



CASEBOOK

ACCESS ALL AREAS?

**PATIENT CONFIDENTIALITY CAN
BE TRICKY - WHEN SHOULD YOU
DISCLOSE PERSONAL DATA?**

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Was a GP negligent for not prescribing antibiotics?

A DISCIPLINARY ON DESKILLING

We represent a surgeon facing a disciplinary over deskilling.

AN ELUSIVE FOREIGN BODY

A child, a plastic toy – and pneumonia?



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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



Of all the calls I see coming into Medical Protection on our advice line, patient confidentiality – and particularly the disclosure of medical records – is one of the most common.

With this in mind, this edition of *Casebook* sees us publish an overview of the do's and don'ts in the disclosure of confidential information. Although it is difficult to be comprehensive on this topic, due to the considerable range of possible dilemmas and the grey areas they often highlight, I hope the article at least helps you to understand the basic guidance.

This year the GMC updated their confidentiality guidance and we reflect this in the article. You can of course always call us on 0800 561 9090 for further, more specific advice on this or indeed any other medicolegal issue that you need our support with.

Advice calls from members are a large part of the workload of our medicolegal advice team, as is the management of all types of cases that many members become involved in. This wide variety of cases isn't always reflected in *Casebook*, where traditionally we have devoted much of the focus to clinical negligence claims, perhaps because of the sheer costs that are often associated with them.

In truth, claims form around 20% of our caseload at Medical Protection, with the rest comprised of advice and assistance with report writing, complaints, GMC procedures, inquests, employer disciplinarys and police investigations.

From this edition on, the *Casebook* team will be working hard to bring you case reports from these different areas of medicolegal jeopardy, painting a more complete picture of the modern landscape in which you practise and the range of services available to you as a Medical Protection member.

We've started things off in this edition with two cases, the first of which describes how we helped a GP respond to a patient complaint about an alleged delay in diagnosing a scaphoid fracture. The quick and thorough way with which the complaint was subsequently dealt helped stave off any possible escalation into a claim or GMC referral.

The second case sees us support a surgeon through a disciplinary he faced at his employing hospital, where we rebutted any allegations over his competence and brought about a swift end to his suspension.

I hope you enjoy these new case reports and the rest of this edition – please do get in touch with your views and comments.

Dr Marika Davies
Editor-in-Chief

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£1.7 BILLION NHS CLAIMS COSTS UNDERLINE NEED FOR REFORM

The publication of the NHS Resolution, formerly the NHS Litigation Authority, 2016/17 annual report has highlighted the enormous cost of clinical negligence to the NHS.

The report stated that while there has been a small but welcome reduction in the number of new clinical negligence claims, the cost of claims to the NHS continues to spiral – with £1.7 billion paid out during 2016/17. This equates to the cost of training 7,300 new doctors.

The cost has risen from £1.5bn in 2015/16 and by a worrying 98% since 2010/11.

In June, Medical Protection launched a campaign – *Clinical Negligence Costs: Striking a Balance* – aimed at controlling the spiralling costs of clinical negligence, keeping more public money in the NHS and ensuring doctors aren't deterred from staying in the profession. At the heart of the campaign is a package of legal reforms.

These include:

- A limit on future care costs, based on the realities of providing home-based care
- A limit on costs relating to future earnings, recognising national average weekly earnings
- The introduction of a fixed recoverable costs scheme for all clinical negligence claims up to a value of £250,000
- The introduction of a ten-year limit between the date of an adverse incident, and when a claim can be made

It is important that there is reasonable compensation for patients harmed following clinical negligence, but a balance must be struck against society's ability to pay. If the current trend continues, the balance will tip too far and the cost risks becoming unsustainable.

Emma Hallinan, director of claims at MPS, said:



Legal reform is required to strike a balance between compensation that is reasonable, but also affordable. This includes the introduction of a limit on future care costs based on a tariff agreed by an expert group and fixed recoverable costs for claims up to £250,000 to stop lawyers charging disproportionate fees. From the £1.7bn paid out in 2016/17, legal costs accounted for 37% of that bill.

Given the pressure on the NHS and the change to the personal injury discount rate – which has significantly increased the NHS' provisions for future clinical negligence costs – there has never been a more pressing time to tackle this issue, alongside continued work to enhance patient safety.

GET INVOLVED

We encourage Medical Protection members to get involved and support the campaign – find out more at www.medicalprotection.org/uk/about-mps/our-policy-work/striking-a-balance and join the debate on Twitter, using #StrikingABalance.

NEW ANNUAL REPORT FROM MPS

MPS's 2016 Annual Report is now available on our website.

The report contains MPS's full financial statements, together with our strategic report, report of the Council and statements by Kay-tee Khaw (Chairman of the Council), Simon Kayll (Chief Executive) and Howard Kew (Executive Director – Finance and Risk).

In previous years, MPS has posted a summary version of our Annual Report to all members worldwide. Following feedback from members, the report will no longer be posted out and, instead, will be published in full on our website each year, representing a cost saving for members.

To view the 2016 Annual Report, please visit the About section of www.medicalprotection.org.

IMPROVING THE WORK ENVIRONMENT

The Royal College of Surgeons of Edinburgh (RCSEd) has published a number of critical recommendations to government to greatly improve safety in the delivery of surgical treatment and patient care, with seven recommendations for best practice.

Improving the working environment for safe surgical care: A discussion paper from the Royal College of Surgeons of Edinburgh uses the views from a cross-section of the UK surgical workforce, and other evidence from across the profession.



ACCESS ALL AREAS?



Disclosing confidential patient information is a dilemma fraught with complexity and grey areas. With children and other patients who lack capacity to consent, there are some basic rules – as Medical Protection’s senior content editor *Gareth Gillespie* outlines below

The issue of confidentiality can be complex, particularly when deciding whether to disclose patient information to third parties (ie, anyone other than the patient). At Medical Protection, such enquiries have been the source of frequent medicolegal advice calls from members for many years.

There is a vast number of potential scenarios surrounding confidentiality, some of which can present significant challenges for busy healthcare professionals. Understanding the issues you need to consider – such as consent and capacity – is a useful foundation to consider when facing such a situation. You can always contact Medical Protection on **0800 561 9090** for advice if the situation is particularly challenging.

You may be asked to provide confidential patient information from the medical records of patients who are incapable of giving consent, are a child, or after the patient has died. Or you may be asked by a child or young person to withhold information from their parents about their condition or treatment. How do you handle requests of this nature?

The GMC, in its guidance *Confidentiality: Good Practice in Handling Patient Information* (2017), states that when making decisions about whether to disclose information about a patient who lacks capacity, you must:

- make the care of the patient your first concern
- respect the patient’s dignity and privacy
- support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information.

Usually you would be able to obtain a patient’s consent to share information about them. For consent to be valid, a patient must be competent to make that decision. Assessment of a person’s capacity should be based on their ability to understand, retain and weigh in the balance the information relevant to a particular decision. The person must also be able to communicate the decision and should be supported to do so (eg, using a translator or written communication). The starting point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.

CHILDREN AND YOUNG PEOPLE WITH CAPACITY

Many young people have the capacity to consent to the disclosure of their medical records. If the child or young person (under 16 years of age) is able to understand the purposes and consequences of disclosure (sometimes known as “Gillick competent”) they can consent or refuse consent to the disclosure. You should discuss disclosing the information with them and only release it with the child or young person’s consent. The capacity to consent depends more upon a young person’s ability to understand and consider the options, than on their age. If a child or young person under 16 refuses consent, you should still consider disclosure, particularly in the following situations:

- If you consider the child or young person to be at risk of neglect or abuse
- To assist in the prevention, detection or prosecution of a serious crime
- Where the child or young person may be involved in behaviour that might put themselves or others at risk of serious harm
- For the purpose of a criminal investigation.

You should involve the child in the decision and ensure it is documented, including notes on how the decision was reached. Such matters are complex though and it is highly recommended that you contact Medical Protection to discuss the particular circumstances, if you are faced with such a situation.

CONFIDENTIALITY ABOUT TREATMENT

As children grow older and become more competent to make their own decisions about treatment, they also become entitled to confidentiality about that treatment. Be aware that “Gillick competent” children may see you alone to talk about issues they want kept confidential (such as contraceptive prescriptions) but may still visit with a parent with other conditions. You must ensure you respect their confidentiality and not share information with others, even their parents, without consent.

CHILDREN AND YOUNG PEOPLE WITHOUT CAPACITY

The overriding principle, when dealing with the disclosure of the medical records of children or young people who do not have the maturity or understanding to make a decision, is ensuring that you act in their best interests.

If the child or young person lacks the capacity to consent to the disclosure of information, those with parental responsibility can consent on their behalf. Although ideally the consent of all with parental responsibility should be obtained, for disclosure of records, the consent of one person with parental responsibility is usually sufficient (unless you know there to be a conflict or issue).

Unless she lacks capacity herself, or it has been removed by court, a child’s mother automatically has parental responsibility. A father will have parental responsibility if any of the following conditions apply:

- He is married to the mother of his child (or was married to her at the time of the child’s birth).
- He has made a parental responsibility agreement with the mother.
- He has obtained a court order granting him parental responsibility.
- The child was born after 15 April 2002 in Northern Ireland, 1 December 2003 in England or Wales, or 4 May 2006 in Scotland and the father is named on the child’s birth certificate, regardless of whether married to the mother or not.

Other individuals or organisations (such as social services) may be given parental responsibility by court order, or by being appointed as a guardian on the death of a

parent. There are also circumstances where parents might temporarily delegate parental responsibility to others, such as the child’s grandparents, so that they can attend the surgery on behalf of the parents.

It is important to record any decision made in the patient’s notes. This should include the information that was provided to the patient and the parents, and how the decision was reached.

CHILD ABUSE

The Children Act 2004 places a statutory duty on medical professionals to safeguard the wellbeing of children. The GMC also advises that if you believe a patient to be a victim of neglect, or physical, sexual or emotional abuse, and that they lack the capacity to consent to disclosure, you must give information promptly to an appropriate responsible person or authority, if you believe this is in the patient’s best interests or necessary to protect others from risk of serious harm. You should usually tell the patient that you intend to disclose the information before doing so. Where appropriate, you should also inform those with parental responsibility about the disclosure.

ADULTS LACKING CAPACITY

If a patient who lacks capacity asks you not to disclose personal information about their condition or treatment, you should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse, and you are convinced that it is essential in their best interests, you may disclose relevant information to an appropriate person or authority. In such a case you should tell the patient before disclosing the information and, if appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient’s record your discussions and the reasons for deciding to disclose the information.



CONFIDENTIALITY AFTER DEATH

Your duty of confidentiality continues after the patient has died. GMC guidance states there are circumstances in which you must disclose relevant information about a patient who has died. For example:

- when disclosure is required by law
- to help a coroner, procurator fiscal or other similar officer with an inquest or fatal accident inquiry
- on death certificates, which you must complete honestly and fully
- when a person has a right of access to records under the Access to Health Records Act 1990 or the Access to Health Records (Northern Ireland) Order 1993, unless an exemption applies
- when disclosure is necessary to meet a statutory duty of candour.

It is also accepted that you would usually disclose information about a patient who has died to those that were close to them, provided that in life the patient had not asked that their information was not shared.

CONCLUSION

Confidentiality is one of the cornerstones of trust that enables patients to be open with doctors about their symptoms and problems. It is generally implied that when a patient consults a doctor, the information about the patient is kept confidential. There are, however, situations when you may have to disclose information about a patient when it is in their best interests, or the interests of the public, with or without their consent.

Ultimately, a doctor’s primary concern is patient safety and ensuring that the patient is cared for. You should be able to justify your reasons for disclosing patient information and always ensure this is documented, particularly on the rare occasions when you are releasing information without patient consent.

For more on this topic, there is a wealth of information on our website, at www.medicalprotection.org. This includes:

- Our "Confidentiality" series of factsheets
- Your online learning hub, Prism
- Workshops and webinars on the principles of confidentiality.

CHAIN REACTION

A patient presents with a sore wrist after a fall. This was followed by a complaint against the doctor

Author: Dr Marika Davies, Casebook editor-in-chief



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Miss P, a 35-year-old teacher, attended her local emergency department (ED) with wrist pain following a fall off her bicycle. She saw Dr A, who examined her and documented that there was some generalised bony tenderness. He arranged an X-ray, which was normal, so reassured the patient and sent her home with analgesia.

The X-ray was later reviewed by a radiologist, who reported it as normal, but recommended follow-up as a scaphoid fracture could not be ruled out. The report was sent to the patient's GP.

Two weeks later Miss P attended her GP, Dr K, complaining of ongoing pain. The radiology report was not in the patient's notes, and the GP relied on the history from the patient that the X-ray had been normal. The notes stated that there was a full range of movement, but there was no record of an examination. Dr K reassured the patient and changed her analgesia.

A few weeks later the patient was still in pain so returned to her GP, who arranged an X-ray. This showed non-union of a fracture of the scaphoid. The patient was referred to an orthopaedic hand surgeon and required bone grafting under anaesthesia.

Miss P made a good recovery, but wrote to Dr K raising concerns about the delay in diagnosing the scaphoid fracture. Dr K took advice from Medical Protection, and was advised to handle the concerns as a complaint using the practice complaints procedure. She was also advised to carry out a significant event analysis, and to ask the patient for consent to forward her complaint to the hospital where she had first been seen.

On investigating the incident the practice found that the radiology report had been received but had been scanned into another patient's records in error, and noted that the two patients had very similar names. A number of flaws in the process for receiving

and acting on X-ray reports was noted, so changes were put in place, along with further staff training. Dr K acknowledged that she had not examined the patient or advised her to return if the pain did not resolve.

The hospital contacted the ED doctor and asked for his comments on the complaint. On reviewing the notes, the doctor saw he had not documented the mechanism of injury, whether there was any anatomical snuffbox tenderness, or what advice he had given the patient. As such, there was no evidence that a scaphoid fracture had been considered or the appropriate advice given. The doctor responded to the hospital saying that he had learned from the incident, had reflected upon it, and had discussed it with his clinical supervisor.

Medical Protection helped Dr K and her complaints manager to prepare a joint response from the practice and the hospital, which set out the findings of the investigation into the complaint. The letter provided a full explanation for the consultations she had attended, and acknowledged that there had been shortfalls in the care provided, for which they apologised. The practice and the hospital demonstrated that they had taken her concerns seriously and had taken steps to reduce the risk of similar incidents occurring again. They offered to meet with the patient to discuss any further concerns, and advised her of her right to refer her complaint to the Parliamentary and Health Service Ombudsman if she remained dissatisfied.

Miss P did not take her complaint further.

Learning points

- Maintain a high index of suspicion of scaphoid fractures when treating and reviewing wrist injuries. If symptoms suggest a broken scaphoid, the injury should be treated as one, even if it is not seen on X-ray.
- Document negative findings and advice given to patients - without adequate documentation it is difficult to reconstruct what took place during a consultation some time after the event, and to justify that the patient was managed appropriately.
- Ensure safety nets are in place, and that patients know what symptoms to be concerned about and when to return to see you.
- A full investigation and co-ordinated response are key to providing a complainant with a detailed and thorough explanation.
- Dealing with concerns promptly and swiftly can help to prevent them from escalating into a claim. In this case both the hospital and the practice provided a full explanation and apology, and showed that lessons had been learned.

DESKILLED DISCIPLINARY PROCEEDINGS

A surgeon faces disciplinary action from his employer, following accusations he has become deskilled

Author: Dr Gordon McDavid, medicolegal adviser at Medical Protection

Mr H was a senior consultant general and breast surgeon who worked in a district general hospital. He was recognised by his colleagues as an expert in breast surgery and an informal arrangement was put in place to transfer all patients with breast problems to Mr H. This arrangement was endorsed by the hospital clinical director but was not formally agreed.

A reciprocal arrangement was put in place so Mr H's general surgery colleagues would take over the care of any patients admitted under Mr H while he was on-call that did not have breast issues. As a result of this arrangement, Mr H was rarely involved in general surgery operations.

Mr H received a letter from his employer stating that they were instigating formal disciplinary action against him. The letter alleged Mr H's general surgical operating technique was felt to be deficient. This followed concerns being raised by Mr H's general surgical colleagues, who were concerned at his postoperative complication rates in emergency general surgery patients and that he may be deskilling.

Mr H was restricted to non-clinical duties pending an investigation. Mr H contacted Medical Protection for advice and support.

His employer refused to clearly articulate the reasons for Mr H being restricted to non-clinical duties, given that no concerns had been raised about his breast practice. Despite repeated requests from Medical Protection, the hospital refused to outline the allegations against Mr H.

Medical Protection made formal representations to the hospital, stating that they had failed to follow their disciplinary process, and in particular fallen foul of a basic tenet of natural justice by not setting out the specific allegations against Mr H.

The hospital refused to correct the procedural irregularity and Medical Protection proceeded to instruct solicitors to threaten court action (an injunction) against the employer to compel them to comply with fair process.

While the hospital attempted to articulate the allegations about Mr H's deskilling in general surgery, they also raised new concerns in relation to his decision-making regarding patients with breast conditions, and suspended Mr H from duty.

Medical Protection made robust submissions on Mr H's behalf and, following the threat of court action, the hospital finally particularised the allegations and supplied copies of the relevant patient records.

Medical Protection accompanied Mr H to multiple meetings with senior hospital management, and an investigatory meeting following the preparation of a detailed written statement once the allegations were articulated.

EXPERT OPINION

The hospital instructed an independent expert surgeon to review a selection of case notes. In short, the only criticism was in relation to record-keeping and there appeared to be no issue with Mr H's surgical performance and abilities.

Medical Protection engaged with the hospital and the expert to ensure a productive dialogue, enabling the hospital management team to better understand the subtleties involved in managing breast patients, and the different skill set required for breast surgery vs general surgery.

The investigation concluded that the concerns did not warrant ongoing suspension. Medical Protection made representations to the employer that the suspension should be lifted and were required to again threaten legal action, which forced the employer to lift the suspension. Mr H was able to return to clinical practice following further negotiation with the employer.

It took two years for the case to reach a conclusion. The external legal costs of ensuring that fair process was followed, and that there was acceptable decision-making in this case, were significant.

Learning points

- The importance of clear medical records cannot be overstated. Mr H may have avoided much of the criticism of his breast practice if more detailed notes had been made that set out his rationale for surgery in each patient. Mr H was ultimately commended on his acceptance that his clinical records had been lacking in detail and the steps he took to address this.
- It is important to seek advice early from appropriate professional organisations if you are in difficulties. If you are in doubt, contact Medical Protection for advice.
- Clear communication with seniors and managers in your organisation can help avoid escalation to formal disciplinary action or suspension from duties.
- The effect that a disciplinary process can have is devastating and Medical Protection's team of medicolegal advisers are on hand to ensure members have robust advice, support and advocacy through these complex procedures.



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AN ELUSIVE FOREIGN BODY

A child suffers recurrent episodes of pneumonia following the inhalation of a plastic toy

Author: Dr Mónica Lalanda, emergency medicine physician



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Child H, a three-year-old boy, was brought into the Emergency Department (ED) of a private hospital by his mother, having inhaled or swallowed a little building brick. They brought a similar piece with them. Child H was seen by a doctor, Dr W, who documented that he appeared well, with no signs of respiratory distress and a normal auscultation. Dr W arranged for him to have a chest x-ray, which both Dr W and a radiologist considered normal.

Two months later, Child H became unwell with a cough and a high temperature. His mother brought him to the ED where, following a chest x-ray, he was diagnosed with right lower lobe pneumonia. Child H's mother mentioned to Dr F – the doctor who saw them – that they had been to the ED not long ago after Child H “swallowed” a little toy. All this was documented.

During the next two years, Child H suffered recurrent episodes of pneumonia and attended the ED five times. He saw a different doctor on every occasion and had five more chest x-rays. All of them were reported as “right lower lobe pneumonia with collapse and some pleural fluid”. There were no indications in the ED cards to suggest that previous cards or x-rays were looked at.

In view of the recurrent chest infections, Child H's GP referred him to the paediatric team for further investigations. Paediatric consultant Dr Q saw Child H in clinic, looked at all the x-rays and became suspicious of the presence of a foreign body. An urgent bronchoscopy was organised and a large piece of plastic removed. Child H required further surgery as the foreign body had caused fibrosis of the pulmonary parenchyma, which required excision.

Child H's mother made a claim against the private hospital and all the hospital doctors involved during those two years.

EXPERT OPINION

The experts commented that “a case of a possible inhaled foreign body has to be followed up closely and even without a clear history of inhalation of a foreign body, this should be considered a possibility in cases of recurrent pneumonia in children with persistent x-ray changes”.

The case was deemed to be indefensible and was settled for a moderate amount.

Learning points

- Taking a good history can save a lot of mishaps in clinical practice; it is important to listen. Digging into the details of what happened to this child could have made it clear whether the foreign body was swallowed or inhaled. The sudden onset of respiratory difficulty, with coughing, stridor or wheezing, needs to be specifically investigated. If inhalation is suspected, careful follow-up is required to determine the need for a bronchoscopy.
- Many types of plastic are radiolucent and will not show up on an x-ray.
- Asking the radiographers to place an example of a foreign body, if brought in by the parents, next to the patient they are going to x-ray will easily determine whether it is a radio-opaque object or a radiolucent one.
- Previous attendances to the ED by children might be relevant in a significant number of cases. Hospital note-gathering systems may be helpful in picking up previous ED attendances. Reviewing old notes is therefore always important and might offer unexpected background to a new presentation.
- With modern computerised radiographic storing systems, there is little excuse not to look at previous x-rays. Both clinician and radiologist would have been alerted to the fact that the changes in the chest x-ray were chronic and would therefore be suspicious of a foreign body being present.



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LIVING UP TO EXPECTATIONS

A surgeon fails to inform a patient about a complication that may have occurred

Author: Dr Rafael Sadaba, cardiac surgeon

Mr G was a 62-year-old office worker; he was overweight (BMI 29) and suffered from exercise-related angina. Mr G had several risk factors for ischaemic heart disease including smoking, diabetes mellitus and hypercholesterolaemia. Following a positive exercise test, a coronary angiography confirmed triple vessel coronary artery disease with a left ventricular ejection fraction of 45%. He was referred to Mr F, a consultant cardiothoracic surgeon, for consideration of coronary artery bypass graft (CABG) surgery.

Based on his symptoms and the severity of his coronary artery disease, Mr F strongly advised Mr G to undergo surgery on both prognostic and symptomatic grounds. He also explained the risks of the operation, stating that the risk of death was below 3%. In view of the seriousness of his condition, Mr G accepted to be put on the waiting list for CABG. He was strongly advised by Mr F to stop smoking and lose weight before the operation.

Mr G underwent an uneventful triple bypass. Mr F documented the use of bilateral internal mammary artery and saphenous vein grafts. Following surgery, Mr G made a good recovery, although a control chest x-ray showed an elevation of the right hemidiaphragm. Mr F and his team decided not to share this finding with Mr G in order to avoid giving him unnecessary reasons for concern. Mr G was eventually discharged home on the seventh postoperative day, having made a good recovery.

Six weeks later, Mr G attended clinic for a postoperative surgical review. He mentioned that he was angina-free but complained of dyspnoea on moderate exertion. Mr F put this down to the fact that Mr G was still recovering from the operation and said that "things would get better soon". Mr G was discharged from the clinic back to the care of his own GP.

The shortness of breath persisted during the next few months and Mr G mentioned this to his cardiologist, Dr T. Dr T reviewed the chest x-rays and arranged an echocardiogram, which showed a poor left ventricular function with significant dyskinesia in the inferior and lateral walls of the left ventricle. Pulmonary function test showed a mild reduction in total lung capacity. A chest fluoroscopy test revealed paralysis of the right hemidiaphragm. The final diagnosis was right phrenic nerve palsy secondary to surgical damage.

Mr G made a claim against Mr F because of the damage to his right phrenic nerve during the operation. The case was defended successfully, based on the facts that damage to the right phrenic nerve is a rare, but known, complication of right mammary artery harvesting and that his deteriorated heart function, rather than the paralysed diaphragm, was the likely cause of his breathlessness.

Learning points

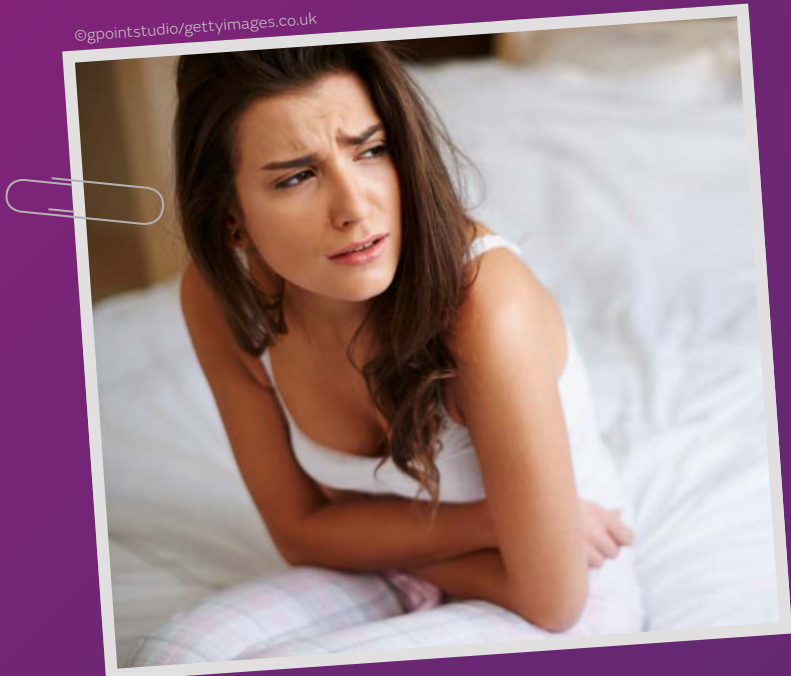
- Mr F was not open about the complication; he should have warned Mr G as soon as it happened, as part of the ongoing consenting process. If he had disclosed the complication and explained why it had occurred, the claim may never have arisen.
- In *Good Medical Practice*, the GMC states you must be open and honest with patients if things go wrong.
- Patients should not be given false expectations. Surgical procedures do not always result in a complete cure, but can slow down deterioration and reduce the risks of serious complications. In this case, Mr G was led to believe that the operation would rid him of all his angina and dyspnoea.
- Surgical complications are not necessarily a result of medical negligence. However, when these do occur, giving an open clear explanation to the patient of the possible causes and consequences decreases the likelihood of complaints and claims.



DELAYED DIAGNOSIS

A patient repeatedly attends the surgery over a number of years, with persistent abdominal symptoms

Author: Dr Ellen Welch, GP



Mrs F, a 30-year-old housewife, visited her GP, Dr O, with a four-week history of diarrhoea. Dr O arranged a stool sample for microscopy and culture (which was negative) and prescribed codeine. Four months later, Mrs F was still having diarrhoea, especially after meals, and she had started to notice some weight loss. She returned to the surgery and this time saw Dr P, who examined her and found nothing remarkable, but decided to refer her to gastroenterology in view of her persistent symptoms.

Mrs F was seen four months later by the outpatient gastroenterology team, who attributed her symptoms to irritable bowel syndrome (IBS). She underwent a sigmoidoscopy which revealed no changes, and was diagnosed with functional bowel disease.

Four years later, Mrs F developed difficulty passing stools after the birth of her second child. She was referred to the colorectal team and underwent a further sigmoidoscopy, which revealed no abnormalities. She was referred for pelvic floor physiotherapy.

Two years later, Mrs F returned to her GP and consulted Dr G with the sensation of a lump in her rectum preventing her from defecating. She reported incomplete bowel emptying and the need to manually evacuate. She was referred back to the colorectal surgeons, who arranged a barium enema, which was reported as normal.

Three months later, Mrs F visited the practice again with a two-week history of diarrhoea and abdominal cramps. Dr B saw her on this occasion and diagnosed her with possible gastroenteritis. He arranged a stool culture, coeliac screen and routine bloods.

Mrs F returned a week later for follow-up with Dr Y, reporting ongoing diarrhoea with no rectal bleeding. Dr Y noted the recent normal barium enema and sigmoidoscopy and normal stool culture. The blood tests remained pending so Dr Y sent Mrs F to hospital to get them done. The results for the coeliac screen were normal.

Another three months later, Mrs F was still symptomatic and attended Dr P with diarrhoea and bloating. No abnormalities were found on abdominal and PR examination. Dr P diagnosed IBS and prescribed amitriptyline.

Over the next three weeks, frustrated at the lack of resolution of her symptoms, Mrs F had several GP appointments with Dr G, Dr P, Dr O, Dr B and Dr Y. She was referred for a colonoscopy and pelvic ultrasound – all of which were normal. She was re-referred to the colorectal surgeons and a family history of pancreatic insufficiency was discussed during the outpatient appointment. Faecal elastase confirmed pancreatic insufficiency and a CT abdomen revealed obstructing pancreatic duct calculi. She underwent ERCP and Frey's procedure, which failed to resolve her symptoms and, at the time of the claim, Mrs F was considering a total pancreatectomy.

A claim was brought against Dr P, Dr Y and Dr O, for failing to take into account Mrs F's family history of chronic pancreatitis and arranging a specialist referral and follow-up investigations.

EXPERT OPINION

On the basis of the medical records and the evidence provided by the doctors involved, the GP expert was supportive of Dr P, Dr Y and Dr O. Given that Mrs F did not mention her family history of chronic pancreatitis, there was no reason to suspect pancreatic insufficiency as a cause for her symptoms. The claim subsequently discontinued.

Learning points

- Where patients are repeat attenders with ongoing symptoms, it is important to consider alternative causes for their symptoms.
- Careful documentation of consultations is imperative and greatly assists when defending claims.
- Where patients are repeat attenders, it is important to consider all past consultations, particularly if patients do not see the same practitioner each time, to ensure that continuity of care is not impacted.

ANTIBIOTIC ALLEGATIONS

A patient alleges her GP was negligent for failing to prescribe antibiotics

Author: Dr Clare Devlin, medical claims adviser at Medical Protection

Miss G, 23, presented to GP Dr Q with a four-day history of fever, cough and green/brown phlegm. On examination, she was afebrile with no chest signs except expiratory wheeze.

Dr Q's clinical impression was of a viral infection. The clinical findings were supported by the fact that Miss G was on day four of a five-day course of amoxicillin, prescribed by her dentist, which had not produced an improvement in her symptoms.

Given the history and examination findings, Dr Q did not feel Miss G required a further course of antibiotics; in any event, Miss G was already receiving the correct antibiotic and course duration, as set out in the NICE guidelines for empirical cover of low risk community-acquired pneumonia.

Dr Q advised Miss G about viral infection, and performed appropriate safety-netting with instructions in the event of the symptoms worsening, new symptoms developing or a failure to improve.

Miss G did not re-present to Dr Q, but did see other doctors when her cough failed to improve, and she received further courses of antibiotics at this point. She later fractured a rib during a bout of coughing, but made a full recovery.

Miss G made a claim against Dr Q, alleging a failure to prescribe any or an adequate dosage of antibiotics to treat the symptoms of fever and productive cough. She also alleged there was a failure to advise against continuing amoxicillin, which allegedly had not been prescribed for Miss G's symptoms and which had only one more day left of the course, and finally alleged that her chronic cough led to her rib fracture.

EXPERT OPINION

In this case, Medical Protection was able to serve a robust Letter of Response denying liability, based on our legal team's assessment and the quality of Dr Q's medical records, supplemented by a helpful detailed account provided by Dr Q.

This approach by Medical Protection enabled the claim to be dealt with rapidly, without the need to instruct an independent expert witness or generate expenditure on an expert report.

The Letter of Response served by Medical Protection highlighted the appropriate history and examination performed by Dr Q and the lack of clinical indication for antibiotics. It also explained that Miss G was already on first-line empirical antibiotic treatment, started by another clinician for a different problem, and that advice to stop the course a day early would not have been appropriate because incomplete antibiotic courses promote the growing problem of antibiotic resistance.

Miss G's solicitors discontinued the claim after receiving the firm Letter of Response from Medical Protection.

Learning points

- On receiving a Letter of Claim, members may be shocked and aggrieved to see allegations that are factually incorrect and may in addition be medically misconceived. In this case, we see contradictory allegations, where Dr Q is simultaneously being criticised for failing to stop an antibiotic and for failure to prescribe an antibiotic.
- Medical Protection is accustomed to allegations of this nature and takes care to address them fully, with a comprehensive rebuttal of all factual and clinical inaccuracies. In this we are greatly assisted by thorough accounts of incidents from our members, and especially quality documentation in the form of contemporaneous medical records.



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A CASE OF MISTAKEN HAEMORRHOIDS

A patient presents with symptoms of haemorrhoids but is it something more sinister?

Author: Dr Emma Green, medical claims adviser at Medical Protection

Mr F, a 33-year-old policeman, attended his GP, Dr B, with a six-month history of abdominal pain and rectal bleeding. The abdominal pain had become more constant over the preceding few weeks and laxatives reportedly eased the pain; the pain had eased on the day of the consultation. The blood was bright red in the toilet bowl and on the stool and paper, there was no mucus in the stool and no family history of cancer. Dr B documented no weight loss or joint pains. A telephone consultation earlier the same day, with another GP, had referred to Mr F “straining” to pass his stool.

The examination revealed a soft abdomen with slight lower abdominal tenderness. There were no masses and no organomegaly, and a rectal examination revealed an empty rectum with no masses.

Given the age of the patient and the description of the blood, Dr B felt this was most likely haemorrhoids secondary to constipation, which was being eased by the laxatives. He advised further laxatives, blood tests to look for inflammatory bowel disease and for Mr F to return in four weeks, if no better.

Mr F did not attend for blood tests nor did he return to see Dr B. One year later he was admitted to hospital and diagnosed with metastatic colorectal cancer, from which he died within a year.

A claim was made against Dr B by Mr F’s family, alleging he was negligent in diagnosing haemorrhoids when these were not visualised, instead of referring to secondary care for further assessment. It was alleged that these failures resulted in a 12-month delay in diagnosis and a nine-month reduction in life expectancy.

EXPERT OPINION

A GP expert considered that the history of straining with fresh red blood on defecation would be consistent with a diagnosis of haemorrhoids. The recorded history was felt to be detailed enough to support Dr B and his logical reasoning that constipation was the most likely cause of the abdominal pain, the improvement with laxatives and the straining to pass stool. The blood tests and safety netting were also considered appropriate and it was felt there was no breach of duty. In addition the expert was supportive of the diagnosis of haemorrhoids in the absence of visualisation, noting that haemorrhoids are frequently not palpated but diagnosed following a history consistent with them that lacks features suggesting something more sinister.

An expert oncologist instructed in the case did not support the claim that Mr F would have survived for a further nine months had the tumour been diagnosed earlier.

Medical Protection served a robust letter of response denying both breach of duty and causation, and the claim was discontinued against Dr B.

Learning points

- Record-keeping was the most important aspect in defending this case. Important positive findings and relevant negatives should be recorded to enable a clear logical reasoning to be followed.
- Rectal examination should always be performed in patients presenting with rectal bleeding. When a patient declines this examination, it should be clearly documented that they are aware of the implications this could have on diagnosis.
- Although uncommon, malignancy can be a cause of rectal bleeding in younger patient groups. In the UK, between 2012-2014 there were, on average, 590 new cases of bowel cancer per year in those aged 30-39.¹

REFERENCES

1. Cancer Research UK; Bowel Cancer Incidence Statistics <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/incidence#heading-One>



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A PAIN IN THE KNEE

An 11-year-old girl repeatedly attends her GP complaining of knee pain

Author: Dr Janet Page, medical claims adviser at Medical Protection



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Miss F, an overweight 11-year-old, attended her GP, Dr A, complaining of knee pain and clicking for two months following a twisting injury whilst playing football.

Examination was unremarkable, with straight-leg raising to 90 degrees and a full range of movement in the knee. Dr A treated with simple analgesia and arranged for an x-ray of the knee the following week. The x-ray was normal and Miss F was advised to see her GP for review.

Miss F next attended the practice seven weeks later, when she was seen by Dr B. She was complaining of pain in the right groin, which was worse on walking or standing. Dr B recorded in her notes that it was “probably muscle strain or too much pressure on hip joint because of her weight”. She prescribed diclofenac.

Five days later, Miss F attended the emergency department (ED) at the local hospital complaining of a painful right hip with difficulty walking. A diagnosis of ligament sprain was made.

Two days later, Miss F again attended the practice and was seen by Dr C. Examination revealed reduced range of movement in the right hip. Dr C arranged a routine appointment for a hip x-ray for the following week.

The day before the appointment, Miss F attended the ED in severe pain. Hip movements, particularly flexion and internal rotation, were noted to be limited. The diagnosis of slipped femoral capital epiphysis was confirmed on x-ray and classified as “mild” (less than 30 degrees). Miss F subsequently underwent pinning of the epiphysis.

Over the course of the next few years, Miss F attended her GP and the hospital on multiple occasions, complaining of intermittent hip pain. Her weight continued to rise and at age 15 her BMI was 41.4. MRI of the hip three years later showed deformity of the right hip with a CAM abnormality (bony deformity of femoral head resulting in femoro-acetabular impingement) and degenerative changes. The features were reported as being consistent with an angle of displacement of 50 degrees (severe slippage).

A claim was brought against Dr A alone, alleging a failure to recognise or appreciate that pain in the knee could be referred pain from the hip, failure to examine the hip and failure to refer for x-ray of the hip. It was additionally alleged that, because of Dr A’s failures, Miss F suffered premature osteoarthritis and was likely to require a primary hip replacement in her late 30s, and two further revisions in her lifetime.

EXPERT OPINION

Medical Protection sought opinion from a GP expert. The expert was critical of Dr A, stating that a reasonably competent general practitioner would know that a slipped upper femoral capital epiphysis is more common in adolescents who are overweight. He also opined that a reasonably competent GP, being presented with an overweight adolescent complaining of knee pain, should have been aware that this may have been referred pain from the hip. In these circumstances the GP should have carried out an examination of the hip and, if any abnormality had been found, should have considered the possibility of slipped upper femoral capital epiphysis and referred the claimant for an x-ray.

The expert said that there was also a failure by Dr A, and subsequently Dr B, to consider the diagnosis and to carry out an appropriate examination of the hip. For the same reason, the expert was also critical of the care provided by the ED doctors and of Dr C for failing to make an urgent referral to hospital the same day.

Based on the critical expert opinion, the case was deemed indefensible and was settled on behalf of Dr A for a moderate sum, with a contribution from Dr B and the hospital.

Learning points

- SUFE is more common in obese adolescents (particularly boys) and may present following an acute, minor injury.
- Pain may be poorly localised. Pathology in the hip can present as referred pain to the knee; hence a full assessment of the joints on either side of the affected joint should be undertaken.
- There may be an associated limp with out-toeing of the affected limb.
- Diagnosis is confirmed on x-ray, which may require a “frog lateral” view for confirmation.

CAUGHT BY CONSENT

A private neurosurgeon faces questions on consent, following a lumbar microdiscectomy sciatica and back pain

Author: Dr Philip White, medical claims adviser at Medical Protection

Mrs P, a 40-year-old nurse, attended her GP complaining of back pain and was prescribed simple analgesia. After a month, the pain was no better so she consulted a private neurosurgeon, Mr S, who advised conservative measures.

One month later, Mrs P phoned Mr S to tell him her back pain had not improved and that she now had left-sided sciatica. This was confirmed by her GP, who arranged an MRI scan, which showed the disc bulge responsible for it. Overall, her condition was worse and she had been off work for over a month.

As Mrs P now had sciatica, Mr S felt that a microdiscectomy was a reasonable approach. He discussed the options with her over the phone, and explained the operation and its pros and cons. Mr S did record the phone call in the medical records, but did not state exactly what was discussed. Mrs P was happy to proceed and so the operation was arranged. Mr S wrote a letter to the GP informing him of the plan.

Mr S next saw Mrs P on the day of the operation as she was brought in to be anaesthetised. He had a brief conversation with her, confirming that she was happy to go ahead and that she had no questions. She then signed the consent form, which listed none of the pros and cons of the operation.

The operation was straightforward and there were no observed complications. However, two months after the operation Mrs P felt that her pain was worse, and she had genital numbness and urinary symptoms. Her urodynamic investigations were normal but she was numb in the S3 dermatome.

Mrs P brought a claim against Mr S, alleging that he had taken inadequate consent and had not informed her that the operation could make her pain worse. She also alleged that the operation had been negligently performed, damaging the left L5 root and the S2 and S3 roots bilaterally.

EXPERT OPINION

Medical Protection sought expert opinion from a consultant neurosurgeon. The expert advised that although the consent form was inadequate, the overall consenting process, including the phone consultation and the brief discussion on the day of the operation, was just about acceptable.

The expert also opined that it was very unlikely that an experienced neurosurgeon, such as Mr S, would have damaged the nerves without noticing and recording it. He noted that there was no suggestion of nerve damage in the immediate postoperative period and suggested that deterioration occurring two months after the operation was more suggestive of a chronic pain syndrome.

The case was deemed defensible and taken to trial. The judge concluded that there had been no negligence during the operation, but that Mr S had taken inadequate consent. The ruling stated that Mrs P had not been warned of a 5% risk that the surgery could make her back pain worse and, if she had been, she would not have gone ahead. Mrs P was awarded a moderate sum.

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Learning points

- Following the Montgomery ruling in 2015, doctors must take reasonable steps to ensure that patients are aware of any risks that are material to them and of any reasonable alternative or variant treatments.
- In deciding whether a risk is material, doctors should consider whether a reasonable person in the patient's position would be likely to attach significance to the risk. The judge in the Montgomery case described this assessment as "fact-sensitive, and sensitive also to the characteristics of the patient".
- The Royal College of Surgeons state that it is important to make a record of the consent discussion in the patient's notes, including key points raised and hard copies or web links of any further information provided. This is in addition to the consent form.¹

REFERENCES

1. Royal College of Surgeons. *Consent: Supported Decision-Making*. 2016.

Further reading

General Medical Council, *Consent: patients and doctors making decisions together* (2008).

COMPLICATIONS OF NITROFURANTOIN

A patient on long-term medication begins to feel short of breath

Author: Dr Anna Fox, GP



Mrs D was a 70-year-old retired teacher who had struggled with recurrent UTIs. Urologists had advised her to take antibiotics in the long term as a prophylactic measure and advised alternating between trimethoprim and nitrofurantoin.

Sixteen months after commencing nitrofurantoin, Mrs D began to feel short of breath, especially when she was walking her dog. She was also feeling tired and generally unwell so she visited Dr W, her GP. Dr W documented a detailed history, noting that there was no orthopnoea, ankle swelling or palpitations. He also noted the absence of cough, wheeze or fever. Dr W referred back to a recent echocardiogram that was normal and mentioned that Mrs D was an ex-smoker. He conducted a thorough examination including satisfactory BP, pulse and oxygen saturation, and commented in the notes that Mrs D's chest had bilateral air entry with no crackles or wheeze and no dullness on percussion. Dr W stated that her heart sounds were normal and that there was no pitting oedema. He organised a CXR initially.

The CXR reported patchy peribronchial wall thickening and suggested a degree of heart failure. Dr W advised a trial of diuretics, which made no difference. Mrs D continued to feel short of breath and drained over the next few weeks. Gradually her breathlessness got worse and she noticed it even when she was sitting reading.

Four months later, Mrs D was admitted to hospital in respiratory failure. A high-resolution CT scan showed pulmonary fibrosis, with the likely diagnosis being subacute pneumonitis secondary to treatment with nitrofurantoin.

Within a month of withdrawal of nitrofurantoin she improved clinically, becoming less breathless, and her respiratory failure resolved. At a respiratory follow-up ten months later, she was found to be breathless after about 400 yards of walking and quite fatigued but able to do all her daily activities, including walking her dog.

Mrs D made a claim against Dr W. She alleged that he had failed to consider that the long-term use of nitrofurantoin may have caused her symptoms.

EXPERT OPINION

Medical Protection sought expert opinion from a clinical pharmacologist and a GP. The clinical pharmacologist referred to the relevant edition of the *BNF*, which stated on nitrofurantoin: “*Cautions: on long-term therapy, monitor liver function and monitor for pulmonary symptoms especially in the elderly (discontinue if deterioration in lung function).*”

She commented that although the *BNF* records the need to monitor periodically, the exact definition of “periodically” is not given. In her view, it should have been every six months.

The expert GP said that many doctors would be unaware of the need for monitoring and that it was probably rarely done in practice. However, he accepted that when prescribing an unfamiliar drug, a GP would need to reference the *BNF*.

Medical Protection served a letter of response rigorously defending Dr W's actions, pointing out that he had seen Mrs D early in her clinical course, had documented a very thorough history and examination and made a reasonable initial management plan. As a result of this, the case against Dr W was dropped. However, the practice partners, who were members of another medical defence organisation, faced a claim regarding the alleged lack of a practice system for monitoring for lung and liver complications in patients on long-term nitrofurantoin. This claim was settled with no contribution sought from Medical Protection.

Learning points

- Detailed contemporaneous notes assist in defending cases. GPs should document a thorough history and examination, including any negative findings.
- Medical Protection sees a number of claims regarding inadequate monitoring of long-term nitrofurantoin with patients developing hepatic or pulmonary complications. Many claims relate to inadequate practice systems for monitoring.
- Expert opinion sought on these claims advises that *BNF* guidance for monitoring should be followed.
- To screen for hepatic complications, repeat prescribing of nitrofurantoin should generate liver function tests (LFTs), at least six monthly.
- To screen for pulmonary complications such as pulmonary fibrosis, doctors should advise patients starting on nitrofurantoin to attend urgently if they develop breathing problems. They could be reviewed for respiratory symptoms at the point of taking LFTs at least six monthly, with consideration of more frequent monitoring.

REPORTED ABUSE

Thank you for the latest edition of *Casebook*. It is always informative, if sobering. I have a comment about one case report: the “Reported abuse” case.

The training that I have received on safeguarding guides me to report incidences of alleged abuse to my local safeguarding team without undertaking investigation or corroboration myself. If the abuse is clear and actual, the report should be direct to the police, or local sexual assault centre (SARC).

The reason for this has been explained as being twofold. Firstly, the safeguarding team is multidisciplinary and is able to undertake a more comprehensive investigation that will be robust in the face of a cross-examination, should it come to that. Secondly, the safeguarding team is privy to a wide range of information, so even small additions may be important.

Notwithstanding the fact that Mrs X told her GP that she had reported the allegation to the police, in this circumstance, as a GP I would have also reported the allegation to my local safeguarding team, informing Mrs X of this action, of course. I should have expected the teacher and Dr B to have done the same thing. I would not have checked with the school myself.

The expert for Mr X reported that Dr B failed to corroborate the allegation with the school. My training would suggest that the expert was wrong in making that comment. Perhaps an example of an expert opining beyond her/his area of expertise as considered in “A complicated claim”.

Whilst this is slightly outside the case, and you do make a general comment about our duty to act in the third learning point, I feel it is important to emphasise the critical nature of collaborative and consistent team working when it comes to safeguarding. All the investigations into failed cases have come to that conclusion. It needs to be reiterated until it is a reflex action across all of health and social care.

Dr Michael Innes

Response



Thank you for your correspondence – we are always pleased to hear from readers and welcome your comments on this case.

Our case reports are taken from different countries around the world where we represent members, and so local practices and policies can differ. However, I agree entirely with your comments on the importance of collaboration and team-working in these cases, as well as liaison with the safeguarding team where appropriate, which are valuable learning points.

NO NEWS IS NOT ALWAYS GOOD NEWS

The article on missed hip dysplasia states that Dr R was alleged to have failed to ensure the report made it to clinic. May I be clear? Is this a system error or is there a duty for Dr R to have phoned the abnormal result?

Incidentally, I don't think it is great journalism to illustrate a case of hip dysplasia with a radiograph of a normal hip.

Dr Jules Dyer

Response



Thank you for your email regarding the case report “No news is not always good news”, in the latest edition of *Casebook*.

The allegation that Dr R (the radiologist) failed to ensure that the report made it safely to the clinic was an allegation brought by the claimant (the parents) in this case. The claim was investigated and the hospital accepted that there had been “a clear administrative error” that allowed the system to file the report without it being sent to the clinical team for action. It would be a matter for an expert radiologist to comment on whether Dr R should have phoned the result or taken any other action. This wasn't explored in this particular case given the hospital's acceptance that there had been an administrative error.

I note your comment on the radiograph used to illustrate the case report. The pictures we use in *Casebook* are for illustrative purposes only and are not intended to be actual representations of the individual cases, and I do hope it did not detract from your learning or enjoyment of this case.



**We welcome all contributions to Over to you.
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