A duty to treat... and to tell?
CONFIDENTIALITY AND THE PUBLIC INTEREST

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Debating DNAR orders
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Welcome
Dr Stephanie Bown – Editor-in-chief MPS Director of Policy and Communications

The impact of the global recession continues to be felt in many jurisdictions where MPS operates and the consequences of rising costs in clinical negligence claims will be felt ever more keenly.

Although the medical profession can offer a financially rewarding career, no-one is immune to the kind of cost increases that cause a health practitioner to question the affordability of their medical indemnity. But increases in claims costs, together with an increase in the number of claims – which are continuing seemingly unabated, particularly in the UK, South Africa and Ireland – make this scenario more realistic.

Many members contact us in dismay that they seem to be feeling the hand of the regulator more often than ever before. We have attempted to identify the reasons why claims and complaints are on the rise – depersonalisation of the doctor–patient relationship, higher patient expectations, errors from working in high stress environments with stretched resources; these are all real issues that face each of you every day.

This is where we hope that Casebook has a part to play. No-one can stop all claims from occurring but we can help to highlight what you can do to ensure that you have a robust defence at your disposal.

I do hope that you find Casebook, and the other range of medicolegal publications that MPS produces, to be sufficiently supportive in these trying times. Please get in touch with any comments or suggestions; it is really helpful to receive your feedback.

Stephanie Bown
MEMBERS ARE INCREASINGLY FACING THE VERY DISTRESSING SITUATION OF MATERIAL HAVING BEEN POSTED ABOUT THEM ON THE INTERNET. THIS CAN TAKE A NUMBER OF FORMS, SUCH AS DISCUSSION FORUMS, OTHER WEBSITES CONTAINING A FEEDBACK ELEMENT, OR AS A RESULT OF INDIVIDUAL CAMPAIGNS BY PATIENTS DISSATISFIED WITH CARE RECEIVED.

WHETHER THE CONTENT IS WRITTEN BY MEMBERS OF THE PUBLIC POSTING ANONYMously OR BY IDENTIFIABLE INDIVIDUALS, IT IS RARE THAT THE CIRCUMSTANCES OFFER THE SUBJECT OF THE MATERIAL A RIGHT OF REPLY.

WHilst MPS WOULD NOT WISH TO RESTRICT FREEDOM OF EXPRESSION AND FAIR COMMENT, WE DO FEEL THAT MEMBERS IN THESE CIRCUMSTANCES DESERVE A RIGHT OF REPLY AND/OR REDRESS, AND IT IS THEREFORE IMPORTANT THAT NEW LEGAL FRAMEWORKS AROUND THE WORLD ARE CREATED TO REFLECT THIS.

THIS IS LESS PROBLEMATIC IN INSTANCES WHERE THE WEBSITE HOST PROPERLY MODERATES THE CONTENT AVAILABLE ON THEIR WEBSITE OR IS ABLE TO OFFER A RIGHT OF REPLY. INCREASINGLY THE PROCESS IS MORE DIFFICULT AND MAY EVEN LEAD TO A SITUATION WHERE THERE IS NO MECHANISM FOR CHALLENGING FALSE OR DEFAMATORY MATERIAL. IT IS THEREFORE IMPORTANT THAT WEBSITE HOSTS CONTINUE TO HAVE LIABILITY FOR THE CONTENT THEY PUBLISH.

WE ARE SEEING THE COURTS BEGINNING TO RECOGNISE THE IMPACT AND IMPORTANCE OF THESE ISSUES. AS AN EXAMPLE, WHERE AN INTERNET CAMPAIGN WAS A PART OF A WIDE RANGE OF HARASSMENT SUFFERED BY A MEMBER, WE HAVE BEEN SUCCESSFUL IN OBTAINING AN ORDER PROHIBITING SUCH INTERNET ATTACKS. THESE SUCCESSES HELP US TO CONTINUE TO MAKE STRONG REPRESENTATIONS ON BEHALF OF MEMBERS, TO ENSURE THAT LEGISLATORS UNDERSTAND THE DEVASTATION THAT SUCH CAMPAIGNS CAN CAUSE.
In September, MPS held the Making it Safer: Out of Hours and Unscheduled Primary Care conference, in Westminster, London. The conference attracted nearly 200 medical and clinical directors, chief executive officers, general practitioners, commissioners of out-of-hours (OOH) services and nurses. The packed programme included talks on: the role of the nurse practitioner; top tips on registering with the CQC; telephone triage; vicarious liability; and learning from adverse events.

In September, the second Hong Kong Expert Witness Training Programme, co-organised by MPS and HKMA, and supported by the HK Academy of Medicine, was held. The event was heavily oversubscribed, with more than 200 applications for 75 places. Topics included: the litigation process, clinical negligence, how to write a report, MPS claims handling ethos and what the courts want from experts.

MPS’s Dr Nancy Boodhoo and Al Neaber visited five countries in the region in October to meet with representatives of medical and dental associations, hospital boards and health services authorities.

In November, MPS Senior Consultant Dr Paul Nisselle presented risk management workshops focused on effective communication in conjunction with Cayman Islands Health Services Authority and the South Eastern and Western Regional Health Authorities in Jamaica.

Chaired by MPS medicolegal consultants Dr Tony Behrman and Dr Liz Meyer, “Ethics for All”, the annual MPS ethics evening, was held in Pretoria (400 attendees) on Monday 21 November and in Cape Town (1,500 attendees) on Wednesday 30 November.

More than 150 doctors attended a lunchtime seminar on consent at Gleneagles Hospital in September. MPS Head of Medical Services (Asia) Dr Ming-Keng Teoh spoke on “Ethical and legal principles”, Edwin Tong from Allen & Gledhill spoke on “Recent SMC and High Court decisions” and MPS Medicolegal Adviser Dr Janet Page spoke on “Where to from here?”

Dr Teoh and Dr Page met with the new SMC President, Prof Tan Ser Kiat, to discuss recent SMC decisions on consent and better ways of working together.

In November, Dr Ming-Keng Teoh delivered a lecture on medical protection and litigation in Penang. Dr Teoh spoke at the King Edward VII College of Medicine, University of Malaya’s annual alumni reunion.

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**MPs Position Statement: Teleradiology**

Teleradiology is the process whereby an image is taken in one location and then transmitted to another for reading, analysis, interpretation and provision of a report by the radiologist at another location.

Members are expected to advise MPs if they are participating in teleradiology and restrict the practice to their respective local jurisdiction. If an indemnity risk arises from that practice then the appropriate grade for that jurisdiction will be charged.

Members who wish to practise teleradiology in circumstances where the image is taken in another jurisdiction must both be appropriately registered and have professional indemnity cover in the jurisdiction where the image is taken. MPs may be able to offer benefits of membership in these circumstances and members should contact MPS for advice. Members should not assume that their current MPS membership will offer such an indemnity.

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**Guidelines on New Patient Choices**

From April 2012, all NHS providers of care will have to accept all clinically appropriate referrals to named hospital consultant-led teams. The change will mean that patients will be seen by named specialists, with some exceptions for emergency care, where clinically appropriate.

In addition, NHS providers will have to publish relevant information about their consultants and the services they provide. There will be no geographical boundaries imposed on referrals. Guidance is available at: www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyAndGuidance/DH_130426

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**Practitioners Suspended for Shorter Periods, Says NCAS**

Practitioners are being suspended or excluded for shorter periods, according to the National Clinical Assessment Service (NCAS).

- An estimated 5,870 working weeks were lost in 2010/11 compared with 6,850 weeks lost in 2009/10 (14% reduction).
- Since 2005 there have been more episodes of suspension or exclusion, but faster resolution.
- For exclusions of hospital and community doctors ending in 2010/11, the average duration was 21 weeks, compared with 23 weeks in 2009/10.
- GP suspensions lasted an average of 35 weeks in 2010/11, compared with 44 weeks in 2009/10.
- An estimated 5,870 working weeks were lost in 2010/11, compared with 6,850 weeks lost in 2009/10 (14% reduction).
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- For exclusions of hospital and community doctors ending in 2010/11, the average duration was 21 weeks, compared with 23 weeks in 2009/10.
- GP suspensions lasted an average of 35 weeks in 2010/11, compared with 44 weeks in 2009/10.
- NCAS is currently part of the NPSA, but this is due to close in early 2012. NCAS will be hosted by NICE from April 2012 to March 2013. The report can be found at: www.ncas.npsa.nhs.uk/publications.

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**NICE Guidance Watch**

This is a selection of the guidance NICE is expected to publish over the next few months. Publication dates may be subject to change; visit www.nice.org.uk.

- **January**
  - Epilepsy: Breast reconstruction using lipomodelling, and deep brain stimulation for refractory epilepsy
- **February**
  - Immunotherapy: Vaccinations for venom anaphylaxis, exenatide for type 2 diabetes, ranibizumab for macular oedema, ipilimumab for stage III or IV melanoma, tocilizumab for rheumatoid arthritis, belimumab for systemic lupus erythematosus
- **March**
  - Pipeline embolisation: Device for the treatment of complex intracranial aneurysms
  - Percutaneous laser atherectomy: For peripheral arterial disease
  - Balloon dilatation: Of subclavian stenosis
- **April**
  - Long-term rehabilitation: For stroke patients
  - Microsurgery: For refractory Ménière’s disease
  - Focal therapy: Using cryoablation for localised prostate cancer
Debating DNAR orders

When a patient suffers a sudden cardiac or respiratory arrest, cardiopulmonary resuscitation (CPR) is often attempted, with presumed patient consent unless explicitly stated otherwise. Sarah Whitehouse asks: should CPR be opt in or opt out?

If, after careful consideration, clinical evidence suggests that it is not in the patient’s best interests to perform CPR should it be needed, this must be discussed fully with the patient and their family if they do not have capacity. Doctors must carry out a thorough assessment of the patient’s condition and consider the likely prognosis, based on the “overall benefit” to the patient. Any decision must be recorded and reviewed regularly.

If, after careful consideration, clinical evidence suggests that it is not in the patient’s best interests to perform CPR should it be needed, this must be discussed fully with the patient.

Sarah Whitehouse, President of the Royal College of General Practitioners, argues opt in: “The default position for most medical interventions is that patients have to opt in by giving informed consent for the procedure. Why should this not be the position for CPR?” Those already in poor health might be better able to have a realistic assessment of their chances of survival, while those in previous good health would be able to opt in without hesitation.

Television hospital dramas give the impression that CPR attempts are usually successful; in fact, the reality is different. After a CPR attempt that takes place in hospital, the chances of surviving to hospital discharge are around 15-20%. Outside hospital, the chances of survival are even lower, at 5-10%. Efforts to restart the heart are traumatic and often cause rib fractures and damage to internal organs. Lack of oxygen can lead to hypoxic brain damage or coma; and, if efforts are unsuccessful, a potentially undignified death.

The GMC’s guidance on end-of-life care starts with the premise: “Patients who are approaching the end of their life need high-quality treatment and care that support them to live as well as possible until they die, and to die with dignity.” There is a dichotomy between this ideal of a dignified death and the often traumatic reality of CPR.

Decisions relating to cardiopulmonary resuscitation, issued jointly by the BMA, Resuscitation Council and Royal College of Nursing, states: “Where no explicit decision has been made in advance, there should be an initial presumption in favour of CPR.” In an emergency, the focus is the preservation of life, and to have a policy other than opt out would be to go against this principle. However, it is not appropriate to prolong life at all costs, with no regard to its quality or to the potential burdens of treatment for the patient.

Sometimes, however, doctors place Do Not Attempt Resuscitation (DNAR) orders in a patient’s notes without discussion. Recently, Janet Tracey, a 63-year-old care manager, died in hospital following a car accident. Doctors placed a DNAR order on her notes – which her family claim was done without their knowledge. Her husband is suing the Health Secretary in a bid to force the government to draw up a national, rather than local, DNAR policy.

Yuen et al have identified two major problems with DNAR orders: firstly, DNAR discussions do not occur frequently enough; and secondly, these discussions occur too late in the course of patients’ illnesses to allow their participation in resuscitation decisions.

There is also the perceived problem amongst patients of a “DNR creep”, the assumption that if patients do not want to be resuscitated, then they do not want any other form of life saving treatment.

Roger Goss, co-director of Patient Concern, says that although doctors argue that CPR offers some patients a poor chance of survival, refusing it when patients want it “reduces it to zero”. However, patients cannot demand a particular course of treatment if clinical evidence suggests it would not be in their best interests.

If a patient refuses CPR, or a patient lacking capacity has a valid and applicable advance decision refusing CPR, this decision should be respected in accordance with the Mental Capacity Act 2005. Patients go to great lengths to make sure that their wishes are known. In a bizarre case, an 81-year-old woman, Joy Tomkins, from Norfolk has had “Do Not Resuscitate” tattooed across her chest and P.T.O. across her back.

CPR, in the right circumstances, can be of benefit to a patient in an emergency, but for those who are seriously ill and at the end of their life, it may not be the most clinically appropriate, or dignified, choice.

Dr Marika Davies, MPS Medicoegal Adviser, says: “The crux of the issue is not whether CPR should be opt in or opt out, but whether the discussions between seriously ill patients, their families, and the doctors who care for them are comprehensive enough to address the clinical appropriateness of CPR and decide on a mutually agreed treatment plan.”

REFERENCES
3. GMC, Treatment and Care Towards the End of Life p8 (2010)
5. Ibid p3
6. Husband’s battle to re-draw ‘do not resuscitate’ rules after wife dies in hospital blunder, Daily Mail (31 August 2011)
9. www.patientconcern.org.uk
Pregnancy problems – think beyond asphyxia

Sara Williams highlights two obstetric cases where doctors faced diagnostic challenges during the early stages of pregnancy.

Early-stage pregnancy is a diagnostic minefield for clinicians. Ectopic pregnancy is a leading cause of maternal mortality in the first trimester, and claims that arise out of the failure to detect a genetic abnormality can be amongst the most expensive. Case 1 highlights the difficulty in diagnosing an ectopic pregnancy even with the knowledge that the patient is pregnant. Likened to a black cat in the dark, ectopic pregnancies are notoriously difficult to diagnose. The case also demonstrates that a diagnosis of ectopic pregnancy should be considered whenever one is assessing a female of reproductive years with abdominal symptoms.

Case 2 follows the story of a GP who chose not to screen his patient for Down’s syndrome for fear of it causing her to miscarry her fourth child. The case highlights why patients should be informed of the risks of screening for genetic disorders, enabling them to make informed choices about their pregnancy.

Ectopic pregnancy

All ectopic pregnancies are silent or asymptomatic in their early phases; the problem lies in that the earlier you catch them the better the problem lies. Pregnancy should be considered and a pregnancy test carried out.

Diagnosing an ectopic pregnancy can be greatly assisted by a transvaginal ultrasound; particularly if it shows a gestational sac inside a fallopian tube (see Table 1). This will normally visualise an intrauterine sac in and around five weeks gestation (see the Royal College of Obstetricians and Gynaecologists’ (ROCG) Green-top guidance with respect to the management on early pregnancy loss).

Prominent fertility expert and Professor of Obstetrics and Gynecology at the University of South Wales Dr William Ledger advises: “The risk factors for ectopic pregnancy are well known and features such as a history of pelvic inflammatory disease, tubal surgery (including reversal of sterilisation), in vitro fertilisation, known pelvic adhesions, previous ectopic pregnancy, etc, should be sought, but such features will only be identified in about half of all cases. Equally, symptoms may be ‘barn door’, with vaginal bleeding, lateralising pain with shoulder tip pain, and a positive pregnancy test, or they may be subtle or practically non-existent. “Early pregnancy ultrasound is commonly performed for ‘soft’ indications where there is no medical need for an early scan, but the woman wants to see the fetal activity and be reassured that all is well. An increasing number of ectopic pregnancies are being diagnosed opportunistically in this way. Early diagnosis may allow for use of medical or conservative tubal surgery, with the possibility of improving the chances of saving the fallopian tube.”

Wrongful life

If a child is born with a severe congenital disability the child can make a claim for wrongful life, while the parents can sue for wrongful birth. The key issue in these cases is whether a doctor should bear the cost of raising and maintaining a child where birth was a consequence of medical negligence, eg, where the parents were not warned that their child may be born with a disability and, if they had been warned, they may have terminated the pregnancy.

A high index of suspicion

Mainstays of practising early pregnancy medicine require a high index of suspicion: people can and do die from ectopic pregnancy and thousands of children are born with undiagnosed genetic abnormalities. Comprehensive examination and investigation in women of child-bearing age with abdominal or gynaecological problems is essential. Pregnancy should always be considered in the differential diagnosis as the consequences of an undiagnosed pregnancy can be catastrophic.

Thanks to Dr Graham Howarth and Dr Sonya McCullough for their help with this feature.

Table 1 – Diagnosis of asymptomatic tubal ectopic pregnancy, Canadian Society of Obstetrics and Gynaecology

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<tr>
<th>Diagnosis of ectopic pregnancy</th>
<th>Table 1 – Diagnosis of asymptomatic tubal ectopic pregnancy, Canadian Society of Obstetrics and Gynaecology²</th>
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<tr>
<td>Possible ectopic pregnancy</td>
<td>Serum beta-HCG level &gt; 1500 mIU/ml</td>
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<td>Abnormality of intrauterine pregnancy on transvaginal ultrasound</td>
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<td>Probable ectopic pregnancy</td>
<td>Serum beta-HCG level &gt; 1500 mIU/ml</td>
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<td>Abnormality of intrauterine pregnancy on transvaginal ultrasound</td>
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<tr>
<td>Adnexal mass on transvaginal ultrasound</td>
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<tr>
<td>Diagnosis of ectopic pregnancy</td>
<td>Gestational sac inside fallopian tube on transvaginal ultrasound</td>
</tr>
</tbody>
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REFERENCES

1. RCOG, Early Pregnancy Loss, Management (Green-top 25)
4. NICIE. 1.7.2 Screening for Down’s, Antenatal Care (2008)

IMAGE: WEBPHOTOGRAFEREER/ISTOCKPHOTO.COM

1. Possible ectopic pregnancy
2. Probable ectopic pregnancy
3. Diagnosis of ectopic pregnancy
Case 1: Black cat in the dark

Ms E, a 25-year-old clinical psychologist, became pregnant unexpectedly after her means of contraception failed. She sought a medical termination at a private clinic promptly at six weeks gestation. While at the clinic, Ms E was reported as showing that she was experiencing some abdominal pain and spotting; an ultrasound was performed. Dr X examined the scan; although she found it difficult to read, she was satisfied that it was normal.

After being appropriately consented for the procedure, Ms E was given medication to induce the termination over a course of two days. She was also given antibiotics and an appointment was made two weeks later.

Ms E never made it to the repeat appointment, as she was admitted to the local emergency department unit suffering from back and abdominal pain, and pain at the tip of her right shoulder.

A scan revealed an ectopic pregnancy in her left fallopian tube and she was taken into theatre. The condition of the tube was such that the only option was salpingectomy. This had catastrophic consequences for Ms E, as the right tube had been damaged due to a ruptured appendix during her childhood.

Ms E, now unable to conceive naturally, issued a claim against the clinic, alleging that there were signs that the pregnancy was not developing in utero. A review of the earlier ultrasound photos that Dr X was given clearly showed the absence of an intrauterine pregnancy that was not investigated. The clinic admitted breach of duty, which took into account Ms E’s reduced fertility, and the claim was settled for a moderate sum.

**USEFUL LINKS**
- RCOG, The Management of Tubal Pregnancy (reviewed 2010)
- RCOG, Early Pregnancy Loss, Management (Green Top 25, 2006)

**LEARNING POINTS**
- According to the RCOG, one in 90 pregnancies is an ectopic pregnancy.
- Ectopic pregnancy is likened to trying to spot a black cat in the dark: an ectopic pregnancy that has not ruptured can have silent or no symptoms; if it has ruptured it may produce shoulder tip pain, abdominal pain and shock.
- Where a patient is known to be in the early stages of pregnancy, or is of child-bearing age, and describes abdominal or pelvic pain, ectopic pregnancy must be considered high on the list of possible diagnoses.

Case 2: Mother knows best

Mrs M had been with her GP surgery for many years and they had supported her through three miscarriages and an ectopic pregnancy. Mrs M had given up on having her own children and had adopted a child. She presented at the surgery after a period of amenorrhea and was delighted, if somewhat apprehensive, to be diagnosed as being pregnant in her early 30s.

Dr P, the GP partner who saw her, was aware of her apprehension and felt that the most important thing to Mrs M was to have her own child. Given her previous history and the slight but real risk of losing a pregnancy following an amniocentesis, he decided against counselling her on the national guidelines regarding screening for Down’s syndrome. She had a torrid obstetric history despite only being in her early 30s and, given her age, he felt the chances of her having a baby with Down’s was low or unlikely, and that she would be unlikely to take the chance of losing the pregnancy if an amniocentesis was suggested.

A few months later, Mrs M gave birth to a baby with Down’s syndrome. She made a claim against the hospital alleging negligent actions and poor genetic counselling. It was held that Dr P had failed in his duty of care to Mrs M by failing to initiate the screening of Mrs M. Mrs M was awarded a substantial sum from the NHS clinical negligence unit.

**USEFUL LINKS**
- DH, UK National Screening Programme, Fetal Anomaly Screening Programme (2010)
- NICE, Antenatal care (2008)
- Contains extensive web links and advice
- RCOG, RCM, Multiple Pregnancy (2011)

**LEARNING POINTS**
- Patients should make informed decisions about whether to be screened or otherwise. Some patients may decide against having diagnostic testing or screening. This discussion and the reasons given should be documented.
- Screening identifies some women where the risk of congenital disease is sufficiently high to justify invasive tests that can carry a risk of miscarriage.
- Blood tests are screening tools; they provide an indication of the risk of an abnormality whereas an amniocentesis is a diagnostic tool and will be able to tell the parents whether or not they have, eg, a Down’s syndrome child.
- All women should be offered screening for Down’s as part of a national screening programme. It should be stressed that it does not give a definite diagnosis. According to NICE:
  - The “combined test” (nuchal translucency, beta hCG and PAPP-A) should be offered to women between 11 weeks 0 days and 13 weeks 6 days.
  - For women who book later, the most clinically and cost-effective serum screening test (triple or quadruple test) should be offered between 15 weeks 0 days and 20 weeks 0 days.
  - When it is not possible to measure nuchal translucency (because of fetal position or maternal raised BMI), women should be offered serum screening (triple or quadruple test) between 15 weeks 0 days and 20 weeks 0 days.¹
A duty to treat ... and to tell?

Confidentiality is the foundation stone of the doctor–patient relationship. However, it is not absolute; disclosures are allowed without consent in instances where it is in the public interest to do so, and such disclosures are sometimes even required by law. **Sarah Whitehouse** looks at a doctor’s responsibility to their patients and to society.

Rioting in England in August 2011 brought this dual responsibility to patients and society to the fore. The GMC states that disclosure of a patient’s personal information may be in the public interest, if it is likely to protect individuals or society from risks of death or serious harm, such as serious communicable diseases or serious crime, or as a result of gunshot or knife wounds.1

Similarly, the NHS Confidentiality Code of Practice states that “serious harm to the security of the state or to public order and crimes that involve substantial financial gain or loss” will general fall into the category of serious crime.2 Does this cover passing on information about a patient’s involvement in public disorder? It does if it threatens the public interest, but the ethical shades of grey become even more blurred in instances where the crime cannot immediately be classed as serious.

The wider context is important, as sometimes crimes may be considered as serious where there is a prolonged period of incidents, even though they might not be serious on their own.3 For example, a patient presents at the emergency department (ED) with unexplained cuts to their hands and wrists. It later emerges that these injuries were sustained whilst looting a sports shop for a pair of trainers. This is, of course, a crime, but is it in the public interest to disclose this confidential patient information? How far should doctors make morally charged decisions about how serious a crime has to be before it is reported?

**Primary duty is to your patients**

MPS Senior Medicolegal Adviser Dr Su Jones says: “It is important to remember that a doctor’s primary duty is to their patient. It is helpful to document any decisions and discussions that have taken place. You should document your disclosure.” She adds: “If you are unsure whether or not to share information, seek advice from an experienced colleague, or call MPS for advice.”

Breaking confidentiality in instances where there is not a clear and justified public interest can erode the confidential nature of the doctor–patient relationship. Without confidentiality, patients may be reluctant to seek treatment or disclose their full history or nature of their injuries, which may compromise their health and erode patients’ confidence in the profession.

In addition, it is important to consider the extent of information which is to be disclosed – disclosing demographic data or the fact that someone attended a clinic...
may be easier to justify than revealing explicit clinical details.4

Safeguarding society

As healthcare professionals interact with the public on a daily basis, they play a vital role in safeguarding; for example, in reporting child protection issues, spotting domestic abuse, or even spotting the potential for terrorist activity. The government’s Prevention of Terrorism Programme, drawn up to help combat home-grown terrorism after the 7/7 London bombings, places particular emphasis on healthcare professionals’ involvement in reporting instances where they suspect a patient may have been drawn into extremist activity.

The strategy states: “Healthcare professionals may meet and treat those who are vulnerable to radicalisation.”6

looking to the future?
Can doctors really look into the future and say how someone might behave? In the UK, GPs receive written notification from the police whenever a patient applies for a licence, or applies for a renewal of a licence for a firearm or shotgun, to bring to their attention any medical condition that may affect shotgun or firearm ownership. However, it would be impossible for doctors to predict whether patients who own firearms would harm others in the future.

A BMA spokeswoman said: “If a doctor did have concerns about a patient who has a firearm, then of course they should raise this within the appropriate channels.”

It is up to a doctor to use the information they have been given to make a professional judgment on the situation, and whether it is necessary to disclose information within the public interest.

It is important to remember that a doctor’s primary duty is to their patient. It is helpful to document any decisions and discussions that have taken place. You should document your disclosure

Those with learning difficulties or mental health problems are, it is argued, more easily drawn into terrorism. For example, Nicky Reilly, who has Asperger’s syndrome, was convicted of trying to blow up a shopping centre in Exeter. It is, however, extremely difficult to generalise or pigeonhole. Such monitoring could lead to heightened suspicion for no justifiable reason, leading to a loss of patients’ confidence in doctors, rather than any significantly improved detection of terrorists.

The strategy goes on to explain: “The key challenge for the healthcare sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker can interpret these signs correctly, is aware of the support which is available and is confident in referring the person for further support.”7

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It is not the medical profession’s responsibility to maintain law and order – its duty is to provide care to those who need it, non-judgmentally, without fear or favour. If doctors lose sight of that, we are doomed.

“Recently, a patient told one of my juniors that they had a shotgun at home. The patient had attended with depression and had expressed suicidal intent,” says Dr Jonathan Jones, Emergency Medicine Consultant at Leeds General Infirmary. “I actually discussed the situation with a mediocolegal adviser at MPS. Following that discussion, I spoke to the patient and clarified the story – they sometimes borrowed a shotgun their uncle kept in a locked gun cupboard and they had some shotgun cartridges at home. I felt that the situation was low risk and we did not inform the police.”

Making moral judgments
Dr Jonathan Jones adds: “As EM consultants we are expected to make moral judgments on the severity of a crime and when to disclose – and this is tricky. Not so long ago, a nurse found that a patient had a carrier bag full of marijuana plants. The patient had attended with mental health problems and claimed they had found it in a bus stop. The nurse contacted our pharmacist, as is policy when it comes to disposing of illicit substances. Because of the volume of material, she could not use the normal processes for disposing of the material and so the police were called. The police were keen to have the patient's details. I felt that this did not constitute a serious arrestable offence – they disagreed, arguing that clearly the patient had access to marijuana being grown, which could be classed as intent to supply, meaning it was a more serious offence. I asked them to get written authority and a request for disclosure of personal data from an inspector or above, before I would then consider their request further.”

Professional and personal response
There is, perhaps, a difference between a citizen's duty and the duty of a medical professional. Dr Su Jones says: “Always ensure that you can justify your decision to break patient confidentiality. Don’t get caught up in any public frenzy; have a measured, professional response in situations such as large-scale public disorder and rioting. Reflect on whether the disclosure is really in the public interest to avoid a knee-jerk reaction.” Whilst doctors should not turn a blind eye to petty crime, it is their professional responsibility to disclose confidential patient information only when there is a serious threat to public safety. Doctors are highly-regarded as upstanding members of society, but ultimately their professional duty has to lie with the individual patient.

The Independent’s Health Editor Jeremy Laurance sums up the debate eloquently. “It is not the medical profession’s responsibility to maintain law and order – its duty is to provide care to those who need it, non-judgmentally, without fear or favour. If doctors lose sight of that, we are doomed.”

CASE STUDY

Dr S is an Emergency Medicine consultant working the night shift in a busy city centre teaching hospital. A 23-year-old male, Mr N, is brought in to the hospital by paramedics with a gunshot wound to his left leg. He becomes extremely distressed when Dr S begins to take a detailed history. When Dr S suggests reporting the crime, Mr N becomes very aggressive and starts to threaten Dr S, warning him not to call the police. What should Dr S do?

Advice
The GMC states that doctors should inform the police quickly whenever a person arrives with a gunshot wound or knife injury, in order to allow police to make an assessment of the risk to the patient and others and to record the crime for statistical purposes.

However, Dr S should make a professional judgment about whether to disclose Mr N’s name and other personal information. If it is probable that a crime has been committed, and Mr N is unwilling to disclose information or allow doctors to do so, Dr S can speak to the police if the information is required by law, or is in the public interest. If you decide not to tell the patient about the disclosure as it may put you or others at risk of serious harm, or prejudice the prevention, detection or prosecution of a crime, you must document this decision and be prepared to justify it.

REFERENCES
1. GMC, Confidentiality p16, 2009 www.gmc-uk.org
2. NHS, Confidentiality Code of Practice, p5, 2003
3. NHS, Confidentiality Code of Practice Supplementary Guidance: Public Interest Disclosures, p9, 2010
4. Ibid p6
5. MPS factsheet, Confidentiality: Disclosures Without Consent www.mps.org.uk
7. Ibid
8. Laurance J, Medical life: Patients’ trust must not be betrayed in the wake of the riots, The Independent, 23 August 2011
On the case

Dr Rob Hendry, Deputy Medical Director, introduces this issue’s round-up of case reports, which highlight the importance of being aware of distracting symptoms, and being prepared to revisit decisions, when making a diagnosis.

In “Too quick to clear the spine” on page 14, the multiple injuries Miss T suffered in a road traffic accident made it difficult to localise the pain to her neck. As a result of these distracting injuries, ED consultant Dr W missed the C6 fracture and removed Miss T’s spinal collar. A detailed record of the severity of the accident might have alerted Dr W to the potential for severe spinal injury. In this case, the two junior orthopaedic doctors did not challenge Dr W’s diagnosis that Miss T’s c-spine had been cleared, despite the paraesthesia in all her limbs. Where necessary, previous clinical decisions should be challenged, even those of senior colleagues.

Similarly, you should always be prepared to revisit your own diagnosis, should symptoms persist. Dr G, in “Double problem, double risk” on page 20, was distracted by Mr E’s multiple complaints and did not reconsider his initial diagnosis. The five-month delay in the diagnosis of squamous cell carcinoma of the tonsil meant that the case could not be defended. Where necessary, previous clinical decisions should be challenged, even those of senior colleagues.

In “Too many records spoil the notes” on page 15, ophthalmology consultant Mrs C failed to diagnose Mr M’s glaucoma, despite there being recurrent abnormalities in his vision and a family history of glaucoma. Listening to the patient is imperative; have an open, unbiased mind at each consultation and consider a second opinion if you are unable to account for a patient’s symptoms or clinical signs. Inaccurate record-keeping and retrospective amendments to the patient’s records made this case indefensible.

Conversely, accurate record-keeping can help to build a successful defence against a claim. We often receive feedback from members asking us to feature more successfully defended case reports; “Right patient, wrong sample” on page 17 and “More than a bruise” on page 18 are such examples. In “More than a bruise”, none of the doctors involved were found to be in breach of their duties, despite Mr U’s sudden and unexpected death. Records clearly showed the careful management of his condition, examination and documentation of symptoms. Had the records not been comprehensive, there could have been reasonable doubt that there were missed symptoms or signs.

Casebook publishes medicolegal reports as an educational aid to MPS members and to act as a risk management tool. The reports are based on issues arising in MPS cases from around the world. Unless otherwise stated, facts have been altered to preserve confidentiality.

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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 £1,000,000+
- Substantial £100,000+
- Moderate £10,000+
- Low £1,000+
- Negligible <£1,000
Twenty-eight-year-old Miss T was a pillion passenger on her boyfriend’s motorbike going at high speed on a motorway. He lost control of the vehicle and tried to regain it by braking, which threw them both over the handles, landing some distance away. Unfortunately, Miss T’s boyfriend was certified dead at the scene of the accident.

The paramedics who dealt with Miss T removed her helmet, following appropriate guidelines, and then immobilised her neck with a rigid collar and head blocks. She was then moved on a long spinal board and rushed to the local emergency department (ED).

Dr W was the consultant in charge and was already expecting Miss T in the resuscitation room, where he took a brief handover from the ambulance crew. Miss T was fully conscious on arrival with a GCS of 15/15 and was hemodynamically stable. Dr W performed a primary survey and then requested a series of trauma x-rays, including c-spine, pelvis and thorax. On a full secondary survey, Dr W suspected fractures of left clavicle, left wrist, right hand and left tibia and fibula, which were all confirmed soon after by x-rays.

Dr W removed the collar and felt for tenderness in Miss T’s cervical spine processes, but Miss T said that it was not painful; neurological examination was also normal. The cervical spine x-ray only showed down to the top of C6 but didn’t show any fractures so Dr W removed the collar and wrote in his notes: “C-spine cleared”.

The orthopaedic team took over Miss T’s care and she was then moved to theatre for surgical management of her fractured tibia and manipulation of her wrist. When she was still in the recovery room following surgery, Miss T mentioned that she had some tingling in her legs and that her legs felt heavy and weak. This was documented in the nursing notes but was not acted upon.

Once she was moved to the orthopaedic ward, Miss T continued to complain about paraesthesias in all her limbs; she also mentioned that her head felt unstable as “it was falling backwards”. She also had a long episode of hypotension that did not respond to fluids. Two different orthopaedic junior doctors made entries in her clinical notes about this and they both commented that Miss T’s c-spine had been cleared earlier on by the ED consultant. They both felt that the symptoms could be related to the multiple limb fractures.

Three days after the accident, the orthopaedic consultant in charge requested a c-spine CT during the ward round since Miss T continued to mention that her limbs felt weak and numb. The CT was done but it was not reviewed by the radiologist until the following morning, when he immediately acted upon it and contacted the orthopaedic team; it was finally confirmed that Miss T had a displaced fracture of C6. Unfortunately, the final outcome was not good and Miss T was left tetraplegic. She made a claim against all the doctors involved in her care and following expert review it became obvious that the case could not be defended. The case was settled for a high sum.

LEARNING POINTS

- In severe trauma cases, getting a detailed history and an accurate description from the paramedics is always a good start. The presence of fatally injured victims in the same accident is an indicator of the severity of the trauma sustained by survivors. The kind of vehicles involved, approximate speed, description of surroundings, distance between motorbike and victims, description of witnesses and so on will give you invaluable information.

- Distracting injuries make clinical evaluation of the cervical spine less useful and sometimes completely unreliable. Localising the pain to the neck becomes far more difficult when there is severe pain in other areas of the body, particularly the torso. In most cases of major trauma an adequate three view cervical spine plain film series will be necessary. When clinical assessment is complicated by multiple injuries or mental obtundation, or the plain films are inadequate, further imaging should be considered.

- Most trauma centres would consider doing a full trauma CT scan from the head to pelvis. You should check the adequacy of cervical spine x-rays and make sure that they are reliable; in this case you should ensure that the cervical spine down to C7 has been visualised.

- Relying on the diagnosis of other colleagues when there are worrying symptoms could result in a missed or delayed diagnosis. Diagnosis is a dynamic process and, when necessary, previous clinical impressions by other colleagues need to be challenged, even those of senior colleagues by more junior doctors.

- When patients do not respond as expected, the situation needs reviewing. A hypotensive trauma patient not responding to fluids might be suffering with neurogenic shock, secondary to spinal injury, but unless it is thought about, the diagnosis will remain missed.

- It is important to ensure that all investigations are followed up – remember your responsibilities when you are part of a multidisciplinary team. Ensure that there is continuity of care.
Mr M, a 51-year-old primary school teacher, was referred to ophthalmologist Mrs C, following a letter sent by an optometrist to his GP. The optometrist had found Mr M to have an abnormal right optic disc, slightly raised intraocular pressures and significant defects in the visual fields of his right eye with suspected glaucoma. Mrs C reassured the patient that the static visual field defect in the right eye was as a result of an optic disc pit and that there were no signs indicating glaucoma at that time.

Mr M then became a patient of Mrs C when he noted a deterioration in his vision. She followed him up for five years. During this period, Mr M consulted Mrs C regularly. She examined him clinically, took intraocular pressure measurements, made optic disc assessments and performed a number of investigations including serial automated visual fields tests. Mr M expressed concern about the progressive deterioration of his vision. His paternal grandmother went blind due to glaucoma and his father was on treatment for glaucoma. Mrs C did not offer an explanation for the progressive deterioration of his sight. She did not offer a referral for a second opinion or referral to a specialist. Mr M relocated to a new town with his job and was seen by a different ophthalmologist, who found abnormalities consistent with advanced glaucoma in both eyes and significant visual field loss. Mr M was registered partially sighted and lost his driving licence. He underwent rehabilitation at work and was unable to work without the use of low vision aids.

Mr M made a claim against Mrs C. The case notes submitted by Mrs C had recorded normal intraocular pressures and normal optic discs. However, during the investigation of the case, it transpired that the documentation presented by Mrs C as her clinical notes regarding her patient were actually retyped “summaries” of the original notes. It was found that the original notes recorded the finding of physiological disc cupping with no mention of a disc pit – yet Mrs C had failed to record the cup-disc ratios, which could have helped to monitor deterioration in the health of the discs and to ultimately diagnose Mr M’s glaucoma. It was obvious that the reproduced “summaries” – which neglected to mention the finding of physiological cupping – was an attempt to disguise the original failure to diagnose.

Expert opinion concluded that the vast majority of peers would agree that Mr M was at risk of glaucoma and that he needed to be carefully monitored with detailed recording of the state of the optic discs, and that he had signs consistent with glaucoma when he was first referred to Mrs C. They would have offered treatment for glaucoma and a referral to a glaucoma specialist for further care.

The case was settled for a high sum considering the permanent and severe nature of the damage to vision.

AK

**LEARNING POINTS**

- The UK’s GMC guidance, Good Medical Practice, states that in providing care you must: “keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment”. [www.gmc-uk.org/guidance/good_medical_practice/good_clinical_care_index.asp](http://www.gmc-uk.org/guidance/good_medical_practice/good_clinical_care_index.asp)

- Doctors failing to make the care of the patient their first concern put themselves at the risk of both disciplinary action and medicolegal claims.

- Early glaucoma is, unfortunately, a diagnosis that is frequently missed. The Royal College of Ophthalmologists and NICE provide easily accessible, up-to-date guidelines on diagnosis and management of glaucoma. All doctors are responsible for keeping up-to-date with professional knowledge, knowing their limitations and working with colleagues to provide the best level of care for their patients.

- Listening to the patient and responding to their concerns is vital, not just for making an accurate diagnosis but also for establishing rapport and trust. Be prepared to reconsider a diagnosis that was eliminated on an earlier visit by having an open, unbiased mind at each consultation. Consider getting a second opinion if you are unable to account for a patient’s symptoms or clinical signs.

- If patients have sight loss or visual field loss and no longer meet the DVLA’s minimum standards for driving, it is the duty of the ophthalmologist to remind the patient of their legal obligation to inform the DVLA. This discussion should be documented in the patient records. This has safety implications and forms part of a doctor’s duty towards public safety. See the GMC’s Confidentiality guidance, [www.gmc-uk.org/Confidentiality_reporting_concerns_DVLA_2009.pdf](http://www.gmc-uk.org/Confidentiality_reporting_concerns_DVLA_2009.pdf)

- Medical notes have to be considered not only as medical documents but also as legal documents. Passing off rewritten records as contemporaneous is a criminal offence and any retrospective change has to be clearly marked, dated and signed, and a reason for the change should be documented. Altering existing medical records, removing records, or adding false records puts a doctor at the risk of referral to a regulatory body for dishonesty.

- Disclosure of authentic, original clinical notes is essential when a claim is brought. Failure to do so can make a claim indefensible.
Mrs T, a 40-year-old secretary, was overjoyed to find herself pregnant for the first time. Unfortunately, a detailed antenatal congenital anomaly scan identified that her baby had a severe congenital heart defect. The pregnancy was closely monitored by the regional cardiology team. Baby T was born in the regional teaching hospital, and first stage cardiac surgery was carried out in the first week of life.

Baby T recovered well from this initial surgery. Despite very slow weight gain and some feeding difficulties, she made good developmental progress. Her cardiac function was closely monitored, and definitive surgery was planned for 18 months of age.

One Friday just before her first birthday, baby T became increasingly breathless. She was admitted to her local hospital, where she was found to have heart failure thought to be secondary to a dysrhythmia. Baby T was started on oral medication, but she deteriorated acutely, and the decision was made to transfer her to the regional Paediatric Intensive Care Unit (PICU).

On arrival at the PICU, baby T was assessed by Dr Q, a newly-appointed consultant. He noted her to be acutely unwell, breathless and hypotensive. Dr Q electively intubated her and proceeded to insert a right femoral catheter to enable intra-arterial blood pressure monitoring.

Two hours later, Dr Q reviewed baby T. He noted that the right foot was cold and poorly perfused. Dr Q elected to remove the right femoral artery catheter. Invasive blood pressure monitoring was still clinically indicated, and he therefore sited a catheter in the left posterior tibial artery. Dr Q recorded in the infant’s notes that the right foot was “slightly warmer but the general perfusion still poor”. Before leaving the unit for the weekend Dr Q asked the nurse looking after baby T to “keep an eye on that leg”.

Over the next 24 hours, baby T responded to medical management of her dysrhythmia. However, on the Sunday morning ward round, she was fully examined for the first time since admission. Her right foot was noticed to be mottled and very cold.

An urgent ultrasound demonstrated thrombosis of the right femoral artery. The vascular team was contacted. Due to the delay in presentation, medical management with thrombolitics was deemed to be inappropriate. An embolectomy and fasciotomy were performed urgently but unfortunately were not successful. The limb was non-viable, and baby T required a below knee right leg amputation.

In reviewing the records, it became apparent that while nursing observations had recorded the look and temperature of the left leg throughout her stay on the PICU, no observations had been made on the right leg for over 24 hours. The medical records did not indicate that any specific examination of the right leg had been made by the junior doctor covering the unit for the weekend.

There was no record of a formal handover from Dr Q to his consultant colleague covering the unit for the weekend. A claim was made against Dr Q. Expert opinion was that Dr Q should have left specific instructions for the nursing staff to check on the right leg in addition to the left. The claim was settled for a high sum.

LEARNING POINTS

- Iatrogenic vascular thrombosis is a well-recognised complication of arterial catheterisation. The risk is particularly high in infants below two years of age. Where intra-arterial catheters are used for blood pressure monitoring, clear local guidelines should be in place for monitoring the insertion site and the limb distal to the insertion of the catheter for signs of potential vascular compromise. This includes a cold, pale limb with a prolonged capillary refill time and reduced or absent pulses. Arterial occlusion can quickly progress to gangrene.

- When delegating to a colleague you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved.

- It is inappropriate to assume that nurses will anticipate complications of a medical procedure, or to understand the significance of a clinical sign. Where any additional nursing observations are to be undertaken, this should be clearly and explicitly stated. Clear instructions and a good handover are essential.

- In relation to medical negligence claims, good documentation makes the difference. “If it’s not in the notes it didn’t happen” is an aphorism worth remembering.
Mr Q, a 23-year-old student, was admitted to hospital as a surgical emergency with an acute abdomen. A provisional diagnosis of acute appendicitis was made and Mr S, consultant surgeon, performed a laparoscopic procedure. The findings at the time of surgery revealed a normal appendix, which was removed. Mr S undertook a thorough inspection of the rest of the abdominal contents and discovered a small perforation of the body of the stomach with thickening of the surrounding tissue and localised contamination. A biopsy of the perforation site was taken and sent to the pathology laboratory for frozen section analysis by consultant pathologist Dr F.

Dr F called the operating theatre a short time later to discuss the biopsy result, which appeared to demonstrate an undifferentiated malignant tumour. Both Mr S and Dr F considered this to be highly unusual, particularly in view of Mr Q’s age. Dr F was confident in the accuracy of his initial assessment of the specimen, but felt that further histopathological analysis and stains together with a second opinion from colleagues in his department would be helpful. Following this discussion, Mr S decided at this point simply to close the perforation with an omental patch, wash out the contaminated fluid and await further assessment of the biopsy. Postoperatively, Mr Q made a straightforward recovery. Mr S requested a CT scan that did not reveal any other disease and only demonstrated some gastric wall thickening at the site of the perforation. After further histopathology tests, the final opinion of Dr F and his colleagues was that the initial diagnosis of an undifferentiated malignant tumour was correct.

Following careful discussion between Mr S and the patient, Mr Q underwent a total gastrectomy three days after the initial biopsy. Again, Mr Q made an uneventful recovery. The final pathology report from the resected specimen proved to be a normal stomach with no features of malignancy.

On the grounds that his major surgery had been unnecessary, Mr Q made a claim against the doctors involved in his care. The hospital initiated an internal investigation and it became apparent that there had been an error in the pathology laboratory. The frozen section sample taken from Mr Q had been mislabelled in the pathology department and actually belonged to another patient who had had surgery some hours earlier. The correct specimen taken from Mr Q was entirely benign.

The case was defended successfully on behalf of the member, Mr S. An investigation by the regulatory body (to whom the clinicians involved had been reported) also exonerated Mr S and Dr F. A separate claim against the hospital did, however, result in a substantial settlement for the claimant on the basis of errors in the pathology labelling processes.

This is a genuine case from outside the UK, and was reported in the media.

SD

LEARNING POINTS

- Many doctors will have a claim made against them during their professional lives. Even when some mistakes occur because of system failures, it is the doctors who may initially be investigated. In this situation the clinicians did go to extra lengths to check the veracity of the pathology report before acting upon it, but were ultimately let down by problems with the hospital’s systems for labelling pathology specimens.
- Misidentification of pathology specimens occurs every year in even the most developed healthcare systems. In the UK, figures obtained via the Freedom of Information Act for the NHS in 2009 revealed almost 12,000 samples were incorrectly labelled by pathology laboratory staff. This can potentially lead to both inappropriate treatment and also delays or false reassurance in the management of unreported conditions.

Despite technological advances and improvements in quality control of system processes, clinicians should always be alert to the possibility of a misidentification error when an unexpected result appears.

- Additional opinions from colleagues and further biopsy material can help confirm or refute an unexpected pathology result and prompt investigation into any mistakes in labelling or specimen identification that may have occurred. In the context of cancer treatment, such processes are facilitated by the multi-disciplinary team approach, which is now standard for the management of gastric cancer in the NHS in England.
- In the case described, it is likely that a wider group of clinicians would have suggested additional biopsy material from an endoscopy and a laboratory check on the identity of the specimen, prior to proceeding with such radical treatment in a very young man.
Mr U, a healthy 30-year-old taxi driver, was on duty when he suffered a minor road traffic accident. He was sitting at the wheel of his car at a red light, when a car hit him from behind. Mr U was wearing his seat belt, and the collision caused the seat belt to impact on his chest, which caused an abrasion and bruising. There was no damage to the other cars involved and Mr U felt no subsequent pain so, after exchanging insurance details, he continued his day as usual. The following day, Mr U awoke with pains in his chest, which caused severe pain, there appeared to be no change in Mr U’s condition. There were no bruises, no crepitus and the breath sounds were normal. The entries on Mr U’s records by all the doctors involved were clear and detailed. Each doctor added a painkiller of increased strength in an attempt to make him more comfortable. All doctors agreed that it was a musculoskeletal pain caused by the contusion.

During the next five days, Mr U attended his GP surgery with increasing pain to the traumatised area. Mr U was seen by three different doctors. At every visit he was fully examined and his temperature, oxygen saturation and HR/BP were recorded. In spite of the severe pain, there appeared to be no change in Mr U’s condition. There were no bruises, no crepitus and the breath sounds were normal. The entries on Mr U’s records by all the doctors involved were clear and detailed. Each doctor added a painkiller of increased strength in an attempt to make him more comfortable. All doctors agreed that it was a musculoskeletal pain caused by the contusion.

Mr U was feeling very unwell. His wife drove him to the ED. On arrival he was hypotensive and tachycardic, his oxygen saturation was low and he was feverish. Mr U was seen again by Dr F, who found on examination a large bruise on his chest. Dr F immediately started treatment with fluids and antibiotics, but as he was waiting for the blood results the bruised area seemed to grow larger than an hour earlier. Suspecting necrotising fasciitis, he called the ICU team, where Mr U was admitted. Mr U was taken to theatre for debridement, but unfortunately he rapidly deteriorated and died from the necrotising fasciitis two days later.

Mr U’s widow made a claim against all the doctors who saw her husband following the accident. The experts reviewed all the medical records and gave supportive evidence, so the decision was made to defend the case, since it was felt that the management had been correct and none of the doctors were in breach of their duties. The case was successfully defended.

LEARNING POINTS

- Sudden and unexpected death will leave questions behind that may affect the perceptions of the bereaved. Good quality records are invaluable in demonstrating that care was of the appropriate standard and reasonable in the circumstances.
- Claims and complaints can and will happen in spite of doctors doing their jobs properly.
- It is always safe practice to treat each patient as if they are being seen for the first time. Diagnoses made by colleagues can lead to a false sense of security and a repeat of the wrong diagnosis.
- In this particular case, each doctor examined the patient and documented it; had this not been the case, there could have been reasonable doubt that there were symptoms or signs missed.
- Beware of pain that is out of keeping with the clinical findings.
- Do not be afraid to go back and rethink the initial diagnosis (whether made by you or somebody else), in light of any new evidence or if the condition is not resolving or behaving in the way you thought it would.
- Necrotising fasciitis is not a common condition, but is still a life threatening one. Useful advice can be found at: http://emedicine.medscape.com/article/1348047-overview#aw2aab6b3; Dr S Hasham, Necrotising fasciitis, BMJ (2005; 330:1143) – www.bmj.com/content/330/7495/830.full
Mrs W, a 42-year-old staff nurse, had long-standing poorly-controlled diabetes. While shopping at the weekend, she twisted her right ankle stepping off a kerb to avoid a push chair, and it became swollen and mildly painful.

The following Monday, she asked one of the doctors on the ward where she worked to “have a quick look at it”. Dr J examined the ankle in the ward office and diagnosed sprained ligaments. Dr J did not document this brief consultation.

Forty-eight hours later, the swelling had not improved so Mrs W asked Dr J to have another look at her ankle and he sent for a plain ankle x-ray. Dr J reviewed the film and reassured Mrs W that there was no fracture, insisting that the swelling had not been caused by a sprain diagnosis.

One month after the injury, with persistent swelling and redness, Mrs W went to see her GP, Dr Y, with a self-diagnosis of cellulitis. During the consultation she mentioned the normal x-ray organised by Dr J. Dr Y prescribed amoxicillin to treat the suspected cellulitis.

The following week, Dr Y saw Mrs W again, and was unable to palpate peripheral pulses bilaterally. Dr Y queried the initial diagnosis of cellulitis and sought urgent telephone advice from Mr N, a vascular surgeon. With no evidence of acute ischaemia, Mr N was not concerned and advised that Mrs W should continue the oral antibiotics and suggested she attend a routine outpatient appointment.

Three weeks later, Mr N assessed Mrs W in an outpatient clinic, studied her x-ray, and sent her for ankle-brachial pressure indices (ABPIs) and an arterial duplex ultrasound of the lower limbs. Following a further appointment, with the investigations not revealing any significant macrovascular insufficiency, Mr N then referred Mrs W for an outpatient orthopaedic opinion. Almost three months following the initial injury, Mrs W was assessed by Mr B, an orthopaedic surgeon, who diagnosed a total midtarsal and hind-foot Charcot collapse with poor prognosis.

Mrs W made a complaint against all the doctors involved. On examination of the case, there was no documentation from Dr J’s initial consultations and it transpired that Dr J did not even know that Mrs W was diabetic. The plain x-ray requested by Dr J did reveal features of established neuropathic osteoarthropathy of the midtarsal joint of the right foot, which was missed by both Dr J and Mr N.

Having been reassured that there was no significant injury, Mrs W had continued to work and weight-bear through the affected foot until the correct diagnosis was finally made. The repeated misdiagnosis had resulted in a delay and failure to initiate potentially effective early treatment.

The experts, although not critical of Dr Y or Mr B, were critical of Dr J and Mr N. Despite two separate consultations and further investigation, the failure of Dr J to document his interactions with Mrs W was criticised. The experts were critical of Mr N’s management, believing it fell below the acceptable standard in that he failed to correctly interpret the history and findings on examination, which contributed to a delay in reaching the correct diagnosis and a poor prognosis for Mrs W.

The case could not be defended and was settled for a moderate sum.

JW

LEARNING POINTS

- Having a member of staff ask for an informal medical opinion is a common event for most doctors. Doing things in a by-the-by way often means not taking a history, or documenting and even dealing with medical problems that are beyond our expertise. However, the medical responsibility remains the same.

- Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal or working relationship.

- Knowing the relevant past medical history of any patient is always useful, even for apparently minor injuries.

- When looking at an x-ray, it is always useful to have a global look at it rather than exclude a diagnosis. The fact that in this case there was no new fracture did not make the x-ray “normal”.

- Severe injury associated with Charcot osteoarthropathy may occur following minimal or unperceived trauma.

- Non-weight-bearing immobilisation in the acute inflammatory stage is crucial to a successful treatment outcome.

- Any patient with peripheral neuropathy who presents with a hot swollen foot should be regarded as having an acute neuropathic osteoarthropathy until proven otherwise. Guidance can be found here – TS Roukis, T Zgonis, The Management of Acute Charcot Fracture-dislocations with the Taylor’s Spatial External Fixation System, Clin Podiatr Med Surg (2006 Apr; 2)
Mr E, a 52-year-old truck driver, visited his GP, Dr G, complaining of a tight chest. Mr E had no significant co-morbidities, but had been suffering with coryzal symptoms for more than a week, which were starting to affect his breathing. He had wanted to attend sooner, but due to his job he had not been able to attend the surgery earlier. During the consultation Mr E mentioned that his throat has been bothering him for a couple of weeks, so he had started to cut down on his usual 20 cigarettes a day.

After examining Mr E’s chest, Dr G was quite concerned about his widespread wheeze. He administered a nebuliser in the surgery, and gave him some smoking cessation advice, but did not investigate Mr E’s throat. A few weeks later Mr E reattended with similar symptoms of wheeziness and a cough, which again required another nebuliser. He mentioned that one side of his throat was painful and this was documented in the notes, but his throat was not examined.

During the following month, Mr E attended the local ENT department for a previously organised appointment to discuss a “recurrent sinusitis problem”. While he was at the hospital, Mr E mentioned his ongoing right-sided sore throat to Dr W, the ENT junior doctor. Dr W suggested that Mr E “tell his GP to check it”. A month later at a follow-up appointment at the ENT clinic, Mr E saw Dr S, who immediately examined his throat. It became clear that there was an abnormal mass in his right tonsil and further tests confirmed squamous cell carcinoma of the tonsil with neck nodes. There was a five-month delay in the diagnosis, which required more aggressive treatment and left a poorer prognosis. The experts were critical of the management of Mr E by both Dr G and Dr W, so the claim was settled for a moderate amount.

**LEARNING POINTS**

- Patients who present with more than one complaint can easily distract a doctor’s attention, particularly if the patient is unwell and the added complaint seems insignificant in comparison. If there is not sufficient time during a consultation to address multiple problems, a record should be made and a follow-up appointment arranged.

- A flexible and open approach can avoid situations like the one in this particular case. Sending a patient to see his GP because the new complaint is not related to the reason for the appointment can leave a patient vulnerable.

- Head and neck cancers are relatively rare, especially those arising from the tonsils. The average GP is likely to encounter only one case every six years (NICE 2004). It is important to be aware of national guidance that advises referral for persistent, particularly unilateral discomfort in the throat, for more than four weeks (SIGN 2006; NICE 2005).

- The most common presenting symptoms of head and neck cancers are also common symptoms of infection, so can be easily dismissed. The key difference is that these symptoms tend to persist; therefore, a patient with unexplained symptoms, who fails to respond to conservative treatment, should be referred for further investigation.
Mrs H was a 35-year-old teaching assistant who also had two school-aged children. She was obese with a BMI of 40. In 2006, she had seen Dr G with left knee pain. Dr G recorded that on examination her knee was tender over her medial joint line but was otherwise stable. He initially prescribed diclofenac and advised her to lose weight. Shortly after, Mrs H returned to see Dr G. She still had knee pain but had also developed epigastric pain. Dr G noted her recent diclofenac use, realised the link and advised her to stop taking it immediately. He initially prescribed naproxen and co-codamol.

In January 2011, Mrs H injured her back while leaning forward to help a child put on a coat at school. After one week of severe pain, she consulted Dr W, a locum GP. Dr W noted that Mrs H was in distress with pain, was not able to work or sleep and was having difficulty caring for her children. He recorded that she was not responding to over-the-counter painkillers. Dr W checked her problem list and repeat medication screen, both of which were empty, and concluded that other than obesity, she was an otherwise fit 35-year-old. Dr W prescribed naproxen with co-codamol, referred Mrs H for physiotherapy and signed her off work for two weeks. He failed to note past history of dyspepsia and did not document any warnings. Mrs H saw Dr G ten days later. Her back pain was improving but she was not yet ready to return to work, was still requiring analgesia and was running out of medication. Dr G advised her to stay off work and issued more naproxen and co-codamol.

Four days later Mrs H was admitted with epigastric pain, coffee ground vomiting, and melena. While in the emergency department waiting to be seen by the medical on-call team, she had a large haematemesis and was taken for urgent endoscopy. Endoscopy revealed a large gastric ulcer but endoscopic intervention failed to control the bleeding and she required emergency laparotomy and a transfusion of five units of blood. Postoperatively she was very unwell and was returned to theatre with recurrent bleeding. She then spent two weeks on ITU. Unfortunately, her recovery was further complicated by a severe wound infection and she spent another three weeks in hospital. It was a further four months before she felt fully fit and able to return to work and fully care for her children without extensive family support.

The large ulcer was attributed to NSAID use in a patient who had previously experienced dyspepsia whilst on NSAIDs, her risk being further increased by concurrent use of an SSRI. She made a claim against Dr G and Dr W. The case was settled for a moderate sum.

**Learning Points**

- It is important to keep in mind that all drugs, even those we prescribe regularly, might be dangerous to certain patients.
- When repeating prescriptions by a previous doctor, it is important to review indications, interactions with other medications and most importantly contraindications.
- It is important to record adverse medication reactions in a way that will be easily displayed for future reference. In this case, the adverse reaction was buried away in a consultation note from five years previously but had not been coded as a problem that would be prominently displayed on the patient’s problem list or prescribing notes.
Mr B was a 30-year-old garage manager who had just returned from a long trip abroad with his wife. After the flight he developed some chest tightness. This showed no signs of improvement after ten days so Mr B made an appointment with his GP, Dr W. Dr W took a brief history and documented only that he had no cough or sputum. He did not ask about the character, site or radiation of the chest pain, or ask about recent long flights or family history of thrombosis. Despite documenting “no cough, sputum and examination of the chest normal”, he diagnosed a chest infection but also documented that he had queried asthma. Dr W prescribed seven days of amoxicillin and arranged a chest x-ray and an ECG.

Over the next few days Mr B’s chest pain persisted. It was retrosternal and he found himself taking shallow breaths because the pain was worse on inspiration. He walked down to the GP surgery and was quite short of breath just walking down the road. Dr W reviewed him the same day and his examination notes stated “no pain or swelling in the legs”. He looked at the chest x-ray report and the ECG and noted them to be normal, although the ECG had showed a sinus tachycardia. Again there was no record of him taking a detailed history of the chest pain or breathlessness. Dr W changed the antibiotics to erythromycin and added in gaviscon to ease the retrosternal chest pain, which he thought was dyspeptic in nature.

The next day, Mr B became very anxious because he was now breathless just walking around at home. His wife was worried so made him another appointment to see his GP. Dr W documented that he was anxious but that examination was normal other than a slightly raised blood pressure and heart rate, which he put down to anxiety. He prescribed some diazepam for his “nerves”.

Almost three weeks after the chest tightness started, Mr B became acutely short of breath and dizzy, then collapsed at home. His wife called emergency services but despite all attempts by the paramedics he was pronounced dead on arrival at hospital. The postmortem showed bilateral pulmonary thromboemboli.

Mr B’s wife was devastated and made a claim against Dr W. The case was settled for a substantial sum.

For patients who keep coming back with the same complaint, it is always wise to review the initial diagnosis. A patient who is not responding to treatment as expected might need to have the whole picture revisited with a fresh pair of eyes. See the article “Tunnel vision”, in Casebook 19(2).

It is important to consider more unusual diagnoses. Although a pulmonary thromboembolus is a relatively rare diagnosis in a healthy young man, it does happen. Unless you think about it you’ll miss it.

It should be remembered that not all pulmonary emboli are preceded by signs of a clear DVT.

When considering the differential diagnosis of breathlessness, it is useful to consider whether it is acute or chronic and to decide whether it is pulmonary, cardiac or physiological in nature.

Great care must be taken when diagnosing anxiety, especially in someone presenting with physical symptoms. Mr B had presented with chest tightness and dyspnoea and had been found to have a tachycardia and an elevated blood pressure. All these symptoms can be attributed to anxiety but this should have only been diagnosed after excluding other causes.
Forty-five-year-old hairdresser Mrs T was diagnosed with an 8cm complex left ovarian mass following some months of left iliac fossa pain. Mrs T had had two previous laparotomies, one for a right oophorectomy and latterly a hysterectomy. The right oophorectomy had been for a dermoid cyst and the hysterectomy for menorrhagia. Mrs T attended the clinic where she saw Mr D, gynaecology consultant, who advised her to have surgery to remove the ovarian mass.

The surgery was complicated due to the presence of considerable adhesions involving the ovarian mass, large bowel and pelvic side-wall. The left ureter was identified and mobilised clear of the left ovarian mass, which was excised as planned. Some hours after the surgery, Mr D had a family emergency and he had to leave the country for a few days. He asked his colleague Mr G to keep an eye on his patients while he was away.

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The first 72 hours after surgery were uneventful, although Mrs T was making slow progress. She was drinking but did not have much of an appetite. She felt bloated and had not passed much flatus nor had she opened her bowels. Indeed, Mrs T’s abdomen was distended and her abdominal wound was beginning to discharge offensive material. The nurses tried unsuccessfully to contact Mr D. Mr G reviewed Mrs T a few times and also checked Mr D’s surgical notes. The documentation was scarce and there was no mention of adhesions or any difficulty encountered during surgery. Mr G decided to adopt a conservative approach as Mrs T’s general condition remained stable, even though the wound continued to discharge. He mentioned to other colleagues that he felt it was difficult to interfere with the care of a senior colleague’s patient as he felt intimidated by Mr D. As a precaution, Mrs T was prescribed broad-spectrum antibiotics.

A week after the initial surgery, Mrs T’s condition deteriorated and she developed an acute abdomen. She had generalised abdominal pain and vomiting, along with a fever and a raised white cell count. Mr G took her to theatre for an emergency laparotomy to find faecal peritonitis and a loculated pelvic collection. There were several perforations of the sigmoid colon which necessitated partial bowel resection and a colostomy. Further surgery was required before Mrs T was finally discharged home two months later.

The case was settled for a moderate sum. Allegations of negligence were in relation to bowel perforation, delay in diagnosis and poor postoperative care.

GM

Your patient, your responsibility

LEARNING POINTS

- An operative note is for the benefit of all personnel looking after a patient. The record should not only give an account of the operation performed, but it should also accurately reflect any degree of difficulty of the procedure or deviation from the norm. Mr D failed to do this.
- Good surgical documentation can alert colleagues to an ensuing postoperative complication and may facilitate early intervention and treatment.
- It is important to ensure appropriate arrangements are in place when leaving patients in someone else’s care. Mr D did in fact do this by informing his colleague Mr G, but it seems he did not inform the ward nursing staff. It is good practice to advise the nursing staff which doctor will be responsible for your patients in your absence. Not only did Mr D fail to write comprehensive surgical notes, but also he should have conveyed the intraoperative difficulties he had to Mr G.
- If you are covering for a colleague, you must take full responsibility for those patients. A patient’s care should not be compromised for fear of offending a colleague. Mr G’s remark that he found it difficult to interfere with a colleague’s patient is difficult to accept, given that Mr D had asked Mr G to look after his patients. If there is uncertainty over how a patient should be managed, you should consider asking the opinion of a colleague.
- A wound that is discharging offensive material following intraperitoneal surgery should be investigated promptly. You need to consider the possibility of bowel injury. In this case, the use of radiological imaging may have helped confirm a significant complication and facilitated earlier intervention.
Right level, wrong site (1)
I read the September 2011 Casebook with interest, specifically the report on “Right level, wrong site” (p21). I know of more than one surgeon who believes that all lumbar disc lesions can be approached surgically from the midline. That is unequivocally untrue as your expert so rightly pointed out.

One of my points comes from your section on learning points in relation to the management of acute lumbar disc lesions. In the lumbar spine the spontaneous resolution rate for acute disc protrusions is closer to 100% than 80%, but specifically time-related. Sadly the world literature is badly biased by the fact that surgeons tend to advocate surgery and it is not in their interest to be promoting conservative management: a cynical but truthful observation. Patients should be advised that the outcome of conservative versus operative treatment is little if no different at 12 to 18 months. Surgery offers the advantage of a short cut but risks not insignificant complications; conservative management has minimal risk but often a drawn-out recovery. Extraordinarily I have read notes that record that patients with lumbar disc lesions will not get better without surgery!

In relation to the time allowed for spontaneous resolution of these lumbar disc lesions, four to six weeks is, I have to say, an exceptionally short period of time to suggest before considering surgery. Certainly there will be occasions, short of cauda equina compression, where in special circumstances early surgery may be considered – but the message that MPS supports such early surgery may not be a good one to be promulgating. I know that the difference between private and public treatment standards in respect of surgical advice exists and I am pleased that you raised that, to try to keep practitioners honest in that respect.

Another interesting point arises in relation to communication. Doctors (surgeons) can be quite foolish on occasions by telling patients that a particular treatment previously given to their patient was wrong simply because it was not their own practice. This is particularly important now that the ‘school of opinion’ defence has been challenged. Doctors should be taught and reminded that they must resist the temptation to portray themselves as the saviour of a situation by denigrating previous unsuccessful but perfectly proper treatment.

As an orthopaedic spinal who performed more than 7,000 open spinal operations, I do speak from a depth of experience. One final point in the form of a question. Are surgical trainees and newly-appointed consultant surgeons being formally and appropriately (not voluntarily) appraised of their responsibilities in relation to medical insurance? It would be difficult if not impossible to argue against mandatory malpractice education as a requirement for medical insurance!

Name and address supplied

Right level, wrong site (2)
Re: “Right level, wrong site” (Casebook 19(3), p21). An interesting case with possible implications wider than the ones you mentioned. Was there a governance structure in place in this doctor’s organisation that reviewed his previous operations to see if he had inappropriately operated on other patients? Do doctors in MPS have an obligation to inform the Medical Council about the possible concerns about this doctor?

Paul Scott, GP, UK

Response
I should reiterate the comment we make in “On the case”, that reports are based on issues arising in MPS cases from around the world, but facts are altered to preserve confidentiality. To that extent the reports are not factual iterations of individual cases. The issue you raise is one MPS takes very seriously and during the course of every case we seek to work with the member to identify any risk management issues that could bear on future practice.

Billy LK Wong, junior doctor, UK

Mother knows best (1)
I read with great interest the case “Mother knows best” in the last issue of Casebook, 19 (3). Whilst we continually strive for excellence and perfection, it is impossible for doctors to make accurate diagnoses on every occasion. The difficulty is highlighted in this case where the initial presentation of intermittent twitching without any other symptoms is rather atypical for bacterial meningitis. This can be easily missed. Therefore, the learning points in the article are absolutely valid and correctly emphasised. Parent concerns should always be considered and a high index of suspicion is required to avoid misdiagnosis.

More importantly, it is imperative that junior doctors on-call should always discuss the working diagnosis with a senior colleague in spite of how confident he/she feels or how cumbersome this may seem. Occasionally, patients may re-present 24-48 hours following the first presentation to hospital with worsening or persisting symptoms. It is vital that the patient is seen by a middle grade doctor or above at this stage. Had this been applied to the baby in the above-mentioned case, the outcome might have been very different.

I believe that the learning points from the article apply to all junior doctors regardless of their specialty rotations. Not least will this exercise be life saving, it could also potentially save a budding career.

Billy LK Wong, junior doctor, UK

Avoiding dosing disasters
David Mitchell’s Professor is correct (Over to You, Casebook 19(3)). Drug charts should be reviewed on all patients at every ward round, and ideally every day. This ensures that prescriptions have not been made overnight that clash with those drugs already prescribed, that initial prescriptions are reviewed regularly and that drugs no longer needed are stopped. I work in critical care and it is our practice to review the drug chart daily, looking for issues before it is reviewed again by the
Mother knows best (2)

I REMINisce to my Foundation Year 2 days in the emergency department. I found dealing with children and particularly neonates to be the most challenging part of my medical career so far. From this stems the utmost respect and admiration for all qualified and aspiring paediatricians.

To get back to the subject matter, I do remember taking two lessons away from my brief period spent in the department. The first one relates to history. We are indoctrinated from our earliest days in medical school that over three quarters of the information you need to make a diagnosis or at least decide on the next course of action is in the history. In the case of the young ones still lacking language skills, we can only rely on the mother’s history, even when this is sometimes limited to a story.

I always felt that a mother’s concern was enough to take things forward, especially if a little reassurance was not adequate. There is no substitute for a mother’s sixth sense of something being amiss. None other than she would be able to discern the smallest changes and nuances in the behaviour and hence the overall condition of her baby, and this is proof enough of her worry. There is no way that you could confidently fully discern normality in the short period of contact you have with the child in the department.

The second lesson is if there is a reattendance within the last 24 hours; an expert consult needs to be sought, even if it is to reassure all parties concerned of the benign nature of the presentation. The worst thing that could happen with getting a second opinion is another medical professional doing what he was trained and is paid to do: his job!

With these two skills in hand, it should not be too difficult to navigate the delicate waters of the paediatric department in accident and emergency.

Ali Abdoel, registrar in cardiology, UK

critical care consultant on the ward round.

Drugs are stopped, doses altered in light of altered renal function and other drugs started if they have been omitted or forgotten. Every day we check if thromboprophylaxis has been prescribed or considered contraindicated, if gastroprophylaxis has been instituted and that appropriate nutrition and anti-pneumonia measures are in place. Analgesics, sedatives, inotropes and vasopressors are reviewed, and antibiotics and steroids stopped if they have run their course.

I strongly agree that focusing solely on the initial prescriber is wrong. The inpatient care of a patient is the responsibility of all of us involved in their care. We should all be reviewing drug charts regularly to minimise prescription errors.

Chris Smith, specialty registrar, Anaesthesia, UK

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Great Discoveries in Medicine
Edited by William and Helen Bynum (Thames & Hudson, 2011)
Reviewed by Wendy Moore, author and journalist, UK. She can be contacted through her website: www.wendymoore.org.

Both marvellously illuminating and beautifully illuminated, Great Discoveries in Medicine is a perfect marriage of simple, clear text and spellbinding pictures. Editors Helen and William Bynum have amassed a team of experts in their fields to provide a breathtaking journey through the story of human efforts to fight illness and disease from ancient Egypt to the modern day. The book is logically organised into seven sections exploring themes; within each section, academic experts offer snapshots on topics as diverse as bubonic plague and beta-blockers.

Inevitably, given the title, this compendium is chiefly – and unusually for some contemporary medical historians – a celebration of medical achievement, just as it should be. Here are all the familiar heroes and triumphs, like Harvey, Pasteur, Snow and Lister, and their extraordinary stories of dogged determination and maverick insights. Yet there are some extraordinary new stories too, along with welcome spotlights on insufficiently hymned figures.

Among the most fascinating of the less well-known innovations is the story of the incubator. Darwinist ideas discouraged doctors in Britain and the US from attempting to save premature babies, but the real stars in the sparkling firmament of this scintillating book are without doubt the illustrations. Ranging from exquisite anatomical drawings to public health posters, from Islamic tapestries to CT images, these expertly chosen and beautifully reproduced images offer us the best understanding of changing attitudes towards health and disease. Together these wise words and stunning pictures offer a humbling story and a visual feast.

Zero Degrees of Empathy: A New Theory of Human Cruelty
By Simon Baron-Cohen
(Allen Lane, 2011) Reviewed by Philippa Pigache, honorary secretary of the Medical Journalists Association in the UK.

Simon Baron-Cohen is Jewish and grew up hearing stories of the unbelievable cruelty shown to the Jewish population by the Nazis in World War 2. It was this that prompted him to use his book to ask the question: what is the cause of human cruelty? He considers that to attribute it to “evil”, as some do, is a cop-out. It explains nothing. Why should some people, in otherwise just and caring societies, carry out aberrantly vicious acts? His hypothesis is that underlying such acts is a total inability to put yourself in another person’s shoes, to feel what they feel and act accordingly; a lack of what is called empathy – this he calls “zero degrees of empathy”.

Baron Cohen is a professor of developmental psychopathology at the University of Cambridge, and one of the foremost names in the study of autism and Asperger’s syndrome. He has blurred the boundaries between such extreme mental health conditions and the normal human brain, developing the concept of the autism spectrum and the “extreme male brain”.

He finds support for his hypothesis in neurology and psychology, and demonstrates, with studies using questionnaires, twins and functional magnetic resonance (fMR) images, that human beings fall along a spectrum in their capacity for empathy. This empathy spectrum forms a normal distribution curve, where most people cluster in the middle and a few at the extreme ends. At one extreme are those who commit, or perhaps have the capacity to commit, extreme acts of thoughtlessness or cruelty (not necessarily physical), and at the other, those exceptional individuals who devote their lives to caring for others. In the middle are you, me and Joe Public; some are more empathic than others. Interestingly, more than women fall into the low-average level and more women than men into the high-average group. Baron Cohen goes on to look at possible explanations for the empathy spectrum and he finds them in childhood experiences, eg, low levels of empathy are associated with childhood abuse, neglect or disturbance, characteristic electrical patterns in the brain and their effect on key neurotransmitters, like serotonin, and in distinct genetic variations, though not upon a single gene. The evidence he cites is inevitably drawn from studies of either mental health patients, or those in conflict with the law in either Europe or the United States.

Does he satisfactorily explain Nazi cruelty? I am not sure he does. I think he explains the behaviour of misfits – mental or penal – in essentially just, caring 21st century societies, but he ignores societal norms. What is regarded as cruel depends on social context. Stoning was not considered cruel 2,000 years ago – such barbaric cruelty was the norm a mere 100 years ago, callous, insensitive treatment of children was routine and it took exceptional free-thinkers to challenge it. But we still await an explanation for how, in the first half of the 20th century, Nazi doctors treated Jewish people no better than laboratory mice.
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