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Medical Protection

Casebook

Volume 29 | Issue 1 | **May 2021** South Africa

Shaping the future

Is telemedicine here to stay? We take stock of the digital revolution

Page 12

From the case files

Casebook CPD questions

Volume 29, Issue 1

CPD accreditation by SAMA

To complete your CPD questionnaire please visit our online learning platform, Prism

Go to: **medicalprotection.org/prism**

After submission, you can check the answers and print your certificate.

1) Disclosure of a patient's confidential information is possible:

a) Always between clinicians
b) Only if the patient has consented
c) If the patient has consented or there is justification for the disclosure

2) When starting work in a new specialty:

a) There are no limitations to your competence within this specialty
b) You should not need the input of senior clinicians
c) You should be aware of the limitations of your knowledge and experience

3) When seeing a new patient:

a) You should start with an open mind
b) You should be sceptical about their complaint
c) You should have already formed an opinion

4) Good record-keeping:

a) Completely eradicates risk
b) Is a minor administrative task
c) Provides the basis for defence if your decision-making is questioned

5) When performing the handover of a complex patient:

a) Your normal handover process applies
b) It is not important that the receiving doctor reviews the notes more thoroughly
c) Extra mechanisms should be in place

6) If diagnostic investigations have to stop due to technical reasons:

a) You should stop and record the reason in the notes
b) You should continue the investigation
c) You should stop but not record this in the notes

7) After an inconclusive or abandoned specialist investigation, if symptoms are ongoing or worsening GPs should:

a) Deal with the matter themselves
b) Do nothing as it is an issue for the specialist
c) Ask for further advice if needed which must be documented in the clinical records

8) The manner of giving evidence in court:

a) Cannot be improved
b) Can get better with practice and preparation
c) Is not something doctors should ever think about

9) A delayed diagnosis:

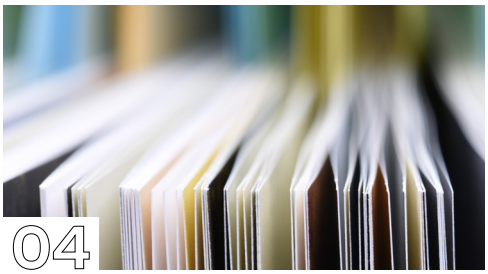
a) Is a definite example of clinical negligence
b) Is unlikely to be defended in court
c) Is not necessarily negligent if the correct investigations and management occurred

10) When treating children:

a) You can rely entirely on their capacity to make decisions about their care
b) There is no need to involve someone with parental responsibility in decision-making
c) It is a good idea to check local guidelines on making decisions relating to children

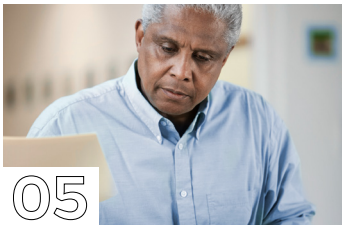
What's inside...

Every issue



Articles

Case reports



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Welcome

Dr Rob **Hendry**
Editor-in-Chief

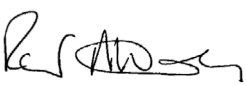
So here we are, more than six months on from the last edition of *Casebook*, and while the COVID-19 pandemic is still very much with us there is undoubtedly a greater sense of hope and optimism that we will find a way out during 2021.

This is, of course, largely thanks to the extraordinary development work on the various COVID-19 vaccines, and the similarly heroic job by healthcare providers around the world to actually administer those vaccines. At the time of writing, there is major promise that the vaccines' effectiveness is driving down death rates and hospitalisations, and we hold immense anticipation that this will prevent a repeat of the harrowing reports from many parts of the world in late 2020 and early 2021, of overcrowded hospitals and frenetic workloads. The challenge remains that all parts of the world receive enough vaccines for their citizens.

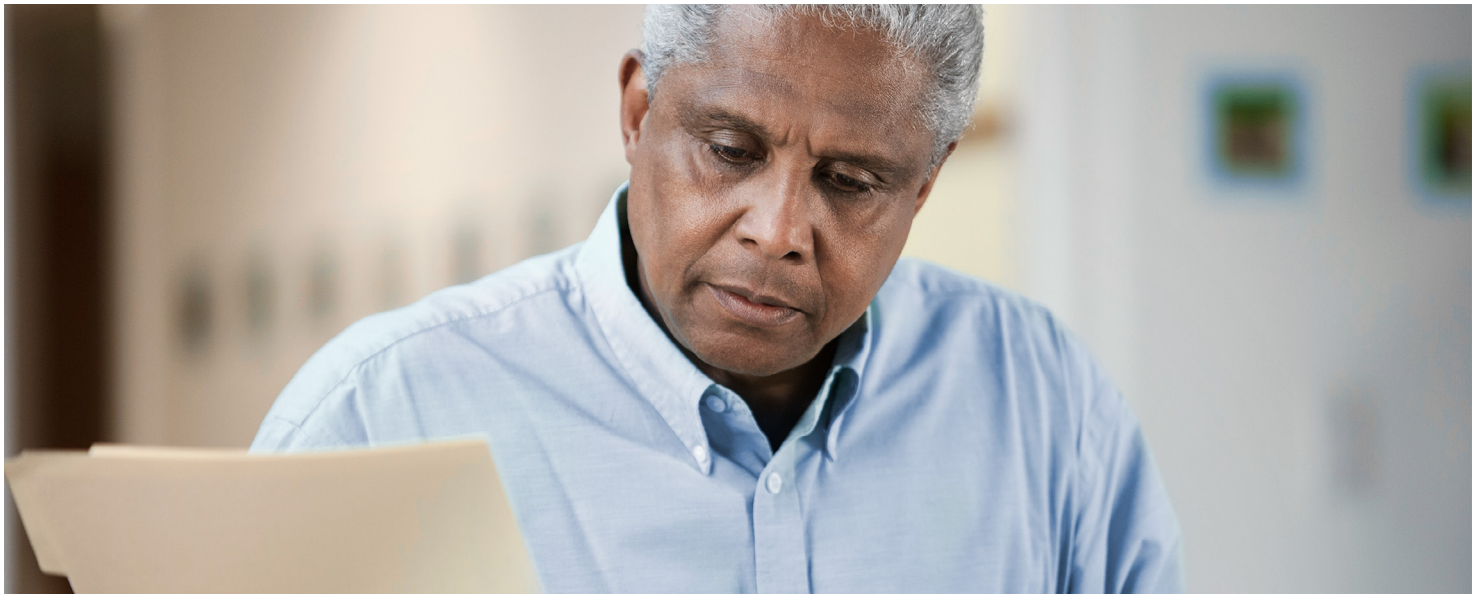
In this edition of *Casebook* we look to the future – specifically, the digital future, which is an area of focus for us to help prepare members worldwide for the rapid technological changes that have been highlighted and rapidly advanced as a result of the pandemic. Our in-house experts will be running regular webinars and sharing podcasts, articles and toolkits to keep you ahead of the curve, providing all the vital medicolegal guidance and risk management advice you need to navigate this new landscape safely.

Remote consulting has arguably been the biggest change posed by the pandemic and has seen clinicians grapple with the multiple challenges of wayward technology and the medicolegal risks of not seeing patients face-to-face. You can read more about our position on telemedicine, and our Digital Future, in this issue.

I hope you enjoy this edition of *Casebook* and that it provides a more encouraging look to the future as we hopefully look towards the end of this terrible pandemic. Please do get in touch with any thoughts, comments or suggestions via **casebook@medicalprotection.org** and, in the meantime, please continue to stay safe.



Dr Rob Hendry
Medical Director, Medical Protection and Editor-in-Chief, *Casebook*



Continuity of care

By **Dr Robyn Webber**

Mr R was a 60-year-old builder who had been retired for several years after suffering a myocardial infarction. For four years he had been under the care of Dr U, consultant urologist, for the treatment of symptoms of bladder outflow obstruction secondary to benign prostatic hyperplasia. His treatment consisted of dual therapy with an alpha adrenergic receptor blocker and five alpha reductase inhibitors, and he was reviewed every six months in Dr U's outpatient clinic.

Mr R was diagnosed with a large colonic tumour. His general surgeon, Dr S, elected to perform a left hemicolectomy and, before this, as his left ureter would potentially be at risk during the procedure, he had a ureteric stent inserted. This was performed by Dr U. The intention was for the stent to be removed in five or six months' time when he was fully recovered from the hemicolectomy. He would also continue to be reviewed regularly for his benign prostatic hyperplasia.

Mr R underwent his left hemicolectomy and made an unremarkable recovery from the procedure. Two months later, Dr U accepted a consultant post in another hospital, and another urologist, Dr F, was appointed in his place. He started work shortly afterwards but did not receive a formal handover of any of Dr U's patients. Several weeks after this he reviewed Mr R in his outpatient clinic. Mr R had a very sizeable set of case notes because of his multiple pathologies, both medical and surgical. Dr F briefly reviewed these files, noting his history of benign prostatic hyperplasia, but missed the notes on the insertion of the ureteric stent. As Mr R's symptoms had been stable on his dual therapy for quite some time, Dr F decided to discharge him from the urology clinic and therefore no further appointments were arranged.

Twelve months later, Mr R consulted his GP complaining of left loin pain and frank haematuria. A urea and electrolyte estimation was performed and showed slight elevation of both his urea and creatinine levels. Because of his symptoms, Mr R was offered a renal ultrasound and flexible cystoscopy. Renal ultrasound demonstrated a slight hydronephrosis of the left kidney, and also the presence of the ureteric stent. At flexible cystoscopy, the distal end of the stent was visualised and was found to be encrusted with stone. Because of the degree of encrustation, Mr R was unable to undergo removal of the stent at the time of flexible cystoscopy and the stent was removed under general anaesthetic at a later date.

A claim was made against Dr U, Dr F and the hospital for failing to arrange removal of the ureteric stent.

Expert opinion

Medical Protection obtained expert opinion from a consultant urologist. In his opinion, it had been Dr U's responsibility to arrange a proper handover with Dr F. The expert commented that there was no reference in the urology section of Mr R's notes to either the ureteric stent or the intended follow-up (ie the need for removal). The hospital was also criticised for failing to have a suitable handover procedure for such patients.

The claim was settled for a low sum, which was shared between the surgeons and the hospital.

Learning points

- **'Forgotten stents' are a regular source of claims in urological practice.**
- **Mechanisms should be in place to ensure the safe handover of complex patients between consultants.**
- **However arduous it may be to review thoroughly the notes of 'inherited' patients, it is very important, and is especially so in complex cases.**
- **For patients with a ureteric stent, clear marking of the notes is required to indicate when that stent should be removed (or indeed changed for patients with long-term ureteric stents). If Mr R's notes had been annotated in this fashion, the circumstances of this claim may have been avoided.**

Pregnancy while taking isotretinoin

By **Aliyah Rashid**, Case Manager, Medical Protection
Dr Zoë Neill, Medicolegal Consultant, Medical Protection

GP Dr C contacted the Medical Protection advice line because she had been informed in an email from the GP out of hours service that one of her patients was going to attend a clinic for a termination of pregnancy.

The patient was taking isotretinoin prescribed by a dermatologist, and the patient had signed a disclaimer stating that there was no chance of her becoming pregnant because she was not sexually active, and therefore was not participating in the pregnancy prevention programme, as is usual practice for patients taking isotretinoin.

The patient asked Dr C not to disclose that she had become pregnant to the dermatologist as she feared they would stop prescribing isotretinoin.

Dr C did not know if the patient had attended for termination of pregnancy when she phoned Medical Protection. She had spoken to the patient who described the pregnancy as "an error" and told Dr C that she did not want to get pregnant. Dr C had "strongly advised" that the patient discuss the risks of isotretinoin during pregnancy, as well as the risks of not using contraception, and had discussed the case with her other GP colleagues. Dr C was still unsure whether the fact of the pregnancy could or should be disclosed to the dermatologist when the patient had told her not to inform them.

How did Medical Protection assist?

Dr C discussed the situation in detail with a Medical Protection medicolegal consultant. He advised that Dr C should have a face-to-face conversation with the patient about the situation to discuss the ongoing risk of pregnancy, and to discern the circumstances of the pregnancy. For example, was the patient having a termination because she did not want to stop taking isotretinoin?

Our medicolegal consultant also advised that with the dermatologist not being informed, the risks associated with that should be considered. The patient's confidentiality could be breached if disclosure would be in the public interest or if serious harm to others would result. The unborn foetus does not have legal protection in this scenario, and disclosure to protect the unborn foetus would not be deemed adequate grounds for breaching patient confidentiality for disclosure to the dermatologist.

Dr C was also invited to consider if there were any risks associated with having a termination whilst taking isotretinoin. She was also advised that a clinician can usually share relevant information with another involved in clinical care providing the patient has not objected to the disclosure. Where a patient has capacity and does not give consent to disclosure, personal information cannot be disclosed except where it is required by law or justified in the public interest. What an individual chooses to do with their pregnancy is personal to them. An unborn child has no legal rights, so the risk to an unborn child would not constitute public interest.

In this case, there did not appear to be any obligation on Dr C to disclose this information to the patient's dermatologist. Dr C was advised to document the discussions she had with the patient carefully, including her agreement not to share information with the dermatologist, and explain the consequences of the patient's decisions.

The patient was entitled to make a request not to disclose personal information, and therefore in this case, Dr C should not disclose this information without her consent.

Learning points

Oral retinoids are teratogenic, exerting their effect by inducing hypervitaminosis A. This can result in craniofacial, central nervous system, cardiovascular and thymic malformations. The MHRA[1] advises that women and girls of childbearing potential being treated with the oral retinoids acitretin, alitretinoin, or isotretinoin must be supported on a pregnancy prevention programme with regular follow-up and pregnancy testing. Before starting isotretinoin, patients must use at least one, and preferably two, forms of effective contraception for at least one month before starting treatment. In exceptional circumstances, females capable of becoming pregnant but who are not sexually active may be exempted from the pregnancy prevention programme.

Every oral retinoid has a dedicated and specific pregnancy prevention programme (PPP).

Under exceptional circumstances, isotretinoin may be prescribed to a woman who is not at risk of pregnancy without following the rules of the PPP. Examples of such circumstances might be a non-sexually active woman who is able to be certain that sexual activity will not start during the period of teratogenic risk, or a woman who does not have childbearing potential, eg following a hysterectomy.

Dermatologists should take every action to ensure that all women being considered for treatment understand the risks and consequences of pregnancy.

If a woman is to be exempted from the PPP, she must:

- **Receive written information of the methods of contraception (contraceptive brochure provided by the drug supplier).**
- **Receive written information of the risks of teratogenicity with isotretinoin (patient information leaflet provided by the drug supplier).**
- **Sign the form (provided by the supplier of the isotretinoin) to confirm that she has received information of the teratogenic risk of the drug and the methods of contraception.**
- **Agree to contact the prescriber of the isotretinoin and the GP if there is any chance of pregnancy occurring during or immediately after the course of treatment.**

The prescriber of isotretinoin outside the PPP should:

- **Document the reason for exclusion from the PPP.**
- **Discuss the teratogenic risks of the drug and the necessity of seeing the patient rapidly if the risk of pregnancy changes during the course of treatment.**

Record on each prescription of isotretinoin that the patient is exempted from the PPP.

The prescriber may wish to take extra written documentation that the patient was aware that she was exempted from the normal PPP and was fully aware of the teratogenic risks of the treatment.

Disclosure of information to a secondary care colleague, and breach of patient confidentiality, would not be easily justifiable in this case, where "serious harm to others" does not apply because the unborn foetus does not have legal protection.

In addition, this is a challenging ethical dilemma. While there is extensive evidence that oral retinoids are teratogenic, a British Association of Dermatologists 2004 audit of 16 pregnancies resulted in seven terminations and one normal healthy baby, while the other eight had unknown outcomes.

References

1. For those outside the UK – the MHRA is the Medicines and Healthcare products Regulatory Agency

Prescribing for a friend: a doctor's story

By **Dr Jo Galvin**
Medicolegal Consultant at Medical Protection

Doctors trying to help can find themselves falling foul of their professional obligations. Dr A found herself facing a regulatory inquiry for prescribing for a friend. Here she shares her experience with Dr Jo Galvin, Medicolegal Consultant at Medical Protection

It all started with an email from the GMC[1] asking to confirm my personal information. I didn't think much about it and replied to it after several days. Then the worst happened – emails and letters came through – I was under investigation from the GMC for concerns relating to its guidance *Good Medical Practice*. I was confused – everything at the hospital was going well; I had nothing but good feedback from patients and colleagues. And then more information came through. This was not about the hospital work. This was about private prescriptions that I had written for a friend a while back.

Some six months earlier my friend asked if I could help obtain some medication for her elderly vulnerable parent. We come from a European country that should have a good medical system but in reality there are many shortcomings, so we are always anxious about our parents' and family's care back home. As a result, the request didn't surprise me. The parent had not taken this medication before, but he might come to require it. My friend was worried her father would not be able to obtain it back home. So here I was, on my first day off work, writing a private prescription for a non-UK patient, a family friend. All that I thought of was that I was helping a friend in need.

Arriving at the pharmacy, things changed. The pharmacist to whom I presented the prescription was concerned. She understood that neither she nor I had access to this person's medical records and that could lead to unwanted complications. She refused to dispense the prescription so I left, somewhat bewildered that a medication that was not a controlled drug could be so problematic.

Then I started thinking about my friend, about her anxiety regarding her parent, and decided to try again until I managed to send my friend sufficient medication for her parent. Once that was done and dusted I didn't think about it anymore.

Then the GMC emails and letter came through and here I was trying to recall what had happened and why. I contacted Medical Protection and my department clinical director, and made a full disclosure of events. But while speaking to people about the events and at the same time reading the GMC guidance, it became apparent to me just how serious this was and what severe consequences could follow from an action that I initially thought quite trivial. On looking at things from a different angle I recognised this was a breach of my professional obligations. I accepted my mistake and tried to learn from it.

It was a steep learning curve. It was particularly difficult to let go of my "but I was just trying to help a friend in need" attitude and dissect things in a more clinical and less emotional way. The GMC guidance is clear and there is a lot of useful information out there. I was wrong, I've done something wrong and now a sanction was just around the corner.

Thankfully, my NHS Trust supported me fully through this process and the GMC concluded the case without further action. However, upon receipt of the GMC letter on the closure of the case I felt very unsettled. It wasn't clear to me that the GMC had the whole picture of what had happened. I felt more anxious after the closure of the case than I had felt while waiting to hear how I would be sanctioned for my breach of GMC guidance.

My medicolegal adviser at Medical Protection and my barrister wrote a letter on my behalf to the GMC and sent the full details of what happened to the GMC, together with my reflection on events. I felt much better knowing the GMC was now in possession of all the facts. I was expecting them to reopen it and investigate it further but I still slept better.

> *Face up to your mistakes. It will give you peace of mind. And peace of mind has no price.*

The final decision came through much sooner than expected. Being honest and candid paid off and the case was definitively closed without further action.

But no sanction doesn't mean no change. For me this has been an eye-opening string of events. It showed me how in one step I could go from being considered a trustworthy and valuable person and doctor to potentially untrustworthy. It showed me how trying to help could potentially cause harm to people close to me. I hope by writing this article, other doctors will avoid this pitfall, and think twice before prescribing for those close to them.

The GMC guidance on prescribing is "wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship".

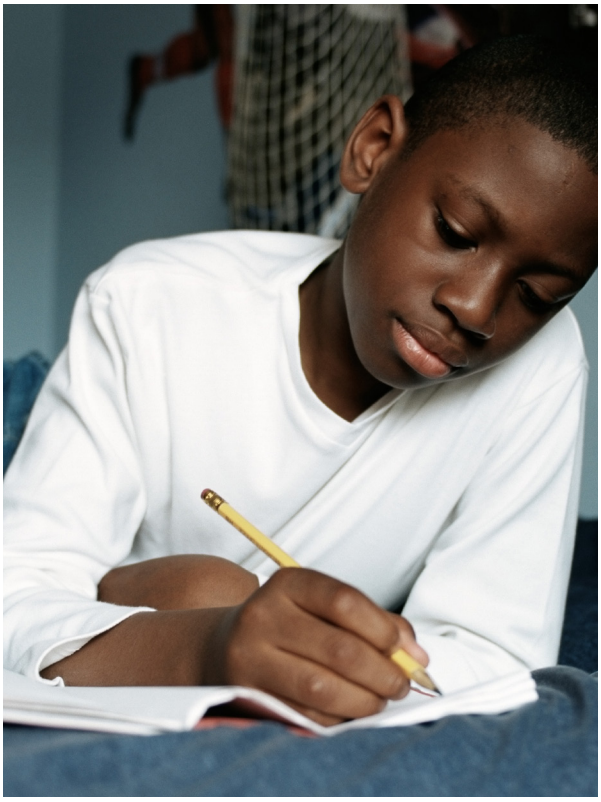
If I could give one piece of advice to every practitioner with a right to prescribe out there it would be: just know the GMC guidance and don't breach it. It is there for the purpose of protecting both the patients and you. It gains its full meaning in uncommon circumstances where we are pressured by the desire to help and fail to see the real risks we take. Be open, honest and respectful in relation to all your colleagues and patients. Be candid and honest with the GMC. Face up to your mistakes. It will give you peace of mind. And peace of mind has no price.

References

1. For those outside the UK, the GMC is the General Medical Council

When family opinions matter

By **Dr Monica Lalanda**



Dr L, a junior doctor, was working on the afternoon shift in the emergency medicine department. He had started the job eight weeks earlier, but due to shift patterns this was only his second time in the children's area.

The nurses asked Dr L to see SB, a 13-year-old boy whose mother, Mrs B, was complaining about the delay in being seen. The nurses told Dr L that there "didn't appear to be anything wrong with the boy" and that "he could probably be sorted out quickly to free up space in the department". Dr L agreed to see him next.

SB explained to Dr L that he had had quite a bad pain in his groin since playing football at PE time that morning. SB found it too painful to walk on the leg and was unable to weight-bear. He admitted that the pain had subsided a little since he had taken some ibuprofen at triage, but he remained unable to walk. Dr L examined SB thoroughly from hip to toe and reassured SB and his mother that it was likely to be just a sprain or a pulled muscle. Mrs B, however, remained anxious and requested an x-ray for her son. Dr L sent SB for a pelvic x-ray.

When SB returned from the radiology department, Dr L looked carefully at the x-ray, and considered that it appeared normal; however, he was conscious of his limitations and told Mrs B that he wanted to discuss the x-ray with a senior colleague. Unfortunately, Mrs B could not wait any longer as she had to pick up her other children from school, and so Dr L gave them an appointment to return in two days' time if SB's condition had not improved.

SB was seen two days later in clinic by one of the emergency department consultants. At this point SB remained unable to weight bear. He was sent for further x-rays to exclude slipped capital femoral epiphysis. The anteroposterior view appeared normal, but the "frog leg" lateral view confirmed the diagnosis. SB was operated upon in the next few hours, but unfortunately subsequently developed avascular necrosis and required further surgery. The final outcome was a shortening of the leg, with restricted movement, as well as the prospect of continuous early arthritis and the likely need for a hip replacement.

Mrs B made a claim against Dr L and the emergency department, which was eventually settled for a moderate amount.

Expert opinion

Orthopaedics and emergency medicine experts agreed that the care provided in this case was suboptimal. The initial presentation of SB as a teenage boy with a traumatic, severe pain in the groin should have immediately triggered a concern about the possibility of a slipped capital femoral epiphysis. The experts confirmed that an early diagnosis and emergency surgical treatment are usually directly related to the long-term prognosis of the pathology. They also agreed that two different x-ray views of the hip are essential to exclude a slipped epiphysis.

Learning points

- **When starting any new specialty, it is important to realise the limitations of your knowledge and experience.**
- **Beware of entering a consultation with a biased view that there is probably nothing wrong with the patient. Always start with an open mind and a suspicion that there might be a serious problem.**
- **The indications to request any investigation need to be clear and should take into account the patient's history and concerns of the patient or relatives (the views requested will depend on the differential diagnosis being considered).**
- **Knowing which x-ray views are required (in this particular case, always two views) is important, but understanding what it is that you are looking for is crucial.**
- **When patients are unable to wait they should be informed of the possible risks and consequences and advised of what to do in the event of further problems, to ensure that safe follow-up is available.**
- **All such discussions should be documented. Good documentation reflects good practice and is the basis for a successful defence.**
- **Be aware of your responsibilities if you feel uncomfortable about your ability to perform the tasks that you have been asked to undertake; take advice from senior members of staff and be aware of your responsibilities in relation to referrals.**

Good records in a worst-case scenario

By **Dr Andrew Bickle**

Mrs Q was a 29-year-old new mother of a 2-month-old baby daughter. She had an established history from the age of 21 of recurrent depressive disorder without psychotic symptoms. The management of two previous episodes had been shared between secondary psychiatric outpatient services and her GP. Her last episode, which had occurred three years previously after a miscarriage, was associated with fleeting suicidal ideation and she was briefly admitted as a voluntary patient. Between episodes she made a good functional recovery and had a successful career as a legal secretary. Unfortunately, her relationship with her husband was strained. While the new baby was welcomed, it further highlighted the difficulties around the husband working away from home in the week in his role as an account manager. Mrs Q's family lived locally and she had a supportive relationship with her elder sister who was a housewife.

Late one Wednesday evening she was brought to the emergency medicine department by her sister, in whom she had confided that she was experiencing intrusive, upsetting thoughts of killing herself by jumping from a motorway bridge. She knew this was wrong and felt extremely guilty towards her baby whom she loved. She had been feeling low ever since the birth, but in the last three weeks she had felt this way all day and nothing brought her any pleasure at all. She was admitted to an acute psychiatric ward for four days and then on to her local sector treatment ward. She agreed she needed to be somewhere safe and came in voluntarily. Her GP had recently started a Selective Serotonin Reuptake Inhibitor (SSRI) antidepressant and this was continued, along with a long-acting benzodiazepine for agitation, which she was given on a few occasions. Her rapport with staff was good and her mental state was recorded frequently by medical and nursing staff. She had regular 1:1 sessions with her named nurse which she reported as being helpful.

After a couple of days she disclosed no further suicidal ideation, but persistent biological symptoms including insomnia and anergia impaired her ability to function independently so her admission continued for another couple of weeks. During this time her baby was being cared for by her sister, to the satisfaction of Mrs Q who didn't want her daughter brought into hospital. As Mrs Q's energy returned she went on increasing periods of unescorted leave to her sister's house. Careful recordings of her mental state with appropriate risk assessments were made before and after each leave and Mrs Q always returned at the agreed time. She wasn't suffering any side effects from the pharmacological treatment given to her. The social worker contacted her sister who confirmed that the leave periods were going well and, in her view, her sister was getting better.

In the third week, Mrs Q went on a fourth period of leave, but failed to return. Ward staff called her sister who said she had left her house hours earlier at the appointed time. Later that day Mrs Q jumped to her death from a multi-storey car park.

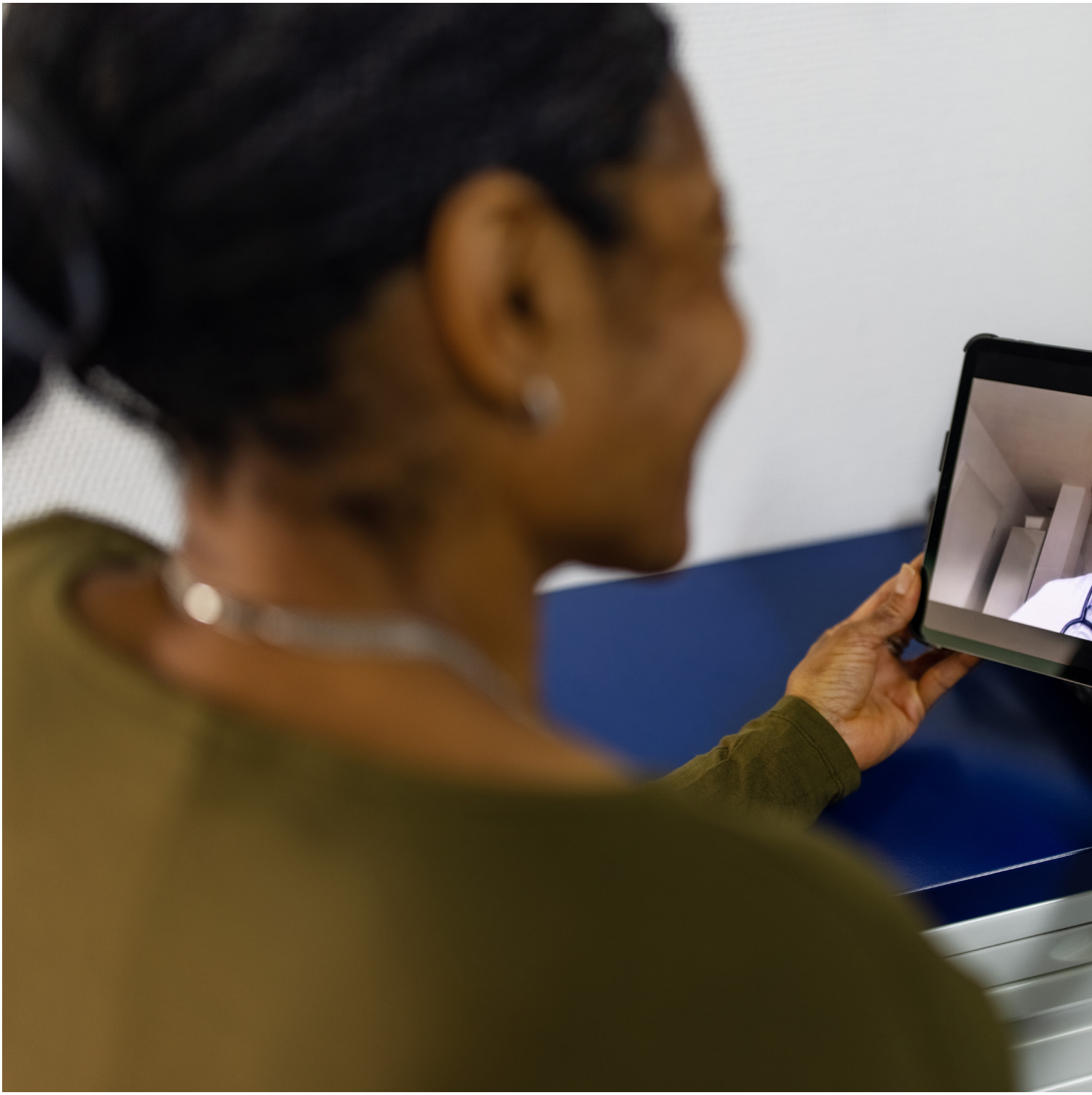
Subsequently, there was an inquest, an internal hospital inquiry and an independent homicide inquiry, all of which received considerable media attention. Medical Protection was able to provide medicolegal support to our members at each stage.

The high quality of the medical records was invaluable – demonstrating the level of care which had been given.

However, Mrs Q's husband made a claim against the hospital and the consultant psychiatrist for failing to provide good care and not preventing her suicide. The case was defended based on the quality of the healthcare record, where every step was reflected upon and every decision explained. The case duly went to trial and the judge found in favour of the defendants.

Learning points

- **As with any other mental disorder, multidisciplinary interventions are required to provide appropriate management of patients with depression, as was provided in this case.**
- **Risks can never be eradicated even with best practice, only reduced. Good record keeping helps to maintain best practice with clear communication between professionals and demonstrates that best practice has taken place.**
- **Appropriate record keeping is recognised as an important component of professional standards and assists healthcare professions to give a logical account when their decision-making is called into question.**



Shaping the future: is telemedicine here to stay?

By **Dr Rob Hendry**

The rapid adoption of remote consulting, or telemedicine, has been one of the most notable changes that the COVID-19 pandemic has brought upon healthcare worldwide. Dr Rob Hendry, Medical Director at Medical Protection and Casebook Editor-in-Chief, takes stock of the impact and outlines what Medical Protection is doing to support members

The digital transformation of healthcare is touching every aspect of our working lives, and the COVID-19 pandemic has only served to accelerate this. Nowhere has this been more impactful than in the way we consult with patients, and for many of us, remote consulting has become part of the new normal. With these rapidly moving changes come new challenges and opportunities.

So what now for telemedicine? A survey by Medical Protection, conducted in November 2020, revealed the following rates of usage among members worldwide:

- **UK – 88%**
- **Ireland – 87%**
- **New Zealand – 83%**
- **Caribbean and Bermuda – 66%**
- **South Africa – 60%**
- **Malaysia – 44%**
- **Singapore – 43%**
- **Hong Kong – 34%**

Of those members who stated they weren't currently undertaking telemedicine, 15% said they were considering doing so in future. Looking more widely, the survey also found that 54% of members said the use of telemedicine had increased a lot. In addition, 93% of members said they expected telemedicine-related changes they had made to their practice would continue post-COVID-19.

The survey found that one of the main barriers to the delivery of telemedicine is patient access to technology. There is considerable anxiety that digital poverty might widen the health divide in society if steps aren't taken to ensure everyone has access to safe and secure internet access.

The challenges of telemedicine

Many of our members have been findings ways of adapting to consulting when it is not possible to carry out a normal physical assessment and carry out the usual investigations. We have been asked for advice about how to cope with this new way of working and have produced a range of educational resources to support members. We continue to work with a wide range of stakeholders in sharing experiences of how technology will support healthcare in the future. I am grateful to the members who have shared their thoughts in the following articles.

The need to work remotely has also affected how teams interact and staff in training are supported. Along with the challenges come new opportunities for working with colleagues and we have been keen to share the experiences of our members. In some countries the new ways of consulting present a challenge to the funding models of medical care.

Consent is a matter we have spoken a great deal about before the pandemic and the news ways of consulting have brought into focus how this process is undertaken and recorded. Information governance is another important area to consider especially if using social media platforms. It is likely that as the systems mature, the risks of data breaches will be reduced, but in the meantime care must be taken not to breach patients' confidentiality.

The teleconsultation webinar series

From May 2021, Medical Protection is providing members with an exclusive series of webinars aimed at preparing you for the challenges of telemedicine. This series of four modules has been developed by senior medical educators, medicolegal consultants and clinicians who understand the emerging issues and the impact on clinical practice. The content of these sessions is based on reviewing evidence and research from across the globe, which we have used to identify the pitfalls.

Module 1

Essentials of teleconsulting communication

COVID-19 has accelerated the adoption of teleconsulting. This introductory module investigates the practicalities and complexities of communication in teleconsulting, gathering evidence and collated best practice from across the globe. You'll get an introduction to the CLEAR communication model and learn how to avoid routine pitfalls by establishing consent, managing expectations, and exemplary record-keeping.

Module 2

Tackling tricky patient scenarios when teleconsulting

Remote consulting can aggravate already challenging situations. Understanding the limits of teleconsulting and communicating effectively is essential in avoiding pitfalls. Building on module 1, this session covers how to ensure adequate consent, managing expectations and communicating sensitively, as well as dealing with patients with mental impairment, and consulting with children.

Module 3

Overcoming risky interactions with colleagues remotely

This module highlights the importance of clear communication with colleagues to reduce the risk of adverse outcomes. The experts will provide guidance on effective communication to ensure the safe transition of care and documentation. They will explore, through case examples, how to optimise professional interactions with the wider team and support peers while working remotely. The webinar will also touch upon innovations, potential models of care and working in the future.

Module 4

Ask the experts: Your teleconsulting questions answered

The live expert panel brings this series to a close with a discussion of case studies based on Q&As from the previous webinars. Panel members comprising senior medical educators, medicolegal consultants, and practicing clinicians with experience and academic expertise in telemedicine will discuss the future of telehealth and share their most valuable advice from the issues raised.

How has technology impacted you?

We asked clinicians around the world for their experiences of technological change over the past year, particularly how it has been accelerated by COVID-19.

Dr Ruth Large, Clinical Director Information Services and Virtual Healthcare, Waikato District Health Board, New Zealand

When I graduated from medical school in 1998 I was pregnant with our first child, blissfully unaware of the impact rapid digital development would have on our lives. There were indications of change during my practical visits in medical school with the gradual phasing out of hard copy radiographs and lab reports in the Auckland area and these changes have accelerated and become more widespread over the past decade.

After gaining registration in 1999 I moved to Outback Australia to gain experience in a variety of remote hospitals. The death of a baby the same age as my own in an isolated Aboriginal settlement with no backup but the telephone, saw me change tack on what I thought was going to be a surgical career instead opting to train in emergency medicine and developing an interest in telehealth. Returning to New Zealand for specialist training I took many of the digital developments for granted. It was not until 2007 when I began my specialist career at Thames Hospital and went back to paper processes, experiencing for the second time a move from paper to digital results management and digitisation of discharge summaries that I realised the discrepancy between District Health Boards (DHBs). This example of time warp is still experienced when moving between DHBs and is an indication of how different DHBs have progressed through the digital era with little consistency between sites giving very different digital experiences.

During these early consultant years I became involved in the 'call to arms' that saw the establishment of the New Zealand Telehealth Forum and, later, the New Zealand Telehealth Leadership Group (NZTLG). Over time the NZTLG have become the subject matter experts for the Ministry of Health, the key supporters to providers of telehealth and advocates for the delivery of healthcare via digital means in an equitable, sustainable manner (telehealth.org.nz).

The mid-2000s witnessed the birth of cloud-based technology alongside miniaturisation of computing and information communication components, resulting in information becoming increasingly portable and accessible. I can now hold in my hand more computing power than I had access to as a school child, enabling me to carry a virtual encyclopedia of knowledge and a portable ultrasound in my pocket. This is the digital harbinger of health system change, where information ownership is distributive. Patients and clinicians now have access to a plethora of information, both their own and others. Access to information creates opportunities which should alter the way we deliver healthcare, growing partnership with our patients and breaking down medical 'paternalism'. It is pleasing to see this potential recognised in the Health and Disability review of 2020.

Of course all is not sunshine and lollipops and the risks of our new digital age remain poorly described and not fully recognised. These risks include privacy and security issues, use of social media, potential of overwork, spread of misinformation and information overload. Possibly the biggest risks of all are lack of clinical and consumer engagement, poor digital literacy and a lack of focus on digital equity.

If clinicians are not fully engaged in leading and developing change, if we are not continuing to digitally upskill or if we are not placing our most disadvantaged populations first then we risk systems continuing to exacerbate inequity, place our individual practices at risk and will fail to take advantage of the potentials of digital transformation. The Clinical Informatics Leadership Network was established in New Zealand in 2019 to give clinicians a joint voice in an effort to reduce these risks; membership is free and new members are welcome.

The past two decades have been a whirlwind of change and there is no doubt that there will be more change in the future. We are only just beginning to see the impact of

> *The COVID-19 pandemic has drastically transformed the terrain of our life and the healthcare system.*

the Internet of Things, personalised and precision medicine, and artificial intelligence for example. This is a pivotal time for New Zealand healthcare with a perfect storm of the exposure of our technical debt, alongside widespread recognition of the role of digital technology brought about by our need for rapid change over the COVID-19 lockdown period. We may never see such a unique opportunity to alter the way we deliver healthcare again and it is encouraging that there is gathering momentum to change.

Dr Wilson Fung, Hong Kong

The COVID-19 pandemic has drastically transformed the terrain of our life and the healthcare system. People nowadays are scared of leaving their homes, let alone making a clinic visit when they are not feeling well. Undoubtedly, traditional healthcare practice is facing unprecedented challenges. Upon the issue of the *Ethical Guidelines on Practice of Telemedicine* by the Medical Council of Hong Kong in December 2019, the practice of telemedicine in Hong Kong has finally kick-started. I conducted a number of video consultations in 2020 and therefore would like to share some first-hand experience with my fellow practitioners interested in engaging in telemedicine practice.

Pre-consultation preparation is paramount. My nurse will validate the patient's identity, gather medical background, vitals and chief medical complaints. We will then access the patient's online public health records (via the Electronic Health Record Sharing System) in order to have a better understanding of the patient's medical history. We may also request the patient to send through photos and videos related to the symptom in question, eg a photo of a sore throat to gauge the cause and extent of the inflammation; a video clip of a sprained knee for assessment of skin signs, bilateral differences and the range of motion of the joint. My nurse will continue to request further information from the patient until I am reasonably satisfied that I have sufficient information, prior to the commencement of the video consultation. Quite often, I start a video consultation with differential diagnosis and management plans well in advance.

Good pre-consultation preparation is the key to smooth and effective communication between the doctor and the patient

However, I will turn down a request for a video consultation right after the pre-consultation preparation phase, if I am of the view that such means of medical consultation is not suitable for the patient.

It would be ideal if every patient's condition could be correctly diagnosed and properly managed following a video consultation. However, that may not always be possible. The video consultation itself could be a triage process resulting in patients being sent to the A&E department, being referred to specialists, or seeing me at my clinic in person. I do not believe that video consultations will solve all patients' problems, but it does give patients considerable comfort and a sense of direction after a 'face-to-face' video consultation with the doctor.

Most patients understand the limitation of a video consultation, and they are quite receptive when I tell them that they need to see me or specialists in person for a proper physical examination or investigation, so that a more definitive diagnosis or management plan can be formed.

After a video consultation, my nurse will follow up with the patient so that appropriate actions can be taken promptly. This is especially important where a patient's condition doesn't improve.

In my opinion, good pre-consultation preparation is the key to smooth and effective communication between the doctor and the patient, and timely post-consultation follow-up enables the doctor identify a deteriorating patient and take the appropriate course of action without undue delay. And of course, all these very much rely on the dedication and experience of our staff members.

During the COVID-19 pandemic, similar to around the world, video consultation is gaining soaring popularity in Hong Kong. I do not think it will ever replace the traditional in-person consultation, but there is no doubt that it has been serving as an additional means so that patients can now have easier access to medical professionals, which will help avoid delays in treatment and hence improve the outcome. I am now also planning to develop a patient satisfaction survey specifically for video consultation.

Dr Samantha Murton, New Zealand

In New Zealand we made a sudden jump to telemedicine consulting over a 48-hour period at the end of March 2020. This challenged the entire sector; doctors, nurses, reception and management. Although essential to control the COVID-19 outbreak it was fraught with difficulty. As one of the instigators of this change in New Zealand it has been good to also be one of those who have experienced the transformation first-hand in my practice.

In our practice and across many others we had resisted going to electronic prescribing. The service had been available for more than a year but due to the cost to the practice, as well as the ongoing requirement to print a

Quite often, I start a video consultation with differential diagnosis and management plans well in advance.

piece of paper for most prescriptions, many did not feel it was worthwhile. The sticking point for the hard copy requirement was within legislation and needed Ministry of Health agreement for this to change.

As pharmacies and practices across the country needed to provide care remotely these two factors were highlighted and changed almost overnight. Funding was provided to encourage practices to take up the service and the requirement for a hard copy was dropped. The country went from 14% using electronic prescribing to 84% within three months. Personally, I would never go back and patients wouldn't either.

Pharmacies have, however, struggled to switch to this new paperless method but have systems in place 12 months on. Many of my patients, even if I see them in person, want the prescription sent to the pharmacy; the electronic systems have developed over the year to the point that I can send a prescription to any pharmacy in the country. It is bar coded and secure, efficient and green.

Phone and video consultations have been much less prolific in their uptake and I am sure this is due to hesitation by both patient and practitioner. My experiences in two consultations have made me reflect on the benefits and cautions we need to consider.

A phone consultation with a mother and teenager, at their request, was on significant stressors in the young person's life manifesting in physical symptoms. I had seen this person previously and it was a follow-up appointment. In this particular situation I felt that I could talk very openly and was not diverted by the body language that may have been occurring between mother and child. The conversation was very open and frank about stress in our lives and how it is visible. They had space to interject and discuss and it was a free-flowing conversation.

On reflection, I felt not seeing the body language meant I did not hesitate in what I said. I have not yet reflected with the patient on how they found the experience.

If the patient had been new to me, an in-person consultation would have been essential and that is certainly something to be cautious of with any phone consultation; we cannot neglect physical examination. The other aspect of phone consultations is the effort of listening only without any other cues – it can be draining.

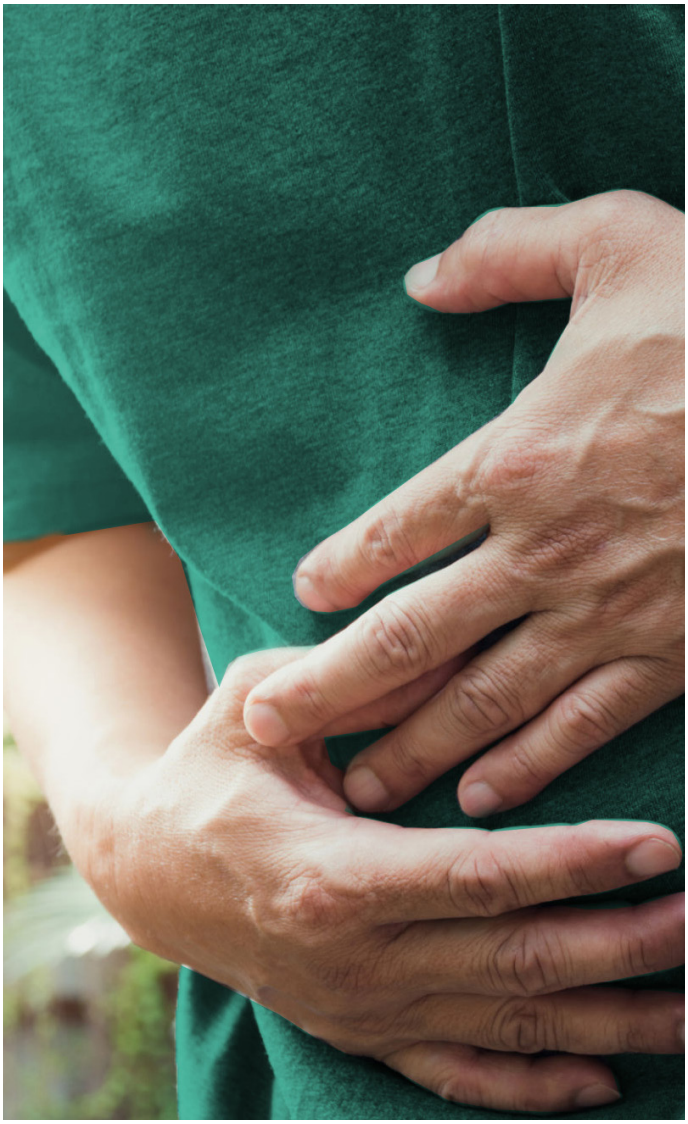
The other consultation that was of immense benefit was a lady who rang late in the afternoon about an urgent issue that needed to be seen. She had no time to come to me and we had no appointments later in the day. We arranged a video consultation on the spot and she was able to show me what was going on. Seeing the patient and their condition is essential in this situation but was easily done with video rather than in-person. Access is often touted as an issue with telemedicine but it can create increased accessibility that is not available with in-person consultations.

In New Zealand we have a funding model that includes a patient co-payment. With less foot traffic in the practice and more activity online, it has been a learning curve working out how to ensure patients are invoiced and paying in a timely fashion. Previously they would come past the reception desk and now they are not physically present. For the most part patients have been very good at paying online, but it is the practices that have had to get the systems up to speed so it feels easy for the patient.

All in all, the telemedicine experiences in New Zealand have had lots of hurdles that we have had to leap but, like all hurdling races, once you get the rhythm right you can jump each one with ease.

Missed diagnosis during colonoscopy

By **Dr Sean Kavanagh**



Mr Y, a 24-year-old plumber, had suffered intermittent bouts of cramping abdominal pain with associated passage of loose stools, mucus and occasional small amounts of fresh red blood, over a period of two months.

His GP, Dr D, referred him to Dr B, a consultant gastroenterologist. Dr B saw Mr Y in clinic and arranged to carry out an outpatient colonoscopy. Dr B managed to pass the scope as far as the splenic flexure, but was unable to progress any further due to difficult anatomy and the pain that the procedure was causing Mr Y. The colonoscopy was terminated. The appearance of the colonic mucosa up to the furthest point reached had been normal.

By the time of the procedure Mr Y's symptoms had settled so Dr B reported the colonoscopic findings and the technical difficulties to Dr D, and discharged Mr Y back to his care.

Unfortunately Mr Y's symptoms returned a few months later. He repeatedly attended Dr D's surgery over a six-month period, with increasingly severe symptoms. Dr D treated Mr Y with PRN loperamide and diazepam as he felt that the symptoms may have been due to anxiety associated with Mr Y having recently lost his job for frequent non-attendance due to illness.

One night Mr Y woke in excruciating pain and was admitted to hospital with an acute abdomen caused by colonic perforation secondary to acute ulcerative colitis. He underwent laparotomy and repair and made a good recovery on conventional medical therapy.

Mr Y made a claim against both Drs D and B, alleging negligence in failing to make a timely diagnosis, causing him to lose his employment and endangering his life through the complications of the missed diagnosis.

Expert opinion

The Medical Protection legal team commissioned an expert in gastroenterology, who felt that Dr B had done all that could be expected of him, given the well documented technical difficulties in performing the colonoscopy, and as Mr Y was asymptomatic at the time. It was held that in this context the risk of perforation due to over-zealous passage of an obstructed colonoscope outweighed the benefits of pressing on with the procedure.

Dr B's letter to Dr D had clearly advised that should Mr Y's symptoms recur it would be advisable to repeat the procedure or consider other forms of investigation. On this basis we elected to defend Dr B and he was eventually dropped from the legal action. The case was settled out of court for a moderate sum on behalf of Dr D.

Learning points

- **If diagnostic investigations have to be curtailed for technical reasons, best practice dictates that clear reasons for abandoning the procedure should be documented in the medical record.**
- **It is important to consider whether alternative investigations or a repeat attempt are necessary after having to abandon an investigation. In this situation, the patient was asymptomatic, but in such a scenario, advice to the referring doctor on what to do if the problem recurs is essential.**
- **GPs should have a low threshold for asking for further advice where there is an inconclusive or abandoned specialist investigation, but ongoing or worsening symptoms.**

Cauda equina claim goes to trial

By **Louise Morgan,** Litigation Solicitor, Medical Protection

Mr W had a history of degenerative disc disease, for which he had been seen by a consultant. Mr W awoke one morning with symptoms consistent with cauda equina syndrome. He called the out of hours GP service and the ambulance service.

GP Dr F was working in the out of hours service and he telephoned Mr W back at 6.04 am. Dr F successfully elicited red flag symptoms consistent with cauda equina syndrome, including possible saddle anaesthesia. Mr W reported that he had not urinated on waking or tried to do so. Dr F advised him to go to the hospital A&E department because he needed an urgent scan and orthopaedic review.

Mr W did not, in fact, follow this advice because the ambulance service also contacted him and then attended his home. They transported him to hospital. He was assessed in A&E by a junior doctor who referred him on to the orthopaedic team. A junior orthopaedic doctor formed the view that he had painless urinary retention and so an MRI was organised. On review of the MRI, Mr W was referred to another hospital for neurology and neurosurgery, where he underwent decompression surgery within 24 hours from when he awoke with cauda equina symptoms.

Mr W makes a claim

Mr W pursued a claim against Dr F, the ambulance trust and the hospital. There were initially four allegations against Dr F but, by the time of trial, the only one remaining was that he should have called the orthopaedic team at 6.12 am to arrange for Mr W to be treated as an orthopaedic expected patient. The ambulance trust conceded a delay of 19 minutes in admitting Mr W to hospital.

Dr F contacted Medical Protection for assistance after being served with the formal letter of claim and the matter was passed to Medical Protection's claims delivery team. A claims manager investigated the case, obtained independent expert evidence and prepared and served a letter of response on his behalf, denying the allegations in full. As well as being supported by a claims manager, clinical input was provided by one of Medical Protection's medicolegal consultants.

The allegations against the hospital were that Mr W was not investigated and treated sufficiently quickly following admission through A&E, despite an MRI within six hours and surgery in under 24 hours from waking with symptoms.

Breach of duty was denied on behalf of Dr F on the basis that he had successfully elicited red flag symptoms and directed the patient to the A&E department of the correct local hospital, it being equipped with an MRI scanner and having access to an orthopaedic team.

Mr W did not accept our defence of the claim and the case went to court. At this stage the case was transferred to Medical Protection's litigation team and handled by an experienced litigation solicitor.

The outcome

The claims against Dr F and the hospital were dismissed in their entirety at trial. The trial judge noted that there was no national policy on how referral from primary to secondary care should take place in suspected cauda equina cases.

Mr W was not satisfied with the court's decision and sought and obtained permission to appeal.

Dr F's legal team maintained their defence and refused an invitation to concede the appeal. The appeal was subsequently dismissed and the original decision upheld. The appeal court commented that they did not find anything to criticise in the conduct of Dr F, a busy out of hours GP, and further expressed their surprise that the claim had been brought against him at all.

Commentary

Dr F demonstrated good clinical practice by asking appropriate questions of his patient, eliciting red flags and directing the patient to the correct place for further care. The transcript and recording of the call demonstrated his caring approach and his notes accurately recorded his suspicion of cauda equina syndrome. There was nothing to criticise in his management of the patient, as confirmed by the appeal court.

Dr F worked very closely with his legal team throughout the claim, which was a key factor in ensuring a successful outcome. He was fully engaged from the outset and he took great care to ensure that he had a good understanding of all the issues and the factual and expert evidence, together with all the relevant medical literature. He performed extremely well in the witness box and clearly impressed the judge, who found him entirely credible, such that his evidence was accepted. Giving evidence in court is a challenging experience, but this can be improved with detailed and careful preparation.

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

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