Anatomy of a claim

Step-by-step through a recent case

HOW RELIABLE IS HEALTHCARE?
Tackling the biggest challenge to patient safety: complacency

THE PERILS OF PRESCRIBING
Including a classic case of a drug name mix-up

OVER TO YOU
Follow the discussion as readers debate recent cases

BOOK REVIEWS
What pages are being turned this month?
Dr Bown focuses on the role of the expert – and describes how they can be key in successfully defending a case.

I write this having just heard that a claim against a member has today been discontinued by a high profile claimant, two days into trial, after the expert evidence had been heard. Fantastic news for the doctor, and vindication for the defence team of the judgments they have made in steering a long and complex journey to success.

There are many elements involved in building a robust and successful defence but, as any seasoned litigator will tell you, the strength of your expert is pivotal in determining the prospects of success or defeat. This is further illustrated in the case reports on pages 16 and 22.

Selecting the right expert is very important; it’s not about being a friend or advocate for the defendant, nor about being a fierce advocatus espousing heavy weight opinion intended to demolish the opposition. The expert’s role is to provide independent assistance to the court through unbiased and evidence-based opinion in relation to matters within his expertise. And before that, the expert plays a critical role in assisting the lawyers to understand the clinical issues and judgments to inform the advice to the member.

This is not just in relation to clinical negligence claims; we are seeing increasing reliance on experts at inquests and medical council hearings in many countries. MPS regularly runs expert training days around the world, to ensure that doctors understand the clinical issues and judgments to inform the advice to the member.

Dr Bown

This can be difficult to defend the case, because the expert will have been provided with all of the relevant information beforehand, and also in consultation with the barrister, they will be able to emphasise or de-emphasise certain features or statements, including the diagnosis and the opinion. There is a fine line and even if the expert is neutral, it is the bias against them. The role of the expert is to provide an opinion, usually independent, and in the opinion of the court, unbiased. As such, the expert should be aware of the potential problems of the expert, whatever their approach, to ensure that they do not lose objectivity.

The role of the expert is not just as an advocate for the defence, but to provide independent evidence to support the opinion and provide the strength of opinion that underpins the advice to the member.

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John Bradley, Chairman of Council 1988 to 1996
Roy Palmer, Medical Director 1989 to 1998

**OBITUARY**

**Sir John Batten, MD FRCP KCVO**

1924-2013

S

ir John Batten was invited to become the President of the Medical Protection Society in 1988 and remained in that post until 1997.

After a distinguished career as a physician at St George’s and Brompton Hospitals, and pioneering the treatment of patients with cystic fibrosis, he gave generously of his time to MPS. In addition to his medical wisdom acquired over the years, he was a man of wide interests in the arts, sailing and gardening, no doubt inspired by living in close proximity to Kew Gardens.

He was appointed as physician to the Queen in 1974 until 1980. He was physician to HM Royal Household 1970 to 1974 and Head of HM Medical Household 1982 to 1989.

Sir John played a key role in the Society’s international expansion and won otage to its international commitments.

Sir John officially opens the MPS Leeds office in 1994

**MPS**

Doctors face a number of challenges when prescribing: Sara Dawson explores some risk strategies and looks at a classic case of a drug name mix-up.

**FEATURE**

Prescribing for patients is fraught with risk: doctors in both primary and secondary care can face major challenges in prescribing safely. The ageing population and the increasing complexity of high-risk medications, coupled with an already highly-prescribed mix of patient taking and time pressures, are increasing these challenges.

In 2012, Professor Tony Avery led a major GMP-funded study, The PRACtICe Study: Prevalence and Causes of
Keeping up-to-date

According to Professor Avery, it is absolutely essential to have all the information you need on the patient you are prescribing for; this will avoid contradictions and hazardous drug-to-drug combinations, and alert you to a history of allergy. He adds: “Access to up-to-date medical records is critical here, as well as having readily available sources of drug information (such as the BNF). Keeping your knowledge of therapeutics up-to-date can also help.”

Analytical thinking

Recognising yourself as doctors and “to error is human” will make us more vigilant in checking that we have not made slip-ups or mistakes, says Professor Avery. This requires using a type of thinking that is purposeful, conscious and analytical. For example, always double-check a prescription before signing it off; don’t let it become an automatic process.

High-risk patients on high-risk drugs

High-risk patients are not only those with very serious illnesses, says Professor Avery, but also patients with multiple long-term conditions. These patients are at risk from the range of different medicines they take and have an increased likelihood of suffering drug-related harm, due to their comorbidities and frailty.

High-risk patients present us with particular challenges because considerable time is needed to manage all of their conditions, and prescribing safety can be overlooked. Professor Avery adds: “High-risk drugs include those prescribed in share care arrangements between primary and secondary care, along with commonly used drugs such as warfarin, antiplatelet drugs, cardiovascular drugs, antiepileptics, psychotropics, opioid analgesics, diabetics drugs, systemic corticosteroids and NSAIDs. “In high-risk patients it is essential to recognise that risks of serious medication-related harm may be considerably higher (possibly 100-fold higher) than in otherwise fit, healthy adults taking relatively safe medicines. We cannot afford to cut corners for our most vulnerable patients.”

Communication with patients

Communication problems often contribute to adverse events associated with medication errors, and are sometimes the main cause. The most common problems with communication occur between the doctor and patient, but there are also major issues at the interface between primary and secondary care.

Patients can and do suffer from medication-related adverse events because either they do not have sufficient knowledge of their medical conditions and the medicines they are taking, says Professor Avery, or they have not been given an adequate explanation of how to take the medicines, the side-effects to look out for and what monitoring is needed.

Communication problems resulting in undertreatment, overtreatment or incorrect use of medication in general practice are particularly important in the following conditions where preventable drug-related hospital admissions may result: • asthma • coronary heart disease with angina • diabetes mellitus (especially in patients taking insulin) • epilepsy • heart failure. For these conditions it is particularly important to try to make sure that patients have a good level of understanding of their medicines. The use of patient information leaflets and websites may also be helpful.

Interface between primary and secondary care

It is not uncommon for patients to suffer medication-related harm as a result of inaccurate or incomplete information at the interface between primary and secondary care, and of acting on medication changes suggested/initiated by primary/secondary care clinicians.

Tips for safe prescribing

1. Keep yourself up-to-date in your knowledge of therapeutics, especially for the conditions you see commonly.
2. Before prescribing, make sure you have all the information you need about the patient, including co-morbidities and allergies.
3. Before prescribing, make sure you have all the information you need about the drug(s) you are considering prescribing, including side-effects and interactions.
4. Sometimes the risks of prescribing outweigh the benefits and so before prescribing think: “Do I need to prescribe this drug at all?”
5. Check computerised alerts in case you have missed an important interaction or drug allergy.
6. Always actively check prescriptions for errors before signing them.
7. Involve patients in prescribing decisions and give them the information they need in order to take the medicine as prescribed, to recognise important side-effects and to know when to return for monitoring and/or review.
8. Have systems in place for ensuring that patients receive essential laboratory test monitoring for the drugs they are taking, and that they are reviewed at appropriate intervals.
9. Make sure you have safe and effective ways of communicating medicines information between primary and secondary care, and of acting on medication changes suggested/initiated by primary/secondary care clinicians.

The BNF view

Good Practice in Prescribing and Managing Medicines and Devices (2013)

“[12] You should make sure that anyone to whom you delegate responsibility for dispensing medicines in your own practice is competent to do what you ask of them. Advice on dispensing support staff can be obtained from the General Pharmaceutical Council.

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Prescribing Errors in General Practice, from England. His team analysed a 2% random sample of patients’ records from 15 general practices across England. Prescribing or monitoring errors were detected for one in eight patients, involving around one in 20 of all prescription items. The majority were of mild to moderate severity, with one in 550 items being associated with a severe event. He says: “It is essential for doctors to do everything they can to mitigate risk.”

The GMC view

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Medication review

It is important for patients’ medications to be reviewed periodically to ensure that essential laboratory tests are undertaken; side-effects are detected; patients are involved in decisions about how their medicines; and therapy is optimised, says Professor Avery, although he notes that this can be challenging.

Controlled drugs

In August 2013, the Care Quality Commission (CQC) released its report, The safer management of controlled drugs: Annual Report 2012, which revealed a 1% rise in 2012 – compared to 2011 – in the number of prescriptions issued in primary care for controlled drugs. Except for a steady fall in prescriptions of temazepam since 2007, the use of benzodiazepine, morphine, salbutamol, codeine, fentanyl, midazolam and diamorphine is on the rise. As a result, CQC chief executive David Behan called for “vigilance” around the prescription of controlled drugs – adding that the CQC would be including indicators and measurements around controlled drugs as part of their inspections.

The recommendations of the report include:

• Health and social care professionals must ensure they have all the information they need to contact their local controlled drugs accountable officer (CDAO) and know the mechanism for reporting controlled drug concerns.

• CDAOs need to ensure they are following the guidance on the CQC’s website to update contact details promptly to ensure the CDAO register is accurate.

• Effective systems developed at the local level for secure gathering, sharing and recording of intelligence relating to concerns about safe
How reliable is healthcare?

Dr Dan Cohen, an international medical director based in the US, looks at the biggest challenge to healthcare safety: complacency

Managing danger

High-reliability organizations (HROs) are those that function safely and efficiently in industries that are very dangerous. HROs have established cultures and supporting processes designed to dramatically reduce the likelihood of human error and harm. They recognise that the interactions between humans and technologies, it is the humans that represent the most substantial sources of risk. Industries commonly considered to portray the attributes of high-reliability include the nuclear power industry, the automotive industry and the aviation industry. In the aviation industry, for example, the airplanes are so well-designed, with redundantly engineered systems, that the risks arise primarily from human factors. Human factors are the source of most substantial risks and errors. It has been argued that if the healthcare industry was to adopt the characteristics and methodologies of HROs, we would move the bars for quality and safety higher. If this is true, then why is there so much inertia in our systems of care? Inertia that plagues our improvement strategies? Why have we not solved this problem, when so many solutions abound? Compliance is the pernicious confounder. We do not see the sources of harm, the near misses, and especially do not see ourselves as sources of harm. The defining characteristics of HROs have been summarised by Weick and Sutcliffe and, in abbreviated form, are portrayed below:

1. Sensitivity to operations – a constant awareness by leaders and staff to risks and prevention, a mindfulness of the complexities of systems in which they work and on which they rely.

2. Reluctance to simplify – avoidance of overly simplistic explanations for risks or failures and a commitment to delve deeply to understand sources of risk and vulnerabilities within systems.

3. Preoccupation with failure – a focus on predicting and eliminating catastrophes rather than reacting to them; a ‘collective mindfulness’ that things will go wrong and that ‘near misses’ are opportunities to learn.

4. Defence to expertise – leaders and supervisors listening to and seeking advice from frontline staff that know how processes really work and where risks arise.

5. Resilience – leaders and staff trained and prepared to respond when systems fail and that work effectively as teams to overcome urgent challenges.

A natural fit

Healthcare systems entail many unique factors that are at variance with HRO industries. Even though some HRO-
THE CASE
Mr P, a high-earning, self-employed management consultant, attended his GP surgery on 10 July 2010 with flu-like symptoms and saw Dr A. He diagnosed a chest infection and prescribed antibiotics; on 15 July Mr P returned with similar symptoms – Dr A referred Mr P for a chest x-ray and prescribed further antibiotics. The x-ray was clear and that he could continue to take his medication.

Mr P was reassessed by Dr C, a high-earning, self-employed management consultant microbiologist, on 21 July 2010 with flu-like symptoms; MPS claims manager and solicitor Antoinette Coltsmann takes an in-depth look at a recent MPS case.

THE LIABILITY
On Mr P’s assessment, Drs B and C had no culpability. Mr P simply reported the chest x-ray was clear. Dr C undertook a very detailed and thorough assessment and this was recorded in Mr P’s contemporaneous GP notes. Indeed Dr C was heavily reliant on Dr C’s very detailed consultation notes to assist him in defending his assessment of Mr P on 4 August.

Mr P was reassessed by Dr C, a locum consultant in infectious diseases.

He made a note of a detailed examination in Mr P’s records. He concluded Mr P was suffering from muscular back pain, and recommended pain relief and a return visit to Dr A in two weeks’ time.

Two weeks later, on 4 August, Mr P reattended the surgery. Dr A noted some chest discomfort and made a referral to physiotherapy for the back pain, which took place five days later. The day after that, Mr P fell unwell and collapsed due to a loss of sensation in his legs. He was admitted to hospital.

At the recommendation of the hospital consultant microbiologist, Mr P’s antibiotics were withheld and the following day he was transferred to another hospital, where an MRI scan was performed. This revealed infective discitis at T5/T6. Mr P underwent an emergency laminectomy with open biopsy, where a soft tissue mass was submitted for histology investigations; once the biopsy samples were obtained antibiotics were recommended. Further surgery was carried out the same day and antibiotics (a combination of ceftriaxone and vancomycin) were administered.

Following the surgery, Mr P was left with T4 ASIA A paraplegia. He underwent rehabilitation at a spinal injury centre.

THE CLAIM
Mr P made a clinical negligence claim against Drs A, B and C. He alleged that all three doctors failed to suspect a spinal infection and refer Mr P to an orthopaedic surgeon, who would have referred him for an MRI scan. It was alleged that the MRI scan would have identified infective discitis, which would have led to hospital admission and antibiotic therapy, avoiding Mr P’s paraplegia.

Having obtained supportive expert evidence, MPS decided to defend the claim and the case went to trial.

THE EVIDENCE
For any claim for clinical negligence to be successful, a claimant needs to prove that, firstly, there has been a breach of the duty of care owed by the doctor to the patient; secondly, a claimant must succeed on causation, ie, that this breach of duty caused or contributed to the injury, loss or damage suffered, and that but for the negligence the claimant’s loss would not have occurred.

Before trial, both parties served evidence of breach and causation, in the form of reports from expert witnesses. For Drs A, B and C, a GP (Dr D) reported on breach and a consultant microbiologist (Dr E), consultant neurologist (Mr F) and consultant neuroradiologist (Dr G) reported on causation.

Mr P served evidence on breach of duty from a GP (Dr I) and causation evidence from a consultant neurological and spinal surgeon (Mr J), and a consultant microbiologist (Dr K). Mr P was not relying on neuroradiology evidence.

THE CLAIM: Consultation: 15 July
Dr A vigorously denied he was informed by Mr P that his back pain was worse, preventing him from lying flat on his back and disturbing his sleep. Dr I considered Dr A in breach of duty for failing to arrange blood tests in conjunction with a chest x-ray. He considered “blood tests were mandatory”. If the court accepted Dr A’s factual evidence, Dr D agreed Dr A’s management was “entirely appropriate”. If, however, the court accepted Mr P’s factual evidence, Dr D agreed this should have “triggered” a neurological examination and, if Mr P had no neurological symptoms, this should have prompted referral within one to two weeks – either for an MRI scan or “more likely to an orthopaedic or neurosurgical specialist who may have requested an MRI scan”.

THE LIABILITY: Consultation: 4 August
Mr P’s GP expert noted that this was the fifth consultation regarding the same illness without a diagnosis. Referral to a physiotherapist without a further clinical examination was “unacceptable care”. He considered the appropriate response was to arrange a series of urgent blood tests and once the results were available (which he surmised would have been abnormal), Dr A should have arranged an urgent referral to an orthopaedic specialist/ASIA or MRI scan within 24 hours.

Dr A’s GP expert considered that on 4 August, Mr P was not displaying any symptoms or signs that would have alerted a GP to possible infective discitis developing. He considered referral within one to two weeks, based on Mr P’s factual evidence, either for an MRI scan or orthopaedic or neurosurgical specialist – who may have requested an MPS scan – appropriate management. He did not consider Dr A in breach of duty based on his factual evidence.

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THE TRIAL

Dr M's cross-examination at trial it was clear he had no real recollection of the different consultations and could not, with any real accuracy, confirm what he told the GPs regarding his symptoms and, in particular, his back pain. He was, therefore, an unreliable witness. Dr I was discredited as not having been in practice for more than ten years. Dr I also accepted, during his cross-examination, that if all the doctors' factual evidence was accepted for each consultation he would not criticise their practice.

Dr A, B and C consulted across as honest, reliable and caring witnesses (Drs B and C now appearing as witnesses rather than defendants).

All confirmed that at no stage were they alerted to Mr P's alleged back pain. They were treating flu-like symptoms affecting the chest, and back pain was secondary and caused by the chest infection and coughing. It was not until 4 August that Mr P complained of back pain, which was now the primary need for the consultation as his chest infection symptoms had resolved. Dr A examined Mr P, concluded it was muscular and referred Mr P to a physiotherapist.

CAUSATION

Mr P alleged if he had undergone blood tests following all consultations, the results would have been consistent with bacterial infection. This would have led to further investigations, prompt referral for orthopaedic investigation suspecting infected spinal pathology, including an MRI scan. A diagnosis would have been made, Dr P would have been admitted to hospital and treated with intravenous antibiotics, making a complete recovery.

Dr E maintained Mr P would have had to receive antibiotics for a period of 48 hours to have avoided all neurological sequelae, without surgery.

Dr K considered antibiotics 24 hours earlier would have avoided onset of neurological deficit.

Dr K, crucially, accepted at the experts' meeting that Mr P's white cell count and temperature would have been within normal range for each consultation. The neurosurgeons agreed Mr P would have displayed no neurological sequelae at any consultation.

It was accepted Mr P would have had investigations been undertaken after all consultations - save 4 August - Mr P would succeed by one way or another. It was vigorously denied that even if blood tests had been undertaken on 4 August they would have altered the outcome.

For Dr A to succeed at trial on causation in relation to the 4 August consultation, the court had to accept:

- Referral to physiotherapist was reasonable based on his factual evidence.
- Referral to orthopaedic surgeon on a 'non-urgent' basis was reasonable, based on Mr P's factual evidence.

Even if the court did not accept referral on a 'non-urgent' basis to an orthopaedic surgeon this reasonable, Mr P needed to establish that referral and appropriate treatment within a five-day window of opportunity (4–9 August) should include referral to an orthopaedic surgeon, MRI scan and antibiotic treatment.

Dr A did not assess Mr P until 5.30pm on 4 August. Accordingly, the earliest that blood tests could have been undertaken, based on a fasting sample, was 5 August, with the results available that afternoon. The earliest Dr A could have seen Mr P is 6 August, and an appointment arranged with an orthopaedic surgeon that afternoon. The earliest an MRI scan could have been arranged is 7 August. The earliest the results could have been available is that same day, with admission to hospital that evening. Mr P was asymptomatic and the appropriate action would have been to undertake a biopsy to identify the pathogen so the appropriate antibiotic was administered.

A biopsy may not have been possible the following day as it was a Sunday, and, as Mr P would not have been displaying any symptoms, the need would not have been "urgent" and would have waited until Monday, 9 August. By that stage, even on Mr P's evidence, administering antibiotics would have been too late.

At trial, Dr A's expert neurorologist was an excellent witness who spoke authoritatively and gave his opinion in a non-partisan way.

THE OUTCOME

Mr P abandoned his claim and discontinued the proceedings after the conclusion of day 3 of the trial. By that stage all witnesses and experts, save the microbiologist, had given evidence. Mr P had funded his claim by way of a Conditional Fee Arrangement backed by insurance. MPS therefore sought and recovered their costs incurred in defending this claim to trial. This was a significant and by no means straightforward claim to defend. The value of the claim was in excess of £5 million, with Mr P's legal costs alone estimated to be an additional £1.5m.

This article is a real MPS case and is published with our member's consent

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Dr Rob Hendry, MPS Medical Director, introduces this issue’s round-up of case reports

MPS works hard to defend claims wherever possible. Part of a strong defence is having knowledgeable and skilled expert witnesses to demonstrate that the doctor in question has acted in the patient’s best interests and in line with good medical practice.

Perhaps the best defence of all is making sure your diagnosis and treatment plans are of the requisite standard; examinations (where necessary) are thorough and well-documented; valid consent is both taken and recorded; and note-keeping is accurate and contemporaneous.

In “The twisted knee” on page 16, Ms C brought a claim against Mr A, alleging, amongst other things, that he had negligently performed an arthroscopy in the absence of an MRI scan and unreasonably diagnosed a meniscal tear. Expert opinion found no liability on the part of Mr A, concluding that his preoperative working diagnosis was eminently reasonable in light of Ms C’s symptoms and signs. As a result, the claim was subsequently discontinued and no payment was made.

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Mrs J made a claim against Dr A in “A tear during delivery” (page 18) as she was advised that if Dr A had carried out an episiotomy and avoided the use of ‘double instruments,’ her symptoms would have been avoided.

She felt that a diagnosis of a third degree tear had been missed, and had subsequently had a major impact on her life. Expert opinion found that the episiotomy was not essential in this case, and, detailed contemporaneous notes confirmed that the anal sphincter was intact, despite the second degree tear that was observed.

Sometimes, when a case cannot be defended, MPS works on a member’s behalf to ensure favourable settlement terms.

For example, in “Common can be complicated” on page 14, Miss G’s family alleged she received negligent care when she went into labour following an expected date of confinement. Her baby was delivered by Caesarean section due to the increased risk of maternal injury due to her persistent symptoms, which they argued would hinder future employment prospects. Investigations by the MPS legal team revealed that Miss G could use public transport independently therefore reducing the final settlement offer significantly.

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Since precise settlement figures can be affected by issues that are not directly relevant to the learning and teaching events (such as the GP’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
Common can be complicated

M iss G, 11 years old, was taken by her mother to see GP Dr A with a viral illness, glandular fever, and to come for a review consultation, so Dr A noted these symptoms and a discharging right ear. He prescribed antibiotics and reassured her that she should recover soon – but that she should return again if she became any worse. Miss G continued to deteriorate over the next few days, prompting her mother to call the clinic. She spoke with the nurse adviser, explaining that her daughter had no energy and had developed problems with her vision. The nurse told her not to worry and reassured her that these symptoms were consistent with glandular fever, and to come for a review if symptoms were persisting after a week. Four days later, the patient’s mother called the surgery to request an emergency appointment and again spoke to the nurse adviser. She was informed that there were no appointments available the following afternoon. Neither of these telephone consultations were documented in the case notes.

The following day, Miss G attended her emergency appointment with Dr A. Her mother explained that she had been getting worse all week and at one point experienced temporary loss of vision. Dr A noted she had an unsteady gait when she entered the clinic, and on examination had fixed pupils with marked papilloedema. He arranged immediate admission to hospital. The paediatric team documented palsy of cranial nerves III, IV, and VI, due to gross papilloedema, and arranged urgent imaging. This confirmed a central nervous venous thrombosis and a middle ear infection with a right mastoiditis. She was transferred to the neurological unit for thrombolytics, antibiotics, and acetylsalicylic acid, and discharged a month later.

The family lodged a negligence claim against Dr A, stating that he had failed to refer for urgent investigation following their second consultation. They asserted that had Mr F seen her this week, she would not have suffered from reduced visual acuity or frequent headaches.

Bluestone CD, Clinical course, complications and sequelae of acute otitis media, Pediatric Infectious Disease Journal; 19(5 Suppl):S37-46

This was communicated to Mrs S who felt that she had been misinformed as to the purpose of the surgery (as she had never had cancer). Mrs S developed an incisional hernia, which was repaired along with a reversal of the Hartmann’s one year later.

Mrs S indicated an intention to bring a claim stating that she had undergone surgery based on a false premise. She alleged that she would have requested repeat biopsy (as recommended on the biopsy findings within the records), which would have come back negative for malignancy and thus she would never have agreed to surgery.

The expert opinion on the case indicated that it was reasonable for Mr F to perform an initial ureteric biopsy, but that it must be recognised that often such biopsies are not diagnostic; hence, repeating the biopsy may not have been justified, even if the true diagnosis of malignancy was made clear to the patient.

Miss G’s family alleged she was unable to use public transport unaccompanied due to her persistent symptoms, which would hinder future employment prospects. MPS’s legal team made use of video surveillance in this case, which provided evidence that Miss G appeared very comfortable using public transport independently. This reduced the final settlement offer significantly, although the case was still settled for a substantial amount.

Learning points

■ The importance of documenting every consultation, including telephone consultations, is highlighted once again with this case. Disciplined documentation of every clinical encounter means that when a claim or complaint arises, you can feel more confident defending your position.

■ A reminder regarding telephone consultations is that arrangements should be made for face to face review if any concerns are raised regarding a patient’s clinical condition.

■ A patient who develops new symptoms should be reassessed and the diagnosis reviewed. In this case the nurse should not have made a new diagnosis of glandular fever over the telephone without arranging for the patient to be seen.

■ This case is a reminder that common ailments can develop rare complications. The majority of cases of otitis media seen in general practice will resolve without complications; however, health professionals should remain vigilant to the possibility of disease progression. Safety netting measures protect you and your patient.

■ Asking the patient to attend for a review is an important safety net to put in place, but it is important to be able to follow this up. Lack of available GP appointments means that clinical staff are often in the position of triaging patients without seeing them in person, which can lead to a deteriorating patient being overlooked.

■ Clinical staff should be trained to spot red flags and be aware of developing symptoms that require immediate review.

■ Mastoiditis is now relatively rare. The incidence of the condition following acute otitis media reduced from 50% to 0.4% following the introduction of antibiotics. Prior to this, mortality rates were 2 per 100,000 compared to <0.01 per 100,000 now.²

Patient confusion: patient claim

M rs S, a 77-year-old woman whose past medical history consisted of a previous hysterectomy for benign fibroid disease, presented to her GP with a history of intermittent haematuria. Her GP recognised the potential seriousness of this symptom and made an urgent referral to a consultant urologist, Mr F.

Mr F arranged an IVU followed by a CT scan, which suggested a tumour in the left distal ureter. Mrs S was advised this was highly suggestive of carcinoma and required surgical removal. However, Mr F arranged a biopsy of this mass via a ureteroscopy which was reported as inconclusive, containing insufficient material to make a definitive diagnosis; repeat biopsy was recommended by histology. There was nothing documented within the records to show that the implications of the same were discussed with Mrs S.

Mr F proceeded with left radical nephro-ureterectomy; a decision supported by the local multidisciplinary meeting. During surgery, Mrs S was found to have a 5cm tumour and a sigmoid colon adherent to the pelvic side wall due to multiple adhesions from her prior surgery. The histology of the nephro-ureterectomy specimen showed no evidence of malignancy with endometriosis in the ureteral wall and lumen. This was contrary to the findings at initial consultation, that Mrs S would have come back negative for malignancy and thus she would never have agreed to surgery.

The expert opinion on the case indicated that it was reasonable for Mr F to perform an initial ureteric biopsy, but that it must be recognised that often such biopsies are not diagnostic; hence, repeating the biopsy may not have been justified, even if the true diagnosis of malignancy was made clear to the patient.

Communication and documentation is vital. Had the specific purpose and limitations of the biopsy been explained clearly to Mrs S at the outset, and the options for further management discussed thoroughly, she might not have brought the claim. As with many claims, the lament did not sue based on the outcome of the surgery but rather because of lack of communication and correct information. All medical practitioners must make time to ensure their patients fully understand all aspects of their management.

Learning points

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REFERENCES

The twisted knee

Ms C, a 42-year-old risk manager, fell from her horse whilst out riding. At the time of the fall she felt her left knee twist, as her left foot had been caught in the stirrup.

Two days later she presented to her GP, who noted that she had not lost consciousness at any stage, had landed on her outstretched hands and knees and that she had sustained some bruising on her neck. He documented that the medial aspect of the left knee had sustained a brace, that the cruciate and collateral ligaments were fine and that McMurray’s test was negative. Analgesia, gradual mobilisation and exercise were advised.

Ten days later Ms C reattended her local clinic. It was noted that an effusion had developed in the left knee and an angle of flexion had decreased. Physiotherapy was advised. A week later, Ms C presented to the local Emergency Department with the same 92% with persistent pain, at which point an X-ray excluded any gross bony injury, a splint was provided and she was re-referred to her GP. Her GP duly sought advice from the local orthopaedic team.

A month after the fall, consultant orthopaedic surgeon Mr A reviewed Ms C in his orthopaedic clinic. He noted the above history and observed that the left knee had in approximately 10° of flexion. Attempts to flex or extend the knee were limited by pain, rather than pain. A significant effusion was also observed. Exquisite tenderness was elicited on palpation over the medial joint line but upon testing the medial collateral ligament, no abnormality was evident. On balance Mr T felt that Ms C “may simply have sustained bruising along the medial joint line, but any chance of a fibial plateau fracture or a meniscal injury should be excluded”. An MRI scan was requested and Ms C was encouraged to mobilise as and whenever possible, whilst wearing a brace.

A fortnight later, Ms C attended a follow-up consultation with Mr A, a consultant orthopaedic surgeon. The MRI had yet to be performed. Mr A noted that Ms C had sustained a significant injury to the left knee and that she was limping heavily. Moreover, she was unable to fully extend the knee and could not flex beyond 90° without severe medial joint line pain.

Concerned about a significant disruption of the medial meniscus with or without an associated injury to the anterior cruciate, Mr A advised Ms C that MRI imaging was likely to be academic and that urgent MRI imaging would be more appropriate.

Admission was arranged a week later and the patient consented for an arthroscopic exploration of any injury. The arthroscopy was performed by Mr A who noted a large injury to the medial meniscal body which was observed but the meniscus was not torn – Ms C was advised that healing would occur with time. After a brief overnight admission due to pain, Ms C was discharged.

However, 48 hours post-arthroscopy, Ms C developed erythema, pain and swelling of her left calf. On the same day she also developed chest pain, following which she attended the ED. Subsequent venography of the left leg did not demonstrate a DVT but a CT pulmonary angiogram demonstrated a number of sub-segmental pulmonary emboli. She was duly anti-coagulated and discharged.

A year after the accident Ms C was subsequently discontinued; no damages or costs were claimed. However, 48 hours post-arthroscopy, Ms C developed erythema, pain and swelling of her left calf. On the same day she also developed chest pain, following which she attended the ED. Subsequent venography of the left leg did not demonstrate a DVT but a CT pulmonary angiogram demonstrated a number of sub-segmental pulmonary emboli. She was duly anti-coagulated and discharged.

A year after the accident Ms C was subsequently discontinued; no damages or costs were claimed.

Learning points

- This case underlines the importance of instructing robust experts – highlighted by Professor D’s key role in securing the discontinuance of the claim.
- A swift conclusion to this case ensured that any anxiety suffered by Mr A was limited and MPS did not pay any claimant costs.
- It is also important to recognise that a complication does not necessarily amount to negligence. Therefore, it is important to cover complications in the consent process and document such conversations diligently.

An unexpected pregnancy

In January 2007, Mrs B, a 33-year-old woman, was seen three weeks after the birth of her second child and was prescribed six months of the progesterone only pill (POP). She was breastfeeding at this stage. She had attended the surgery earlier that month with phlebitis but it was noted that the varicose veins were “clear” at the time of prescribing.

In July 2007 the practice nurse prescribed a further six months of the POP without face-to-face consultation, and a further one month’s supply was issued in December 2007. In January 2008 Mrs B presented with stress incontinence, for which a referral to urology was made. At this consultation it was noted that there were “no problems with the POP and the BP was normal”. Six months of the POP was issued.

In May 2008 Mrs B consulted about mild acne and asked if co-cyprindiol could be prescribed. The GP noted that Mrs B’s father had previously suffered a DVT and advised against it. In July 2008 the practice nurse supplied a further six months of the POP.

In October 2008 Mrs B presented to the practice with an unplanned pregnancy and she was referred to the antenatal clinic. A review of the records revealed that Mrs B had been registered with the practice since 1999. She had been on the combined oral contraceptive (COCP) since 1992, which she had stopped in 2000 when she began trying for a family. At her new patient medical in 1999 it was noted that she was a non-smoker, and there was no family history of diabetes or heart disease.

The original consultation, when she was prescribed the POP, was in October 2003 after the birth of her first child. The notes read: “16 days post-natal. Wants contraception. Discussed and started N.”

Over the next four years there were a dozen clinical encounters. Three of these were pill checks with the practice nurse. A typical entry read: “On Monday. Happy with 8. No missed pills, occasional headaches [BP normal].” Mrs B was prescribed the POP and the GP noted that the POP was issued without face-to-face consultations and four encounters for unrelated issues.

Mrs B’s legal team alleged that she should have been advised to change from a POP to a COCP when she finished breastfeeding her second child in 2007 and that the GP would have helped to prevent her unwanted pregnancy in 2008. The expert opinion was that when prescribing contraception there is a duty to discuss contraceptive choices with a patient – specifically about the pros and cons of a COCP compared to a POP. The discussion should cover failure rates, the method of taking the pill, common side effects including effects on menstruation and the risk of thrombosis. This would allow the patient to reach an informed decision. The expert felt that part of this could have been achieved by advising the patient to read the product information in the packet insert.

In this case the expert felt that it was reasonable not to prescribe the COCP due to the family history of DVT (no contraindication to the COCP), family history of DVT (contraindication if age <45 in the family member) and the risk of thrombosis. This would allow the patient to reach an informed decision. The expert felt that part of this could have been achieved by advising the patient to read the product information in the packet insert.

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A tear during delivery

Ms J, a 37-year-old woman, was pregnant with her third child. She had an uneventful forcesceps delivery with her first child and a spontaneous vaginal delivery with her second. She had been previously diagnosed with irritable bowel syndrome, but endoscopies had revealed no evidence of any other disease. The GP records showed that she had colicky pain with constipation and diarrhoea, but she had a history of poor bladder control and incontinence. This pregnancy had been uneventful and she went into spontaneous labour at 34+5 weeks.

At 5.15pm she was 4cm dilated and, as the contractions had reduced, she was started on an oxytocin drip. She had an episiotomy and was found to be fully dilated at 9.45pm. As the head was ‘high’ she was given an hour for it to descend and started active pushing at 11pm. The baby’s head had come down to station 0 and appeared to be in the correct position vaginally confirmed the midwife’s findings. She advised Mrs J that she would need an epidural sited and was found to be fully dilated and at 12.30pm. Dr A felt the perineum was stretching out and, when she was seen by her GP for her six-week check up, it was documented that ‘she had no problems with her bladder or bowels’.

Unfortunately, 12 months following the birth, Mrs J was referred to obstetrics and gynaecology consultant Mr B, with signs suggestive of utero-vaginal prolapse, menorrhagia and lack of bowel control. An endo-anal ultrasound found only minimal scarring of the external sphincter, and the internal sphincter appeared intact. A clinical neurophysiologist also assessed the patient and felt ‘there was evidence of bilateral chronic pudendal neuropathy with pelvic muscle function on the right and left side’.

Ms J underwent a vaginal hysterectomy and posterior pelvic floor repair, and her symptoms improved significantly. She made dietary modifications and biofeedback. Ms J made a claim, as she was able to carry out an operative delivery and documented fully in the notes that a verbal consent had been obtained. She deflated the Foley catheter, which had been put in place when the episiotomy was sited.

Dr A then applied a silicone ventouse cup over the ‘friction point’ on the baby’s head. She increased the pressure to 0.2kg/cm² and checked there were no maternal tissues under the cup. She then increased the pressure gradually to 0.8kg/cm² and, with good maternal effort, pulled along the pelvis. Despite using the correct technique, the cup slipped off and the suction was lost. She re-examined the patient and still felt the baby was in the correct position, and that ‘the head had descended well to station 1’. Dr A decided to use the Nevile-Blanes forcesceps to complete the delivery. The blades were easily applied and, using the ‘Sadhoro-Pajol’ technique, the baby’s head was delivered with one pull.

Dr A felt the perineum was stretching out well, and did not carry out an episiotomy. The patient was noted to have a second degree tear. Dr A carefully examined the perianal and anal canal following the delivery and documented that the ‘anal sphincter was intact’ and there was no evidence of any sphincter damage, and repaired the tear routinely.

The patient made an uneventful recovery and, when she was seen by her GP for her six-week check up, it was documented that ‘she had no problems with her bladder or bowels’.

A catalogue of errors

Ms M, a 58-year-old woman, was referred by Mr A, a consultant orthopaedic surgeon, for a history of left-sided knee pain. She had seen him several years previously with a similar complaint – at that time, an arthroscopy had demonstrated degenerative change in both medial and lateral compartments of the knees. Upon being re-referred, Mr A performed a second arthroscopy – severe degenerative changes and bone-on-bone contact were observed. Ms M was duly listed for a left-sided total knee replacement, which was performed three months later.

When undertaking the consent procedure Mr A stated that he would be performing a partial knee replacement, that the indications for this type of surgery included arthritis and chronic pain, and that the surgery was ‘relatively minor and that the patient and, the serious and frequently occurring risks had been fully discussed. The procedure was performed through a midline incision. The finding, as anticipated, was gross tri-compartmental osteoarthritis.

The prosthesis was inserted, the patellar osteotomies were trimmed but the patella was not resurfaced. The operating note does not record any untoward intraoperative events. Routine antibiotics and thromboprophylaxis were prescribed.

The following day an x-ray was performed. This showed that the tibial component of the prosthesis had been sited in a suboptimal position. Over the course of the week, the nursing notes consistently commented that it was very painful for Ms M to move her leg, that she was profoundly immobile and that physiotherapy was almost impenetrable. Mr A thought that Ms M should be mobilised – unphyrathy with this advice, Ms M pursued a second opinion. This was provided by Mr B.

Seven days after the operation Mr A wrote to Ms M’s GP. In this letter he stated that the operation seemed to go very well but that the postoperative x-ray demonstrated a suboptimal result. He indicated that revision should not be pursued aggressively and that there were both advantages and disadvantages to this conservative approach.

Moreover, he reported that most of Ms M’s pain was in the thigh.

Three days after the correspondence and ten days after the original operation, revision surgery was undertaken by Mr B. The operating note described the suboptimal position of the tibial component and recorded a fracture of the medial tibial plateau. The component was replaced and the patella resurfaced. A swab taken at the time of revision grew a coagulase negative Staphylococcus but this was thought to be a contaminant. The claimant made a reasonable recovery and was duly discharged four days later.

Follow-up was arranged by Mr B and Ms M was seen six weeks later. At the interval, Mr M was left with a stick. The knee was a little stiff but physiotherapy was ongoing. At this point a second issue supervened. Ms M complained of severe troublesome pain along the pelvis area. Despite an MRI scan of the lumbar spine demonstrated an L4/L5 disc protrusion. A concurrent CRP of 35 and ESR of 31 were felt to be of questionable relevance and were attributed to delayed wound healing and the signs of marking.

Further follow-up, six months later, found that Ms M was walking without the aid of a stick. The knee was a little warm. The range of movement was 0° to 100° and it was considered that the knee was healed.

Fifteen months after the first operation, Ms M’s GP referred her to a rheumatologist, Dr L, on account of persistent knee pain and bone pain. He requested a bone scan, which was reported as showing probable parosteal osteosarcoma. Ms M was then referred back to Mr A who performed a diagnostic arthroscoathy. This demonstrated an extensive synovitis and Statphylloccoccus epidermidis was isolated from the biopsies obtained. A protracted course of antibiotic therapy ensued. Two years after the index operation, a stoppage explant was undertaken. Over a period of several months, the operative wounds healed and satisfactory x-ray appearances were obtained. However, Ms M continued to be troubled by persistent pain.

Six months later Ms M made a claim against Mr A, it alleged that Mr A was negligent on multiple counts, in that he had fractured the tibial plateau at the time of the original surgery, failed to identify the fracture during surgery and then failed to take remedial action intraoperatively. Moreover, it alleged that Mr A had been negligent in failing to proceed urgently to revision surgery and in persistently advising Ms M to mobilise, despite her severe pain, the concerns expressed at multidisciplinary team meetings and all the clinical and radiological indications that the knee joint was mal-aligned.

Ms M also claimed that were it not for Mr A’s negligence, the total knee replacement would have been successful and she would have recovered swiftly following surgery. Furthermore, Ms M alleged that she would have been relieved of her preoperative symptoms and would have not required a further revision for approximately two decades. It was also suggested that the initial revision, the ensuing septic arthritis, the subsequent arthroscopy and the final two-stage revision were all consequent to Mr A’s negligence.

Expert evidence was sought from Mr D, a consultant orthopaedic surgeon, with regards to breach of duty and causation. Although Mr D acknowledged that Mr A was not aware of any adverse event occurring during the original operation, he was highly critical of Mr A for failing to act on the immediate signs and symptoms of infection, not proceeding to urgent revision surgery and for repeatedly advising Ms M against an early revision.

Mr D was also critical of the persistent advice to mobilise and acknowledged that, in his opinion, this was one of the worst total knee replacements he had seen. Moreover, Mr D felt that the subsequent operations Ms M underwent were a result of Mr A’s breach of duty during the index operation. In terms of breach of duty, Mr M alleged that Mr A had breached the ‘golden hour’ rule. In this instance, the highly critical expert evidence required swift decision making and decisive intervention. The defensive position was accepted. This case demonstrated the importance of early intervention and the scrutiny of the nosology. It was inconceivable that, in the light of the expert evidence, Mr A was not found guilty.
Cutting corners

L was a healthy four-year-old boy who had accidentally caught his finger in a bicycle wheel, amputating part of the distal phalanx. In the Emergency Department of the local hospital, it was found that the pulp and nail bed of the finger were lost and the bone of the distal phalanx was exposed. L was admitted under plastic surgery, fasted, and booked for theatre for terminalization.

He was assessed for general anaesthesia by consultant anaesthetist Dr B, who noted that L was a fit and well boy weighing 17.5kg, had no medical problems or allergies, and had been appropriately fasted.

Dr B conducted an inhalational induction of anaesthesia, with 70% nitrous oxide, 30% oxygen and 4% sevoflurane. An anaesthesia by consultant anaesthetist and booked for theatre for terminalisation.

Plastic surgeon Mr T performed the surgery, which proceeded uneventfully. Mr T infiltrated a ring block with 3ml of 0.5% plain bupivacaine for postoperative analgesia. Towards the end of the operation, as Mr T was applying the dressings, the theatre sister, Sr S, noted that L’s pulse was very slow at 45 beats per minute. The pulse oximeter showed that the saturations were 52%. Dr B removed the drapes and L’s face was noted to be cyanosed and his pupils widely dilated. Dr B removed the LMA, but the throat was clear. He applied 100% oxygen by facemask and an oropharyngeal airway. No pulse was palpable after 20 seconds of high flow oxygen, so Dr B instructed the surgeon to perform external chest compressions. He gave 0.1mg of adrenaline and a second saline was administered.

Dr B performed a ring block with 3ml of 0.5% plain bupivacaine for postoperative analgesia. As Mr T was applying the dressings, Dr B had finished a 12-hour list with another surgeon and had agreed to help out at short notice. After induction, Dr B had left the reservoir bag concealed under the drapes, where he could not see its movement. He had not used a capnograph to monitor respiration. He had not recorded a blood pressure or respiratory rate at any time during the case. The monitor alarms had all been switched off earlier in the day and he had not checked or reinstated them. Dr B accepted that there was a protracted period of inadequate vigilance during the case, during which a prolonged episode of severe hypoxia occurred.

This case occurred over a decade ago and L is now a teenager. He has profound impairment of function and memory. L’s parents made a claim against Dr B, which was settled for a high sum.

A restoration problem

Mr A, a 46-year-old accountant, had a long history of biopsy-confirmed ulcerative colitis. Because of escalating medication, he was referred by his gastroenterologist for consideration of surgery after repeated exacerbations. He saw Mr C, a colorectal surgeon, who discussed the options available. Mr A had been unable to work for several months. He had done some independent research on the internet and concluded that he wished to undergo a restorative procto-colectomy to avoid a permanent stoma. Mr C documented the risks of this complex procedure and warned Mr A of possible leaks, pelvic sepsis and possible future pouchitis. He planned to perform the operation laparoscopically, which would carry the advantages of a quicker recovery, fewer adhesions and minimal scarring. Mr A underwent a laparoscopic procto-colectomy with complete intra-corporeal ileo-anal pouch formation and a covering loop ileostomy. He made a slow but straightforward recovery. He remained in hospital for ten days, requiring a course of intravenous antibiotics for presumed urinary sepsis and training in the management of his ileostomy. Two days after discharge he re-presented with urinary retention requiring urethral catheterisation. Mr A subsequently developed increasing perineal and pelvic pain. Digital rectal examination revealed separation at the anastomosis, and a subsequent CT scan demonstrated a 6x10cm pelvic abscess adjacent to the anastomosis. A CT-guided drainage of the abscess was successfully carried out, and a week later Mr A was discharged home with the drain in situ.

There was a four-month period of ongoing review by Mr C, with a series of CT scans and contrast enemas demonstrating a slow but steady resolution of the abscess cavity with removal of the drain. After such frequent reviews the patient and surgeon were well-acquainted with one another and were on first-name terms. Mr A was desperate for his ileostomy to be closed so he could return to work and, following a normal water soluble enema, Mr C decided to close the loop ileostomy. Preoperatively he documented the “high risk of pelvic sepsis if there is a persistent anastomotic dehiscence.” Before surgery Mr C performed an examination under anaesthesia, which showed a very small dehiscence posteriorly at the pouch-anal canal anastomosis. Nevertheless, Mr C proceeded with closure of the ileostomy, in the hope that this would heal.

Mr A then suffered a recurrence of his previous problems with urinary retention, pelvic pain and sepsis. A further 12-month period of repeated hospital admissions ensued, with radiologically-guided drainage of the pelvic collections and treatment against pelvic sepsis. The relationship between surgeon and patient gradually broke down and Mr A was referred to Professor X, who undertook a revision open procedure to retain the pouch, which eventually produced a satisfactory outcome. Mr A instigated a claim against Mr C, citing that he had insufficient experience in undertaking laparoscopic procto-colectomy with a pouch. Mr A and Mr C instead have undertaken an open procedure. Mr A also complained that he provided negligent postoperative care, performing a closure of ileostomy whilst an anastomotic defect remained.

Expert opinion agreed that the decision to perform a restorative procedure was correct and Mr C had sufficient experience and training to undertake the procedure laparoscopically. They were, however, in agreement that closure of the covering ileostomy – despite the operative finding of a persistent anastomotic defect – was not defensible. Mr C accepted the criticism, but noted that on a personal basis he had felt responsible for the patient’s complications, and had been influenced by a desire to help the patient back to a normal life as rapidly as possible.

The case was settled for a substantial sum.

Learning points

- A series of human and equipment factors interacted to bring about this tragic outcome from a trivial initial injury.
- Fatigue can be a powerful cause of reduced vigilance, and is associated with increased risk of error. It does not amount to a defence. The mnemonic HALT reminds all healthcare professionals to be extra careful if they are Hungry, Angry, Late or Tired. Ask yourself: am I safe to work?
- The AAGBI recommends capnography in all patients under general anaesthesia, regardless of their location in the hospital or the type of airway device used.
- Most anaesthetic machines now incorporate capnography automatically. It is now very difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.
Learning points

- Leg length discrepancy is the second most common cause of litigation in orthopaedics.
- Approximately 15% of hip replacement surgery results in a limb length discrepancy.
- Less than 1cm discrepancy is the ideal goal, but up to 2cm is reported to be tolerable by patients.
- The importance of good documentation concerning consent.
- In this case, expert opinion found some of Mrs K's claims inaccurate and found Mr B had dealt with the patient in an appropriate manner.
- RMach

Learning points

- The results of investigations should be reviewed promptly and acted upon accordingly.
- Adhesive small bowel obstruction requires surgical intervention if, after appropriate conservative treatment, there is no sign of clinical improvement.
- Medical problems often arise long after the clinical encounter.
- Expert opinions were critical in the delay in making the diagnosis of small bowel obstruction and undertook surgery. They felt that an ultrasound examination had been unnecessary and that Mr S should have reviewed the abdominal x-ray (which clearly showed evidence of obstruction) when he initially reviewed the patient and not the following day.
- The case was settled for a moderate sum.
A confidential issue?

May I comment on the article “On deadly ground” (Casebook 21/8), the case “CONFIDENTIALITY”. I feel that Dr W was not at fault in divulging Miss B’s HIV status with the mother present. The mere fact that Miss B allowed the mother to be present at the consultation gives the doctor the right to discuss ALL problems and queries of the patient, as long as this was within the mother’s presence. I agree that the doctor should discuss ALL the queries with the patient’s consent, but that was not the case. Also, the patient had not expected that information to be divulged, and the case illustrates the dangers of making assumptions. Fortunately, although the GP had to endure the stress of a complaint to the Medical Council, the case did not proceed to a hearing.

Poor notes: why?

It is a recurring observation that poor record-keeping is one of the major obstacles for MPS in defending complaints of negligence. Yet writing patients’ notes is one of the chores drilled into all of us, especially when we are training as interns. This practice seems to warn us as we get more experience and the notes become shorter and shorter, to in no notes at all sometimes! This is because of too much confidence, laziness or sheer carelessness? I don’t think so. It must be a combination of many factors. I wonder if MPS could design a study to investigate this matter, difficult as it may be. Thanks for a great journal.

Dr Dauda Malekarsiya, GP, Grahamstown, South Africa

Response

In this scenario, the GP had wrongly assumed that the patient was content for her daughter to know confidential information regarding her HIV status. The patient, in making her complaint, had not expected that information to be divulged, and the case illustrates the dangers of making assumptions. Fortunately, although the GP had to endure the stress of a complaint to the Medical Council, the case did not proceed to a hearing.

Stumbling block

Thank you for highlighting the important case of a nerve injury following a femoral nerve block, “Stumbling block”, Casebook 21 [8]. However, I would dispute your statement that use of ultrasound has revolutionised the safety and efficacy of regional anaesthesia. Published works show a rate of nerve injury whilst using ultrasound to be similar to traditional techniques.1 Surely the key factors in this case were the use of an unsafe nerve block technique, as well as severe deficiencies in consent and communication. From these, the clinician should have avoided the nerve injury. Indeed, the plaintiff should have been able to secure a conviction.

Dr Howard Bluett (retired consultant anaesthetist), Teeside, UK

Response

If legally possible, MPS should push hard for prosecution in cases such as these to reduce and deter unwanted compensation payments.

Dr Chris Fox, Consultant Physician, East Kent Hospitals NHS Trust

Response

At this case, the claimant had a valid claim, and was entitlement to the amount of compensation which was ultimately paid to her. However, she pleaded exaggerated damages, which led MPS to investigate and establish that her injury was less severe than she was claiming. This would not have impacted on her entitlement to public funding of her claim at the outset, but led to withdrawal of funding when it was possible to show that a reasonable offer had been made.

Given that her claim was, in fact, successful, it would be difficult to secure a conviction in this case. However, I hope that this case does demonstrate how rigorous MPS is in investigating claims, paying when and where it is right to do so, and at the same time safeguarding members’ funds.


It will be reviewed in a future edition of Casebook.

One needs to be aware of which of one’s actions one needs to “take responsibility for”, and how to do that. Behavioural patterns can be negative and can even be perpetuated by communication failures, and may then find it helpful to read something on the subject. I would recommend a book by three American authors, which of the hundreds available and several I have read is really outstanding. Though I have not read the latest edition of 2012 there is every reason to believe that it will be as good as earlier ones.

Changing our own approach might encourage change in “the opposition” and avoid the need for involving a third party.

Dr Howard Bluett (retired consultant anaesthetist), Teeside, UK

REFERENCES

1.   Fredickson MJ, Kilfoyle DH, Neurological complication analysis of 1,000 ultrasound-guided peripheral nerve blocks for elective orthopaedic surgery: a prospective study. Anaesthesia 2010

Casebook and other publications from MPS are also available to download in digital format from our website at: www.medicalprotection.org
Common Neuro-Ophthalmic Pitfalls: Case-Based Teaching
By Valerie A Purvin and Aki Kawasaki
(M58.00, Cambridge University Press, 2009)
Reviewed by Dr Sacha Moore, consultant ophthalmologist

This book is part of a series of similar case-based books on different specialties, and is enjoyable and well written. If you are tired of didactic reference textbooks that serve up boring writing on layers of indigestible tedious lists and tables, like sawdust on bread and crackers, then this will be the choice and graspas that render neuro-ophthalmology not just palatable but moreish. Let’s be honest: most of us non-neuro-ophthalmic specialists sit away from this subject and typically look for the nearest exit or window to jump through when a patient presents with double vision and headaches. Patients almost never present with textbook findings and almost always have confusing, subtle and variable symptoms or signs. This makes for a long corridor of bear traps, at the end of which awaits your own headache and diploria if you are not careful. The authors have nicely addressed the main subjects that cause anxiety amongst clinicians in neuro-ophthalmology and use real cases with relevant pictures and simple tables. There are 12 chapters:

■ When ocular disease is mistaken for neurologic disease
■ When orbital disease is mistaken for neurologic disease
■ Making congenital anomalies for acquired disease
■ Radiographic errors
■ Incidental findings (seeing but not believing)
■ Failure of pattern recognition
■ Clinical findings that are subtle
■ Misinterpretation of visual fields
■ Neuro-ophthalmic look-alikes
■ Over-reliance on negative test results
■ Over-ordering tests
■ Management misadventures.

The style feels like a rewarding one-on-one tutorial and makes you feel like you may actually be able to deal with similar cases in future. You can dip into it like a textbook or enjoy reading it straight through from start to finish – there are many interesting and surprising facts that I have not found in other textbooks. This book will help you better understand subjects you thought you knew and those you know you didn’t know. Neuro-ophthalmologists will find this book serves as a good tune-up on their knowledge; non-neuro-ophthalmologists may benefit from the insights, like a full service on the rusting remains of their faded membership memories.

It is satisfyingly clinically relevant and not just another book for membership examinations. Overall the book deserves the honour of being well-thumbed and to stand battered and frayed from much use amongst the shiny, thick volumes of untouched neuro-ophthalmic monoliths in your, or your institution’s, library.

Errornomics: Why We Make Mistakes and What We Can Do To Avoid Them
By Joseph T Hallinan
(£8.99 Elsevier Press, 2009)
Reviewed by Dr Matthew Sargeant, consultant psychiatrist and clinical human factors group member

I learnt so much from this easy-to-read, enjoyable little book. Why We Make Mistakes is available as paper book, ebook or audio book. How we look at things without seeing, forget things in seconds, and are all pretty sure we are way above average are the themes. Such themes are of immediate contemporary clinical relevance to practice and comprehensively described. The book is good for everyone, whether on a course on clinical human factors or not. For more than 20 years Hallinan, a journalist, collected many errors and obtained comments from academics who study various aspects of human performance and psychology related to human error making. There are many helpful references, a guide to chapters and footnotes. The book is an inviable primer for academic literature for human factors/ergonomics terminology. Grouped exhaustively simply under 13 chapters, we are told making fewer mistakes is not easy, especially if the reader merely desires to do so without reflection. Hallinan urges: put effort into thinking of the small things we do and do not do, for the consequences are big. To improve patient safety with the very next patient you manage, read the book.

The book advises team members to work together, to communicate and to have a supportive and accessible attitude to reduce error in team members. Clinicians are also advised to look up at the organisation they work in for the sources of errors, as well as down at what they are doing. Clinicians are also told to avoid multitasking. The book implies that designing, investigating, delivering and managing clinical care are onerous responsibilities to promote patient safety.

The book is a lifeline for all medical students and doctors who make complaints and litigation.

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