On deadly ground
Explore the pitfalls of practice as we look at problems beyond claims

PAGE 6

CASE REPORTS
PAGE 14

THIS ISSUE...
TELEPHONE CONSULTATIONS
Hanging up on the risks – with a focus on two MPS cases

ASPECTS OF CONFIDENTIALITY
Unusual dilemmas – the first in our new series

ETHICS 4 ALL
CPD points on offer at this year’s big MPS event – save the date

BOOK REVIEWS
What pages are being turned this month?
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What’s inside…

04 Under the influence
MPS Medical Director Dr Rob Hendry looks at the importance of teamwork.

04 Welcome
Editor-in-Chief Dr Stephanie Bown draws attention to other ways in which your professional practice may be called into question.

05 News update
Save the date for MPS’s large-scale, three-city event Ethics 4 All – plus read a factual update on employment contracts with indemnity clauses: a popular query to the MPS advice line.

06 On deadly ground
As well as claims, doctors face the possibility of complaints, regulatory investigations, disciplinaries and a whole host of everyday dilemmas that MPS is approached about.

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

10 Telephone consultations: hanging up on the risks
As consultations via telephone become more common, so do the problems reported to MPS – Charlotte Hudson warns of some frequent pitfalls and highlights two MPS cases that resulted in clinical negligence claims.

14 From the case files
Dr Graham Howarth, MPS Head of Medical Services (Africa), introduces this issue’s round-up of case reports.

15 Penetrating the eyeball

16 Rash decisions

16 A brain-damaged baby

17 Paraplegia after spinal surgery

18 Stumbling block

19 An unavoidable amputation

20 Sinus surgery – damaged vision

21 It’s all about consent

22 A weekend of back pain

CASE REPORTS

Every issue…

24 Over to you
A sounding board for you, the reader – what did you think about the last issue of Casebook? All comments and suggestions welcome.

26 Reviews
In this issue Dr Catherine Walton looks at The Secret Anatomy of Candles by Quentin Smith, and Dr Omar Mukhtar casts a critical eye over Dr Atul Gawande’s Complications: A Surgeon’s Notes on an Imperfect Science.

27 CPD
Earn five CPD ethics points with our questionnaire.

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MPS
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Welcome

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

There has been a lot of talk about the rising cost of clinical negligence: the increasing number of claims, and the increasing levels of awards. We also hear the rhetoric that the fear of litigation drives doctors to practise defensive medicine. But I hear members tell me that it is the dread of a complaint to the Medical Council, and the risk of a public hearing, trial by media and reputational damage that concern them much more than a claim.

That is not to disregard the stress of litigation – but, generally speaking, the fact that your indemnity arrangements will step in to meet the financial costs of a claim makes it a less personally traumatic experience than the sanctions you might face at, for example, the hands of your employer, regulator or even the police.

Although the cost of claims is far and away the largest call on members’ funds at MPS, they only represent about 20% of the cases we handle worldwide – the rest are complaints, inquests, disciplinary cases and other medicolegal challenges to a member’s professional practice. Our feature on page 6 illustrates just some of the wide-ranging problems that members contact us for advice on.

It is also possible for a single incident to take a member through a series of procedures. For example, a perinatal death might give rise to complaint, claim, inquiry, inquest, disciplinary and regulatory investigations. And doctors who rely solely on employers’ indemnity have no entitlement to ask for assistance with anything other than the claim for compensation – so you might want to have a word in the ear of a colleague who could unwittingly be leaving themselves exposed to a range of sanctions.

Finally, I hope you enjoy reading the case reports in this edition we share learning from both settled and ongoing cases as well as alerting you to problems that members contact us for advice on.

As always, I welcome your feedback – whether in response to content within Casebook or to share your own experiences.

Under the influence

MPS Medical Director Dr Rob Hendry reminds doctors of their unique opportunities to influence and inspire those working around them

Doctors are often surprised how influential they are within their teams and organisations. The things they do and say and the way they conduct themselves is increasingly being recognised as central to effective healthcare.

Most medical care is now delivered by teams rather than by individual healthcare professionals working in isolation. When teams work well the results can be spectacular, but when teams are dysfunctional, patient care can suffer. Stories in the press about “failing hospitals” are, in fact, often actually about failing teams.

Sadly at MPS we frequently see doctors getting into difficulties with their employers and their regulators, not because of their lack of specialist knowledge or poor technical skills, but because of the way they interact with their colleagues.

When relationships break down in healthcare teams not only do things go wrong more often, but when they do the impact on everyone involved is usually much greater.

One of the characteristics of being a professional is taking responsibility for one’s actions.

Often, choosing to turn a blind eye to problems within a team can lead to problems becoming magnified and intractable.

Product liability and MPS

Issues with product liability have made the headlines in a number of countries around the world recently – notably the DePuy metal on metal hips in South Africa and Ireland, and the PIP breast implants in the UK.

These issues arose from faulty products, where normally responsibility lies with the manufacturer or supplier of the product.

However, in both cases, attempts were made by claimants to include surgeons in the claims – in the DePuy hips case, the justification given was that the surgeons had failed to properly fit the prostheses; with the PIP implants, the insolvency of the manufacturer was the motivation for involving the surgeons in the claims.

In both situations, whilst MPS is not providing an indemnity for product liability, MPS is supporting members with these cases by doing whatever is possible to prevent the development of litigation targeting clinicians, when other more appropriate sources of compensation (the manufacturer or supplier) are no longer available.

In the meantime, members can take steps to protect themselves in the event of a claim for product liability, by retaining documentation relating to:

- Evidence of purchase.
- Where possible, the serial number of the item in question – it can be used as evidence of the batch of goods obtained.
- Terms and conditions.
- Express warranties and guarantees.
- Instructions and packaging.
- Correspondence regarding product specification and any alteration.
- Where whole goods are transported by an external logistics company, relevant contracts/terms/correspondence.
- Complaints history relating to product and similar products (if relevant).
- Order forms, emails, faxes.

Clinicians should also take care regarding any verbal statements made to patients regarding a product. Statements that erroneously imply a lifetime guarantee, for example, can make a clinician liable in the event of a related allegation or claim.
Save the Date for Ethics 4 All 2013

Registration for our annual ethics event – Ethics 4 All – is now open!

The event provides an opportunity for members to examine ethical challenges and enable attendees to obtain CME/CPD points for the ethical component of their professional development. Ethics 4 All has been running for the past five years, and last year more than 2,500 delegates attended across three locations.

In 2013 we are delighted to be hosting three events:

DURBAN:
Sunday 1 December 2013 (morning event)
Venue: Southern Sun Elangeni Hotel
In conjunction with KZNMC
Chaired by Dr Mzukisi Grootboom, Chairperson, South African Medical Association (SAMA)

PRETORIA:
Monday 2 December 2013 (evening event)
Venue: CSIR International Convention Centre
In conjunction with Ampath
Chaired by Professor Martin Veller, Professor and Head, Department of Surgery, University of Witwatersrand

CAPE TOWN:
Wednesday 4 December 2013 (evening event)
Venue: Cape Town International Convention Centre (CTICC)
In conjunction with PathCare
Chaired by Dr Mark Sonderup, Vice Chairperson, South African Medical Association (SAMA)

The programme has been developed to cover core bioethical and medicolegal issues, based on feedback from last year’s events. The 2013 programme will include:

- Walking the Ethical Tightrope – Falling Foul of Ethics – Trends in Complaints and Claims; MPS Claims Experience in South Africa; Common Problems
- Ethics of Managed Healthcare Resources – Squeeze on Private Health; Undercover Reporting and Distributive Justice
- Adverse Events in Healthcare and the Ethics of an Apology – The Importance of Being Open; Raising Concerns; Professionalism and Criticising Colleagues
- Mastering Shared Decision Making to include: Unreasonable Patient Demands; Appropriate and Informed Choices about Treatment; Patient Decision Making; What Leads to a Complaint or Claim; and the Principles of Consent.

Dr Graham Howarth, MPS Head of Medical Services (Africa) says: “Set against the backdrop of an adverse claims environment and increasing complaints to the HPCSA, providing support and guidance to doctors about ethical issues by way of these conferences is both timely and fulfils a key educational need.

“We know that issues surrounding ethics and professionalism can be challenging for doctors to navigate and, although we’re here for doctors when things go wrong, we very much want to help them get it right.”

The events are free of charge for MPS members. A full copy of the conference programme can be found at: [www.medicalprotection.org/southafrica/events-and-conferences/ethics-for-all](http://www.medicalprotection.org/southafrica/events-and-conferences/ethics-for-all)

For more information about Ethics 4 All please contact: stacey.mack@mps.org.uk.

MPS update: Contract queries

MPS has recently been contacted by a number of members regarding contracts that they have been asked to sign by private hospitals or clinics where they carry out medical practice.

Members have highlighted clauses within the contract requiring them to indemnify the hospital or clinic against any losses that might occur in relation to their clinical practice.

Whilst MPS cannot advise members on their individual contractual liabilities, we have seen examples of contracts requiring particularly broad and potentially unclear indemnities from doctors and other healthcare professionals.

MPS recommends that any doctor entering into a contractual relationship with a hospital or clinic ensures that he or she takes advice from a lawyer or other appropriately qualified professional.

MPS membership is designed to indemnify members against claims arising from their professional practice, including clinical negligence claims and regulatory matters, but it is not intended to meet liabilities arising from commercial contracts.

More information about the benefits of MPS membership can be found in the members’ handbook, which is available on our website at [www.medicalprotection.org/southafrica/membership/guide](http://www.medicalprotection.org/southafrica/membership/guide).
On deadly ground

It is a harsh reality of medicine that doctors face multiple avenues of complaint related to their practice. In Casebook we focus on the learning points afforded when a doctor is sued for clinical negligence, but members come to MPS requesting assistance with a wide range of other matters, such as ethical queries, complaints and regulatory body investigations.

Here we present six diverse cases from MPS’s files, listed by theme and not including claims. They are drawn from incidents in South Africa and some facts have been altered to preserve confidentiality.

G P Dr W was visited by 20-year-old patient Miss B, who had a history of drug dependency. Miss B was accompanied by her mother, Mrs V. During the consultation, Dr W inadvertently made reference to the fact that Miss B was HIV positive; Mrs V was not aware of this. Dr W immediately apologised for this disclosure. He wrote to Miss B that evening acknowledging the breach of confidentiality and again apologising for it. Miss B was very angry and complained to the HPCSA, forwarding Dr W’s letter, making reference to other concerns about the care she had received.

The Registrar of the HPCSA had passed the complaint on to the Ombudsman and the Ombudsman asked Dr W for an explanation. Dr W approached MPS for assistance in responding to the HPCSA. In his letter of response, Dr W admitted the inadvertent breach of confidentiality but clearly showed insight into his oversight and extended his apologies, once again, to the patient. The Ombudsman accepted the apology.

Learning points
Dr W should not have assumed that the mother was aware of her daughter’s HIV status. At the start of the consultation he should have asked Miss B whether she was happy for her mother to stay and should not have mentioned anything the patient or mother had not brought up themselves. If it had been necessary to mention Miss B’s HIV status he should have asked the mother to leave as he had a potentially sensitive matter to explore with her daughter.

MPS offered to review his letter to the patient and advise if necessary.

Dr L received a letter from the HPCSA regarding a complaint from a patient, Ms D. Dr L was infuriated. The complaint related to a minor clinical oversight which had had no clinical effect on Ms D. Dr L felt that the complainant was suggesting he had completely missed an obvious diagnosis and was not competent to practise as a result. He felt that the complaint was defamatory and immediately wrote a curt letter of response, rebutting the allegations and outlining his concerns that they had been raised in the first place. He then contacted MPS and informed the medicolegal adviser that although he had received a spurious complaint, he had dealt with it. Dr L also requested assistance in suing Ms D for defamation.

Learning points
However spurious or frivolous a complaint may seem, all complaints should be thoroughly investigated and responded to appropriately. If a patient makes a complaint, the HPCSA is duty-bound to investigate it.

If you are the subject of a complaint, take a moment to stop and think before responding. A well-thought-out letter of response is far more likely to be successful than an intemperate one, which will only serve to make matters worse. It would have been preferable if Dr L contacted MPS before responding to the complaint, as MPS would have written a letter of response on Dr L’s behalf, through one of our panel law firms.

MPS is unlikely to assist members in suing for defamation in response to a complaint made by a patient.
Dr A arrived at his surgery first thing Monday morning to find a letter addressed to him from the HPCSA. The letter explained that the HPCSA was investigating a complaint against Dr A’s colleague, Dr P.

The patient, Mr M, had complained after he was prescribed amoxicillin for an acute ear infection, which resulted in a severe rash and vomiting. Mr M claimed that his previous adverse reaction to the drug should have been recorded in his notes, as he had been similarly unwell after taking the drug a few years previously. He felt the prescribing error was a combination of Dr P’s negligence and inefficient systems at the practice to flag medication allergies.

The HPCSA requested Dr A to write a report, as a witness of fact, in relation to the complaint. This was because Dr A had seen Mr M when he presented with the rash. Dr A contacted MPS for advice about what he should include.

Learning points
If you are asked to write a report as a witness of fact, it is important to make the distinction between whether the HPCSA is investigating you, or a colleague. The HPCSA’s investigation will be based on the patient’s letter of complaint in the first instance, but the remit of the investigation may well broaden as it progresses. MPS explained to Dr A how the investigation might progress, and the possibility that Dr A might be investigated, and advised accordingly.

MPS advised Dr A that he could only comment on his factual involvement. Therefore, he could only say that the rash followed the apparent administration of antibiotics and on his examination he felt it might fit in with recognised side effects of amoxicillin.

Although the witness of fact report had to be thorough, Dr A could not reveal confidential patient information. MPS also provided advice on queries relating to patient confidentiality.

Dr B was working as an intern in general surgery. Three months into her new post she received a “friend request” on Facebook from a former patient, Mr T. She had got to know him whilst doing her medical school psychiatry attachment as he had been an inpatient for a brief period of time.

Mr T told her that he was doing really well and was off all his medication. He had started a course at the local college. Dr B accepted his friend request. Initially she enjoyed reading Mr T’s posts, but gradually she noticed his comments were becoming more bizarre, culminating in the statement that he felt he was being followed by the CIA. She recognised this as a symptom of his mental illness and sent him a personal message urging him to go and see his GP.

Mr T replied stating that he didn’t trust his GP. He asked to meet up with Dr B. She told him that she couldn’t do so and suggested he speak to his GP on his behalf. He became angry and upset. Dr B was concerned about Mr T so she contacted his consultant psychiatrist who arranged to review him later that week. Mr T ‘de-friended’ Dr B a few days later.

A month later Mr T complained to Dr B’s consultant supervisor. He was unhappy that Dr B had declined to meet him as he had felt that they were friends. He was disappointed that she had contacted his psychiatrist, although he admitted that he was feeling a lot better and back on his medication.

The consultant and Dr B met with Mr T to discuss his concerns. Dr B apologised to Mr T and stated that she should never have accepted his friend request. She told him that she had been concerned about him and had felt she had to contact his psychiatrist to try to access help for him.

Mr T accepted Dr B’s apology. He asked her to share the experience, anonymously, with her colleagues, so that they could all learn from this incident.

Learning points
Doctors should ensure that their conduct justifies patient and public trust in themselves and the profession as a whole. This applies equally online as it does in the consultation room.

Using social media creates new risks, particularly where social and professional boundaries become unclear. If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships, and decline any friend requests.

CONTINUED OVERLEAF
FEATURE

How can MPS help?

Members sometimes come up against problems that are out of the ordinary. MPS considers borderline requests for assistance on their merits, balancing the individual member’s needs against their responsibility to use members’ funds wisely and in the interests of the membership as a whole. The following are examples of problems where detailed consideration of the exercising of discretion to assist may be warranted.

Criminal proceedings arising from non-clinical practice

We can exercise our discretion to assist with criminal allegations, but this does not usually extend to allegations of fraud or theft, on the basis that these offences arise from the business aspects of practice.

Allegations of fraud

It is unlikely that we would provide assistance in connection with allegations of fraud arising from business dealings. Occasionally, allegations of fraud may have arisen from professional life, for example, errors on a CV, or in research. Such cases are considered on their individual merits.

Defamation

If a member is the named defendant in a defamation claim, we may assist if the alleged defamation stems from their professional practice and their professional reputation is likely to suffer serious harm.

Other employment and disciplinary issues

MPS is unlikely to assist where a member faces a disciplinary investigation or hearing arising from:

- Employment or contractual issues
- Working relationships with colleagues
- The business of practice.

Personal conduct

Assistance is very unlikely to be offered with complaints or claims arising from a member’s conduct that is of a wholly personal nature clearly unrelated to professional practice, or only loosely related to the practice of medicine (for example, by virtue of having been committed at the work/practice premises, or because they happened to involve an employee or working colleague).

Taken from MPS cases handled between June 2012 and May 2013. Words by Sarah Whitehouse
Aspects of confidentiality:

When your patient is an impaired practitioner

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

Dr A, a GP, saw patient Dr G, a practising dentist, over recent seizures. Dr G had previously presented with an encephalitis complicated by seizures; she had recovered from the encephalitis but had since had a breakthrough seizure. There was no residual deficit but Dr G was now considered an epileptic, as she had had more than one seizure, and was placed on an antiepileptic agent.

Dr A contacted MPS because of his concerns over Dr G’s ability to return to work as a practising dentist. He was unsure of the implications if Dr G resumed her practice, and faced a dilemma of breaching Dr G’s right to confidentiality in order to safeguard her patients.

MPS advice:
The first question is whether Dr G can be considered impaired in her ability to practise as a dentist. Section 1 of the Health Professions Act 56 of 1974 defines impairment as “a mental or physical condition which affects the competence, attitude, judgement or performance of professional acts by a registered practitioner.” It is down to Dr A’s judgment whether this fulfils the description of Dr G’s condition.

If Dr A considers Dr G to be impaired in her ability to practise, then section 25 of the Act obliges him to report Dr G to the HPCSA. It says: “Reporting of impairment or of unprofessional, illegal or unethical conduct (1) A student, intern or practitioner shall – (a) report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired.”

In addition, the HPCSA’s guidance Confidentiality: Protecting and Providing Information (2007) – in its section “Disclosures to protect the patient or others”, sections 9.3.1 to 9.3.1.1 – says: “Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk or death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient’s right to confidentiality, health care practitioners should seek consent to disclosure where practicable. If it is not practicable, they should disclose information promptly to an appropriate person or authority. They should generally inform the patient before disclosing the information.

“Such circumstances may arise, for example: A colleague who is placing patients at risk as a result of illness or some other medical condition (eg. an impaired colleague); If health care practitioners are in doubt about whether such disclosure is justified they should consult an experienced colleague, or seek advice from a professional organisation. The safety of patients must come first at all times.”

Dr A discussed his concerns with Dr G. As an impaired practitioner, Dr G had an obligation to self-report to the HPCSA and Dr A was advised to give her that opportunity. However, Dr A was advised that he had to be satisfied that this self-reporting had occurred, and to remember his own obligations to report.
The telephone has been used as a tool for delivering healthcare since 1876 when Alexander Graham Bell invented the device. In fact, the very first telephone call was also the first telephone call for medical assistance after Bell spilt sulphuric acid on his clothes.

Not long after its appearance, physicians were answering the telephone even during consultations with other patients in the room, which, today, would breach patient confidentiality. The Lancet then proposed a rule that “calling up the doctor on the ‘phone should be limited to urgent cases”. As the 20th century evolved, however, the Lancet insisted that practitioners must make themselves available by telephone.

In 1906 there was an entry in the Lancet stating how a man had phoned his doctor for professional advice and when the patient was billed for the advice he refused to pay. On the question of whether or not it was proper to consult by telephone, the judge ruled that it was the doctor’s duty to decide whether he might safely give further instructions by telephone provided he had previously seen the patient.

Today, telephone consultations are widely used by GPs and patient satisfaction is high. Speed, improved access, convenience to patients and possible cost savings are the principal advantages of consultations by telephone.

Talking to a patient on the phone, however, exaggerates the difficulties of a face-to-face consultation because there are fewer cues to pick up on. From the moment a patient walks into the consultation room you can immediately

**Telephone consultations:**

Hanging up on the risks

Delivery of clinical care via telephone is becoming more common but the practice carries unique risks to both doctor and patient; Charlotte Hudson looks further into the issue.
see their facial expressions and, sometimes, their symptoms. A full clinical assessment is not possible by telephone, but if the limitations of the telephone consultation are recognised, and a careful history taken and documented, patients can be managed in a reasonable, appropriate and safe way.

Benefits of telephone consultations
In March 2012, 165,371 qualified health practitioners in both public and private sectors were registered with the HPCSA. This includes 38,236 doctors and 5,560 dentists. Scarcity of healthcare practitioners is experienced around the world, but the situation seems worse in African countries, as reported by the Department of Health. A report issued in March 2008 highlights the fact that Africa carries 24% of the world’s disease burden with only 3% of the world’s health workers. The doctor-to-population ratio is estimated to be 0.77 per 1,000 but because the vast majority of GPs – 73% – work in the private sector, there is just one practising doctor for every 4,219 people. In this environment, with a shortage of doctors and medical specialists in both rural hospitals and the referral centres, telephone consultations can help ease the pressure on doctors and allow them to help more patients without the patients having to travel from one area to another.

Confidentiality
During a telephone consultation with a patient you should ensure that your conversation cannot be overheard by other people, and you should make sure that it is the patient you are speaking to on the phone and not a relative or friend, as this is a breach of patient confidentiality. In the HPCSA guidance Confidentiality: Protecting and Providing Information (2008), the principles that should be applied are set out, including:

- Patients have a right to expect that information about them will be held in confidence by healthcare practitioners. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide good care.

Recording calls
Some hospitals record incoming and outgoing telephone calls. These electronic sound files form part of the patient’s records and can provide useful information in the event of a complaint or claim. Provided all reasonable steps have been taken to inform callers, telephone calls may be recorded. Secret recordings are not permitted.

Prescribing by telephone
The General Medical Council (GMC), which regulates UK doctors, states that before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient’s consent. You should identify when you should see a patient in person, for example, if the symptoms aren’t clear or you can’t evaluate the patient over the telephone.

Tips for an effective telephone consultation

- Obtain and document a thorough history. Telephone consultations do not give a doctor the opportunity to assess clinical signs.
- When calling a patient, remember not to breach confidentiality – be cautious about revealing your identity until you have confirmed that you are speaking to the patient. You should only discuss details with a friend or relative if you are sure that the patient has given their consent. Try to take the call in a quiet room on your own.
- Inform the patient when recording a telephone consultation. There should be robust procedures in place for storage, retrieval and transcription of the call.
- When gathering information on the caller’s problem, make sure you ask some open questions and closed questions, ensure that you are in a position to reach a sound clinical judgment, agree a plan of action with the patient, and check that they agree with it and understand it.
- Request that the patient repeats advice given (several times throughout the consultation).
- Document the consultation accurately and contemporaneously.
- Be able to justify any course of action that is taken, eg, diagnosis.
- Follow-up: check existing medication when prescribing new medication, explain to patients what they should expect by way of improvement, significant symptoms to report, or when to phone back if they are not getting better.

Provided all reasonable steps have been taken to inform callers, telephone calls may be recorded. Secret recordings are not permitted.

The rationale for the treatment should be explained together with its risks, benefits and burdens. Adequate follow-up in the event of no improvement, worsening symptoms or side effects should be made.

The World Medical Association (WMA) states: “While the practice of telehealth challenges the conventional perception of the physician-patient relationship, there is a ‘duty of care’ established in all telehealth encounters between the physician and the patients as in any healthcare encounter.”

Informed consent
Relevant legislation and regulations that relate to patient decision-making and consent should be applied to telephone consultations. To the extent possible, informed consent should be obtained by the physician before starting any service or intervention. Where appropriate, the patient’s consent should be noted in the documentation of the consultation.

CONTINUED OVERLEAF
**CASE STUDY 1**

Surgeon Dr S performed a laparoscopy on Ms L for suspected endometriosis. However, during the procedure Dr S became worried about the possibility of a bowel perforation; he requested that general surgeon Dr K perform a sigmoidoscopy. No damage was detected. Dr S was to be away from the hospital for a week and advised Ms L to inform Dr K immediately if there were any complications.

Four days later, however, Ms L’s husband contacted Dr S directly with concerns over the pain his wife was suffering. Instead of advising Mr L to take his wife to see Dr K, Dr S reassured him that the symptoms were in fact normal and that Ms L was probably improving. Two days later, Ms L was taken to see her GP and was admitted to hospital with septic shock; she underwent an emergency laparotomy and colostomy.

Mr L made a claim against Dr S. Dr S knew he could not evaluate Ms L’s condition over the phone and admitted that he should not have relied on Mr L’s interpretation of his wife’s symptoms. He should have referred her to Dr K. The claim was settled for a low sum.

**CASE STUDY 2**

Mr Q was admitted to casualty with abdominal pain. Surgeon Dr P, who was at least five hours away from the hospital, was phoned and asked to take over management of the patient. After a brief conversation with the referring casualty doctor Dr P asked that the patient be admitted in the ward and kept nil-by-mouth. When he arrived, Dr P saw Mr Q; he realised that the patient was sicker than he had thought and required an urgent laparotomy; Dr P’s working diagnosis was that the patient had a dissecting aortic aneurysm. On opening the abdomen it was clear that Dr P’s diagnosis was correct and the patient bled profusely from an underlying dissecting aorta aneurysm. Unfortunately attempts to stop the bleeding were unsuccessful and Mr Q died.

Mr Q’s relatives made a claim against Dr P. Expert opinion was that all the symptoms of impending aortic aneurysm rupture were present when Mr Q was first seen: the patient had back and/or chest pain, hypertension and dilated bowel loops on abdominal X-ray. Although not all this information was initially passed on to Dr P, he should have excluded it prior to having accepted Mr Q.

The problem in the case really revolved around the referral of a patient with an acute abdomen where Dr P was not immediately available. Under the circumstances, he should have tried to exclude conditions that would have been life-threatening in the short-term; here aortic aneurysm was one of the possibilities and, had he interrogated the doctor, then he would have been aware of the fact that the signs and symptoms were all present.

The claim was settled for a substantial sum.

**Conclusion**

Telephone consultations are a useful tool for the assessment and management of both acute and chronic conditions. They have inherent risks, but as long as you are aware of these risks, have a low threshold for arranging a face-to-face consultation, put yourself in the position to make the diagnosis, make thorough records and ensure the patient is content with the proposed management plan, then those risks can be minimised.

Although these are based on real MPS cases, some facts have been altered to safeguard confidentiality.

**REFERENCES**

3. Ibid
The annual MPS ethics event

Don’t miss out on the chance to earn ethics points from our annual Ethics 4 All events

**DURBAN**

Sunday 1 December 2013  
**Venue:**  
Southern Sun Elangeni Hotel  
**Time:**  
Registration from 0830 for a 0945 start – 1215 close (followed by lunch)

In association with:

**PRETORIA**

Monday 2 December 2013  
**Venue:**  
CSIR International Convention Centre  
**Time:**  
Registration from 1800 for a 1930 start – 2200 close (supper provided)

In association with:

**CAPE TOWN**

Wednesday 4 December 2013  
**Venue:**  
Cape Town International Convention Centre (CTICC)  
**Time:**  
Registration from 1730 for a 1930 start – 2200 close (supper provided)

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

In theory, all doctors are aware of the need to keep accurate and comprehensive medical records. But in busy clinical practice, high standards can sometimes slip as a result of the need to see ever-growing patient numbers. In many of the claims MPS handles, we come across examples of patient notes where there is no record of informed consent being taken; there is no record of discussions around potential postoperative complications; or there is no record of test results being ordered. This can make the job of defending a clinical negligence claim very difficult indeed.

No matter how busy you are, it is important not to underestimate the value of detailed notes. Not only do they help if a clinical negligence claim is brought against you, they are the gold standard of good patient care – leading to better communication between colleagues and smoother handovers.

In “Penetrating the eyeball” on page 15, Dr R’s records showed no evidence of discussion of indication, risks or alternatives for Ms J’s periocular injections. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. As a result, the case was indefensible and was settled for a substantial sum.

Good record-keeping means not only recording consent taken and treatments offered, but doing so contemporaneously. In “Rash decisions” on page 16, Dr P made notes retrospectively after Mr M rang the surgery with swelling, throat discomfort and difficulty breathing after he had been taking allopurinol and steroids for severe foot pain. Remember that alteration of records is a probity issue – and any alterations or retrospective entries should be clearly marked and dated.

Good record-keeping also means recording accurate observations at regular intervals. In “A brain-damaged baby” on page 16, experts were critical of the monitoring of the fetal heart rate both during Mrs N’s induction with prostaglandin, as well as during labour. Poor monitoring and documentation of the CTGs, with a failure to record the date and time, meant that labour was allowed to continue in place of a caesarean section, resulting in intrapartum asphyxia. The case could not be defended.

CASE REPORT INDEX

<table>
<thead>
<tr>
<th>PAGE</th>
<th>TITLE</th>
<th>SPECIALTY</th>
<th>SUBJECT AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Penetrating the eyeball</td>
<td>OPHTHALMOLOGY</td>
<td>CONSENT/INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>16</td>
<td>Rash decisions</td>
<td>GENERAL PRACTICE</td>
<td>DIAGNOSIS/RECORD-KEEPING</td>
</tr>
<tr>
<td>16</td>
<td>A brain-damaged baby</td>
<td>OBSTETRICS AND GYNAECOLOGY</td>
<td>INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>17</td>
<td>Paraplegia after spinal surgery</td>
<td>NEUROSurgery</td>
<td>CONSENT/INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>18</td>
<td>Stumbling block</td>
<td>ANAESTHETICS AND ORTHOPAEDICS</td>
<td>CONSENT/INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>19</td>
<td>An unavoidable amputation</td>
<td>GENERAL PRACTICE</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>20</td>
<td>Sinus surgery: damaged vision</td>
<td>ENT</td>
<td>CONSENT/INTERVENTION AND MANAGEMENT</td>
</tr>
<tr>
<td>21</td>
<td>It’s all about consent</td>
<td>UROLOGY</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>22</td>
<td>A weekend of back pain</td>
<td>GENERAL PRACTICE</td>
<td>DIAGNOSIS/RECORD-KEEPING</td>
</tr>
</tbody>
</table>

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

- High R15,000,000+
- Substantial R1,500,000+
- Moderate R150,000+
- Low R15,000+
- Negligible <R15,000
Ms J, a 36-year-old banker with myopia, consulted Dr R, an ophthalmologist, with a one-week history of pain and blurring of vision in the left eye. Dr R diagnosed anterior uveitis and prescribed corticosteroid eye drops, and proceeded to give a sub-tenon’s injection of 0.5ml depomedrol under local anaesthesia in the lower outer corner of the left eye. The patient felt minor pain with the local anaesthetic injection but felt excruciating pain with the depomedrol injection. Within seconds a black spot blocked the central vision in the left eye. The spot expanded rapidly until the vision was completely lost. Dr R continued injecting till the full dose was given. On examining the left eye Dr R found that the eye was filled with fluid — he arranged a follow-up consultation the next day.

Ms J called later that afternoon to ask if she could see Dr R immediately but was advised to return the next day. Ms J chose to see another ophthalmologist who diagnosed a localised retinal detachment and referred her to a retinal surgeon, who performed surgery eight hours later. The retinal detachment was caused by two needle punctures penetrating the eyeball and injecting depomedrol into the eye instead of the intended sub-tenon’s space. She underwent surgery to repair the retinal detachment and remove the intraocular drug but complete removal of the steroid was not possible.

Postoperatively, the retina was flat, but scattered retinal hemorrhage and macular nerve fibre layer oedema was noted. About three weeks later, Ms J developed an inferior retinal detachment, epiretinal membrane and retinal necrosis. She underwent further surgery to remove the epiretinal scar membrane and correct the retinal detachment. Her intraocular pressure was raised postoperatively but was controlled with medical treatment.

The iritis subsided, the intraocular pressure normalised and the remaining subretinal steroid dissipated completely within three months. Her final visual acuity was hand movement in the left eye and 6/6 in the right eye. The left eye remained painful and uncomfortable. Ms J had difficulty with near work and computer work, suffered eye strain and easy fatigue in the right eye and experienced frequent headaches and imbalance when walking downstairs.

She was assessed as having 20% impairment of vision and 20% impairment of the whole person, with 50% loss of capacity. She also developed depression and was under the care of a psychiatrist. She returned to work six months later but, due to mental distress and intense eye pain, she had to work part-time in a less intense position, and with a lower salary.

Ms J made a complaint and a civil claim. The claim was indefensible and was settled for a substantial sum.

AK

Learning points

- Ample guidance is available through professional bodies and the scientific literature on the management of common eye conditions. Periocular corticosteroid is not indicated for uncomplicated anterior uveitis. Where topical corticosteroids are ineffective, a sub-conjunctival injection of a short acting corticosteroid may be considered. Dr R chose the wrong primary method of treatment, the wrong injectable drug and the wrong route of injecting the drug.

- Periocular injections carry a risk of globe penetration that is much higher in myopic eyes. The records showed no evidence of discussion of indication, risks or alternatives. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. Guidance on the principles of taking informed consent is available in a number of different countries.

- Dr R failed to discontinue the injection when the patient had severe pain and loss of vision. Even though the globe had been injured, the extent of damage may have been reduced had he stopped immediately. Immediate exclusion of a penetration either by ultrasound or by clinical examination is mandatory when patient symptoms suggest globe penetration. Failure to do this established a breach in the duty of care. Early diagnosis and referral for emergency intervention may have reduced the extent of the irreversible damage.

- Adverse outcomes and complications are part of a doctor’s working life. Responding to these events in a timely manner, showing respect, being open and communicating honestly help to reduce the impact of these events on both the patient’s wellbeing as well as the doctor’s professionalism.

- A patient can withdraw consent at any time during the procedure. When pain is not what you expect, it is good practice to stop and reconsider your treatment.
Rash decisions

Mr M, a 56-year-old clerical worker, developed severe pain in his left foot and made an appointment to see his usual GP. Dr P. Dr P knew him well, having diagnosed Mr M with chronic kidney disease several years earlier, and supported him when he suffered a stroke. Dr P suspected he was suffering from gout on this occasion and prescribed diclofenac, with omeprazole cover, since he was also taking aspirin.

Less than a month later, Mr M’s symptoms deteriorated and he requested a telephone consultation with his doctor. Dr P arranged for him to have a further prescription issued for diclofenac and omeprazole, and organised blood testing with the nurse to monitor his renal function.

A further month after attending for bloods, Mr M attended his follow-up appointment with Dr P, where he was advised that the blood tests had confirmed gout, alongside the ongoing chronic kidney disease. He was commenced on allopurinol, with the advice that he should double the dose of this after ten days of treatment.

A fortnight after commencing the new medication, with Mr M now on 200mg of allopurinol, Mr M started to feel unwell. He initially reported nausea and a small itchy area on his torso. Over the next few weeks, a similar rash began to appear on his face. He used calamine lotion without success, and eventually returned to see Dr P for advice.

Dr P concluded that the rash was likely to be secondary to a viral illness, and antihistamines were prescribed. That night, the rash seemed to be getting worse, so Mr M consulted with Dr P again the very next day, and a course of prednisolone was commenced. The allopurinol was briefly discussed, and the patient was advised to continue taking it at a dose of 200mg daily.

The situation continued to deteriorate and Mr M had two further appointments with Dr P over the course of the next week. His steroids were initially increased, and when this failed to improve symptoms, Dr P realised at this stage he had failed to document his previous consultations so made some brief notes, without declaring he was doing this retrospectively.

Dr P suggested the allopurinol should be discontinued. To complicate matters further, Dr P forgot to document the second consultation since he had a busy surgery. Three days later, Mr M developed generalised swelling, throat discomfort and difficulty breathing. Dr P spoke to the patient over the telephone and advised he was likely to be suffering from thrush.

Dr P realised at this stage he had failed to document his previous consultations so made some brief notes, without indicating he was doing this retrospectively. The next day Mr M was admitted to hospital by ambulance and diagnosed with Stevens-Johnson syndrome. He spent a week being treated in ICU with sepsicaemia and renal failure, but unfortunately died as a result of these conditions.

Causation reports concluded that on the balance of probabilities, the patient developed Stevens-Johnson syndrome due to allopurinol, and experts were critical of Dr P’s decision to initiate the treatment after just one attack of gout, and at an increasing dose.

Experts agreed in this case that Dr P had ample opportunity to make the connection between the rash and the allopurinol, and furthermore, the steroid treatment, which is likely to have contributed towards the ulceration, could have been avoided. The case was indefensible and was settled for a moderate sum.

EW

A brain-damaged baby

Mrs N was admitted for induction of labour at a gestation of 38 weeks. Mrs N had requested induction as she was feeling very tired. Antenatally, there had been no concerns over mother or baby. A cardiotocograph (CTG) was normal. As the cervix was unfavourable, Dr L inserted 1mg prostaglandin gel into the vagina. Dr L asked the midwife to commence continuous fetal heart rate monitoring. However recordings were not documented at regular or consistent intervals.

Six hours later, Mrs N was not in labour and the cervix was still unfavourable. Dr L inserted a second prostaglandin gel. Two hours later, Mrs N was in labour with the cervix 3cm dilated. The membranes were artificially ruptured after five hours, after which labour progressed rapidly, resulting in a normal delivery within two hours. During the induction process and labour, the fetal heart was monitored electronically using a CTG.

The baby was born in poor condition with low Apgar scores and transferred to the neonatal intensive care unit.

Mrs N developed a primary postpartum haemorrhage due to anatomic uterus, which failed to respond to medical intervention. The bleeding was so severe that Mrs N needed a laparotomy and ligation of the internal iliac arteries, which successfully arrested the uterine bleeding.

Analysis of the baby’s blood shortly after birth revealed metabolic acidosis consistent with intrapartum hypoxia. Unfortunately, the baby developed seizures and investigations revealed hypoxic ischaemic encephalopathy. The child now has severe spastic cerebral palsy.

A claim was brought by Mrs N. The experts were critical of the monitoring of the fetal heart rate both during the induction phase with prostaglandin, as well as during labour. There was a combination of inadequate fetal heart rate documentation and inaccurate interpretation by the midwife. The CTGs were incorrectly interpreted as normal when they were actually pathological. Allowing labour to continue, rather than performing a caesarean section, led to intrapartum asphyxia and the resultant brain injury. The obstetric expert was also critical of the poor documentation on the CTGs, with a failure to record the date and time, or contractions in some instances.

There was no criticism of the management of the postpartum haemorrhage. The case was settled for a high sum.

GM

Learning points

- The basics can sometimes be overlooked – an apparently trivial rash, as in this case, can herald a more serious condition, which reflects the need for joined up thinking.
- Clear and contemporaneous note-keeping is essential and this case highlights the importance of adequate documentation. Clinical notes are legal documents and any alterations or retrospective entries should be clearly marked and dated. Alteration of medical records is a probity issue.
With any operation it is important to have a valid indication for induction.

A CTG is a tool to monitor the fetal heart rate both during the antenatal period and during labour. In labour it is also used to monitor uterine contractions. The fetal heart rate (FHR) has a number of features that must be examined to allow proper interpretation. There are different levels of abnormality of the FHR. An intrapartum CTG classified as pathological requires urgent intervention.

Training in CTG interpretation and regular updates should be mandatory for all healthcare professionals working in obstetric units.

Misinterpretation of CTGs and failure to act on abnormal CTGs are cited as major factors in maternity claims in the United Kingdom. Between 2000 and 2010, “CTG interpretation” was the second most expensive category in terms of claims by value at over £246 million – Ten Years of Maternity Claims - An Analysis of the NHS Litigation Authority Data (October 2012).

Stumbling block

Mr G was a 52-year-old school headmaster. His lifelong enjoyment of sports was becoming more difficult due to increasing pain from his left knee, although there was no injury or trauma to account for it. His GP, Dr M, initially referred him to a physiotherapist with only temporary improvement. Eventually Mr G asked to be referred privately to a specialist and was referred to Ms S.

Ms S assessed the knee thoroughly. The pain originated in the anterior aspect of the knee around the patellar tendon. There was no history of locking, swelling, or giving way. On examination, the only abnormal finding was mild tenderness along the medial joint line. X-rays revealed small osteophytes around the patella, but normal joint architecture and no other abnormality. An MRI scan of the knee revealed mild degenerative change of the medial meniscus, with no tears, and mild arthritis of the patellofemoral joint.

Mr G was keen to have this treated, so Ms S offered him an arthroscopic assessment and lateral release of the patella. This was performed under general anaesthesia, which was administered by Dr H. After induction, but prior to surgery, Dr H placed a femoral nerve block to provide postoperative pain relief. Dr H did not document any discussion about the block beforehand, nor Mr G’s consent.

Mr G seemed to recover well and was discharged home the following day. At his ten-day follow-up visit to Ms S, he complained of pain in his heel. Ms S recommended physiotherapy and made a plan to follow Mr G up in two weeks. At this visit, the heel pain had settled, but Mr G was experiencing giving way and locking of the knee, as well as numbness and burning pain in his thigh. Ms S noted marked wasting of Mr G’s left quadriceps, and documented he was barely able to perform a straight leg raise. She referred him for electromyography, and commented that she could not think of any reason why a knee arthroscopy would be associated with quadriceps wasting.

Neurophysiologist Dr R performed EMG studies of Mr G’s lower limbs, which revealed an isolated left femoral nerve lesion. Dr R commented that she could not initially identify a cause for the lesion, but speculated that a femoral nerve block might be responsible. She found documentation of Dr H’s block in the anaesthesia chart, and ascribed the nerve damage to the block.

Twelve months later, Mr G had no recovery from his injury. He had almost complete loss of function of the femoral nerve, and experienced difficulty climbing stairs, rising from a sitting position, and walking even short distances. He was required to use a lockable knee brace. As a result of his symptoms, he had been unable to continue working.

Mr G brought a claim against Dr H, in which he alleged that Dr H had not discussed the femoral nerve block with him, and had not sought his consent. Mr G believed that he would not have agreed to undergo the block. Ms S had not known at the time of surgery that a block had been performed, and did not see it being placed.

Dr H’s technique was also criticised. He had used a 25mm blue needle to perform “fan infiltration lateral to the femoral artery using a continuously moving needle technique”. Several of the experts concluded that the nerve had been severely injured by this technique.

Dr H’s failure to obtain informed consent for the block, and his questionable technique, were considered indefensible. The case was settled for a substantial sum.

Learning points

- An important point in this case was the informed consent. Dr H asserted that he had discussed the femoral nerve block with Mr G beforehand, but failed to document any discussion. Consent given by the patient for general anaesthesia does not imply consent to undergo other types of anaesthetic intervention while anaesthetised; for example, a regional nerve block. Where extra procedures are required, their specific risks and benefits should be discussed with the patient, and consent obtained to perform them. These discussions need to be documented.

- Dr H was criticised by the experts for his use of an outdated, unsafe technique. There are several readily-available techniques to make regional blockade safer, including performing the block awake, or the use of a regional block needle, a nerve stimulator, or an ultrasound probe. Ultrasound, in particular, has revolutionised the safety and efficacy of therapeutic nerve blockade.

- Dr H also failed to communicate his block to Ms S. Although it did not affect the outcome, had Ms S known about the femoral block, she may have caught on sooner. The surgeon and the anaesthetist should each know broadly what the other is doing at all times. Dr H should have documented more carefully.

- The WHO surgical safety checklist is a useful tool. Visit: www.who.int/patientsafety/safesurgery/ss_checklist/en
Mrs N was a 26-year-old researcher with a four-year-old daughter. She enjoyed dancing and attended a salsa class with her husband each week. Her right knee was slightly painful so she missed a class to see if it improved but it got gradually worse over the next few weeks.

She made an appointment with her GP, Dr B, to discuss her knee pain and seek his opinion on a skiing holiday she had booked. His notes commented on her right knee pain which was “possibly due to dancing”. He documented some tenderness over the tibial insertion of the medial collateral ligament. He noted that the joint was stable and that there was no effusion. Dr B prescribed diclofenac and explained that he felt her skiing holiday did not need to be cancelled, but that it may not help matters.

Mrs N enjoyed her holiday but was becoming aggrieved by the knee pain, which was troublesome most of the time and when dancing. She saw Dr B and explained that the pain had been ongoing for four months with no improvement and that she couldn’t remember any specific injury. Dr B documented the history and referred her to physiotherapy. His completed musculoskeletal referral form did not highlight any red flags including intractable night pain, weight loss, systemic illness or previous history of cancer.

While she was waiting for her physiotherapy appointment Mrs N rang the surgery again asking for a GP appointment. This was the first appointment she was given with Dr G. Mrs N explained that she had not taken the diclofenac because she was nervous about possible side effects and she felt the pain was getting worse. Dr G’s records stated “history as above” and also noted that there was no locking or giving way. His examination notes were thorough. He documented that she was able to weight bear, that there was no swelling and that the knee was stable with a normal range of movement. He noted mild tenderness medially. He encouraged her to take the diclofenac and to rest, ice and elevate the knee. He advised buying a tubigrip to offer some compression to the knee. He gave safety-netting advice: asking her to return if things got worse while waiting for physiotherapy.

Mrs N saw the physiotherapist, Mr Y, who noted her four-month history of gradual onset knee pain. He recalled the patient saying that the pain intermittently flared. His examination noted a limping gait and an inability to extend her right knee fully due to pain. He noted slight swelling and that the knee was very warm to touch. McMurray’s test was positive. Mr Y’s initial thoughts were an injury, mono-arthritis or cartilage damage. He advised a review after two weeks of anti-inflammatory and ice. At the review it was noted that there was swelling most days and the pain was worse. Mr Y was concerned that there was an inflammatory cause and suggested inflammatory marker blood tests through Mrs N’s surgery. These were found to be normal but Mr Y referred her to a consultant rheumatologist because her knee was still hot and swollen with no obvious cause.

Mrs N was seen urgently in the rheumatology clinic. Blood-stained fluid was aspirated and an x-ray arranged. The x-ray reported “possible tumour” and a subsequent MRI scan and biopsy confirmed the diagnosis of osteosarcoma of her right tibia.

Mrs N sustained a tibial fracture and was given chemotherapy. She struggled with nausea and fatigue and was devastated when she was told that she needed an above knee amputation because the tumour was aggressive and had not responded to chemotherapy. She later had a prosthesis fitted.

Mrs N was extremely upset and made a claim against Dr G. She felt that there had been a delay in the diagnosis of her tumour and that earlier diagnosis could have saved her leg from amputation. Mrs N claimed that the first time she had seen Dr G, she had complained of severe pain in the day and night and that the knee was hot and swollen at that time.

Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given.

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Mr Y responded to chemotherapy. She later had a prosthesis fitted. Mr Y was concerned that there was swelling most days and the pain was worse. Mr Y was concerned that there was an inflammatory cause and suggested inflammatory marker blood tests through Mrs N’s surgery. These were found to be normal but Mr Y referred her to a consultant rheumatologist because her knee was still hot and swollen with no obvious cause.

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Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given. It was felt that Dr G’s examination was of a good standard and that his actions were reasonable. The decision to wait for the physiotherapy appointment with the safety net of reattending if symptoms worsened was found to be reasonable. No indication could be found to arrange an x-ray, blood tests or referral at Dr G’s initial consultation.

It was noted that Mrs N was still dancing at this point and had just returned from a skiing holiday, which would not raise alarm bells. It was also noted that Mrs N was not taking the diclofenac, so it was reasonable to think that her pain was manageable.

Expert opinions were sought from a consultant orthopaedic surgeon, a professor of medical oncology and a consultant radiologist. It was their agreed view that an amputation would have been needed even with an earlier diagnosis, because of the tumour’s poor response to chemotherapy and its aggressive nature.

The case was successfully defended and Dr G was not found to be in breach of duty. MPS took steps to recover their costs.

Learning points

- Although the patient’s circumstances were very tragic, this did not equate to negligence.
- This case reflects the importance of strong expert opinion. The successful defence hinged around the experts’ opinion.
- Good note-keeping is important for good medical practice and essential in defending a case.
- If a patient attends multiple times with the same problem, alarm bells should start ringing. It is useful to stop and think “what could I be missing?”
- Always try to exclude the worst case scenario. It is useful to document the absence of red flags.
Mr P, a 40-year-old office worker, had a long history of sino-nasal problems, and had even had a previous septoplasty operation. Soon after returning from a holiday, he consulted his GP, Dr A, with worsening blockage in the left side of his nose. Dr A saw a polyp on this side and referred Mr P to ENT surgeon Mr E for his opinion.

Soon after this, however, Mr P was admitted to hospital with some breathing problems and sinusitis, and was extensively investigated. These investigations included a CT scan of his sinuses. During this admission, he was seen by Mr E, who also identified the polyp, and a number of other problems on the scan, which he felt would benefit from some endoscopic sinus surgery.

Mr P was discharged from hospital and an ophthalmology opinion was arranged for a few days later. This confirmed an orbital haematoma and some limitation of movements, but no evidence of alteration to visual acuity.

A second ophthalmological opinion was requested some months later when the symptoms of double vision did not settle. In addition, Mr P described symptoms of dizziness and discomfort in the affected eye. This limited his ability to drive and rendered him unable to work. Sadly, no curative interventions were available.

Varifocal lenses were suggested to try and help Mr P with his vision, along with the hope that things might improve further with the passage of time. More positively, his chronic sinus problem appeared to have been successfully addressed.

Expert opinion determined that the breach in the lamina papyracea and the subsequent orbital haematoma had been the cause of Mr P’s visual problems, by limiting the movements of the superior oblique muscle. This is a rare but well-known complication that can happen even to experienced surgeons.

Expert opinion found a breach in the standard of care around the process of consent. Mr E did not appear to explain that the surgery was for quality of life and therefore not essential, or that ongoing medical treatment was a therapeutic option. Nor did he specifically warn Mr P that orbital damage might result in impairment of vision, including diplopia.

The case was settled for a substantial amount.

Learning points

- Informed consent must involve an explanation of the role of medical treatment, or no treatment at all, rather than just surgery, in non-life threatening medical conditions. In this case, Mr P’s chronic sinus condition might have been controlled with steroids and antibiotics.
- The consent process must also include details of the consequences of a complication, not just a general mention of possible adverse events.
- This case is a reminder that even in what might be considered simple or straightforward surgery, significant problems or complications can, and still do, occur.
- MPS’s free workshop for members, Mastering Shared Decision Making, shows how the shared decision making model is an effective way to ensure that patients make appropriate and informed choices about the treatment options available to them. For more information visit the Education section of the MPS website.
Mr K, a 37-year-old self-employed businessman, consulted his GP, Dr P, requesting sterilisation. Mr K stated that although he had two children, aged 17 and 9, he wished to undergo a vasectomy. Dr P explained to Mr K that the procedure was irreversible, and Mr K stated he still wished to go ahead and to use his private insurance. Hence, Dr P referred Mr K privately to a consultant urologist, Dr S.

The patient saw the urologist and was subsequently listed for a vasectomy. Dr S then carried out the procedure under local anaesthesia, with no immediate complications. A few days following the procedure, Mr K noticed some weeping from one of the wound sites, and attended Dr P, who prescribed him a course of antibiotics. By the end of the seven-day course, the situation had worsened with increasing weeping at the wound site as well as pain both at the wound site and in the testis and groin on that side; Mr K thus attended the Emergency Department (ED).

On assessment there his pain was reported as 10/10 and constant, thus not allowing him to sleep, despite oral paracetamol. He was discharged with co-codamol. Four days later Mr K attended a different ED and a diagnosis of post-vasectomy haematoma was made, and Mr K was again discharged with yet stronger analgesics. The following day the patient saw Dr P again and was advised to take a week off work. Things did not improve and the patient called Dr P the following day to see him at home, and was then subsequently admitted to hospital with a diagnosis of infected hydrocoele/haematoma.

After hospital admission, the wound burst and the patient was taken to the operating theatre where the infected haematoma was drained. Two days later the patient was discharged home, and subsequently reviewed four weeks later in outpatients by Dr W, consultant urologist, who discharged him from further follow-up.

Mr K alleged breach of duty due to lack of informed consent on the part of Dr S. As the complication was handled appropriately and is a recognised complication of vasectomy, no issue of technical incompetence by Dr S was alleged. The claim thus solely related to a lack of informed consent; specifically, Mr K alleged that Dr S did not warn him before he consented about the possible complication he subsequently suffered. Mr K stated that he was uncertain about whether to go ahead with the vasectomy and if he had known about the potential complications, he would not have undergone the surgery.

The signed consent form was the key piece of evidence in this case. Mr K used a standard form of consent, but one in which all complications were not printed, and thus Dr S handwrote the complications of pain, bleeding, bruising, haematoma and infection at the bottom of the form. It was alleged by Mr K that Dr S did this after the claim was filed, and thus that Dr S doctored the consent form days after the procedure. This was proven to be untrue as a copy of the consent form was sent to Dr P with a letter stating these complications had been explained, on the same day as the initial consultation.

Dr P confirmed that Dr S did not have access to Mr K’s files after the procedure and thus could not have amended the consent form at a later date as alleged. Also, Dr S had a practice nurse sitting in during the consent procedure and she reiterated the complications to Mr K as well herself after the initial consultation, and this practice nurse confirmed that the consent procedure by Dr S was thorough and complete. The claim was therefore discontinued and costs were recovered from the claimant.

Learning points

- This case illustrates one of the commonest reasons for litigation against doctors, and especially surgeons; that of issues of consent before a procedure. It is not uncommon for a patient to feel happy to proceed for a surgical procedure at the time of the procedure, but then to feel unhappy with that decision to proceed when he suffers a well-accepted complication.
- Vasectomy is one of the most litigious procedures for urologists, although it is one of the simplest operations within that specialty. The procedure is typically day case and under local anaesthesia, taking an average of 20 minutes. However, the pre-procedure consent process and consultation typically lasts longer than this. Having copies sent to the patient’s GP and having a nurse during the consultation further safeguards against litigation.
- When surgeons operate on patients in the private sector and their complications are then managed by different doctors in the public sector, patients can often feel aggrieved at the operating surgeon who is now ‘nowhere to be seen’. Good communication between all doctors involved in such situations can facilitate the optimal management of the patient, and thus lessen the risk of future litigation. This case provides a valuable lesson: however straightforward and routine the surgery might be, proper documentation is vital.
- There were two missed opportunities to intervene here. The patient was left unhappy and aggrieved.
- The surgeons should have given their contact details and been responsible for the follow-up arrangements.
Mrs P was a 42-year-old housewife who lived with her husband, daughter and their first grandchild. She had suffered with chronic lower back pain for many years, which was helped by regular paracetamol. She had struggled with flare-ups over the years, usually after gardening or lifting the shopping. Symptoms always settled within a few days with co-codamol or ibuprofen prescribed by her GP.

Mrs P had been looking after her granddaughter and had lifted her rather awkwardly into the car. This aggravated her back so she took some co-codamol she had at home from the most recent flare-up. When this failed to relieve the pain, she made an appointment with her GP. She was unable to lift her granddaughter because of pain in her lower back. He prescribed ibuprofen and arranged a follow-up appointment in a week. He referred her to physiotherapy because of the frequent exacerbations.

Her pain became more severe through the week. She took the co-codamol and ibuprofen but couldn’t manage the pain. By the Friday evening she was in tears and her husband demanded that she saw a doctor that evening. The nurse documented that she “would like to see a doctor for stronger meds” and made her an appointment to see the out of hours GP, Dr M, that evening.

Dr M reviewed the triage nurse’s history, in particular the lack of any noted red flags. He documented that she had complained of pain over the coccyx area and that she had claimed she could not sit or lie down due to pain. He therefore examined her standing and noted an absence of spinal tenderness over the coccyx. He prescribed some dihydrocodeine to help her manage the pain and asked her to ring back if the situation worsened.

On the Sunday, Mrs P became anxious because she felt completely numb at the bottom of her back. She rang the out-of-hours service again and spoke to a triage nurse. She explained that she “felt so numb she couldn’t feel the toilet seat beneath her and that she couldn’t feel the passing of water”.

She was also very embarrassed but mentioned that she had been dribbling urine without being aware of it. She explained that despite taking the dihydrocodeine she had developed severe pain at the back of her right leg and near her ankle. She wondered if the dihydrocodeine had constipated her because she was unable to open her bowels. The nurse documented the history and advised her to see her own GP in the morning and to keep the physiotherapy appointment that was pending the following week. She gave her advice on taking senna and lactulose for the constipation.

Mrs P had a dreadful night. She couldn’t sleep because of the pain and when she tried to walk to the toilet she noticed that her right leg felt “floppy” and that she could not feel the floor with her right foot properly. Her husband took her straight to her own GP surgery on Monday morning. Her own GP took a history and examined her, documenting an absent ankle reflex, a straight leg raise which was reduced on both sides and weak anal tone. He diagnosed probable cauda equina syndrome and arranged for an urgent assessment with orthopaedics.

His referral letter stated that she developed the numbness and the voiding difficulties the day before. The orthopaedics team saw her the same day, also noting that her symptoms suggestive of cauda equina had started the day before. They catheterised her due to retention and...
arranged an MRI scan of her lumbar spine. The MRI showed a massive L4/5 disc prolapse causing severe central canal stenosis and also impinging on the traversing right L5 nerve root. Mrs P subsequently had an L4/5 decompression and discectomy and partial L4/L5 laminectomy.

After the surgery, Mrs P was seen in the spinal clinic. She had no true urinary incontinence following the retention although she still had some difficulty in assessing when she had finished passing urine. Fortunately she had full control of her bowels. She was still upset about worsening right leg pain, which was severe.

Mrs P made a claim against the out-of-hours service, firstly against the nurse for failing to triage appropriately and secondly against the GP, Dr M, for failing to recognise and promptly refer her cauda equina syndrome. She claimed that she had had the cauda equina symptoms on the Friday that she consulted Dr M.

MPS sought the opinion of a GP expert who was not critical of Dr M’s consultation on the Friday evening. The triage notes did not indicate any problems with new symptomatology, specifically no mention of any development of radiation of the pain, altered sensation or problems with micturition and bowels. It was agreed that the limited examination in the absence of these symptoms was reasonable. It was also considered that Dr M’s prescription for stronger analgesia was effective since the patient did not contact a doctor the following day.

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Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions.
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Suspected epilepsy: when to warn

It was stated in “Suspected epilepsy: when to warn” (Casebook 21(2)) that “there was nothing in the notes to suggest the hospital intended to rule out anything serious, like epilepsy”. Yet an EEG was arranged. I cannot conceive of a reason for EEG other than to rule out something serious – like epilepsy. The mere fact that it was arranged – isn’t it ample proof?

Moreover, presumably the patient’s parents were given the EEG appointment card or information before leaving the hospital; they then chose not to bring the patient for the EEG, without bothering to find out what the test was and what it was for. Don’t they bear some responsibility?

Dr Chun How Ooi, Singapore

Response

I agree with you that the statement you quote in your first paragraph is somewhat illogical.

Regarding the parents’ responsibility, courts generally are reluctant to hold a patient – or in this case the child’s parents – as contributing to the negligent outcome. You can imagine the persuasive power of a parent saying: “Of course if I had been properly informed of what the test was for and why it was important, I would never have knowingly put my child at risk...” And the notes usually do not document the detail of such a conversation.

Many thanks for your interesting and thoughtful comments.

Two cases: one theme

Re: the articles on pages 20 (“A rash oversight”) and 21 (“A failure to monitor”), Casebook 21(2).

Two articles have a common theme. Patients in both cases sued their GP while the healthcare system and government policy neglected to ensure patient safety.

The healthcare industry should take steps to prevent chickenpox in pregnancy. We could have a national immunisation program [here in the UK] like that in the US (www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html). We could also check women for immune status at booking or preconception. As it is we rely on GPs remembering to follow a post-exposure prophylaxis protocol. Murphy’s Law applies so patients suffer and doctors pay, via indemnity subscriptions, to help clear up the mess.

Why does the healthcare system have us install a piece of electronics in a man’s chest without having a way to monitor it? The GP’s notes may have been poor but the responsibility for the device should rest with the company that made it and the clinic that inserted it. A cardiac pacemaker is a ‘mission critical’ device. If it stops the patient might die. In the case you describe recording the pulse or an ECG wouldn’t have given information about its activity over a period longer than a few seconds. There should be systems to ensure that it can’t fail without that failure being detectable in

When normal is wrong

In the section headed “Learning points”, it is written: “The failure rate of vasectomy, either due to failure to remove adequate sections of both vasa or recanalisation, albeit small, is of crucial significance, and must be mentioned and documented.”

Unfortunately, this sentence implies that removing an “adequate section” of vas will prevent failure. Evidence from vasectomy randomised studies shows that the best way to prevent failure is to lightly cauterise the lumen of each vas and to separate the ends by a tissue plane. Separating the ends by a tissue plane but without luminal cautery is nearly as good. The older method of removing a long length of vas is associated with a higher complication rate (bleeding and pain) and higher recanalisation rate.

If any vas is removed then it should only be a small section, not an “adequate section”, as one has to remove a very long section to prevent end approximation and vasectomy failure. Removing very long sections is associated with an unnecessarily higher complication rate and also makes reversal much more difficult should circumstances change. The ideal vasectomy is minimally invasive, has minimal complications, is 100% effective and 100% reversible. No technique perfectly meets these criteria but the no-scalpel technique with fascial interposition and ideally with luminal cauter is the best we currently have.

Tim Hargreave, Consultant genito-urinary surgeon (retired), Current member, research review panel, human reproduction programme, WHO, Geneva. References have been supplied, and are available on request.
A case of renal failure

I found “A case of renal failure” (Casebook 21(2)) rather worrying. It states that Dr T was criticised for failing to notice that Mrs B’s renal function had not been rechecked.

Mrs B had been advised by Dr T to have her bloods rechecked but if she failed to do so, then that is her fault. I see between 36–40 patients a day but do not make a list of which patients have not had the blood tests that I requested them to have.

Is MPS suggesting that this is what we should be doing?

Secondly, the report mentions that the GP should have sent a urine for ACR. My understanding is that an ACR should only be sent for diabetic patients and non-diabetic patients should have a PCR sent instead.

Please do let me know if I am wrong in this regard.

Dr Muhammad Shahbaz Sharif, Salaried GP, Leicester, UK

Response

We acknowledge the practical challenges of having a system that will pick up patients who do not return with results of tests that have been ordered – it is a frequent source of debate as to whether a court would invariably hold the patient totally responsible for the consequences; a court might take the view that patients are less likely to act in a way that puts them at risk, if they understand those risks. However, there was no excuse for the GP not to have checked her renal function at subsequent visits, and the results were so significant as to suggest that the GP could not have explained the importance to the patient.

Finally I am advised that most CKD guidelines advise annual ACR checks, on all patients with an eGFR under 60, regardless of underlying aetiology.

I hope that this addresses the issues you raised.

A rash oversight

I read with interest your case report regarding the patient who was given incorrect medical advice by non-medical staff (“A rash oversight”, Casebook 21(2)). I notice the doctor involved was criticised for “allowing administrative and nursing staff to provide negligent medical advice”. Although not knowing the full case, I assume that the doctor had no knowledge of his administrative staff giving such advice; so I wonder why the doctor is the subject of the claim and not the member of staff involved?

Secondly, with the increasing use of non-medical practitioners to cross-cover several specialties out-of-hours, who would be responsible overall for any errors in a patient’s management? One example would be an error made by a member of the Hospital at Night (H@N) team on a surgical ward. The teams are not usually specialty-specific (as medical staff traditionally are) and the consultant responsible for the patient would not line manage the members of the H@N team or be involved in setting out their roles and responsibilities.

With this case report – and the increasing use of non-medical staff – I worry that when I am a consultant I may be deemed responsible for the erroneous actions of a member of staff I do not even know, purely as my name is above the bed.

Dr Callum Kaye, UK

Response

In the first case which took place in general practice, the GPs who employ practice staff are vicariously liable in law for their acts and omissions. And they would be expected as a matter of good practice to have systems and procedures in place regarding the scope of their responsibilities, as a safeguard against people acting outwith the scope of their knowledge.

It would be an unsuccessful defence for the GP to argue that they were unaware of what their staff were doing.

In the hospital setting, whilst each individual is personally responsible (as opposed to liable) for their own actions, any claim would be brought against the hospital, which is liable for the acts and omissions of its employed staff, as well as for any deficiencies in policy and procedure.

I hope that this clarifies the different situations.
Complications: A Surgeon’s Notes on an Imperfect Science
by Dr Atul Gawande (£8.99, Profile Books, 2008)
Reviewed by Dr Omar Mukhtar, ‘Darzi’ Fellow, Health Education South London (UK)

Complications: A Surgeon’s Notes on an Imperfect Science is a collection of essays focusing on the fundamentals and imperfections of modern surgery. With many originally written for The New Yorker magazine, where Atul Gawande has been a staff writer since 1998, the essays provide an honest insight into the world of modern healthcare that extends beyond the operating theatre and the consulting room – ultimately, affording readers an opportunity to reflect on the human condition itself.

Broadly grouped around three central themes – Fallibility, Mystery and Uncertainty – Gawande’s essays slowly dismantle the misconceptions held by the general public whilst challenging the status quo fostered and maintained by the medical hierarchy. He admits freely that medical professionals make mistakes, that much of the knowledge we hold so dear is based on a loose interpretation of facts (often acquired many years ago) and that we do learn ‘on the job’. He also acknowledges that there is much about the human body that remains stubbornly mysterious, that good doctors do go ‘bad’ and that there might be a case for super-specialisation from the outset of medical training.

Written with a clarity often lacking in ‘populist’ musings on healthcare, Gawande’s work draws not only on his experiences as a general/endocrine surgeon at Brigham and Women’s Hospital, Boston, Massachusetts, but also on his experiences as a father. Equally, many of the essays make reference to the scientific literature without resorting to a dry recall of facts, in a manner that must be applauded – regardless of whether they relate to the chronic pain of a stranger or the horror of a life-threatening respiratory infection afflicting his youngest child (born prematurely). That said, despite being a Rhodes Scholar who studied PPE at Oxford, Gawande’s observations tend towards the superficial cliche – perhaps a consequence of the immediacy required when writing for a periodical that is published 47 times a year.

Despite this, Complications has a charm, confidence and humility that you suspect is intrinsic to Gawande himself. The first of three books (the others being Better: A Surgeon’s Notes on Performance and The Checklist Manifesto: How to Get Things Right), you might not be wrong in assuming that it is Gawande’s personal testament to a quality and safety agenda that is only now taking root in certain countries – a decade after Complications was first published.

The Secret Anatomy of Candles
By Quentin Smith (£8.99, Troubador Publishing LTD, 2012)
Reviewed by Dr Catherine Walton, CT3 Psychiatry, Wales (UK)

Quentin Smith has delivered a promising debut novel. The Secret Anatomy of Candles is a medicolegal drama with an ethical dilemma that will hook even the most world-weary of medics, and stir them to discuss the central themes with colleagues over coffee.

The ideas and questions raised by the novel are topical and relevant; for example, one important theme of the book is the MMR vaccine. The week I read the novel was during the time of intense media coverage of the measles outbreak in the Swansea area, so it was immediately relevant.

The world of Jasper Candle, a “ruthless compensation lawyer”, is set in the courts, bars and streets of Durham. The description of the city is excellent: Smith shows a flair for this, and it was effortless to conjure up the areas described in my mind’s eye.

The man himself, Jasper Candle, is a character of some depth, with the flaws and nuances one would expect of a successful lawyer of his standing. Unfortunately, the character is perhaps rather too typical – the flaws and nuances feel somewhat unoriginal. It is clear that Candle is troubled by a physical ailment, the development and diagnosis of which is essential to the plot. Unfortunately, as a medic reading this novel, the diagnosis became clear rather sooner than I feel the author would have hoped in order to maintain suspense through to the twist at the end.

However, having discussed the plot with family members, I feel that this would not have been so apparent to a non-medical audience. Other characters within the book are somewhat more intriguing. In particular, the investigator Lazlo is perhaps the most interesting. His clothes and ‘cheap’ piercings put him firmly in the lower class, but he shows understanding and insight into the feelings and motivation of his employer, Candle.

The plot itself is complex and several themes run in parallel. This would be confusing were it not for some skill on Smith’s part in keeping the chapters short and succinct. It also had the added benefit of keeping the pages turning. If I had any criticisms of the novel it was the use of cockney rhyming slang to add ‘depth’ to Candle as a character – it felt unnecessary and at times plain out of place. I also think that sometimes Smith utilised long and challenging words and sentences, which over-complicated the style of the book.

Overall, I felt that this was a great read. The storyline is relevant, up-to-date, and made me think about certain issues from a different perspective; it is certainly one to consider for your next bedtime book.

Read a review of The Checklist Manifesto in the next Casebook.
1. When non-standard treatment is offered consent does not need to be as rigorous as for standard treatment.
   True/False

2. While a complication itself does not necessarily mean there was negligence, poor management of an acknowledged complication can result in a claim of negligence.
   True/False

3. Adverse outcomes and complications are part of a doctor’s working life. They should be responded to timeously, showing respect and openness and communicating honestly with a patient.
   True/False

4. Once the patient has given consent you can proceed. Consent cannot be withdrawn.
   True/False

5. When discussing a surgical procedure with a patient it is only necessary to include the common and minor side effects.
   True/False

6. As long as you have discussed the potential complications of the procedure with a patient there is no need to document that discussion.
   True/False

7. The HPCSA places no obligation on doctors to keep up to date in their field of specialty.
   True/False

8. Consent given by a patient for general anaesthesia implies consent to undergo other types of intervention, such as regional anaesthesia and analgesia, while under general anaesthetic.
   True/False

9. Whether or not a claim is settled is heavily influenced by the expert opinion of the defence expert.
   True/False

10. Good notes can make defending a case difficult as the claimant’s lawyers then have the opportunity to see exactly what you have done.
    True/False

11. During the course of informed consent you are not obliged to inform the patient of the consequences of no treatment or intervention.
    True/False

12. The consent process is essentially a discussion where possible adverse events are mentioned in passing; there is no obligation to include details of the consequences of complications.
    True/False

13. Simple and straightforward surgery is such that significant complications seldom occur; therefore, they do not have to be discussed.
    True/False

14. Vasectomy is one of the most litigious procedures for urologists.
    True/False

15. If you are not sure whether or not a colleague has an impairment that may interfere with them practising safely, then it would be prudent to discuss the case confidentially with a colleague.
    True/False

16. If the HPCSA asks you to write a factual report they can only be investigating a colleague and you do not have to worry.
    True/False

17. Disputes between doctors and medical aids with respect to fees do not fall within the benefits of MPS membership.
    True/False

18. Spurious or frivolous complaints are such that they do not need to be investigated or responded to.
    True/False

19. When writing a report it is important not only to set out the facts but also to speculate on what has happened.
    True/False

20. If you feel that a fellow practitioner is impaired to the extent that it interferes with their ability to practise, then Section 25 of the Health Professions Act 56 of 1974 obliges you to report the practitioner to the HPCSA.
    True/False
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