



CASEBOOK



This issue...

FROM THE CASE FILES

Our latest collection of case reports

RISK ALERT – MEDICATION ERRORS AND SAFER PRESCRIBING

Common problem areas in prescribing

A FAMILY MATTER

The risks of treating friends and family

ACHIEVING SAFER AND RELIABLE PRACTICE

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PAGE 6

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CASE REPORT WRITERS

Dr John P Adams



Dr Rachel Birch



Dr Anna Fox



Dr Bobby Nicholas



Dr Janet Page



Prof Carol Seymour



Please address all correspondence to:

Casebook editor
Medical Protection Society
Victoria House
2-3 Victoria Place
Leeds LS11 5AE
United Kingdom

casebook@medicalprotection.org



WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



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

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

As part of our commitment to education we have launched a new workshop in New Zealand on 'Achieving safer and reliable practice', to help members lower their risk. On page 6 we take a look at what the workshop involves and provide some hints and tips on achieving safer practice.

Treating friends and family may seem convenient, but can be fraught with difficulties. We examine the issue on page 8.

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

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

Dr Marika Davies
Casebook Editor-in-Chief
marika.davies@medicalprotection.org

RISK ALERT

MEDICATION ERRORS AND SAFER PRESCRIBING

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

Prescribing is one of the greatest risk areas for all clinicians and can be particularly hazardous for the inexperienced doctor. It is fraught with potential pitfalls, ranging from transcription errors and inadvertent dosage mistakes to overlooked drug interactions, allergies and side effects, the consequences of which may be profound both for the patient and the prescriber.

It is imperative that you have a good knowledge of the pharmacology and the legislation surrounding drugs, and any protocols and controlled drug routines that apply within your workplace – if unsure, ask.

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

Below are two case reports highlighting some common potential hazards.

CASE 1

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

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

Discussion with Mr A and review of his records revealed that although he had attended for reviews at his previous GP, these had been at the asthma clinic. His records had

been coded as "medication review done". He had initially been prescribed hydrocortisone 1% ointment for his face but had stopped ordering this as well as his emollients when he found the stronger steroid more effective. The prescriptions for fluocinolone cream had simply stated "apply twice daily".

LEARNING POINTS

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

CASE 2

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

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

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

LEARNING POINTS

- Distractions and interruptions are a common cause of error.
- A study in the UK has shown that vaccination errors are one of the most frequently reported medication safety incidents reported in primary care¹.
- When prescribing or giving advice about a new or unfamiliar drug, be prepared to look up information on your clinical record system, in a formulary or in specific guidelines as appropriate.
- Make contemporaneous records of all contacts/discussions with colleagues about patients.
- Administration of a routine vaccination is not urgent and, although inconvenient for the patient, it may be safer to rebook, allowing time to check facts – particularly if, as here, the patient had a short appointment earmarked just for the flu vaccination.

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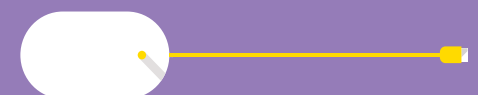
1. National Reporting and Learning System. NPSA. Medication Incidents in Primary Care. Quarterly Data summary issue 7 2008. National Patient Safety Agency

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

To take part in the Medical Protection Medication Errors and Safer Prescribing e-learning module and help lower your prescribing risk, visit:

medicalprotection.org

and click on the e-learning link.



ACHIEVING SAFER AND RELIABLE PRACTICE

Medical Protection’s Dr Suzy Jordache and Sam McCaffrey look at how a new workshop for members is making for a more reliable healthcare experience

Safe healthcare requires both the expert knowledge and technical skill of healthcare professionals as well as reliable delivery and application of that knowledge and skill.

In the new Medical Protection workshop, *Achieving Safer and Reliable Practice*, reliability is defined as minimal unwanted variability in the care we have determined our patients should receive. Any figure below 80% reliability would be termed ‘chaos’ in other safety critical sectors, and yet in healthcare we regularly report ‘success’ rates of 80% or lower. For example, the latest national data¹ is that in October 2015 DHBs reached and sustained handwashing rates at or above 80%.

Examples of the variation in reliability in healthcare are readily available. In New Zealand the Health Quality and Safety Commission’s Atlas of Healthcare Variation² has many examples of variation between DHB regions in everything from post-operative infection, tonsillectomy rates and medication after cardiac events to glycaemic control for diabetes. In the NHS the Health Foundation’s report in 2010³ found that in nearly one in five operations equipment was faulty, missing or used incorrectly; around one in seven prescriptions for hospital inpatients contained an error; and full clinical information was not available at just under one in seven outpatient appointments. The report also commented on the wide variations in reliability between and within organisations.

HOW RELIABILITY IS QUANTIFIED

Reliability is often expressed in terms of failure rate as a power of 10. For example, a procedure that is reliable nine times out of ten fails 10% of the time, or has 10^{-1} reliability. A procedure that fails 20% of the time has a reliability of $>10^{-1}$.

Systems that fall below 10^{-1} reliability are generally considered ‘chaotic’.

WHAT LEVEL IS ACHIEVABLE?

Research suggests that implementation rates in healthcare for standard procedures that impact on patient safety are between 50% and 70%, or $>10^{-1}$.

Other industries such as aviation and nuclear power have achieved reliability levels of 10^{-6} in critical processes. In healthcare, anaesthetics has been successful in achieving this level of reliability during the induction of anaesthesia. This and other reliable practices, such as blood transfusions and pathology labelling, can inspire and lead the way for all of us, whether practising in primary or secondary care.

HUMAN FACTORS

The science of human factors examines the relationship between people and the systems with which they interact, with the goal of minimising errors. In healthcare, human factors knowledge can help design processes that make it easier for doctors and nurses to do the job correctly.

Some of the factors that have been identified as having the potential to impede human performance include:

People

- Perceptual deficits under stress.
- Fatigue;
 - physical,
 - decisional.
- Poor interpersonal communication;
 - transmission/reception,
 - challenge.
- Poor understanding of the nature of human error;
 - causes,
 - extent,
 - the weakness of 10^{-1} strategies in prevention.

Processes and systems

Inadequate:

- Structured decisional support and checking tools.
- Measurement, feedback and accountability mechanisms.
- Briefing and simulation.
- Environmental design and control.
- Equipment design.

ALWAYS CHECKING

In order to mitigate the risks from these factors Medical Protection advocates the AlwaysChecking™ approach, which offers five manageable, evidence-based steps to raise reliability in any healthcare setting:

Moving to 10^{-2}

The MPS AlwaysChecking™ approach

Principle	Strategy
<i>We always check:</i>	
<i>each other and welcome being checked</i>	Speaking up
<i>what we’ve agreed should be done</i>	Checklists
<i>message sent is message received</i>	Repeatback/Readback
<i>we know how to work together</i>	Briefing and Simulation
<i>always means always</i>	Measurement and Accountability

Perhaps the most important strategy is that of ‘speaking up’ – safe cultures train and insist on respectful assertive communication. In healthcare, we often find that following an error, one member of the team had ‘seen it coming’ but felt unable to say anything. There are complex reasons for this and simple steps by individual clinicians can transform safety.

Speaking up is only possible in a culture that accepts that everyone will make mistakes. In many teams the perceived negative consequences of speaking up can be greater than those of not speaking up. Explicitly telling others of your expectation that they will speak up and ‘have your back’ and thanking anyone who challenges you – especially when they are wrong – can help change this perception.

Engaging with those in your team who are reluctant to speak up is also essential. This may require training to ensure that the necessary skills are taught and learnt.

CHECKLISTS

The use of checklists in healthcare has been demonstrated in numerous studies to improve reliability and outcomes for patients, yet they are still resisted by some in the profession and are often hotly debated during the workshop.

Some of the benefits of using a checklist:

- Reduce cognitive work.
- Facilitate concentration on first order concerns.
- Critical in preventing “never events”.
- Change the culture of a team;
 - validate the importance of a safe process,
 - empower team members to challenge.

In one example the successful implementation of a checklist saved lives and millions of dollars by eliminating central venous line infections⁴.

The intervention involved the education of staff, creating a dedicated catheter insertion cart, daily assessment as to whether catheters could be removed, implementing a checklist to ensure guidelines for preventing infections were followed, and training and empowering nurses to challenge colleagues if they were not following the checklist.

It resulted in the infection rate falling from 11.3/1000 to 0/1000 catheter days, as well as 43 infections and eight deaths being prevented.

The workshop includes a guide on how to develop effective checklists and implement them in organisations.

MEASUREMENT AND ACCOUNTABILITY

Another key aspect of the AlwaysChecking™ approach is “Measurement and Accountability”. Within many organisations and teams there will be some clinicians who do not conform to agreed safety procedures. Allowing ‘special rules’ for some is toxic and can sabotage success.

Challenging these individuals can be difficult, but without doing so high reliability and safety cannot be achieved. The success story from Vanderbilt University Hospital system in the USA demonstrates the importance of measurement, feedback and accountability⁵ – highlighting the power of insisting that “always means always” around handwashing

The results achieved in 2009 (>10⁻¹) were achieved using strategies based on individual memory, diligence and vigilance. In 2010 the centre moved to a detailed monitoring and individualised clinician and team benchmark feedback process, leading to 10⁻¹ levels of reliability.

Since 2011 the level of compliance has been maintained (and even increased again) to 10⁻². The benefits to patients, in terms of morbidity and mortality reduction, along with the economic benefits to the hospital and the decreased risk of complaint and claim for the clinicians employed by Vanderbilt, are a testament to the value of measurement and accountability in achieving 10⁻² reliability.

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3. The Health Foundation, How Safe are Clinical Systems? Primary research into the reliability of systems within seven NHS organisations and ideas for improvement. May 2010
4. Berenholtz S et al, Eliminating catheter-related bloodstream infections in the intensive care unit, Crit Care Med 32(10):2014-2020 (2004)
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Example: Handwashing programme

Year	Handwashing Rate
2009	58%
2010	80%
2011	92%

- 30% reduction in serious hospital infections.
- Estimated annual net savings of US\$4.5m.
- Tenfold reduction in ICU central line infection rate (now one quarter of national benchmark).

Vanderbilt U.M.C



WORKSHOP

To book your place on a workshop, visit medicalprotection.org and click on ‘Education and Events’.



A FAMILY MATTER

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

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

THE GUIDANCE

The MCNZ has published a statement on providing care to "those close to you". It states: "The Medical Council recognises that there are some situations where treatment of those close to you may occur but this should only occur when overall management of patient care is being monitored by an independent practitioner. Wherever possible doctors should avoid treating people with whom they have a personal relationship rather than a professional relationship. Providing care to yourself or those close to you is neither prudent nor practical due to the lack of objectivity and discontinuity of care."¹

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

THE ETHICS

Many doctors would trust themselves above all others to provide good care to their loved ones, but it is hard to imagine that the objective standard of clinical care would not be impacted by an emotional relationship to the patient. Doctors are always interested in the continued health and treatment of their patients, but the stakes are never higher than when the outcome would personally affect the practitioner and their family. Additionally, the doctor may not feel able to ask sensitive questions or perform

intimate examinations, and the patient may not feel comfortable disclosing intimate or embarrassing issues to close relations. If the patient is then likely to attend a separate GP as well, the risk of disjointed care and incomplete records becomes significant.

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

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

PRESCRIBING

Although prescribing for family or friends may not be illegal, it can be risky. In order to have a dispassionate appreciation of the medical diagnosis and treatment plan, the prescriber should not be emotionally involved with the patient. If the patient is seeking medical advice from both a family member and a separate GP, the drugs prescribed may result in being duplicated, or even contraindicated. Disjointed treatment plans and duplicated or incomplete records may result in inadequate or dangerous health care.

The patient may also require review or monitoring that could be missed if they are not seeing their regular doctor.

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

REFERENCES

1. Medical Council of New Zealand, *Statement on providing care to yourself and those close to you*, June 2013.

CASE STUDY

Dr E's colleague told him he was feeling low but didn't feel able to talk to his GP or anyone else about it. Reluctantly, Dr E agreed to prescribe him a course of anti-depressants. The colleague's mood improved and, when he was due to move jobs, he reassured Dr E that he would be fine and would seek medical care elsewhere. A few weeks later Dr E was devastated to hear that his former colleague had attempted suicide. The colleague's partner reported Dr E to the MCNZ. Dr E sought assistance from Medical Protection, and his case was assigned to a medicolegal adviser who assisted him in providing an explanation for his actions. At the end of its investigation the MCNZ concluded the case with a warning, with a recommendation that Dr E undergo educational courses on prescribing and documentation.

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

WHAT DO YOU THINK?

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



MEDICAL PROFESSIONALS AND THE VULNERABLE CHILDREN ACT

New safety checks on workers who have regular contact with children have started to be phased in. Victoria Knell, Senior Solicitor at DLA Piper, explains what this means for medical professionals

The Vulnerable Children Act 2014 introduces the vetting of people in the workforce who have regular contact with children¹ where a parent or guardian of the child may not be present. GPs, locums, nurses and support workers will all be considered children's workers under the Act and will be required to be screened by the organisation they work for.

ORGANISATIONS

If a hospital or medical practice receives any amount of public funds they will be required to ensure safety checks on the workers they employ, but those in private practice who receive no state funding are not covered.

Self-employed practitioners and locums, however, are covered and the Ministry of Health is currently establishing an independent screening service to have the appropriate checks completed for such individuals.

CORE AND NON-CORE CHILDREN'S WORKERS

The Act makes a distinction between "core children's workers" and "non-core children's workers". The main difference between the two is that the Act comes into force earlier for core children's workers who are also subject to the workforce restriction (explained below).

A **core children's worker** is someone who, when present with a child, is the only children's worker present or is the children's worker who has primary responsibility for, or authority over, the child present (GPs and nurses will likely be considered core children's workers).

A **non-core worker** is a children's worker who does not fit the definition of core children's worker (administrative and general practice staff will likely be considered non-core children's workers).

THE WORKFORCE RESTRICTION

People who have been convicted of offences involving children, violent behaviour and sexual offending² will face restrictions and will be required to apply for an exemption³ if they wish to be a core children's worker.

For core children's workers starting a new job, the restriction already applies. However, for those already employed, the restriction

applies from 1 July this year (2016) and they have until 1 July to apply for an exemption.

If a practice or organisation becomes aware that a core children's worker has a conviction for a specified offence, they must suspend the worker, while continuing to pay them. When suspending a worker the employer must specify the period of suspension (which must not be less than five working days), inform the worker of the reason behind the suspension and ask them to respond.

When a worker is suspended their employment cannot be terminated until at least five working days after the suspension begins.

Workers who are terminated due to the workforce restriction are not entitled to any compensation or other payment and the termination will be deemed to be justifiable dismissal.

OFFENCES UNDER THE ACT

An organisation that does not ensure each child's worker is safety checked and re-checked within three years will be liable on conviction to a fine of up to \$10,000.

An organisation that employs a person convicted of a specified offence and who does not hold an exemption will be liable on conviction to a fine of up to \$50,000.

The Act's obligations are likely to be particularly onerous on medical practices and self-employed practitioners who receive state funding. Organisations should create a child protection policy and maintain records about the safety checking process as compliance may be checked. If you are concerned about how the Act might impact you and your practice, contact Medical Protection at: advice@mps.org.nz.

KEY DATES

- 1 July 2015** – all new core children's workers must be safety checked before starting with a specified organisation.
- 1 July 2016** – all new non-core children's workers must be safety checked before starting with a specified organisation.
- 1 July 2018** – all existing core children's workers must have been safety checked.
- 1 July 2019** – all existing non-core children's workers must have been safety checked.

Children's workers are required to have their checks updated within three years of the initial checks.

SAFETY CHECKS

The checks that practices will be required to undertake are:

New workers

1. Identity confirmation of the proposed children's worker.
2. Collection of information including the children's worker's work history, references and:
 - (a) an interview which should include open questions and be conducted by people confident to ask questions about child safety; and
 - (b) verification that the proposed worker is registered with the appropriate professional body.
3. Police vetting. This can take up to 20 days to complete and results must be considered before a proposed worker commences work.
4. An evaluation of all the information obtained and an assessment of any risk of employing the proposed children's worker, including consideration of whether the role is for a core children's worker or non-core children's worker.

Existing workers

There are fewer checks required for those children's workers who are already employed or engaged by a specified organisation. For an existing worker the specified organisation is required to undertake requirements 1, 2(b), 3 and 4 above.

The information obtained for each children's worker must be updated every three years.

REFERENCES

1. A child is a person under the age of 17 years and who is not, or has not been, married
2. A full list of specified offences can be found in Schedule 2 of the Act
3. Information regarding the exemption can be obtained by emailing Core_Worker_Exemption@msd.govt.nz



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ACHIEVING SAFER AND RELIABLE PRACTICE

NEW



This is a topic
that is a long
time overdue –
I have had a
little awakening

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FROM THE CASE FILES

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



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

Think beyond the common

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

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

The difficulty that a clinician faces when assessing a patient is that, by definition, common things are common and (usually, but not always) are either benign and/or self-limiting in their nature. For example, most children who present with coryzal symptoms will not have serious underlying pathology; most pregnant patients who develop ankle swelling will not have pre-eclampsia; most patients who present with headache will not have serious underlying pathology etc. One of the challenges for

clinicians is identifying those patients that require further investigation (and/or treatment) in order to establish or rule out serious underlying pathology and arranging for that investigation (and/or treatment) to be undertaken within a reasonable time frame (which, depending on the circumstances, may be on an emergency basis). There is an abundance of diagnostic algorithms, standards and guidance available, and whilst it is not always easy to access them in the midst of a consultation, if there is an adverse outcome, your care will be judged to the relevant standards and guidance (that prevailed at the time of the incident).

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

1. Have I advised the patient of red flag symptoms to look out for and explained what they should do in the event that these develop?
2. Have I informed the patient as to what should prompt them to return for review?
3. If the diagnosis subsequently turns out to represent serious underlying pathology, would I be in a position to justify not making (or contemplating) that diagnosis based on the information available to me?

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

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

What's it worth?

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

- HIGH NZ\$1,000,000+
- SUBSTANTIAL NZ\$100,000+
- MODERATE NZ\$10,000+
- LOW NZ\$1,000+
- NEGLIGIBLE <NZ\$1,000

MISSED MENINGITIS

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THEME SUCCESSFUL DEFENCE



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

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

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

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

Two months after his illness JC had a hearing test that showed moderately

severe sensorineural hearing loss. Despite hearing aids JC had delayed speech and language development. His mother was upset because he struggled with poor concentration at school and found it difficult to interact in groups.

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

EXPERT OPINION

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

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

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

The orthopaedic surgeon noted the minor x-ray abnormalities in JC’s right hip. He felt that given the patient’s

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

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

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

Learning points

- BPAC have a useful traffic light system for identifying risk of serious illness in feverish children under five¹. Along with other clinical signs, it requires GPs to check pulse, respiratory rate, temperature and capillary refill time in order to categorise them into groups of low, medium or high risk of having serious illness.
- Safety netting is an important part of a consultation. In this case Dr R advised the mother to contact services again if he deteriorated. This helped Medical Protection defend his case.
- In some cases claims can be brought many years after the events. This makes good note-keeping essential as medical records will often be the only reliable record of what occurred.

REFERENCES

1. Identifying the risk of serious illness in children with fever, BPAC, July 2010: bpac.org.nz/BPJ/2010/July/fever.aspx

AF

PROBLEMATIC ANAESTHETIC

SPECIALTY ANAESTHETICS
THEME CONSENT/INTERVENTION
AND MANAGEMENT

○ SUBSTANTIAL

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

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

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

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

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

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

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

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

EXPERT OPINION

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

1. Dr S had failed to inform Mrs B that he intended to perform a paravertebral block and failed to discuss the risks and benefits of such a technique.
2. He was somewhat critical of the decision to perform the block with Mrs B anaesthetised. He opined that had Mrs B been conscious or lightly sedated, she would have alerted Dr S when the

needle was in proximity to nerve tissue. However, Dr M did concede that there was a body of responsible anaesthetists who would support the notion of performing a paravertebral block with the patient anaesthetised.

3. He was critical of Dr S's decision to keep persisting with the block when he was struggling to locate the correct needle position. He felt that Dr S should have abandoned the block or called for help. He also concluded that the technique used by Dr S was very poor given the complications that followed.
4. Dr M was critical of the levels chosen by Dr S to perform the block. He felt that C7 was too high, given that the dermatomal level of the surgery was approximately T4. He also felt that the surgery was very minor and did not warrant the paravertebral block. Dr M was of the opinion that infiltration of local anaesthetic by the surgeon, combined with simple analgesics, would have sufficed.

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

Learning points

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

JPA



FAILURE TO FOLLOW SPECIALIST ADVICE

SPECIALTY GENERAL PRACTICE/NEUROLOGY
THEME PRESCRIBING

● SUBSTANTIAL



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HOME

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

Subsequently, Mr G was seen by both Dr L and his optician, complaining of tired, heavy eyes. No visual field check was carried out on either occasion. Nine months later Mr G returned to see Dr L, requesting a referral to the epilepsy clinic as he had read a newspaper report about the visual side effects of vigabatrin. An appointment was made at the clinic but Mr G failed to attend on two occasions. An urgent referral was ultimately made by Mr G's optician several months later following detection of a visual

field defect on a routine examination. The ophthalmic surgeon, Mr D, noted that Mr G had been on vigabatrin for in excess of 11 years during which time he had not been monitored. His visual fields were noted to be markedly constricted, which was attributed to the vigabatrin. Mr G was referred to another neurologist who recommended a change of anticonvulsant. Mr G was gradually weaned off the vigabatrin.

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

EXPERT OPINION

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

Learning points

- If a doctor signs a prescription, they take responsibility for it – even if it is on the advice of a specialist. Good communication between primary and secondary care is vital to ensure patients receive the appropriate treatment. See the MCNZ statement on *Good prescribing practice*: mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf.
- Patients should be informed if there is a need for monitoring or regular review of long-term medications. Where there is shared care with another clinician, agreement should be sought as to the most appropriate arrangements for monitoring. All advice should be clearly documented.
- When alerted to a potentially serious side effect of medication, prompt arrangements for review should be made, with a specialist if appropriate.

JP

UNDESCENDED TESTIS

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE



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HOME



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

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

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

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

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

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

EXPERT OPINION

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

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

Learning points

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

REFERENCES

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

DIAGNOSING PNEUMONIA OUT OF HOURS

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE



HOME



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

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

Dr Z rang Mr B and noted his history of chest pain triggered by coughing and the normal ECG. She noted his temperature of 39 degrees and that he had taken some ibuprofen to help. She documented "no shortness of breath" and advised some cough linctus and paracetamol. She offered

him an appointment at the out-of-hours centre, which he declined, but he did agree to ring back if he was worse. She documented that her advice had been accepted and understood.

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

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

Later the same day Mr B's breathing became rasping and very laboured. He collapsed and an ambulance took him to A+E. Cardiopulmonary resuscitation was

attempted but sadly failed. A post mortem was performed, giving the cause of death as "right-sided lobar pneumonia and bilateral pleural effusions".

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

EXPERT OPINION

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



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

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

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

Learning points

- Medical Protection can use recorded data as evidence to support members who are the subject of a claim.
- According to BPAC guidelines, the decision to refer patients to hospital can be aided by pneumonia-specific algorithms, such as the CRB-65 score¹. The score is based on the presence of confusion, raised respiratory rate, low blood pressure and the age of the patient. One point is given for confusion (AMTS 8 or less or new disorientation in person, place or time), raised respiratory rate (30 breaths per minute or more), low blood pressure (systolic <90mmHg or diastolic <60mmHg), age 65 years or more. A score of 0 is classed as low risk and is associated with less than 1% mortality. A score of 1 or 2 is classed as intermediate risk and is associated with 1-10% mortality. A score of 3 or 4 is classed as high risk and is associated with more than 10% mortality.
- Clinicians should be aware that that Maori are six times more likely to die of pneumonia than non-Maori.
- When communicating between healthcare services, it is important to hand over all relevant information. In this case the ambulance crew did not pass on the patient's low oxygen saturations or his raised pulse rate. These vital signs could have conveyed the severity of the patient's illness to the out-of-hours GP.

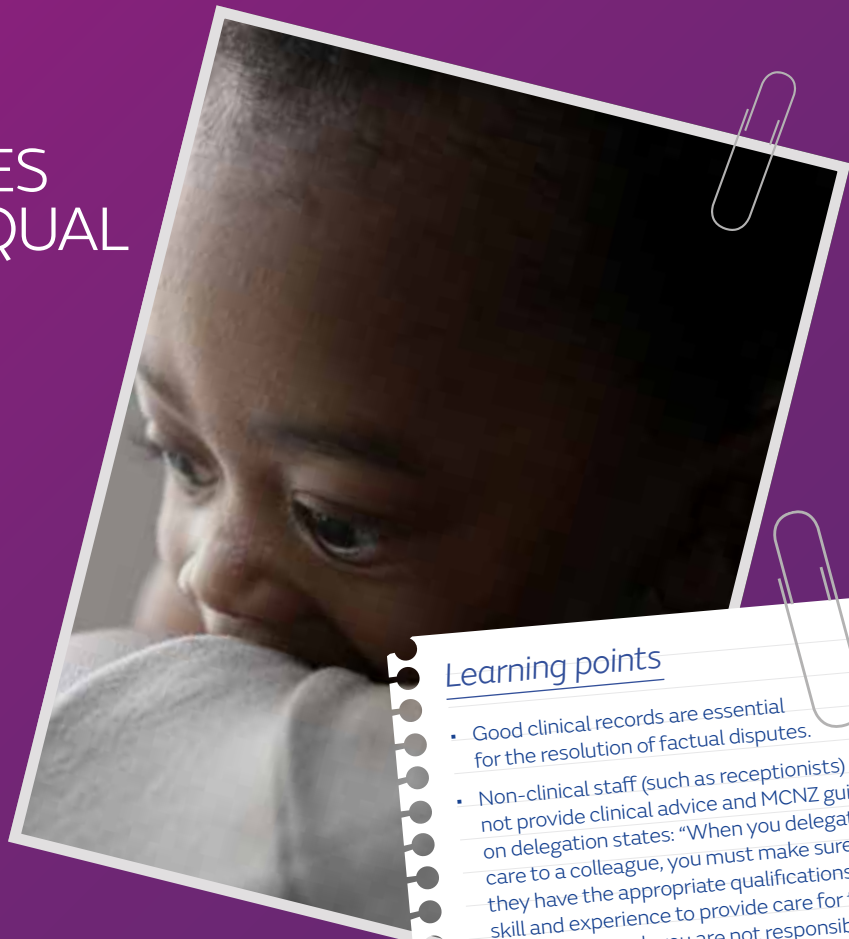
REFERENCES

1. bpac.org.nz/BPJ/2012/August/pneumonia.aspx

AF

TRAGIC OUTCOMES DON'T ALWAYS EQUAL NEGLIGENCE

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS



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

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

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

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

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

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

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

Learning points

- Good clinical records are essential for the resolution of factual disputes.
- Non-clinical staff (such as receptionists) should not provide clinical advice and MCNZ guidance on delegation states: “When you delegate care to a colleague, you must make sure that they have the appropriate qualifications, skill and experience to provide care for the patient. Although you are not responsible for the decisions and actions of those to whom you delegate, you remain responsible for your decision to delegate and for the overall management of the patient¹.”
- Although the outcome was tragic, this does not always equal negligence.
- Parents should be advised on the signs to look for and when to seek further help, and this should be documented.

REFERENCES

1. mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf

BN

EXPERT OPINION

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

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

STRETCH MARKS AND STEROIDS

SPECIALTY GENERAL PRACTICE/ENDOCRINOLOGY
THEME PRESCRIBING

● MODERATE

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

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

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

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

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

Over the next few weeks most of the symptoms resolved, but Mr A was left with stretch marks that he found unsightly

and embarrassing. He became very self-conscious and felt he could only go swimming with a T-shirt on. The stretch marks were itchy and uncomfortable, requiring frequent application of emollient, and he was advised that, although they would fade, they would never go away.

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

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

EXPERT OPINION

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

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

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

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

The case was settled for a moderate sum.



HOME

Learning points

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

RB

LOST OPPORTUNITY

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS

Learning points

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

CS

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

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

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

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

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

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

At that review, eight days later, Dr B noted the U&Es were still abnormal and decided

to await the results of the ultrasound scan. The ultrasound result was delivered the next day, which stated that "both kidneys demonstrate slight increase in cortical brightness; otherwise both kidneys are normal size, shape and morphology with no pelvi-calyceal dilatation". The results were filed by Dr P as no major abnormality was demonstrated.

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

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

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

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

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

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

EXPERT OPINION

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

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

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

DIFFICULT MATTERS OF OPINION AND RECALL

SPECIALTY PATHOLOGY
THEME DIAGNOSIS

Mrs S's GP referred her to Dr M, specialist breast surgeon, as she had noticed a lump in one of her breasts. Dr M arranged mammography and fine-needle aspiration cytology (FNAC) of the lesion, which were carried out on the same day. Dr M's initial clinical opinion was that the lump was benign.

Mrs S's mammogram was negative; the FNAC report stated that there were many benign ductal cells but a few clusters of malignant cells. At a clinical pathology case conference (CPC), Dr M discussed the FNAC results with the reporting pathologist, Dr V.

They had seen two patients recently who had normal mammography and malignant cells in the FNAC; these turned out to be cases of breast carcinoma, and they thought that Mrs S's case might be similar.

Dr V remembers discussing the possibility of carrying out frozen section histology to establish the diagnosis, and thus the optimal surgical plan. Dr M has a different recollection and remembers Dr V saying that this was not needed, given the findings of the FNAC.

Dr M re-examined Mrs S. He now felt that the lesion had characteristics of a malignant tumour and advised Mrs S to have wide excision of the lump with an axillary lymph-node clearance.

Histology of the excised tissue revealed no evidence of tumour. Dr V reviewed the FNAC slides and agreed there was no definite evidence of malignancy.

Mrs S sued Dr V for misinterpreting the FNAC result and performing what she alleged were an unnecessarily large surgical excision and spurious axillary clearance.



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HOME

EXPERT OPINION

We took advice from an expert in cytopathology and histopathology.

The expert noted that although there were some signs of cellular atypia in the FNAC slides, there were no changes to signify a definite diagnosis of malignancy.

The expert discussed the means by which the evidence from all three avenues (clinical examination, mammography and FNAC) needed to be considered together, in context, to decide on an appropriate plan. This approach minimised danger to patients by considering all the results together, to prevent under- or over-treatment.

The expert pointed out that FNAC requires a very high degree of skill and experience to interpret. This is why pathologists review each other's slides in borderline cases.

Even so, it is still possible for false positive and false negative results to occur. The expert felt that, where there is disagreement between the diagnostic modalities, the wisest course of action is lumpectomy and intraoperative histological examination by frozen section to confirm the diagnosis. Where the diagnostic modalities conflict, a cautious and considered approach is needed. We settled the case, with liability being shared equally between Drs M and V.

Learning points

CPCs are a good way for clinicians and pathologists to ensure that they are using information from investigations optimally. However, as this case demonstrates, it is essential to keep records of the discussions and the agreed plan.

This allows the decision-making process to be understood in its full context and clarifies everyone's position, should a claim or complaint ensue.

FNAC as part of the triple assessment may be superseded by core biopsy of breast lesions.

Magnetic resonance imaging of the breast may become an increasingly useful tool, helping to make these difficult decisions easier in future.

Further reading:

1. Eltahir A et al. The Accuracy of "One-Stop" Diagnosis for 1110 Patients Presenting to a Symptomatic Breast Clinic, *J R Coll Surg Edinb*, 44:226-30 (1999).
2. Chuo CB and Corder AP. Core Biopsy versus Fine Needle Aspiration Cytology in a Symptomatic Breast Clinic, *Eur J Surg Oncol*. 29(4):374-8 (2003).
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FAILURE TO DIAGNOSE PRE-ECLAMPSIA

SPECIALTY GENERAL PRACTICE/OBSTETRICS
THEME DIAGNOSIS/RECORD-KEEPING

● MODERATE

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

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

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

EXPERT OPINION

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

The obstetric expert advised that prodromal symptoms such as headache and nausea are more prominent in ante-partum eclampsia than signs, and blood pressure is often not



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dramatically increased, hence it is possible that the patient would not have had significant hypertension and/or proteinuria when seen by Dr M. However, the absence of any clinical record of the home visit made it difficult to rebut the claimant's allegation that she should have been admitted to hospital.

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

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

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

Learning points

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

JP

IF IT IS NOT RECORDED...

SPECIALTY GENERAL PRACTICE/NEUROLOGY
THEME REPEAT PRESCRIBING



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● LOW

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

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

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

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

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

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

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

EXPERT OPINION

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

The expert believed that the over-prescribing of high prednisolone doses was largely the responsibility of Dr P, who gave insufficient information about the initiation dosage and

duration of the initial steroid dose. It would be a not unreasonable assumption by the GP that treatment commenced by the consultant was to be continued until the patient saw the consultant again. Clearly there was delay as the patient did not attend regularly. When the over-prescribing was identified, Dr P failed to put in place a clear management plan with appropriate guidance to Dr O.

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

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

HOME



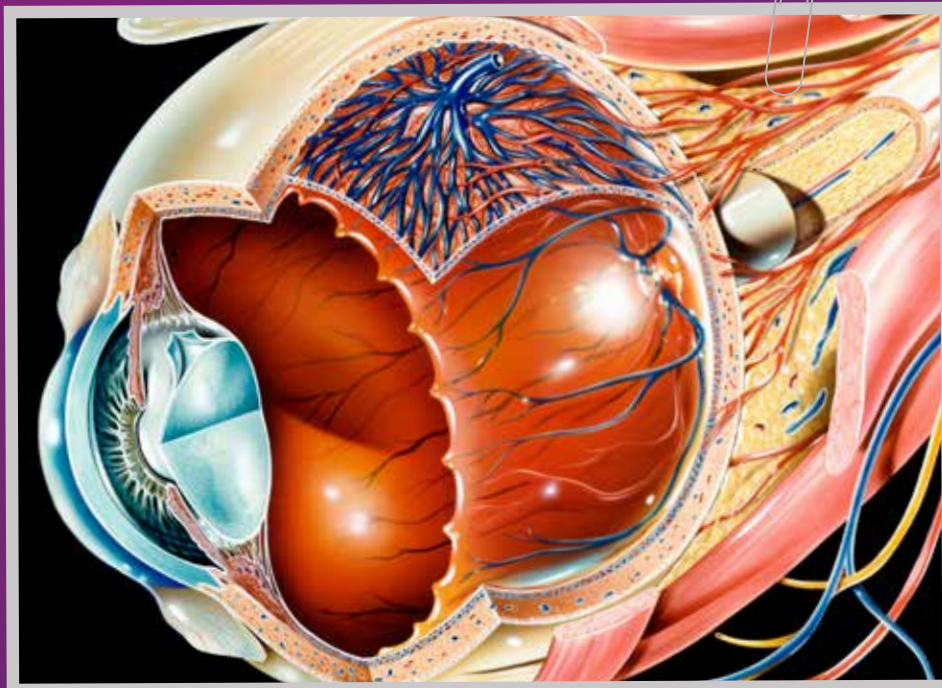
Learning points

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

CS

ONE IN THE EYE FOR SPURIOUS LITIGATION

SPECIALTY OPHTHALMOLOGY
THEME SUCCESSFUL DEFENCE



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HOME

Miss T was three years old when she injured her right eye whilst playing with a stick. Six hours after the injury she was seen by Mr F, consultant ophthalmologist.

He found a superficial laceration of the cornea containing purulent slough in its floor and margin. There was oedema, conjunctival congestion and evidence of pus in the anterior chamber.

Mr F felt that the globe was perforated and contained a foreign body. In the presence of infection, his preferred course was to treat with oral and topical antibiotics, with a view to later surgical exploration. Miss T's mother, a medical practitioner, attended with Miss T, and Mr F explained his opinion and plan to her.

Mr F reviewed Miss T the next day, about 15 hours after the original injury, and arranged to examine Miss T's eye under general anaesthetic, after she had been starved. At operation he found a perforating conjunctival-scleral tear and removed a 2cm splinter from the eye.

He repaired the tear and applied conjunctival gentamicin. Miss T did well and by the seventh postoperative day all inflammation had resolved and the tear had healed nicely.

To Mr F's surprise, a claim alleging negligence was brought by Miss T's family. He was accused of 'examining the eye roughly with a torch, when he knew this to be inadequate', of failing to examine the eye in theatre under general anaesthesia, subjecting Miss T to unnecessary 'torture' by directing torchlight at the eye, failing to diagnose a perforation and foreign body, giving the wrong treatment and delaying removal of the splinter for 22 hours.

EXPERT OPINION

We sought expert ophthalmological advice. The expert agreed with all of Mr F's management and found it "perfectly reasonable, on his part, to administer intensive antibiotic treatment... before attempting exploration". The expert asserted that a more forceful examination at first presentation was contraindicated, with a risk of worsening the degree of trauma and spreading infection.

The expert noted, "Mr F's management succeeded in saving an eye which, at the outset, was in grave danger of being lost... I do not see any evidence that his management in any way added to the patient's pain or distress." We resolved to defend the case to trial.

The claimants failed to attend the court and the claim was dismissed.

Learning points

- Dissatisfaction with unpleasant aspects of therapy seems to have been the motivation for this litigation, which is surprising given that a medically-qualified family member was present, receiving full explanation, at the time of the treatment. The failure of the claimants to attend the trial suggests that they realised there was no genuine basis to their claim.
- Unless a patient can prove both a breach of duty of care and a causal link to an injury resulting from this, they cannot successfully pursue a claim. Simply being unhappy with some aspects of an inevitably distressing treatment is not enough.
- We defend such frivolous claims, even where this involves significant expenditure, in order to discourage the continuing rise in the frequency of unfounded litigation.

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

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OVER TO

YOU

RISK ALERT – RETAINED THROAT PACKS

I read with interest the article regarding throat packs. In both cases measures were taken to prevent error yet error still occurred. I think that we as practitioners need to have a more sophisticated understanding of error and our own fallibility.

Firstly, this article illustrates the danger of presumption – the doctor presumed the surgeon removed the throat pack, the doctor presumed delirium (and we may all do the same). If in doubt, check it out, test the hypothesis.

Secondly, a checklist, briefing or standard operating procedure does not in and of itself eradicate error. In fact regular, repeated, routine skills and checks can become so familiar they are performed with little attention thus becoming a potential source of error.

Thirdly, we do not know the details of the WHO checks in these cases but distractions, interruptions or team changes all diminish the effectiveness of the checklist. It is also influenced by culture and belief – if practitioners do not value the tool it has little power to change practice.

I believe that we need to learn how to identify potential error and use the tools available to manage error.

If we use the WHO checklist in terms of threat and error management, we are actively evaluating the case in question, this requires attention. For example, in case 2 the anaesthetist was new to the hospital; this is a “threat” to performance because the team and the routine practices of that department are unknown. This should be stated during the team brief with the request that the team keep the new doctor informed regarding their normal practices.

The use of a throat pack is an “airway threat” and should be stated as such. The anaesthetist should inform the rest of the team how they plan to manage this. This includes the team directly in the management plan promoting team situation awareness and vigilance.

Maybe what is required is a shift in attitude, a change in “mind-set” from a passive “tick box exercise” to an active evaluation for error management, a point when all team members are united and engaged in planning their workload.

Dr Heather Gallie
Salford
UK

ELBOW ARTHROSCOPY AND RADIAL NERVE PALSY

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

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

I feel this point is lost in the summary.

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

Dr Cormac Kelly
Shoulder and Elbow surgeon
UK

Response

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

POOR NOTES, FATAL CONSEQUENCES

Thank you for such a stimulating and unfortunate case report.

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

All of the above are basics in the management of hypertension in pregnancy as recommended by NICE guidelines (CG107)¹ published August 2010.

Dr T Hamouda
Consultant O&G,
New Zealand

REFERENCES

1. nice.org.uk/guidance/cg107

HOME



REVIEWS



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

by Oliver Warren, Bryony Dean and Charles Vincent

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

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

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

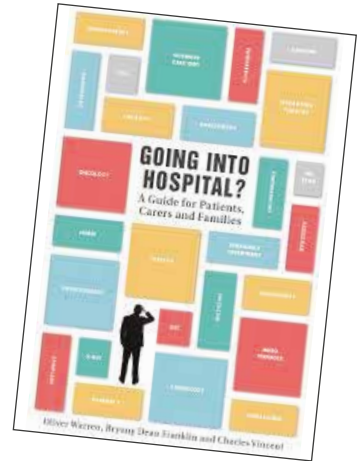
Throughout the book practical advice is offered to reduce the anxiety often encountered

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

With the demise of paternalistic medicine, it is our responsibility to ensure patients are enlightened and able to participate in their care. *Going into Hospital* will empower

patients to make informed, collaborative decisions with their healthcare team. The book seeks to dispel many of the myths obtained from the media. It helpfully lists reliable, useful sources of information accessible on the internet.

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



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

By Atul Gawande

Review by: Dr Rebecca Aning, Medical Protection Medicolegal Adviser

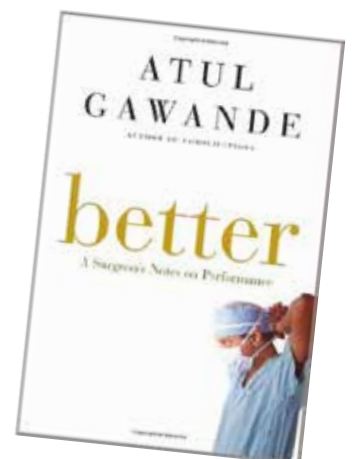
“Good, better, best, never will I rest, until my good is better and my better is best.” I don't know a single doctor who wants to be average! But, if you measure our success, it is probable that most of us would hover around the peak of the bell curve. To replicate the positive deviants, we need to know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

Who would have thought that handwashing gurus would take guidance from those encouraging better nutrition in

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

compassion and competency to those on death row?

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



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