test for correct placement? – Do not flush tubes or start feeding until you can confirm by testing with quantitative pH indicator paper.

■ What is a safe pH level? – Obtain a nasogastric aspirate (pH levels between 1 and 5.5 are safe). Double-check with another person if you are unsure. Always record the result and the decision to start feeding.

■ When should I get an x-ray? – If no aspirate can be obtained or the pH reading is above 5.5, request an x-ray specifying the purpose so the radiographer knows the tip of the NG tube should be visible.

■ What should I look for on the x-ray? – That the tube is in the correct position (see guide in Figure 1).

■ What about repeat checks? – Tubes can be dislodged so they should be checked every time they are used, by aspirating and confirming a low pH, and only x-raying if this is not the case.

Organisations and managers can make systems safer by:

■ identifying a clinical lead to implement actions

■ reviewing existing policies and training and competency frameworks (eg, ensure a doctor with sufficient seniority is responsible for signing off the use of NG tubes)

■ ensuring stock of correct equipment (approved pH indicator paper and radio-opaque tubes with clear length markings)

■ restricting procedures done out-of-hours.

MPS strongly advocates mandatory documentation of the method by which the NG tube’s position is confirmed. Documenting confirmation of correct placement should safeguard against accidental and potentially catastrophic use of NG tubes.

New developments

Further clinical research is needed in this area, but small studies have suggested that magnet-tracking devices, where a magnet is inserted into the tube tip, may hold promise for the future.3 In the meantime, no existing bedside methods are completely reliable in testing the position of NTs, so being mindful of the complications will mitigate the dangers.

Thanks to Sir Liam Donaldson and Dr Sukhmeet Panesar from the NPSA for their help with this feature.

REFERENCES


2. NPSA, Reducing Harm by the Placement of Nasogastric Feeding Tubes (Feb 2005) – www.nrls.npsa.nhs.uk/resources/?EntryId45=59784

3. NPSA, Harm from Flushing of Nasogastric Tubes Before Confirmation of Placement (March 2012) – www.nrls.npsa.nhs.uk/resources/type/alerts/?entryId45=133441

4. Mayor S, NHS extends never events list and introduces cost penalties, BMJ (2011;342:d1263)

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:

**WHAT’S IT WORTH?**

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

Dr Graham Howarth, Head of Medical Services (Africa), introduces this issue’s round-up of case reports, a number of which feature problems with diagnoses and investigations.

“Skipping over the details”, on page 14, carries a warning about the dangers of falling foul of the ‘HALT’ mnemonic – Hungry, Angry, Late, Tired. Dr G was reported by his patient, and the patient’s wife, to be tired and dismissive during his consultation, and it appears that this may have played a part in Dr G falsely reassuring his patient Mr K. He also failed to keep an adequate note of the consultation, leaving little opportunity to investigate Mr K’s account of what happened.

Poor investigations were also the cause of a delayed diagnosis in “Squash and a squeeze”, on page 18. The failure by GP Dr V to carry out a squeeze test on the patient’s calf led to a delay in diagnosis of an Achilles tendon rupture – a diagnosis that was only made following referral to an orthopaedic consultant. In “Missed ectopic pregnancy”, on page 21, an ectopic pregnancy was missed after a young doctor in the emergency department, Dr Y, failed to request pregnancy tests on two occasions. Dr Y also failed to seek assistance from the on-call gynaecology team, despite the patient presenting with abdominal pains having undergone a recent termination of pregnancy.

Amid the steady stream of costly settlements in Casebook, it can be easy to forget the instances where we successfully defend our members from claims. Discovering where the doctor went right is often as valuable a learning tool as discovering where the doctor went wrong, and in “A pain in the leg” on page 16, we demonstrate the value of good record-keeping. Dr C’s failure to diagnose DVT was defended by her excellent clinical records, which revealed that she had done everything she could possibly have done.

Similarly, in “A complication, not negligence” on page 20, record-keeping again allowed us to defend our member from a claim. The allegation of bad management following the unfortunate neurological complication suffered by Baby R was refuted by comprehensive clinical notes, which clearly described the level of observation of Baby R post-surgery. The consent process was also well-documented, which showed the parents were fully aware of the potential for neurological damage. “A frozen shoulder” rounds off this issue’s case reports on page 22, showing how adverse outcomes are not always necessarily negligent.

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One night Mr K, a 37-year-old bricklayer, felt a lump in his testicle. Worried, he decided to attend the emergency surgery on Saturday with his wife to have it checked.

When Mr K arrived at the surgery, he was seen by Dr G as his last patient. The consultation was short, only lasting a few minutes. Dr G examined Mr K briefly and reported his finding to them as “just a little gristle that will go away with time”. He did not give any particular advice. He added that there was “nothing to worry about” and he wrote in his medical notes “testicular examination: NAD”. Dr G appeared disgruntled that Mr K had used the emergency appointment for a routine check-up. Mr and Mrs K later reported that Dr G had appeared dismissive and tired throughout the brief consultation.

One year later, Mr K attended his GP surgery with a painless hard lump in his neck. Further investigations and referrals led to Mr K being diagnosed with a testicular choriocarcinoma. Despite treatment Mr K died two years after the diagnosis.

A claim was made against Dr G regarding his management of Mr K. The experts agreed that earlier diagnosis would have improved Mr K’s prospects and they were very critical that Dr G didn’t advise on any further follow-up or investigations; the case was therefore settled for a substantial sum.

**LEARNING POINTS**

- Unplanned appointments are inherently high risk, so writing good notes is even more important in this setting. On this occasion the records did not help resolve the factual dispute in the case. The medical notes should always reflect the clinical findings. If there was a palpable lump described as “gristle” to the patient, the clinical notes should have made a mention of it.
- MPS has considerable experience of claims that have arisen from factual disputes between patients and doctors. This case emphasises the importance of making as full a note as you can, particularly if you cannot find what the patient is reporting.
- In this case the patient presented as an emergency, which would have been taken into account in assessing the honesty of his assertion that he was acutely worried.
- It has been recognised that delay in presentation is an important factor in men with tumours. Even if the clinical findings are clear then men should be given advice, which is documented in the notes, to seek attention again if they have any concerns.
- Always be mindful of how human factors can affect your performance. Remember the HALT mnemonic (Hungry, Angry, Late, Tired); where possible anticipate these and take action to mitigate their impact.
- Where they are unexpected then be prepared to seek the opinion of your colleagues or bring patients back at the earliest opportunity to fully address their needs.
- Most patients present with a painless, solid, unilateral mass in the scrotum or an enlarged testicle. However, it is worth being aware that there can, rarely, be a decrease in testicular size. Around one in five men with tumours will have pain at presentation. The SIGN guidance Management of Adult Testicular Germ Tumours provides advice on the diagnosis and presentation of testicular tumours – www.sign.ac.uk/pdf/sign124.pdf. The guidelines recommend that anyone with a lump or doubtful epididymo-orchitis or orchitis not resolving within two to three weeks should be referred urgently for urological assessment.
A 45-year-old woman, Ms B, suffered from severe heartburn and was referred to consultant general surgeon Dr X. He undertook an upper gastro-intestinal endoscopy, which demonstrated erosive oesophagitis above a large sliding hiatus hernia. Ms B’s symptoms were not controlled with maximal medical therapy and therefore Dr X recommended anti-reflux surgery. He subsequently performed a laparoscopic fundoplication, but Ms B continued to have significant reflux symptoms and was unhappy with the results of her operation. At two years after the initial surgery, Ms B was desperate for further intervention but had now started smoking and had put weight on to the point that her BMI > 40.

A further consultation with Dr X resulted in a repeat endoscopy, a barium swallow, oesophageal manometry and 24-hour pH monitoring. These investigations demonstrated a recurrent hiatus hernia with a breakdown in the fundoplication resulting in marked recurrent gastro-oesophageal reflux disease. Ms B agreed to a further revision laparoscopic fundoplication but Dr X was unable to complete the procedure laparoscopically due to the presence of multiple adhesions. Dr X decided against an immediate conversion to open surgery as he had not discussed this with the patient or documented it on her consent form.

Three days later, after further discussion with Ms B and completion of a more detailed consent form, Dr X performed a laparotomy and a difficult revision anti-reflux operation requiring partial resection of the gastric fundus. Ms B developed a severe abdominal wound infection and experienced a stormy and prolonged postoperative recovery. There then followed several readmissions, culminating in a major plastic surgical procedure to reconstruct her abdominal wall.

Ms B made a claim against Dr X, alleging negligence in the management of her case. Expert opinion was obtained and there was agreement that the indication for revision anti-reflux surgery and preoperative work-up had been satisfactory. However, the process of consent was criticised in several areas. The failure to warn Ms B of the possibility of an open conversion was felt to be a significant failing, causing a three-day delay and requiring another operation and anaesthetic. There was also no evidence of any preoperative discussion regarding the risks of infection or gastric resection, even before the second procedure. It was additionally felt that Dr X should have given more consideration to Ms B’s high BMI and smoking habits as potentially reversible risk factors for postoperative complications. The case was settled for a moderate amount.

**LEARNING POINTS**

- The process of consent for any operation should be a detailed conversation between clinician and patient with documented evidence. The incidence and potential impact of any common and potentially serious complications should always be discussed and documented.
- Patients should be made aware of any aspect of their health or lifestyle that may adversely affect the outcome of an operation, particularly where action could be taken to optimise such conditions before surgery. In this case, preoperative weight loss and smoking cessation may have averted or lessened the extent of the subsequent complications.
- Postoperative infection is not necessarily a sign of negligence or substandard care. In this case, although some responsibility for the infection could be attributed to the patient’s body habitus and smoking, it was the failure by the surgeon to specifically warn Ms B of this risk that may have constituted substandard care in the quality of consent taken.
- Any laparoscopic operation, no matter how minor, may not go to plan, necessitating an open conversion. Patients should always be made aware of this with any consent form clearly reflecting the discussion.
- Consent for procedures should be a personalised discussion so that the information given to patients includes not only the general and procedure-specific risks, but is also tailored to the specific values held by the individual patient. With revision anti-reflux surgery, adhesions and scarring from the original surgery may increase the risk of damage to organs such as the liver, spleen or stomach (as in this case) with a variety of clinical consequences, including resection. Dr X should have warned Ms B about this.
Miss Y was a 36-year-old housewife with three children. She presented at her GP surgery with spontaneous pain in the leg, which was associated with a cramping sensation and pins and needles in her left foot. Miss Y saw her GP Dr C, and upon entering the consultation room raised the possibility of DVT, as she had been recently reading about DVTs in the news and her symptoms appeared similar. Dr C took a careful history and, with Miss Y’s suggestion in her mind, concentrated particularly on the possibility of a DVT. She asked if there was any swelling of the legs, shortness of breath, chest pain or haemoptysis. Miss Y had confirmed that she had none of these symptoms. She asked if there was any personal or family history of thromboembolism, which there was not. She also asked about smoking history and Miss Y had stated that she had never smoked. Dr C also examined Miss Y thoroughly. She had found her pulse to be 70 beats per minute and her respiratory rate to be 12 breaths per minute. She noted that Miss Y’s chest was “clear to auscultation”. She had measured calf circumferences and found them to be equal. She had also documented that she could palpate normal pulses in both her legs and feet. Dr C could not find anything wrong but had written that she had told Miss Y to reattend if she developed any swelling in the legs, shortness of breath, chest pain or haemoptysis.

Ten days later, Miss Y collapsed suddenly and was found dead at home. The postmortem found the cause of death to be a pulmonary embolus secondary to a DVT. Her family were devastated and brought a claim against Dr C because of failure to diagnose. Dr C could not remember the case but her note-taking was excellent. She had documented a thorough history, a full examination and sensible safety-netting advice. Despite the fact that she did not make a diagnosis of the DVT, the case was found to be defensible because Dr C had done everything she could and should have done.

The case was successfully defended.

LEARNING POINTS

- Good note-keeping is not only good practice, but it will make a possible defence much easier if needed.
- A DVT can be difficult to diagnose clinically and GPs should have a low threshold for referring patients for ultrasound scanning to either confirm or refute the diagnosis.
Mr F, a 45-year-old executive manager in a major sales company, saw his GP, Dr D, for a cold. The GP noted from the records that Mr F had attended three times prior to this for minor ailments. His blood pressure that day was 150/90mmHg and his BMI was 36. Dr D arranged a cholesterol test, gave some lifestyle advice and asked him to reattend to recheck his blood pressure. Mr F did not attend the follow up appointment with the healthcare assistant for a blood pressure check.

Six months later, Mr F attended surgery again and was seen by a different doctor in the same practice. Looking at the notes, the patient had attended and received treatment for minor ailments six times since his last attendance at the practice. His cholesterol was significantly raised on the blood test taken six months ago and it appeared a note had been sent to the patient to discuss the result. When asked about this, Mr F explained that he had received the note but that he had had the same test done at his in-house occupational health department, with whom he had discussed the result, and that he had been also seeing them for minor ailments. Once again, Mr F’s BP was raised but was significantly higher than before and the GP was concerned, despite Mr F’s protests that it was likely because he was a “bit stressed”. The GP and Mr F discussed the best management option and the GP decided to refer Mr F to cardiology based on this high reading, and started Mr F on an antihypertensive. Mr F failed to attend the appointment.

Two months later, Mr F had an episode of indigestion. At the consultation with his occupational health doctor, when asked whether he was on any medication, Mr F said he was taking none. He was given antacids. However, he continued to have pain for three days on and off. He then suffered a cardiac arrest and unfortunately could not be resuscitated. The postmortem showed myocardial infarction.

Looking back over his notes, there had been repeated blood pressures recorded in his notes from various appointments at the practice, the occupational health department and emergency services, and readings had been steadily increasing, without the instigation of a proper management plan and with inadequate follow up.

A claim was made against all doctors involved. The case was settled for a substantial sum reflecting Mr F’s age and the fact he was a high earner.

MR

LEARNING POINTS

- When patients use multiple doctors for care, there is a risk of concern for their symptoms being diluted by spreading the consultations across a number of healthcare providers. This can be a particular problem with people with demanding jobs, and where employers provide a work-based health service. It is important to work together and communicate with colleagues. The occupational health service should inform the patient’s GP, with the patient’s consent, and it should be clear who will be following up – usually the GP.
- When patients attend multiple times for minor ailments, it may be worth addressing this in the consultation and explaining alternatives, to avoid a lack of continuity of care.
- Any advice given to non-compliant patients should include the risks of failing to take medication or attend appointments, and should be documented.
- Arranging follow-up for any appointments missed or medication started makes practice safer. In this particular case, the patient missed an outpatient appointment and a GP appointment and was not followed up for either non-attendance to find out what happened.
- With poorly compliant patients, or those who are difficult to track, it is important to take advantage of opportunistic follow-up, and perform routine checks, such as blood pressure.
Case Report

Forty-seven-year-old shop assistant Mr U had noticed a persistent pain in his heel for several months, which deteriorated suddenly whilst playing his weekly game of squash. It took him two weeks before he attended his local casualty, where he was x-rayed and diagnosed with a bony spur on his calcaneus. He was advised to rest and to follow-up with his own GP if it did not resolve.

For the next three months, the symptoms continued and Mr U saw his GP Dr V on several occasions to have his leg examined. He distinctly recalled two separate episodes of acute heel pain when he was playing squash, which he felt had precipitated his ongoing symptoms. No weakness or immobility was noted, and the pain appeared to be isolated to the heel only. Reassured by the normal x-ray and unremarkable examination, Dr V recommended further conservative treatment.

Unfortunately, Mr U’s heel pain did not resolve and he reattended a few weeks later complaining of swelling and erythema of the calf on the affected side. A definitive diagnosis was not obtained, and over the course of several weeks he was investigated for DVT on two occasions and commenced on antibiotics for suspected cellulitis. Three months after the initial event, symptoms remained much the same and Dr V sent Mr U to see an orthopaedic consultant in clinic. The orthopaedic surgeon made a clinical diagnosis of an Achilles tendon rupture, which was then confirmed with a soft tissue ultrasound. Mr U required surgical repair of his injury and made a very slow recovery with various complications. He made a claim against Dr V for the delay in diagnosis.

The case was complex since it was considered that it was not a case of sudden rupture of the Achilles, with the more recognisable associated signs, and it would have been very difficult for the GP to make an early diagnosis, especially as the patient did not present immediately following injury. It was further complicated by the fact that there was no mention at all of a calf squeeze test having been performed, so it was difficult to judge at what point the tendon finally snapped.

Expert evidence was sympathetic to the unusual presentation of the case, but felt that there were weaknesses in the case because there was no documentation of the squeeze test. The case was therefore settled for a moderate sum.

Learning Points

- No matter how careful you are and how much effort you take on dealing with your patients in an appropriate manner, things sometimes do go wrong. Most doctors will have at least one claim against them during their practising lives.
- Documenting consultations thoroughly is essential. Keep records of any specific test or examination carried out – “whatever is not written has not happened” is a good safety motto.
- The calf squeeze test is used to examine the integrity of the Achilles tendon. The patient lies prone with the foot extended beyond the edge of the examination couch. The examiner squeezes the calf and watches the foot for mild plantarflexion in a normal exam. Lack of ankle movement can indicate rupture of the Achilles tendon.
Mr T was a 50-year-old successful interior designer. He was taking 5mg of warfarin daily for recurrent DVTs and regularly visited the warfarin clinic for INR checks. The clinic found his INR to be above target and he was advised to omit the following day’s medication and then go back to his usual dose. He was asked to return for an INR check after ten days.

Three days later Mr T started suffering with neck and back pain, which was very unusual for him. He was an enthusiastic cyclist and was used to “aches and pains”. The pain became quite severe quickly and he didn’t feel able to cycle to his GP’s surgery so he rang his GP to request a home visit, which was arranged for the same day. Dr B saw Mr T at his apartment and took a history of his complaint. He had developed back pain quickly and he didn’t feel able to cycle to his GP’s surgery so he rang his GP to request a home visit, which was arranged for the same day. Dr B saw Mr T at his apartment and took a history of his complaint. She had examined Mr T fully and noted that his gait was normal and that he had full range of movement in his back and neck. She also documented that his tone, power, sensation and reflexes were normal in both legs. Dr B gave Mr T some diclofenac to ease the pain and spasm but advised him to contact the surgery if things did not improve.

Mr T felt reassured but within a couple of hours of Dr B’s departure his back pain became even more severe. He panicked when he suddenly lost sensation in his legs and was incontinent of urine. He called an ambulance, which took him straight to casualty. The doctors at casualty did some urgent investigations and found his INR to be 10. Scans showed an extensive extradural haematoma. Mr T had to have emergency surgery to remove the haematoma within the vertebral canal but outside the dura which was causing compression of his spinal cord. Despite the surgery Mr T was left in a wheelchair and needed extensive rehabilitation.

Mr T was understandably devastated because he would never walk or cycle again. He made a claim against the clinic and also Dr B for having contributed to the high INR causing the haematoma and for not recognising his neurological symptoms.

During the case Dr B admitted that prescribing diclofenac to a patient on warfarin is contraindicated, but the experts commented that the INR could not have been affected that quickly by the diclofenac, so Dr B’s error did not cause the injury. Dr B’s notes were very comprehensive and aided her defence regarding the lack of neurological symptoms and signs.

The case was settled by the clinic, but the allegations against Dr B were successfully defended.

**LEARNING POINTS**

- Home visits can be particularly tricky since you do not have the usual tools to elicit information about the patient. If possible, read patients’ notes carefully before setting off on a visit and take a printout with you, listing past medical history and the patient’s medications and allergies.

- Full examination, including a neurological assessment, should be undertaken in all patients with severe back pain to exclude cord compression. Spinal cord compression is a surgical emergency. The outcome of treatment depends on a timely diagnosis.

- As the proportion of older people grows, there will be more patients on multiple medications. Polypharmacy goes hand in hand with the increasing risk of drug interactions. Be aware of the risks of patients on anticoagulants.
A complication, not negligence

Baby R presented at 18 months of age with a fit. He seemed otherwise healthy, but a CT scan was performed, which showed a Sylvian fissure arachnoid cyst with a shift of midline structures. After careful discussion with the parents, it was agreed that the baby would have a craniotomy and fenestration of the cyst into the subarachnoid space. Following this procedure, carried out by consultant neurosurgeon Dr F, Baby R began to do well and had no further fits.

A few months later he was re-referred by the GP because he had become increasingly lethargic and off his food. A CT scan demonstrated that the cyst had recurred and was now bigger than it had been originally. Dr F again discussed with the parents the various options and their potential complications; these were documented in a letter back to the GP. In the end, it was agreed that Dr F would take Baby R back to theatre and perform a cysto-peritoneal shunt. During the insertion of the shunt, fresh blood began to appear in the proximal catheter. Dr F flushed the tubing with sterile water until the cerebro-spinal fluid became clear. After waiting a short period, more blood began to appear in the tubing and Dr F decided to open the dura to find the bleeding point. After reopening the craniotomy, Dr F found that the shunt had penetrated the brain tissue, causing bleeding from a vein on the cortical surface. The bleeding was stopped and the shunt procedure completed.

Baby R was taken from the operating theatre for a CT scan, which showed a slight brain contusion at the site of the cortical puncture and shrinkage of the cyst. He was then extubated and taken to the paediatric intensive care unit where he was closely watched by Dr F and the paediatric intensive care consultant. Dr F informed the parents about what had happened in the operating theatre but said that he felt everything would now be fine. For the next couple of hours, there were entries in the clinical notes every few minutes and initially all was well. Unfortunately, four hours following the operation, Baby R developed a dilated pupil and a bradycardia. He was taken back for a CT. The scan showed a large haematoma had developed at the site of the cortical puncture and the baby was taken immediately to theatre for drainage of the clot. In spite of the surgery, Baby R was left with a severe neurological impairment.

A claim was made against Dr F by Baby R’s family, alleging bad management both during and after the operation. Experts reviewed all the notes and concluded that the management had been careful and appropriate and Dr F wasn’t to be blamed. In particular, the consent process was well documented and it was clear that the parents knew about the possibility of bleeding and the potential consequent neurologic damage. The case was successfully defended.

LEARNING POINTS

- In particularly complicated cases, the more detailed the medical records, the more robust the defence. As this case demonstrates, documenting the time of the notation can be very important. It was clear from the medical records that Baby R had been observed very closely in the hours following his surgery and therefore the postoperative care could not be criticised.
- Complications are unfortunate but do happen and, in some cases, can have terrible and lifelong effects on patients. The medical records are clearly vital in documenting the consent process, which is at the heart of patient-centred medical care.
Missed ectopic pregnancy

Miss G was a 33-year-old single parent who had two children, aged 4 and 6. She had previously had chlamydia and three weeks ago had had unprotected sexual intercourse. Her periods were overdue by four days, so she had a pregnancy test, which was positive. She made an urgent appointment at a clinic to discuss the possibility of a termination.

When she was first seen in the clinic, she was scanned and they were unable to identify an intrauterine sac. She was therefore asked to come back ten days later. When she returned, the scan showed what was reported as “…an 8.5mm intrauterine sac compatible with five weeks gestation”. The gynaecologist, Dr W, warned Miss G of the risks of having such an early termination, but she insisted that they went ahead with the procedure as soon as possible. Dr W agreed and carried out a surgical termination under local anaesthesia. The procedure was deemed to be uneventful and no histology was requested.

Ten days later, Miss G attended her local casualty with nausea, dizziness and abdominal pains. She was fully examined by the young casualty doctor Dr Y, who thought she had endometritis and gave her some antibiotics, reassured her and sent her home.

A week later Miss G collapsed at home with severe right iliac fossa pain. She was brought back into the hospital by ambulance, hypotensive (BP90/50mmHg) and tachycardic (P 120). She was seen again by Dr Y who suspected appendicitis and requested an abdominal USS and routine bloods (FBC, U&Es). The USS showed a large amount of fluid in the pelvis and abdomen and an empty uterus, and the radiologist suggested carrying out an urgent pregnancy test.

This was indeed positive and the gynaecologists were called out to attend to Miss G urgently. Two litres of blood were found in Miss G’s abdominal cavity and a ruptured ectopic pregnancy on the right side was confirmed. Her left fallopian tube had scarring from her previous chlamydial infection; regrettably, the right tube could not be conserved. She required a blood transfusion, but made a full physical recovery, although she was quite traumatised by the events that had occurred and was upset by the advice that she might have problems conceiving naturally in the future.

Miss G made a complaint to the HPCSA against both Dr W and Dr Y. It was deemed that Dr W had offered appropriate counselling to the patient with regards to the risks of the procedure at such an early stage of the pregnancy, although he was criticised for not requesting histology in this case. Dr Y was felt to have been negligent in not requesting a pregnancy test on each occasion she attended and not requesting advice from the on-call gynaecology team, especially in view of her recent gynaecological surgery.

The claim was settled for a moderate sum on behalf of both clinicians.

**LEARNING POINTS**

- When undertaking early terminations at less than seven weeks gestation, it is possible that only decidual endometrium is aspirated rather than the actual gestational sac. As such these procedures must be performed with the appropriate safeguards to ensure that the abortion is complete. Visual inspection of the tissue aspirated is of utmost importance. See: RCOG, The Care of Women Requesting Induced Abortion. Evidence-based clinical Guideline Number 7, London: RCOG (November 2011) – www.rcog.org.uk/womens-health/clinical-guidance/care-women-requestinginduced-abortion

- Although terminations are common procedures, as with all surgical procedures, all the common and significant complications must be fully explained to the patients and documented carefully in their notes – www.bpas.org/bpasknowledge.php?page=154-13k

- Although urinary pregnancy tests may stay positive for two weeks following any miscarriage or termination, they should be requested on any female of reproductive age attending casualty with gastrointestinal symptoms or unexplained abdominal pain. Gastrointestinal symptoms, particularly diarrhoea and dizziness, in early gestation can be important indicators of ectopic pregnancy.

- An early pregnancy ultrasound that fails to identify a definite intrauterine sac should stimulate active exclusion of tubal pregnancy. Dr Y had two opportunities to keep a broad differential diagnosis and should have requested a urinary pregnancy test +/- and an ultrasound, and sought advice from the gynaecology on-call team, to exclude an ectopic pregnancy.

- Even in the presence of a small uterine sac (eg, pseudosac), an ectopic pregnancy cannot always be excluded. See: 2011 Centre for Maternal and Child Enquiries (CMACE), BJOG 118 (Suppl 1), 1–203.
Mrs H, a 54-year-old gardener, had been complaining of left shoulder pain for several weeks. It had become gradually worse, affecting her normal daily activities and causing her significant sleep disturbance. As Mrs H's shoulder became progressively stiffer, she was referred to Dr Z, consultant orthopaedic surgeon.

Dr Z made a diagnosis of frozen shoulder, and sought to manage this conservatively with nonsteroidal analgesia and physiotherapy treatment. Unfortunately, after three months, Mrs H's symptoms had not improved. After suitable verbal counselling, Dr Z administered an intra-articular steroid injection and reviewed Mrs H two weeks later. Again, Mrs H's pain had not improved, and her range of movement remained severely restricted.

Dr Z discussed the option of surgical management with Mrs H, explaining that he could perform a shoulder arthroscopy and manipulation under anaesthesia. Dr Z documented in the hospital notes that he had a “long chat” with Mrs H as a way of informing her of the implications of the planned procedures, although he did not write down what possible complications were discussed.

The patient underwent the combined procedure. Dr Z confirmed the diagnosis of frozen shoulder, also identifying some rotator cuff degeneration. He performed a debridement of the rotator cuff as well as a subacromial decompression, injecting a mixture of local anaesthetic and adrenaline as part of his standard practice for this procedure. It all went uneventfully and the patient was discharged home the following day.

Although the mobility on the affected shoulder improved, the pain became worse. Dr Z suspected a possible injury to the axillary nerve that could have occurred at the time of the manipulation under anaesthesia or during the arthroscopy. He asked Dr N, a colleague neurologist with special interest in nerve injuries, to review Mrs H. Dr N could not find any neuropathy or evidence of nerve injury to explain the increasingly severe shoulder pain.

Mrs H made a claim against Dr Z on the basis that there had been nerve damage during the operation, causing her worsening pain. She alleged that Dr Z had not warned her that this was a possible complication of the surgery. She also claimed that had she known of this surgical risk, she would not have had the procedure.

An expert commissioned by Mrs H supported the thesis that during the manipulation under anaesthesia an excessive force was used, resulting in nerve injury. The expert also stated that on the balance of probabilities, had the patient known this risk, she would not have had the procedure. He supported this on the fact that no written consent, including risks, benefits and alternatives, was given to the patient. He concluded that Dr Z had acted negligently.

On the other hand, an expert on behalf of MPS stated that if the patient had a nerve lesion, this was most likely to have been present prior to surgery. He said that even if this injury occurred during the procedure, this was such a rare event that Dr Z could not be found negligent.

Given the strength of our defence expert’s opinion the case was taken to trial and the court found in favour of Dr Z. He was able to rely on a causation defence.

LEARNING POINTS

- Unforeseeable adverse outcomes, while deeply regrettable, are not always negligent.
- Informed consent is a fundamental part of the decision-making process between the doctor and the patient regarding treatment options. Most regulatory bodies across the world have specific guidance on consent. To ensure consistency in practice, it may be worth considering the use of informed consent templates for specific procedures. A template for a specific procedure may be helpful as an aide memoire, but it is not a substitute for a conversation with the patient.
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A dangerous cough

I must take issue with one of the usually excellent learning points associated with a case report published in Casebook 20(2) entitled “A dangerous cough”. You recommend: “When administering anaesthesia during an elective procedure, it is preferable to stop should you encounter difficulties and reassess for surgery at another time.” Although it is apparent that this would have been the correct course of action in the case described, this is not always so.

Can I suggest the slightly more verbose but much more accurate:

If you encounter problems that you cannot be completely confident you have diagnosed accurately, and resolved fully when a patient is under general anaesthesia for an elective procedure that has not yet started, you should consider abandoning the procedure and waking the patient up.

Dr William Harrop-Griffiths, Consultant anaesthetist, UK

All in the detail

I am having increasing difficulty relying on Casebook for considered advice. The editorial standard is at odds with the excellent verbal advice I have received from the organisation over the last 20 years or so. What amounts to an apology regarding poor DNA CPR advice given in January this year appears in the same edition as the following example of clumsiness:

“Your first obligation is to act in the patient’s best interests and you should not be pressured by the patient into doing anything that is counter to this” (learning points, “A dangerous cough”, Casebook 20(2), May 2012.). This seems to suggest that the patient does not know what their best interests are but the doctor does. Modern medical ethics tend more towards the notion that if a patient is able to make a decision regarding their own best interests it is not for the doctor to paternalistically impose their own views of best interests on them:

“A person is not to be treated as unable to make a decision merely because he makes an unwise decision.” s1(4) Mental Capacity Act 2005.

In the instant case I would have hoped that the advice given by the MPS would have been along the lines of:

Your first obligation is to act in the patient’s best interests and you should not be pressured by anyone else into doing something that is counter to this. In this case, more comprehensive preoperative assessment may have led the anaesthetist (in consultation with the surgeon) into concluding that the surgery would be safer once the chest infection had fully cleared. Presented with this information the patient would very likely agree to the postponement. If she felt her best interests were served by proceeding anyway the anaesthetist and surgeon would have the opportunity to seek second opinions from colleagues.

A doctor is under no obligation to provide treatment he feels would be detrimental to the patient’s health simply because the patient demands it. The notion that a vaginal hysterectomy under spinal anaesthesia might have been a reasonable alternative in the presence of pneumonia is a contentious point (particularly in an elective setting) that detracts from the otherwise sound advice regarding good communication.

Also, condensing what appears to be a very complicated case into a single glossy page might look attractive but for those experienced professionals reading the piece it usually leaves more questions than it provides answers. The poor writer has a Herculean task on his hands. Perhaps a much fuller summary could be provided online as might be found on Westlaw.

I do feel that the glossy Casebook does something of a disservice to MPS. There should be greater use of references and quotations from statute, case law and guidelines from professional bodies and considerably less reliance on well meaning, but sometimes ill-considered, bullet points.

Response

Regarding your point about patients’ best interests, from a medicolegal standpoint you are of course correct – and no authority can impose treatment on them against their wishes, save under the provisions of mental health legislation. However, the principle applies to the patient’s rights, and not the doctor’s responsibility; in other words, the patient cannot insist on being provided with inappropriate or negligent treatment simply because they believe it will be in their best interests to have it. The doctor has responsibilities and duties both in law and – in the UK at least – as imposed by the GMC to exercise their judgment and professionalism in assessing what treatment options are appropriate for the patient’s condition. After a proper informed discussion it is then for the patient to decide which option is best for them. I agree with your comment about the wording of the first learning point; precision and detail can be lost at the expense of limitations on space. I also recognise that in seeking to provide material that is interesting, practical and relevant to the very wide range of doctors who receive Casebook, we do not always provide the level of detail in case reports which an experienced specialist in your position might wish. We have recently started publishing more specialty specific material, including an anaesthetic e-bulletin, and would welcome ideas for topical issues to cover in future editions.

Casebook does not purport to be an academic or peer reviewed journal; the case reports are based on MPS cases from around the world but, unless otherwise stated,
I read with interest the article “Spreading the use of HIV testing”, and entirely agree with the need for “normalisation” of the investigation of this virus. Encouragement to present to healthcare services and the stage at which patients present may be outside our control, but from their point of contact with healthcare professionals we have a window of opportunity to modify their prognosis. Proactive consideration of the condition among our differential diagnoses of patients presenting with signs of immunosuppression (recurrent infections, atypical infections), PUO, obscure dermatological changes and non-specific signs (weight loss), should prompt investigation at the time of disease consideration, like any condition.

The demonstration projects clearly identify key educational needs among practitioners to dispel the myths around investigation and build professional confidence (consent, results management, insurance fallacies). Empowerment of junior doctors to consider the disease in their diagnoses and to elucidate risk factors among patients they encounter on the acute take or new outpatient referrals could improve early investigation. Through junior doctors presenting their reasons for investigation choice to senior clinicians, as any investigation with significant implications (genetic testing tumour markers, radiation exposure, invasive procedures), test appropriateness could be confirmed or refuted.

Also teaching communication skills to develop patient rapport prior to enquiring into the sexual history may assist clinicians.

If the barriers are not in diagnosis consideration, but clinician fears in discussing the investigation – what will the patient think? What if I cannot answer their questions? How do I tell them they have a positive result? – we are failing patients by potentially delaying diagnosis and thus denying life-preserving treatment at the earliest interval. Any concern regarding managing the results is our responsibility, to nurture the working relationship with sexual health services.

By the time the doctor with all the answers is encountered, it may be too late.

Dr Claire Brough, specialty trainee, cardiology, UK

Oh by the way, doctor

I would like to offer a comment on your latest “Oh by the way, doctor” in Casebook 20(2), May 2012. Fair enough, the GP did miss the SUFE and didn’t make any notes, but when you examine the structure of the consultation, there would be few GPs in any country who couldn’t have ended up in the same unpleasant situation. The advice about the limping child is all apt but, just as importantly, there needs to be training and advice about managing the structure of consultations and demands that you cannot meet in a busy day that is already fully booked.

For example, the GP could have made a one-line entry in the mother’s notes about the request and then insisted she book in for a proper consultation for the child. Yes, she might have been angry and demanding, but it is ok to set boundaries with patients: “I’m sorry Mrs Smith, but assessment of a limp in children is not a quick thing and I really want to do my best for Johnny, I can give you an appointment tomorrow.”

Or: “I’m sorry Mrs Smith, but I am heavily booked today, and in fairness to the booked patients who are already waiting I cannot provide you with a double appointment.”

Better to weather some short-term annoyance from the patient and create a long-term understanding with the patient that you practise good medicine, and that off-the-cuff double bookings are not part of that practice.

In my own practice I will oblige with minor “quick look” things, eg, checking the child’s tonsils for which I gave antibiotics last week when he accompanies mum for her appointment. This sort of quick follow-up is useful for me and creates goodwill, but new assessments, of the type above with the limping child, should be deferred.

It is also important that both your reception and nursing staff have clear guidance about what is acceptable to double-book and that you should be consulted about double bookings. This creates a consistent culture across the practice, which prevents the doctor being overloaded and resentments developing within the practice team.

Dr Phillipa Story, GP, New Zealand
**Medscape app**

Reviewed by Dr Emily Lee, Academic Clinical Fellowship Year 1 in Paediatrics at Alder Hey Hospital in Liverpool, UK

As a newcomer to the world of smartphones, I was astonished by the number of medical apps available and the vast array of functions they serve. From Shiftworker (creates attractive calendars documenting your shift patterns), to PaedsED (provides rapid drug-dose calculations and a pain scale containing cute animal pictures) – there is something to suit every specialty and taste.

Of all the apps I discovered, Medscape stands out as being an incredibly versatile and useful tool, containing abundant functions, which I’ll highlight below. There is also a mind-bending back catalogue of evidence available for download, all the more incredible for the fact that it is free. All that is required of you is an email address with which to set up an account.

Medscape ranks in Apple’s top app downloads, and it is easy to determine why. The app can be downloaded on to many devices, eg, iPhones, iPods, Blackberrys, Androids and Kindlefires, and has an easily navigable format, with large enough icons that you won’t forever be hitting the wrong button.

Medscape is developed by WebMD, the group responsible for various online medical resources, including eMedicine and Rxlist. The Medscape app is constantly developing with frequent evidence updates and an ever-expanding number of conditions covered (currently 4,000+). The content is written and peer-reviewed by 7,000 physicians representing numerous institutions, so somewhat more reliable than the good doctors Google and Wiki. Many articles also come with illustrations and videos, which are particularly handy for the anatomy segments and the section giving step-by-step instructions for 600-plus clinical procedures – an improvement on the ‘see one, do one’ ethos.

Medscape’s drug reference contains detailed prescribing information for more than 8,000 drugs (prescription, OTC and supplements). The only downfall is that some of the drugs are not listed in their English format (eg, Acetaminophen is listed for Paracetamol). There is also a drug interaction checker that allows the user to cross-check multiple drugs/supplements against each other to ensure they’re prescribing safely. Not only that, Medscape incorporates numerous medical calculator tools, relevant to each specialty. I’ve highlighted some of my favourite aspects of the app, but there’s much more to take advantage of including daily news updates, 100-plus clinical protocols, monthly hot topics with latest practice updates, and the ability to carry out Medline searches within the app.

I’d thoroughly recommend adding Medscape to your device, and whilst you may not be fast enough to impress your senior by looking up the answers to ward round questions, you can enter each on-call, whatever your specialty, armed with the wisdom of 100 textbooks in your back pocket.

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**The Rise & Fall of Modern Medicine (2nd edition)**

By James Le Fanu

(Abacus Books, 2011)

Reviewed by Dr Matthew Daunt, specialist registrar in anaesthesia at Nottingham University Hospitals NHS Trust

This new version has been updated to include the changes in the decade since its first release. It is essentially divided into two parts, a superb historical narrative of medicine’s greatest achievements in the post-war years, followed by a somewhat cynical review of the current medical world.

The first part – the “Twelve definitive moments of modern medicine” – is a must-read for all doctors and medical students. Covering the 45 years from the beginning of World War II, Le Fanu articulately describes the most significant developments of modern medicine, recounting details that are both entertaining and enlightening. The well-researched and heavily-referenced chapters depict events such as the discovery of penicillin, the birth of intensive care, open heart surgery and the first test-tube baby. This section of the book alone is enough for me to recommend it.

The uplifting book goes on to describe the development of newly-qualified doctors, from the 1930s when they had “a dozen or so proven remedies” at their disposal, to the end of their career when they have “over 2,000”. Le Fanu revels in telling the reader that these discoveries were fortuitous, and often accidental. The change in the way research occurs is one of his reasons for the “fall” in modern medicine.

The second half of the book tackles the reasons behind the relative dearth of significant breakthroughs. The subsequent decline in new discoveries in the last 30 years are attributed mostly to the overwhelming impact of the human genome project, and the pharmaceutical companies whose interest in profit-making prohibits the effects of individual research. The latter half of the book is quite depressing, but ends with a sense of optimism overall as to what the future may hold.

This fascinating book gives an expert account of how modern medicine affects us all as doctors and patients, whilst also calling for change in order to prevent stagnation in the field of research.
1. Making good notes when you see patients during an unplanned appointment is of great importance, as one is more vulnerable to criticism.  
   True or False

2. When it comes to complaints or claims, there are seldom factual disputes between patients and doctors.  
   True or False

3. Human factors seldom affect your performance.  
   True or False

4. The consent process is a detailed conversation between the clinician and the patient, which should be documented.  
   True or False

5. A doctor is under no obligation to inform patients of lifestyle choices that may affect the patient adversely.  
   True or False

6. Postoperative infection is a sign of substandard care or negligence.  
   True or False

7. Given that laparoscopic procedures are seldom converted to a laparotomy, one is under no obligation to inform a patient of the possibility.  
   True or False

8. Consent for a procedure should be personalised to the individual patient.  
   True or False

9. Good clinical notes play no role in the defence against a complaint or claim.  
   True or False

10. Poor communication seldom plays a role in complaints or claims.  
    True or False

11. Communication and interpersonal skills training is unlikely to diminish one’s risks.  
    True or False

12. The arrogance of a doctor has never led to a serious claim.  
    True or False

13. Passing a nasogastric tube is a minor procedure and complications are almost unheard of.  
    True or False

14. The National Health Act 2003 makes no reference to disclosure of information about patients.  
    True or False

15. There are no statutory circumstances that mandate one to share confidential patient information.  
    True or False

16. Patients have no right to request that certain clinical information be withheld from members of the clinical team.  
    True or False

17. The parents of children under the age of 12 have no right of access to their children’s notes.  
    True or False

18. If a child, under the age of 12, has had a termination of pregnancy the parents are entitled to know about it.  
    True or False

19. The police have a special right of access to clinical records and can demand to see a patient’s notes.  
    True or False

20. Once a patient dies the obligations of confidentiality are substantially diminished.  
    True or False
How to contact us

THE MEDICAL PROTECTION SOCIETY
33 Cavendish Square
London, W1G 0PS
United Kingdom

www.medicalprotection.org
www.dentalprotection.org

General enquiries (UK)
T +44 113 243 6436
F +44 113 241 0500
E info@mps.org.uk

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

T +44 113 241 0696
F +44 113 241 0710
E education@mps.org.uk

Please direct all comments, questions or suggestions about MPS service, policy and operations to:
Chief Executive
Medical Protection Society
33 Cavendish Square
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United Kingdom
chief.executive@mps.org.uk

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AFRICA MEMBERSHIP ENQUIRIES
Ian Middleton
T 0800 118 771 (toll-free within RSA)
E mps@global.co.za

Alika Maharaj
T 083 277 9208 (cell phone)
E mps@iburst.co.za

South African Medical Association
T 0800 225 677 (toll-free within RSA)
E mps@samedical.org

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