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His edition of Casebook is one of welcomes and farewells. Dr Pardeep Sandhu is the new executive director of your professional services division, where he will be responsible for maintaining and building on the quality of the medicolegal advice and legal support that is available to you.

The appointment is a considerable boost to our aim of providing you with world class service. You can read more about Dr Sandhu’s appointment on page 5, but in summary, Dr Sandhu brings with him many years’ experience of working within diverse healthcare environments around the world, and he has also worked extensively with governments to advise on health policy and clinical governance – something that is becoming increasingly important to Medical Protection as we seek to shape the clinical negligence landscape in many countries in which we have members.

The cost of clinical negligence claims continues to rise in a number of countries around the world, and we are speaking regularly with relevant governments and policy-makers to find ways to control costs and simplify what can be long-running legal processes. This is particularly true of South Africa, and you can read more about our proposals on page 6.

This edition of Casebook contains, as ever, our latest collection of case reports. Along with the usual salient points – and in this edition there is a general theme on the value of good record-keeping – you will also be interested to note some successful defences. As well as demonstrating the value of our legal expertise that is available to you, these cases also show how the clinicians involved were able to help their own position, be it through excellent documentation, a robust consent process or an articulate presentation of evidence at trial.

I mentioned at the beginning of this editorial that this edition of Casebook was one of welcomes and farewells. This is my last edition as editor-in-chief of Casebook, as I am moving into a new role within Medical Protection. I have greatly enjoyed my time in the position, especially as it has given me so many opportunities to hear your feedback directly.

I am happy to announce that Dr Marka Davies will be taking on the role, please do get in touch with any comments or suggestions that you wish Dr Davies to take on board.

Dr Nick Clements
Casebook editor-in-chief

FEATURE

NEW EXECUTIVE APPOINTMENT: DR PARDEEP SANDHU

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu joins us from Aetna international, a global health benefits provider in the USA, where he was medical director and head of business development.

Dr Sandhu spent more than seven years working with governments to create and expand robust healthcare systems. In this international role, Dr Sandhu worked across health policy, clinical governance, business development and strategy, as well as designing and launching Aetna’s international care management programmes in multiple geographies.

Dr Sandhu trained at the University College London and was GP before serving as a clinical advisor to the UK Department of Health. He also holds a MBA from Kellogg School of Management, Northwestern University, USA.

Simon Kayll, Chief Executive, said: “We are delighted to welcome Dr Pardeep Sandhu.

“We work in an increasingly challenging environment and one in which litigation, complaints and appearances before the regulator are now becoming more common. Dr Sandhu will head up a large team of more than 200 medical, dental and legal experts providing members with advice, support and protection tailored to their circumstances.

“He will also play a critical role as part of the Executive Committee, providing direction across the whole organisation. With his international experience and background as a physician and senior health care executive, Dr Sandhu will help strengthen our position as a world-class protection organisation.”

Dr Sandhu said: “I am very excited to be joining a team of such talented individuals, and look forward to building on their established expertise to deliver an even better service to our members.

“With numerous challenges facing the medical and dental professions worldwide, it is vital that we are there for members in the right place, at the right time. As a former practising physician myself, I understand the unique dilemmas clinicians face on a daily basis – and I very much subscribe to the Medical Protection ethos that prevention is better than cure. Ensuring the expertise of my team benefits our membership is a key goal for me.

“Of particular interest to me is the challenge of meeting the needs of our members around the world. With so much variation from country to country, it is imperative that we tailor our services to meet everyone’s requirements as fully as possible. I look forward to working with you and hearing your views on how we can improve even further.”
A recent years Medical Protection has become increasingly concerned about the claims experience in South Africa, with the rising cost and frequency of medical malpractice claims.

Our data indicates that between 2009 and 2015, there has been an escalation in the likely value of claims being brought against doctors, with claim sizes increasing by over 14% on average, each year, during that period. Our data also indicates that the estimation of the long-term average claim frequency for health professionals in 2015 is around 2½ times higher than that in 2009.

GOVERNMENT CONCERNS
The situation is also of concern to the South African government and has been described as a “crisis” by Health Minister Aaron Motsoaledi.1 “The nature of the crisis is that our country is experiencing a very sharp increase - actually an explosion in medical malpractice litigation - which is not in keeping with generally known trends of negligence or malpractice,” he said at a medi­­­­­­­­ico­­­­­­­­lical summit in Pretoria in March 2015.

The cost of medical malpractice claims has skyrocketed and the number of claims increased substantially.”

He identified four specialties that are persistently targeted for litigation: obstetrics and gynaecology, neurosurgery, neonatology and orthopaedics.

RISING INDEMNITY COSTS
Our experience broadly reflects the government’s view. For obstetricians in particular, the subscription rate that Medical Protection has had to charge members is becoming ever more expensive due to the increasing awareness of the future cost of providing protection for obstetric risk on an occurrence basis.

In response to this Medical Protection is now offering private obstetricians and gynaecologists a choice between continuing with the existing occurrence-based protection and claims-made protection.

With claims-made protection subscription rates are lower in the early years but will increase over time. Members will also need to put additional arrangements in place if they decide to leave Medical Protection or retire.

As a responsible not-for-profit organisation owned by members, Medical Protection has an obligation to ensure that we collect sufficient subscription income to meet the expected future claims and so that we can be in a position to defend their interests long into the future.

With the current claims environment in mind, Medical Protection will be publishing a policy paper that identifies some of the potential factors contributing to it and will make proposals that we hope will contribute to the important debate about potential reform.

WHY DO CLAIMS HAPPEN?
There are likely to be a number of interrelated factors that have led to the current claims environment. Potentially among the most significant is the provision of the Road Accident Fund Act which may have resulted in some attorneys focusing their area of interest onto personal injury claims and, in particular, clinical negligence.

The government has also identified this as a leading cause; Dr Motsoaledi told the medi­­­­­­­­­ical conference that the lawyers leading the litigation against medical practitioners are the same that bankrupted the RAF.

“They are driven by this pocket-lining phenomenon. They are simply in hospitals because the platform from which they have been living their pockets, and not that of the wronged patients, has now changed.” 3 We are also concerned that without the opportunity to make a complaint through a transparent complaints system, a dissatisfied patient is likely to consider other options to express their concerns. This may be reporting a doctor to the HPCSA or instructing an attorney to make a claim for clinical negligence, or both. Both options involve lengthy processes and delay, and inevitably involves additional emotional stress for the doctor, but also the patient. This is particularly the case if the complaint is not upheld or if the claim is successfully defended.

Medical Protection acknowledges and welcomes the fact that some progress has been made towards the development of an efficient, patient-centred complaints system, such as that envisaged by the Office of Health Standards Compliance and its Ombud, and that there are in some areas small-scale complaints systems instituted by private practices. However, we are concerned that such systems are not standardised and robust enough to compete with litigation as a means to resolve concerns.

The priority must be to develop a robust, efficient and, above all, patient-centred, complaints system to address patient concerns as an alternative to litigation. Such a system should also allow for effective, local resolution in the first instance.

THE LEGAL PROCESS
It is Medical Protection’s experience that the claim journey is made onerous due to the pre-litigation stage as they are wholly reliant on the plaintiff’s co-operation to move the claim early. This results in an increase in costs, and delay, as well as anxiety on the part of patients and defendants.

Once litigation commences both patients and defendants are faced with delay and costs as there are few procedural mechanisms in place to advance the litigation and those that are in place are, in our experience, cumbersome, costly, and in some instances result in even further delay in the resolution of the matter.

RISING COSTS
It is against this backdrop that Medical Protection has over the past five years seen an increase in the size of medical claims. In particular, special damages (for loss of future earnings and care, medical and hospital expenses) have increased considerably. This is especially true in high value catastrophic claim cases. The cost of caring for an injured patient for the duration of their life has increased drastically.

WHAT IS TO BE DONE?
We believe that legal and procedural reforms are required to begin to tackle some of the factors that have led to this claims experience and ensure a fairer and more efficient system for all parties. Added to this, a patient-centred, standardised complaints system should be developed to ensure that patient concerns are addressed, where possible, before they become a claim.

These proposals are not intended to be prescriptive; Medical Protection acknowledges that these proposals should be explored further, and others considered. Rather we hope that these will add to the debate.

For more detail on what Medical Protection recommends, please visit our website: medicalprotection.org.

REFERENCES
3. Medical Protection recommends, please visit our website: medicalprotection.org.

With a deteriorating claims environment in South Africa, Sam McCaffrey looks at Medical Protection’s suggestions for change.
IS DOCTOR-ASSISTED SUICIDE NOW LEGAL IN SOUTH AFRICA?
A brief analysis of the Stransham-Ford judgment

Suzette van der Merwe, director at MacRobert Attorneys, takes a look at a controversial recent case

WHAT THE JUDGMENT MEANS

In order to gain a better understanding of the reasoning behind the judgment and its scope, the South African Constitution should be considered. Section 36 of the Constitution in respect of the interpretation of the Bill of Rights, reads that when interpreting the Bill, a court, tribunal or forum:

1. Must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
2. Must consider international law, and
3. May consider foreign law.

THE CASE

Stransham-Ford, a lawyer who was terminally ill with cancer, brought an application in the North Gauteng High Court in April 2015 for a court order. The order was that if Mr Stransham-Ford’s doctor were to assist him in committing suicide by either supplying him with or administering a drug that would hasten his death, the doctor would not be held criminally liable or be charged with unprofessional conduct by the HPCSA.

The controversial order was granted by Judge Hans Fabricius mere hours before the patient died of natural causes, thereby establishing a cause of action where no cause of action had existed before in our law.

Mr Stransham-Ford had been experiencing intractable pain on a daily basis for years and, despite taking various medications, these were ineffective in alleviating his suffering. He wanted to exercise his right to human dignity and bring an end to his life by taking a lethal dose of a drug but, in the process, needed the help/resistance of his doctor.

In his founding affidavit, Mr Stransham-Ford said that the purpose of the application was to have judicial oversight, to obtain a court order giving effect to his fundamental rights, and to ensure that there would be no civil, criminal or disciplinary liability due to the administration of or provision of the lethal agent to him by the medical doctor. He also said that he was not afraid of dying, but afraid of dying while suffering.

THE AFTERMATH

After the judgment, an application was brought by the Justice and Health Ministers, the National Director of Public Prosecution and the HPCSA requesting Judge Fabricius rescind the order. The argument was that due to the fact that Mr Stransham-Ford had died before the order had been granted, it meant that his rights had fallen away and that the court order was moot. The judge disagreed and turned down the application, reiterating that the judgment established a cause of action and that it would have a practical effect on other parties, because they would now be entitled to approach the court.

The professional duty of a doctor requires that he/she promotes life and prevents harm. However, there are those who believe that doctors have special moral duties when death was inevitable and suffering intractable. The public reaction that the judgment unleashed revealed that there is general disagreement about questions such as freedom of conscience, a doctor’s right to dignity and the right to life; whether suicide should be a purely personal matter; the effectiveness of safeguards; the limits of professional duty; and religious beliefs should be dealt with in constitutional interpretation.

EUTHANASIA IN THE SPOTLIGHT

In 1998, the South African Law Commission found in favour of euthanasia and brought out discussion paper 71 (Project 86), on Euthanasia and the Artificial Preservation of Life, and proposed legislation that the Commission submitted to the Minister of Health. One of the options in the paper was that a medical practitioner would be allowed to carry out a patient’s request to die. Certain safeguards were recommended, namely that the patient had to be terminally ill, subjected to extreme suffering but mentally competent. A second independent medical practitioner would have to confirm the diagnosis and the findings also had to be recorded in writing. The request must, therefore, be based on an informed and well-considered decision. However, in the 16 years since then, Parliament has not acted upon the recommendations. The Fabricius judgment has brought the findings of the Commission under the spotlight once again and highlighted the need for new legislation regulating active euthanasia.

Whilst the World Medical Association Declaration on Terminal Illness expressly refers to a patient’s “right to autonomy in decision-making” that must be “respected with respect to decisions on the terminal phase of life”, this only refers to refusal of palliative care that may accelerate the dying process (so-called “passive euthanasia”) but does not include active euthanasia. According to the judgment, the applicant’s counsel pointed out that there are at least 11 foreign countries/states in which assisted suicide or active voluntary euthanasia was not unlawful, namely Albania, Belgium, Canada, Colombia, Luxembourg, the Netherlands, Switzerland, Oregon, Vermont, Washington, New Mexico and Montana.

Neither the South African Medical Association nor the HPCSA supports the Stransham-Ford ruling and there are many objections from religious groups. It is clearly a case that should be taken to the Constitutional Court and, until that happens, an application for leave to appeal will be necessary in all cases of active euthanasia for medical practitioners to escape legal liability.
SUSPECTED CHILD ABUSE:
A DOCTOR’S OBLIGATIONS

It is mandatory to report suspected abuse of a child, whether that abuse be physical, emotional, sexual or neglect. Medicolegal adviser Dr Angela Farquhar explains the law, and advises on how and where to report your concerns.

THE LAW

Two different pieces of legislation cover the mandatory reporting of child abuse in South Africa. Section 110 of the Children’s Amendment Act compels doctors and healthcare workers, along with certain other professional groups, to report when they suspect that a child has been “abused in a manner causing physical injury, sexually abused or deliberately neglected.”

Sexual abuse is also covered in section 54 of the Sexual Offences and Related Matters Act, which compels any person to contact the police if they have “a reasonable belief or suspicion” of any form of sexual abuse against a child or mentally challenged individual.

While the Sexual Offences Act compels a person to report the suspicion to the police, for other forms of abuse under the Children’s Amendment Act there is a choice of whom to report to. It stipulates that suspected child abuse must be reported using Form 22 to one of three agencies: a designated child protection organization such as child welfare, the Department of Social Development, or the police.

Once a report has been made to one of these agencies a social worker should be assigned to investigate the case.

GOOD FAITH

Both Acts state that the reporting has to be done in “good faith”, this means that a report of suspected abuse must be made without any malicious or spiteful intent.

If this standard is followed when reporting, and supported by a set of facts, it will not give rise to any successful claims of liability. The person reporting will not be held liable in civil or criminal proceedings even if it is found that there is no evidence of abuse or neglect.

ACCOUNTABILITY

Healthcare professionals can be held accountable if they fail to report suspected abuse. As previously mentioned they may face fines and time in jail. Additionally, the HPCSA guidelines urge members to report any unethical or illegal conduct, and according to the Health Professions Act No 56 of 1974, the HPCSA may order a fine or a suspension for a period of time, or remove a member’s name from the register if they are found guilty of failing to report suspected abuse.

CASE 1

A CAMPING INJURY

Patient Z, a five-year-old boy, visited Dr Y at his practice with a bad cough. When examining his chest Dr Y came across some unusual burn marks and scarring. Z also had significant bruising around his upper arms.

Dr Y asked Z’s mother what had caused these burns and bruising, and she stated Z had trapped and fallen after a recent camping holiday and that the chest lesions were insect bites.

Comparing mother’s story to the injuries on Z, Dr Y was unsure that she was telling the truth and was very concerned that the injuries may be evidence of physical abuse.

Dr Y completed Form 22 to report suspected abuse and submitted it to the Department of Social Development. An investigation was launched by social workers.

CASE 2

A MESSY DIVORCE

Patient R was a 13-year-old girl who had a nine-year-old sister. Her parents divorced acrimoniously three years previously and were involved in ongoing court cases regarding the children’s custody and maintenance payments. R was referred to Ms S, a counselling psychologist in private practice, for the treatment of childhood depression and anxiety. After five sessions R disclosed to Ms S that her father forced her into sexual activity. She explained to Ms S that she started after her parents got divorced. She had not disclosed this information to anyone yet and was fearful that her father would find out. He had threatened to harm her and her mother if she told anyone.

Ms S remembered that she had a legal and ethical duty to report suspected child abuse to the authorities but was unsure of how to proceed. She called Medical Protection to speak to a medicolegal adviser, and asked if completing Form 22 and submitting it to child welfare was the correct procedure.

The adviser informed her that while submitting Form 22 to child welfare would be appropriate under Section 110 of the Children’s Amendment Act, due to the sexual nature of the abuse she also had a legal obligation to inform the police of her suspicions immediately, under the Sexual Offences Act.

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REFERENCES

YOUR LOCAL SERVICE IN SOUTH AFRICA

Your calls to the Medical Protection medicolegal advice line are now being handled by legal professionals in South Africa – find out why we made this change and what it means for you.

The Medical Protection medicolegal advice line that was previously hosted by advisers in the UK is now being handled by legal professionals in South Africa, providing an improved and truly local service.

Attorneys at the law firm MacRobert now take all calls between 7.30am and 5.30pm RSA time, while out-of-hours calls continue to route to an adviser in the UK.

MacRobert attorneys have expert medicolegal knowledge and a great understanding of the HPCSA and South African rules and regulations. They are also able to speak Afrikaans as well as English, allowing you to speak in whichever language you are most comfortable with, while receiving truly local advice.

The change has been made following feedback from members, that indicated you wanted a local voice on the ground to handle your queries.

Dr Graham Howarth, Head of Medical Services for Africa, said: “Changing the way we deal with calls from South African members so that they can speak to local experts with local expertise is an example of how Medical Protection listens and responds to member concerns.”

We are always looking at ways we can improve our service and make it easier for members to access our expert advice and protection.

The new service began on 2 June and is running as a pilot scheme until the end of December. We are seeking feedback from members during this period with a view to making the change permanent.

For medicolegal advice members should call 0800 982 766 (toll-free within RSA).

We ask for your feedback.
FROM THE CASE FILES

Gillian Williams, claims manager, introduces this edition’s collection of case reports and reminds readers of the importance of informed consent and good note-keeping.

I am delighted to have been asked to review the cases in this edition of Casebook in my current position as South African Claims Manager. With more than 15 years’ experience as a dual-qualified South African attorney and UK solicitor I have worked for Medical Protection as a panel lawyer in both jurisdictions.

Having represented members at inquests, trial hearings and before the HPCSA, in addition to providing general medicolegal advice, it is my experience that overwhelmingly the dominant reason for patients seeking redress is a breakdown in the doctor–patient relationship. Patients who perceive their doctors as being likeable and trustworthy, even in the face of a mistake, are less likely to seek compensation or report a doctor to the HPCSA.

As patients become more sophisticated, their demands for information about their care has increased. This means that aside from the doctor’s technical skill and reputation, a patient’s confidence in their doctor is to a large degree determined by the doctor’s ability to convey information to the patient in a compassionate and caring manner.

I know that the issue of informed consent to treatment will cause many a doctor to roll their eyes and sigh, as it seems that all lawyers ever do is bang on about it. I want to tackle this issue from a slightly different perspective and suggest that in order to foster a positive therapeutic rapport with patients, doctors should encourage a free flow of good communication between them and their patients. This empowers patients and allays anxiety, as they feel that they are meaningfully participating in and exercising control over their care.

By providing information about the proposed care in a manner that can be understood by the patient, the doctor bridges the divide between patients who may be perceived as uninformed and the doctor who might be perceived as all-knowing. By taking the time to explain the different treatment options available, the treatment being recommended as well as the risks and possible complications, doctors have a golden opportunity to strengthen their rapport with their patients.

It is important for doctors to use language that is reassuring but does not create unrealistic expectations in patients. A fine balance needs to be struck so that patients are fully informed of the care they will be receiving in the full knowledge that even in the best of hands, and in the absence of any negligence, the desired outcome might not be achieved.

As no-one’s memory is wholly reliable, accurate recording of all doctor and patient communications is essential, as it reminds the treating doctor as well as other health professionals of the patient’s care and management plan. In addition it also demonstrates to the patient that what they are communicating to the doctor is being considered, which helps to build trust and confidence in the context of an ongoing therapeutic relationship.

Because prevention is always better than cure, I encourage members to invest more time in building good relationships with their patients, so that should a situation arise where there is an adverse outcome the chances of it escalating to a claim or a complaint to the HPCSA is minimised.

In the event that a claim or complaint cannot be avoided, you will be in the best possible position to defend yourself based on a comprehensive set of clinical records. In the absence of such notes, the chances of defending a claim or complaint is significantly reduced, resulting in cases having to be settled where better record-keeping might have secured a successful defence – as illustrated in these case reports.

What’s it worth?

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

- **HIGH** R15,000,000+
- **SUBSTANTIAL** R1,500,000+
- **MODERATE** R150,000+
- **LOW** R15,000+
- **NEGLIGIBLE** <R15,000
Mr S was a 51-year-old teacher. At the start of term Mrs S developed a troublesome cough and went to see her GP. Dr B, about it. Dr B diagnosed a chest infection and prescribed antibiotics but also noted that she had an irregular pulse. An ECG was performed at the surgery the same day, which showed that Mr S was in atrial fibrillation. Dr B sent Mrs S to a local physician for urgent review.

The physician confirmed the diagnosis of atrial fibrillation and prescribed warfarin to reduce her risk of thromboembolic stroke and bisoprolol to slow her heart rate. The physician referred her to a cardiologist for a cardioversion procedure and discharged her home.

Mrs S attended for her cardioversion procedure but was found to be in sinus rhythm. The cardiologist (Dr T) advised Mrs S to stop taking her warfarin and to reduce her bisoprolol. Dr T gave Mrs S a letter to take to her GP, which detailed his advice, and told her that she would be called back to clinic.

Dr B saw Mrs S again with the cardiologist’s letter. Dr B documented that her pulse was regular now (although she was slightly bradycardic). Dr B arranged a further ECG for the following week and reduced her bisoprolol dose further. Dr B documented that Mrs S was “awaiting cardioversion follow-up” and that she had had a chest infection when the atrial fibrillation was initially diagnosed.

The ECG the following week showed sinus rhythm with a rate of 60 bpm. Dr B saw Mrs S again to inform her that her ECG was normal. Dr B noted her pulse on that day was regular and that she was waiting for cardiology review.

Soon after, Mrs S received a letter asking her to return for another cardioversion procedure. Mrs S rang the cardiologist’s secretary to explain that she had been advised that this was not necessary but that she was waiting for follow-up.

Dr B received a letter from the warfarin clinic stating that she had not attended for INR testing for at least four weeks. Dr B circled the response “no longer requires anticoagulation”.

A month later, Mrs S suffered a stroke. There were no other risk factors for stroke identified other that atrial fibrillation, thus the likely cause of Mrs S’s stroke was an embolic event arising as a consequence of thrombus formation within the atrium.

As a result of the stroke, Mrs S felt unsteady and hesitant every time she walked. Despite rehabilitation, her writing was slow and clumsy and she slurred her words. Sadly, teaching was no longer possible and Mrs S had to retire early on grounds of ill health.

Mrs S was devastated. She felt that her stroke could have been prevented if she had been anticoagulated. Mrs S made a claim in negligence against Dr B. It was alleged that Dr B should have prescribed some form of anticoagulation and that he should have contacted the hospital to query the medication position, especially in light of the non-attendance letter from the anticoagulation clinic.

**EXPERT OPINION**

Medical Protection sought the advice of an expert GP, Dr H. Dr H felt that the care given by Dr B was of a reasonable standard. Dr H did not consider that Dr B had a mandatory duty to prescribe anticoagulation or that he should have contacted the hospital to query the medication position. Dr H noted that the decision to stop anticoagulation had been clearly relayed on an advice slip from a cardiologist. Mrs S had also told Dr B that she was waiting for cardiology review and her subsequent ECG had shown sinus rhythm.

The opinion of a professor in stroke medicine (Professor G) was also obtained by Medical Protection. Professor G confirmed that the likely cause of Mrs S’s stroke was thromboembolic. Professor G pointed out that some patients develop atrial fibrillation secondary to other illness such as chest disease. In such a setting, if the atrial fibrillation resolves when the underlying cause has been treated, and the clinician feels that there is a low risk of it recurring, then it is reasonable not to anticoagulate. Mrs S would have had a CHA2DS2-VASc score of 1 because of her sex but an absence of congestive heart failure, hypertension, diabetes, stroke or vascular disease and age below 75 years, Professor G felt that it would have been quite reasonable not to anticoagulate in this context.

Medical Protection served a letter of response denying liability and Mrs S did not pursue the claim any further.

**Learning points**

- NICE, Atrial fibrillation: the management of atrial fibrillation (June 2014) state that doctors should consider anticoagulation for men with a CHA2DS2-VASc score of 1 and to offer anticoagulation to people with a CHA2DS2-VASc score of 2 or above, taking bleeding risk into account.

- Documentation of the reasons behind the decision-making was invaluable in defending this case.
Miss F, an 18-year-old university student, had been taking the combined oral contraceptive pill microgynon for 18 months for dysmenorrhea, when she presented to her GP Dr K worried about acne on her back. Miss F had heard from her flatmate that dianette is a better pill to take for acne than microgynon and wanted to give it a try. Dr K recorded that Miss F was a non-smoker with a normal BMI and BP, and switched her pill to dianette, advising her to start it when her microgynon cycle finished in another fortnight.

Two weeks after commencing the dianette, Miss F was rushed into hospital with sudden onset chest pain and shortness of breath. Miss F was diagnosed with a pulmonary embolism, and went on to have a cardiac arrest in the emergency department. Miss F was in hospital for three weeks and was transferred to intensive care. On waking she complained of spontaneous circulation, and she was advised to discontinue her claim, with each party to bear their own costs.

Two months after discharge, a formal cognitive assessment revealed ongoing difficulties with verbal and visual recall and cognitive assessment revealed ongoing physiotherapy and occupational therapy was ongoing. Miss F spent over a month recovering in hospital and it was thought that the cerebral bleed to be a result of the blood clot Miss F suffered, but considered dianette definitely made a contribution to the bleeding.

A claim was made against Dr K stating that he prescribed dianette to Miss F when she was not suffering with severe acne. He failed to advise Miss F regarding the increased risk of venous thromboembolism, and did not try alternate treatments for her acne such as topical therapies or oral antibiotics. The claim stated that had Miss F not been exposed to dianette, she would not have suffered the massive PE that led to her suffering anoxia brain damage.

Dr E, expert consultant in pharmacology, was also supportive of Dr K, stating that although there is probably an increased risk of VTE with dianette, the size of this increase is small, and the risk appears to peak between four months and one year of use. The timing of Miss F’s PE appeared to be closely linked to switching contraception; however, on the balance of probabilities, he was likely to have still suffered her PE had she continued on microgynon.

Medical Protection defended this case and prior to trial made a deep hands offer, Miss F to discontinue her claim, with each party to bear their own costs. This was accepted by Miss F’s solicitors. This is largely because it cannot be entirely accepted that it was wrong to prescribe dianette to the claimant; and perhaps more importantly, the claimant would have suffered the PE in any event – considering Miss F had only just been prescribed the dianette.

Mrs B was a 27-year-old secretary with a ten-year-old daughter. She had just enjoyed a trip to Malawi, where she had been visiting relations. Three days after her return she developed profuse, watery diarrhoea. She made an appointment with her GP because she was opening her bowels seven times a day and couldn’t face eating anything.

Her GP Dr A noted her recent return from Malawi and her diarrhoea. He was happy with her pulse and blood pressure and documented her temperature as 37 degrees. He found her chest physiotherapy was being well maintained and non-tender. He prescribed some paracetamol and co-phenotrope and advised her to return if there was no improvement.

Mrs B waited for a week but she began to feel worse. She was so nauseous that she couldn’t eat her dinner and the diarrhoea had been relentless for ten days. She was feeling rather weak so she made another appointment with Dr A. His history notes were brief, just stating “diarrhoea”. He noted that she was apyrexial with a satisfactory pulse and blood pressure. He examined her abdomen again, which was soft, and prescribed some codeine linus and loperamide.

Two days later Mrs B began to feel very faint and lethargic with ongoing diarrhoea. She had been staying with her mother-in-law who was really worried about her. Her mother-in-law drove Mrs B’s daughter to school, then took Mrs B to her GP surgery where she was given an emergency appointment. Dr A saw her again and found her restless and sweating with a tender abdomen to soft and non-tender.

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Dr A’s action, stating that dianette is usually prescribed for acne, was indefensible. He failed to discuss the potential benefits and risks of dianette as a contraceptive pill, and failed to inform Miss F that dianette could increase the risk of venous thromboembolism.

Dr K recorded that Miss F was a non-smoker with a normal BMI and BP, and switched her pill to dianette, advising her to start it when her microgynon cycle finished in another fortnight. Dr K’s action, stating that dianette is usually prescribed for acne, was indefensible. He failed to discuss the potential benefits and risks of dianette as a contraceptive pill, and failed to inform Miss F that dianette could increase the risk of venous thromboembolism.

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Mr K was a 36-year-old man who ran a restaurant. Mr K smoked and drank heavily. Mr K’s dentist had noticed a painless swelling on the right side of his neck during a routine check-up and asked him to see his GP. Mr K was seen by Dr A, one of the GPs at his surgery, who noted that Mr K was unsure how long the lump had been there, and referred him to a local surgeon.

A letter came back to the practice confirming the presence of a lymph node in the anterior triangle of Mr K’s neck, which was felt to be innocent. The letter was for Mr K to be reviewed in six weeks’ time and for further investigations to be pursued if the node was still present.

Mr K was busy at work and did not feel too concerned about a lump in his neck because it was not painful. He did not attend his follow-up appointment and a letter stating this was sent from the surgery to his GP.

Eight months later, Mr K began to get some discomfort in his neck swelling so decided to see his GP again. This time he was seen by Dr B at the surgery. Dr B noted his painless swelling and also a history of chronic tympanic membrane perforations. Dr B did not establish or document his previous referral to the ENT department regarding the same lump or the intended follow-up. Dr B’s brief examination of Mr K’s neck included no examination of the lymph node, tonsil or trapezius muscles.

Mr K’s neck lump subsequently proved to be malignant. As a result he had to have neck surgery and resection of a primary in his tonsil. He had a course of radiotherapy and since has not had recurrence of his disease. Unfortunately he was left with shoulder weakness and a dry mouth, which he found difficult to cope with.

Mr K was angry with Dr B and felt that he caused a delay in his diagnosis. He brought a claim for negligence against Dr B because he felt the delay had necessitated more radical surgery, leaving him with debilitating symptoms.

Expert opinion
Medical Protection sought the advice of an expert GP (Dr F) and Dr F felt that Dr B bore liability for the delayed diagnosis. He was critical of Dr B’s history taking and record-keeping. Dr F commented that Dr B had responsibility for establishing the history of his previous referral to the surgical assessment unit. Had Dr B known of that referral, then the duration and the continuing nature of the lymph node would have necessitated immediate re-referral back to that team. Dr F also criticised Dr B’s inadequate examinations, stating that he should have documented an examination of the patient’s neck, mouth, tongue and throat.

In addition, Professor Y considered that it may have been possible to spare radiotherapy if he had been treated earlier. The need for radiotherapy in this case was due to the size of the lymph node in the final specimen and the positive margins, which was evident following removal of the tonsil primary.

Due to expert opinion finding Dr B to be in breach of his duty, the claim was settled for a high amount.

Mr P, a right-handed project manager, developed a stiff right elbow following a previous injury, and had reached the limit of his progress with physiotherapy. X-rays showed degenerative changes and he was referred to an orthopaedic consultant, Dr A, who diagnosed osteoarthritis of his elbow. He advised Mr P that as he had significant anterior and posterior osteophytes he may need multiple arthroscopic debridements to achieve a good outcome.

After an arthroscopic anterior debridement, there was only minimal improvement and further surgery was planned. There were another two debridements, the third one being more than six months after the initial procedure before Dr A was happy with the result.

Two months later Mr P returned with a reduced range of movement in his elbow. X-rays confirmed the presence of massive heterotopic ossification (new bone growth), which was confirmed on CT. Dr A planned a fourth arthroscopic debridement two months later. No discussion relating to the possible risks and complications of surgery was documented. The limited operation note for this complex arthroscopic debridement did not include significant bone removal and a full range of movement at the end of the procedure.

In clinic two days later Mr P was noted to have a radial nerve palsy, but Dr A felt that some nerve conduction was present and that this was a neuropraxic nerve injury which should recover completely. He commented that the procedure had been lengthy at over an hour and ten minutes. Mr P returned ten days later as there was no change in his symptoms, but Dr A was measured by the presence of a positive Tinel’s test and felt the nerve palsy would recover. He planned to follow Mr P in six months, which he felt that he would return six months post-surgery, but again there was little improvement. Dr A commented that the positive Tinel’s could now be felt up to the fingertips. An appointment for three months later was made, but still there was no improvement.

It was not negligent to carry out the surgery arthroscopically. There is still a risk of radial nerve injury when carrying out this surgery with an open technique. However, Dr A was found to be negligent in causing the nerve injury, keeping poor documentation, and delaying arranging nerve conduction studies.

On review of the case, an expert felt that as long as Dr A had the necessary experience...
Mrs Y, a 39-year-old chef, opted to have private antenatal care. It was her first pregnancy and other than a BMI of 30 she had no pre-existing medical problems. She was reviewed regularly throughout her pregnancy and noted to have elevated blood pressure through the first trimester, between 126/83 – 157/90. Methyldopa was considered at 23 weeks but not initiated since a 24-week scan was negative, and close monitoring continued.

At 36 weeks Mrs Y presented to the emergency department complaining of a headache and feeling generally unwell. Her BP was 170/120 and she was admitted to hospital. She was reviewed by the consultant obstetrician and provided telephone advice to continue antihypertensive therapy. She was discharged on oxprenolol to control her blood pressure through the first trimester, but this was persistently elevated. Mrs Y was discharged and close monitoring continued.

Mrs Y gave birth to a healthy son. She was discharged on oxprenolol to control her blood pressure. She was reviewed regularly throughout her pregnancy and noted to have elevated blood pressure through the first trimester, between 126/83 – 157/90. Methyldopa was considered at 23 weeks but not initiated since a 24-week scan was negative, and close monitoring continued.

A weak following delivery Mrs Y’s BP continued to have elevated BP readings of 160/90. Dr B asked her to see her GP Dr A. Mrs Y attended one home visit two days later and found Mrs Y had a headache and a raised BP of 180/90. She treated her with voltarol suppositories and a combination of bisoprolol and irbesartan.

Three days later Mrs Y was unchanged and Dr A visited her at home again. Her BP of 170/120 was treated with half hourly BP and hourly urine output measurements, which Dr B and Dr A should have initiated.

Dr A was also criticised by the experts, particularly regarding his consultation note, which was lacking in a clear description of the headache and its associated symptoms. The BP was recorded but there was no evidence of any further examination including fundoscopy. The experts felt on the basis of the letter Dr B wrote requesting a second opinion, the patient was displaying red flag symptoms and a reasonably competent GP would have made arrangements to admit Mrs Y as an emergency to exclude intracranial haemorrhage.

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Dr A reported at the 24-week scan a scan confirmed a cerebral haemorrhage. She died four days later.

EXPERT OPINION

Experts were critical of Dr B, commenting that it was unacceptable for him to fail to visit Mrs Y when called by the word team regarding her symptoms. Mrs Y’s persistently elevated BP warranted high dependency management with half hourly BP and hourly urine output measurements, which Dr B and Dr A should have initiated.

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Ms L, a teacher, was first prescribed the oral contraceptive pill, microgynon, by Dr F, when she was 17. Her blood pressure was taken and recorded as normal. At this time, no other mention was made in the records of her risk profile or family history. Later, Mrs L's medical records showed that she was changed to avonan and then ovarine, but there was no explanation why these changes were made. Mrs L was changed again to ovulen 50. The reasoning this time was due to "excessive bleeding on ovarine." At her review consultation, Mrs L's blood pressure was taken and recorded as normal.

When she was 26, Mrs L was seen by her GP for antenatal care, where it was recorded that she now smoked one cigarette a day. Her blood pressure was recorded as normal. After her first child had been born, Mrs L was prescribed amitriptyline, before she changed to the combined pill.

Three years later, Mrs L consulted her GP as she was under significant stress. Her records showed that she had increased her smoking to 25 cigarettes per day and did not exercise. Counseling was started, and she was given a referral to smoking services. Mrs L was pregnant at the time and was seen by a pharmacist to discuss smoking and other matters, including the use of nicotine patches. Mrs L was referred to the chest clinic, where she was diagnosed with non-cardiac chest pain.

Mrs L was seen on a number of occasions in the practice for a repeat prescription for microgynon and other matters, including further chest pain, collapse, and migraine.

Aged 41, Mrs L collapsed and was admitted to the Emergency Department, where investigations found that she had had a stroke. She was unable to return to work due to paralysis affecting her left side.

Two years later, Mrs L fell to the floor with severe central chest pain and attended her GP surgery the next day. Mrs L had been getting palpitations once every two weeks that lasted two hours to two days over the previous two years. These were accompanied by sharp central chest pains. Mrs L was noted to be under less stress now and was smoking slightly less at 20 per day. She was advised about smoking. Mrs L was referred to the chest clinic, where she was diagnosed with non-cardiac chest pain.

Mrs L was advised to stop smoking and was prescribed atorvastatin. Mrs L's notes show that she was suffering from anxiety and had a history of heart disease and smoking, but despite these risks continued to prescribe the pill.

The case was settled for a substantial sum.

**Expert Opinion**

Expert opinion found that a reasonably competent GP would have stopped prescribing microgynon from the age of 35 onwards and changed Mrs L to a progestogen-only pill or at least have warned Mrs L of the increased risks in order that she could have considered the alternative options. Mrs L's notes show that the practice knew of Mrs L's family history and her smoking, but despite these risks continued to prescribe the pill.

The case was settled for a substantial sum.

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**Learning Points**

- **Dr F should have considered all the risk factors involved in prescribing the contraceptive pill to Mrs L. He should also have revisited the prescription as the patient reached 35 and discontinued it.**
- **Mrs L's medical records showed that she was suffering from anxiety and had a history of heart disease and smoking, but despite these risks continued to prescribe the pill.**
- **Counselling was started, and she was given a referral to smoking services.**
- **Mrs L was referred to the chest clinic, where she was diagnosed with non-cardiac chest pain.**

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**Medical Protection**

Medical Protection sought an expert vascular surgery opinion from Professor T. Although the risk of vessel rupture and bleeding was discussed, he was critical of the failure to warn of the small risk of death from aortic balloon inflation.

**Learning Points**

- **Good communication and documentation are essential in avoiding the risks of medical errors.**
- **Patients need to be able to weigh up the benefits and risks of medical intervention.**
- **An unintended decision as to whether they want to proceed should be made.**
MISSED CRITICAL LIMB ISCHAEMIA

I don’t understand why the out-of-hours GP faced with rest pain in a foot he thought had circulation problems was not involved in the litigation. He missed the problem and failed to act properly by admitting straight away. I was left with the rather depressing notion after reading all the cases that we should not trust anyone.

It is interesting that the drive from the NHS is to be more stream-lined and use records to improve continuity of care, and prevent patients having to repeat themselves at every point on their illness pathway – and yet the legal drive is to treat each appointment as an individual legal entity that will be judged in isolation.

Dr James A H Cave
Berkshire
UK

Response

Your assessment of the legal situation is quite right. Each professional involved in the care of a patient is responsible for their own actions, and can be held negligent for their actions or omissions. Every consultation will turn upon its own facts, and that will include what information the clinician has at hand, both from their own history and examination, and from any information in the records, or conveyed by others involved in the case.

Whether any individual has been negligent will depend on whether they have breached their duty of care, and whether the alleged injury was caused by or materially contributed to, by the breach of duty (causation).

The claimant and his or her legal advisers will determine which individuals to claim against, based on their understanding of the facts and the opinion of their experts. Of course in the case of an NHS hospital, the claim will be against the organisation itself (which is responsible for the actions of all its staff), but for GPs or those in private practice the claim is usually aimed at individual clinicians.

It is sometimes the case that the defendant or defendants in a case will wish to bring additional parties into the case (again usually based on expert opinion), but would need good grounds for doing so.

In this case neither the claimant nor the defendant sought to involve the out-of-hours service, based on the above principles. I hope this helps clarify the issues you raise about this case.

A PROBLEM WITH POLYPS

LETTER 1

Thank you for another stimulating and informative Casebook. In the case “A problem with polyps”, you quote your GP expert as saying: “A digital rectal examination would have revealed the polyps and thus prompted a more timely referral.” Really? This suggests that your GP expert’s opinion is that rectal polyps are all detectable on DRE, which is hardly the case.

It seems to me that the crucial error in this case was failing to refer in the knowledge that another doctor had seen two rectal polyps and had recommended further investigation (even if this information came by an unconventional route). A normal DRE, while contributing to a comprehensive assessment, would not influence that decision. It is difficult to see what Dr A could have learned from history or examination that would have trumped the clear recommendation from the overseas clinic. An element of irrefutation, perhaps understandable, at 95%’s deviation from standard procedure could have clouded Dr A’s judgement.

In most of your GP cases, I can identify with the doctors involved, to the extent that I can envisage circumstances where I might have acted as the involved doctor did, and this is the great value of Casebook; this was not such a case.

Dr Aidan Finnegan
Waterford
Ireland

Response

Thank you for contacting us with your comments on this case.

Upon looking more closely at this case, the view of the expert GP was not that all polyps are detectable on DRE – they are not – but that, on the facts of this particular case, a DRE would have detected them. This view was echoed by the comments of our other expert, a professor of colorectal surgery.

On reflection, we could perhaps have made this clearer in the narrative. Thank you once again for drawing my attention to this point.

A PROBLEM WITH POLYPS

LETTER 2

I always enjoy reading Casebook and have often thought “there but for the grace of God...”

However, reading the report “A problem with polyps”, I do find it extraordinary that MPS took this case to court. In the first paragraph a colonoscopy was properly recommended. Not arranging this is, to my mind, completely irresponsible, and the professor’s comment about repeating the rectal examination just ignores the previous proctoscopic findings. The patient’s lawyers must have enjoyed the case at great legal expense to MPS.

A B Richards
Tadley
UK

Response

Thank-you for getting in touch and drawing our attention to it.

TOO MUCH OXYGEN

I read with interest your case report of an extremely preterm baby with high oxygen saturations, who was not screened for retinopathy of prematurity (ROP) and who subsequently developed severe ROP, causing blindness.

However, the learning point that safe levels of oxygen saturation in low birth weight infants are between 86–92% is incorrect. In two large, multi-centre trials a targeted oxygen saturation level of 85–89% increased infant mortality compared with an oxygen saturation target level of 91–95%.

While the incidence of ROP was lower with lower oxygen saturation target levels, this does not outweigh the increased risk of babies dying. It is recommended that extremely preterm babies should have target oxygen saturations levels between 91–95%.

Dr Jane Alsweiler
Neonatal paediatrician
Auckland
New Zealand

Response

Thank-you for your email. We have discussed your comments with the author of the case report in question.

He has confirmed that the oxygen range quoted was from guidelines issued in 2010 and that a more recent meta-analysis has found that the lower range of oxygen saturations are associated with higher mortality at a later stage.

We are happy to correct this point and would like to thank you for your helpful comments.

REFERENCES


ESTABLISHING, MANAGING AND PROTECTING YOUR ONLINE REPUTATION – A SOCIAL MEDIA GUIDE FOR PHYSICIANS AND MEDICAL PRACTICES

by Kevin Pho and Susan Gay

Dr Aidan O'Donnell, consultant anaesthetist, New Zealand

How social media savvy are you? If you are a medical student, the chances are that you are online more or less permanently. If, like me, you are a practising doctor who qualified in the last century (read ‘dinosaur’), you might be a bit less comfortable. I’ve been using computers since you could measure the pixels with a ruler, and I carry my smartphone as if it were grafted onto my hand, but even I admit I am feeling a little left behind by the social media tsunami that has arisen around us. Social media is becoming increasingly popular among doctors and patients alike.

Where clear ethical and behavioural boundaries are well-established in traditional face-to-face relationships, the online community has developed so rapidly that the medical profession is finding itself in uncharted waters. How do you respond when a patient wants to “friend” you on Facebook? Or when someone harshly criticises your doctoring on a public forum?

My organisation has released guidelines about how to behave online, but they are a series of don’ts. Don’t publish pictures of yourself drunkenly incapacitated on your Facebook page, where employers and patients can see them.

Into this environment come Kevin Pho and Susan Gay, with their book, Establishing, Managing and Protecting your Online Reputation. Pho is himself a doctor, writing for doctors, which gives him immediate authority. His blog, www.kevinmd.com, is well-known and successful.

The central theme of the book is that doctors’ online reputation is just as important as their real-life one. Whether we like it or not, our basic information is already out there, but we usually don’t take any ownership of it. Done properly, we can establish and cultivate an online reputation, which can be professionally and personally rewarding. In short, we can use social media to our professional advantage. To quote: “First, do no harm; second, get an online profile.” Rather than don’ts, this book is full of dos.

The book is informal and readable, and covers the absolute basics well: techno-novices need have no fear. My main criticism is the book’s overwhelmingly American perspective. Patterns of work and ethos of practice are very different where I work, and I don’t need to build myself – or my practice – as a brand, or attract my paying customers. Social media is here to stay, and need not be a threat. We can ignore it, or use it to our advantage, and this book goes a long way toward telling us how.

I’LL SEE MYSELF OUT, THANK YOU: THIRTY PERSONAL VIEWS IN SUPPORT OF ASSISTED SUICIDE

Edited by Colin Brewer and Michael Irwin

Reviewed by Dr Ellen Welch – GP, London

Following the recent rejection of the Assisted Dying Bill in the UK House of Commons by an overwhelming majority of 330 against to 118 in favour, this collection of essays in support of the issue provides the reader with some of the key arguments in the debate for the legalisation of what the authors term medically assisted rational suicide (MARS).

The book has been compiled by former psychiatrist Colin Brewer and former medical director of the United Nations Michael Irwin, with essays contributed by doctors, priests, politicians, philosophers and, most poignantly, from people suffering with terminal illness.

The writers discuss the facts and the law surrounding the subject in both the UK and overseas, with both ethical and religious perspective offered. Dignitas writes a chapter on their experiences in Switzerland over the last 16 years of their existence. And a chapter is dedicated to palliative care – both its promises and its limitations.

Perhaps the most thought-provoking stories come from people who have been faced with the reality of a painful, undignified death. They tell of their struggle, their pain, the frustration that they feel in a life they no longer want to live, but are unable to end. Several quotes are given from the 2014 House of Lords debate which sum up some of the main arguments.

A major limitation of this book is that it only presents one side of the argument on the debate and it would certainly provide more of a balanced read if there had been contributors from those who oppose assisted dying. Whatever your viewpoint may be, it does provide an interesting and comprehensive read in support of the issue.
Poor record-keeping may place you at risk of medicolegal challenges.  
True/False

The taking and documenting of a thorough history can be of assistance when defending a medicolegal case.  
True/False

It is important to reassess patients carefully when they are not improving and document your findings.  
True/False

You should beware of attributing any new symptoms that a pregnant patient develops to the pregnancy itself.  
True/False

It is important to ensure that patients have access to adequate care when you are not available.  
True/False

When performing a procedure only minimal notes are required to describe the procedure.  
True/False

If you do not understand what the patient is trying to tell you, you are putting both yourself and the patient at risk.  
True/False

Signing repeat prescriptions poses virtually no risk.  
True/False

When taking consent you only have to inform the patient of common complications and you are not obliged to inform them of serious adverse outcomes.  
True/False

The consent process is to enable the patient to weigh up the benefits and risks of a proposed intervention.  
True/False

Reviewing a patient’s previous records is seldom of any consequence.  
True/False

When defending a medicolegal case it can be useful if you have documented the reasons behind your decision-making.  
True/False

It is important to review your management should the patient’s risk change substantially.  
True/False

The HPCSA and SAMA support a recent ruling on doctor-assisted suicide.  
True/False

Claims-made protection subscription rates are lower in the early years but will increase over time.  
True/False

According to Dr Aaron Motsoaledi, there are five specialties persistently targeted for litigation.  
True/False

The Children’s Act of 2005 defines a child as a person under the age of 18.  
True/False

Child abuse is restricted to physical or sexual abuse.  
True/False

Healthcare professionals can be held accountable if they fail to report suspected child abuse.  
True/False

In the absence of a specific court order, doctor-assisted suicide remains unlawful.  
True/False
How to contact us

MEDICAL PROTECTION
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medicalprotection.org

Please direct all comments, questions or suggestions about our service, policy and operations to:

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33 Cavendish Square
London W1G 0PS
United Kingdom

info@medicalprotection.org

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

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