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CASEBOOK

HIGH VALUE CLAIMS

EXPLORING THE MEDICAL CONDITIONS BEHIND SOME OF THE HIGHEST VALUE CLAIMS AGAINST MEMBERS

PAGE 6

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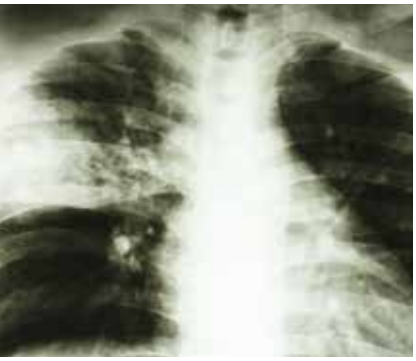

CASE REPORTS

Every issue...

FEATURES

FACTS AND OPINION

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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF

I am delighted to welcome you to this latest edition of *Casebook* and my first as Editor-in-Chief. I would like to express my thanks to my predecessor, Dr Nick Clements. For many years Nick has made an enormous contribution to both *Casebook* and to the work we do on behalf of members, and his considerable knowledge and experience have been invaluable resources. Fortunately he has not gone far, and we wish him all the best in his new role within Medical Protection.

Having been a medicolegal adviser at Medical Protection for over 12 years I have had the privilege to advise and assist many doctors going through difficulties in their professional lives. I am very aware of the stress and anxiety that doctors experience when they are the subject of criticism or an investigation, and the impact this can have on them both personally and professionally. Helping doctors to avoid such difficulties in the first place through education and awareness of risk is one of the key aims of *Casebook*, and I hope to continue the tradition of publishing informative, educational articles and case reports that help to improve practice and prompt discussion.

In this edition, we examine what conditions have led to some of the highest value claims against members, highlighting what you should be aware of and how to avoid catastrophic outcomes.

Not all doctors face the same challenges in their profession. Those that choose to practise in a rural setting face a unique set of risks. On page 9 we examine these risks and the steps that can be taken to mitigate them.

The case reports in this edition have a particular focus on conditions that can lead to claims of particularly high value. While some of these medical conditions may not be that common, they can lead to significant disabilities for the patient, unless diagnosed early and appropriate action is taken. One of the challenges for clinicians is identifying those patients that require further investigation in order to establish or rule out serious underlying pathology. As the cases demonstrate, good documentation is essential in order to justify your clinical decisions if there is an adverse outcome.

I hope you enjoy this edition. We welcome all feedback, so please do contact us with your comments or if you have any ideas for topics you'd like us to cover.

Dr Marika Davies
***Casebook* Editor-in-Chief**
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ON THE POLICY FRONT

Thomas Reynolds, Medical Protection's Public Affairs and Policy Lead, provides a round-up of what our policy team is doing for members in Scotland

At Medical Protection, we work hard to promote and defend your medicolegal interests. Whether it is a revised piece of GMC guidance, or a Bill going through the Scottish Parliament about openness with patients, we use our considerable medicolegal experience and expertise to inform debates about changes that could impact on members' professional practice.

The Policy team and I strive to influence positive changes that will benefit the profession as a whole, as Medical Protection is more than a last line of defence. We aim to play an active role in shaping public policy and regulation that impact on you, our members.

Recent months have seen a considerable number of issues arise...

HEALTH BILL

The Scottish Government is currently bringing forward a piece of legislation with wide-ranging implications for healthcare professionals. Two measures contained within the Health (Scotland) Bill are a statutory duty of candour and a new additional criminal offence of ill-treatment and wilful neglect for healthcare professionals. We opposed both measures when they were brought forward in England.

The principle of the duty of candour is that care organisations have a general duty to act in an open and transparent way in relation to care provided to patients. The statutory duty applies to organisations and "registered persons". The duty is not new, but the statutory element is.

As doctors already have a professional duty to be open and honest when something goes wrong, we remain unconvinced that the additional legal duty of candour and criminal offences are required in Scotland. Our experience in promoting and defending your medicolegal interests shows that government's reliance on legislation and regulation to bring about positive behavioural changes can sometimes have the reverse effect. Such reliance can risk creating defensive behaviours. We believe that to bring about a positive cultural change, a focus is instead needed on fostering a culture of openness and trust.

We have met with officials to discuss these concerns. However, the Scottish Government is committed to enacting both measures. Therefore we are working constructively with the Government to ensure that any guidance for the profession, associated with the duty of candour and the offence of wilful neglect, is clear and robust. Dr Rob Hendry, Medical Director at Medical Protection, has appeared before the Scottish Parliament Health Committee to stress the importance of getting the implementation right. Dr Hendry is also part of a small group that has been set up to advise the Government about how best to work with the profession, so the statutory duty of candour doesn't become an additional administrative burden for those on the front line.

MEDICAL INNOVATION

The issue of medical innovation has once again ignited debate in Westminster. Following on from the *Medical Innovation Bill* last year, a new – albeit very similar – Bill was introduced following the General Election; the *Access to Medical Treatments (Innovation) Bill*. While not applying directly to Scotland, there are many aspects of the Bill that could have an indirect impact. For instance, the Bill seeks to create a database of innovative treatments, which could impact on the care and treatment doctors in Scotland provide to their patients.

We remained concerned that such a Bill could inhibit responsible innovation. Further, that it had the potential to give false reassurance to some doctors about informed patient consent, and could damage the doctor-patient relationship. Our concerns were shared across the medical and healthcare community – from Royal Colleges, to research charities, to patient groups. Working collaboratively with these organisations, to inform MPs about our concerns, Medical Protection welcomed the House of Commons vote to remove the more dangerous sections of the Bill, dealing with negligence and consent.

The Bill now moves forward to its next stage, in the House of Lords, where we will continue to monitor developments.

WHAT DO YOU THINK?

We want to hear from you. Send your comments to:
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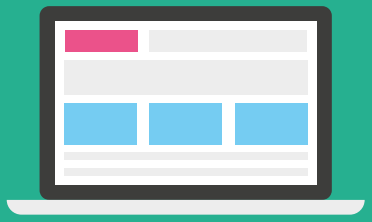


HIGH VALUE CLAIMS

Dr Rachel Birch and Dr Iain Barclay explore the medical conditions behind some of the highest value claims against members

Doctors in the UK are practising in an increasingly litigious environment in which claims and complaints are now becoming more common. The increasing number of clinical negligence claims and the ever increasing value of these claims have also caused an increase in membership subscriptions in a number of different specialties.

Medical Protection deals with a small number of significantly high value claims each year, ranging from several hundreds of thousands of pounds to a few million. These very high value claims are rare but can have a disproportionate effect on the overall estimating and reserving of funds, both for now and for the future.

In order to try to address the adverse effect of such claims, we carried out a review of the top high value claims opened in the UK last year – a hundred cases in all.

We found that missed or delayed diagnosis of certain conditions featured fairly often:

- **Cauda equina syndrome**
- **Meningitis and encephalitis**
- **Cancers**
- **Peripheral ischaemia**

Although some of these conditions are more common than others, unless diagnosed and treated early, all may lead to significant and often permanent disability and care needs for the patient.

Our review has also revealed that suboptimal chronic disease management crops up frequently in high value claims. This article looks at each of these groups of conditions in turn to consider some of the reasons why they are so often the basis of high value claims.

CAUDA EQUINA SYNDROME

This syndrome accounted for 13% of the potentially very high value claims opened by Medical Protection in the last year.

Failure to recognise the symptoms of compression of the cauda equina, undertake an MRI scan and treat it with emergency surgical decompression, can lead to long-term sequelae and disabilities. These include significant motor and sensory lower limb problems, urinary and bowel incontinence and sexual dysfunction.

Doctors should ensure that they are aware of the "red flag" symptoms of cauda equina syndrome and take urgent action in their presence:

- severe low back pain with bilateral or unilateral sciatica;
- bladder or bowel dysfunction;
- anaesthesia or paraesthesia in the perineal area or buttocks (saddle area);
- significant lower limb weakness;
- gait disturbance;
- sexual dysfunction.

The cases handled by Medical Protection show that delay in diagnosis, referral and treatment can contribute to an adverse outcome. Early diagnosis and treatment of cauda equina syndrome is likely to lead to a better outcome for the patient[1].

Doctors should therefore remain alert to the possibility of cauda equina syndrome and arrange urgent investigations if there is clinical suspicion of the syndrome. Not to do so would make defence of any claim difficult.

MENINGITIS/ENCEPHALITIS

Eight per cent of the very high value claims opened by Medical Protection last year related to failure to diagnose or treat meningitis or encephalitis. Although different diseases, both conditions may lead to significant long-term complications and disability.

With public health measures, including vaccination programmes, the incidence of bacterial meningitis has halved in the past 27 years, although new cases still occur in the UK every year. The annual incidence is estimated to be 3,200 patients per year[2].

Although in severe or untreated cases of meningitis patients may die, other patients may develop long-term disability, including deafness, significant neurological disability, developmental delay, behavioural problems, damage to bones, vascular compromise requiring amputation and renal problems. Patients may sometimes be disabled to the extent that they require 24-hour lifelong care.

NICE have published guidelines on the diagnosis and management of bacterial meningitis in under 16-year-olds[3]. It can be difficult to diagnose because many of the symptoms and signs of meningitis are extremely non-specific and include fever, vomiting, drowsiness, confusion, neck stiffness, headache and joint pain.

The guidance outlines more specific symptoms and signs, including photophobia, altered mental state, leg pain, seizures, a bulging fontanelle in babies, a non-blanching rash and shock. The progress of septicaemia secondary to meningitis is fast and doctors must ensure they are fully familiar with the emergency treatment of meningitis.

The British Infection Association has published guidelines on the diagnosis and management of meningitis in adults[4].

There were three cases of meningococcal meningitis in our review, involving two children and one adult. There were also two cases of pneumococcal meningitis involving adult patients and a case of tuberculous meningitis. Meningitis still remains an extremely important diagnosis to consider in all age groups.

Encephalitis is a relatively rare infection of the brain parenchyma with an estimated UK incidence of 4,000 patients per year. It is important to recognise encephalitis promptly, as for many viral causes, treatment is effective if started promptly; in contrast, delays in treatment can be devastating.

A history of a current or recent febrile illness with altered behaviour or consciousness, or new seizures or focal neurological signs, as well as nausea, vomiting and headache, should raise the possibility of encephalitis or another CNS infection and trigger appropriate investigations[4].

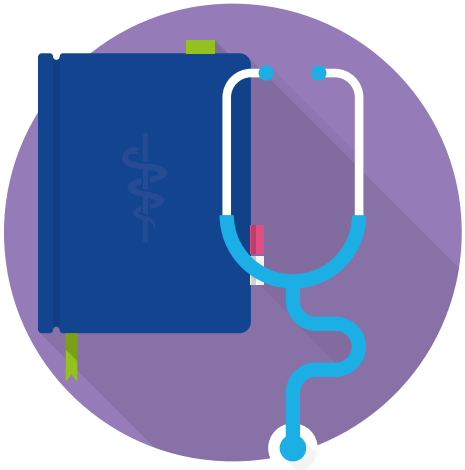
CANCERS

Diagnosis and treatment of cancers accounted for 16% of very high value claims.

There was considerable variation in the type of malignancy involved, including rectal, breast, brain, skin, prostate, bladder and sarcoma. In analysing these cases, we identified several areas where the care of patients could be criticised:

- failure to diagnose cancer;
- delay in referral for investigation;
- delay in treatment.

It is important for doctors to consider the possibility of cancer in any patient, especially if a patient is not responding to a treatment as expected or continues to experience symptoms despite a presumed less serious diagnosis. In many cases of failure to diagnose a cancer, a thorough examination was not performed. Even if the patient has been previously examined, doctors should undertake subsequent examinations if symptoms persist, as subtle signs may otherwise be missed.



Systems failures often contribute to delays in investigation and treatment of patients with cancer. For example, a skin biopsy result may detail invasive malignant melanoma, but does the practice have a system to ensure that reports come back for every specimen sent to histology? A consultant may want to review the patient a week after his CT scan, but are administrative systems in place to ensure that the patient receives the appointment? Is there a risk, in each situation, that the patient may assume the results were normal?

Doctors should ensure that there are robust systems in place to ensure that patients do not "slip through the net".

PERIPHERAL ISCHAEMIA

These cases account for 7% of the very high value claims, of which three are directly related to diabetes.

The criticisms of care involved included:

- failure to diagnose ischaemia;
- delay in treatment of ischaemia;
- inadequate treatment of ischaemia.

NICE guidance[5] states that patients should be assessed for the presence of peripheral arterial disease if they:

- have symptoms suggestive of peripheral arterial disease or;
- have diabetes, non-healing wounds on the legs or feet or unexplained leg pain or;
- are being considered for interventions to the leg or foot or;
- need to use compression hosiery.

There is also NICE guidance on the monitoring of leg ulcers and peripheral circulation in diabetics[6].

CHRONIC DISEASE MANAGEMENT

Deficiencies in chronic disease management made up 11% of the very high value claims. Although there were no acute failures as in the other groups above, over time suboptimal management of chronic disease can cause a more insidious development of complications and associated distress and disability.

Systems failures were contributory in this group of patients, as well as individual clinicians' actions. Categories included:

- failure to ensure adequate monitoring;
- failure to adjust treatment when necessary;
- failure to act on test results.

Examples included:

- inadequate monitoring of renal function in a patient with hypertension, leading to the development of chronic renal failure, ultimately requiring dialysis.
- inadvertent continuous long term use of oral steroids, in the treatment of severe asthma, leading to osteoporosis, back pain and disability.
- failure to monitor a patient's full blood count during Carbimazole treatment, leading to the development of neutropenia.

Doctors should ensure that there is a robust system for appropriate monitoring of patients with chronic diseases, which ensures that patients have the necessary blood tests and reviews, that any results are returned, and resultant advice is communicated to patients, including the stopping or adjustment of medication.

For more examples of cases involving conditions associated with high value claims, see the case reports section starting on page 14.

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A FAMILY MATTER

MEDICAL PROTECTION'S PIPPA WEEKS EXAMINES THE LEGAL AND ETHICAL CONSIDERATIONS OF TREATING FRIENDS AND FAMILY

Every doctor has probably faced the dilemma where someone they know asks for their medical advice. Sometimes it is an informal comment they are seeking, and sometimes it is a more serious commitment. Either way, doctors should be aware of the General Medical Council's (GMC) guidance that says you should avoid treating anyone with whom you have a close personal relationship.

THE GUIDANCE

GMC guidance is set out in its publication *Good Medical Practice*, which says: "In providing clinical care you must, wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship."

Although it is recognised that there are some situations in which it might be unavoidable, such as a solo practitioner in a remote community, or in an emergency situation, the GMC takes the view that the standard of care and the professional relationship between doctor and patient is adversely affected if there is also a personal relationship and should be avoided wherever possible.

The GMC acknowledges that this is a contentious area, however the current guidance is that treating yourself, your family, friends or staff members should be avoided and doctors face investigatory and disciplinary action for failing to adhere to this principle.

THE ETHICS

Many doctors would trust themselves above all others to provide good care to their loved ones, but it is hard to imagine that the objective standard of clinical care would not be impacted by an emotional relationship to the patient. Doctors are always interested in the continued health and treatment of their patients, but the stakes are never higher than when the outcome would personally affect the practitioner and their family. Additionally, the doctor may not feel able to ask sensitive questions or perform intimate examinations, and the patient may not feel comfortable disclosing intimate or embarrassing issues to close relations. If the patient is then likely to attend a separate GP as well, the risk of disjointed care and incomplete records becomes significant.

The patient may also feel unable to refuse treatment, or to seek an alternative opinion. These issues are particularly true for children or young people, who may not wish their relations to know details of their lives and who are not able to seek alternatives.

Maintaining trust and a confidential relationship between doctor and patient becomes significantly challenging when the doctor and the patient belong to the same family or group. For example, a father who is doctor to his daughter may feel pressured to discuss her health with her mother. Although doctors might feel that this could never happen to them or their family, it is far too important a scenario to dismiss.

PRESCRIBING

Although prescribing for family or friends may not be illegal, GMC guidance on prescribing says: "Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship."

The guidance goes on to say that, if you prescribe for yourself or someone close to you, you must make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient and the reason it was necessary for you to prescribe. The guidance also says that you must tell the patient's general practitioner what medicines you have prescribed and any other information necessary for continuing care, unless the patient objects.

The guidance is based on the principle that in order to have a dispassionate appreciation of the medical diagnosis and treatment plan, the prescriber should not be emotionally involved with the patient. If the patient is seeking medical advice from both a family member and a separate GP, there is also the risk that the drugs prescribed could be duplicated, or even contraindicated. The patient may require review or monitoring that could be missed if they are not seeing their regular doctor.

Treating those close to you may be tempting, and it is often difficult to refuse, but you should approach such requests with great caution and be prepared to justify your actions.

CASE STUDY

Dr D's daughter complained of an earache the day before the family was meant to leave for a holiday abroad. Since the family was short of time Dr D took the decision to issue a prescription for antibiotics to her daughter, and arranged to collect this from her local pharmacy. The pharmacist reported the doctor to the GMC. On return from the holiday Dr D received a letter from the GMC informing her that they were investigating the complaint that she had prescribed to a member of her family.

Medical Protection assisted the doctor to provide a response to the GMC, in which she explained her reasons for prescribing to her daughter and confirmed she was aware of and understood her professional duties as set out in Good Medical Practice. Fortunately the GMC closed the case without any further action, but only after a very stressful few months for the doctor.

The cases mentioned in this article are fictional and are used purely for illustrative purposes.

To read the full GMC guidance visit: **gmc-uk.org**

WHAT DO YOU THINK?

We want to hear from you. Send your comments to: **casebook@medicalprotection.org**

THE CHALLENGES OF RURAL GENERAL PRACTICE

Being a rural GP is a hugely rewarding career, but it is not without its challenges. Medicolegal Adviser Dr Rachel Birch, provides advice on how to avoid potential pitfalls

For some GPs, rural general practice epitomises all that they hoped for in a career in medicine. It offers the chance to be a true generalist by providing many aspects of care in a remote community.

However, as the following case studies demonstrate, doctors should be aware of possible risks and take steps to reduce them, where possible.

CASE 1 – PATIENTS AS FRIENDS

Dr F works in an island community as one of three GPs and is friends with many of his patients. He saw Miss B at the weekend at a school social event. She is a local teacher and told him that she was not sleeping. She said that she hadn't got time to come and see Dr F and asked him to give her a prescription for sleeping tablets. She was also reluctant for anything to be documented in her records as her sister works as Dr F's receptionist and she was worried she would find out. She said that people have been talking about how tired she looks in the local post office.

What should Dr F do?

- Explain to Miss B that she requires review in the appropriate setting. Do not undertake an assessment at a social event.
- Arrange a suitable time for Miss B to consult with him at the practice, perhaps when her sister is off duty.
- Document the conversation in her medical records contemporaneously or as soon as practicable.
- Reassure Miss B that her medical record is confidential and, if she is concerned, ask her to consider password protecting her record, so that only clinicians may access consultation details.
- Whilst such situations may occur, patients in rural communities are often very aware of the importance of doctors maintaining boundaries between personal and professional life.

CASE 2 – CONCERN ABOUT A COLLEAGUE

Dr A and Dr D work as GP partners in a remote and geographically large area. On Monday morning Dr D arrived looking tired and dishevelled and Dr A could smell alcohol on his breath. Dr A confronted Dr D, who stated that he overdid things the night before. Dr A suggested Dr D went home and that he would cover Dr D's workload as well as his own. After two further episodes the following week, Dr D eventually confided in Dr A that he felt very down and was using the alcohol to help him sleep. Dr D is registered as a patient at the practice.

How should Dr A respond?

- Dr D's health and drinking may affect his clinical judgement. Dr A should discuss this with Dr D and suggest he takes time off work to address his health issues.
- The GMC states that doctors should consult medical colleagues and not make their own assessment of their health[1]. Dr D should consult his own GP.
- The GMC states that doctors should avoid, where possible, treating those with whom they have a close personal relationship.
- If Dr A is unable to find a locum GP to cover Dr D, he may wish to consider seeking advice from the Health Board[2].

There was a conflict here as Dr D was both Dr A's only GP colleague and patient. They discussed this and Dr D preferred to go and stay with his sister in Glasgow and seek advice from her GP. He made a successful return to work four weeks later.

CASE 3 – NO SIGNAL

Dr S works in a remote mountainous area in north-west Scotland. The nearest hospital is two hours away. Late one snowy evening he undertook a home visit to Mr B, who lived on his own on a farm. He was complaining of abdominal pain and Dr S diagnosed probable early appendicitis. He advised hospital admission, but Mr B had no relatives or friends with transport, so Dr S planned to arrange an ambulance to take him. On attempting to make the call, he realised he had no signal on his mobile phone. The patient did not have a home telephone either. Dr S told the patient he would go to a neighbouring farm to call for the ambulance.

Due to the poor weather, it took two hours for the ambulance to arrive. Mr B started developing worsening pain in the ambulance and was found to have a perforated appendix when surgery was undertaken later that night.

Although Mr B made a full recovery, he made a complaint to the practice. He was unhappy about the delay in admission to hospital and believed that Dr S had not called the ambulance quickly enough.

What steps should Dr S take?

- Respond to the patient, offering an apology for the distress that the patient experienced, outlining the steps he took to ensure that the ambulance was arranged.
- The practice may wish to consider undertaking a SEA to consider any changes that could be implemented to prevent similar future incidents.
- If a patient doesn't have a house telephone, consider the use of alerts on the medical record. Take the name and number of the caller when house visits are requested for these patients.
- Consider raising his concerns with the Health Board as funding may be available.

These case studies illustrate some common themes within rural general practice. There are many other factors to consider in rural practice; below are a few examples.

IT ISSUES

Due to their wide spectrum of work, rural practices may find themselves routinely accessing several different clinical systems that vary from their own GP computer system, each requiring separate usernames and passwords.

In a remote environment, the benefits of being able to access clinical information from other healthcare systems is clear[3]. Extensive IT work and planning would be required to enable integration of health systems, including consideration of confidentiality if such a system were to be proposed.

As email communication may be used more than in non-rural settings, doctors should ensure that clinical emails are filed in the patient's medical record.

Sometimes broadband connectivity may be poor, especially at branch surgeries. Doctors may have difficulties accessing out-of-hours records or the hospital pharmacy system. This has implications for clinical safety and workload, as clinicians may resort to duplicating records in case of internet unavailability. It is important to identify issues and address them, where possible, or develop safe ways to work despite the challenges.

PRIMARY/SECONDARY CARE INTERFACE

Rural GPs usually enjoy good links with secondary care. Many rural practices provide medical cover for local community hospitals and discuss cases frequently with consultants. Outreach clinics for hospital specialties are also opportunities for GPs and consultants to discuss cases.

The benefits of good communication are clear. Consultants will know the GPs and the community when they are discharging patients. The community hospital can offer a beneficial interim care step.

The overlap between community and hospital care may foster collaborative working between specialties and staff.

RECRUITMENT

Rural practices may find difficulty in recruiting permanent staff, especially doctors. Despite the many attractions of working in a rural setting, it is not for everyone. Understaffing is a potential risk to both patients and practice staff.

For GPs taking a week's holiday, the effort may sometimes feel comparable to climbing a mountain. Doctors should not allow this to be a barrier, as it is important to have time off from this challenging role. When recruiting a locum, as well as finding someone willing to cover the work, they must have suitable experience and skills to be able to perform the challenging job of a rural GP.

The General Medical Council states[4] that doctors must be satisfied that the person to whom they delegate has the knowledge, skills and experience to provide the relevant care or treatment, or that the person will be adequately supervised.

Colleagues may agree to supervise any GP locum that is employed, with a reciprocal arrangement when they are on leave. Locums should have a good induction process before they start work and a handover from the GP who they are covering, being clear on the expectations of the role as well as providing an insight into the geography of the area and how to arrange certain care.

The advent of RCGP initiatives and specific training in rural medicine, for both medical students and GP trainees, are great steps to improving safety and recruitment of locum GPs in rural medicine.

EDUCATION AND PEER SUPPORT

In the remote setting, it may be challenging to keep up to date, attend courses and organise training. Online CPD may be particularly helpful, as will the discussion of cases with secondary care when the opportunity arises.

Within practices and the wider primary care team it is important to discuss and learn from any significant events, including potential near misses and also good outcomes.

GPs may wish to arrange peer support relationships with GPs on the mainland or other rural GPs, so that they can share learning and discuss cases. The use of telephone or videoconferencing may be useful in such circumstances.

OWN HEALTH

Rural GPs need to be aware of their own health and consult their own GP when appropriate. There is the potential for both social and professional isolation and it is important to take steps to ensure that this doesn't happen. In addition, in a busy all-encompassing job, with challenges such as 24-hour on-call sessions, there is always the potential for burnout.

Doctors should ensure that they maintain a good work-life balance and ensure that when they are not working they are truly away from work. Living in some of the country's most beautiful locations can present wonderful opportunities for enjoying that time off.

LOCATION

Rural GPs often work a long way from secondary care and need to be able to cope with a diverse range of emergency situations. They may spend several hours with the patient prior to transfer and, at certain times of year, weather and road conditions may render roads impassable for ambulances. Using a helicopter as an alternative is an invaluable option, but the decision to use it balances clinical need against resource implications.

Despite having local midwifery colleagues, GPs may still become involved in obstetric emergencies. Having protocols, training and advance planning, for example transferring at-risk patients to the mainland, is essential.

Rural GPs undergo appropriate training, which should be updated regularly. This includes advance trauma life support (ATLS), paediatric and adult life support (PALS and ALS) and pre-hospital care (BASICS). Such training is an essential part of being able to deal with any emergency situation.

Even seemingly simple tasks like organising blood tests may be dependent on the ferry timetable. Regular treatment such as dialysis needs careful planning and coordination.

PRIMARY CARE WORKLOAD

It is important to ensure a balanced and well-managed appointment system for the different facets of a rural GP's work. Telephone appointments may be offered if the practice area is large and patients have difficulties with travel. The practice should have a chaperone policy, which may present particular challenges for small practice teams.

Good liaison with the community nursing team helps to ensure that patients receive good care, and a multidisciplinary approach is essential, as all members of the team will be reliant on each other.

For more information and support on rural practice, visit the Rural GP Association of Scotland at: **ruralgp.scot**

WHAT DO YOU THINK?

We want to hear from you. Send your comments to:
casebook@medicalprotection.org

The author would like to thank Dr David Hogg of the Rural GP Association of Scotland and GP Principal at Arran Medical Group for his input on this article.

The case studies mentioned in this article are fictional and are used purely for illustrative purposes.

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RISK ALERT

MEDICATION ERRORS AND SAFER PRESCRIBING

GP and Medical Protection Clinical Risk Facilitator Dr David Coombs examines two cases that demonstrate common risks associated with prescribing

The sheer number of prescriptions issued in primary care means that the potential for patients to be affected by errors is high. For example, just over one billion prescriptions are issued in primary care in England alone each year[1]. The study, which involved examination of 6,048 unique prescription items for 1,777 patients in English general practices, found that prescribing or monitoring errors were detected for one in eight patients, involving around one in 20 of all prescription items. The vast majority of the errors were of mild to moderate severity, with one in 550 items being associated with a severe error[2].

Errors can occur at each step of the primary care medication process, including prescribing, dispensing, administration, monitoring and at the interfaces of care. Fortunately most errors don't cause harm, but they still contribute to a significant proportion of admissions, patient safety incidents and claims.

To help members control their risk Medical Protection has developed a new e-learning module on this subject, which can be found on our e-learning platform, Prism.

Below are two case reports highlighting some common areas of risk.

CASE 1

Mr A registered with a new GP practice and requested a repeat prescription for his regular medication, which included fluocinolone 0.025% cream (a potent topical steroid). He was asked to attend for a GP appointment with Dr B, who immediately noticed the patient's "bright red shiny face". Mr A explained that he had suffered from asthma and eczema for many years and that he had started using the fluocinolone on his face about two years earlier when his eczema had been bad. Although the eczema on his body and limbs had cleared up, he found that as soon as he stopped using the steroid on his face it became very uncomfortable, so he continued to use it.

Dr B discussed the risks of continuing to use the potent steroid on his face and referred him to a local dermatologist who initiated a regime to reduce gradually the strength of topical steroid used on the face. After four months Mr A found he no longer needed to use any topical steroid on his face.

Discussion with Mr A and review of his records revealed that although he had attended for reviews at his previous GP, these had been at the asthma clinic. His records had been coded as "*medication review done*". He had initially been prescribed hydrocortisone 1% ointment for his face but had stopped ordering this as well as his emollients when he found the stronger steroid more effective. The prescriptions for fluocinolone cream had simply stated "*apply twice daily*".

LEARNING POINTS

- A change of GP practice is a good opportunity to review all medication.
- Medication reviews should encompass all items.
- Include relevant information on the prescription, such as the problem being treated and any monitoring requirements. This will appear on the label once the medication is dispensed and may improve adherence to treatment. For example, "*apply twice daily to body, arms and legs for severe eczema only*".
- Consider restricting the number of issues allowable for certain drugs, such as potent topical steroids, before a review.
- In some cases it may be preferable not to add as repeat prescription until clear that the condition is responding as expected.
- Consider the use of patient information leaflets to explain the management of chronic conditions more clearly.

The cases mentioned in this article are fictional and are used purely for illustrative purposes.

CASE 2

Mr C was on long-term immunosuppressive treatment and attended the "flu clinic" with his practice nurse in September 2013 for his annual flu vaccine. He asked if he could also be given the new shingles vaccine. The nurse said he was not sure and would check with one of the GPs. He waited outside one of the consulting rooms and quickly popped in between patients. Dr D was already running behind with her surgery and after a brief thought said, "Yes, that would be fine."

Mr C was given the vaccine and unfortunately developed an atypical herpes zoster infection. A few months later a complaint and subsequently a claim were made against the GP practice.

A significant event analysis at the practice revealed that Dr D had not accessed the patient notes before giving advice. There was nothing in the clinical notes to record the discussion between the nurse and Dr D.

LEARNING POINTS

- Distractions and interruptions are a common cause of error.
- Vaccination errors are one of the most frequently reported medication safety incidents reported in primary care[3].
- When prescribing or giving advice about a new or unfamiliar drug, be prepared to look up information on your clinical record system, in a formulary or in specific guidelines as appropriate.
- Make contemporaneous records of all contacts/discussions with colleagues about patients.
- Administration of a routine vaccination is not urgent and, although inconvenient for the patient, it may be safer to rebook, allowing time to check facts – particularly if, as here, the patient had a short appointment earmarked just for the flu vaccination.

REFERENCES

1. Health and Social Care Information Centre. Prescriptions Dispensed in the Community, Statistics for England - 2002-2012 [NS]. Published July 30th 2013. (Accessed 26/01/16) hscic.gov.uk/searchcatalogue?productid=12055&topics=0%2fPrescribing&sort=Relevance&size=10&page=2#top
2. Reference: Avery et al (2012) Investigating the prevalence and causes of prescribing errors in general practice: The PRACtICe study. Commissioned by GMC gmc-uk.org/about/research/12996.asp
3. National Reporting and Learning System. NPSA. Medication Incidents in Primary Care. Quarterly Data summary issue 7 2008. National Patient Safety Agency

To take part in the Medical Protection *Medication Errors and Safer Prescribing* e-learning module and help lower your prescribing risk, visit: **medicalprotection.org/uk/education-and-events/online-learning**

FROM THE CASE FILES

Dr Richard Stacey, Senior Medicolegal Adviser, introduces this edition's case reports

Want to join the discussion about this edition's case reports? Visit medicalprotection.org and click on the "Casebook and Resources" tab.

Think beyond the common

When I was at medical school, I recall being admonished for suggesting an esoteric cause for a presentation of acute renal failure (or acute kidney injury as it is now known), under the explanation from the consultant that common things are common and that when providing a differential diagnosis, I should start by providing a list of the common causes. Then, without a hint of irony, the consultant suggested that I might wish to see a patient who had been admitted overnight with acute renal failure as a consequence of Wegener's Granulomatosis.

This edition of *Casebook* highlights a number of cases in which allegations have arisen as a consequence of a missed and/or delayed diagnosis of serious underlying pathology: in the case of Mr B it was alleged that the severity of his symptoms was underestimated and that a home visit should have been arranged; there are two paediatric cases in which the allegations related to a missed/delayed diagnosis of meningitis/meningococcal septicaemia; there is a case in which there was a missed diagnosis of pre-eclampsia with catastrophic consequences for the baby; and there is a case in which there is an unusual presentation of renal disease, which was subsequently complicated by a subarachnoid haemorrhage.

The difficulty that a clinician faces when assessing a patient is that, by definition, common things are common and (usually, but not always) are either benign and/or self-limiting in their nature. For example, most children who present with coryzal symptoms will not have serious underlying pathology; most pregnant patients who develop ankle swelling will not have pre-eclampsia; most patients who present with headache will not have serious underlying pathology etc. One of the challenges for clinicians is identifying those patients that require further investigation (and/or treatment) in order to establish or rule out serious underlying pathology and arranging for that investigation (and/or treatment) to be undertaken within a reasonable time frame (which, depending on the circumstances, may be on an emergency basis). There is an abundance of diagnostic algorithms, standards and guidance available, and whilst it is not always easy to access them in the midst of a consultation, if there is an adverse outcome, your care will be judged to the relevant standards and guidance (that prevailed at the time of the incident).

In circumstances when you have made a diagnosis of a common benign and/or self-limiting illness, it is useful to ask yourself the following check questions:

1. Have I advised the patient of red flag symptoms to look out for and explained what they should do in the event that these develop?

2. Have I informed the patient as to what should prompt them to return for review?

3. If the diagnosis subsequently turns out to represent serious underlying pathology, would I be in a position to justify not making (or contemplating) that diagnosis based on the information available to me?

Check questions 1 and 2 amount to the provision of safety-netting advice and if the answer to check question 3 is 'no' then this should prompt consideration as to whether further investigation is indicated.

I hope that you find both the cases and the above suggestions thought-provoking and draw your attention to the fact that the cases have common themes relating to both communication and record-keeping.

What's it worth?

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

- HIGH £1,000,000+
- SUBSTANTIAL £100,000+
- MODERATE £10,000+
- LOW £1,000+
- NEGLIGIBLE <£1,000

MISSED MENINGITIS

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE

JC was a 20-month-old boy who had been up all night with a fever. It was the weekend so his mother rang the out-of-hours GP. She explained that his temperature was 39.4 degrees and that he was clingy and sleepy. Dr R assessed him at the out-of-hours centre and documented that there was no rash, vomiting or diarrhoea. His examination recorded the absence of photophobia and neck stiffness. He stated "nothing to suggest meningitis". Examination of the ears, throat and chest were documented as normal. He noted that his feet were cool but he appeared hydrated. Dr R diagnosed a viral illness and advised paracetamol and fluids. He advised JC's mother to make contact if he developed a rash, vomiting, or if she was concerned.

JC's mother felt reassured so she took him home and followed the GP's advice. JC remained tired and off his food over the next two days. The following day he began vomiting and mum could not get his temperature down. He seemed drowsy and was just lying in her arms. She took him straight to A+E.

He was very unwell by the time he was assessed in A+E. The doctors noted that he was pale, drowsy, and only responding to pain. His temperature was 38 degrees and his pulse was 160bpm. A diagnosis of "sepsis" was made. Full examination revealed neck stiffness and he went on to have a lumbar puncture. This confirmed meningitis with Haemophilus influenzae.

JC was treated with IV fluids, ceftriaxone and dexamethasone and showed great improvement. Four days later he developed a septic right hip needing aspiration and arthrotomy. The aspirate revealed Haemophilus influenzae. A month later he was assessed at a fracture clinic and was walking unaided and fully weight-bearing. An x-ray eight years later showed that the right femoral capital epiphysis was slightly larger than the left. His mother claimed that he complained of daily hip pain, giving way and morning stiffness.

Two months after his illness JC had a hearing test that showed moderately severe sensorineural hearing loss. Despite hearing aids JC had delayed speech and language development. His mother was upset because he struggled with poor concentration at school and found it difficult to interact in groups.

JC's mother made a claim against Dr R, alleging that he failed to diagnose meningitis and admit her son. She felt that if his meningitis had been treated earlier his hearing could have been saved and he would not be at risk of arthritis in his hip in later life.

EXPERT OPINION

Medical Protection obtained expert opinion from a GP, a professor in infectious diseases, an orthopaedic surgeon and a consultant in ENT.

The GP thought Dr R had made a comprehensive examination of a febrile child and had demonstrated an active consideration of the possibility of meningitis. He commented that the features of many childhood viral illnesses are indistinguishable from the very early stages of meningitis. He noted that Dr R had advised JC's mother to make contact if he deteriorated. He was a little critical of Dr R for not recording JC's vital signs such as pulse and temperature. He felt this was an important part of determining a child's risk of having a serious illness.

The professor of infectious diseases thought that JC did not have meningitis when he saw Dr R but was likely to be in the bacteraemic phase of the illness. This phase shares features with many other more trivial infections. He explained that Haemophilus influenzae meningitis can present in an insidious fashion over several days. He felt that the vomiting three days later may have signified cerebral irritation due to meningitis.

The orthopaedic surgeon noted the minor x-ray abnormalities in JC's right hip. He felt that given the patient's excellent initial recovery and the minor x-ray changes it was difficult to explain the alleged hip symptoms as children with coxa magna generally have no symptoms even with contact sports. He thought that JC would have a lifetime risk of needing hip replacement of 12-20% due to past septic arthritis.

The ENT consultant concluded that JC would need to use hearing aids for the rest of his life. He felt that his speech and language development had also been compromised by poor hearing aid usage.

In response to the Letter of Claim from the claimant's solicitors, Medical Protection issued a letter of response denying liability based on the supportive expert opinion and the claim was discontinued.

Learning points

- NICE have a useful traffic light system for identifying risk of serious illness in feverish children under five[1]. Along with other clinical signs, it requires GPs to check pulse, respiratory rate, temperature and capillary refill time in order to categorise them into groups of low, medium or high risk of having serious illness.
- Safety netting is an important part of a consultation. In this case Dr R advised the mother to contact services again if he deteriorated. This helped Medical Protection defend his case.
- In some cases claims can be brought many years after the events. This makes good note-keeping essential as medical records will often be the only reliable record of what occurred.

REFERENCES

1. Fever in Under 5s: Assessment and Initial Management, NICE guidelines [CG160], May 2013 – nice.org.uk/guidance/cg160/chapter/recommendations#table-1-traffic-light-system-for-identifying-risk-of-serious-illness

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PROBLEMATIC ANAESTHETIC

SPECIALTY ANAESTHETICS
THEME CONSENT/INTERVENTION AND MANAGEMENT

SUBSTANTIAL

Mrs B was a 57-year-old lady with a past history of breast cancer treated with mastectomy and adjuvant therapy. She re-presented to her consultant breast surgeon, Mr F, three years after the original surgery with a worrying 2cm lump in the vicinity of her mastectomy scar. Mr F recommended an urgent excision biopsy of the lump under general anaesthetic.

On the day of surgery, Mrs B was reviewed by consultant anaesthetist Dr S. She told Dr S that she had been fine with her previous anaesthetic and that she had no new health problems. Dr S reassured Mrs B that it should be a routine procedure and that he anticipated no problems. He warned her about the possibility of dental damage and sore throat and promised that he would not use her left arm for IV access or blood pressure readings, because of the previous lymph node dissection on that side.

In the anaesthetic room, Dr S reviewed the anaesthetic chart for Mrs B's mastectomy procedure. He saw that Mrs B had received a general anaesthetic along with a paravertebral block for post-operative analgesia, and this technique appeared to have worked well. He did not, however, discuss this with Mrs B.

Dr S inserted a cannula in Mrs B's right arm and induced anaesthesia with fentanyl and propofol. He inserted a laryngeal mask airway and anaesthesia was maintained with sevoflurane in an air/oxygen mixture. Mrs B was then turned on to her side and Dr S proceeded to insert left-sided paravertebral blocks at C7 and T6. Although Dr S used a stimulating needle and a current of 3mA, he had difficulty eliciting a motor response at either level. At T6, Dr S finally saw intercostal muscle twitching after a number of needle passes. Twitches were still just visible when the current was reduced to 0.5mA and Dr S therefore slowly injected 10ml of Bupivicaine 0.375% with clonidine. At the upper level, Dr S could not elicit a motor response despite several needle passes. He eventually decided to use a landmark technique and injected the same volume of local anaesthetic mixture at approximately 1cm below the transverse process.

Dr S then administered atracurium 30mg and Mrs B was ventilated for the duration of the operation. The operation was largely uneventful apart from modest hypotension, which Dr S treated with boluses of ephedrine and metaraminol.

At the end of surgery, Dr S reversed the neuromuscular blockade and attempted to wake Mrs B. However, Mrs B's respiratory effort was poor and she was not able to move her limbs. Dr S diagnosed an epidural block caused by spread of the local anaesthetic. He reassured Mrs B and then re-sedated her for approximately 40 minutes. Following that she was woken again and her airway was removed. Weakness of all four limbs was still noted.

Over the next five hours Mrs B regained normal sensation and power in her lower limbs and left arm. However, her right arm remained weak, with an absence of voluntary hand movements. She also had gait ataxia on attempting to mobilise. An MRI was performed the following day, which demonstrated signal change and subdural haemorrhage in the spinal cord at a level consistent with her persistent symptoms.

Mrs B remained in hospital for physiotherapy and rehabilitation. Her walking and right hand function gradually improved and she was discharged three weeks after her operation. Six months later, Dr S received a solicitor's letter stating that Mrs B was still having problems with her hand and was seeking compensation.

EXPERT OPINION

Medical Protection instructed Dr M, a consultant anaesthetist, to comment on the standard of care. Dr M was critical of Dr S for four major reasons:

1. Dr S had failed to inform Mrs B that he intended to perform a paravertebral block and failed to discuss the risks and benefits of such a technique.

2. He was somewhat critical of the decision to perform the block with Mrs B anaesthetised. He opined that had Mrs B been conscious or lightly sedated, she would have alerted Dr S when the needle was in proximity to nerve tissue. However, Dr M did concede that there was a body of responsible anaesthetists who would support the notion of performing a paravertebral block with the patient anaesthetised.

3. He was critical of Dr S's decision to keep persisting with the block when he was struggling to locate the correct needle position. He felt that Dr S should have abandoned the block or called for help. He also concluded that the technique used by Dr S was very poor given the complications that followed.

4. Dr M was critical of the levels chosen by Dr S to perform the block. He felt that C7 was too high, given that the dermatomal level of the surgery was approximately T4. He also felt that the surgery was very minor and did not warrant the paravertebral block. Dr M was of the opinion that infiltration of local anaesthetic by the surgeon, combined with simple analgesics, would have sufficed.

On the basis of the expert evidence Medical Protection concluded that there was no reasonable prospect of defending the claim. The case was eventually settled for a substantial sum.

Learning points

1. Local anaesthetic blocks should only be performed when there is a clear indication.
2. The risks and benefits of the block should be discussed with the patient and clearly documented. The process of consent for any operation should be a detailed conversation between clinician and patient with documented evidence. The incidence and potential impact of any common and potentially serious complications should always be discussed and documented.
3. Local anaesthetic blocks should only be performed by practitioners with appropriate training and expertise.
4. If difficulties are encountered, either the procedure should be abandoned or assistance summoned.

JPA

FAILURE TO FOLLOW SPECIALIST ADVICE

SPECIALTY GENERAL PRACTICE/NEUROLOGY
THEME PRESCRIBING

SUBSTANTIAL

Following a hospital admission for status epilepticus, which was attributed to a previous cerebral insult, Mr G, a 35-year-old clerical officer, was started on an anticonvulsant regime of phenytoin and sodium valproate. Over the next few years, the medication was changed by the hospital several times in response to the patient's concerns that his epilepsy was getting worse. After a further seizure led to hospital admission, the patient was discharged on vigabatrin on the advice of the treating neurologist, Dr W. Readmission for presumed status epilepticus a short while later led the hospital to conclude that there might be a functional element to the seizures. This was supported by psychiatric evaluation. The patient was discharged to psychology follow-up with a recommendation at the end of the discharge summary to gradually tail off and stop the vigabatrin. This advice was overlooked by Mr G's GP, Dr L, who continued to prescribe as before. The error was not picked up by either Dr L or the hospital despite multiple contacts and several hospital admissions over the next five years, for the first three years of which Mr G remained under the care of Dr W.

Subsequently, Mr G was seen by both Dr L and his optician, complaining of tired, heavy eyes. No visual field check was carried out on either occasion. Nine months later Mr G returned to see Dr L, requesting a referral to the epilepsy clinic as he had read a newspaper report about the visual side effects of vigabatrin. An appointment was made at the clinic but Mr G failed to attend on two occasions. An urgent referral was ultimately made by Mr G's optician several months later following detection of a visual field defect on a routine examination. The ophthalmic surgeon, Mr D, noted that Mr G had been on vigabatrin for in excess of 11 years during which time he had not been monitored. His visual fields were noted to be markedly constricted, which was attributed to the vigabatrin. Mr G was referred to another neurologist who recommended a change of anticonvulsant. Mr G was gradually weaned off the vigabatrin.

As a result of the damage to his eyesight, Mr G brought a claim against the hospital for negligent prescription of vigabatrin and failure to warn the claimant of the side effects. Mr G also brought a claim against Dr L for continuing to prescribe vigabatrin against the advice of the neurologist, failing to review the medication at regular intervals, and failing to refer to an ophthalmologist.

EXPERT OPINION

Medical Protection's GP expert was critical of Dr L's failure to act on the neurologist's advice to tail off the vigabatrin and for the absence of any record that Dr L monitored the patient or reviewed his medication. Dr L's decision to refer Mr G to an epilepsy specialist once he was alerted to the potential side effects was appropriate and Dr L could not be held accountable for Mr G's failure to attend a number of hospital appointments, which may have contributed to the delay in diagnosing the visual field defect. The claim was settled on behalf of Dr L and the Trust for a reduced but still substantial sum.

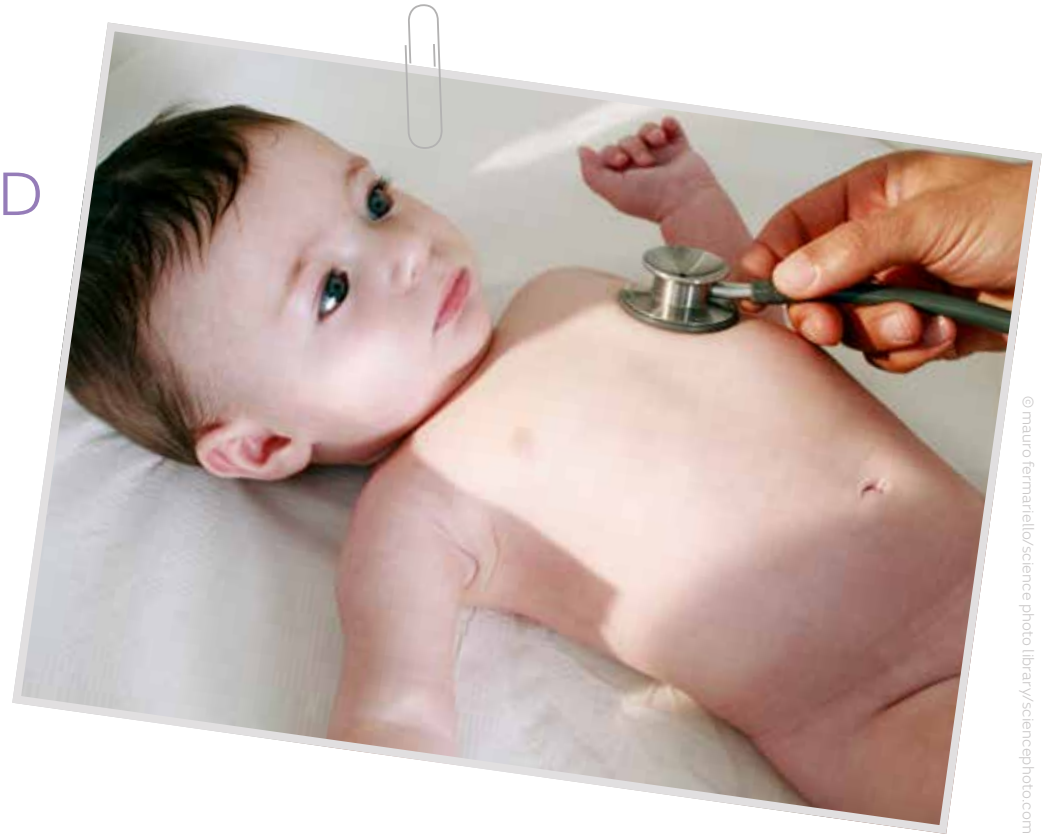
Learning points

- If a doctor signs a prescription, they take responsibility for it – even if it is on the advice of a specialist. Good communication between primary and secondary care is vital to ensure patients receive the appropriate treatment. See the GMC, *Prescribing Guidance on Shared Care*: **gmc-uk.org/guidance/ethical_guidance/14321.asp**.
- Patients should be informed if there is a need for monitoring or regular review of long-term medications. Where there is shared care with another clinician, agreement should be sought as to the most appropriate arrangements for monitoring. All advice should be clearly documented.
- When alerted to a potentially serious side effect of medication, prompt arrangements for review should be made, with a specialist if appropriate.

JP

UNDESCENDED TESTIS

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE



Baby LM was taken to see his GP, Dr E, for his six-week check. During this examination Dr E noted that his left testis was in the scrotum but his right testis was palpable in the canal. He asked LM's mother to bring him back for review in a month.

Two weeks later his mother brought him to see Dr E because he had been more colicky and had been screaming a lot in the night. As part of that consultation, Dr E documented that both testes were in the scrotum.

LM was brought for his planned review with Dr E in another two weeks. Both testes were noted to be in the scrotum although this time the left testis was noted to be slightly higher than the right. His mother was reassured.

When LM was 16-months-old he appeared to be in some discomfort in the groin when climbing stairs. His mother was worried so she took him back to Dr E for a check-up. Dr E examined him carefully and documented that both testes felt normal and were palpated in the descended position. He also noted the absence of herniae on both sides. He advised some paracetamol and advised his mother to bring him back if he did not improve.

When LM was 15-years-old he noticed that one of his testicles felt different to the other. At that time he was found to have a left undescended testis which was excised during surgical exploration.

LM's mother felt that Dr E had missed signs of his undescended testis when he was younger. A claim was brought against Dr E, alleging that he had failed to carry out adequate examinations and that she should have referred to the paediatric team earlier. It was claimed that if Dr E had referred to paediatrics earlier then this would have resulted in a left orchidopexy, placing the testis normally in the scrotum before the age of two years and thus avoiding removal of the testis.

EXPERT OPINION

Medical Protection obtained expert opinions from a GP and a consultant in paediatric surgery. Both were supportive of Dr E's examination and management. The consultant in paediatric surgery thought that LM had an ascending testis. This is a testis which is either normally situated in the scrotum or is found to be retractile during infancy, and later ascends. He thought that even if LM had been referred in infancy, it would have been likely that examination would have found the testes to be either normal or retractile and he would have been discharged with reassurance. He explained that it is thought that in cases of ascending testis testicular ascent occurs around the age of five years. Therefore, on the balance of probabilities, referral to paediatrics before the age of four would not have led to diagnosis of an undescended testis.

This claim was dropped after Medical Protection issued a letter of response to the claimant's legal team which carefully explained the expert opinion.

Learning points

- Medical Protection were able to defend Dr E in light of his appropriate clinical management, good note-keeping and the expert advice.
- Good documentation helped Dr E's defence. Doctors should always document the presence or absence of both testes in the scrotum at the six-week check.
- A testis that is retractile or normally situated in the scrotum in infancy can ascend later. NHS-choices have a useful leaflet for parents outlining that "retractile testicles in young boys aren't a cause for concern, as the affected testicles often settle permanently in the scrotum as they get older. However, they may need to be monitored during childhood, because they sometimes don't descend naturally and treatment may be required"[1].
- NICE have published a Clinical Knowledge Summary that covers the primary care management of unilateral and bilateral undescended testes, including referral. It can be found here: **cks.nice.org.uk/undescended-testes**.

REFERENCES

1. nhs.uk/conditions/undescendedtesticles/Pages/Introduction.aspx

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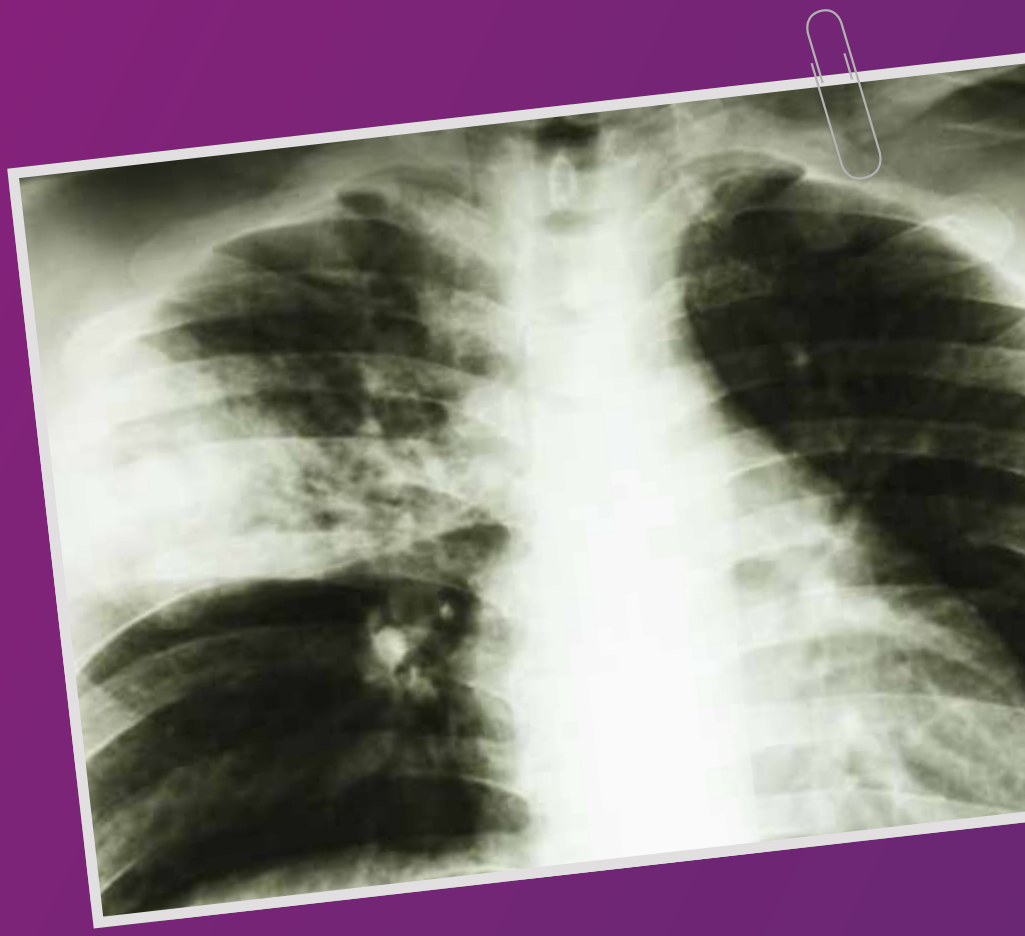
DIAGNOSING PNEUMONIA OUT OF HOURS

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE



Mr B was a 31-year-old man with three children. His mother was staying with him over the weekend because he was in bed coughing and shivering. On Saturday he complained of chest pains so his mother rang an ambulance. The paramedic recorded a temperature of 39 degrees, oxygen saturations of 94%, pulse 134, respiratory rate of 16 and a blood pressure of 120/75. An ECG was done and noted to be normal. The paramedic explained to Mr B that he should be taken to hospital. Mr B declined and was considered to have capacity so the ambulance left.

The ambulance crew called their control centre who in turn contacted an out-of-hours GP, Dr Z. The control centre left a verbal message for Dr Z, explaining the situation, but did not hand over details of Mr B's vital signs including his oxygen saturations and pulse rate.

Dr Z rang Mr B and noted his history of chest pain triggered by coughing and the normal ECG. She noted his temperature of 39 degrees and that he had taken some ibuprofen to help. She documented "no shortness of breath" and advised some cough linctus and paracetamol. She offered him an appointment at the out-of-hours centre, which he declined, but he did agree to ring back if he was worse. She documented that her advice had been accepted and understood.

Mr B was no better on Sunday so his mother rang the out-of-hours centre again. This time a nurse spoke to Mr B and noted his history of productive cough, fever and aching chest pain. She documented that he had some difficulty in breathing on exertion but that he could speak in sentences over the telephone. Again she offered him an appointment at the out-of-hours centre but he refused, saying he would prefer to see his own GP on Monday.

Three days later Dr B's mother took him to see his own GP. He found coarse crepitations in his right upper and mid chest but with good air entry. He noted that Mr B was not unduly distressed and had no shortness of breath so opted for oral antibiotics and a review in two days.

Later the same day Mr B's breathing became rasping and very laboured. He collapsed and an ambulance took him to A+E. Cardiopulmonary resuscitation was attempted but sadly failed. A post mortem was performed, giving the cause of death as "right-sided lobar pneumonia and bilateral pleural effusions".

Mr B's mother was distraught and brought a claim against the out-of-hours GP, Dr Z. She claimed that her son had been extremely short of breath on the telephone and that she had not paid adequate attention to this. She was upset that Dr Z had not arranged to visit her son at home and had incorrectly diagnosed a simple chest infection.

EXPERT OPINION

Medical Protection obtained expert opinions from a GP and a respiratory specialist. The GP was supportive of Dr Z. He noted that cough, fever and malaise are very common symptoms in a young adult. He listened to the recorded consultation and considered Mr B to have been only mildly short of breath and showing no verbal signs of delirium. He felt it was reasonable for Dr Z to suggest attendance at the primary care centre. He also noted that if Mr B had been well enough to attend his own GP four days later, then he could probably have travelled to see Dr Z on the day she spoke to him. He felt it had been neither possible nor necessary to define the diagnosis beyond a respiratory tract infection

during their telephone consultation. He thought it was unhelpful that Dr Z had not received Mr B's oxygen saturations or pulse rate from the ambulance crew.

The respiratory specialist noted that Mr B was assessed by the ambulance crew on the same day he consulted with Dr Z on the telephone. At that time he was not confused, his respiratory rate was 16 and his blood pressure was satisfactory. This would have given him a CRB65 score of 0, which is associated with a good prognosis. He commented that this, along with clinical judgement, would have supported home-based care for this patient rather than the need for hospital assessment.

It was highlighted that Mr B had refused to go to hospital with the ambulance crew and to attend the out-of-hours centre. This and the supportive expert opinion helped Medical Protection to successfully defend Dr Z.

Learning points

- Medical Protection can use recorded data as evidence to support members who are the subject of a claim. GPs working out-of-hours should be aware that a telephone recording is an additional record of the consultation when speaking to patients on the telephone.
- According to NICE guidance, after diagnosing pneumonia GPs should use the CRB65 score to determine the level of risk and help guide decisions on where to manage a patient[1]. One point is given for confusion (AMTS 8 or less or new disorientation in person, place or time), raised respiratory rate (30 breaths per minute or more), low blood pressure (systolic <90mmHg or diastolic <60mmHg), age 65 years or more. A score of 0 is classed as low risk and is associated with less than 1% mortality. A score of 1 or 2 is classed as intermediate risk and is associated with 1-10% mortality. A score of 3 or 4 is classed as high risk and is associated with more than 10% mortality.
- When communicating between healthcare services, it is important to hand over all relevant information. In this case the ambulance crew did not pass on the patient's low oxygen saturations or his raised pulse rate. These vital signs could have conveyed the severity of the patient's illness to the out-of-hours GP.

REFERENCES

1. nice.org.uk/guidance/cg191/chapter/1-recommendations

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TRAGIC OUTCOMES DON'T ALWAYS EQUAL NEGLIGENCE

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS

JS, a four-month-old baby, was felt by his mother to be developing a cold and was given oral paracetamol solution, which was effective. The following day his mother noted he was warm and snuffly. His breathing was laboured and he was making moaning noises. He was not feeding well, although he was taking some milk. He apparently had a rash on his back. JS was given oral paracetamol solution but it now had no effect and as his condition was worsening an appointment was made for him to be seen by the GP.

Dr D reviewed the baby at around 2-3pm that day, stating in his notes that the baby had been unwell and tachypnoeic since the morning, but drinking. The examination findings that Dr D recorded were that the baby felt hot, was alert, had a soft fontanelle and equal and reactive pupils. No abnormality was recorded on examination of the throat, ears, chest and abdomen and there was no photophobia or neck stiffness. A diagnosis of a virus was made and regular oral paracetamol solution recommended, with advice to return if JS did not improve.

Dr D stated that if he had confirmed an abnormally high respiration rate when examining the baby he would have noted it. He was confident he was not told of or shown any rash, and would have noted any history or examination findings in relation to it.

The mother stated that when JS did not improve she sent her other son (aged 11-years-old) to explain that she was concerned that the oral paracetamol solution was not working. This was about 5:30pm. The son apparently spoke to the receptionist who advised that "the oral paracetamol solution needed time to work". No doctor was spoken to although the receptionists that were working at the time stated that they did not recall the son attending or providing such advice.

JS is said to have remained unwell during the evening and the mother awoke at 6:30am the following day to find that JS had developed large purple spots. She contacted the doctor. Dr W, who was on call for the practice, arrived at about 8am. On arrival it was immediately apparent to him that the baby was very unwell as he was very drowsy, greyish in colour and also exhibiting a purpuric rash. He immediately took the child to hospital in his car and stated that he administered an intramuscular injection of benzylpenicillin.

Meningococcal septicaemia was diagnosed and following treatment JS was found to be profoundly brain damaged. He was later diagnosed with severe microcephaly, cognitive impairment, poor vision and intractable epilepsy.

His mother brought a claim alleging that Dr D failed to take an adequate history and perform an adequate examination, give adequate consideration to the age of the child and the risk of rapid deterioration in his condition, failed to observe and act in the presence of a rash and to consider diagnoses other than a viral infection and failed to refer the baby to hospital. It was also alleged that the practice reception staff failed to seek medical advice and that they provided inappropriate advice to the 11-year-old son about treatment with oral paracetamol solution.

Learning points

- Good clinical records are essential for the resolution of factual disputes.
- Non-clinical staff (such as receptionists) should not provide clinical advice and GMC guidance on delegation and referral states (in paragraph 4) that "when delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised".
- Although the outcome was tragic, this does not always equal negligence.
- Parents should be advised on the signs to look for and when to seek further help, and this should be documented.

BN

EXPERT OPINION

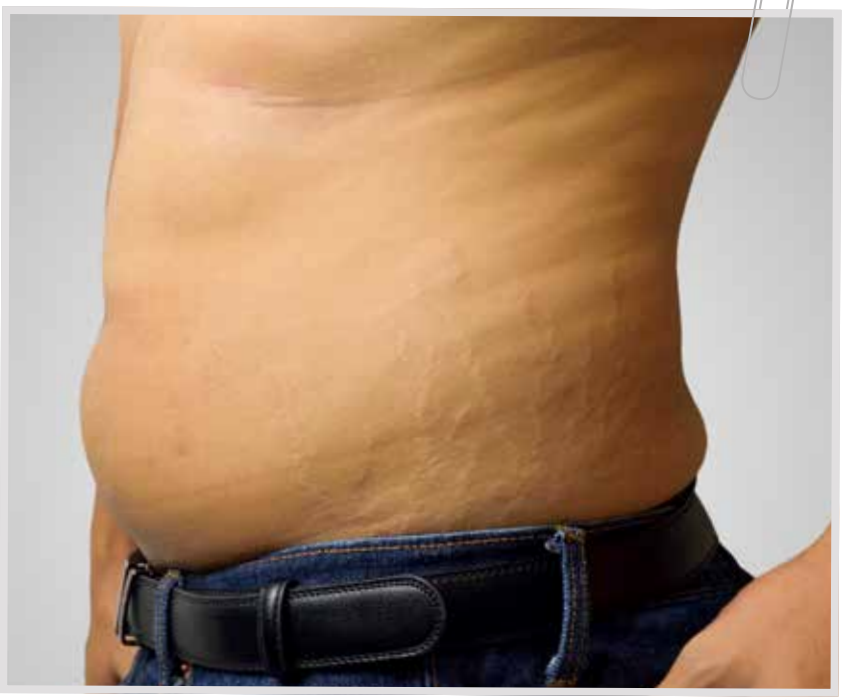
Medical Protection sought expert opinion from a GP, a paediatric neurologist, a paediatric infectious diseases specialist and a medical microbiologist. The expert GP's opinion on breach of duty stated that if the mother's account of the consultation with Dr D was accepted, the standard of care was unreasonable. However, on the basis of the records and witness statement, and having seen the member in conference, the expert was satisfied that the doctor's actions were reasonable. The paediatric infectious diseases expert report on causation indicated that if the baby had been admitted by Dr D and treated in hospital with intravenous antibiotics immediately, his opinion was that JS would have made a full recovery.

On the basis of the supportive expert GP report Medical Protection opted to defend the case at trial. The claimant discontinued three days into the trial.

STRETCH MARKS AND STEROIDS

SPECIALTY GENERAL PRACTICE/ENDOCRINOLOGY
THEME PRESCRIBING

MODERATE



Mr A was a 25-year-old man who was on lifelong steroid medication for congenital adrenal hyperplasia. He was under the care of Dr F, a consultant endocrinologist. Dr F advised him to change his steroid medication from hydrocortisone to prednisolone, 7.5mg in the mornings and 5mg in the evenings. He gave him a prescription and wrote to Mr A's GP to advise him of the steroid dose change.

A few weeks later Mr A had run out of prednisolone and went to see his GP, Dr S. He was prescribed 12.5mg prednisolone in the mornings and 10mg in the evenings. Dr S told him he had recently received a letter from Dr F about this dose.

Three weeks later Mr A started experiencing muscle cramps and mood swings. A few weeks after this his friends commented that his face was becoming swollen. In the subsequent weeks Mr A noticed he felt weaker and was not able to exercise as much at the local gym. He noticed he was bruising more easily.

Four weeks later he noticed he was developing large unsightly stretch marks on his body, especially around his back and abdomen. He consulted with another GP, Dr T, as he was concerned these, and his other symptoms, could be related to his steroid medication. Dr T examined him but advised him to wait and discuss his concerns with his endocrinologist at his appointment two months later.

At his endocrinology review Dr F advised him that all his recent symptoms were attributable to being on too high a dose of prednisolone. He reduced the steroid dose to 5mg prednisolone in the mornings and 2.5mg in the evenings.

Over the next few weeks most of the symptoms resolved, but Mr A was left with stretch marks that he found unsightly and embarrassing. He became very self-conscious and felt he could only go swimming with a T-shirt on. The stretch marks were itchy and uncomfortable, requiring frequent application of emollient, and he was advised that, although they would fade, they would never go away.

A DEXA scan revealed a decreased bone density and Mr A was commenced on Calcium tablets.

Mr A made a clinical negligence claim for undue suffering against Dr S and Dr T.

EXPERT OPINION

The GP expert was critical of both Dr S and Dr T's actions and felt this constituted a breach of duty.

It appeared that Dr S had misread Dr F's letter and prescribed an excessively high dose of prednisolone. Mr A continued to receive prescriptions for this medication every 28 days and Dr S and Dr T continued to issue the prescriptions without querying the dose.

He was particularly critical of Dr T for not questioning the dose of steroid when the patient presented with a multitude of steroid-related symptoms as well as new stretch marks.

The endocrinology expert felt that all the symptoms were attributable to an excess prednisolone dose over a five-month period. He advised that most of the symptoms would be reversible, including the decreased bone density. However, he felt that the stretch marks would be permanent, although would fade to a certain extent over time.

The case was settled for a moderate sum.

Learning points

- Side effects of corticosteroids are dose-related. Doctors should be alert to the potential side effects of long-term corticosteroids. These include all of the symptoms that Mr A was experiencing.
- If a patient complains of new symptoms while on corticosteroid medication, review the current dose and ensure the patient is taking the medication correctly.
- If there is any doubt about a patient's dose of corticosteroid, have a low threshold for discussing the matter with the patient's endocrinologist. If Dr T had telephoned Dr F for advice, the excess steroid dose would have been picked up two months earlier and might have reduced the severity of the stretch marks that the patient developed.
- If a patient is receiving long-term corticosteroid treatment, it would be helpful for them to carry a steroid treatment card. This gives clear guidance on the precautions to be taken to minimise the risks of adverse effects, and provides details of the prescriber, drug, dosage, and duration of treatment.
- The National Institute for Health and Care Excellence (NICE) has a useful resource addressing the management of patients receiving oral corticosteroids in primary care: "*Clinical Knowledge Summary. Corticosteroids-oral. August 2015*": **cks.nice.org.uk/corticosteroids-oral**.

RB

IF IT IS NOT RECORDED...

SPECIALTY GENERAL PRACTICE/NEUROLOGY
THEME REPEAT PRESCRIBING

LOW

Mr M, aged 39, presented initially to the Emergency Department with headaches, limb weakness and a drooping eyelid, but took his discharge before full investigations were completed. He was reviewed two weeks later by a neurologist who noted numbness in the arm and unsteadiness. He arranged for a CT scan which was normal. The patient did not attend for an MRI scan.

Three months later, Mr M presented to an ophthalmologist with blurred vision. Examination showed retrobulbar neuritis and he was referred to a neurologist.

A few months later the patient was seen by a neurologist, Dr P, who wrote a letter to the patient's GP, Dr O, indicating a possible diagnosis of multiple sclerosis (MS). She said that an MRI scan had been organised. Mr M was reviewed by the neurologist four months later when he was started on oral methylprednisolone and referred to support services. Dr P wrote that she would review the patient in two months, but no indication was given of the dose or duration of the course of steroids. Five days later, the GP pharmacy records indicate dispensing of the prescription of methylprednisolone as *"150 methylprednisolone tablets 16 mg. 5 tablets to be taken daily as directed by your doctor"*. The signature of the doctor was not a known doctor at the Practice. There were no entries in the records corresponding to this or in the computerised prescribing records.

The patient received repeat prescriptions of methylprednisolone from Dr O. Four months later, Mr M was admitted to hospital with back pain after lifting a heavy object. He was diagnosed with a fractured T6 secondary to osteoporosis (due to high-dose steroids). Subsequently, further fractures were found between T4 and T12 and L1-L5. The discharge medication included alendronate, prophylactic treatment against steroid-induced osteoporosis. The entry in the computer record under active problems in the GP record notes, *"at risk of osteoporosis, see A&E letter"*.

There is no further record of methylprednisolone in the GP records, although in a consultation with a Dr P the long-term steroid regimen was picked up. She recorded the patient should only have taken a single four-day high-dose methylprednisolone course.

Eighteen months after his presentation with fractures Mr M suffered further falls. Suspicions of spinal cord compromise at that time were not confirmed on MRI. His underlying disease and associated disability had progressed steadily. He had not walked independently for over two and a half years and suffered urinary incontinence requiring an indwelling catheter. He had poor feeling in both hands, with coordination, visual and swallowing problems and mid-thoracic pain.

Mr M brought a claim against Dr O and the hospital, alleging that both Dr O and Dr P had allowed the continued repeat prescription of high-dose steroids, which had caused his severe osteoporosis.

EXPERT OPINION

The case was reviewed for Medical Protection by an expert GP. He considered Dr O's records inadequate, with insufficient details of the patient's problems, particularly related to his MS. Care was substandard in respect that prescriptions were issued and not recorded. Furthermore, steroid prescription should never have been on a repeat basis. Lack of records about specific prescriptions made it difficult to judge the overall standard of care.

The expert believed that the over-prescribing of high prednisolone doses was largely the responsibility of Dr P, who gave insufficient information about the initiation dosage and duration of the initial steroid dose. It would be a not unreasonable assumption by the GP that treatment commenced by the consultant was to be continued until the patient saw the consultant again. Clearly there was delay as the patient did not attend regularly. When the over-prescribing was identified, Dr P failed to put in place a clear management plan with appropriate guidance to Dr O.

The steroids caused severe osteoporosis, resulting in multiple vertebral crush fractures and collapse of the vertebral bodies and myopathy. These problems aggravated the disability attributed to the patient's MS and interfered with his rehabilitation.

The standard of record-keeping made this a difficult claim to defend. It was settled for a small sum with a contribution from the hospital.

Learning points

- When a patient registers at a new Practice, this is an important opportunity to review their notes and medication.
- Careful documentation in clinical records is essential, particularly with chronic disease.
- Good communication with secondary care is vital in relation to patient management.
- Be clear as to who prescribes for the patient who regularly attends secondary care.
- Regular review of repeat prescriptions should be routine.

CS

LOST OPPORTUNITY

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS

SUBSTANTIAL

Learning points

- Seeking specialist advice or referral early may be appropriate in certain situations. Good communication is essential for continuity of care between primary and secondary care.
- Guidance on the management of AKI is available from NICE: **nice.org.uk/guidance/cg169**.
- Correlation of investigation results with the clinical picture is essential and could have avoided the renal ultrasound being filed in this case without further action being taken.
- Carrying out simple tests in primary care, such as urine analysis and blood pressure, should always be considered and may affect a patient's management and the eventual outcome.
- Ultrasound scans can be falsely reassuring and need to be correlated with the clinical features. In this case the cause of the renal failure was not clear and warranted further investigation, rather than the ultrasound scan alone offering reassurance.

CS

Ms C, a 43-year-old smoker who was otherwise well, presented to her GP, Dr Q, complaining of a few days' discoloration to the tip of her right index finger. She explained that her fingers had always felt cold and often turned white and went numb when she was outside.

When Dr Q examined the finger, there was purplish discoloration of the tip and it felt cold. He noted the presence of good peripheral pulses. Dr Q advised her to stop smoking and made a non-urgent referral to the vascular team.

Nine days later, the patient consulted a second GP, Dr P, as the fingertip had become painful. The records of this consultation were limited, but he diagnosed cellulitis and prescribed flucloxacillin, with an appointment for review in 10 days.

When Ms C returned for review, her finger was much better but she now complained of tiredness with some back pain, which she thought was related to her periods. Dr P arranged some investigations, including full blood count, urea and electrolytes (U&Es), liver and thyroid function tests and planned a further review with the results.

The next day, the results were available and alarmingly revealed some abnormalities. Her eGFR was just 22; urea 14 (2.8-7.2); creatinine 211 (58-96); albumin 33 (35-52). The results were reviewed by a third doctor, Dr B, who arranged to see Ms C the next day. As there were no previous U&Es, Dr B arranged for a repeat set of bloods, including an ESR. He also arranged an urgent renal ultrasound scan.

The repeat bloods showed creatinine 216, urea 10.7 and ESR 104. These were reviewed by Dr P, who took no action as the renal ultrasound scan was to be carried out three days after that and the patient was due to be seen by Dr B for review thereafter.

At that review, eight days later, Dr B noted the U&Es were still abnormal and decided to await the results of the ultrasound scan. The ultrasound result was delivered the next day, which stated that "both kidneys demonstrate slight increase in cortical brightness; otherwise both kidneys are normal size, shape and morphology with no pelvi-calyceal dilatation". The results were filed by Dr P as no major abnormality was demonstrated.

One and a half months later, Ms C was admitted to hospital with a subarachnoid haemorrhage. On admission, her GCS was 11, BP 175/103, and the creatinine 573, urea 50 and albumin 29. The patient was referred to a neurosurgeon who organised a CT scan, which confirmed blood in the interventricular systems. An angiogram was performed, which revealed a left pericallosal aneurysm, which was successfully embolised. There were also noted to be other aneurysms. Ms C was initially aphasic with significant neurological impairment after the first procedure.

Ms C was also seen by a nephrologist in light of her significant renal impairment. She was found to have +++proteinuria and +++blood in her urine. Further investigation revealed raised inflammatory markers, mild anaemia and the presence of antinuclear antibody. A repeat renal ultrasound showed two normal kidneys. A renal biopsy was performed, which revealed acute necrotising glomerulonephritis.

A potential diagnosis of systemic vasculitis was made. She was commenced on peritoneal dialysis, high-dose oral prednisolone and cyclophosphamide. Ms C eventually required renal transplantation, three months after the presentation with subarachnoid haemorrhage. Her kidney function stabilised thereafter.

In conjunction with renal support, Ms C was successfully treated for the multiple aneurysms, and recovered from her aphasia. Her neurological deficit improved, such that she was able to mobilise, albeit with assistance.

Following discharge from hospital, Ms C brought a claim against Dr P and Dr B, alleging they failed to refer her to a renal specialist when the abnormal U&E results were initially found.

Medical Protection instructed experts in general practice, nephrology, neurology and radiology to assist in managing the claim.

EXPERT OPINION

The GP expert opined that a reasonably competent GP should have checked the patient's urine on the first consultation after the increased creatinine was noted, as proteinuria and blood in the urine would more than likely have been present. Urgent referral to a renal specialist would have been appropriate at that stage. He was critical of Dr B for waiting for a second blood sample and ultrasound. Furthermore, when the second set of blood results was reviewed and then the ultrasound report received, Dr P should have referred the patient.

The nephrologist expert considered that end stage renal failure would have been deferred but not avoided if the patient had been appropriately diagnosed and treated earlier. As there was no evidence of polycystic renal disease, he did not consider there was any connection between the kidney disease and the cerebral aneurysms. However, it is noted that although the pre-subarachnoid haemorrhage blood pressure was not available, the blood pressures at the time of the haemorrhage were elevated. It was felt that if Ms C had been referred earlier, any hypertension would have been treated aggressively. The neurologist expert considered that strict control of blood pressure would have been sufficient to prevent the subarachnoid haemorrhage.

On the basis of the critical expert reports the case was settled for a substantial sum.

FAILURE TO DIAGNOSE PRE-ECLAMPSIA

SPECIALTY GENERAL PRACTICE/OBSTETRICS
THEME DIAGNOSIS/RECORD-KEEPING

MODERATE

Ms B was 28 weeks pregnant with her first child. She became acutely unwell and requested a visit from her GP. Dr M attended the patient, who gave a short history of nausea and headache. She also complained of swollen ankles and puffiness of her fingers and face. Dr M did not have access to the patient's GP records at the time and did not subsequently make a note of the consultation. However, Ms B showed him her antenatal record card, which documented a weight gain of 25kg. Dr M took Ms B's blood pressure but performed no other examination. Dr M prescribed Gaviscon and a diuretic and advised Ms B to rest.

A few hours later Ms B developed epigastric pain and loss of vision, followed 20 minutes later by a grand mal seizure. An ambulance was called. During the transfer Ms B suffered two further grand mal seizures, which were treated with IV diazepam. On arrival at hospital the eclampsia protocol was initiated and Ms B underwent an emergency caesarean section. The baby was resuscitated and transferred to SCBU, where she was subsequently noted to have spastic quadriplegic cerebral palsy with dystonia.

Ms B subsequently brought a claim against Dr M for failing to diagnose pre-eclampsia.

EXPERT OPINION

According to our GP expert, a history of nausea, headache and oedema, coupled with the likelihood she had a mildly elevated blood pressure, should have suggested the possibility of pre-eclampsia, and urinalysis to exclude proteinuria was mandatory. In failing to perform this test, or alternatively to arrange it by referral to hospital, Dr M breached his duty of care to Ms B.

The obstetric expert advised that prodromal symptoms such as headache and nausea are more prominent in ante-partum eclampsia than signs, and blood pressure is often not dramatically increased, hence it is possible that the patient would not have had significant hypertension and/or proteinuria when seen by Dr M. However, the absence of any clinical record of the home visit made it difficult to rebut the claimant's allegation that she should have been admitted to hospital.

Had Ms B been admitted to hospital at the time and proteinuria detected, it is likely she would have been observed, and antihypertensive treatment would probably have been initiated if the diastolic blood pressure exceeded 110mm/Hg. By the time she complained of epigastric pain, the window of opportunity to alter the outcome would have been missed.

Expert opinion from a paediatric neurologist concluded that the marked neurological injury sustained by the baby most likely resulted from an acute severe hypoxic ischaemic insult to the thalamus at or around the time of the seizures and a more chronic hypoxic ischaemic insult prior to delivery, rather than as a consequence of premature delivery at 29 weeks gestation. It is likely on the balance of probabilities that had the baby been delivered prior to the onset of maternal seizures she would have sustained mild neurological injury, at most.

Given the absence of GP records for the crucial consultation, it was difficult to rebut the allegations. The claim was therefore settled for a moderate sum.

Learning points

- It is difficult to defend a case without adequate records and it is important that doctors document home visit consultations in the patient's notes at the earliest opportunity. This is essential for good communication with others caring for the patient, and can prove invaluable should a complaint or claim arise.
- A failure to carry out or record simple bedside tests (e.g. urine dipstix) and temperature can also make a case difficult to defend, especially where they can help to make a serious diagnosis.
- Prodromal symptoms may be more prominent than signs in the immediate pre-eclamptic state. BP readings in particular may not be dramatically raised.
- Delivery before the onset of eclampsia can have a marked effect on outcome and substantially reduce the risk of cerebral injury.

JP

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

Please address correspondence to: Casebook, Medical Protection, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK.

Email: casebook@medicalprotection.org

Join the debate in the Medical Protection forums – read *Casebook* on medicalprotection.org and let us know your views!

OVER TO YOU

I WILL SURVIVE/MENTAL HEALTH AND DOCTORS

The article by Dr Michael Blakemore, describing his experience of addiction and recovery, also describes the journey of those who call us at the Sick Doctors Trust (SDT) on our 24/7 helpline.

It is disappointing that nowhere in the four pages of your articles on doctors' health do you give contact details for the services mentioned. Doctors calling the SDT helpline on 0370 444 5163 will be able to talk in total privacy to a fellow doctor with experience of addiction. They don't even have to give us their name if they don't want to. Our website (sick-doctors-trust.co.uk) provides a wealth of information on the disease of addiction, and how it can be treated.

Dr Michael Wilks
Trustee
Sick Doctors Trust

Response

Please accept our apologies for not including the contact details for these invaluable services for doctors. Below are contact details for some of the services that support doctors:

Sick Doctors Trust
Web: sick-doctors-trust.co.uk Phone: 0370 444 5163

BMA Doctor Advisor Service
Phone: 0330 123 1245 (ask to speak to a doctor advisor)

NHS Practitioner Health Programme
Web: php.nhs.uk Phone: 020 3049 4505

Medical Protection Counselling Service
Email: querydoc@medicalprotection.org
Phone: 0800 561 9090 (for members experiencing stress due to dealing with a medicolegal issue)

ELBOW ARTHROSCOPY AND RADIAL NERVE PALSY

I read with some distress the case regarding elbow arthroscopy and radial nerve palsy. I am an upper limb surgeon who does perform elbow arthroscopy for arthritis.

What bothers me about this case is the management plan where it appears that the surgeon had planned multiple arthroscopic operations to debride an arthritic elbow. Leaving the radial nerve palsy aside, this decision was negligent from the start. This was not an acceptable management plan. One elbow arthroscopy has its risks and planning multiple procedures would certainly increase the risks to the surrounding nerves and vessels.

I feel this point is lost in the summary.

Many of the cases in your magazine are unfortunate and do lack evidence of documentation, which Medical Protection has repeatedly highlighted the importance of. Thus they come to litigation, but this is different.

Dr Cormac Kelly
Shoulder and Elbow surgeon
UK

Response

Thank you for your letter. I note your concerns about the management plan in this particular case. As you may know, our case reports are based on cases in which Medical Protection has assisted members around the world. Interestingly, the allegations in this case, as set out by the claimant's solicitors, focused solely on the operation that caused the radial nerve injury, the post-operative care, and the delay in diagnosis of the nerve injury. The claimant did not allege that there had been any negligence prior to this and as such this was not a point that our expert or Medical Protection had to address.

POOR NOTES, FATAL CONSEQUENCES

Thank you for such a stimulating and unfortunate case report.

I can see a few pitfalls in the management of Mrs Y. First, I would have considered a low dose aspirin as she was at risk of developing early-onset pre-eclampsia. Second, her blood pressure was moderately elevated in the second trimester (where BP is at its lowest). However, methyldopa was considered but never initiated! Third, when she was admitted with severe pre-eclampsia, she was commenced on methyldopa and nifedipine. Methyldopa is known to have a slow onset of action that could last a few hours, and although her BP was never controlled, she was not offered a second-line therapy (e.g. IV hydralizine or labetalol) to control the BP before the delivery, which was conducted the next day semi-urgently.

All of the above are basics in the management of hypertension in pregnancy as recommended by NICE guidelines (CG107) published August 2010.

Dr T Hamouda
Consultant O&G, New Zealand

Response

Thank you for your comments, you have set out some interesting clinical observations on this case.

We are always pleased to receive correspondence from our members, and to hear how the case studies have caused doctors to reflect on their own practice and that of others. Members interested in the NICE guidelines can find them at **nice.org.uk/guidance/cg107**

REVIEWS

GOING INTO HOSPITAL? A GUIDE FOR PATIENTS, CARERS AND FAMILIES ★★★★

by Oliver Warren, Bryony Dean and Charles Vincent

Review by: Dr Timothy Knowles (ST2) and Dr Rebecca Smith (Consultant), Department of Anaesthesia, Chelsea and Westminster Hospital, London

Going into Hospital is the collaborative work of three well-respected healthcare professionals – a surgeon, a pharmacist and a psychologist. This book is the first of its kind, providing a road map to help patients, relatives and carers to navigate the complex world of hospital medicine.

The book is designed in a similar fashion to a travel guide, allowing the reader to dip in and out of relevant chapters. It describes the culture of modern healthcare, the roles of various health professionals, and the diverse wards and experiences encountered during a typical patient's journey.

Throughout the book practical advice is offered to reduce the anxiety often encountered by patients. Checklists are frequently provided, covering topics such as "Questions to consider asking during your outpatient appointment" and "Reducing your risk of deep vein thrombosis while in hospital". Wherever possible, authentic patient stories and experiences are included. These powerful messages portray the vulnerability and loss of dignity that many people experience when admitted to hospital. To a doctor, this book serves as a stark reminder of how debilitating an overwhelmingly unfamiliar environment can be.

With the demise of paternalistic medicine, it is our responsibility to ensure patients are enlightened and able to participate in their care. *Going into Hospital* will empower patients to make informed, collaborative decisions with their healthcare team. The book seeks to dispel many of the myths obtained from the media. It helpfully lists reliable, useful sources of information accessible on the internet.

The anxiety of being in hospital for a prolonged period of time can be compounded by the frustration and stress of trying to understand the complex way in which hospital care is delivered. We would encourage anyone being admitted to hospital, or those close to someone going into hospital, to read this book. For healthcare professionals this book is an eloquent reminder of how we all can play our part in reassuring patients on their hospital journey.

BETTER – A SURGEON'S NOTES ON PERFORMANCE ★★★★

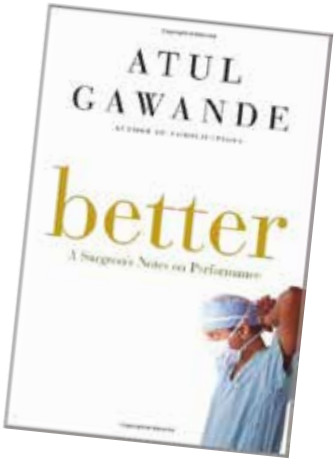
By Atul Gawande

Review by: Dr Rebecca Aning, Medical Protection Medicolegal Adviser

"Good, better, best, never will I rest, until my good is better and my better is best." I don't know a single doctor who wants to be average! But, if you measure our success, it is probable that most of us would hover around the peak of the bell curve. To replicate the positive deviants, we need to know who is at the top. But is anyone willing to be at the bottom, in order that we could all learn to be closer to the best?

Who would have thought that handwashing gurus would take guidance from those encouraging better nutrition in malnourished African children? Or that army medics could find the time to capture 75 pieces of information on every patient to reduce the Golden Hour of Trauma Medicine to the golden five minutes? Do we really need more expensive cures to do the best for our patients? What if doing what we know, well, and making a science out of performance could further improve the care that we offer? Is money important to medics? Does the modern trend towards informality by doctors blur the lines for patients and effectively encourage claims of misconduct? Should we extend compassion and competency to those on death row?

Gawande is a Harvard professor and highly acclaimed. But above all, he has listened to those around him and those that no one cares much to listen to. He trusts that his audience is intelligent enough to understand the points illustrated, consider their importance and be changed by what they read. Not once will you feel lectured, but if you have not reconsidered a single part of your practice or been inspired to improve anything by the end, then I urge you to read this book again.



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Medical Protection

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How to contact us

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

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London W1G 0PS
United Kingdom

info@medicalprotection.org

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

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