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Medical
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CASEBOOK

HANDLING A MEDICAL COUNCIL COMPLAINT

HOW WE CAN HELP YOU THROUGH THE PROCESS
PAGE 8

CELEBRATING
125 YEARS
OF MPS

CELEBRATING
25 YEARS
OF CASEBOOK

This issue...

BACK TO BASICS

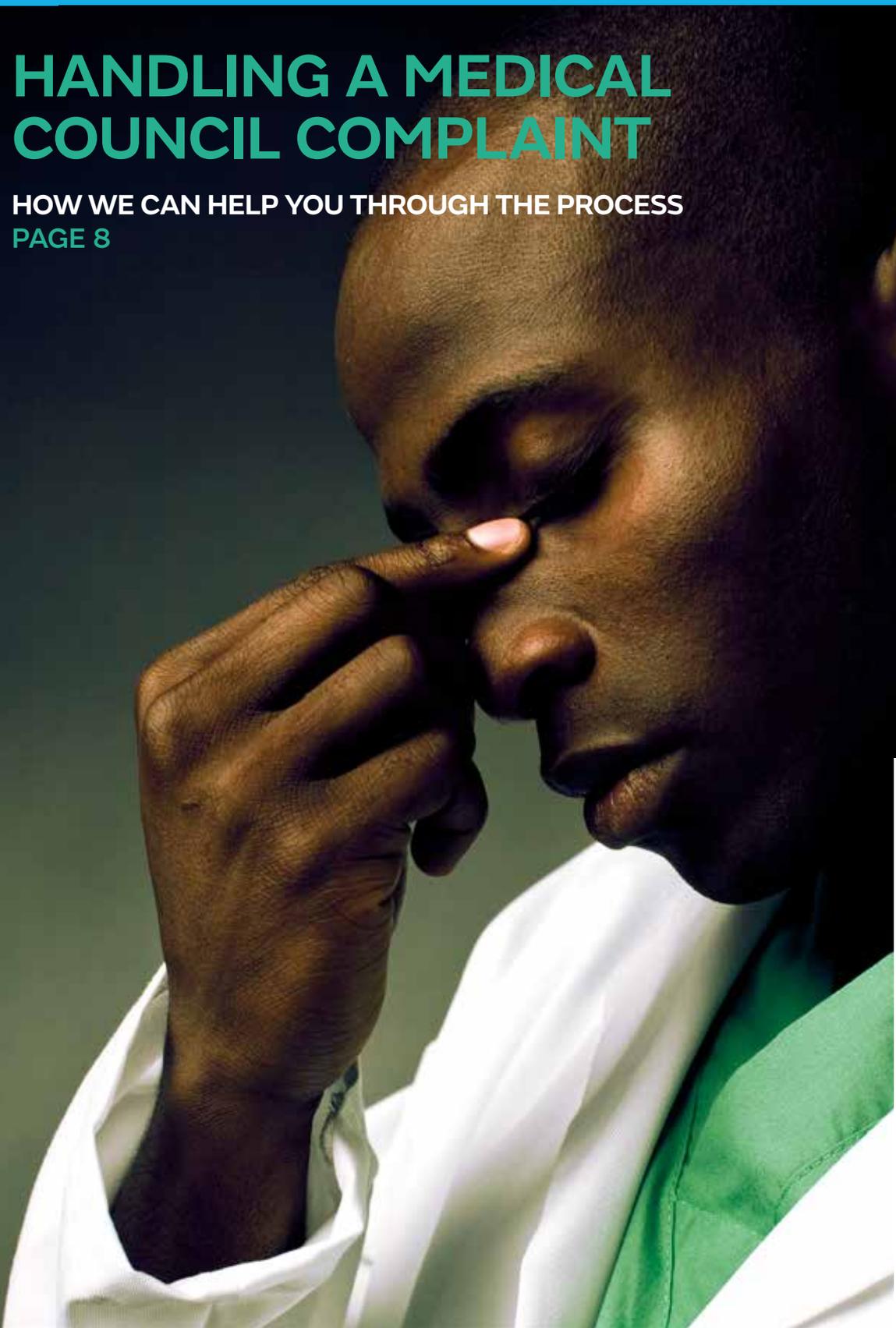
A patient repeatedly attends his GP with worsening back pain

REPORTED ABUSE

A child makes an allegation of abuse

A FRIEND IN NEED

A patient suffers complications during spinal surgery





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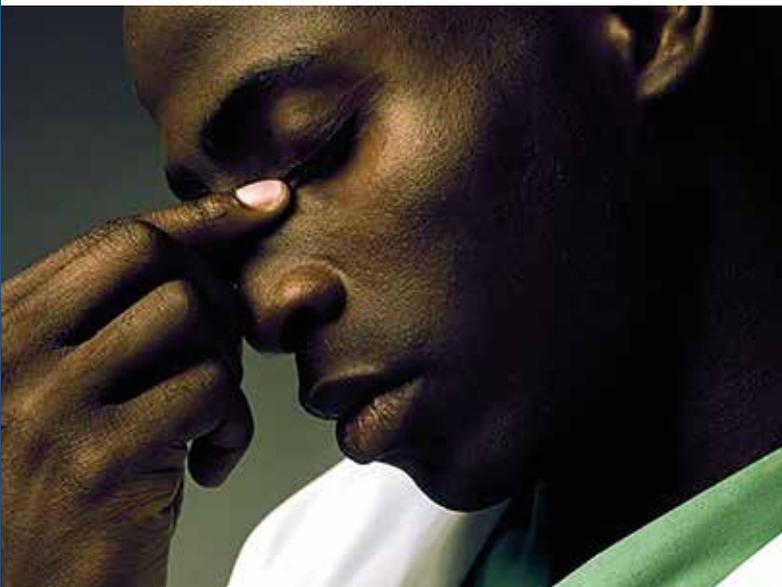
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WHAT'S INSIDE...



FEATURES

06 Hazard perception – five key risks for junior doctors

A new year of medical students recently celebrated their graduation from medical school. We examine five key medicolegal hazards they will face in their first months as qualified doctors.

08 Handling a Medical Council complaint

Dr Jonathan Bernstein explores what happens when a doctor becomes the subject of a complaint to the Medical Council, and outlines how Medical Protection can support them.

CASE REPORTS

10 Back to basics

A patient repeatedly attends his GP with worsening back pain.

11 Reported abuse

A child makes an allegation of abuse.

12 No news is not always good news

A newborn is referred with a clicking hip.

14 A failure to monitor

A patient attends his GP multiple times with symptoms of dizziness.

15 A complicated claim

A surgeon's experience is questioned when he acts as an expert witness.

16 A friend in need

A patient suffers complications during spinal surgery.

17 Unforeseeable complications?

A patient undergoes corneal graft surgery for deteriorating keratoconus.

EVERY ISSUE...

04 Welcome

Dr Marika Davies, Editor-in-Chief of *Casebook*, welcomes you to this edition and comments on some topical issues.

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ISSN 2056 4449

Casebook is designed and produced twice a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

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05 Noticeboard

News and updates from the *Casebook* team.

18 Over to you

What did you think about the last issue of *Casebook*? All comments and suggestions welcome.

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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



This year marks a significant anniversary for Medical Protection, as we celebrate 125 years of supporting members. We were founded in 1892 as a mutual organisation to provide members with expert advice, support and protection in their professional practice.

Though our purpose remains the same as it always has, the world around us has changed dramatically. Life is faster and more complex, presenting healthcare professionals with even greater opportunities and challenges.

The breadth of specialist advice and support, and the education and training we provide, have expanded exponentially, not only to keep pace with advances in medicine, but to stay ahead of the curve – anticipating challenges and risks before they emerge.

This year *Casebook* is also marking 25 years of supporting members with learning from case reports and medicolegal and risk management articles.

While we are proud of the support we have provided through *Casebook* over the years, we must always look to the future. As part of that forward focus, you may notice some changes to *Casebook*, starting with this edition.

Going forward we want to focus *Casebook* on the content that really matters to you – case reports. Each edition will also feature one or two articles that focus on topical medicolegal issues.

In this edition, we provide advice on the risks faced by newly-qualified doctors, and explain how we can support you if you receive a Medical Council complaint.

As always, we welcome your feedback. Please let us know what you think of the changes to *Casebook*, and contact us with any questions or comments on the articles and case reports.

I hope you enjoy this edition.

Dr Marika Davies
Editor-in-Chief
marika.davies@medicalprotection.org

FIRST STEPS: MEDICAL PROTECTION WELCOMES NEW DOCTORS

Medical students across the Caribbean celebrated their graduation in June, and are now taking their first steps as junior doctors.

We were proud to be involved in many of the graduation events, sponsoring prizes for the highest performing students.

BARBADOS

The oath-taking ceremony took place on 11 June with 50 doctors graduating.

The student with the highest grade point average over the five year period was Dr Kamaria Jordan who was awarded a cheque for B\$650.

JAMAICA

The oath-taking ceremony took place on 7 June with 224 doctors graduating.

The student with the best overall performance in the MBBS programme was Dr Timothy Henry who was awarded a cheque for J\$40,000.

TRINIDAD

The oath-taking ceremony took place on 8 June with 192 doctors graduating.

The student with the best overall performance in the MBBS programme was Dr Jameela Daniel who was awarded a cheque for T\$2,200.

These first few months following graduation are an exhilarating time for new doctors; however, it is also a time when they face new risks that they need to be prepared for. On page 6 we highlight five key medicolegal risks for junior doctors, and provide tips on how to survive them.

GRENADA MEDICAL RECORDS GO ELECTRONIC

In May, Grenada launched a new electronic system to manage medical records. The new system will be implemented island wide, so that wherever patients choose to access their healthcare the provider will have access to their medical record.

Hon Nickolas Steele, Minister for Health and Social Security, said: "The most significant part of the electronic medical records is, as we say, 'one patient – one record', and that record follows the patient around wherever they choose to access the system.

"So, individuals can go to the north at Princess Alice and take an x-ray, get on a bus, come to the general hospital or a doctor in St George's, and be able to access their record there."

The system will also be linked to pharmacies, and patients who need to travel will have access to information that will give practitioners abroad a comprehensive understanding of their medical history.

To read more on the new system, go to: <https://goo.gl/PjziLy>

EDUCATION UPDATES

NEW WORKSHOP FOR CORPORATE MEMBERS

We are launching a new workshop for doctors employed by hospitals and healthcare organisations that have a corporate membership with Medical Protection.

Delivered by Dr Brian Charles, *Achieving Safer and Reliable Practice* will give you a firm grounding in ways to improve reliability, which can result in reduced risk for you and your patients. The workshop also discusses the complex relationship between innovation and reliability, as well as the role played by human error.

Members will be advised of dates nearer the time. Doctors interested in attending should discuss it with their employer.

ONLINE LEARNING

Our online learning platform, Prism, allows members to complete free online learning modules around the clock to help you keep your knowledge up to date. Courses are available covering the following areas:

- Medicolegal issues
- Professionalism and ethics
- Communication and interpersonal skills
- Systems and processes
- Clinical risk management

To access Prism, visit: prism.medicalprotection.org



HAZARD PERCEPTION

FIVE KEY RISKS FOR

JUNIOR DOCTORS

Good doctors apply clinical knowledge in a way that is legally and ethically correct – but all doctors can make mistakes. We provide information and advice on how to avoid five key medicolegal risks for junior doctors

READ THIS ARTICLE TO:



- ✓ Understand the key medicolegal risks junior doctors face
- ✓ Learn how to avoid the risks and practise safely

01 CONSENT

Failure to take consent properly can lead to medicolegal problems including complaints, claims and disciplinary proceedings. Junior doctors should not feel pressurised to do anything beyond their knowledge, experience and competence – this includes obtaining consent for a procedure that they are not familiar with.

Consent is a process, rather than a form-filling exercise. Guidance emphasises the importance of working in partnership with patients, to ensure they can make a fully informed decision.

ADVICE

- Record in the notes what a patient has been told about the procedure and its risks and benefits, as well as any alternative treatment options as part of the consent process.
- Consent is patient-specific and depends on the individual's circumstances, including age, lifestyle, occupation, sporting interests, expectations etc. It may well be that you are not in a position to advise fully (for example, professional sportspeople) and you should seek senior input if you have any concerns.
- Patients are presumed competent to consent unless proved otherwise. Remember that any competent adult can refuse treatment.
- The law concerning incompetent adults, who are unable to give valid consent, is more complicated, and varies between jurisdictions. If you are in doubt, consult senior colleagues or take advice from Medical Protection.
- Remember there may be circumstances where a child can give consent without reference to a parent – if in doubt, consult a senior colleague or Medical Protection.

02 PRESCRIBING

Prescribing is fraught with complications – from over-prescribing, transferring information incorrectly to new charts and prescribing for the wrong patient, to forged prescriptions and overdoses, incorrect dosages, interactions and allergies. As well as having good knowledge of the pharmacology and the legislation surrounding drugs, you should be familiar with the hospital protocols and routines for restricted drugs (for example, narcotics) – if you're unsure, ask.

ADVICE

- Prescriptions should clearly identify the patient, the drug, the dose, frequency and start/finish dates. They should be legibly written or typed and be signed by the prescriber.
- Always check whether a patient has drug allergies.
- Maintain your knowledge and stay up-to-date by referring to relevant drug formularies.
- Verbal prescriptions are only acceptable in emergency situations and should be written up at the first available opportunity.

03 CONFIDENTIALITY

Confidentiality is central to maintaining trust between patients and doctors. As a doctor, you have access to sensitive personal information about patients and you have a legal and ethical duty to keep this information confidential, unless a disclosure has been consented to by the patient, is required by law or is necessary in the public interest.

ADVICE

- Doctors can breach confidentiality only when their duty to society overrides their duty to individual patients, and it is deemed to be in the public interest.
- If you must breach confidentiality, it is good practice to try to obtain consent. At the very least, patients should be informed that their personal information is to be disclosed.
- Remember that confidential information includes the patient's name.
- Doctors are required to report to various authorities a range of issues, including notifiable diseases (for example, TB), births, illegal abortions and people suspected of terrorist activity.
- The courts can also require doctors to disclose information, although you should contact Medical Protection if you find yourself presented with a court order.
- Inadvertent breaches of confidentiality can easily occur in places such as lifts, canteens, wards, emergency departments, and around computers and printers.
- Be careful not to leave memory sticks or handover sheets lying around.
- Competent children have the same rights to confidentiality as adults.

04

RECORD KEEPING

Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. The notes will also form the basis of the hospital's defence should there be any future litigation against your hospital, and will assist you to provide a response if a complaint is made about you. Notes are a reflection of the quality of care given so get into the habit of writing comprehensive and contemporaneous notes.

ADVICE

- Always date and sign your notes, whether written or on computer. Don't change them. If you realise later that they are factually inaccurate, add an amendment.
- Any correction must be clearly shown as an alteration, complete with the date the amendment was made, and your name.
- Document decisions made, any discussions, information given, relevant history, clinical findings, patient progress, investigations, results, consent and referrals.
- Only include information that is relevant to the health record. Bear in mind that patients have a right to access their own medical records so could read any comments you make.

Doctors must be honest and trustworthy when signing forms, reports and other documents. Doctors should make sure that any documents they write or sign are not false or misleading. Breaches of this trust could lead to disciplinary action by your employer or the Medical Council/Medical Board or, in some circumstances, even the police.

ADVICE

- Never sign a form unless you have read it and you are absolutely sure that what you are saying is true.
- Be honest about your experiences, qualifications and position.
- Be honest in all your written and spoken statements, whether you are giving evidence or acting as a witness in litigation.
- You must be open and honest about any financial arrangements with patients and employers, insurers and other organisations or individuals.

05 PROBITY

MORE ADVICE

Members who are made aware they are the subject of a claim, or a complaint to their employer or Medical Council, should contact us for advice and support on +44 113 243 6436 or complete the contact form on our website – medicalprotection.org. Our team of expert medical advisers are available to guide you through the process and provide the best support, advice and protection.

MORE SUPPORT

Medical Protection has a series of online learning modules on a range of topics including the risks associated with confidentiality and record keeping. To find out more, visit medicalprotection.org and click on the 'E-learning' link.

HANDLING A MEDICAL COUNCIL COMPLAINT

A Medical Council complaint can be a difficult and stressful experience. Dr Jonathan Bernstein, Medical Protection Medicolegal Adviser, explains the process and how we can support you

READ THIS ARTICLE TO:



- ✓ Find out what to do if you receive a Medical Council complaint
- ✓ Learn how Medical Protection can support you

For many doctors, their interaction with their local Medical Council (also known as the Medical and Dental Council or Medical Board, depending on the country) is limited to the initial registration and renewal of that registration on the relevant Medical Register. However, Medical Councils are also charged with maintaining the proper standards of medical practitioners. Complaints by patients and others to the Council may result in a disciplinary procedure.

Many doctors, at some stage in their career, will be subject to a complaint to the Medical Council. These experiences can be difficult and stressful for the doctors involved, and can lead to serious consequences, including being suspended from practising medicine.

Medical Protection has a great deal of experience in assisting members with these matters, both in the Caribbean and Bermuda, and around the world. We understand how upsetting it can be for a member to receive a letter from the Medical Council advising them of a complaint about them.

RECEIVING A COMPLAINT

You will likely be notified about any complaint through a letter. The initial letter should outline the complaint to you and may invite your comments. Your comments should be carefully considered, and demonstrate the necessary insight and consideration for the patient.

An intemperate response may address the facts but expand the investigation by raising concerns about your behaviour. There are times where a response may be ill-advised and risk exacerbating matters.

In responding to a complaint it is useful to consider including the following:

- A short paragraph or two detailing your background, experience and qualifications to date.
- If relevant, a paragraph or two providing detail on the system in place in the unit in which you work.
- What you understand the complainant's concerns to be – each of the issues of concern should be identified and responded to in turn.
- The chronology of your involvement in the case and your justification for treatment offered.
- An appropriate apology for any errors that are identified, and evidence of reflection and remediation.

HOW WE CAN SUPPORT YOU

Handling a complaint requires time and commitment during a period when you might be feeling at your most vulnerable. We strongly advise you to contact us immediately and not respond to the Medical Council until you have had an opportunity to discuss the case with us.

It is important that we are in receipt of a full copy of the correspondence that you have received, including the initial letter from the case officer and the full letter of complaint.

The adviser who will assist and support you with the response will require the following information:

- Details of your period of involvement in the case, including the date on which you first saw the patient and the date on which you last saw the patient.
- A complete copy of the full bundle of documentation that you will have received from the Medical Council so that we have sufficient information on all aspects of the case with which to provide comment.
- Your views on the allegations/background to the case.

You will be allocated a unique reference number, which should be quoted in all future correspondence with us, and directed to the expert medicolegal adviser dealing with your case.

WHAT HAPPENS NEXT?

The Medical Council will consider your response and decide if there is a case to answer. They may decide to refer the matter for a full hearing before the Medical Council's disciplinary committee.

In cases where the matter is particularly complex, or the allegation is serious in nature, Medical Protection will instruct one of our local panel firm attorneys to assist with the matter. Where it is unlikely that the case will go forward and the complaint is limited, it is less likely that there will be any requirements to instruct an attorney and the medicolegal adviser will work with you to assist in drafting a robust response to the Medical Council.

CASE STUDY

Dr X contacted the Medical Protection telephone advice line after receiving a letter from the Medical Council informing him that a complaint had been made against him.

According to the complaint, Dr X had inappropriately touched a female patient, and made inappropriate remarks, while performing a breast examination.

Dr X spoke to a medicolegal adviser (MLA), a former practising physician with additional law qualifications, regarding the case. She asked him to submit further information, including anonymised records regarding his consultations with the patient.

After reviewing the submitted information, the MLA contacted Dr X to provide further advice and assist in drafting a response for the Medical Council. In this case, Dr X had kept meticulous notes, and had used a chaperone to supervise the examination. The chaperone provided a supportive statement, backing Dr X's version of events that nothing untoward had occurred.

After reviewing the response drafted with the help of the MLA, along with the chaperone's supportive statement, the Medical Council closed the case without any further action.

MORE ADVICE

If you receive correspondence from the Medical Council/Medical and Dental Council/Medical Board, please contact Medical Protection for advice via the contact form on our website or call **+44 113 243 6436**.



Handling a complaint requires time and commitment during a period when you might be feeling at your most vulnerable

BACK TO BASICS

A patient repeatedly attends his GP with worsening back pain

Author: Dr Philip White, Medical Claims Adviser at Medical Protection



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Mr B, a 42-year-old builder, attended his GP, Dr S, with a three-week history of back pain and left sided sciatica. Dr S found nothing of concern on further questioning or examination, so made a referral for physiotherapy and recommended ibuprofen. Over the next few weeks the pain increased and the patient required diclofenac and cocodamol to control his symptoms.

Two months later, while still waiting for his physiotherapy appointment, the pain got so bad that Mr B called an ambulance and was taken to the Emergency Department (ED), where he was found to have a slight left foot drop and bilateral straight leg raising of 45 degrees. Mr B's neurology was not examined. The ED doctor thought that this was not sciatica but simple back pain made worse by moving Mr B's legs. Mr B was sent home with diazepam.

One week later, the pain was even worse and there was now intermittent numbness in both buttocks. Mr B called the out-of-hours GP service and was seen at home by Dr T. He told Dr T that he was able to pass small amounts of urine, and Dr T also recorded "no saddle anaesthesia". Dr T carried out a very brief examination of the legs which was unremarkable, started tramadol, and advised Mr B to keep active and see his own GP the following day.

Mr B was reviewed by Dr S the next day, who again recorded in the notes: "No red flags, no loss of bowel or bladder function. No saddle anaesthesia."

Dr S gave Mr B a diclofenac injection and arranged an MRI scan. He too only carried out a very brief examination of the back and legs.

Two days later, due to intolerable pain, Mr B was on his way to the ED again when he suffered urinary incontinence in the ambulance. On admission, he had an MRI scan that showed a large L4/5 central disc pressing on the cauda equina.

Mr B underwent surgical decompression the next day but was left with bilateral foot drop, requiring the use of a wheelchair, and bowel, bladder and sexual dysfunction.

Mr B brought a claim against all the doctors involved in his care. He alleged that they had failed to take a proper history and perform an adequate examination, including assessment of perineal sensation and anal tone. The claim also alleged that they did not give proper regard to bilateral and worsening pain and buttock numbness, and did not refer for urgent assessment.

EXPERT OPINION

Medical Protection instructed an expert GP who was critical of the care provided by both general practitioners. She opined that Dr T did not carry out an adequate assessment after the report of intermittent buttock numbness, and that Dr S conducted a "very severely substandard" examination the next day.

Emergency medicine and orthopaedic experts concluded that the ED doctor's assessment had been inadequate and were critical of the delay before decompression. They also stated that if Drs S or T had assessed Mr B more thoroughly they would likely have found perineal numbness and/or urinary retention, and the resulting emergency decompression would have left Mr B in a much better condition.

On the basis of the expert opinion, the case was deemed indefensible and was settled for a high sum, shared equally between the hospital, Dr S and Dr T.

Learning points

- Even when referral to physiotherapy has already been made, keep a low threshold for reassessment if things change.
- Issuing analgesia, especially increasing the strength, is an opportunity for reassessment.
- Do not assume that the doctor who saw the patient before you has carried out an adequate assessment, even though nothing might have changed.
- If you ask a patient if they have saddle anaesthesia, make sure they know exactly what that is. It might be useful to ask about rectal function, numbness between the legs or around genitals and anus, and if they have any difficulty getting an erection.
- Any suggestion of perineal numbness or urinary symptoms mandates a thorough assessment of both. Don't forget that urinary tract infections can be caused by retention.
- Giving patients information about the red flags for cauda equina in writing can improve safety netting, however it is no substitute for discussing them with the patient and explaining how the different red flags can present and what the symptoms may mean.

REPORTED ABUSE

A child makes an allegation of abuse

Author: Dr Clare Redmond, Medicolegal Adviser at Medical Protection

Mrs X asked her GP to refer her eight-year-old daughter, Child F, to be assessed by a consultant psychiatrist in child and adolescent mental health. The GP referral letter stated that Child F had reported to her teacher that her father frequently touched her genitalia. The child's parents had recently separated acrimoniously and the mother had reported the matter to the police.

The consultant psychiatrist, Dr B, obtained a history from Mrs X, who confirmed these details. She then took a history from Child F and wrote a report based on these discussions. The report detailed that Child F had reported numerous incidents of touching by her father, and the descriptions provided by the child indicated the father was sexually abusing his daughter.

The police investigated the allegations but no charges were brought against the father, Mr X. However Dr B's report was used by the mother in custody proceedings, and the mother gained sole custody of Child F.

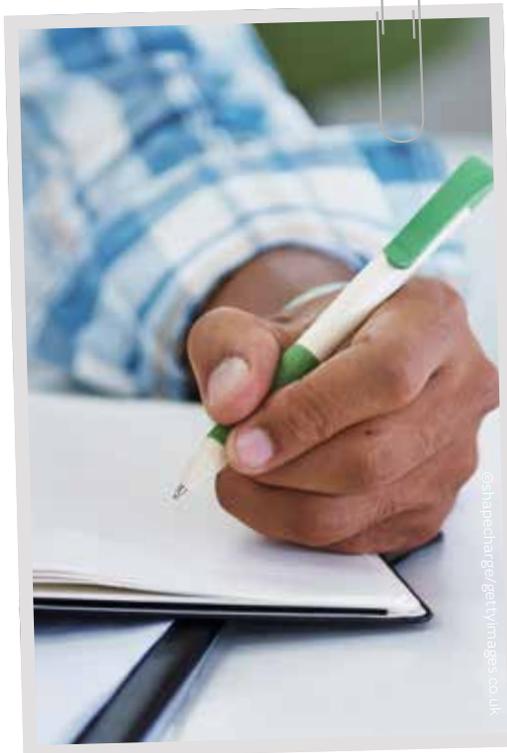
In the course of the proceedings, Mr X obtained his own expert psychiatric report. Mr X's expert concluded that Dr B had obtained an inadequate history in three areas. The expert said that Dr B had failed to confirm the history with the school directly, had failed to seek an explanation from Mr X, and had failed to consider that Mrs X may have coached Child F in giving her answers. This expert was less certain that this was a case of sexual abuse, but deemed the child was best placed with her mother, with supervised contact with her father.

Mr X brought a claim for negligence against Dr B, alleging a failure to take an adequate history from a range of sources to evidence her conclusion of sexual abuse.

EXPERT OPINION

Medical Protection obtained further expert opinion from a psychiatrist. This expert concluded that Dr B carried out her interview with Child F appropriately, and that there was no evidence of pressure or undue influence by the mother. She concluded that there may have been some shortcomings in failing to obtain collateral history from the school and Mr X, but that the activity that Child F had described to Dr B, if true, would unequivocally amount to child sexual abuse and that Dr B's conclusions to that effect were reasonable.

Medical Protection successfully defended the claim.



Learning points

- When writing a professional report you should take reasonable steps to check the information provided, to ensure it is not false or misleading. A report should make clear where a patient has provided information about events or another party, and this should not be recorded as fact. You must not deliberately leave out relevant information even if requested to do so.
- When writing a professional report you should set out the facts of the case and clarify when you are providing an opinion. Do not be tempted to comment on matters that do not fall within your area of expertise. In this case, Dr B was assisted by her clear and robust report-writing.
- All doctors have a duty to act on concerns about the welfare of children, and child protection work is recognised as challenging and emotionally difficult.

NO NEWS IS NOT ALWAYS GOOD NEWS

A newborn is referred with a clicking hip

Author: Dr Mónica Lalanda, Emergency Medicine Physician and Medical Writer



@fatcamera/gettyimages.co.uk

Child J, a one-week-old baby girl, was noticed to have a clicking right hip when she was seen by the community midwife. A referral to the orthopaedic clinic was requested and Child J was reviewed by orthopaedic junior doctor, Dr M, three weeks later. Dr M confirmed that there was no relevant family history and examined Child J. Dr M documented that there was no clicking of the hips, and Ortolani and Barlow tests for assessing hip stability were negative. Dr M discharged the baby back to the care of her GP.

During a routine check-up at eight months, Child J's GP, Dr N, found she had limited rotation of her right leg and immediately arranged for her to have an x-ray. Two days later, following the x-ray, consultant radiologist Dr O described the results as follows: "The left hip is normal. The right hip appears dislocated with associated moderate acetabular dysplasia."

However, due to a failure in the system, the report was simply filed in the hospital record and Dr N did not receive a copy at his surgery.

Three weeks later Child J's mother brought her in with a minor cold and asked about the x-ray results. Dr N reassured her that he had not heard anything so it was a case of "no news is good news" but he promised to check up on it. Unfortunately, the clinic was very busy and he forgot to look into it.

Child J was reviewed at 16 months, when her mother complained that she "walked funny". Child J had an obvious limp, and on examination her right hip was clearly abnormal. Dr N made an urgent referral to the orthopaedic clinic and a consultant paediatric orthopaedic surgeon, Dr P, confirmed the diagnosis of developmental dysplasia of the hip.



@stockdevil/gettyimages.co.uk

Child J was initially treated with a closed reduction and immobilisation with hip spica, but on follow up at three months, the hip appeared dislocated again. An osteotomy was performed and appropriate immobilisation applied but unfortunately, months later, the dislocation reoccurred and the dysplasia also seemed to have deteriorated. Child J was referred to a sub-specialist paediatric orthopaedic unit where she was seen by Dr Q, a specialist in hip dysplasia. Dr Q arranged for Child J to have specialised physical therapy and explained to her parents that it was likely that Child J would require further surgery within the next few years, although it was still too early to predict when and what kind of surgery Child J would need.

Child J's parents brought a claim against all the doctors involved in the management of their daughter's care. They alleged that Dr M should have requested an x-ray to exclude the dislocation on the initial visit to the orthopaedic clinic. They also alleged that Dr O failed to ensure that the report made it safely to the clinic, and that Dr N had not checked the x-ray but had dismissed their concern. The parents also claimed against the orthopaedic surgeon, Dr P, for failing to treat their daughter's hip appropriately.

EXPERT OPINION

Medical Protection sought expert opinions from a paediatric orthopaedic surgeon and a GP.

The orthopaedic expert considered that Dr M, the junior orthopaedic doctor, had demonstrated an acceptable standard of care. The examination of the baby was normal, with no suggestion of a dislocated hip, and was well documented. There was no family history to suggest higher risk, therefore an x-ray was not indicated at that time.

The expert GP's opinion on the care provided by Dr N stated that the standard of care was below a reasonable standard, since he failed to follow up the investigation that he had rightly requested. The expert expressed sympathy for Dr N, who had diagnosed the abnormality appropriately, but then failed to follow up on the investigation. If the mother's account of the next consultation was right, he missed a second opportunity to review the x-ray report. All this translated into a long delay of several months in the surgical treatment of Child J's hip.

The orthopaedic expert commented that the surgical treatment by Dr P was in keeping with acceptable practice and that the failure was caused by the advanced state of the dysplasia that made the hip very unstable.

The supportive orthopaedic expert's report enabled Medical Protection to extricate Dr M and Dr P from this action. The hospital accepted that there had been a clear administrative error that allowed the system to file the report without it being sent to the clinical team for action. The failings in this case meant it was considered indefensible and it was therefore settled for a substantial sum, with the hospital contributing half the costs.

Learning points

- Good history taking and careful documentation of physical examination can make a huge difference if a patient makes a claim against you, which can often be many years after the event.
- When you request a test, you are responsible for ensuring the results are checked and acted upon.
- All systems need a safety net where results are checked so that abnormal results are not missed. It is vital to ensure you have a robust system for acting on tasks that arise from a consultation.
- Poor outcomes are not necessarily the result of negligent medical management. Sometimes poor outcomes are a result of the particular condition. You can help protect yourself from criticism by always ensuring your records outline the rationale for any decision you have taken.

A FAILURE TO MONITOR

A patient attends his GP multiple times with symptoms of dizziness

Author: Dr Ellen Welch, GP



©bdsprn/Getty Images.co.uk

Retired engineer Mr S, 77, went to see his GP, Dr J, with symptoms of dizziness. He had returned from a pacemaker check at the hospital that morning and while travelling home on the train had started to feel off-balance. He managed to get an emergency appointment to see Dr J, by which time the symptoms were resolving.

Dr J noted that the pacemaker had been fitted for complete heart block six years ago, and had remained in situ without any problems since then. Mr S reported no chest pain or palpitations and Dr J, feeling reassured by the recent pacemaker check and a normal examination, attributed the symptoms to motion sickness and prescribed cinnarizine.

Despite taking the medication regularly, Mr S's dizziness continued, so he returned to the practice two days later to see Dr K, his usual GP. Dr K recorded his BP as 140/50 and attributed the symptoms to benign paroxysmal positional vertigo. No record was made of Mr S's pulse. Dr K advised Mr S to continue the medication prescribed by Dr J.

During the next six weeks, Mr S consulted with Dr K on three further occasions with ongoing symptoms of intermittent dizziness. Note-keeping from all three consultations was sparse, with no defined cause of the symptoms documented, and no further cardiovascular examination or ECG performed. Mr S was given a trial of betahistine for presumed Ménière's disease.

Two months after his initial presentation, Mr S was taken into the Emergency Department after collapsing on the street when out shopping. He was found to be in complete heart block, with a pulse rate of 32 beats per minute. The admission ECG showed atrial pacing but no ventricular spikes, and his symptoms were attributed to a malfunctioning pacemaker.

He was admitted to hospital, and while being monitored on telemetry, the pacemaker activity resumed without intervention. Mr S became acutely confused after admission to the ward. He was treated for a urinary tract infection, and underwent a full confusion screen, which was unremarkable.

A CT scan of his brain showed small vessel disease. The patient continued to deteriorate, leading to him becoming fully dependant. He was discharged into a care home following a prolonged admission.

Mr S's family made a claim against Dr K, stating that the confusion and memory loss developed as a result of hypoxia, linked to the malfunctioning pacemaker.

EXPERT OPINION

Experts agreed that a competent GP would rethink the diagnosis of vertigo and carry out a cardiovascular examination, including an ECG.

Dr K defended his actions by stating that by taking a manual blood pressure reading, he would have listened to the pulse and been aware of any significant irregularity or abnormal rate. However, opinion was divided on the causation of Mr S's decline.

Experts found no evidence to support an episode of circulatory failure significant enough to cause prolonged hypoxic damage. The general deterioration was considered to be due to a pre-existing cognitive impairment, which was exacerbated by the hospital environment and the bradycardia – which experts agreed, would have occurred in any event with an earlier hospital admission.

The case was settled for a low sum to reflect the partial causation defence.

Learning points

- Make clear and detailed notes. Lack of clear documentation makes a case difficult to defend. In this case, there was no record in the notes that the patient's pulse had been taken. If an investigation is not written down, it is hard to prove that it took place.
- Be wary of repeat consultations. Dizziness is common, but revisiting a diagnosis and carrying out a basic examination, especially in a patient with a cardiac history, is essential to ensure that good quality care is provided.
- The allegation in this instance was of memory loss as a result of hypoxia. Ultimately, the deterioration of the patient was attributed to pre-existing cognitive impairment, hence the low settlement. From a medicolegal standpoint, this highlights the importance of fully investigating claims, since taking the claim at face value may have resulted in payment of long-term care costs.

A COMPLICATED CLAIM

A surgeon's experience is questioned when he acts as an expert witness

Author: Dr Janet Page, Medical Claims Adviser at Medical Protection



Dr A, an orthopaedic surgeon, was approached by a claimant's solicitors to provide an expert report on behalf of their client. He was advised that the claim related to alleged negligence in the conduct of an L4/5 spinal decompression and fusion with malposition of the pedicle screws, following which the claimant developed right S1 nerve root damage, causing right foot drop. Dr A sent the solicitors his CV – which set out his area of practice – as evidence of his suitability for the role, and agreed to provide the requested report.

In his report, Dr A criticised the conduct of the surgery. His opinion was that the hospital inappropriately allowed a specialist registrar to perform the operation unsupervised, that there was a failure to use an image intensifier and a failure to check the position of pedicle screws immediately postoperatively, resulting in delayed diagnosis of the malposition of the screws and permanent foot drop. A Letter of Claim was served on the hospital based on Dr A's expert opinion.

In their Letter of Response, the hospital's solicitors denied liability. They commented that Dr A "does not claim to have expertise in spinal surgery". They advised that the operation had been performed by a locum consultant, an image intensifier was used and that foot drop is a recognised complication of spinal decompression and fusion, about which the claimant was warned preoperatively.

Proceedings were nevertheless commenced by the claimant's solicitors. In response, the hospital's solicitors submitted questions to clarify Dr A's expertise in spinal surgery. When answering the questions, Dr A confirmed that he had never held a substantive consultant post in the public sector, that he had last performed spinal surgery 15 years earlier and that he had not operated at all in three years. He also stated

that he had never performed complex spinal surgery and that he had not personally performed the operation in question, because of the high risks associated with it.

Following this, the claimant's solicitors instructed a new expert. She agreed with Dr A's original opinion that there was a failure to check the position of the pedicle screw immediately postoperatively and that there was a delay in making the diagnosis of foot drop. However, the expert also identified new areas of concern, namely that there was a failure to check the neurovascular status of the limb during the procedure, and that there were deficiencies in the consent that had been taken.

She concluded that, on the balance of probabilities, the neurological damage sustained would have been less severe with earlier diagnosis of the foot drop and subsequent correction of the underlying cause (malposition of the screws).

The claimant's solicitors sought financial redress from Dr A for the increased costs incurred by their client in instructing a second expert and revising their claim. They alleged that Dr A was wrong to maintain that he had sufficient expertise in the field of spinal surgery, and to comment on the current public sector standards and operational procedures on the facts of this case. They pointed out that the hospital's solicitors were quick to notice this weakness, and as a result of this their client faced an Adverse Costs Order.

EXPERT OPINION

Dr A remained of the view that he had the appropriate expertise to report on the case, relying on the elements of spinal surgery in his training in general orthopaedic surgery and his efforts to keep up to date with developments in this area.

Medical Protection advised that he should seek to settle on the basis that whilst there was no suggestion that Dr A deliberately misrepresented his expertise, he did not make explicitly clear the limits of his knowledge and personal experience. Additionally, although he clearly stated an interest in spinal surgery outcomes, he did not advise that he had not carried out a spinal decompression in 15 years, nor did he advise that he had never carried out the decompression and fusion that was the subject of the original claim.

The matter was settled with Dr A's agreement for a low sum and without admission of liability.

Learning points

- **Be clear and explicit about the limits of your expertise to avoid misunderstandings.**
- **Your credibility is likely to be undermined if you are providing an opinion about an area of practice in which you have no (or no recent) practical experience.**
- **This case highlights the importance of having understanding and experience appropriate to the location of a claim (for example, private or public sector) in order to avoid making incorrect assumptions about personnel or protocols.**

A FRIEND IN NEED

A patient suffers complications during spinal surgery

Author: Mr Ian Stephen, Consultant Orthopaedic Surgeon (Retired)



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Ms N, a 33-year-old accountant, presented to Dr X, a consultant orthopaedic surgeon, with severe lower back pain radiating to both legs. A clinical diagnosis of a central disc protrusion at L4/5 was confirmed on MRI scan. Dr X advised laminectomy with discectomy, to which Ms N consented. Dr X did not record the details of the consent process, but has since stated that he would have warned of potential complications.

Dr X recorded the operation as uneventful, but Ms N rapidly became hypotensive postoperatively and an ultrasound scan revealed a large retroperitoneal haemorrhage. Dr X requested an opinion from Dr Y, a consultant general surgeon, who assessed the patient and advised an emergency laparotomy.

During the laparotomy by Dr Y, retrocolic exploration revealed a clot adjacent to the abdominal aorta. Removal of this clot caused a gush of blood and haemodynamic collapse. The aorta was found to have been transected just below the left renal artery. Dr Y clamped the aorta above the renal artery which controlled the bleeding, and the patient's condition then improved.

Dr Y then attempted to perform an end-to-end anastomosis of the aorta, but this failed. There was then bleeding from the left kidney, which proved uncontrollable, so Dr Y took the decision to remove the kidney. Dr Z, a consultant vascular surgeon, was called in and successfully repaired the aorta with a synthetic graft.

Ms N subsequently made a good recovery. She later brought a claim against the orthopaedic surgeon, Dr X, alleging that there had been an indisputable act of gross negligence in damaging the aorta and in causing the left kidney to be removed.

EXPERT OPINION

Medical Protection's medicolegal experts considered the case carefully and concluded that it would be difficult to defend the fact that the aorta was transected during an otherwise straightforward laminectomy procedure. The decision was made to negotiate settlement of the claim as swiftly as possible in order to minimise costs.

The case was therefore settled on behalf of Dr X for a substantial sum.



Learning points

- Work within the limits of your competence. If an emergency arises in a clinical setting you must take into account your competence and the availability of other options for care. Specialist input was sought in this case, which helped to avoid a more serious outcome for the patient.
- Make clear and detailed notes. When things go wrong during a surgical procedure, the absence of any documentation of the consent process makes a claim very difficult to defend. Patients must be given clear, accurate information about the risks of any proposed treatment, and this must be clearly documented in the medical records.
- Vascular and visceral injuries are a recognised complication of surgery for herniated lumbar disc disease, and frequently result in the death of the patient.
- In this case, there were clear vulnerabilities and it was considered unlikely that it would be possible to successfully defend the claim. Medical Protection's legal team therefore made every effort to avoid incurring unnecessary legal costs and focused on achieving a satisfactory settlement of the claim as soon as possible. As well as saving costs, this also reduced the stress and anxiety to Dr X by shortening the time it took to resolve the matter.

UNFORESEEABLE COMPLICATIONS?

A patient undergoes corneal graft surgery for deteriorating keratoconus

Author: Dr Anusha Kailasanathan, Ophthalmologist

Mr M, a 45-year-old lawyer, consulted Dr L, an ophthalmologist, for the management of deteriorating keratoconus. He had become intolerant of contact lenses and was experiencing visual difficulties. His right eye had a corneal scar secondary to severe keratoconus, and he had keratoconus forme fruste in his left eye. Visual acuity was 6/20 in the right eye and 6/12 in the left eye.

Dr L offered Mr M corneal graft surgery in order to improve his symptom of deteriorating vision. He was counselled regarding complications, specifically that eye infections were a possibility, but he was not told about the rare risk of loss of the eye. Dr L performed uncomplicated corneal graft surgery on the right eye, and before discharging Mr M, provided him with his mobile phone number and a postoperative information leaflet, which informed patients that they should contact him immediately if they experienced any pain or poor vision.

Written records show that Dr L reviewed Mr M on the first day post-surgery. He was satisfied with the eye and prescribed a topical corticosteroid and a topical antibiotic. On the morning of the second day following the surgery, written and telephonic records show that Dr L gave Mr M a courtesy call and that Mr M did not inform Dr L of any pain during this conversation. Twenty-four hours later, Mr M called Dr L and complained of severe, worsening pain in the right eye, that started shortly after Dr L's phone call the previous day. Dr L saw Mr M immediately and observed a fulminant endophthalmitis.

Mr M was referred to Dr G, a vitreo-retinal surgeon, who arranged immediate treatment with intra-vitreous and systemic antibiotics. A

posterior vitrectomy and lensectomy were performed, but B-scan ultrasonography later showed a retinal detachment. Bacterial culture of the vitreous revealed a *Serratia marcescens* infection, sensitive to the antibiotics being used. As a result of the retinal detachment Mr M lost all vision in the right eye. His corrected visual acuity in the left eye was 6/36.

Mr M made a claim against Dr L, alleging that he had failed to inform him of the risks of corneal graft surgery or of the significance of pain postoperatively. He further alleged inadequate postoperative care, which led to Mr M developing an uncontrolled infection and subsequent blindness in that eye.

EXPERT OPINION

Medical Protection sought expert opinion from an ophthalmologist. She was supportive of the care provided by Dr L and concluded that the postoperative patient information leaflet had sufficient information about warning signs. She also noted that Dr L did warn that eye infections were a possible complication and opined that loss of vision due to an infection was such a rare complication that the patient did not need to be warned specifically about the risk.

The expert made the additional point that, in Mr M's case, there was a real risk that the natural course of the disease may have led to blindness through the complications of keratoconus itself, in the long term.

The case was considered to be defensible and was taken to trial. The court was satisfied that Dr L's management was appropriate and that there was no evidence of a failure to provide adequate informed consent or negligent after care. Judgment was made in favour of Dr L.



Learning points

- Doctors must now ensure that patients are aware of any "material risks" involved in a proposed treatment, and of reasonable alternatives, following a judgment in a 2015 UK case, *Montgomery*, which is likely to be the new yardstick by which Caribbean courts may judge cases.¹
- When providing important information in a written format, the patient must be made aware of its importance. Consider providing verbal information as well as written information for important matters. When giving written information to sight-impaired patients, the format and font should be suitable for their visual ability. When applicable, consider adjunctive methods to deliver information such as audio or video formats.
- Although the primary purpose of medical records is to ensure continuity of patient care, medical records are used as evidence of care when dealing with complaints and claims. Therefore, clear and detailed medical records are in both the patient's and the doctor's best interest.

REFERENCES

1. *Montgomery v Lanarkshire Health Board*. 2015. UKSC 11.

A space for your comments and opinions on what you've read in Casebook

TURNING A BLIND EYE

To summarise this case: two specialists – a virologist and an ophthalmologist – diagnosed a dangerous but treatable disease. They apparently made no attempt to contact the patient, and neither did they phone to discuss the case with the GP, who simply received another letter among the mountain of mail that a GP receives daily. The GP (who had not seen the patient at all) wrote to the patient saying an appointment was needed, but the patient did not respond.

The regulatory advice is that the doctor who does the test is the one who should follow up the result. In this case that is clearly not the GP, but the specialists, and yet the GP is the one who is found to be at fault, with no fault laid at the door of the specialists. What did you expect the GP to do – write about a diagnosis of syphilis in a letter that could be opened by anyone at the address?

This issue needs to be debated.

Dr Ted Willis,
UK

Response “ ”

Looking back at the details of the case, it may help to clarify that the ophthalmologist contacted the GP by telephone to inform the GP of the result and the need for urgent treatment, as a result of which the GP agreed to take on the responsibility of arranging for specialist referral. In this case, the ophthalmologist could perhaps have done more, but did not breach his duty of care as he informed the GP, who accepted the responsibility of referring the patient. By not taking appropriate timely action (for example, with a phone call or by stating that an urgent appointment was required) the GP breached his duty of care and caused irreversible harm.

With regard to your comment on responsibility for following up a test result, doing so includes reviewing the result and either taking action personally or referring the patient to an appropriate person to do so, which the ophthalmologist did in this case.

The outcome of a case will always depend on the individual facts and specific circumstances (including local arrangements). It is often difficult to convey all of the detail of a case in the limited word count we have, and I do hope this explanation helps to clarify your queries.

A HIDDEN PROBLEM

In this case, there is again the increasing problem of GPs being burdened with extra work that is not always appropriate. It is not clear from the report if Mr T had any symptoms at the time of the 'private health check'. However, the regulatory guidelines are clear that the clinician who initiates investigations is obliged to complete the entire treatment pathway that he/she has embarked upon; therefore the person providing the 'health check' should have been the one to make the referral to the nephrology services for the patient.

I opine that, regardless of subsequent omissions Dr W made in documenting the urine abnormality, it was negligent of the healthcare professional conducting the private health check to hand Mr T a letter and wash his/her hands of the renal failure; at the very least a phone call to Dr W should have been made.

Could a GP who receives an unsolicited report on his/her patient such as this, return it to the sender with a brief reply asking them to ensure complete follow up?

Dr Colman Byrne,
Ireland

Response “ ”

I note your concern that GPs may be burdened with extra work that may not be appropriate, and we are very aware that this is a cause of concern for primary care doctors. I agree entirely that a phone call to notify the GP of a significant result would have been of assistance. Unfortunately, in this case, I have not been able to establish if there was such a call given the time that has passed since the incident.

In general it is in the best interests of the patient that the overall management of their health is under the supervision and guidance of a general practitioner. Although a GP may not have initiated a test, and there is an obligation on the doctor who did to follow it through, a GP may find it hard to justify not taking action on significant information that they have been sent, and could face criticism if an incident were to arise and a patient come to harm.



We welcome all contributions to Over to you. We reserve the right to edit submissions.

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