Professional support and expert advice from your leading medicolegal journal

Inside...

THE HIGH ANXIETY OF THE GMC
Counting the emotional cost of a GMC investigation

HUMAN PERFORMANCE AND MEDICAL ERROR
Exploring the case for human factors training in the health service

OVER TO YOU
The place to debate hot topics

REVIEWS
Book, film, app – read our reviews

DIVERTED BY THE DIAGNOSIS
HOW A HOSPITAL ASSESSMENT MISLED A GP – PAGE 16
Friday 19 June 2015, London

Our one day conference is ideal for GPs and the primary care team who want to focus on making practice safer and improve on patient safety.

£95 for GPs and £50 for GP Registrars, Practice Managers, Practice Nurses and Practice Staff

Programme
- Managing Challenging Interactions with Patients
- Human Factors and Systems Errors
- Reporting Incidents
- Personal Impact of a Claim and Complaint

Plus Workshops on
- Medicolegal Dilemmas
- Safe Prescribing
- Infection Control
- Managing Conflict and Aggression
- Complaints: How Does Your Practice Measure Up?

99% of delegates would recommend this conference to a colleague

An enjoyable informative day with learning points for both me and my practice allowing us to reduce risk and enhance our safety

Find out more
www.medicalprotection.org/gp-conference

What’s Inside...

05 Noticeboard
Latest news updates on a landmark Supreme Court ruling – plus find out about MPS’s latest enhancements to the protection of your sensitive information.

06 Human performance and medical error
Sara Dawson explores the case for human factors training in the health service. Plus, a snapshot of other hot topics from the latest Risky Business event in London.

08 The high anxiety of the GMC
Gareth Gillespie looks at the emotional and physical consequences of being investigated by the GMC, as revealed by two recent reports.

04 Welcome
Dr Nick Clements, editor-in-chief of Casebook, comments on some topical issues affecting healthcare.

10 From the case files
Melanie Rowles, head of claims management at MPS, looks at what can be learned from this edition’s collection of case reports.

Features

Case Reports

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

26 Reviews
In this issue Dr Sam Dawson reviews Being Mortal by Atul Gawande, while Dr Anand Narahbhi looks at Postmortem: The Doctor Who Walked Away by Maria Phalime.

Every issue...

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

26 Reviews
In this issue Dr Sam Dawson reviews Being Mortal by Atul Gawande, while Dr Anand Narahbhi looks at Postmortem: The Doctor Who Walked Away by Maria Phalime.
WELCOME

Dr Nick Clements
EDITOR-IN-CHIEF

NEW JUDGMENT ON PATIENT CONSENT

The law on informed consent has changed following a Supreme Court judgment.

Doctors must now ensure that patients are aware of any ‘material risks’ involved in a proposed treatment, and of reasonable alternatives, following the judgment in the case Montgomery v Lanarkshire Health Board.

This is a marked change to the previous “Bolam test”, which asked whether a doctor’s conduct would be supported by a responsible body of medical opinion. This test will no longer apply to the issue of consent, although it will continue to be used more widely in cases involving other alleged acts of negligence.

It is notable that this decision enshrines in law principles that are already in the GMC’s guidance on consent, Consent: Patients and Doctors Making Decisions Together (2009), and which are reflected in MPS’s own advice materials on consent.

THE CASE

In 1999, Nadine Montgomery gave birth by vaginal delivery to Sam. The birth was complicated by shoulder dystocia. The medical staff performed inappropriate manoeuvres to release Sam but, during the 12-minute delay, he was deprived of oxygen and subsequently diagnosed with cerebral palsy.

Mrs Montgomery brought a claim against Lanarkshire Health Board, alleging that she had been advised of the 9.10% risk of shoulder dystocia and that, because the risk of such an outcome was small (less than 0.1% risk of cerebral palsy), it was also alleged that delivery by caesarian section should have been offered to Mrs Montgomery, and that this would have prevented the child’s injury.

The Supreme Court held that the question should have been about Mrs Montgomery’s likely reaction if told of the risk of shoulder dystocia. The unequivocal position was that she would have chosen to give birth by caesarian section.

The Bolam test was deemed unsuitable for cases regarding the discussion of risks with patients, at the extent to which a doctor may be inclined to discuss risks with patients is not determined by medical learning or experience.

The court ruled that Mrs Montgomery should have been informed of the risk of shoulder dystocia and given the option of a caesarian section. Mrs Montgomery was awarded £2.25 million in damages.

PROTECTING INFORMATION – PROTECTING YOU

As it is to MPS. Introducing this enhanced email security is part of our commitment to providing the highest level of security in place to protect this data.

HOW WILL IT IMPACT ME?

However, for some members, depending on their existing email provider and the content of the email correspondence, they may in future be directed to retrieve and exchange messages with MPS via a secure portal.

If you are likely to be affected by this change, we will be writing to you to provide more information on the changes and how to use the portal. There will also be plenty of information and helpful guides available on our website to ensure that we make the transition to this new way of handling emails from MPS as simple as possible.

We know that ensuring the security of your confidential data, and that of your patients and other third parties, is as important to you as it is to MPS. Introducing this enhanced email security in part of our ongoing commitment to ensuring we continue to put the protection of our members’ interests first.
HUMAN PERFORMANCE AND MEDICAL ERROR

Sara Dawson explores the case for human factors training in the health service

BEGINNINGS OF HUMAN FACTORS TRAINING

The study of human factors began in the aviation industry in the 1980s. Guy Hirst is a human factors expert, he was a training standards captain on the Boeing 747 and was instrumental in making human factors training a core part of pilot training. “Aviation accidents receive instant press attention, with images of charred hulls appearing in the media more or less immediately after the incident occurred. In the 1980s accidents were being tagged as being caused by ‘human error’ or ‘pilot error’. The authorities finally decided that the status quo was unsustainable and thus research into understanding human error began.”

HUMAN FACTORS IN MEDICINE

Medicine has slowly to fully embrace the relevance of human factors in medical error. In 2006 the Chief Medical Officer (CMO) reported in his review Good Doctors, Safer Patients: “It is only recently that attention has been focused on patient safety. Despite the relatively high level of risk associated with healthcare – roughly one in ten patients admitted to hospital in developed countries suffers some form of medical error – systematic attempts to improve safety and the transformations in culture, attitude, leadership and working practices necessary to drive that improvement are at an early stage.”

According to Guy Hirst, medicine is probably more complex than any other field of human endeavor, and patients are far more complex and idiosyncratic than aircraft, ships or power stations. The critical similarity is that they all rely on teams of professionals working together, so there is much to gain from learning about human factors.

Glenn Mead, from the team that launched The Chimp Paradox, an internationally acclaimed mind management model, says that clinicians experience a lot of stress because there are great consequences and expectations of what actions they take. “In this highly pressured and charged environment, being aware of how you think, sometimes irrationally and emotionally under pressure, is important. You should be able to step back and observe, getting some perspective on the situation.”

THE PSYCHOLOGY OF HUMAN ERROR

Professor James Reason is widely regarded as the world’s leading expert on human error. He argues that there is a paradox at the heart of the patient safety problem. Medical education is expected to bring about a “trained professional mentality”, after an extensive education, healthcare professionals are expected to get it right, but they are fallible human beings like the rest of society. However, many errors equate to incompetence or worse, meaning mistakes may be stigmatised or ignored rather than seen as chances for learning.

The other part of the paradox is that healthcare, by its very nature, is highly error-prone. Guy Hirst says one of the reasons that healthcare is so challenging is the requirement to make decisions on the basis of incomplete evidence. “Events are constantly surprising, particularly as human anatomy is variable and each patient is unique.”

Studies of disasters such as Three Mile Island, The Herald of Free Enterprise, and Bhopal have illustrated human factors issues similar to those found in medical practice. According to James Reason, all humans make frequent errors and this has two implications. Firstly, novices make errors due to incomplete knowledge and experts make errors due to the intrinsic hazards of semi-automated behaviour.

Professor Reason argues that although error can never be completely eliminated it can be managed. There are two distinct cognitive processes: firstly there is the conscious cognitive process, which is used when a task is new, and secondly, there is an automatic cognitive process where the task has been practised and perfected and this process occurs at a subconscious level. The salient point is that the working memory is extremely capacity limited. It is also very effortful to be using the working memory and it is the least preferred option.

THE CASE FOR HUMAN FACTORS TRAINING

Evidence is growing that human factors training should be an essential element of the broader patient safety curriculum. As with all the limitations of human information processing, the way to reduce the potential for error-provoking situations is by effective team communication, and the design of systems and protocols that appreciate the inadequacies of human cognitive processes. By being conscious of our attitudes and the cognitive factors discussed above, professional performance can be improved and the effects of human factors mitigated.

This article introduces the concept of human factors training. In the next edition of Casebook we will look at how this concept applies on the wards and in your consulting room, and specifically how it translates into practical advice and guidance.

The inspirational people quoted in this article shared their stories at the Risky Business Conference in London, which features patient safety and risk experts from high-risk industries, business, sport and exploration around the world.

USEFUL LINKS

MPS has joined forces with Risky Business to produce a series of videos exploring key areas of risk. Read the tablet edition of Casebook to see the videos.

REFERENCES

Gareth Gillespie looks at the emotional and physical consequences of being investigated by the GMC, as revealed by two recent reports.

The pressures of practising in medicine today are well-known: rising patient expectations have perhaps, been fed by an increasingly hostile media, a problem that has potentially led to a more litigious landscape at a time when dwindling NHS resources are already posing an obstacle to the safe delivery of healthcare.

Against this background, an investigation by the doctor’s regulatory body imposes a further significant burden – which can sometimes have tragic consequences. When the GMC published its report into doctor suicides last December, it was shining a light on its own involvement in causing anxiety among doctors, revealing that 28 had taken their own lives between 2005 and 2013.

But if prevention is truly better than cure, this upcoming report has at least highlighted the magnitude of the issue – presenting an opportunity to tackle this problem at its source and prevent such levels of stress and depression in future. One recommendation from the GMC was to establish a national support service for affected doctors.

But if prevention is truly better than cure, this upcoming report has at least highlighted the magnitude of the issue – presenting an opportunity to tackle this problem at its source and prevent such levels of stress and depression in future. One recommendation from the GMC was to establish a national support service for affected doctors.

Dr Pallavi Bradshaw, MPS medicolegal adviser, wrote in her opinion column in MPS’s New Doctor magazine: “While saddened by the findings of both reports, I was not entirely surprised. I saw the negative impact GMC investigations have on doctors and, while most will be dismissed without further action, the damage of the process cannot be underestimated.”

“IT is important that any doctor struggling to cope, whether under GMC investigation or not, should seek help and support as soon as possible from occupational health and/or their GP. MPS has a confidential counselling service to its members. The recommendation in the GMC report for a national support service is welcome, as is the need to treat a doctor as ‘innocent until proven guilty’ – surely a fundamental principle of our justice system.”

OTHER FACTORS

The GMC’s report also found that many of the doctors who committed suicide suffered from a recognised mental health disorder, or had problems with drug and alcohol addictions. Other factors that may have played a part in the suicides or attempted suicides included marriage breakdown, financial hardship and, in some cases, police involvement in top of the GMC investigation.

In terms of support, over a quarter of respondents (28%) called for clearer expectations from the GMC.

Dr Pallavi Bradshaw, MPS medicolegal adviser, wrote in her opinion column in MPS’s New Doctor magazine: “While saddened by the findings of both reports, I was not entirely surprised. I saw the negative impact GMC investigations have on doctors and, while most will be dismissed without further action, the damage of the process cannot be underestimated.”

“The GMC’s openness in putting in the public domain the issue of doctors’ suicides whilst under their process. Going forward they need to continue to show their commitment to reducing the impact of investigations on vulnerable doctors whilst always maintaining patient safety – a substantial task.

“Doctors are sometimes patients too, and supporting vulnerable doctors is a shared responsibility. It is important that in taking forward the recommendations in the review the GMC works in partnership with everyone who has an interest in this area, including the Practitioner Health Programme, the Royal College of Psychiatrists and the BMA.”

PREVENTION AND CURE

There are a number of other areas relating to the investigation process that MPS believes would help to reduce the stress for doctors involved. Dr Richard Stacey, senior medicolegal adviser at MPS, discusses the key points:

Case conferences

Recently we assisted a member with a GMC investigation that took four months to be closed with no further action. After receiving an expert report that was supportive of the doctor’s case, we requested that the GMC promptly close the case.

While we appreciate that GMC investigations sometimes have to move at a slow pace – and in many cases this is outside the GMC’s control – more can be done to reduce delays and allow doctors to be more actively involved in the investigation.

The fourth recommendation in the GMC’s report is to introduce regular case conferences into the investigation process. This potentially allows doctors to co-navigate the investigation process with the GMC and reduce delays, and may also reduce unnecessary paperwork and give doctors more direct involvement. It may also go some way to resolving the problem, in our experience, of GMC investigators seldom giving explanations or updates for such delays. Such uncertainty only adds to doctors’ anxiety.

Case conferences would help all parties understand their roles, something that the MPS survey revealed to be a popular request – 28% of respondents called for the GMC to provide clearer expectations.

Review deadlines

Reasonable deadlines for doctors to respond to allegations is another way to reduce anxiety, with current timeframes of 28 days proving relatively short when considering the many other commitments of doctors.
FROM THE CASE FILES
Melanie Rowles, head of claims management at MPS, introduces this edition of the collection, and looks at how they are often viewed very differently by doctors and lawyers.

WHAT’S IT WORTH?

If you detect a fault in the care you have received, is it possible to quantify the extent of the harm you have suffered? The answer is yes and no – yes because it is relatively straightforward to establish whether the care you received was faultless, but often the full extent of the harm is not immediately obvious.

What’s the point of compensation?

One of the most common questions we receive at MPS is “What’s it worth?” There are many factors which determine the value of a claim. Compensation for pain and suffering, or the costs associated with additional medical help, may be awarded. In some cases, compensation is paid for loss of earnings, or for pain and suffering that flows from an error, and which is irrespective of the adverse event: “What has been the eventual outcome for a patient is the same why compensation is still paid even though the patient has recovered.”

As a final thought I can see how some may wonder why compensation is still paid even though the patient has recovered. The former regulator, ‘reform’ and ‘insight’ are words that are used repeatedly in that arena. Again, reflection can be the key to a successful outcome.

CASE REPORTS

PULLED IN ALL DIRECTIONS

SPECIALTY ANAESTHETICS

THEME INTERVENTION AND MANAGEMENT

HIGH £1,000,000+

SUBSTANTIAL £100,000–£1,000,000

MODERATE £10,000–£100,000

LOW £1,000–£10,000

NEGLIGIBLE £1,000–

Mrs J was a 32-year-old female patient who was involved in a road traffic accident. The pain was localised to the left side of her neck and she was given very occasional paraesthesia in her left hand. Despite regular analgesics and exercises, the pain was still complained of and she was keen for a specialist opinion.

Mrs J was referred to Dr M, a pain consultant. Dr M noted slight restriction in neck movement on the affected side and elicited tenderness over the left C5/6 and C6/7 facet joints. Imagining revealed fusion of the C3 and C4 vertebrae and some loss of normal cervical spine curvature, but at the vertebral bodies and spaces remained otherwise well preserved.

Dr M recommended C5/6 and C6/7 facet joint treatment and told Mrs J that there was a 50% chance of getting long-term pain relief. He suggested two diagnostic injections with local anaesthetic followed by radiofrequency lesioning if benefit was felt. Dr M then engaged the risks of the procedure with Mrs J, including lack of benefit, relapse of pain, infection and damage to nerves.

Mrs J returned for the first of the two diagnostic blocks. The block was performed in the lateral position and Dr M injected a mixture of 0.5% levobupivacaine and triamcinolone. The block provided good pain relief and Mrs J felt it was easier to move her neck.

Mrs J left the same day for the second diagnostic injection. Mrs J was placed in the prone position and local anaesthetic infiltrated into the skin. Using fluoroscopic imaging, 2mg of local anaesthetic were injected into the C5 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and triamcinolone in the C5/6 and C6/7 facet joints. The needle had not been placed in the correct position for the mixture to be able to contact the facet joint. Unexpectedly, as soon as Dr M started the injection, the patient jumped with pain and her left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later the same day developed numbness in her left arm and right leg. She also complained of headache when sitting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr M decided to admit Mrs J for overnight monitoring and analgesia.

The next morning Mrs J was no better. She felt unstable on her feet and complained of a burning sensation in her right leg, as well as pain in her left neck and shoulder. She was not able to sit for her breakfast and was eventually removed from bed by her partner. Dr W, an expert neuroradiologist, was consulted and advised that the first and second needle insertions, inferring the possibility of nerve damage, should be removed. Dr W concluded that insufficient images were taken to satisfactorily position the needles. Mrs J also felt that the use of triamcinolone in the diagnostic injections could be critical, as injection of particulate matter into the spinal cord is known to be associated with a higher risk of cord damage.

Dr W, an expert neuroradiologist, was concerned about the needle position reviewed from the second diagnostic injection. He concluded that neither needle was within the respective facet joint and that the lower needle tip was within the spinal canal at the level of C5, less than 1cm from the midline. Dr W also advised that the MRI abnormality corresponded with the position of the lower needle tip.

Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 20 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

MPS then instructed a causation expert to comment on Mrs J’s progression of symptoms. Professor C concluded that the development of neuropathic pain in the right leg was understandable, although the disabling effects were more than he would have expected. Whilst the patient did have a history of neck pain, the patient’s symptoms were consistent with a lesion affecting the spinothalamic tract on the contralateral side of the cervical spinal cord.

The case was considered indefensible and was settled for a high sum.
Mr S was a 60-year-old lorry driver. He was overweight and smoked, and could not walk because his legs were so painful. He had diabetes and had a history of smoking. He was referred to the ED and advised him to come for emergency treatment, explaining that his leg was still very painful and that he needed to be reassured in the ED. He rang his GP and was told to stop smoking and attend his Doppler assessment the next day.

Mr S struggled to sleep for the next few nights because he had a burning sensation in his right foot and leg, which felt cold and numb. He had to get up and walk around to relieve the pain. He made an appointment with his own GP, Dr A, the next day. Dr A noted the history of numbness and rest pain. He documented that his right foot was pale and felt cold. He requested a non-urgent Doppler assessment because he could not detect any pulses in his right foot and prescribed quinine sulphate.

Mr S’s Doppler scan was arranged for the following week but he rang his GP surgery three days later because the pain in his foot and leg had not resolved. He was asked to hang his foot over the edge of the bed to get relief from it. Dr A advised him to go straight to the Emergency Department (ED).

The ED doctor sent him home despite documenting the leg pain and a cool, pale right foot with weak pulses. The diagnosis of arterial insufficiency rather than acute ischaemia was made. Mr S was advised to stop smoking and to attend his Doppler assessment in a few days’ time.

Mr S was really worried about his leg despite being reassured in the ED. He rang his GP explaining that his leg was still very painful and that he needed to be reassured in the ED. Dr A reassured him because he had been discharged home from the ED and advised him to come for his Doppler scan the following day. When he attended the operator was unable to get a result due to swelling and pain but noted that his foot pulses were difficult to detect. Mr S was given an appointment with Dr A the next day to discuss the results.

Dr A discussed the Doppler results and documented that his right foot was cold. He made the diagnosis of “worsening peripheral vascular disease” and arranged for Mr S to attend the surgical assessment unit the following day.

Mr S was admitted urgently from the surgical assessment unit with a diagnosis of an acute ischaemic right leg. On femoral angiography, he was found to have thrombus in the distal superficial femoral artery. He put a right femoral artery embolotomy, which was unsuccessful and converted to a right femoral popliteal bypass. Unfortunately his leg was still not viable following this procedure and he went on to have an above knee amputation. Mr S suffered with phantom limb pain and despite undergoing rehabilitation he remained severely limited in his daily activities.

The opinion of a professor in vascular surgery was also gained. He considered that Mr S’s foot was obviously ischaemic when he presented to his GP. He thought that an amputation may well have been avoided if Mr S had been admitted earlier.

The case was settled for a high amount against both the hospital and the GP.

Mr S, 34, presented to the delivery suite at 12.38pm, 38 weeks into his first pregnancy.

Her antenatal care had been uneventful apart from measuring slightly “large for dates” at 36 weeks. She was found to have a longitudinal lie with a cephalic presentation, and was experiencing three contractions every ten minutes. The midwife examined her and found her to be 2cm dilated with a fully effaced cervix and “intact membranes”.

At 3.30pm she was re-examined and found to be fully dilated and was given 100mg pethidine IM.

At 8.30pm she was examined by the midwife again and still found to be 3cm dilated. The cardiotocograph (CTG), which had been started one hour before, was normal, with a baseline of 140b/min and good variability and good reactivity. Mrs G was now experiencing more painful contractions and an epidural was sited.

At 10pm, she was found to be 3cm dilated and the “membranes were still intact” despite still having regular contractions of three every ten minutes. No artificial membrane rupture was carried out, however, Mrs G was started on a syntocinon regime to induce labour. Despite still having regular contractions of three every ten minutes. No artificial membrane rupture was carried out, however, Mrs G was started on a syntocinon regime to induce labour. Despite having stopped the syntocinon, Dr A was informed, but he was “busy” and had still not arrived to review the CTG by 3.31pm.

He was re-contacted and came to assess Mrs G at 4am. He felt she was now “fully dilated” with the head at the level of the ischial spines. He decided to carry out a ventouse delivery, which was started at 4.15pm. This was recorded as a “difficult delivery”, but no other documentation was made. The 3.9kg baby girl was delivered at 4.35am with an Appgar score of 3 at one minute after birth, and 5 at five minutes. The cord gases showed severe metabolic acidosis with a pH 6.9 and BE-18 (arterial). The paediatricians were called subsequently, and the baby was transferred to NICU. Although the baby survived, she had significant hypoxic ischaemic encephalopathy and severe cerebral palsy as a result.

Mrs G made a claim against Dr A and his team for their failure to adequately monitor her baby and recognise signs of fetal distress. This lack of communication between the teams and lack of recognition of the severity of the condition resulted in the infant having severe cerebral palsy, requiring lifelong care.

The claim was settled for a substantial sum.

Learning points
• NICE has published useful guidelines on the diagnosis and management of critical limb ischaemia. It suggests that if the limb is still viable after the first procedure and there is evidence of reflow, then another procedure should be considered. If the limb is not viable following this, then an amputation may well have been avoided.
• If there is an amputation, then the communication of the findings with the patient should be reviewed by the doctor before synchocin is prescribed, before this is done because there is the risk of amniotic fluid embolism. The patient should be fully advised on an individual basis, i.e., sign of fetal distress, the frequency and severity of the contractions, previous obstetric history etc.
• If there is any delay in a patient being assessed by one example of a team, seek advice from a higher level to get this expedited (e.g., supervisor of midwives, consultant).

When things go wrong it is rarely because of a single isolated event. It is often a sequence of events that occur before an accident happens.

Although the mother and the baby were “safely delivered” throughout the whole labour, the expert witnesses felt that there was significant substandard care in the instigation of the syntocinon and the communication of the findings with the doctor involved.

In this case, the handover was poor throughout. A clear handwritten note in a nuchal paper may be a useful way of ensuring good communication and effective handover between health professionals and teams.

All verbal advice about the proposed procedure was documented in the notes, but there was insufficient documentation of the nature, position of suction cup over the flexion point on the occiput, course of the spine, and position of the baby in the delivery. In this case, the baby had to be transferred directly to NICU before appropriate resuscitation was started.

Learning points
• NICE has published useful guidelines on the diagnosis and management of critical limb ischaemia. It suggests that if the limb is still viable after the first procedure and there is evidence of reflow, then another procedure should be considered. If the limb is not viable following this, then an amputation may well have been avoided.
• If there is an amputation, then the communication of the findings with the patient should be reviewed by the doctor before synchocin is prescribed, before this is done because there is the risk of amniotic fluid embolism. The patient should be fully advised on an individual basis, i.e., sign of fetal distress, the frequency and severity of the contractions, previous obstetric history etc.
• If there is any delay in a patient being assessed by one example of a team, seek advice from a higher level to get this expedited (e.g., supervisor of midwives, consultant).

When things go wrong it is rarely because of a single isolated event. It is often a sequence of events that occur before an accident happens.

Although the mother and the baby were “safely delivered” throughout the whole labour, the expert witnesses felt that there was significant substandard care in the instigation of the syntocinon and the communication of the findings with the doctor involved.

In this case, the handover was poor throughout. A clear handwritten note in a nuchal paper may be a useful way of ensuring good communication and effective handover between health professionals and teams.

All verbal advice about the proposed procedure was documented in the notes, but there was insufficient documentation of the nature, position of suction cup over the flexion point on the occiput, course of the spine, and position of the baby in the delivery. In this case, the baby had to be transferred directly to NICU before appropriate resuscitation was started.

The patient should be reviewed by the doctor before synchocin is prescribed, before this is done because there is the risk of amniotic fluid embolism. The patient should be fully advised on an individual basis, i.e., sign of fetal distress, the frequency and severity of the contractions, previous obstetric history etc.

If there is any delay in a patient being assessed by one example of a team, seek advice from a higher level to get this expedited (e.g., supervisor of midwives, consultant).

When things go wrong it is rarely because of a single isolated event. It is often a sequence of events that occur before an accident happens.

Although the mother and the baby were “safely delivered” throughout the whole labour, the expert witnesses felt that there was significant substandard care in the instigation of the syntocinon and the communication of the findings with the doctor involved.

In this case, the handover was poor throughout. A clear handwritten note in a nuchal paper may be a useful way of ensuring good communication and effective handover between health professionals and teams.

All verbal advice about the proposed procedure was documented in the notes, but there was insufficient documentation of the nature, position of suction cup over the flexion point on the occiput, course of the spine, and position of the baby in the delivery. In this case, the baby had to be transferred directly to NICU before appropriate resuscitation was started.
A baby was born by caesarean section at 27 weeks gestation. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first four hours of life, the baby’s oxygen saturations were recorded as ranging between 96-97%. A blood gas taken five hours after delivery showed a pH of 7.68 (normal 7.3-7.4), a PaO2 of 95.3 kPa (normal 6-10), a PaCO2 of 35.8 kPa (normal 5-8) and a bicarbonate level of 2.6 mmol/L (normal 4.5-6.0). This was concerning because the baby was being over-ventilated.

The baby was ventilated for three days, placed on continuous positive airway pressure (CPAP), and then placed on 0.5% nasal cannula oxygen due to recurrent apnoeic spells. Overall the baby received 204 hours of oxygen with oxygen saturation levels of 96-100% throughout.

The baby was not referred at four to six weeks of age for retinopathy of prematurity (ROP) screening, and was first seen by an ophthalmologist at the age of seven months when a diagnosis of diabetes mellitus type 1 (DM1) causing blindness, was made. The baby’s parents made a claim against the consultant paediatrician who handled the baby’s care.

EXPERT OPINION

The baby had inappropriately high oxygen saturation levels and PaO2 levels for a period of 204 hours. During oxygen administration to premature infants, very high blood oxygen levels can develop if saturation levels rise above 96%. Weaning of the Fraction of Inspired Oxygen (FiO2) seldom occurred despite oxygen saturation levels of between 96% and 100%, indicating that the nursing staff had no protocol for weaning of oxygen according to oxygen saturation.

There was no record that an ophthalmological appointment for the screening of ROP was made at the recommended four to six weeks of age. The baby developed severe ROP and blindness due to excessive oxygen administration. The opportunity to limit the condition and save the infant’s vision was missed due to the fact that the child was not referred for screening for ROP.

There was negligence on the part of the paediatrician and nursing, in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a four-day period, and for not referring the child at the appropriate time for an eye examination.

The case was settled for a substantial sum.
Miss A, a 40-year-old IT consultant, was talking to a colleague at work when she developed a headache, along with blurred vision and nausea. Her symptoms worsened as an ambulance was called. In the Emergency Department (ED), Miss A was triaged as moderate urgency and examined by Dr X who recorded that her head felt “heavy” at work and she’d felt herself breaking out in a cold sweat, with a throbbing frontal headache radiating to each temple.

The notes describe Miss A lying on a trolley covering her eyes with her hands, with temperature of 35.4, blood pressure 133/96, pulse rate 58/min, and tenderness over her temporal muscles. Her neurological examination was essentially normal. Kernig’s sign was negative and she had no sinus tenderness or neck stiffness. There was no past medical history of migraine or family history of note. She was given IM metoclopramide and diclofenac.

A record followed of a telephone discussion with another doctor, who requested that Miss A have hourly neurological observations, be given analgesia and reviewed in the emergency observation unit. Miss A received intravenous fluid and analgesia. She had a normal full blood count, electrolytes, liver function tests, bone profile and c-reactive protein. ESR was mildly raised at 30mm/hr. Two hours later, Miss A was assessed and, although the headache was still present, she was feeling better and the blurred vision and dizziness had resolved. The raised ESR was noted with a comment that it was unlikely to represent giant cell arteritis. Following a diagnosis of migraine headache, she was discharged with analgesia and advised to return if the symptoms worsened.

Two days later, Miss A returned to work, though she still had the headache and preferred to be in a dark room. The next week she attended her GP, Dr X, who listened about her history and read the hospital letter, noting that Miss A had no sinus tenderness or neck stiffness. There was no past medical history of migraine or family history of note. She was given IM metoclopramide and diclofenac.

Miss A phoned to report that her headache was much better. Dr X recorded a discussion about a possible ophthalmology opinion and follow-up.

Over the next three weeks, Miss A continued to have a headache, which varied in severity. She didn’t seek further medical advice because she expected the headache to pass, after being investigated at hospital and attending her GP. Her partner said later she had no reason to doubt the advice she had been given.

One month after the headache started, Miss A left work early because of another severe headache. While brushing her teeth, she lost consciousness and collapsed. She vomited twice before an ambulance took her to the ED where, on arrival, her GCS was 12/15. Resuscitation was attempted but following a CT scan of her brain, she died. The scan confirmed a large subarachnoid haemorrhage involving the 3rd and 4th ventricles on the left side and a frontal intracerebral haemorrhage.

A claim was made, alleging delay in referring Miss A, resulting in late diagnosis of subarachnoid haemorrhage from which she died. Allegedly, Dr X had failed to notice the ED records, which showed a history of sudden onset headache. He did act cautiously and refer Miss A for investigations for suspected SAH. After considering the possibility of a vascular anomaly, he did not act and hadn’t arranged an urgent hospital admission and investigations. He’d made an unreasonable diagnosis of migraine with respect to Miss A’s age and symptoms.

The claim also alleged that the hospital had failed to establish Miss A’s subarachnoid haemorrhage and hadn’t reviewed her appropriately in the ED.

Learning points
- It is important to be prepared to reject a colleague’s diagnosis, particularly if the patient’s condition has changed. In this case, Dr X was misled by the diagnosis made at the hospital, where the necessary investigations did not take place. He’d planned to wait before arranging referral for an expert GP instructed by MPS, but the patient’s condition has changed. He’d made an unreasonable diagnosis of migraine and reinforced the diagnosis. Miss A had work stress, which may have precipitated a migraine and reinforced the diagnosis. Migraines usually present as unilateral headaches, but bilateral headaches can also occur. Miss A’s headache was frontal to begin with and then bi-temporal when she attended Dr X. Although she had no history of aura, migraines without aura are more common. In Dr X’s opinion, it did not matter that Miss A had no past history of migraine – not all patients are aware they may have experienced migraines in the past.
- The claim was settled against both Dr X and the hospital for a moderate sum.
Mr M, a 44-year-old architect, attended his GP, Dr C, for a skin check. Dr C diagnosed a papilloma on the left arm. Mr M noted a “large crusty seborrhoeic wart with almost black hard surface and a small area warty texture”. There was no catching or bleeding and Dr B discussed removal with Mr M only “if it was a nuisance.”

The following month, a third doctor in the practice, Dr A, saw Mr M and referred him to the practice’s minor surgery clinic for removal of the lesion.

A month later, Mr M returned to the GP practice about the skin lesion – it had increased in size and was bleeding. Dr A prescribed flucloxacillin as he felt the lesion had been infected. Mr M was referred urgently to the dermatologist. Dr B advised the lesion as malignant sooner.

Mr M’s widow made a claim against the doctors at the practice for failing to diagnose the lesion as malignant sooner.

**Expert Opinion**

Claimant expert opinion was critical of the standard of care provided and felt that Mr M should have been referred straight away, rather than three months after the initial presentation. They also felt the earlier description of the lesion was not adequate or detailed enough, quoting NICE guidelines. They stated the clinician did not follow the guidelines and hence the diagnosis was missed.

Mr M had been referred to the dermatologist. Dr A maintained he had referred the lesion as malignant sooner.

**Learning Points**

- Whenever a patient presents with a skin lesion, apply appropriate guideline checklists to help diagnose the lesion.
- Describe the lesion carefully, including the location, size, shape, texture, and color.
- Be suspicious of lesions that change rapidly or persist for more than a few weeks.
- Always consider the possibility of a malignant lesion, especially in patients with a history of skin cancer.
- Follow up with patients who have had lesions removed to ensure there is no recurrence.

**Case Reports**

**FATAL CONDITION**

**Specialty General Practice **

**Theme Successful Defence**

Mr J, a 62-year-old housewife, did not visit her GP often. However, she consulted Dr D with a two-week history of cough and fever. She was otherwise fit and well, but for the previous fortnight she reported lethargy, body aches and a cough productive of green sputum. Dr D recorded a temperature of 39°C with a pulse of 102, respiratory rate of 24 and oxygen saturation levels of 95%. Despite a lack of chest signs on auscultation, he commenced treatment for a lower respiratory tract infection, prescribing co-amoxiclav and clariromycin, which the patient had taken in the past without problems.

The following day Mrs J felt worse than before and her husband requested a visit at home. This time she was seen by Dr A, who found no fever and surface continued and she now had a sore throat and a rash. Her husband mentioned that she had been confused through the night and had been hallucinating. Dr A measured her temperature at 40.5°C and found her throat to be red and swollen with bilateral exudates. He documented a blanching rash on her chest and back, which appeared to be erythema multiforme. He also noted bilateral conjunctivitis, for which he started chloramphenicol. Since she also complained of thirst, Dr A added campaign to her script and advised Mrs J to give the antibiotics to control her fever.

Mrs J continued to deteriorate and the following morning she called the surgery. She reported pain in the chest and she was now unable to swallow any medication due to her sore throat. The rash and fever were ongoing. Dr C converted the paracetamol and antibiotics to a dispersible form and advised the patient to seek medical attention if the fever persisted once she managed to swallow her medications.

Mr D advised that Mrs J was febrile, hallucinating and had a widespread rash. Dr A maintained that she had been confused and manoeuvred the patient but felt that hospital admission would not have changed the patient’s treatment at this point. It was unclear whether the Stevens-Johnson syndrome was drug-induced and expert opinion agreed that it was reasonable for Dr D to have commenced antibiotics in a patient with an unknown history of drug allergy, who had been given both of the medications in the past without problems. It proved difficult to speculate on whether or not earlier withdrawal of these medications would have affected Mrs J’s outcome.

MPS served a detailed letter of response, defending the claim on a causation basis. As a result, the case was discontinued.

Learning Points

- Stevens-Johnson syndrome is a rare but potentially fatal condition, usually triggered by drugs or infection. Useful summaries and videos of the condition can be accessed here for medicolegal updates.
- www.patient.co.uk/doctors/stevens-johnson-syndrome
- Learning points is available here. This provides further information on the course of action.
- Take care to revisit the earlier diagnosis of another doctor, especially if the condition was not one that he or she dealt with regularly. There may be some important variation in treatment.
- Whether or not to administer corticosteroids, and when.
- Whether the Stevens-Johnson syndrome was drug-induced and expert opinion agreed that it was reasonable for Dr D to have commenced antibiotics in a patient with an unknown history of drug allergy, who had been given both of the medications in the past without problems. It proved difficult to speculate on whether or not earlier withdrawal of these medications would have affected Mrs J’s outcome.

**Case Reports**

**MALIGNANT LESION**

**Specialty General Practice**

**Theme Successful Defence**

One month later, in March, Mr M underwent wide excision and axillary dissection, but his condition deteriorated. Unfortunately, he had developed brain metastasis by April and stage 4 malignant melanoma. He died in July of progressive metastatic disease, despite chemotherapy and radiation therapy.

Mr M’s widow made a claim against the doctors at the practice for failing to diagnose the lesion as malignant sooner.

**Expert Opinion**

Claimant expert opinion was critical of the standard of care provided and felt that Mr M should have been referred straight away, rather than three months after the initial presentation. They also felt the earlier description of the lesion was not adequate or detailed enough, quoting NICE guidelines. They stated the clinician did not follow the guidelines and hence the diagnosis was missed.

Mr M had been referred to the dermatologist. Dr A maintained he had referred the lesion as malignant sooner.

**Learning Points**

- Whenever a patient presents with a skin lesion, apply appropriate guideline checklists to help diagnose the lesion.
- Describe the lesion carefully, including the location, size, shape, texture, and color.
- Be suspicious of lesions that change rapidly or persist for more than a few weeks.
- Always consider the possibility of a malignant lesion, especially in patients with a history of skin cancer.
- Follow up with patients who have had lesions removed to ensure there is no recurrence.

**FATALLY ENDANGERED**

**Specialty General Practice**

**Theme Successful Defence**

Mr J underwent wide excision and axillary dissection, but his condition deteriorated. Unfortunately, he had developed brain metastasis by April and stage 4 malignant melanoma. He died in July of progressive metastatic disease, despite chemotherapy and radiation therapy.

Mrs J’s widow made a claim against the doctors at the practice for failing to diagnose the lesion as malignant sooner.

**Expert Opinion**

Claimant expert opinion was critical of the standard of care provided and felt that Mrs J should have been referred straight away, rather than three months after the initial presentation. They also felt the earlier description of the lesion was not adequate or detailed enough, quoting NICE guidelines. They stated the clinician did not follow the guidelines and hence the diagnosis was missed.

Mrs J had been referred to the dermatologist. Dr A maintained he had referred the lesion as malignant sooner.

**Learning Points**

- Whenever a patient presents with a skin lesion, apply appropriate guideline checklists to help diagnose the lesion.
- Describe the lesion carefully, including the location, size, shape, texture, and color.
- Be suspicious of lesions that change rapidly or persist for more than a few weeks.
- Always consider the possibility of a malignant lesion, especially in patients with a history of skin cancer.
- Follow up with patients who have had lesions removed to ensure there is no recurrence.

**Case Reports**

**MALIGNANT LESION**

**Specialty General Practice**

**Theme Successful Defence**

Mr M, a 44-year-old architect, attended his GP, Dr C, for a skin check. Dr C diagnosed a papilloma on the left arm. Mr M noted a “large crusty seborrhoeic wart with almost black hard surface and a small area warty texture”. There was no catching or bleeding and Dr B discussed removal with Mr M only “if it was a nuisance.”

The following month, a third doctor in the practice, Dr A, saw Mr M and referred him to the practice’s minor surgery clinic for removal of the lesion.

A month later, Mr M returned to the GP practice about the skin lesion – it had increased in size and was bleeding. Dr A prescribed flucloxacillin as he felt the lesion had been infected. Mr M was referred urgently to the dermatologist. Dr B advised the lesion as malignant sooner.

Mr M’s widow made a claim against the doctors at the practice for failing to diagnose the lesion as malignant sooner.

**Expert Opinion**

Claimant expert opinion was critical of the standard of care provided and felt that Mr M should have been referred straight away, rather than three months after the initial presentation. They also felt the earlier description of the lesion was not adequate or detailed enough, quoting NICE guidelines. They stated the clinician did not follow the guidelines and hence the diagnosis was missed.

Mr M had been referred to the dermatologist. Dr A maintained he had referred the lesion as malignant sooner.

**Learning Points**

- Whenever a patient presents with a skin lesion, apply appropriate guideline checklists to help diagnose the lesion.
- Describe the lesion carefully, including the location, size, shape, texture, and color.
- Be suspicious of lesions that change rapidly or persist for more than a few weeks.
- Always consider the possibility of a malignant lesion, especially in patients with a history of skin cancer.
- Follow up with patients who have had lesions removed to ensure there is no recurrence.
He described two months of symptoms, occurring up to six times per week, mainly in the mornings and associated with nausea. Dr P took a thorough history and neurological examination, including fundoscopy. He excluded alcohol, stress or carbon monoxide poisoning as potential precipitants, and found no other “red flag” symptoms. He mentioned that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded and referred him for an early neurological opinion.

As part of his examination, Dr P checked Mr H’s blood pressure and found it to be elevated. Mr H was arranged with the practice nurse a few days later and this had reduced to 132/72. No further action was taken.

Mr H was seen by neurologist Dr B some six months after his initial GP presentation, and underwent an MRI scan. The scan was normal and Dr B advised Mr H that his headaches were likely to be related to muscle tension.

Mr H didn’t see Dr P again for another two years. When he re-presented to Dr P, it was noted that his blood pressure was in the normal range for an MSU and bloods to be taken (CPK, LFTs, PV and PSA) and commenced sumatriptan for migraines as a new diagnosis. Blood pressure was not checked. Mr H was reviewed the following week and investigations were all normal. His headache also appeared to have improved.

Three months later, Mr H returned about his headaches again. He felt sumatriptan had been successful. His blood pressure was recorded as 130/90 on this occasion, and when repeated a week later was still elevated at 136/120. Lisinopril was started at 10mg once daily. This was continued until he saw Dr P again four months later with symptoms of a UTI. Blood pressure was documented as 150/96 and lisinopril was doubled to a dose of 10mg daily.

Time went on, and apart from a blood pressure check with the practice nurse every couple of months, Mr H was not followed up until seven months later when he was called in for some routine blood tests. His renal function was notably impaired with a serum creatinine of 262 umol/l, an eGFR of 20 ml/min and a urea of 173 mmol/l. Investigations were initiated (renal USS was normal) and he was reviewed by consultant nephrologist Dr C. Dr C made note of recurrent LFTs during Mr H’s childhood and his hypertension, and concluded that reflux nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly.

Further noted that the main tool available to delay renal deterioration is optimal control of blood pressure, using renal protective drugs like the lisinopril Mr H was given.

Mr H made a claim against Dr P for alleged breach of duty – stating that renal function could have been tested on several occasions; Mr H also claimed for causation, stating that had renal function been tested when he first presented with headaches, then he would have been diagnosed as a few stages earlier, which would have allowed him to retain his renal function by a judicious use of medication and diet.

Mr H subsequently discontinued his claim.

Mr H is a 45-year-old solicitor and father of three, visited his GP Dr P with a persistent headache. His blood pressure was recorded as 180/100 on this occasion, and when repeated a week later was still elevated at 165/120. Lisinopril was started at 10mg once daily. This was continued until he saw Dr P again four months later with symptoms of a UTI. Blood pressure was documented as 150/96 and lisinopril was doubled to a dose of 10mg daily.

Time went on, and apart from a blood pressure check with the practice nurse every couple of months, Mr H was not followed up until seven months later when he was called in for some routine blood tests. His renal function was notably impaired with a serum creatinine of 262 umol/l, an eGFR of 20 ml/min and a urea of 173 mmol/l. Investigations were initiated (renal USS was normal) and he was reviewed by consultant nephrologist Dr C. Dr C made note of recurrent LFTs during Mr H’s childhood and his hypertension, and concluded that reflux nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly.

Further noted that the main tool available to delay renal deterioration is optimal control of blood pressure, using renal protective drugs like the lisinopril Mr H was given.

Mr H made a claim against Dr P for alleged breach of duty – stating that renal function could have been tested on several occasions; Mr H also claimed for causation, stating that had renal function been tested when he first presented with headaches, then he would have been diagnosed as a few stages earlier, which would have allowed him to retain his renal function by a judicious use of medication and diet.

Mr H subsequently discontinued his claim.
Miss C, a 30-year-old accountant, developed an asymptomatic left neck lump. CT revealed a 23 x 17 x 27mm mass at the carotid bifurcation consistent with a carotid body tumour. Miss C’s carotid angiogram by Professor A for “radical excision of left carotid body tumour”. During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 3.1 litres. Professor A arranged an urgent MRI scan. This revealed a 23 x 17 x 27mm mass at the carotid bifurcation consistent with a carotid body tumour. Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also assumed that while anti-coagulation may have prevented thrombus formation, such a high dose of anti-coagulation carries its own additional risks. The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to postoperative toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C’s stroke may have led to a worse neurological outcome. However, the main focus of criticism centred on the consent process. Experts expressed concern that Professor A failed to inform Mrs Bowen of the risks of surgery and Professor A handled the consent process in an inappropriate manner. Although questioning the need for three periods of carotid clamping was felt to be within the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks. Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate. The case was settled for a high sum, reflecting the severe neurological outcome and the need for continuous care.

**EXPERT OPINION**

Miss C’s family felt the process had been rushed and that she had not fully understood the magnitude of the risks of surgery. Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

The case was settled for a high sum, reflecting the severe neurological outcome and the need for continuous care.

**EXPERT OPINION**

Professor A argued that arterial bleeding from excision of a carotid body tumour is a well-recognised and inherent potential risk of such surgery and Professor A handled this complication in an appropriate and timely manner. Although questioning the need for three periods of carotid clamping was felt to be within the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks.

Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also assumed that while anti-coagulation may have prevented thrombus formation, such a high dose of anti-coagulation carries its own additional risks.

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to postoperative toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C’s stroke may have led to a worse neurological outcome. However, the main focus of criticism centred on the consent process. Experts expressed concern that Professor A failed to inform Mrs Bowen of the risks of surgery and Professor A handled the consent process in an inappropriate manner. Although questioning the need for three periods of carotid clamping was felt to be within the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks.

Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also assumed that while anti-coagulation may have prevented thrombus formation, such a high dose of anti-coagulation carries its own additional risks.

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to postoperative toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C’s stroke may have led to a worse neurological outcome. However, the main focus of criticism centred on the consent process. Experts expressed concern that Professor A failed to inform Mrs Bowen of the risks of surgery and Professor A handled the consent process in an inappropriate manner.

During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 3.1 litres. Professor A arranged an urgent MRI scan. This revealed a 23 x 17 x 27mm mass at the carotid bifurcation consistent with a carotid body tumour. Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also assumed that while anti-coagulation may have prevented thrombus formation, such a high dose of anti-coagulation carries its own additional risks. The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to postoperative toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C’s stroke may have led to a worse neurological outcome. However, the main focus of criticism centred on the consent process. Experts expressed concern that Professor A failed to inform Mrs Bowen of the risks of surgery and Professor A handled the consent process in an inappropriate manner. Although questioning the need for three periods of carotid clamping was felt to be within the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks. Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate. The case was settled for a high sum, reflecting the severe neurological outcome and the need for continuous care.

**EXPERT OPINION**

The family of Miss C initiated proceedings against Professor A and Dr B, as they were critical of numerous aspects of their care.

**OVER TO YOU**

I am emailing to say thank you for publishing the heart-wrenching story of little Beth Bowen in the September edition of Casebook.

Please help me raise awareness.

The story of Beth Bowen as narrated by her mother, in Casebook (2014) 22(3): pp 10-11. I wish to express my deepest sympathy to the Bowen family and concur with Mrs Bowen that the medical profession fell short of expectations in this case and much needs to be done.

The irony was that the child would not have died 30 years before, with the widespread introduction of laparoscopic surgery. If she had open splenectomy, a properly qualified surgeon could have completed the operation with minimal risk. Even if a major blood vessel is torn, it could have been handled without delay. Laparoscopic surgery denies the surgeon the important faculty of tactile sensation and stereoscopic vision. It also denies the surgeon rapid response to accidental tear of major blood vessels and organs as illustrated in this case. Worst of all, it opens a floodgate and permits the introduction of high risk instruments like the morcellator, which has killed other patients, including adults. And it is not young surgeons that are dangerous; senior surgeons trained in the open classical procedures are even more dangerous if they try their hands on laparoscopic procedure without proper retraining.

It is important to have a small scar that we should compromise safety standards?

**Dr John SM Leung, FRCS, Hong Kong**
MISS EDUA EQUINA
You report a case of a GP missing a cauda equina syndrome in a patient with a slipped disc (page 17, Casebook September 2014). I do not believe this is within the expertise of a GP and is not even within the expertise of many specialists. I have seen several of these cases not from slipped disc but from anaesthesia either by inserting a needle into the lumbar spine or from the insertion of a plastic catheter to anaesthetise the abdomen or legs. Most anaesthetists claim the procedure is harmless and that “soft” catheters can’t harm. It may be rare but it is completely false to assume it is harmless.

HIGH EXPECTATIONS
I am rather puzzled by “High Expectations”, on pages 22 to 23 of the September 2014 issue. From the description of the case, it sounds very likely that this was indeed a case of post viral fatigue syndrome (also known as Myalgic encephalomyelitis or chronic fatigue syndrome). No diagnosis is given on the first page. There appears to be no possible diagnosis of chronic fatigue or what management was given for the condition.

Post viral fatigue syndrome is a common condition probably affecting about 1% of the population. It is not difficult to diagnose as there are clear diagnostic criteria available today and it would be interesting to know whether this patient fitted the diagnostic criteria or not. They did seem so bizarre to doctors that I feel a misdiagnosis would be unlikely if the criteria were properly used. In addition, in the following paragraph it is stated that the patient “…was convinced that there was a physical cause for his symptoms…”, as if this rebutted the specialist opinion. However, it is well-known today that chronic fatigue is indeed an organically-based physical condition. The was clearly shown at the last conference of 2014 in the United States and it is no longer considered acceptable to consider a non-organic cause for a physical condition. It is probably a chronic encephalitis but this has not been definitely proven. There is management available for chronic fatigue syndrome.

In my opinion, it is indeed negligent to miss this diagnosis in a patient who fits the criteria for it (L. G. Caruthers et al 2003 and 2011 – these are the criteria). In addition the patient’s prognosis can be adversely affected if proper management including management of activity scheduling is not instituted as soon as possible.

Unfortunately, at least in South Africa, this disease now occupies the same space as mental illnesses did in the dark ages and as multiple sclerosis did at the turn of the last century (‘Faker’s Disease’). Patients generally do not have the energy or financial means to pursue their cases against doctors regarding diagnosis but in my opinion it certainly should be a source of litigation because of the poor diagnostic skills of most practitioners. From a diagnostic point of view, the ignorance about management and the stigma which doctors attach to this disease, greatly increases the significant suffering of patients.

Dr Elizabeth Murray, Roundbosch Medical Centre, Medlicine, Constantiaberg, UCT Private Academic Hospital, South Africa

THE ELUSIVE DIAGNOSIS
Re: “The elusive diagnosis”, Casebook September 2014: I am very surprised from the evidence given that the claim for late diagnosis of diabetes (presumably mellitus) was successfully defended. The failure to test the plaintiffs urine is inexcusable.

Many years ago the late Professor Peter Jackson estimated that in Cape Town there were an estimated 20,000 asymptomatic people with undiagnosed diabetes mellitus. Since then the provincial facility at which I used to practise has tested the urine of every new and return patient for glucose et al. We were newly diagnosing two to three diabetes mellitus patients every week.

Dr Stephen A Crensen, Hon Lecturer in Family Medicine, University of Cape Town, South Africa

I read “The elusive diagnosis” (Casebook 22(9), September 2014) with great interest, in particular the mention during two presentations of ‘symptoms’, described as “sore scratch on L side of penis” and “a rash on the gums penis”.

Some years ago I submitted with a medical student a paper to the BMJ in the hope it would be published as “Lesson of the week”. We reported case histories of four men, aged 26, 34, 40 and 51 years, who presented to our department of geriatric medicine in the month of July 2008 and were found on examination to have balanoposthitis, while three of them also had fossuring of the penis skin. All gave a history of or had a tight prepuce at presentation. None here is that of a responsible body of general practitioners, and not any higher or different, standard. It is also the case that where there might be more than one school of thought on a particular issue, a doctor will not be negligent for choosing one over the other. As long as the option he chooses is supported by a responsible body of practitioners, skilled in that particular specialty, even if that is a minority opinion.

In this case, the claimant withdrew their claim before the matter came to court, which generally indicates that their solicitor did not consider this option to be a viable one. Hence the claimant has advised them that their case is unlikely to succeed.

Of course, medicine is constantly changing and advancing, and what would have been acceptable practice five years ago may no longer be supportive. In the context of medical negligence litigation, the standard which applies is, of course, that which applied at the time in question.

Thank you once again for your comments.

REFERENCES
1. Hershfield M, Dahlen CP, Phimosis with balanoposthitis in Type 1 diabetes (presumably mellitus) was successfully defended. The failure to test the plaintiffs urine is inexcusable. Many years ago the late Professor Peter Jackson estimated that in Cape Town there were an estimated 20,000 asymptomatic people with undiagnosed diabetes mellitus. Since then the provincial facility at which I used to practise has tested the urine of every new and return patient for glucose et al. We were newly diagnosing two to three diabetes mellitus patients every week.

Dr Mike Witzman, Consultant in Gerontourinary Medicine, George Elliot Hospital, Hove, UK

Thank you once again for your comments about this case.

The chronology of the symptoms relating to the skin in this case was a sore scratch to the penis (possibly infected) in June 2006, and of a rash on the hand and penis eight months later, in February 2007.

Whether a doctor would be considered negligent in not considering diabetes in such circumstances revolves around whether the actions would be supported by a responsible body of medical opinion, skilled in the relevant specialty.

In this case, the relevant specialty is general practice, and the GP expert instructed by MPS was supportive of our member’s actions.

It is important to realise that where there might be differing views as to the appropriate steps to take in an individual case, a doctor is not negligent for choosing one option over another, as long as the option he or she chooses would be supported by a responsible body of opinion.

It was on the basis of the supportive opinion that MPS decided to defend the case.

Subsequently, the claimant discontinued his case, presumably on the advice of his solicitors and any expert opinions they had obtained.

CORRECTION
The following correction relates to a photo accompanying the case “A canula complication” in the previous issue of Casebook. Our photographs are taken from stock image libraries and are chosen to reflect the general theme of an article or case. Here, the case related to the potential risks associated with cannulation, specifically necrotic damage to the radial nerve, and the image was chosen to reflect that theme. In this case a picture of venous cannulation would have been better, and we apologise for any confusion caused by this error.

Response (to both letters): Thank you for your correspondence about this case.

The following correction relates to a photo accompanying the case “A canula complication” in the previous issue of Casebook. Our photographs are taken from stock image libraries and are chosen to reflect the general theme of an article or case. Here, the case related to the potential risks associated with cannulation, specifically necrotic damage to the radial nerve, and the image was chosen to reflect that theme. In this case a picture of venous cannulation would have been better, and we apologise for any confusion caused by this error.
REVIEWS

BEING MORTAL
Atul Gawande

Review by Dr Sam Dawson (Specialty trainee, Anaesthetics, Northern Ireland)

Atul Gawande barely needs an introduction. He is the author of three bestselling books, winner of multiple awards for writing and Professor at Harvard Medical School. He was also a key figure in the implementation of the WHO checklist revolution.

His new book Being Mortal is a compassionate yet unflinching look at what mortality means in the 21st century. In it he explores the way in which modern medicine is letting our patients down at the ends of their lives whether in nursing homes, hospitals or hospices. At the same time, he reveals the people and institutions redeeming medicine and into a new career. In the second part of the book, Gawande searches outside herself, wondering if there were external factors that played a role in her decision to leave. She interviews others with various experiences in medicine as a way of providing perspective on her own story.

I found reading the first part of the book laborious, although I was interested in her childhood and high school years. From then on the cliches and anecdotes were unoriginal to my ears, although these do provide, for the general public, one account of what practising medicine in the public sector can be like.

The second part was far more enlightening. I enjoyed reading the interviews she conducted with those who have either left clinical medicine, or are still practising. For comedian Raad Moosa, it was a natural progression away from medicine and into comedy. For Nina (pseudonym), it was the combination of clinical depression and being a junior doctor in the South African public health sector. This second part of the book highlighted common factors that played a role in her decision to leave. She interviews others with various experiences in medicine as a way of providing perspective on her own story.

I read most of this book in my on-call room, pausing to attend the critically ill in the wards, theatre and emergency department in which I work. This added extra poignancy to what is already an emotional, compelling and challenging book. It isn't perfect – at times the interlinking of stories is disorientating and the section on assisted dying appears somewhat tacked on. However, this book is for anyone who has ever stared speechlessly into the eyes of someone who knows they are dying, or who has had the difficult task of counselling their relatives. In fact, it is for anyone who wants to live well, help others live well and, in the end, die as well as they can.

What would a new era of ingenuity, empathy and dignity look like for our patients as they approach the end of their lives? It is obvious Gawande is not entirely sure, but in Being Mortal he is asking the right questions and exploring novel solutions to a situation we desperately need to improve.

POSTMORTEM: THE DOCTOR WHO WALKED AWAY
Maria Phalime

Review by Dr Anand Naranbhai (Specialty trainee, Anaesthetics, Western Cape, South Africa)

After practising clinical medicine for four years, Maria Phalime decided to stop. Postmortem: The Doctor Who Walked Away tells the story of her search for an explanation and provides a useful commentary on the profession.

The book is divided into two parts. In the first part, Phalime searches within herself for reasons why she left. She tells of her life growing up in Soweto and her life in the general public, one account of what practising medicine in the public sector can be like.

In the end, Phalime's decision to leave is multifaceted. She concludes: “It was tough, it was sad, and I left, that's all.” She practised medicine during the dark age of HIV-denialism, and in the often frustrating, pressured and disheartening South African public health sector.

There is a bigger lesson in the book: an interview with Stellenbosch University Dean of Health Sciences, Professor Jimmy Volmink, Phalime is told: “We are all on a journey, and sometimes that journey takes us overseas, into the private sector, or even out of the profession altogether. People have got to be allowed to take that journey.” Phalime is on her journey, each of us is on our own, and for our patients, maybe the point of what we do by caring for their health, is to give them an opportunity to take their own journey.
How to contact us

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

www.medicalprotection.org
www.dentalprotection.org

Please direct all comments, questions or suggestions about MPS service, policy and operations to:
Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

info@medicalprotection.org

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

UK MEDICO LEGAL ADVICE
Tel 0800 561 9090
Fax 0113 241 0500
querydoc@medicalprotection.org

UK MEMBERSHIP ENQUIRIES
Tel 0800 561 9000
Fax 0113 241 0500
member.help@medicalprotection.org

MPS is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.
The Medical Protection Society Limited. A company limited by guarantee. Registered in England No. 36142 at 33 Cavendish Square, London, W1G 0PS

www.medicalprotection.org