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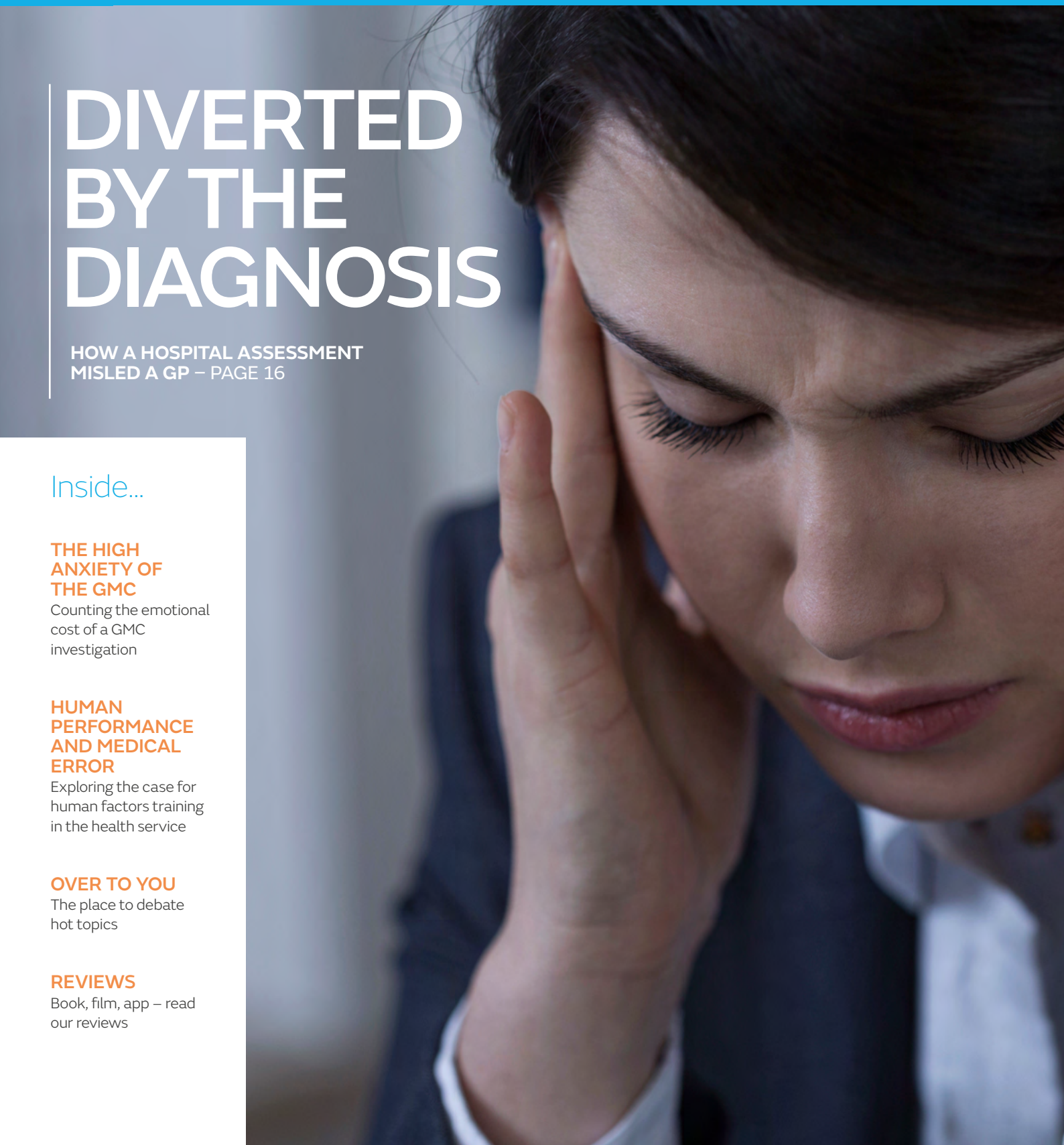
MPS

CASEBOOK



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HOW A HOSPITAL ASSESSMENT MISLED A GP – PAGE 16

Inside...

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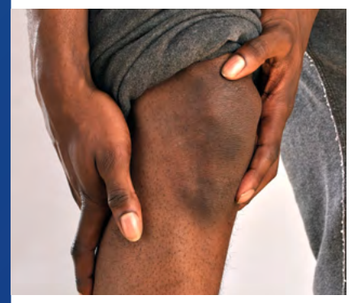
WHAT'S INSIDE...



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WELCOME

Dr Nick Clements
EDITOR-IN-CHIEF

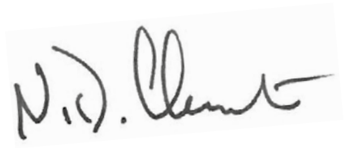
Medical matters, unsurprisingly, continue to feature heavily in the headlines and the media in general. There seems to be an endless appetite among the public for such stories, whether they are announcing the arrival of new and better treatments or procedures, or reporting shortfalls, errors or even scandals. Politicians frequently feel obliged to step in, but their attempts to remedy things don't always have the desired result.

Inevitably this is felt by you on the wards or in your consulting rooms, with increasing patient expectations in the form of unrealistic demands or a raft of self-researched information from the internet. This can make for some challenging situations, at a time when workloads grow in intensity, perhaps due to budgetary cutbacks or other local factors.

It continues to be an important time to be part of an organisation like MPS. We work in partnership with you to protect and support your career at every stage, and this work takes many forms, beyond the litigation work that we are more traditionally associated with. This includes an extensive range of educational products such as online learning, workshops and seminars, as well as continuous consultative work with governments and policy-makers worldwide. The latter is often 'behind the scenes' and often not highly-publicised, but you can be reassured that our specialist teams are fighting hard to safeguard your interests.

Many of you got in touch with us following the last edition of *Casebook* in September, regarding our cover story on the case of Beth Bowen. While the emotional reaction from a number of correspondents was not surprising, I was heartened by the way the article made everyone think about their own approach to communication, openness and consent. Anger at the treatment of the Bowen family was palpable in some of your letters, and if this deeply tragic case results in reflection and changes in culture and practice, then something positive will have been achieved.

We have published a short response to this correspondence in our "Over to you" section on page 23. I hope you find this edition of *Casebook* an equally thought-provoking one and, as ever, I am keen to hear your feedback.



NEW JUDGMENT ON PATIENT CONSENT

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

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

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

It is notable that this decision enshrines in law principles that are already in the GMC's guidance on consent, *Consent: Patients and Doctors Making Decisions Together* (2008), and which are reflected in MPS's own advice materials on consent.

THE CASE

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

Mrs Montgomery is diabetic and small in stature and the risk of shoulder dystocia was agreed to be 9-10%. Despite expressing concern to her consultant about whether she would be able to deliver her baby vaginally, the doctor failed to warn Mrs Montgomery of the risk of serious injury from shoulder dystocia or the possibility of an elective caesarian section.

Mrs Montgomery brought a claim against Lanarkshire Health Board, alleging that she should have been advised of the 9-10% risk of shoulder dystocia associated with vaginal delivery notwithstanding the risk of a grave outcome was small (less than 0.1% risk of cerebral palsy).

It was also alleged that delivery by caesarean section ought to have been offered to Mrs Montgomery, and that this would have prevented the child's injury.

Lanarkshire Health Board argued that only the risk of a grave adverse outcome triggered the duty to warn of such risks and that, because the risk of such an outcome was so low and that an expression of concern was not the same as a direct question requiring a direct answer, no warning was required.

JUDGMENT

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

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

The court ruled that Mrs Montgomery should have been informed of the risk of shoulder dystocia and given the option of a caesarean section. Mrs Montgomery was awarded £5.25 million in damages.

To read the judgment in full, visit: www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf

PROTECTING INFORMATION – PROTECTING YOU

At MPS we recognise the importance of protecting individuals' personal data and the responsibility we all have in ensuring the security of the data we hold.

In today's world we are increasingly reliant on exchanging data via email and it is important that we continue to have the appropriate level of security in place to protect this data.

MPS already uses an industry standard email encryption solution to help minimise the risk of interception and misuse of confidential and sensitive information. As email security standards and technology advance, we have introduced additional email protection measures from April 2015.

WHY ARE WE INTRODUCING THIS CHANGE?

"This change is an important step in ensuring we are doing our utmost to protect the security of the data we hold and exchange via email with our members. It demonstrates our ongoing commitment to providing the highest level of service for our members."

David Wheeler
General Counsel at MPS

HOW WILL IT IMPACT ME?

The vast majority of our members will not see any difference as a result of these changes and will continue to be able to send and receive emails securely to and from MPS as they do now.

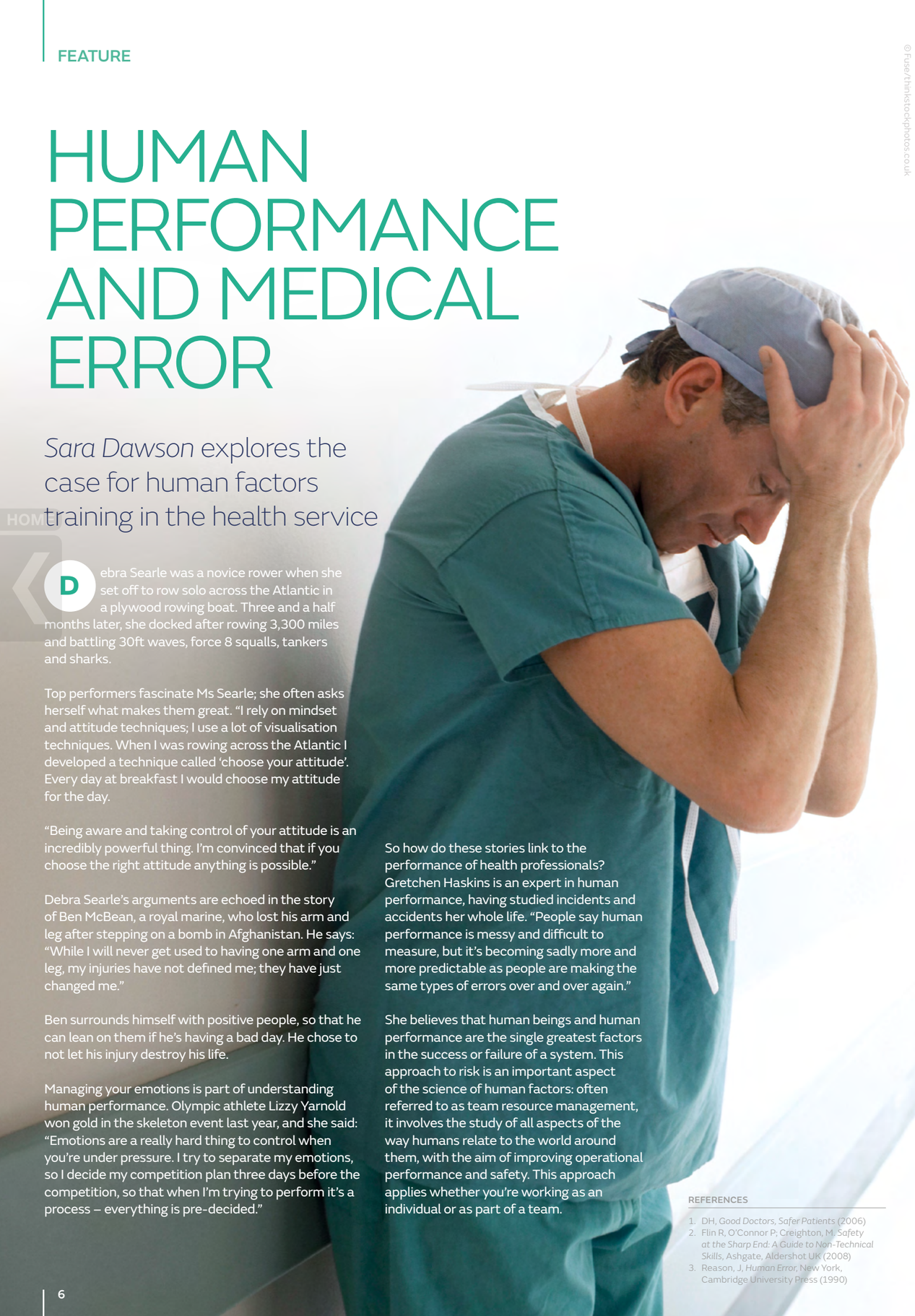
However, for some members, depending on their existing email provider and the content of the email correspondence, they may in future be directed to retrieve and exchange messages with MPS via a secure portal.

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

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

HUMAN PERFORMANCE AND MEDICAL ERROR

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



Debra Searle was a novice rower when she set off to row solo across the Atlantic in a plywood rowing boat. Three and a half months later, she docked after rowing 3,300 miles and battling 30ft waves, force 8 squalls, tankers and sharks.

Top performers fascinate Ms Searle; she often asks herself what makes them great. "I rely on mindset and attitude techniques; I use a lot of visualisation techniques. When I was rowing across the Atlantic I developed a technique called 'choose your attitude'. Every day at breakfast I would choose my attitude for the day.

"Being aware and taking control of your attitude is an incredibly powerful thing. I'm convinced that if you choose the right attitude anything is possible."

Debra Searle's arguments are echoed in the story of Ben McBean, a royal marine, who lost his arm and leg after stepping on a bomb in Afghanistan. He says: "While I will never get used to having one arm and one leg, my injuries have not defined me; they have just changed me."

Ben surrounds himself with positive people, so that he can lean on them if he's having a bad day. He chose to not let his injury destroy his life.

Managing your emotions is part of understanding human performance. Olympic athlete Lizzy Yarnold won gold in the skeleton event last year, and she said: "Emotions are a really hard thing to control when you're under pressure. I try to separate my emotions, so I decide my competition plan three days before the competition, so that when I'm trying to perform it's a process – everything is pre-decided."

So how do these stories link to the performance of health professionals? Gretchen Haskins is an expert in human performance, having studied incidents and accidents her whole life. "People say human performance is messy and difficult to measure, but it's becoming sadly more and more predictable as people are making the same types of errors over and over again."

She believes that human beings and human performance are the single greatest factors in the success or failure of a system. This approach to risk is an important aspect of the science of human factors: often referred to as team resource management, it involves the study of all aspects of the way humans relate to the world around them, with the aim of improving operational performance and safety. This approach applies whether you're working as an individual or as part of a team.

REFERENCES

1. DH, *Good Doctors, Safer Patients* (2006)
2. Flin R, O'Connor P, Creighton, M. *Safety at the Sharp End: A Guide to Non-Technical Skills*, Ashgate, Aldershot UK (2008)
3. Reason, J, *Human Error*, New York, Cambridge University Press (1990)

BEGINNINGS OF HUMAN FACTORS TRAINING

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

HUMAN FACTORS IN MEDICINE

Medicine has been slower to fully embrace the relevance of human factors in medical error. In 2006 the Chief Medical Officer (CMO) reported in his review *Good Doctors, Safer Patients*: "It is only... recently that attention has been focused on patient safety. Despite the relatively high level of risk associated with healthcare – roughly one in ten patients admitted to hospital in developed countries suffers some form of medical error – systematic attempts to improve safety and the transformations in culture, attitude, leadership and working practices necessary to drive that improvement are at an early stage." [1]

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

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

THE PSYCHOLOGY OF HUMAN ERROR

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

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

Studies of disasters such as Three Mile Island, The Herald of Free Enterprise, and Bhopal have illustrated human factors issues similar to those found in medical practice.[2]

According to James Reason, all humans make frequent errors and they make errors in predictable and patterned ways. Novices make errors due to incomplete knowledge and experts make errors due to the intrinsic hazards of semi-automated behaviour.[3]

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

THE CASE FOR HUMAN FACTORS TRAINING

Guy Hirst explains: "When humans work in complex systems, the opportunities for error-inducing conditions are unlimited and may be exaggerated by cultural and systems deficiencies. We have documented many examples of these error-inducing conditions during our own research working in operating theatres. The danger is that eventually the consequences of some of these familiar and generally tolerated conditions may well be fatal."

THE CASE FOR HUMAN FACTORS

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

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

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

USEFUL LINKS

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

THE HIGH ANXIETY OF THE GMC

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

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

Against this background, an investigation by the doctor's regulatory body imposes a further significant burden – which can sometimes have tragic consequences. When the GMC published its report into doctor suicides[1] last December, it was shining a light on its own involvement in causing anxiety among doctors, revealing that 28 had taken – or were suspected of taking – their own lives while being investigated by the GMC between 2005 and 2013.

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

DEEPER ISSUES

To coincide with the GMC's report, MPS conducted our own survey of 180 members to measure the impact of GMC investigations on their careers, health and wellbeing. The survey was aimed at members from both primary and secondary care who had been involved in a GMC investigation over the past five years. Some of the key findings are below.

- Top five areas impacted by GMC investigations:
  - stress/anxiety (93%)
  - personal life (76%)
  - health and wellbeing (74%)
  - confidence (69%)
  - professional reputation (52%).
- Almost three quarters of respondents (72%) believed that experiencing a GMC investigation had a detrimental impact on their mental and/or physical health.
- Almost half of respondents (47%) did not believe they received enough support in looking after their health throughout the investigation.
- 70% of respondents said that the GMC should offer more support to doctors facing an investigation.
- More than a quarter of respondents (28%) considered leaving the profession as a result of their experience; 8% changed their roles and 2% left the profession.
- In terms of support, over a quarter of respondents (28%) called for clearer expectations from the GMC.
- Media attention was experienced by 26 doctors as a result of the investigation.

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

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

OTHER FACTORS

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

Niall Dickson, chief executive of the GMC, said: "We know that some doctors who come into our procedures have very serious health concerns, including those who have had ideas of committing suicide. We know too that for any doctor, being investigated by the GMC is a stressful experience and very often follows other traumas in their lives. Our first duty must, of course, be to protect patients but we are determined to do everything we can to make sure we handle these cases as sensitively as possible, to ensure the doctors are being supported locally and to reduce the impact of our procedures.

"Although a referral to the GMC will always be a difficult and anxious time for the doctor involved, we want to handle complaints as effectively as possible and ensure our processes are as quick, simple and as low stress as we can make them. We have made some progress on this but we have more to do, and that includes securing legal reform. We will now review our current process for dealing with doctors with health problems and identify any further changes that may be needed."

PREVENTION AND CURE

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

Case conferences

Recently we assisted a member with a GMC investigation that took four months to be closed with no further action. After receiving an expert report that was supportive of the doctor's care, we requested that the GMC promptly close the case. While we appreciate that GMC investigations sometimes have to move at a slow pace – and in many cases this is outside the GMC's control – more can be done to reduce delays and allow doctors to be more actively involved in the investigation.

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

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

Review deadlines

Reasonable deadlines for doctors to respond to allegations is another way to reduce anxiety, with current timeframes of 28 days proving relatively short when considering the many other commitments of doctors.

AN OPPORTUNITY FOR CHANGE

The unpredictable and sometimes drawn-out nature of GMC investigations can have a significant impact on the mental and physical health of doctors, and the GMC's willingness to hold itself to account is most welcome. Improvements to existing processes will hopefully go some way to limiting the emotional impact of investigations, particularly as they are already likely to be one of the most stressful experiences a doctor will face.

Dr Clare Gerada, medical director of the Practitioner Health Programme, said: "I welcome this long-awaited and important review. I applaud the GMC's openness in putting in the public domain the issue of doctors' suicides whilst under their process. Going forward they need to continue to show their commitment to reducing the impact of fitness to practise investigations on vulnerable doctors whilst always maintaining patient safety – a substantial task.

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

REFERENCES

1. GMC, *Doctors who commit suicide while under GMC fitness to practise investigation* (December 2014)

FROM THE CASE FILES

Melanie Rowles, head of claims management at MPS, introduces this edition's collection of cases, and looks at how they are often viewed very differently by doctors and lawyers

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

I am pleased for this opportunity to review the cases in this edition of *Casebook* from a claims management perspective. I have been qualified as a solicitor for nearly 30 years and the majority of my career has been spent working with doctors. After a few years of working with my medical colleagues, it became clear to me that lawyers and doctors often speak a different language and look at events from a very different perspective.

So having read the cases, I thought I would highlight where I see some of those key differences – and clarify those situations where a lawyer's advice may seem difficult to understand or even illogical.

As I was reading each case I could see where the story would end before I got there. I think this was because I was seeing them as a lawyer: seeing the whole scenario unfold and not just seeing a snapshot in time. This is exactly how a judge would see a case and I think that is worth reflecting on.

As a doctor you are often dealing with a snapshot in time, and often under significant time pressure. However, it is always worth checking that in carrying out your role, you are taking the whole picture into account. In many of the cases in this edition, this has been a failure of the doctor, which has led to cumulative errors and a chain of events leading to an adverse outcome for the patient.

Often we see claims where the patient has suffered an avoidable harm because of a whole chain of events set in motion by one person failing to act appropriately, or misdiagnosing a condition. This then leads to others relying on that view, even as the picture is changing or not fitting together. Think of stuffing an incorrect jigsaw piece into a space that is quite similar, yet when you stand back the picture is wrong and often there are missing pieces. If each doctor had looked at the whole picture that was emerging, then the chain of events would have been halted earlier and the outcome for the patient would probably have been better.

When a claim appears before a judge they see the whole picture with all the missing pieces and an adverse outcome. A judge will use the experts to inform him on medical issues and look at the expert opinion, but will apply legal tests and a layman's view of common sense. With that in mind you will see how easy it is for them to reach a view that if someone had stood back and looked at all that had gone before, and assessed the issues objectively, the chain of events could have been stopped.

Interestingly, having had the opportunity to discuss this with my colleagues who deal with matters before the regulator, 'reflection' and 'insight' are words that are used repeatedly in that arena. Again, reflection can be the key to a successful outcome.

As a final thought I can see how some may wonder why compensation is still paid even though an eventual outcome for a patient is the same irrespective of the adverse event: "What has been *caused*?" you may ask. Legal causation is any pain and suffering that flows from an error, and which otherwise would not have been there. So any period of additional pain is compensatable, even if it is hours or days.

I will leave you with these thoughts and let you ponder again on the words we use and their different meanings, as you read the cases.

What's it worth?

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

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

PULLED IN ALL DIRECTIONS

SPECIALTY ANAESTHETICS
THEME INTERVENTION AND MANAGEMENT

HIGH £1,000,000+

Mrs J was a 32-year-old female patient with a long history of neck pain following a road traffic accident. The pain was localised to the left side of the neck and left shoulder, with only very occasional paraesthesia in her left hand. Despite regular analgesics and exercises, the pain was still troublesome and she was keen for a specialist opinion.

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

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

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

Mrs J later returned for the second diagnostic injection. Mrs J was placed in the prone position and local anaesthetic infiltrated into the skin. Using biplanar fluoroscopy, 22G spinal needles were inserted toward the C5/6 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and triamcinolone at the lower level. Unfortunately, as soon as Dr M started the injection the patient jumped with pain and her left arm twitched. The procedure was abandoned.

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

The next morning Mrs J was no better. She felt unsteady on her feet and complained of a burning sensation in her right leg, as well as weakness and shooting pains in her left arm. Dr M decided that a second opinion was required and referred Mrs J to a neurosurgical colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved but Mrs J continued to suffer from terrible neuropathic pain. It affected many aspects of her daily life and she found it difficult to return to work as she was not able to sit for any length of time. A spinal cord stimulator was inserted by another pain specialist to try and help with the pain, but this was largely unsuccessful and was later removed.

Mrs J subsequently lost her job and, following that, decided to bring a claim against Dr M.

EXPERT OPINION

The case was reviewed for MPS by Dr F, a specialist in pain management. Dr F was of the opinion that the initial assessment and management plan were entirely appropriate. She was somewhat critical of the approach used by Dr M for the diagnostic injection as it was not consistent with the planned approach for the radiofrequency lesioning and, in her opinion, more likely to be associated with the possibility of damage to the spinal cord. She also felt that the use of triamcinolone in the diagnostic injections could be criticised, as injection of particulate matter into the spinal cord is known to be associated with a higher risk of cord damage.

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

Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

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

The case was considered indefensible and was settled for a high sum.

Learning points

- Although it is commonplace for a doctor to assume multiple roles, this case highlights the risks during an individual procedure. Dr M was acting as an anaesthetist providing sedation, analgesia and reassurance, whilst at the same time carrying out the facet joint injections.
- Although Dr M warned the claimant about the possibility of nerve damage, this does not mean that a defence can necessarily be made. Both the expert pain consultant and radiologist concluded that neither needle was positioned as intended prior to the injection and that the lower needle tip was clearly within the spinal canal and thus potentially within the substance of the cord.
- The experts were of the opinion that a pain medicine consultant should be confident in interpretation of live radiological imaging including needle trajectory and accurately determine needle trajectory and position prior to performing the procedure. It is important to allow the necessary time regardless of other pressures and to follow guidelines published by professional societies/bodies, eg, International Spinal Injection Society. There is a body of opinion that advises against the use of particulate steroid injections in the cervical area.
- When an elective procedure or service has been offered to a patient, the practitioner may feel an obligation to fulfil this, even when they may not be entirely confident about doing so. Where there is any doubt or concern, it is far better to abandon the procedure or seek a second opinion, particularly where a mistake may lead to a serious complication.

DB
JA

MISSED CRITICAL LIMB ISCHAEMIA

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS

HIGH £1,000,000+

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Mr S was a 60-year-old lorry driver. He was overweight and smoked, and couldn't walk far because he suffered with pain in his calves.

During a long drive he became aware of pain in his right calf and foot. This became so severe that he attended the out-of-hours service that evening. The GP measured both calves and found them to be the same. A history of forefoot pain but no calf tenderness was noted and a DVT was excluded. He told Mr S he likely had a problem with his circulation. Mr S was prescribed aspirin and advised to consult with his own GP for further follow-up.

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

Mr S's Doppler scan was arranged for the following week but he rang his GP surgery three days later because the pain in his foot and lower leg was becoming more severe. He had to hang his foot over the edge of the bed to get relief from it. Dr A advised him to go straight to the Emergency Department (ED).

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

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

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

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

He was devastated and made a claim of negligence against his GP. It was alleged that Dr A had not appropriately acted upon his symptoms of rest pain or made the correct diagnosis of critical limb ischaemia. It was claimed that Dr A had failed to refer him for urgent surgical review and that he had wrongly asked him to wait for a week for a Doppler scan.

Learning points

- NICE has published useful guidelines on the diagnosis and management of lower limb ischaemia.
- Critical limb ischaemia is characterised by any of: rest pain, arterial ulceration or gangrene. It has a high risk of amputation. If a patient has rest pain they need same-day surgical assessment.
- You should not be completely reassured by another doctor's assessment. In this case the GP had been reassured by the diagnosis in the ED, which was incorrect. Doctors should use their own clinical acumen.

AF

EXPERT ADVICE

MPS sought the advice of an expert GP. She felt that Dr A had performed below the acceptable standard of GP care. She considered that there was sufficient evidence of critical ischaemia in the description of rest pain at night coupled with an alteration in colour and temperature of the foot. She said that this required urgent same-day surgical assessment. She felt that there was no clinical indication for quinine sulphate and the decision to request a Doppler scan, which was clearly not performed with any degree of urgency, was insufficient in the light of the history and clinical findings.

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

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

CUMULATIVE ERRORS

SPECIALTY OBSTETRICS & GYNAECOLOGY
THEME COMMUNICATION

SUBSTANTIAL £100,000+

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Mrs G, 34, presented to the delivery suite at 12pm, 38 weeks into her first pregnancy.

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

At 3.30pm she was re-examined and found to be 3cm dilated and was given 100mg pethidine IM.

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

At 10pm, she was found to be 3cm dilated and the "membranes were still intact", despite still having regular contractions of three every ten minutes. No artificial membrane rupture was carried out; however, Mrs G was started on a syntocinon regime by the midwife. There was no documentation as to whether this was carried out after verbal advice from the doctor or not, but no written prescription could be found on the drug chart, when the notes were reviewed retrospectively.

At 12.30am the CTG had become "suspicious", with the baseline 150b/min and typical variable decelerations and the contractions were coming five every ten minutes. Dr A, the staff grade obstetrician on-call, was notified and he advised "verbally" to stop the syntocinon infusion, change the position of Mrs G and give her oxygen. The midwife felt the CTG improved after this.

At 3am, Mrs G was re-examined and her cervix was found to be 6cm dilated with "bulging membranes". These were artificially ruptured and she was found to have grade II meconium. The CTG baseline had risen to 180b/min and there were deep late decelerations and the contractions were still strong, coming four every ten minutes, despite having stopped the syntocinon. Dr A was informed, but he was "busy" and had still not arrived to review the CTG by 3.35am.

He was re-contacted and came to assess Mrs G at 4am. He felt she was now "fully dilated" with the head at the level of the ischial spines. He decided to carry out a ventouse delivery, which was started at 4.15am. This was recorded as a "difficult delivery", but no other documentation was made. The 3.9kg baby girl was delivered at 4.35am with an Apgar score of 3 at one minute after birth, and 6 at five minutes. The cord gases showed severe metabolic acidosis with a pH 6.9 and BE-18 (arterial). The paediatricians were called subsequently and the baby was transferred to NICU. Although the baby survived, she had significant hypoxic ischaemic encephalopathy and severe cerebral palsy as a result.

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

The claim was settled for a substantial sum.

Learning points

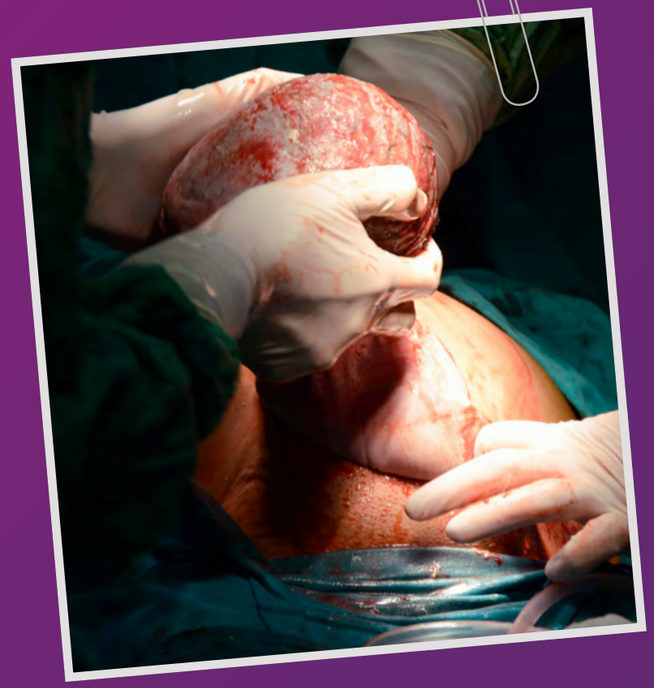
- When things go wrong it is rarely because of a single isolated event. Errors and incidents occur within a system and usually there is a sequence of events that occur before an accident happens.
- Although the mother and the baby were "adequately" monitored throughout the whole labour, the expert witnesses felt that there was significant substandard care in the interpretation of this CTG and the communication of the findings with the doctor involved.
- In this case the handover was poor throughout. A recognised handover model is a useful way of ensuring good communication and effective handover between health professionals and teams.
- All verbal advice about the proposed procedures should be carefully documented in the notes, eg, position of suction cup over the flexion point on the occiput, number of pulls (ideally less than three) and time for completion (less than 15 minutes). In this case there was a 20-minute time from application to delivery.
- The patient should be reviewed by the doctor before syntocinon is prescribed. The membranes should be ruptured before this is done because there is the risk of amniotic fluid embolism. The patient should be fully assessed on an individual basis, eg, signs of fetal distress on the CTG, frequency and strength of the contractions, previous obstetric history etc.
- If there is any delay in a patient being assessed by one member of a team, seek advice from a higher level to get this expedited (eg, supervisor of midwives, consultant).
- Whenever a suspected fetal compromised baby is to be delivered, the paediatric team need to be alerted, such that resuscitation can be instituted as soon as the baby is delivered. In this case the baby had to be transferred directly to NICU before appropriate resuscitation was started.

AF

TOO MUCH OXYGEN

SPECIALTY PAEDIATRICS
THEME INTERVENTION AND MANAGEMENT

SUBSTANTIAL £100,000+



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A baby was born by caesarean section at 27 weeks gestation with a birth weight of 980grams. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first four hours of life, the baby's oxygen saturations were recorded as ranging between 90-97%. A blood gas taken five hours after delivery showed a pH of 7.68 (normal 7.3-7.4), a PaCO2 of 1.91kPa (normal 4.5-6.0), a PaO2 of 35.84kPa (normal 5-8) and a bicarbonate level of 24.6mmol/L (normal 18-24). This demonstrated the baby was being over-ventilated.

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

The baby was not referred at four to six weeks of age for retinopathy of prematurity (ROP) screening, and was first seen by an ophthalmologist at the age of seven months when a diagnosis of inoperable Grade 5 ROP, causing blindness, was made.

The baby's parents made a claim against the consultant paediatrician who handled the baby's care.

EXPERT OPINION

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

There was no record that an ophthalmological appointment for the screening of ROP was made at the recommended four to six weeks of age. The baby developed severe ROP and blindness due to excessive oxygen administration. The opportunity to limit the condition and save the infant's vision was missed due to the fact that the child was not referred for screening for ROP. There was negligence on the part of the paediatrician and nursing, in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a four-day period, and for not referring the child at the appropriate time for an eye examination.

The case was settled for a substantial sum.

Learning points

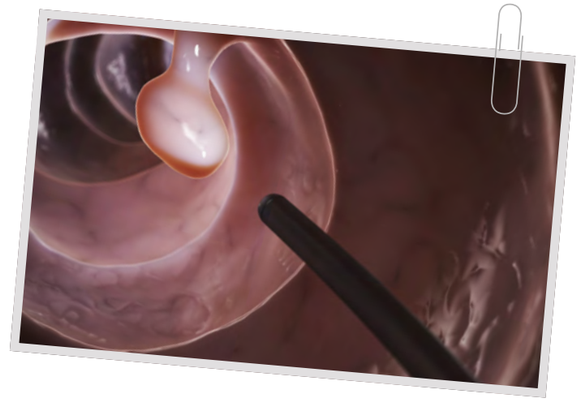
- Neonatal units should have written guidelines for oxygen saturation levels during the administration of oxygen to very low birth weight premature infants, and these must be adhered to.
- Attention should be paid to weaning oxygen when the saturation levels are more than 95%. The recommended safe levels of oxygen saturation in very premature, low birth weight infants are between 86%-92%. Unrestricted and prolonged oxygen exposure in very low birth weight infants is significantly associated with severe grades of ROP.
- ROP is a retinal disease that affects premature infants, and can be limited by adhering to the specific guidelines for oxygen administration and by screening of premature infants at four to seven weeks of age by an ophthalmologist experienced in the identification and treatment of ROP.

MG

A PROBLEM WITH POLYPS

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS

HIGH £1,000,000+



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Mr S was a 35-year-old taxi driver who was visiting his extended family abroad. While he was there he decided to have a routine health check in a private clinic. He told the doctor in the health clinic that he had noticed some rectal bleeding over the previous four months. The doctor did a digital rectal examination and proctoscopy and saw two rectal polyps. He gave Mr S a letter to take to his GP at home, explaining the findings and recommending a colonoscopy to further investigate his bowel.

Mr S returned from overseas a week later and made an appointment with his GP, Dr A. He gave Dr A the letter from the overseas health clinic and explained that he had noticed occasional rectal bleeding. Dr A noted that he had seen one of his colleagues a month before who had seen external haemorrhoids that were bleeding slightly. Dr A advised Mr S to avoid constipation to help with his haemorrhoids. He filed the letter from the health clinic but did not act on it.

The following year Mr S was still bleeding occasionally. He remembered the concerns of the overseas doctor and rang his GP surgery. He was given an appointment with Dr B. He explained that he had seen maroon blood on the toilet paper and in his stool for months and was concerned about the cause. Dr B examined him externally and noticed some simple haemorrhoids. He noted that Mr S was not keen on medication so advised him to drink more fluids and increase his fibre intake. Mr S tried following this advice for six months, but the bleeding persisted so he visited Dr B again. Dr B did a purely external examination again and documented "simple external piles". He prescribed anusol suppositories.

Over the next three months Mr S began to lose weight and feel very tired. His wife was concerned that he looked pale. He still had the bleeding and was having episodes of diarrhoea and constipation. He made an appointment with Dr C, another GP from his practice, who arranged for some blood tests, which showed significant iron deficiency anaemia. She referred Mr S to the colorectal team, who diagnosed rectal carcinoma.

He had a panproctocolectomy and the histological diagnosis was of two synchronous rectal carcinomas, Dukes stage C1. Multiple adenomas were found, some with high grade dysplasia, and it was considered that Mr S had Attenuated Polyposis Syndrome.

Mr S and his family were devastated. He struggled through chemotherapy and radiotherapy. He was told that it was not possible to reverse his iliostomy and that his five-year survival rate was 45-55%. He was very angry and made a claim against Dr A for not referring him earlier or taking notice of the overseas health clinic's recommendations.

EXPERT OPINION

MPS sought the advice of an expert GP. He was critical of Dr A for failing to perform any examination of his own, relying instead on a prior examination by one of his colleagues. He felt that Dr A should have taken a fuller history including possible alteration in bowel habit, weight loss and abdominal pain. He felt that choosing to ignore the recommendations of the overseas clinic without making any attempt to reach his own diagnosis to explain the rectal bleeding failed to provide a reasonable standard of care. He commented that haemorrhoids are a common cause of rectal bleeding in a 35-year-old but the decision to dismiss the clinic's advice without adequately assessing the patient could not be defended.

The expert GP was also critical of Dr B. The notes from his two consultations gave no indication that any further history was taken. He felt that he should have conducted a digital rectal examination rather than just an external inspection and that this represented an unreasonable standard of care. He felt that a digital rectal examination would have revealed the polyps and thus a more timely referral.

Learning points

- Common, normally benign symptoms can on occasion be more serious.
- Be prepared to reassess patients if their symptoms are not resolving by taking a detailed history and conducting a thorough examination.
- A diagnosis may need to be revisited on subsequent consultations rather than relying solely on former colleagues' decisions.
- Regardless of the fact someone has a consultation overseas out of context, it is never safe to ignore the findings of those consultations and investigations without properly ruling them out first.
- In the UK the National Institute for Clinical Excellence (NICE) has produced guidelines for referring suspected cancer cases: www.nice.org.uk/guidance/cg27/chapter/guidance

AF

The opinion of a professor in colorectal surgery was sought. He considered that if Dr A had performed a digital rectal examination at Mr S's first presentation he would have been able to palpate the polypoid lesion in the lower rectum. This should have raised suspicions such that he would have made the referral for colonoscopy. He felt that Mr S would not have avoided a panproctocolectomy because he had multiple other polyps in his colon and was thought to have Attenuated Polyposis Syndrome. He did state that if the resection had been done closer to presentation, the tumour would have been more likely to be a Dukes A or B and he would have had a five-year survival rate of 70-95%.

The case went to court and was settled for a high amount.

DIVERTED BY THE DIAGNOSIS

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS

MODERATE £10,000+

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

The notes describe Miss A lying on a trolley covering her eyes with her hands, with temperature of 35.4, blood pressure 152/96, pulse rate 58/min, and tenderness over her temporal muscles. Her neurological examination was essentially normal. Kernig's sign was negative and she had no sinus tenderness or neck stiffness. There was no past medical history of migraine or family history of note. She was given IM metoclopramide and diclofenac.

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

Two days later, Miss A returned to work, though she still had the headache and preferred to be in a dark room. The next week she attended her GP, Dr X, who listened to her history and read the hospital letter, noting that she still had a throbbing bi-temporal headache worse on movement and relieved by being in a dark room. He recorded a blood pressure of 130/80, no carotid bruits on auscultation, and a normal neurological examination with normal cranial nerves and no papilloedema.

When Dr X asked about her social circumstances, Miss A became upset as she was worried she might lose her job. Dr X explained that the likely cause of her headache was an acute migraine precipitated by work stress. Due to her blurred vision, Dr X decided an ophthalmology opinion and an MRI scan might be useful to rule out a vascular abnormality and this was recorded in the notes. He prescribed Maxalt wafers and asked Miss A to call him the next day to report her progress. Later, Miss A's partner said Dr X explained the migraine might be linked to her eyesight but did not recommend an MRI or suggest that there might be anything more serious causing it.

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

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

One month after the headache started, Miss A left work early because of another severe headache. While brushing her teeth, she lost consciousness and collapsed. She vomited twice before an ambulance took her to the ED where, on arrival, her GCS was 6/15. Resuscitation was attempted but following a CT scan of her brain, she died. The scan confirmed a large subarachnoid haemorrhage involving the 3rd and 4th ventricle on the left side and a frontal intracerebral haemorrhage.

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

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

EXPERT OPINION

Expert opinion found that it is reasonable for GPs to rely on diagnoses made at hospital after a period of inpatient observation and investigation. In this case, however, the patient presentation to Dr X was so suggestive of a subarachnoid haemorrhage that hospital admission was essential that day to exclude a diagnosis.

Dr X had reasonably considered a vascular event as a cause of the headache. However, he'd planned to wait and arrange an MRI scan if the headache did not settle with treatment. In this case, Dr C, an expert GP instructed by MPS, said it was not reasonable to wait before arranging referral for investigations.

Dr X felt his actions were defensible. After their consultation, Miss A had his telephone number so could have phoned him at any stage. He'd instructed her to return if her condition deteriorated. He'd acted cautiously and responsibly – the patient declined medical follow-up and specialist referral the next day. She'd been investigated at ED before attending him and the diagnosis had been migraine.

Dr X had based his own diagnosis on the reported pulsating headache lasting 4-72 hours of moderate to severe intensity, aggravated by routine exertion and associated photophobia. Miss A had work stress, which may have precipitated a migraine and reinforced the diagnosis. Migraines usually present as unilateral headaches, but bilateral headaches can also occur. Miss A's headache was frontal to begin with and then bi-temporal when she'd attended Dr X. Although she had no history of aura, migraines without aura are more common. In Dr X's opinion, it did not matter that Miss A had no past history of migraine – not all patients are aware they may have experienced migraines in the past.

The claim was settled against both Dr X and the hospital for a moderate sum.

Learning points

- It is important to be prepared to revisit a colleague's diagnosis, particularly if the patient's condition has changed. In this case, Dr X was misled by the diagnosis made at the hospital, where the necessary investigations did not take place. On the day she presented to ED, Miss A's blood pressure and pulse rate were not entirely within normal range and this should have prompted further investigation, ie, CT scan.
- Dr X attributed Miss A's symptoms to stress at work – although stress and anxiety can cause physical symptoms, you must ensure you have excluded any serious physical causes first.

GMcK

A MALIGNANT LESION

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE

Mr M, a 44-year-old architect, attended his GP, Dr C, for a skin check. Dr C diagnosed a papilloma on his right chest wall as well as a seborrhoeic keratosis skin lesion of the upper left arm. A brief record was made in the notes, but there was no detailed description of how the lesion looked and no action was taken.

Five months later, Mr M was seen by another member of the practice, Dr B, for heartburn symptoms and Mr M also mentioned the skin lesion on his left arm. Dr B noted a "large crusty seborrhoeic wart with almost black hard surface and red flare around with warty texture". There was no catching or bleeding. Dr B discussed removal with Mr M only "if it was a nuisance".

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

A month later, Mr M returned to the GP practice about the skin lesion – it had increased in size and was bleeding. Dr A prescribed flucloxacillin as he felt the lesion was infected. Mr M was referred urgently to a dermatologist. In the referral letter, Dr A wrote: "Pigmented lesion that he claims he has always had, although it was quite small. Over recent months it has increased in size and is now bleeding on occasions. It may be a malignant melanoma or squamous cell carcinoma. Can you see him as a matter of urgency?"

The day after the urgent referral was made, Mr M presented for minor surgery at his general practice, for the appointment that had been arranged by Dr A two months earlier. Only the crust of the lesion was removed as the doctor noted the possibility of squamous cell or "more likely a malignant melanoma". The practice arranged for Mr M to be seen urgently by the dermatologist within two days. There were now palpable axillary nodes and melanoma seemed likely.

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

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

EXPERT OPINION

Claimant expert opinion was critical of the standard of care provided and felt that Mr M should have been referred straight away, rather than three months after the initial presentation. They also felt the earlier description of the lesion was not adequate or detailed enough, quoting NICE guidelines. Lifting the crust off the top of the lesion was criticised. However, expert opinion instructed by MPS felt that the overall outcome would not have been affected by a referral after the second GP consultation, given the rate and rapid progression of the disease by the time Mr M was first seen by the dermatologist.

In summary, the practice had been in breach of duty, but this breach was not the cause of death. The case was successfully defended.

Learning points

- Whenever a patient presents with a skin lesion, apply appropriate guidelines such as NICE's seven-point checklist: http://cks.nice.org.uk/skin-cancer-suspected. Given Mr M's age, the GP should have checked for and recorded anything sinister, especially as Mr M said he had always had the lesion. What had changed about the lesion that made Mr M attend the surgery for examination in the first place? This should have been investigated further and a full history documented.
- Meticulous record keeping is important, especially in relation to lesions and whether they are growing or changing in appearance. When referring, it is helpful to detail how the lesion looks in terms of size, colour and shape, rather than simply making a diagnosis. To find out more, MPS runs a workshop on Medical Records for GPs: www.medicalprotection.org/uk/education-and-events/medical-records-for-gps
- Further reading: Watch out for the melanoma black spot, *MPS Your Practice*, (December 2012) www.medicalprotection.org/uk/your-practice-december-2012/watch-out-for-the-melanoma-black-spot

PH

FATAL CONDITION

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE

Mrs J, a 62-year-old housewife, did not visit her GP often. However, she consulted Dr D with a two-week history of coryzal symptoms. Apart from hypothyroidism, she was otherwise fit and well, but for the previous fortnight she reported lethargy, body aches and a cough productive of green sputum. Dr D recorded a temperature of 40˚C with a pulse of 102, respiratory rate of 24 and oxygen saturation levels of 95%. Despite a lack of chest signs on auscultation, he commenced treatment for a lower respiratory tract infection, prescribing co-amoxiclav and clarithromycin, which the patient had taken in the past without problems.

The following day Mrs J felt worse rather than better and her husband requested a visit at home. This time she was seen by Dr A, who found that her fever continued and she now had a sore throat and a rash. Her husband mentioned that she had been confused through the night and had been hallucinating. Dr A measured her temperature at 40.5˚C and found her throat to be red and swollen with bilateral exudates. He documented a blanching rash on her chest and back, which appeared to be erythema multiforme. He also noted bilateral conjunctivitis, for which he started chloramphenicol. Since she also complained of thrush, Dr A added canesten to his script and advised Mrs J to give the antibiotics longer to work, and to take paracetamol, ibuprofen and fluids to control her fever.

Mrs J continued to deteriorate and the following morning she called the surgery again. She spoke to Dr C, explaining that she was unable to swallow any medication due to her sore throat. The rash and fever were ongoing. Dr C converted the paracetamol and antibiotics to a dispersible form and advised she crush the clarithromycin. She advised the patient to seek medical attention if the fever persisted once she managed to swallow her medications.

Later that day, Mrs J deteriorated further and her husband called the surgery, this time speaking to Dr B. She was now unable to swallow fluids at all. Dr B advised she would need IV treatment and told them to go urgently to the Emergency Department.

The ambulance transferred them to hospital within 30 minutes. On arrival in the ED a temperature of 39 was recorded. Mrs J was noted to have macules and papules with urticarial plaques and bullous erythema multiforme over her face, scalp and neck as well as her trunk (30% of her body). Oral ulceration and conjunctivitis was present.

A diagnosis of Stevens-Johnson syndrome was made presumed secondary to penicillin or to mycoplasma pneumonia, and she was transferred to the ICU where she remained for over a month. CXR showed a left lower zone consolidation and skin swabs detected herpes simplex virus, which was treated with acyclovir. By the time of Mrs J's discharge from ICU her skin had greatly improved, but she became colonised with pseudomonas and suffered with recurrent chest infections. She had significant muscle loss, which required intensive physiotherapy.

Another month after being discharged to the ward, Mrs J's breathing began to deteriorate and she was transferred back to ICU with severe type 2 respiratory failure attributed to toxic epidermal necrosis (TEN), and associated bronchiolitis obliterans. She was intubated, ventilated and treated with methylprednisolone, cyclophosphamide and IV immunoglobulin. Despite this, Mrs J continued to deteriorate and died.

EXPERT OPINION

Experts reviewing the case were critical of Dr A and considered she had breached her duty of care in this case. When she visited Mrs J, there was a clear deterioration in her condition. She was febrile, hallucinating and had a widespread rash. Dr A maintained that she had been concerned about the patient but felt that hospital admission would not have changed the patient's treatment at this point. It was unclear whether the Stevens-Johnson syndrome was drug-induced and expert opinion agreed that it was reasonable for Dr D to have commenced antibiotics in a patient with no history of drug allergy, who had been given both of the medications in the past without problems. It proved difficult to speculate on whether or not earlier withdrawal of these medications would have affected Mrs J's outcome.

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

Learning points

- Stevens-Johnson syndrome is a rare but potentially fatal condition, usually triggered by drugs or infection. Useful summaries and images of the condition can be accessed here for a knowledge update:
  - www.patient.co.uk/doctor/stevens-johnson-syndrome
  - http://dermnetnz.org/reactions/sjs-ten.html
- Take care to revisit the earlier diagnosis of another doctor, especially if the condition has changed. Treatment does take time to work, but in this case, a more careful assessment was needed in light of the changes in the patient's condition. Expert opinion agreed hospital admission should have been initiated earlier for Mrs J, but was unlikely to have made a difference to the overall outcome.
- The decision as to whether to admit patients to hospital is often very difficult – documentation of observations is important so that if there is any uncertainty later regarding a hospital admission, someone reading your notes can be clear how the patient was at the time, and why you agreed on the course of action.

EW

A PERSISTENT HEADACHE

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE

Mr H, a 45-year-old solicitor and father of three, visited his GP Dr P with a persistent headache. He described two months of symptoms, occurring up to six times per week, mainly in the mornings and with associated nausea. Dr P took a thorough history and neurological examination, including fundoscopy. He excluded alcohol, stress or carbon monoxide poisoning as potential precipitants, and found no other 'red flag' symptoms. Mr H mentioned that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded and referred him for an early neurological opinion.

As part of his examination, Dr P checked the patient's blood pressure and found it to be elevated at 164/89. A follow-up visit was arranged with the practice nurse a few days later and this had reduced to 132/72. No further action was taken.

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

Mr H didn't see Dr P again for another two years. When he re-presented to Dr P, it was mainly to discuss some terminal dysuria. He mentioned that the headaches had been ongoing for two years and were still associated with vomiting. Dr P arranged for an MSU and bloods to be taken (CRP, LFTs, PV and PSA) and commenced sumatriptan to treat the headaches as migraine. Blood pressure was not checked. Mr H was reviewed the following week and investigations were all normal. His headache also appeared to have improved.

Three months later, Mr H returned about his headaches again. He felt sumatriptan was no longer effective and requested a trial of physiotherapy to address his muscle tension. This was arranged, along with pain clinic review, and the patient was not seen by Dr P for another six months, until he presented with a presumed sinus infection. His blood pressure was recorded as 180/100 on this occasion, and when repeated a week later was still elevated at 166/110. Lisinopril was started at 5mg once daily. This was continued until he saw Dr P again four months later with symptoms of a UTI. Blood pressure was documented as 150/96 and lisinopril was doubled to a dose of 10mg daily.

Time went on, and apart from a blood pressure check with the practice nurse every couple of months, Mr H was not followed up until seven months later when he was called in for some routine blood tests. His renal function was notably impaired with a serum creatinine of 262 umol/l, an eGFR of 23 ml/min and a urea of 17.3 mmol/l. Investigations were initiated (renal USS was normal) and he was reviewed by consultant nephrologist Dr C. Dr C made note of recurrent UTIs during Mr H's childhood and his hypertension, and concluded that reflux nephropathy was the most likely culprit. Dr C commented that it was likely that Mr H already had significant renal impairment when his hypertension was originally diagnosed, and although it would have been good practice to have checked renal function at this time, it was unlikely to have affected his outcome significantly. He further noted that the main tool available to delay renal deterioration is optimal control of blood pressure, using renal protective drugs like the lisinopril Mr H was given.

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

EXPERT OPINION

Expert opinion was supportive of Dr P's initial management. When Mr H first presented with headaches he had a single mildly elevated blood pressure reading followed by two normal results, which would not be consistent with a headache secondary to malignant hypertension or renal disease. Although outside his area of expertise to comment on a GP's standard of care, he did comment on Dr P's failure to follow up Mr H more intensively once his hypertension was diagnosed and for failing to assess baseline renal function in conjunction with starting lisinopril. However, since the treatment to delay renal deterioration is to use an ACE inhibitor, experts agreed that on the balance of probabilities, earlier intervention is unlikely to have significantly affected Mr H's long-term renal prognosis.

Mr H subsequently discontinued his claim.

Learning points

- When starting new anti-hypertensives, it is important to have a baseline measurement of renal function, and ongoing monitoring of renal function thereafter. See NICE guidelines on *Clinical Management of Primary Hypertension in Adults* for more information: www.nice.org.uk/guidance/cg127/chapter/guidance
- In a ten-minute GP consultation, blood pressure is often checked, but may not be the main focus of the consultation. It is important not to overlook monitoring of hypertension when dealing with multiple other complaints and have systems in place to ensure this is followed up.
- In this case, MPS wrote a robust letter of response denying liability, which led to the claim being discontinued.

EW

THE SWOLLEN KNEE

SPECIALTY RADIOLOGY
THEME DIAGNOSIS

SUBSTANTIAL £100,000+

Forty-four-year-old Ms M presented to her GP with pain and swelling of her right knee. She had experienced similar symptoms three years earlier whilst pregnant but had not undergone any investigations at the time. The GP made a provisional clinical diagnosis of recurrent meniscal injury and referred Ms M for an MRI scan.

The radiologist, Dr A, reported the scan as normal. Plain films taken at the same time showed evidence of mild degenerative change and several small loose bodies above and below the joint, which were not considered significant. Ms M underwent a course of physiotherapy. Fourteen months later she re-presented with acute locking of the knee after an aerobics class. She was experiencing difficulty sleeping and reduced movement in the knee joint and was referred to Mr B, who noted tenderness over the medial side of the joint and a 15 degree fixed flexion deformity. He advised an arthroscopy for further evaluation. This confirmed the presence of multiple loose bodies and attached soft tissue structures. Mr B made a provisional diagnosis of a foreign body reaction and took biopsies for histology.

Interpretation of the histology proved extremely challenging and the specimens were sent to a number of eminent pathologists for review. The consensus was that this was a high grade, undifferentiated soft tissue sarcoma, although malignant pigmented villonodular synovitis (PVNS) could not be entirely excluded.

A further MRI scan was carried out, which identified a residual soft tissue mass that was also biopsied and confirmed to be consistent with the initial histology. Ms M underwent an above knee amputation followed by chemotherapy.

She subsequently made a claim against Dr A for alleged failure to properly interpret and report on the original MRI scan, thus leading to a delay in diagnosis of synovial sarcoma, which necessitated an above knee amputation.

EXPERT OPINION

In the opinion of the MPS radiology expert, Dr J, Dr A had underreported the MRI scans in that he had failed to mention the presence of a joint effusion with non-specific tissue in the supra-patellar pouch. In his opinion, however, it would have been inappropriate on this evidence to consider a sarcoma in the differential diagnosis. In the context of a recurrent acute episode these findings were likely to represent breakdown products of blood.

Further investigation would have been dictated by the subsequent clinical course of events, albeit that this may have been influenced by the MRI findings. Mr K, the orthopaedic expert, agreed with Dr J that the MRI findings were non-specific and not indicative of malignancy. Had the MRI been reported in the terms suggested by Dr J, Mr K considered it likely that the GP would have reassured Ms B and treated her conservatively with physiotherapy, which was, in fact, what happened.

Had Ms B's symptoms not settled down following the first MRI scan it is likely the GP would have referred Ms B to an orthopaedic surgeon who would probably have arranged an arthroscopy, and biopsied the lesion. This would have resulted in the same course of action and outcome as that which subsequently transpired. The treatment options that would have been offered would have been above knee amputation or tumour resection followed by radiotherapy. The prospects of success for the latter option would have been low, with a high risk of recurrence. In Mr K's opinion, the only safe option was above knee amputation. He disagreed with the claimant's expert, Mr C, that amputation would have been avoided had the diagnosis been made 14 months earlier.

MPS argued that although there was a breach of duty by Dr A in failing to report the presence of an effusion and soft tissue within the knee joint, this would not have altered the outcome. Had Dr A reported the MRI scan correctly, management would have been dictated by the subsequent clinical course and would most likely have been conservative in the first instance. From the outset, above knee amputation would have remained the only curative treatment option, and hence the amputation could not be attributed to any failure on Dr A's part to report the abnormalities on the original MRI scan and so causation could not be established.

Although the claimant could not be persuaded to discontinue on the causation defence alone, it enabled MPS to settle the case for a reduced amount, based on the patient's additional pain and suffering.

Learning points

- A poor outcome does not necessarily mean negligence.
- In radiology, errors of perception or interpretation that lead to a failure to recommend further investigation may constitute a breach of duty, even if the diagnosis cannot be made from the presenting features. The same principle also applies to failure to elicit or correctly interpret clinical signs and symptoms.
- Breach of duty alone is insufficient to establish negligence. The claimant must prove a causal link between the breach and the subsequent injury or harm suffered.

JP

STROKE AFTER CAROTID SURGERY

SPECIALTY GENERAL SURGERY
THEME CONSENT

HIGH £1,000,000+

Miss C, a 30-year-old accountant, developed an asymptomatic left-sided neck lump. A CT scan revealed a 23 x 17 x 27mm mass at the carotid bifurcation consistent with a carotid body tumour. Miss C saw a vascular surgeon, Professor A, who noted there was no significant medical or family history and confirmed that she was normotensive with no neurological signs. He explained that this was a rare tumour with the potential for malignancy and recommended surgical excision, which he undertook the following day. Miss C signed a consent form completed by Professor A for "radical excision of left carotid body tumour".

During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 1,100mls. Professor A recorded that the bleeding was controlled by clamping the common carotid artery three times for a total of 16 minutes. The injury was repaired "with difficulty" using a 5/0 prolene suture and at the end of the procedure there was good flow in the internal carotid artery.

Postoperatively, Miss C was transferred to the ICU where she was extubated and initially appeared drowsy, but had no obvious neurological deficit. She remained stable overnight but the following morning appeared drowsier and was noted by the nursing staff to have profound right-sided weakness. Dr B, ICU anaesthetist, reviewed Miss C and attributed her drowsiness to opiate toxicity and prescribed naloxone. Miss C's condition did not improve and when Professor A saw her, he arranged an urgent MRI scan. This demonstrated a large left middle cerebral artery territory infarction with complete occlusion of the entire extra-cranial left common carotid, internal carotid, external carotid arteries. Despite further intervention by the ICU team and neurosurgeons, Miss C suffered permanent brain damage with severe hemiplegia and cognitive impairment requiring continuous nursing care.

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

EXPERT OPINION

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

Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have prevented thrombus formation, such a strategy would have carried a high risk of major haemorrhage and was contraindicated.

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to opiate toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C's stroke may have led to a worse neurological outcome.

However, the main focus of criticism centred on the consent process. Experts questioned why Professor A carried out surgery the day after the initial consultation, given the slow growing nature of carotid body tumours. Miss C's family felt the process had been rushed and that she had not fully understood the magnitude of the risks of surgery.

Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

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

Learning points

- Communicating within the team is important – the nursing staff did not inform the medical team of the patient's deterioration – consider a team approach for raising concerns.
- Good communication and documentation are essential in the process of consent. Patients must be made aware of the risks of surgery and their implications. This should include common complications as well as any serious adverse outcomes, including rare complications, which may result in permanent disability or death. Patients need to be able to weigh up the benefits and risks of medical intervention so that they can make an informed decision as to whether they want to proceed.
- Complications can and do occur and are not necessarily a sign of negligence.
- Litigation can be prevented or successfully defended if patients are warned about the risks in advance and this discussion is recorded.

SD

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

Please address correspondence to: *Casebook*, MPS, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK.
Email: casebook@medicalprotection.org

OVER TO YOU

THE STORY OF BETH BOWEN

Casebook 22(3), September 2014

Our cover story in the previous edition of *Casebook*, "The Story of Beth Bowen", drew a powerful and emotional response from many readers – indeed your letters were so numerous that we can only print a small selection in this edition.

The two letters below capture many common themes: respect and admiration for Clare Bowen in speaking openly about her daughter's loss and anger and disbelief at Mrs Bowen's struggle to obtain answers and information.

Although mistakes in medicine are unavoidable, many issues in this case combined to contribute to the tragedy and its aftermath: from the surgical team's misplaced confidence (in terms of the equipment used), to the lack of an appropriate and valid consent process. This was only exacerbated by the institutional behaviour of the hospital, which made it so difficult for the Bowen family to get the explanations and apologies that were their basic right.

MPS has long campaigned for greater openness in healthcare, particularly when things go wrong. This is a challenging and difficult process, which needs the support of culture, colleagues and organisations. The story of Beth Bowen is a stark reminder of why this is so important to everyone involved, and of the responsibilities of the medical profession, healthcare workers and managers.

Dr Nick Clements
Editor-in-chief, Casebook

Responses

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

Her mother Clare has shown much courage and strength of character in standing up and speaking out about these harrowing events. One can but only begin to imagine the desolation of losing a daughter and subsequently a husband under such devastating circumstances.

Her words are humbling and a timely reminder for doctors regarding the privileged positions of trust and responsibility that we hold. I hope this article will provide food for thought amongst our profession and for the institutions that we work within.

Dr Rachel Jones , GP,
Auckland, New Zealand

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

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

John SM Leung, FRCSEd,
Hong Kong

EXPERT REPORTS

I am writing to say how much I enjoyed reading your article "A guide to writing expert reports" in the Ireland edition of *Casebook* 22(3), September 2014 [*for members outside Ireland, visit here to read the article: www.medicalprotection.org/ireland/casebook-september-2014/a-guide-to-writing-expert-reports*].

I think that all of the important aspects of report writing were well covered in the article apart from one.

To be comprehensive and complete the article should have mentioned that, having supplied a written report, there is a small but definite chance that the expert may be called to give evidence and stand over the opinions expressed and the conclusions reached in either the Circuit or the High Court.

The expert will normally be led through his report but may then expect a sometimes rigorous cross-examination by the other side.This may include but not be limited to questioning the expert's qualifications, impartiality, experience, opinions and conclusions.

A cross-examination, particularly one from an experienced, clever and sometimes deprecating barrister, is rarely an enjoyable experience but one that an expert should expect to undergo from time to time.

Writing a report is one thing. Standing over it in a court of law is a part of the totality of being an expert and should, I feel, have received at least a mention in an otherwise excellent article.

Dr Stephen Murphy, The Park Clinic
Dublin

Response

I completely agree with the point you make regarding cross-examination in the context of formal legal proceedings. The article was intended to apply more widely to expert reports in general, many of which are written for purposes other than litigation. The role of an expert in the litigation process (depending on the jurisdiction of course) can be considerably wider and may involve attendance at conferences, provision of supplementary reports and opinions, and meeting the expert for the other side with a view to reaching an agreed, joint position.

I will ask the author of the original piece to see whether a follow-up article, dealing with some of these other issues, might be helpful.

Thank-you once again for your comments.

OVER TO YOU

MISSED CAUDA EQUINA

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

I recently saw a previously completely healthy middle-aged businesswoman who had weak legs and disabling and permanent urinary and faecal incontinence immediately postoperatively, after she had 'soft' catheter cauda equina anaesthesia. Various alternative explanations were given but the timing of her signs and symptoms were indisputable and occurred immediately after surgery.

Other neurological colleagues I have discussed this with have had similar experiences. I suggest that spinal catheters should be avoided whenever possible.

John W Norris , Emeritus Professor, Clinical Neurosciences
St Georges Medical School, London

Response

Thank-you for your letter.

Our case report was, as you point out, concerned with the care provided by the GP, and was settled on the basis of expert opinions from a GP and a neurosurgeon. Our GP expert was of the view that the care provided by the GP was in this case substandard, and the neurosurgeon was of the view that an earlier admission would have (on the balance of probabilities) led to a more favourable outcome.

I quite agree that cauda equina syndrome may arise in a number of circumstances, but the key issue in this case was the delay in the GP recognising the "red flag" symptoms, and consequently failing to take appropriate timely action.

HIGH EXPECTATIONS

I am rather puzzled by "High Expectations", on pages 22 to 23 of the September 2014 issue. From the description of the case, it sounds very likely that this was indeed a case of post viral fatigue syndrome (also known as Myalgic encephalomyelitis or chronic fatigue syndrome). No explanation is given of the basis of the probable possible diagnosis of chronic fatigue or what management was given for the condition.

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

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

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

Dr Elizabeth Murray, Rondebosche Medical centre, Mediclinic Constantiaberg, UCT Private Academic Hospital,South Africa

Response

Thank you for your letter of 21 September, regarding the case report "High Expectations".

By necessity, our case reports are a summarisation of the actual case, where the documents often run into many hundreds of pages. This does mean that we are only able to focus on the most salient features of the case from a medicolegal perspective.

In this particular case, even after the involvement of a number of specialists, the diagnosis was not completely certain. The claimant alleged a failure to make the diagnosis (probably a variant of chronic fatigue syndrome), as well as a failure to arrange vestibular rehabilitation. This will have been based on the advice of his solicitors and, in all probability, an expert opinion.

However, the expert opinion obtained by MPS on behalf of our member was supportive, as explained at the end of the article. It is important to bear in mind that the standard to be applied here is that of a responsible body of general practitioners, and not any higher, or different, standard. It is also the case that where there might be more than one school of thought on a particular issue, a doctor will not be negligent for choosing one over the other, as long as the option he chooses is supported by a responsible body of practitioners, skilled in that particular specialty, even if that is a minority opinion.

In this case, the claimant withdrew their claim before the matter came to court, which generally indicates that their solicitor (with the help of their expert) has advised them that their case is unlikely to succeed.

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

Thank you once again for your comments.

THE ELUSIVE DIAGNOSIS

Re: "The elusive diagnosis", *Casebook* September 2014. I am very surprised from the evidence given that the claim for late diagnosis of diabetes (presumably mellitus) was successfully defended. The failure to test the plaintiff's urine is inexcusable.

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

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

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I read "The elusive diagnosis" (*Casebook* 22(3), September 2014) with great interest, in particular the mention during two presentations of penile symptoms, described as "sore scratch on L-side of penis" and "a rash on the glans penis".

Some years ago I submitted with a medical student a paper to the *BMJ* in the hope it would be published as "Lesson of the week". We reported case histories of four men, aged 26, 34, 40 and 51 years, who presented to our department of genitourinary medicine in the month of July 2008 and were found on examination to have balanoposthitis, while three of them also had fissuring of the penile skin. All gave a history of or had a tight prepuce at presentation. None had a previous diagnosis of diabetes but all four were found at their first attendance to have glycosuria, with random blood sugars of 28.8 mmol/L, 14.8 mmol/L, 24.3 mmol/L and 17.5 mmol/L, in order of their ages as above. The 26-year-old gave a ten-month history of self-use of anabolic steroids for bodybuilding and was subsequently diagnosed with Type 1 diabetes requiring insulin. All four had their diabetes managed by their GPs and at least two were prescribed metformin.

These patients all presented with balanoposthitis and at some stage appeared to have associated phimosis. It has been previously suggested that the sudden appearance of these symptoms in a patient without a prior history justifies investigating such patients for possible diabetes.[1]

The paper was not accepted for publication as it was felt that the association with balanoposthitis and diabetes was well-known, although interestingly the 40 and 51-year-old had been advised to attend our department by their GPs.

It is difficult from the description of the penile findings in the case presented in "The elusive diagnosis" to fully assess their relevance in regard to missing the diagnosis of diabetes in this case but balanoposthitis (and vulvitis particularly when recurrent) certainly warrant at least checking the patient's urine for glycosuria.

Dr Mike Walzman, Consultant in Genitourinary Medicine, George Eliot Hospital, Nuneaton, UK

REFERENCES

1. Hershfield M, Dahlen CP, Phimosis with balanoposthitis in previously undiagnosed diabetes mellitus, *GP* 1968; 38:95.

Response (to both letters):

Thank you for your correspondence about this case.

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

Whether a doctor would be considered negligent in not considering diabetes in such circumstances revolves around whether their actions would be supported by a responsible body of medical opinion, skilled in the relevant specialty. In this case, the relevant specialty is general practice, and the GP expert instructed by MPS was supportive of our member's actions.

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

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

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

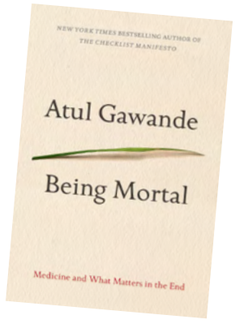
CORRECTION

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

REVIEWS

BEING MORTAL ★★★★

Atul Gawande



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

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

His new book *Being Mortal* is a compassionate yet unflinching look at what mortality means in the 21st century. In it he explores the way in which modern medicine is letting our patients down at the ends of their lives whether in nursing homes, hospitals or hospice. At the same time, he reveals the people and institutions redeeming the situation with unparalleled passion and creativity.

Gawande does this by telling the stories of his patients facing cancer, of his neighbours and, most movingly, of his own family as they face old age, decline and death. He weaves together research, philosophy, historical study and personal anecdotes to show that many of us are neither living well in our last days nor dying the way we want.

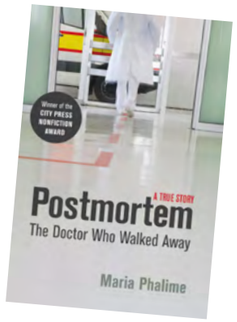
Most damning of all, however, is the realisation that the medical profession is not only hapless in the face of this suffering but acting harmfully as a result of paternalism, lack of imagination and fear. Gawande's previous book *The Checklist Manifesto* ushered in a new global paradigm of perioperative safety with a simple, yet radical, idea. *Being Mortal* could do the same for end-of-life care.

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

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

POSTMORTEM: THE DOCTOR WHO WALKED AWAY ★★★

Maria Phalime



Review by Dr Anand Naranbhai (Intern at New Somerset Hospital, Western Cape, South Africa)

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

The book is divided into two parts. In the first part, Phalime searches within herself for reasons why she left. She tells of her life growing up in Soweto and then studying medicine at the University of Cape Town. She also documents her experiences as an intern in the United Kingdom and then as a community service officer in Mannenberg and Khayelitsha. Finally, she discusses the years during which she worked her way out of clinical medicine and into a new career. In the second part of the book, Phalime searches outside herself, wondering if there were external factors that played a role in her decision to leave. She interviews others with various experiences in medicine as a way of providing perspective on her own story.

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

The second part was far more enlightening. I enjoyed reading the interviews she conducted with those who have either left clinical medicine, or are still practising. For comedian Riaad Moosa, it was a natural progression away from medicine and into comedy; for 'Nina' (pseudonym), it was the combination of clinical depression and being a junior doctor in the South African public health sector. This second part of the book highlighted common but often benignly accepted issues that we face in the medical profession.

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

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

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