



CASEBOOK

BACK TO BASICS

HOW A DIAGNOSIS OF CAUDA EQUINA
WAS MISSED IN A PATIENT WITH
LOWER BACK PAIN

PAGE 10

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125 YEARS
OF MPS

CELEBRATING
25 YEARS
OF CASEBOOK

Inside...

STRIKING A BALANCE

Why legal reform is needed
to tackle the rising cost of
clinical negligence

REPORTED ABUSE

A child makes an allegation
of abuse

A FRIEND IN NEED

A patient suffers
complications during spinal
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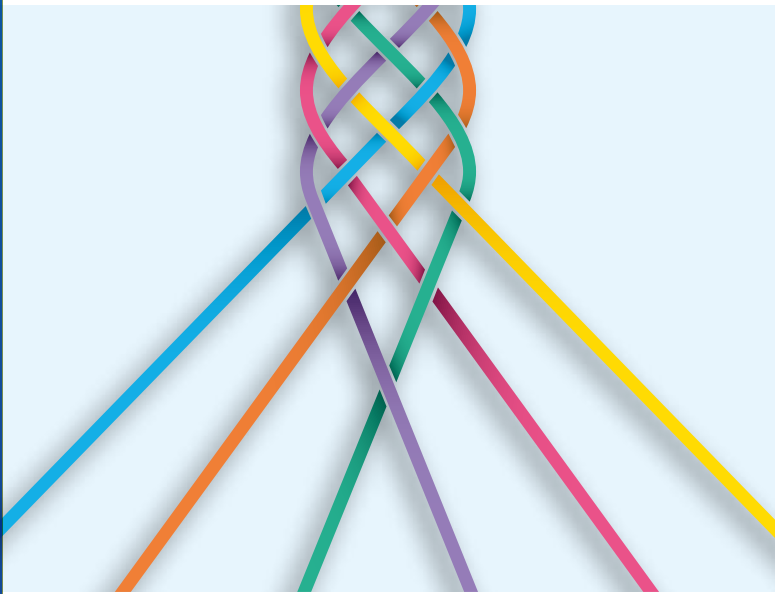
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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



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

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

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

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

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

Last year we conducted some extensive research among members to better understand what information you find most valuable and how you want to receive it. Based on this research, we have focused Casebook on the content that really matters to you – case reports. Each edition will also feature one or two articles that focus on topical medicolegal issues.

In this edition, our main story is on the cost of clinical negligence claims. As the claims environment continues to be challenging, and costs continue to spiral, Medical Protection's Emma Hallinan, Director of Claims, and Pallavi Bradshaw, Senior Medicolegal Adviser, discuss the launch of our new campaign aimed at controlling costs while ensuring patients are fairly compensated.

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

I hope you enjoy this edition.

Dr Marika Davies
Editor-in-Chief
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GMC UPDATES CONFIDENTIALITY GUIDANCE

The GMC has expanded, updated and reorganised its guidance on confidentiality to reflect the way doctors use information.

Confidentiality: good practice in handling patient information was published by the GMC in January 2017, and came into effect on 25 April 2017.

Revisions have been made to the guidance, last published in 2009, following an extensive consultation exercise. While the principles of the current GMC guidance remain unchanged, it now clarifies the following:

- The public protection responsibilities of doctors, including when to make disclosures in the public interest.
- The importance of sharing information for direct care, recognising the multi-disciplinary and multi-agency context doctors work in.
- The circumstances in which doctors can rely on implied consent to share patient information for direct care.
- The significant role that those close to a patient can play in providing support and care, and the importance of acknowledging that role.

Read the guidance on the GMC website at:
www.gmc-uk.org/Confidentiality2017

QUICK HITS



Professor Carol Seymour, a senior medicolegal adviser at Medical Protection, took up office as the President of the Faculty of Forensic & Legal Medicine of the Royal College of Physicians at its AGM in May.



The NHS Litigation Authority has been rebranded as NHS Resolution to reflect the body's new focus on settling cases quickly, learning from what goes wrong and the prevention of errors.



The GMC has decided not to increase the information available on its registers following a period of consultation in 2016. However, the GMC has asked the Academy of Medical Royal Colleges to undertake exploratory work looking at enhancing the GMC's Medical Register by recording doctors' scope of practice.

MEDICAL PROTECTION RISK MANAGEMENT MODEL REDUCES CCG PRESCRIBING RISK BY 88%



In 2015, Medical Protection Educational Services was commissioned by Lambeth NHS CCG in South London to deliver Repeat Prescribing Support Visits to 48 GP practices in the locality.

By completion of the project, practices had reduced their prescribing risk across the locality by 87.9%.

The team behind the project have had a paper published in the *Journal of Evaluation in Clinical Practice* detailing how this success was achieved. 'Repeat prescribing of medications: A system centred risk management model for primary care organisations' can be read online at:
<https://goo.gl/pO8Fco>

REFERENCES

1. Price J, Man S, Bartlett S et al. Repeat prescribing of medications: A system-centred risk management model for primary care organisations. *Journal of Evaluation in Clinical Practice* Published Online First: 2017. doi:10.1111/jep.12718

MEDICAL PROTECTION TO HOST INTERNATIONAL CONFERENCE ON MEDICAL LIABILITY



Medical Protection is delighted to be co-hosting an international conference on medical liability in London on 4-6 October on behalf of the Physicians Insurers Association of America (PIAA).

'Change and Disruption: Strategies for managing the evolution of medical liability' will bring together a global audience of healthcare, risk and insurance professionals with an interest in medical liability.

Attendees will review emerging medical liability trends and new care models, as well as patient safety, risk mitigation and the link to litigation. Commercial themes such as investment strategies, reinsurance and underwriting will also be addressed, and there will be opportunities to discuss strategies for how to adapt and respond to the evolving challenges in the medical liability industry.

For more information, visit the conference website at:
piaa2017.com



CLINICAL NEGLIGENCE

CAN A BALANCE BE STRUCK?

As the cost of clinical negligence continues to spiral and the claims environment for doctors remains challenging, Medical Protection's Emma Hallinan, Director of Claims, and Pallavi Bradshaw, Senior Medicolegal Adviser, explain the legal reforms that underpin our campaign aimed at tackling the rising costs of clinical negligence

READ THIS ARTICLE TO:



✓ **Learn more about the increasing cost of medical negligence**

✓ **Discover how Medical Protection is advocating for change**

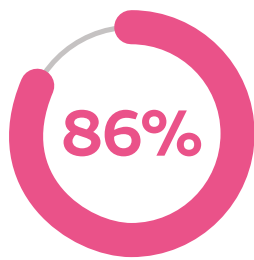
Doctors in the UK are practising in an increasingly challenging environment. For example, Medical Protection data shows that a GP can now expect to receive two clinical negligence claims over their career. These claims range in cost from a few thousand pounds to many millions of pounds.

The annual figures published by NHS Resolution (formerly NHS Litigation Authority) provide a stark but true assessment of the wider claims environment. It is estimated that £56.1 billion will be needed for future clinical negligence costs, relating to claims arising from incidents that have already occurred. Spend on claims has increased by 72% over the five years to 2015/2016 – and this equates to an average increase of 11.5% every year.

Last year alone, the NHS spent nearly £1.5 billion on clinical negligence costs. To put that into context, it is an amount that could pay for the cost of training 6,500 new doctors.¹

The spiralling cost of clinical negligence means money is being diverted away from frontline care at a time when the NHS is facing increasing financial pressure. But we know it is also affecting our members. When the cost of clinical negligence increases, membership subscriptions must also increase to reflect this, and we recognise the pressure this places on members.

Working in a litigious society day in and day out is also taking its toll on doctors. A recent Medical Protection survey found that 88% of healthcare professionals are concerned about the impact that working in a more litigious environment is having on their welfare, and the way they practise. Nearly three quarters of those surveyed (72%) said the fear of being sued has caused them stress or anxiety, and 63% said the fear of being sued is making them consider their future in the profession.²



of Medical Protection members say they would support changes to the legal system to tackle the rising cost of clinical negligence



of the public support change to the legal system

THE NEED TO STRIKE A BALANCE

Patients who are harmed due to clinical negligence should have access to reasonable compensation, but it is also clear that a balance must be struck. If the balance tips too far, the situation will become unsustainable – for the NHS, healthcare professionals, and society.

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.**

This would help to ensure consistency, fairness, and avoid the enormous differentials between costings proposed by care experts working for the claimant, and the defendant. The unpredictability on the size of awards makes it difficult to settle cases quickly and can result in long and expensive disputes, so this reform would also result in cost savings and quicker resolution.

- **A limit on costs relating to future earnings, recognising national average weekly earnings.**

This reform would introduce greater consistency in the size of awards claimants receive. Currently, damages awarded are based on the claimant's weekly earnings and this means that for a similar claim, higher earners can receive far more in compensation than lower earners.

- **The introduction of a fixed recoverable costs scheme for all clinical negligence claims up to a value of £250,000.**

This scheme presents an opportunity to create a more proportionate, fairer system, while generating substantial savings. The Department of Health has proposed a fixed recoverable costs scheme to stop lawyers charging high legal costs. It has suggested the scheme includes claims up to the value

of £25,000 – but we believe it could include claims up to £250,000, thus generating even greater savings.

- **The introduction of an ultimate ten-year limit between the date of an adverse incident, and when a claim can be made.**

It is not unusual to see late notification of claims. Late notification means that records may have been lost or destroyed, or medical staff may have retired or have little recollection of the facts. The longer the delay between the incident and the claim, the greater the opportunity there is for claims to inflate and damage levels to increase. However, we recognise the need for judicial discretion in certain circumstances, such as where the claimant is a child who would not have reached the age of 18 before the expiry of the ultimate limitation period.

A THREE-PRONGED APPROACH TO A SUSTAINABLE FUTURE

A whole package of reforms is necessary if we are to really tackle the root of the problem.

In a survey, 86% of Medical Protection members say they would support changes to the legal system to tackle the rising cost of clinical negligence, and interestingly, a YouGov survey showed 73% of the public support change.³

There is also growing recognition of the need for legal reform from others – including NHS England, NHS Resolution and the Department of Health. The recent reduction in the Personal Injury Discount Rate, which significantly increased the cost of settling future loss claims at a time when the cost of clinical negligence is already worryingly high, must serve as a wake-up call about the sustainability of the situation.

Of course, tackling the cost of clinical negligence once a claim is made, through legal reforms, is just one part of the jigsaw.

Our new policy report also explores the causes of adverse incidents and where patient safety and the reliability of care can be improved, and it looks at the many complex and interrelated drivers of clinical

negligence claims – from changing patient expectations, through to greater awareness by patients about how to bring a claim.

This three-pronged approach is important if we are to deal with the challenging claims environment for the long term, and achieve a more sustainable future.

GET INVOLVED

We encourage members to get involved and support the campaign – find out more at medicalprotection.org/balance

You can also join the debate on Twitter using **#StrikingABalance**

PERSONAL INJURY DISCOUNT RATE

The Lord Chancellor announced on 27 February that the Personal Injury Discount Rate will be reduced from 2.5% to -0.75%. This decision, which took effect on 20 March 2017, will significantly increase the cost of settling awards for clinical negligence.

To illustrate the impact on claims, consider a 21-year-old woman requiring long-term care, but with a normal life expectancy, resulting from a GP's failure to diagnose a sub-arachnoid haemorrhage. A claim of £1million prior to 20 March (comprising of £700k of future care costs and £300k of other claims costs) would now, at the new discount rate of -0.75%, cost £2.3million. A similar claim at £5million would now cost £12.8million.

Soon after the discount rate changed an NHS Trust nearly tripled an injury pay-out from £3.8 million to £9.3million as a result.⁴

FOOTNOTES

1. Calculated using figures that it costs £230,000 to train a GP according to <https://fullfact.org/health/cost-training-doctor>.
2. Survey of 4,157 UK based Medical Protection members, conducted by Medical Protection in February 2017.
3. Survey of 2,034 GB adults conducted by YouGov on behalf of Medical Protection in February 2017.
4. NHS trust triples injury pay-out to £9.3 million under controversial new rules: <https://www.theguardian.com/business/2017/mar/20/nhs-trust-injury-payout-health-service-insurance-ogden-formula>

CONFIDENTIALITY MATTERS

As the GMC's new guidance on confidentiality comes into effect, Dr Marika Davies describes some cases in which Medical Protection has assisted members following an unintentional breach of confidentiality

READ THIS ARTICLE TO:



- ✓ Find out about more about unintentional breaches of confidentiality
- ✓ Learn how to guard against unintentional breaches

The GMC's updated guidance on confidentiality came into effect on 25 April 2017. We frequently receive calls from members asking whether they should disclose personal information about their patients and, as the GMC guidance sets out, there are exceptional circumstances in which confidentiality can be breached.

The guidance also says you must make sure any personal information you hold or control is 'effectively protected at all times against improper access, disclosure or loss'. Unfortunately, information about patients is sometimes disclosed in error, which can lead to a complaint or request for compensation.

We examine three cases in which we have assisted members following an unintentional breach of confidentiality.





Unfortunately, information about patients is sometimes disclosed in error, which can lead to a complaint or request for compensation

CASE 1

Dr X was on call from home and decided to catch up with some paperwork in a local coffee shop. She was writing a report on a patient and called a colleague to discuss the case. She took care not to mention the patient's name given the public setting.

A few days later she was made aware of a complaint. A member of the public who was in the coffee shop at the same time had recognised her and contacted the hospital. They had seen the name of the patient on her laptop screen, and had also overheard personal information about the patient in the doctor's conversation.

The trust asked Dr X for her comments and Medical Protection helped her to prepare a response. Fortunately, the trust dealt with the matter under its complaints procedure and did not take disciplinary action against the doctor.

CASE 2

Dr Y was on call overnight and drove home after finishing the morning handover. She left some papers, including her handover sheet, on the back seat of her car, which was parked in the street outside her home.

A member of the public who passed by, saw the sheet, which clearly displayed a number of patient names and their diagnoses. She took a photograph, which she sent to the local NHS trust with an expression of concern about the breach of confidentiality.

Dr Y was informed by her medical director that they would be investigating the matter under its disciplinary process. Medical Protection helped Dr Y to prepare a report, and accompanied her to the investigatory meeting. Dr Y provided a clear explanation and apology, and no further action was taken.

CASE 3

Dr Z called her 16-year-old patient, Miss R, to let her know that a recent chlamydia test result was positive. She got through to the patient's voicemail, and was careful not to disclose the diagnosis when she left a message. Instead, she asked the patient to attend the surgery to collect her results. She attached an advice leaflet to the results along with a note inviting Miss R to make an appointment.

Dr X did not realise that the phone number on file actually belonged to the patient's mother. Mrs R came in to the surgery and was given the documents by the receptionist. The patient complained about her breach of confidentiality and requested compensation for the distress and embarrassment caused.

Dr X sought advice from Medical Protection, and was assisted in preparing a response. The practice apologised and offered the patient a small sum as a financial redress under the complaints procedure, which the patient accepted.

LEARNING POINTS:



- ✓ Be aware of your surroundings when discussing patients or writing notes. As well as wards and emergency departments, other high-risk areas where breaches can occur are lifts, canteens, computers, and printers.
- ✓ Be careful not to leave memory sticks or handover sheets lying around. Use a privacy screen on your laptop and avoid leaving messages on unidentified voicemail.
- ✓ Make sure all staff are trained on the importance of confidentiality and are aware of the protocols in place to maintain it.
- ✓ If there is an inadvertent disclosure, you should inform the patient of the error and provide an explanation and apology. The incident should be investigated so that lessons can be learned.
- ✓ Serious breaches should be reported to the Information Commissioner's Office – take advice from Medical Protection if you find yourself in this situation.

FURTHER INFORMATION:

GMC - Confidentiality: good practice in handling patient information (2017)
www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

Medical Protection - Confidentiality series of factsheets
medicalprotection.org/factsheets

MORE SUPPORT FROM MEDICAL PROTECTION

If you require assistance or advice from one of our medicolegal advisers, please contact **0800 561 9090** or querydoc@medicalprotection.org



BACK TO BASICS

A patient repeatedly attends his GP with worsening back pain

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



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

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

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

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

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

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

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

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

EXPERT OPINION

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

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

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

Learning points

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

REPORTED ABUSE

A child makes an allegation of abuse

Author: Dr Clare Redmond, Medicolegal Adviser at Medical Protection

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

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

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

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

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

EXPERT OPINION

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

Medical Protection successfully defended the claim.



Learning points

- When writing a professional report, you should take reasonable steps to check the information provided, to ensure it is not false or misleading. A report should make clear where a patient has provided information about events or another party, and this should not be recorded as fact. You must not deliberately leave out relevant information even if requested to do so.
- When writing a professional report, you should set out the facts of the case and clarify when you are providing an opinion. Do not be tempted to comment on matters that do not fall within your area of expertise. In this case, Dr B was assisted by her clear and robust report-writing.
- All doctors have a duty to act on concerns about the welfare of children, and child protection work is recognised as challenging and emotionally difficult. GMC guidance makes clear that all doctors should have confidence to act if they believe a child or young person may be abused or neglected. As long as their concerns are 'honestly held and reasonable' and they take appropriate action, doctors should not face criticism even if the allegations prove unfounded.

Further reading

Medical Protection factsheet – Report writing
[medicalprotection.org/factsheets](https://www.medicalprotection.org/factsheets)

GMC guidance – Protecting children and young people: doctors responsibilities
www.gmc-uk.org/guidance/ethical_guidance/13257.asp

NO NEWS IS NOT ALWAYS GOOD NEWS

A newborn is referred with a clicking hip

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



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

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

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

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

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



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

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

EXPERT OPINION

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

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

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

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

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

Learning points

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

A FAILURE TO MONITOR

A patient attends his GP multiple times with symptoms of dizziness

Author: Dr Ellen Welch, GP



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

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

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

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

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

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

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

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

EXPERT OPINION

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

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

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

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

Learning points

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

A COMPLICATED CLAIM

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

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



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

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

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

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

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

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

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

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

EXPERT OPINION

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

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

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

Learning points

- Be clear and explicit about the limits of your expertise to avoid misunderstandings. The GMC states in *Good Medical Practice*: "You must only give expert testimony and opinions about issues that are within your professional competence or about which you have relevant knowledge including, for example, knowledge of the standards and nature of practice at the time of the incident or events that are the subject of the proceedings."¹
- Your credibility is likely to be undermined if you are providing an opinion about an area of practice in which you have no (or no recent) practical experience.
- This case highlights the importance of having understanding and experience appropriate to the location of a claim (for example, private or public sector) in order to avoid making incorrect assumptions about personnel or protocols.

REFERENCES

1. General Medical Council. *Good Medical Practice*. GMC 2013.

A FRIEND IN NEED

A patient suffers complications during spinal surgery

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



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

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

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

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

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

EXPERT OPINION

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

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

Learning points

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



UNFORESEEABLE COMPLICATIONS?

A patient undergoes corneal graft surgery for deteriorating keratoconus

Author: Dr Anusha Kailasanathan, Ophthalmologist

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

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

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

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

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

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

EXPERT OPINION

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

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

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

Learning points

- Doctors must now ensure that patients are aware of any "material risks" involved in a proposed treatment, and of reasonable alternatives, following the judgment in the *Montgomery* case in 2015. GMC guidance¹ also recommends that serious adverse events (such as irreversible loss of sight) must be discussed even if they are rare.
- When providing important information in a written format, the patient must be made aware of its importance. Consider providing verbal information as well as written information for important matters. When giving written information to sight-impaired patients, the format and font should be suitable for their visual ability. When applicable, consider adjunctive methods to deliver information such as audio or video formats.
- Although the primary purpose of medical records is to ensure continuity of patient care, medical records are used as evidence of care when dealing with complaints and medicolegal claims. Therefore, clear and detailed medical records are in both the patient's and the doctor's best interest.

REFERENCES

1. General Medical Council. *Consent: Patients and doctors making decisions together*. GMC 2008

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

TURNING A BLIND EYE

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

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

This issue needs to be debated.

Dr Ted Willis

Response “ ”

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

We are aware of the difficulties around the issue of communication of test results between primary and secondary care and in fact included a feature on this in the November 2016 edition (A testing problem). With regard to your comment on responsibility for following up a test result, doing so includes reviewing the result and either taking action personally or referring the patient to an appropriate person to do so, which the ophthalmologist did in this case.

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

A HIDDEN PROBLEM

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

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

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

**Dr Colman Byrne,
Ireland**

Response “ ”

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

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



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

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