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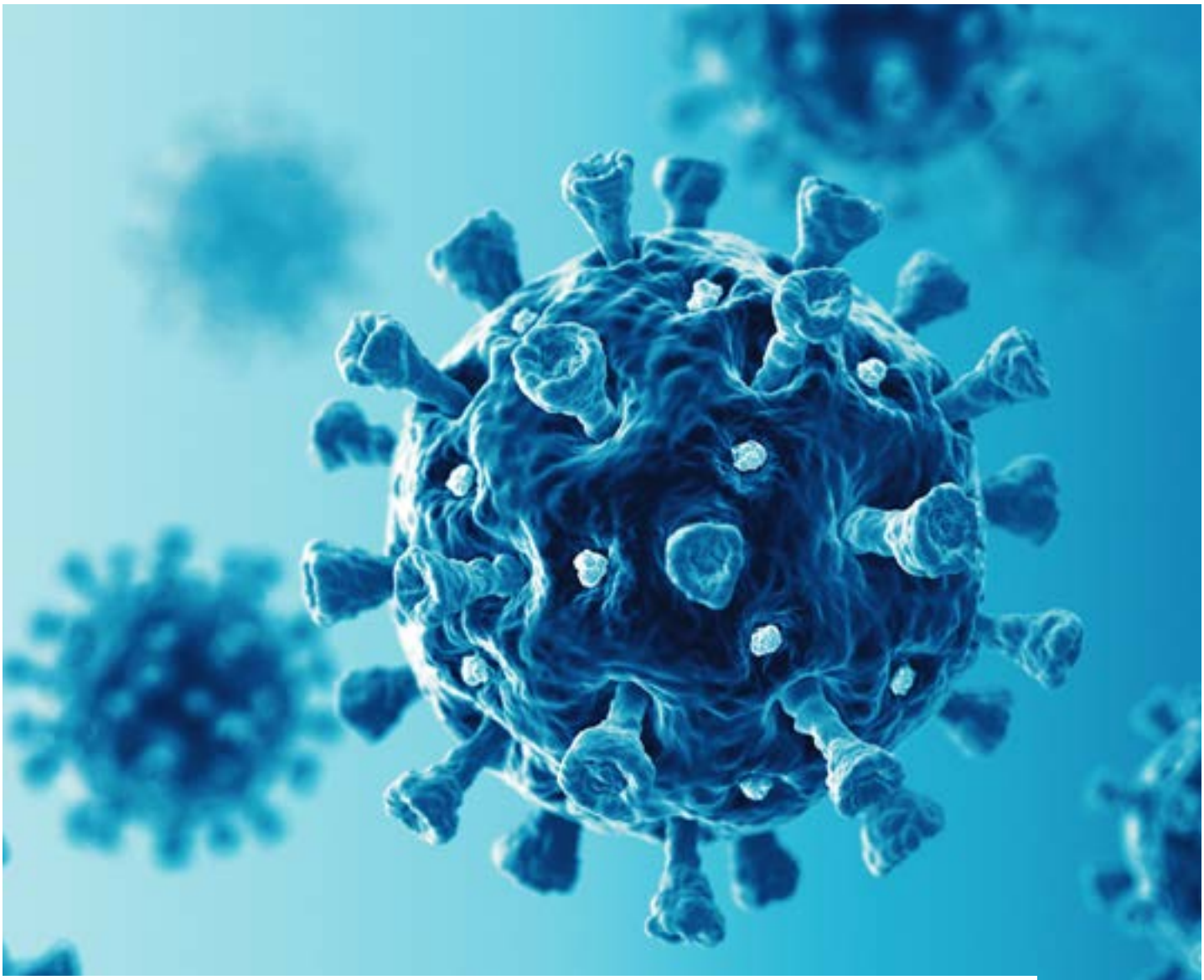
Medical Protection

Casebook

Volume 28 | Issue 2 | **November 2020** South Africa



COVID-19: the global experience

A look at the pandemic's past, present and future...with its impact on healthcare

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From the case files

Managing unwelcome attention from a patient

We provide advice to GP Dr C after he receives inappropriate contact from a patient.

Alleged failure to investigate chest pain

Mediation plays a key role in managing a claim for delayed diagnosis of coronary artery disease.

Delayed diagnosis of renal disease leads to claim

A patient makes an exorbitant claim over a delayed diagnosis – how did we challenge it?

Casebook CPD questions

Volume 28, Issue 2

CPD accreditation by SAMA

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

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

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

1) As a form of alternative dispute resolution, mediation is:

(a) More costly than going to court
(b) A loose, unstructured process
(c) Most likely to reach an agreement from all parties

2) A claim for damages means:

(a) Going to trial is always preferable
(b) The sum being claimed can be challenged and lowered
(c) A payout is inevitable

3) Clinical records:

(a) Can substantiate what happened in the event of a claim or complaint
(b) Are not as reliable as a clinician's memory
(c) Are not an essential part of clinical treatment

4) The use of telemedicine:

(a) Is widely available to everyone
(b) Is a simple, risk-free form of patient consultation
(c) Is restricted by some patients' limited internet access

5) Telemedicine makes cross-border healthcare possible. This is:

(a) A risk-free way of accessing healthcare
(b) One of the key risks of telemedicine, because of the regulations in different countries
(c) Not something regulators should be concerned with

6) What do patients see as a proxy indicator for competence and skill in a clinician?

(a) Empathy and clear communication
(b) A paternalistic approach
(c) Detached and unemotional demeanour

7) How significant are clinical guidelines in everyday practice?

(a) Not very significant
(b) Must be followed to the letter
(c) Can be deviated from but only with good justification, which must be documented in the clinical records

8) Emotional attachments from patients are:

(a) Perfectly normal and nothing to worry about
(b) A potential breach of doctor–patient boundaries
(c) Uncomfortable but it should be ignored and will go away

9) How important is it to keep social media accounts private from patients?

(a) Essential to avoid breaches of doctor–patient boundaries
(b) Not important – it makes doctors seem more human
(c) Social media plays no part in the doctor–patient relationship

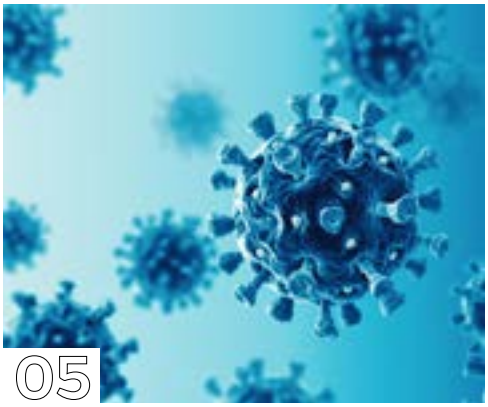
10) When a doctor is investigated over their clinical performance, the best course of action is to:

(a) Pay little attention to the investigation and carry on as normal
(b) Always expect the worst
(c) Seek to demonstrate remediation through insight and further learning

What's inside...

Every issue

Articles



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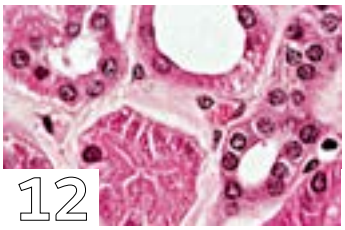
Casebook publishes medicolegal reports as an educational aid to Medical Protection members and to act as a risk management tool. The reports are based on issues arising in Medical Protection cases from around the world. Facts have been altered to preserve confidentiality.

Case reports



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Welcome

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

How the world has changed since the last time I sat down, back in February this year, to write what was my first welcome column as the new Editor-in-Chief of *Casebook*. Since then there has been only one topic on everyone's minds, which is of course the COVID-19 pandemic.

As Medical Director of Medical Protection, I have spoken to many members around the world about the unprecedented level of intensity that has at times surrounded frontline health services this year. So many of you have risked personal safety – and continue to do so – to maintain the ongoing battle against this devastating pandemic. As an organisation, we have been desperate to ensure we are supporting you in every way possible, whether through our expert medicolegal advice or via our expanded access to vital wellbeing support, including our counselling service. We have also been focused on fighting for leniency for healthcare professionals who might face difficulties relating to their treatment of patients during the pandemic.

This edition of *Casebook* is, unsurprisingly, largely dedicated to COVID-19 and my lead article is based on our global experience in supporting members with related issues throughout the pandemic. There is particular focus on remote consulting, which looks likely to stay in some form or another even when the pandemic has passed. The article also features very welcome contributions from a number of members from around the world, including MPS President, Professor Dame Jane Dacre. Many of the accounts are very poignant and accurately capture the sense of foreboding that accompanied the initial stages of the pandemic.

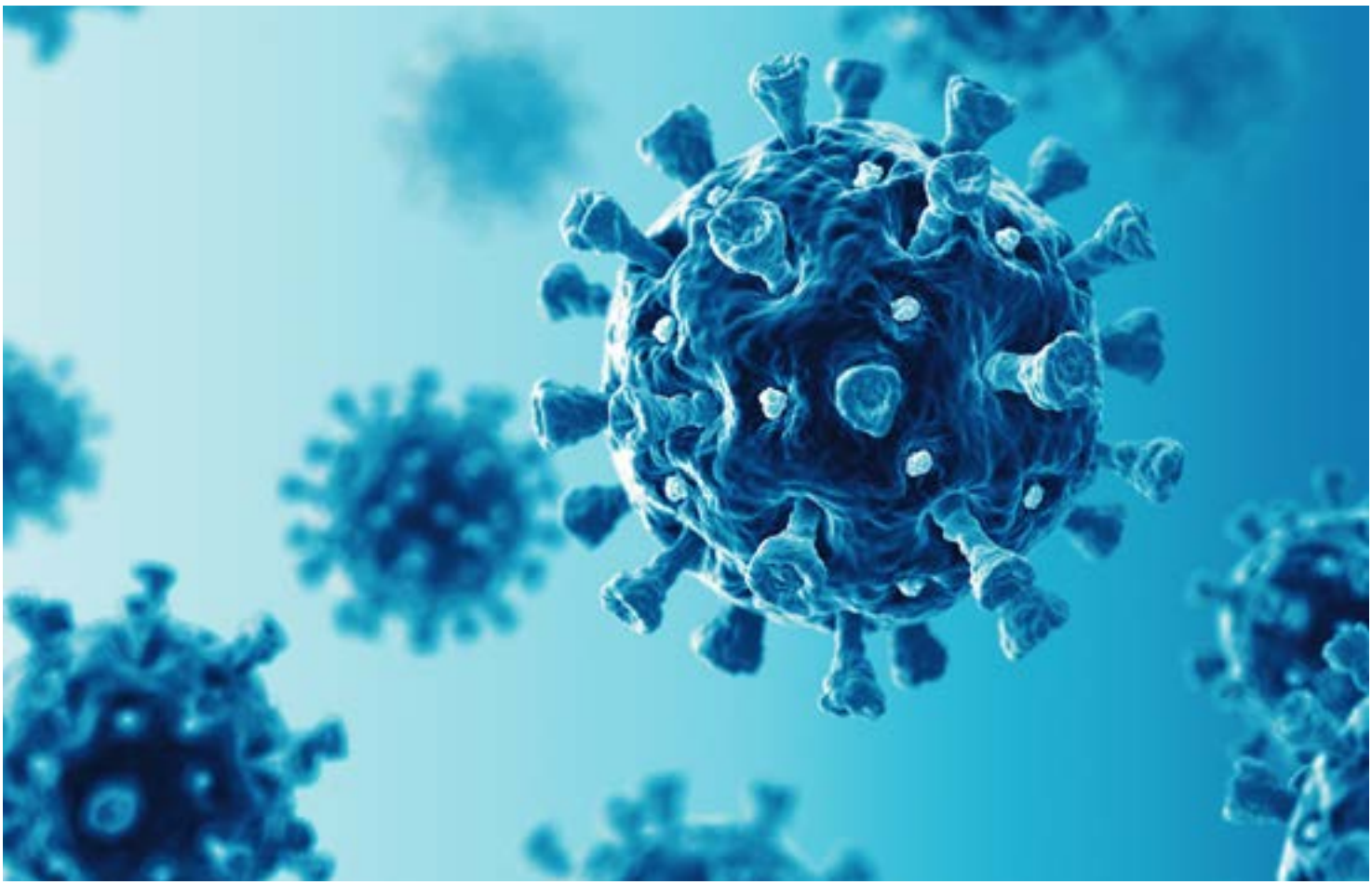
While much of this edition is given over to COVID-19, we do also have our regular collection of case reports as a reminder that no matter how much the pandemic has changed things, some aspects of medicine stay the same. The cases we have included here provide some insight into the breadth of issues we regularly assist members with.

I hope you enjoy this edition of *Casebook* and that it provides stimulating, supportive reading while this very challenging situation continues. Please do get in touch with any thoughts, comments or suggestions via **casebook@medicalprotection.org** and, in the meantime, please stay safe.

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

Correction

In volume 28 of Casebook (May 2020) we included an article entitled "A joint message to our members from the MPS President and the Chair of MPS Council". In this article, we incorrectly stated that members who were reducing their workload due to COVID-19 could "...adjust their membership and pay less." This statement was incorrect and should not have been included in the article. We apologise for any confusion this may have caused. We understand that there is still much uncertainty about the future and a great deal of concern about any further impact of COVID-19, and we will continue to be here to support members during this time.



COVID-19: the global experience

*Dr Rob **Hendry**, Casebook Editor-in-Chief and Medical Protection's Medical Director, looks at the impact of the COVID-19 pandemic and how it might influence the future delivery of healthcare*

> *It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of light, it was the season of darkness, it was the spring of hope, it was the winter of despair.*
>
> ***Charles Dickens**, A Tale of Two Cities*

The COVID-19 pandemic has been the focus of everyone from the time it exploded around the world in early 2020. It has been an intensely worrying time for everyone, but particularly so for those healthcare practitioners who are providing frontline services and advice to patients.

Developments in the situation change almost daily and at Medical Protection, we continue to do all we can to support our members in whatever way we can. This ranges from offering relief to members who have had sudden and dramatic losses of income, to advising members on the latest guidance from respective governments and regulatory bodies worldwide. All our latest information and FAQs can be found on the homepage of our website **medicalprotection.org** We also lobby for specific protection of our members while working during the pandemic to reduce the burden of anxiety they carry when caring for their patients.

How and when the pandemic will play out, and exactly what its long-term effects will be on our lives, is impossible to predict with certainty. But an interesting development in healthcare – the increased use of technology in supporting clinical care – is something that will be a permanent change, with many positive benefits for stretched health services around the world and greater flexibility for patients.

Telemedicine is here to stay – but what will it look like?

One of the clear spin-offs of the crisis has been the rapid adoption of telemedicine, particularly remote consulting and triage of patients. Some doctors have found this is an attractive way of interacting with their patients, while others have expressed a sense of dissatisfaction at having to work in this way. This mode of interaction is perhaps better suited to a transactional approach to consulting and varying responses by doctors to it may reflect individual preferences for communications with patients.

Many patients seem to like to access healthcare in this way, but concerns remain about those who suffer digital poverty, with limited access to the internet in a secure and confidential environment. The crisis also brought to the fore the difficulties regulators have in dealing with cross-border consulting, since technology now allows doctors to consult with patients who are in different countries and jurisdictions.

Doctors who are undertaking video consultations have been on a self-taught crash course in how to use the new technologies and are finding out the risks and benefits the new way of interacting with patients brings. It is very likely that the use of remote consulting will continue after the pandemic and it will be important for regulators to properly review the risks and benefits. There will likely be a drive to develop new guidelines that adequately help healthcare professionals manage this new way of working – something that Medical Protection will play a leading role in. In the meantime we are supporting members in this new way of working.

Should you need to do a remote consultation with a patient whom you would ordinarily see face-to-face, your membership with Medical Protection will enable you to request assistance for matters that could arise from such consultations during this time. We have more information regarding remote consultations (telemedicine), including webinar recordings, on our website at **medicalprotection.org**

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In the future it is likely that developing skills in remote consulting will be a core part of all doctors' training. We must also not lose sight of the fact that patients may need assistance in accessing healthcare via these platforms.

Has the doctor–patient relationship changed?

There are few relationships as sacrosanct as that of a doctor and a patient. It is built upon trust, communication, mutual respect and empathy, and is influenced by the practice of medicine, ethics and the law – all of which have been disrupted by COVID-19. The crisis has meant patients have been physically and emotionally separated from doctors by use of PPE, remote consulting and fear of accessing healthcare at all.

Empathic and clear communication is seen by patients as a proxy indicator of competence and skill. Research shows that only around 1-5% of patients litigate after negligent treatment, with poor communication often the differentiating factor between those who are sued and those who are not, even if clinical incident rates are equitable.

We see the interests of our patient as paramount and yet during the pandemic, many have received less or different care to usual. In some countries there has been a struggle to agree on fundamental issues of resource allocation and when it would be appropriate to withdraw treatment from one patient in favour of another. Doctors normally make decisions based on what is in the best interests of individual patients, but in a crisis should we accept a more utilitarian approach advocated by some to act for the greater good – and is this compatible with our sense of empathy or indeed the criminal law?

We have seen an outpouring of respect and empathy by the public and press toward healthcare workers during the crisis. Will this adoration of healthcare heroes translate into greater tolerance of medical error? Is it likely that society will accept that over-stretched staff and resources will not always deliver the high quality care we aspire to and that, on occasion, patients will be harmed? Despite all the goodwill, there is a fear amongst many that a wave of claims may be about to hit us owing to delayed and missed diagnoses from the interruption of care, further aggravated by economic hardship and recession.

Medical Protection has already urged governments to give greater legal protection to healthcare professionals when making momentous decisions in very challenging circumstances that are in the best interests of their patients.

Here to help you

In recognition of the great mental strain of working through this crisis, we extended our counselling service to all members experiencing any work-related stress, or stress that you feel could impact upon your practice. Our use of discretion also allowed us to provide access to free support to retired Medical Protection members who wanted to return to the frontline in Ireland, New Zealand, South Africa and the UK, while our discretionary approach also enabled us to set out various options for different member groups in making membership subscriptions more affordable.

We have also produced an extensive collection of webinars, podcasts and online articles to help and support you with the many questions you will have had during this pandemic. You can access these via our website **medicalprotection.org** or in the e-learning platform PRISM, which is also available through our website.

Reflections on COVID-19

Professor Dame Jane Dacre, MPS President and Consultant Physician and Rheumatologist, shares her experiences of the impact of COVID-19 in the UK

As a rheumatologist, with a background in internal medicine, I was keen to support the response to COVID-19 in my local hospital. We didn't have much warning but were hit hard and early by the outbreak in London. One by one, my colleagues were seconded to support the patients with COVID-19, and to provide care to the significant and nearly overwhelming numbers of patients coming in with severe pneumonia and hypoxia.

We increased our ITU capacity by using theatre and recovery space, and were close to running out of ventilators and oxygen. At the peak, I was part of an ethics group of senior physicians on call to help with the difficult decisions about treatment escalation plans, and what to do if we had to prioritise ventilator support. Although we all agreed that it was good practice to discuss treatment escalation plans with our patients and their relatives, we had never needed to do it on the basis of the availability of a resource, like a ventilator or CPAP, and it was very difficult.

It was made worse by the barriers to good communication from PPE, and the banning of relatives from the wards. Fortunately, we never needed to make a decision between two patients as the outbreak began to subside. At the time, we were grateful for Medical Protection's support in calling for protection for doctors against subsequent legal action when making these difficult decisions.

As my colleagues were diverted to the acute medicine wards, there was a big problem with the delivery of outpatient services. There were suddenly no doctors available to run the large number of routine clinics, and the outpatient department was closed. The hospital IT department was wonderful in setting up provision for remote access to all of the hospital systems within a week, and clinics were changed to telephone or other remote consultations. I was set up to work from home, and was able to pick up other colleagues' clinics, and make contact with waiting list patients to give advice and to let them know what was going on. We kept just two 'live hot clinics' to see those patients in the most need of a face-to-face consultation, with everyone else being 'seen' remotely.

Although there are communication problems with some patients, and remote clinics are not for everyone, I have become a fan. It is much easier for those patients who are at work, or busy for other reasons, to have a booked time for a call to discuss issues. If something needs to be seen to be evaluated properly, that decision can be made on the call.

COVID-19 is still a problem worldwide, and further waves have happened, or are happening, in some places; we are all still waiting anxiously to see what will happen next. This means that, as physicians, we need to build resilience into our practice and to continue to develop more sophisticated ways of working remotely. This will keep our doctors and patients safe, and equip us for future practice.

Managing COVID-19 from intensive care

Dr Sian Saha was working in the intensive care unit (ICU) in Wales when COVID-19 struck

I am a respiratory registrar working in Wales, and part of this training requires a period working in intensive care. It was either perfect timing, or the worst of luck, that my time in ICU correlated with the biggest pandemic in over 100 years.

The creeping virus initially felt like an absurd concept. I realised that the perceived threat was lower in Wales than elsewhere when I travelled to London and saw commuters in masks. This happened to coincide with Wales having its first confirmed case.

Rapid mitigation plans, specialty guidance, emergency rotas and capacity expansion occurred nationwide. Conversely, both A&E and acute medical admissions experienced a disconcerting lull. There was an uncomfortable anticipation of the inevitable and, during the quietest periods, the sentiment of "it just needs to happen now" was common.

Over the coming weeks I gained rapid familiarity with recognising phenotypic patterns in presentation and clinical course of COVID-19. I have also been struck by difficulties in delivering non-COVID urgent care due to the safety precautions in place. A few particularly emotive cases will be forever etched in my memory, as will the phone conversations with their relatives.

With this all-consuming new world, I ignored the 'shielding letter' I received. I am on immunosuppressive anti-TNF treatment, but have been well for so long that I had chosen to disregard this risk, as I felt it didn't apply to me. Eventually, I took the advice to refrain from direct patient contact. I was frustrated by my inability to contribute to my specialty in the usual way. I frantically searched for ways to help.

A first foray into telemedicine

And thus began my experience with telemedicine. Telephone clinics are an excellent way to ensure our outpatients remain well and lower the risk of neglecting serious or worsening pathology. It ensures that our patients, many of whom are both clinically vulnerable and socially isolated, realise that we are continuing to support them. I have been humbled by the gratitude expressed by many I have contacted.

There are a few obvious pitfalls, namely the inability to assess the accuracy of symptoms where clinical assessment would be useful. People often attend clinic with members of their support network, who can provide valuable information and be important in the communication process. I have felt that some patients would benefit from this, but as and when distancing rules ease, hopefully this won't continue to be a barrier.

Tele-clinics are much more efficient in terms of patients-per-clinic and ability to discharge appropriately. I can send blood forms and sputum pots by post, request radiology, organise medication changes and re-contact them with the results. Patients seem to like the convenience and, in reality, the only times I have brought anyone back for a face-to-face consultation is for communication purposes rather than for a physical examination. One 'lockdown specific' barrier to efficiency is that some isolated individuals are clearly lonely, and grateful for the opportunity to connect. I have found that in these cases, I no longer have access to the usual non-verbal cues to signal the end of the consultation.

COVID-19 has already transformed the way we think about viral pneumonias. As I'm writing this, evidence has emerged that COVID-19 is airborne, rather than the previous consensus of droplet carried. This led to a complete pause on lung function testing, a test integral to our diagnostics, monitoring and prescribing. Certainly for my specialty, the future of how we work is likely to be dramatically changed. Reconciling that this uncertainty will be present for the foreseeable future is paramount, and we need to continue to be adaptive and open to new ways of working.

> *It was made worse by the barriers to good communication from PPE, and the banning of relatives from the wards.*

Swift government action in Malaysia

Dr Myelone Tharmaseelan looks back at the course of the pandemic in Malaysia

When the first news of an outbreak in Wuhan was reported at the end of last year, little did I realise the magnitude of events that were to unfold in the coming months. The Malaysian government, using its past experience of handling the Nipah and Mersocov virus outbreaks, had stepped up preparations very early on.

Malaysia had very few reported cases in the initial stages. As the numbers were low, people were still going about their business normally until the emergence of a large cluster from a gathering of 15,000 people attending religious prayers. Alarm bells were soon ringing as some of the participants were showing symptoms of COVID-19. As the emergence of this cluster was identified, many people who had attended the gathering started to panic.

Our healthcare facility started seeing a huge rise in numbers of patients coming to check on their symptoms. Meanwhile, the number of cases abroad had started climbing too. Initially, restrictions were placed on those returning from high risk countries, most notably South Korea, Japan, Italy and Iran, and they were sent to the nearest healthcare clinic for testing. As days went by, more countries were added to the list and we simply did not have the resources and capabilities to test everyone.

Fortunately, the government acted swiftly, imposing a lockdown with the aim of flattening the curve and avoiding overcrowding at healthcare facilities. They set up online portals where people could assess their own risk and whether testing was required. They had a private–public partnership in place in the event the public hospitals were unable to cope with the overwhelming demand. Many other government agencies like the military, police, the national disaster agency and the volunteer corps complemented the Health Ministry, to streamline the response. Many other non-government organisations played their part by donating PPE, masks, thermometers and much more to support those on the frontline. In short, the unity and solidarity made us much stronger in our battle against COVID-19.

The pandemic has brought about new norms that most of us are still coming to grips with. In our clinical setting, all patients prior to entering the clinic will be asked a series of questions, have their temperature taken and are triaged accordingly. Patients with upper respiratory tract infections or any SARI symptoms are treated in a separate section. The clinic also has a separate section for patients taking their COVID-19 swab, which is aimed at mitigating the risk of transmission. Even in the clinic, social distancing measures are in place where patients have to sit at a distance from the doctor. The 'new normal' has served as a catalyst to speed up our adoption of technology. To ensure no overcrowding the clinic has adopted a new queue management system that allows patients to choose their slots. Our clinic has also started remote consultations for our patients. These initiatives enhance the patient experience by improving flexibility, transparency and accessibility.

As a primary healthcare physician, I am ecstatic that I was able to play my part for the betterment of the community. As the world patiently waits for the release of a vaccine, everyone should continue to play their part as we are all in this together.

How Barbados tackled COVID-19: the early days

Dr Brian Charles, emergency physician based in Barbados, looks at local preparations in the Caribbean

As COVID-19 spread to become a pandemic, many countries watched with bated breath and calculated the possible implications of this disease. Having an economy that is at least 75% reliant on tourism, Barbados started many plans to manage this eventual spread of the disease to our shores.

From as early as February, the government created committees of experts from health (public- and hospital-based), tourism, foreign affairs, the social partners and NGOs to start formulating protocols for management in a stepwise fashion coincident with the levels of local transmission. Resources for PCR testing and contact tracing were enhanced and by March, the public health teams were well trained and prepared for any eventuality. From early on it was decided that the only way to control the infection was to prevent its importation. Barbados instituted tight controls of its borders from mid-March, and after the first two positive cases at the end of March, the island was placed in full lockdown mode for 15 weeks. This approach limited community spread.

At huge expense, the government also ramped up its local capability for handling this infectious disease crisis. A purpose-built COVID-19 management facility was built in the north of the island by retrofitting and renovating an old military base. This facility was completed in seven weeks to house 38 ICU beds with ventilatory capacity, 30 high dependency beds, 150 well COVID-19 positive beds (quarantine) and all support facilities, including sampling and testing. There are also two other government quarantine centres on the island, and several satellite testing facilities. The possibility of private hotel and villa quarantine accommodation has also been arranged for people not willing to be quarantined in public accommodation.

Initially, only symptomatic patients received PCR testing, but as contact tracing began to show no community spread, the program was expanded and anyone can now get a COVID-19 PCR test from the public lab free of charge, with results available in six to eight hours depending on volume and batch time.

Even with full mitigation efforts, there was a huge stigma associated with COVID-19. This was compounded by many horror stories on international news, fake news, hoaxes of cures and of course the reality of limited medical resources including that of PPE availability. Many medical facilities experienced great difficulty in acquiring PPE in the initial stages of the pandemic, mostly from limited availability from conventional sources but also huge increases in prices. Some items have recorded up to an 800% increase in cost. Thankfully, availability has improved but cost is still astronomical. Barbados has benefited from donations of PPE from several international agencies as well.

A massive public health education campaign has helped decrease the stigma of COVID-19. Healthcare workers and ancillary staff, who initially were reluctant to manage a suspect COVID-19 case, are now familiar with, and are using, up-to-date protocols for any suspected case. Because of this stigma and of uncertain quarantine and isolation practices, people with positive travel histories and symptoms suggestive of COVID-19 have been reluctant to volunteer this vital information. This made management of respiratory illness exceedingly difficult, with several cases being positive after exposing multiple layers of medical and paramedical staff. Consequently, some facilities have had to close temporarily, or curtail activities due to staff being quarantined following contact tracing.

Though medical and paramedical human resource is limited on the island, we have benefited from the rearrangement of medical and nursing staff to critical areas for infectious disease management. This local resource has been supplemented by over 100 infectious disease doctors and nurses from Cuba.

The economic fallout of COVID-19 has been tremendous. Many people have been furloughed and jobs lost, and people are unable to afford private medical care. Private medical practices have been shut or hours reduced due to markedly lower attendances. Another reason for this is that patients with respiratory illnesses were initially discouraged from attending medical surgeries.

One hopes that with rigorous testing, physical distancing, contact tracing, adequate hygiene and appropriate management of positive cases that the impact of COVID-19 will be minimal.

My personal COVID-19 survival guide

Dr Peter Haug, neurologist in Cape Town, South Africa, recounts his own hospitalisation after contracting COVID-19

So much has been written about COVID-19, inevitably causing information fatigue. Still, I spent time in hospital after having been affected myself. I developed pneumonia, needed additional oxygen but fortunately did not develop a shock lung or require ventilation. I'm a medical doctor with almost 30 years of experience since qualifying. Amongst others I am a fully trained specialist physician. Via electronic media I potentially have instantaneous access to the pinnacle of medical knowledge 24/7: knowledge is power, and some idea whether or not there is danger or not can alternatively be comforting, or frightening. Still, going through the experience of being a patient myself for the first time in my life gave me insights that I could not have learned through any form of academic study.

After having had almost no symptoms for the first day after testing positive, my personal COVID-19 journey started with a very sudden and complete loss of the ability to smell anything. This happened over the period of less than one hour, in absence of any symptoms of nasal congestion or any respiratory symptoms. The sense of my tongue for basic perception of sweet, sour, salty or bitter tastes was not affected. This seems to be a very common manifestation of COVID-19.

From imaging/brain MRI studies we today know that this loss of smell sensation is possibly caused by direct invasion of the brain by the coronavirus (encephalitis), causing inflammation of brain structures such as the olfactory bulbs. This is frightening because we do not yet know whether this causes long-term consequences, such as potentially an increased susceptibility to developing neurodegenerative diseases. The return of smell sensation can be delayed and gradual. During the recovery process the sense of smell and taste is frequently distorted. When my sense of smell started to return any form of complex odours emitted by food evoked an extremely unpleasant sensation reminiscent of having to eat cold, greasy and burnt bacon and egg leftovers. Trying to eat any cooked food was nauseating and near impossible. My personal experience was that it was easier to eat food that had a clear taste, but little odour. This included apples, raw carrots, plain lettuce leaves and raw almonds.

Suffering from COVID-19 symptoms and having to be admitted to hospital was traumatic. During the first days of strict self-isolation I frequently felt lonely. Time passes very slowly, particularly when constantly feeling unwell. This can be inevitable at home, even with the most caring of families, as contacts needed to be reduced to an absolute minimum, preferably communicating through closed doors. This did not improve after admission to hospital. Being a medical practitioner and staff member probably contributed to me obtaining the dubious privilege of having a single room.

I insisted on going home after not having had a documented elevated temperature for 24 hours, but subsequently had to return to hospital only a few hours later with hypoxia and heart rhythm abnormalities. It almost felt as a relief when I was admitted to the ICU for cardiac monitoring, as just the background sound of a busy ICU appeared comforting, breaking the loneliness. Simple caring gestures of individual nursing staff members, and the calm compassion of the colleague who treated me, will probably remain etched in my brain for the rest of my time.

In the end all went well. My COVID-19 manifestations can in retrospect be classified as only moderate and I expect to make a full recovery. Still, this good outcome was only made possible by the concerted effort of many individuals, organisations and society as a whole. In a different environment the outcome of my simple viral infection could have been different. How a society manages its healthcare resources has a direct impact on hard fatality rates, as comparing statistics from the United States, Latin America, various European countries and conflict areas indicate.

I praise the measured actions of South Africa's government. The immediate hard lockdown helped buy time to continuously improve testing strategies and treatment algorithms. I felt that the government tried to listen and implement scientific advice, avoiding populistic self-promoting statements for political gain which are so prevalent in other countries on this globe. I feel that the government communicated very well concerning public awareness about the impact of COVID-19, and implemented well-measured instructions concerning protocols to return to work, including how and when to seek help.

The crisis is still unfolding and deepening. Public healthcare facilities in the Western Cape were overflowing, part of the reason being that many patients need to be kept quarantined due to an inability to safely self-isolate at home. The private sector only shortly trails behind. On arrival, my hospital had almost been filled to capacity with confirmed COVID-19 positive patients, in spite of the hospital having already drastically reduced avoidable and elective surgical admissions, with all the implications on the income of other specialists. The allocation of intensive care beds and ventilator usage needed to be judiciously monitored.

Still, there was no impression of hysteria. Staff members appeared well-trained and disciplined, performing their allocated duties. This culture of discipline, adhering to agreed protocols at the same time as constantly striving to fine-tune and adapt more effective solutions for the benefit of individual patients and society as a whole, will undoubtedly go great lengths in mitigating the devastating effects of this crisis, across all spheres of society. It is my perception that South Africa has so far managed extremely well compared to other countries of the world, and in this spirit will continue to do so.

UK: the rise of virtual clinics

Dr Meenakshi Nayar, consultant in rehabilitation medicine, looks at the role of technology in supporting healthcare delivery in the UK

In a normal environment, patients are admitted to our ward for rehabilitation following brain or spinal cord injuries. Upon the outbreak of coronavirus, however, there was a drive to discharge our patients to limit their chances of exposure and free up resources to deal with the increasing number of COVID-19 cases. This meant that a lot of work was done by the multidisciplinary team (MDT) in conjunction with social workers to ensure that patients were discharged to a suitable environment quickly and safely.

During the height of the pandemic, our ward provided acute medical services to help with the overflow of patients from other parts of the hospital. This meant that I went back to doing acute medicine after not having done it for several years. Although it was very strange for everyone, I have to say there was great camaraderie between all the teams who were involved. For example, a lot of cross-covering took place to ensure that enough doctors were present on the front line. In addition to this, many members of our MDT were redeployed, with several colleagues posted to the intensive care unit.

As I'm sure was also the case across the UK, many of our staff had either contracted COVID-19 or lived with people who had COVID-like symptoms. This meant that the affected staff members were unable to work and had to self-isolate for 14 days. So significant were the infections (and possible infections) that, at their peak, around 60% of our staff had to be off at the same time. From a personal perspective, I was greatly concerned for the health of our staff and for their family members. I was also incredibly inspired to see how the team carried on, stayed optimistic and worked together in these difficult times.

At the beginning of the outbreak, protective measures were introduced such as not permitting visitors into the hospital. I found this tough for a number of reasons. Firstly, 'breaking bad news' over the telephone was very distant to the face-to-face meetings I usually had. Secondly, it was heartbreaking to see patients who were very ill unable to receive visits from their loved ones. Using hospital iPads did, however, allow us to call families so that patients could see their relatives' faces. Many remote therapy sessions were also conducted by iPad too.

All outpatient services were also halted during the outbreak. This meant that the patients who I would normally see for spasticity and pain interventions were not able to come to the hospital to receive treatment.

My biggest learning point from COVID-19 has been the use of virtual clinics. The downsides to such clinics are that interventions cannot be carried out virtually and I miss the in-person interaction with patients. The positive, however, is a lot of time can be saved for the patients by not having to travel to and from the clinic. As a service, we have also started doing our weekly MDT meeting and the community ward round on a virtual platform. The increased use of virtual meetings has meant that digital collaboration is increasing and a lot more online teaching is happening. In the long run, I hope this use of technology will mean patients get more streamlined and flexible care with easier access to specialists.

Primary care in New Zealand: a perspective

Dr Kiyomi Kitagawa, GP at Carefirst Medical Centre, Taranaki, reflects on the response of the New Zealand government and looks at the potential silver linings for the future delivery of healthcare

It was summer (January 2020) in New Zealand and I feel like I spent it glued to my phone instead of out in the sunshine with my family, while I anxiously watched COVID-19 roll to our little island nation of Aotearoa.

I remember so much uncertainty, anxiety and fear waiting for our government to respond, not knowing what approach they would take. Would they react too late? Would we be the next Italy and face an unimaginable, uncontrollable outbreak that would cost lives and leave scars on us all? I felt such relief at the announcement of Level 4 Lockdown that I cried. Our country was going to put protecting its people first. Maybe we stood a chance at avoiding the mass deaths and having to ration healthcare, something so heart wrenching to watch our counterparts grapple with overseas. Maybe I wouldn't get COVID-19 or bring it home to my young family, or spread it to my elderly patients and watch others suffer because I had become a vector. I became a high risk person to be around. Such an isolating feeling, which I'm sure so many of us felt as healthcare workers through the pandemic.

Our practice changed overnight. I mean, literally in the span of one Sunday we completely changed the way we deliver primary care. We had been given a very welcome forewarning from our college that the government was about to take action and that general practice should start preparing. So we did. We rallied together with astounding agility, adaptability, innovation and resilience.

We kept ourselves focused on a few simple goals:

1. **Keep our patients safe.**
2. **Keep our staff and ourselves safe.**
3. **Continue to provide primary care, just in a different way.**
4. **Keep our business afloat and staff employed.**

The doors were closed but the lights were on and we were busy. Busy trying to keep our vulnerable patients at home and safe. Busy trying to keep those with chronic conditions well managed. Busy trying to keep this virus from breaching our front doors. All while trying to keep the business afloat; pay our bills, keep staff employed and ensure we would be there to continue to provide primary care when this was over.

We adopted overdue changes to the system and embraced what IT had to offer, such as e-scripts and virtual consults. We ran our seasonal flu vaccine clinics as a drive-thru in the carpark. Staff loved it and our patients loved it even more. We saw the vast majority of our patients through virtual consults; most days only 10-20% of patients were being seen in person on site. We screened all patients for symptoms or risk of COVID-19 and they were either managed virtually or in a tent in the car park for assessment and swabbing, or referred to dedicated testing sites. We kept those with infectious symptoms separate from the well and from now on it will no longer be acceptable to sit in a petri dish waiting room at your doctor's office. Another little positive we will hold on to going forwards.

We swabbed a lot in the early days and thankfully we only had a small few positive cases for our region. While we avoided mass outbreaks, hospitalisations and deaths in NZ, there have been some obvious negative impacts on our patients and ourselves. I worry about the delayed diagnoses we're still to see the impact from, the mental and psychological impact and the likelihood that it will widen inequalities for Māori, Pacific Islanders and those with low socioeconomic status. I worry about the mental toll it has taken on the health profession here and around the world.

I hear people talk about getting back to 'business as usual', but I don't think that exists anymore. The impact of this pandemic will be with us from now on and, for me, the positives in New Zealand primary care are many and I will endeavour to embrace the positives. COVID-19 united us in a common goal, with our colleagues here and abroad. It pulled us together collectively to keep our patients, our community and ourselves safe. We have built stronger relationships with our patients and our community.

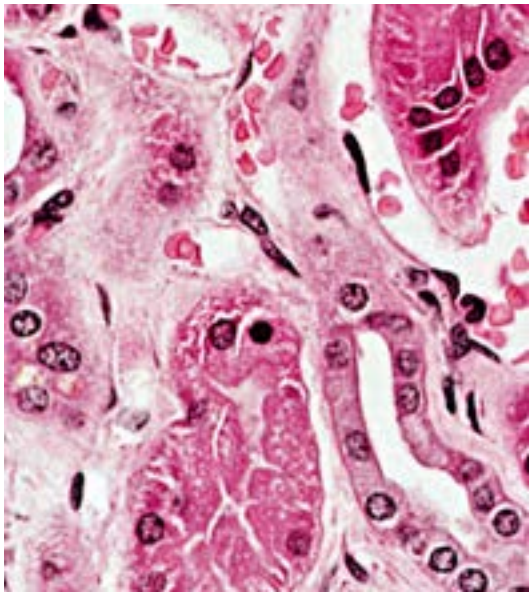
Like so many of us do with our patients in primary care everyday, I want to bring the focus back to the silver linings; the opportunities to regenerate our approach to providing primary care and encourage positive changes going forward. And most of all continue to put our patients at the centre of what we do.

I am incredibly proud of our little island nation, my colleagues here and around the world and our communities for all the kindness, compassion, collegiality and resilience I have witnessed.

Kia kaha.

Delayed diagnosis of renal disease leads to claim

*By Dr Sophie **Haroon**,*
Medicolegal Consultant, Medical Protection



Mrs Z was 30 years old; unbeknown to her, she had congenital kidney disease. When she registered with a local GP practice she had a new patient check. Her blood pressure (BP) was found to be normal but she had significant protein in her urine. She was advised to have this repeated in a couple of weeks but never did.

At a subsequent consult with Dr A, no observation of BP and proteinuria was made. At a second consult with Dr A, Mrs Z's BP was noted to be slightly up but the previous proteinuria went unnoticed. She saw Dr A a third time that year and a raised BP was again recorded. This time the previous proteinuria was seen and Mrs Z was advised to have this repeated. She never did and this was not picked up. Mrs Z had no further investigations at this time.

Two years later, Mrs Z saw Dr B for a contraceptive pill check. Her BP was raised and her previous proteinuria was picked up. She was again told to have repeat urinalysis but again this never materialised. She saw Dr B a further three times that year and Dr A one more time. On each occasion her BP was raised. Dr A considered 24-hour BP monitoring but this was not arranged further. Mrs Z had no further investigations at this time.

Five years after her new patient check, Mrs Z had some blood tests done. Her eGFR was found to be 76. Later that same year she became pregnant. The local hospital took over her antenatal care due to persistent raised BP and proteinuria. At one point during her antenatal care, she saw a nephrologist who ordered further blood tests, 24-hour BP monitoring, formal urine protein/creatinine testing and an ultrasound. The latter revealed a crossed fused ectopia of the kidneys, effectively forming a single kidney.

Mrs Z had her baby without event and was discharged. There was no follow up arranged nor any communication given to her or her GP about the results of the investigations they had done.

The year after Mrs Z had delivered, she had several BP checks at a new GP practice. These consistently showed borderline or raised BPs. She voiced her concerns to Dr D who noted the same and ordered some blood tests. Her eGFR was found to have fallen to 52 and was filed with no action.

When Mrs Z's child was nearly two, she saw Dr E complaining of low mood and tiredness. Her BP was 177/118. Blood tests were ordered and the plan was to either do home BP monitoring or start an anti-hypertensive. Tests showed Mrs Z's eGFR to have fallen very slightly again, to 50. Dr E filed these with no action.

Mrs Z continued to present to her GP practice the following year. Further renal function tests showed her creatinine to be raised at 131 and her eGFR had fallen to 42. Dr D marked these as abnormal and for repeat in three months. When this happened, her creatinine was 147 and her eGFR was 37. Mrs Z was out of the country when the results came back but Dr D marked them as abnormal and to be discussed with the patient on her return.

This did occur, four months later, when again the creatinine had risen, now at 161, and the eGFR had fallen, now at 33. Dr D marked them for repeat in three months. Mrs Z circumvented this, however, and saw Dr E. He noted variable but often raised BP over several years, Mrs Z's lack of compliance with any suggested home BP monitoring, and deteriorating renal function plus proteinuria. A referral to nephrology was made for stage 3 chronic kidney disease (CKD).

Nephrology confirmed Mrs Z's crossed fused ectopia of her kidneys and also found scars in the upper and mid poles. They started her on an angiotensin receptor blocker, which stabilised her eGFR at 32 and improved her BP control.

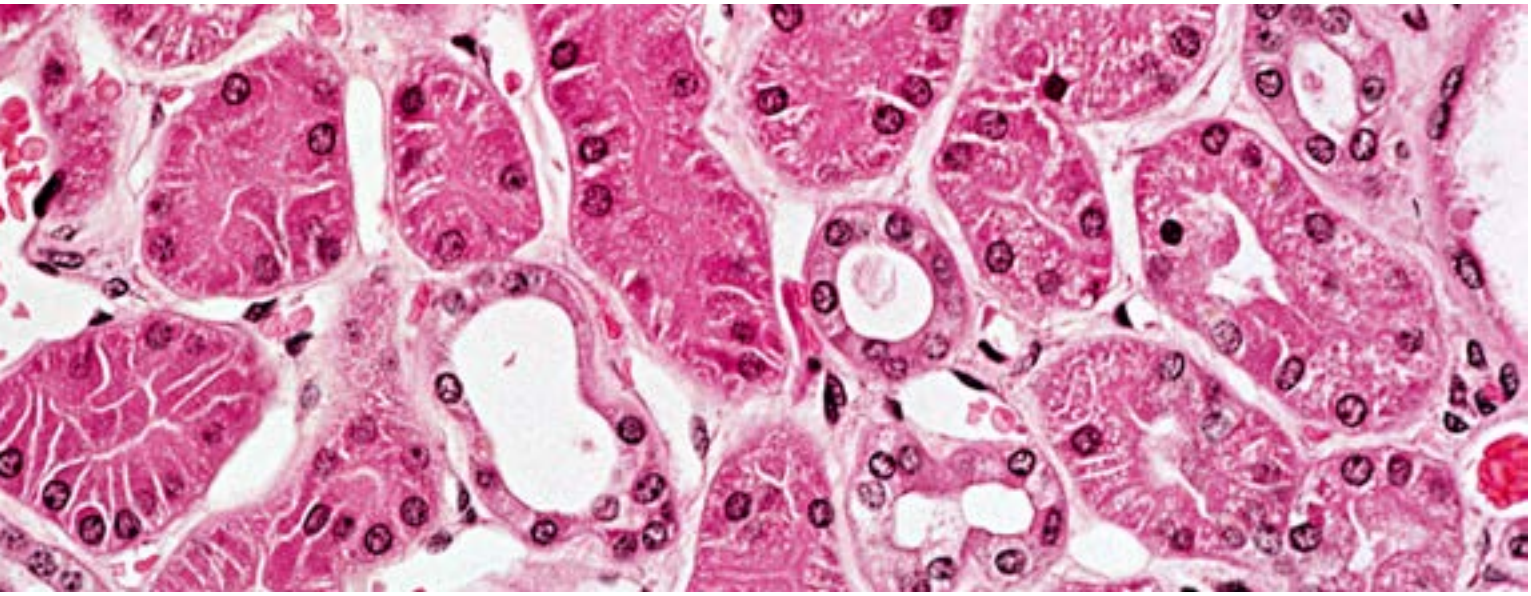
Mrs Z's condition subsequently progressed. Her latest eGFR was 19 and she was to have a kidney transplant from her mother when she reached an eGFR of 15. She had reduced her working hours due to fatigue.

Mrs Z makes a claim

Allegations of negligence were brought against the hospital who cared for Mrs Z in her pregnancy and also her GPs over a period of eight years. In respect of the hospital it was alleged there was failure to recognise her underlying renal condition and ensure there was postnatal follow up by a nephrologist.

Regarding the GPs, it was alleged that there were several missed opportunities to note and act on Mrs Z's proteinuria, hypertension and declining renal function, especially in someone as young as she was, and a failure to refer to nephrology earlier.

Mrs Z's solicitors went on to plead that if she had been started on antihypertensives then the onset of her renal disease, including her predicted end stage renal failure (ESRF), could have been delayed by up to 20 years. They accepted that ESRF was inevitable but contended that the defendants' negligence had accelerated the progression of the disease and advanced the predicted onset of it. Their expert went on to predict when Mrs Z might need a renal transplant or, if not available or not successful, when lifelong dialysis might be required.



How Medical Protection assisted

Several GPs were involved in Mrs Z's care. Only one was a member of Medical Protection and expert GP evidence was sought. Whilst not critical of the GPs' initial care at the start of Mrs Z's presentation, concern was raised about subsequent care and failure to manage Mrs Z's BP over a prolonged period of time, act more aggressively on the deteriorating renal function, and not repeat the urinalysis for protein. Additionally, a referral to nephrology was deemed mandatory from any time point after Mrs Z had had her baby. Relying on the NICE guidance for hypertension and CKD at the material time, the expert deemed there were serial failures by the GPs to reflect the practice contained therein and that this amounted to a breach of duty for them.

Turning to causation, again expert evidence was sought by Medical Protection, and by each of the other defence organisations involved, from various consultant nephrologists. The expert for Medical Protection confirmed that while Mrs Z's underlying renal disease was not amenable to a cure, there had been the missed opportunity of slowing progression to ESRF, that she had not benefited from careful BP control, and that eventual deterioration to ESRF and renal replacement therapy (RRT) was certain.

However, the real crux of this case lay in how much the decline could have been slowed by earlier treatment, and how much ESRF could have been put off – likewise dialysis or time to transplant. Overall, the various experts were less optimistic than that of Mrs Z. Various predictions and models were proposed, all accepting that there was some difficulty inherent in the postulations due to lack of renal results from the very start of Mrs Z's story. However, figures consistently reducing those of Mrs Z were deemed, on balance, to be more likely.

Consequently, while all parties accepted their respective breach allegations, the extent of Mrs Z's causation argument was contested. It was also noted that Mrs Z's pregnancy had, in itself, accelerated the decline in her renal function, and that on several occasions she had showed non-compliance with medical instruction in terms of monitoring her BP at home, having blood tests or undertaking urine sampling.

Various damages for Mrs Z's case were considered by her solicitors. These would have covered matters like pain, suffering and loss of amenity, loss of earnings, expenses, care support, travel, future losses, future therapies and reduced life expectancy. The initial schedule of loss was significant. This did not include the solicitor's costs.

This was a case to be settled given the breach of duty and that this led to causation. However, Mrs Z's expert and the defendants' experts disagreed on the extent of that causation and this in turn had an impact on the likely damages to be paid to Mrs Z. Taking this into account, a counter-offer on behalf of all defendants was made, which was substantially less than what Mrs Z's solicitors proposed.

Arguments to reduce Mrs Z's damages were that her lack of compliance with previous medical instructions was such that she would have done the same if investigations had been offered to her, that she had yet to prove she would have been compliant with treatment if offered to her earlier, and that ESRF had only been accelerated by approximately five years due to the delay – much less than that proposed by Mrs Z's solicitors.

Outcome

This was accepted by Mrs Z's solicitors. The defendants' expert evidence was overwhelmingly consistent in their conclusion. Medical Protection settled the case for a small share of a moderate sum, which was substantially less than what Mrs Z's legal team had put forward.

Learning points

Experts will turn to the guidance for the material time of the claim to substantiate their conclusions on allegations. Being compliant with guidance, such as by NICE, is important but if it is deviated from, you must be able to reasonably justify why.

Sometimes experts lack definitive guidance and need to rely on previous research, models and predictions. These can draw different conclusions. Where there is parity of evidence, more strength can be weighed on those conclusions. Different defendants can work together where their evidence is similar, to mitigate the similar losses they face. It is also important that all parties have access to good balanced experts whose knowledge is up-to-date.

The damages proposed by claimants can seem exorbitant. However, there is often a realistic prospect of mounting a counter-offer and efforts to do this should be attempted (even if this incurs some costs) as it can save so much more in the long run.

Contributory negligence cannot form a complete defence but is a useful tool in an argument to reduce damages.

For more on this topic, see "Non-compliant patient sues doctor: whose fault is it?" by Dr Dawn McGuire, on our website at ***https://www.medicalprotection.org/uk/articles/non-compliant-patient-sues-doctor-whose-fault-is-it***

Partnership dispute leads to disciplinary investigation

*By Dr Kirsa **Morganti**, Medicolegal Consultant, Medical Protection*

GP Dr X contacted Medical Protection after receiving a telephone call from the Performance Management Team at NHS England, advising her that she had been suspended from the Performer's List and was required to stop working immediately. This was an unexpected call but with the background of an acrimonious partnership dispute.

It transpired her partner had collated information regarding what he considered deficient clinical performance and had submitted this to NHSE. Unfortunately the number of alleged concerns, spanning a range of topics including poor record keeping, unsafe prescribing and inadequate management of chronic diseases, raised sufficient patient safety concerns that NHSE had decided the most appropriate course of action was immediate suspension of Dr X until the concerns could be properly investigated. This was naturally extremely upsetting to Dr X, who was seeking advice on how to challenge the suspension. She had received correspondence by email after the call from NHSE, which had advised her of her right to request an oral hearing to have the suspension reviewed, which she opted for.

How Medical Protection assisted

Dr X was allocated an experienced medicolegal consultant (MLC) at Medical Protection. Due to the extremely distressing events and the perceived urgency of the situation, Dr X had a lengthy telephone conversation with her MLC to discuss her situation. The MLC explained to Dr X the legal basis on which NHSE had taken this action and the prospect of success from an oral hearing to immediately challenge the suspension decision. Such a decision is rarely reversed unless there is a clear indication that the concerns are unjustified, for example the doctor's identity having been mistaken.

Dr X conceded that due to the stress of her current partnership situation there was a possibility that her clinical performance may have been adversely impacted. She had also, unfortunately, received several recent patient complaints, lending some credibility to the allegations. There was limited information available regarding the concerns at that time, preventing a detailed analysis of the relevant patient records that may have provided supportive information for Dr X to present. However, Dr X agreed that it was extremely unlikely that she would be able to refute all of the allegations being considered.

It was explained to Dr X that although the suspension may appear deeply punitive, it was in fact a financially supportive action that had been taken by NHSE. Under the legislation, a doctor is entitled to suspension payments from NHSE to ensure they are not financially disadvantaged by a suspension. A risk to challenging a suspension decision includes NHSE amending the suspension to conditions attached to the doctor's inclusion on the Performer's List. Such conditions, which may include direct supervision of the doctor's work, may in effect prevent any work as a GP, with no financial protection afforded.

It was clear to the MLC, also a qualified doctor, that Dr X herself was unwell and this was explored sensitively during the call. Dr X was signposted to suitable support including contact with her GP and the Practitioner Health Programme. The MLC offered to correspond with NHSE on Dr X's behalf regarding both the suspension and arrangements for her to receive suspension payments, removing that additional stress from Dr X so she could focus on receiving help for her health prior to engaging in a disciplinary process with NHSE. Dr X was also signposted to contact her local LMC to seek their assistance with her partnership difficulties.

Outcome

Dr X remained suspended for a number of months. During this time, she received treatment for her health, leading to a full recovery that enabled her to carefully review all the concerns that had been raised regarding her performance. NHSE provided details of the patient records that required her review prior to her providing a detailed response on the concerns that had been raised. Dr X worked closely with her MLC to provide a detailed response that demonstrated the insight and learning that she had achieved since the concerns had been first raised. Dr X also attended an interview with the NHSE clinical adviser for her case, accompanied by her MLC. Following this, her response was amended to ensure it included sufficient detail regarding all of the topics raised as being of particular concern to NHSE by the clinical adviser.

Dr X's case was reviewed by the Performer's List Decision Panel after receipt of her submission in relation to the concerns. It was recognised by NHSE that the concerns were raised in the context of a difficult partnership relationship and attention was focused on the clinical concerns that NHSE had been able to substantiate from the medical records. Dr X had demonstrated appropriate insight into those clinical failings and, with the support of her MLC, had completed relevant and applicable CPD to remediate.

By this point, Dr X's health was such that she was anxious to return to work. Her partnership issues had improved after mediation, with Dr X recognising that her poor health leading up to the suspension decision had created a vicious cycle of poor decision making on her part which had increased the stress and workload upon her partner, resulting in a further deterioration in their relationship.

After reviewing Dr X's submission, NHSE were agreeable to lifting the suspension, enabling Dr X to return to work under conditions that included supervision. This required her to meet with an approved GP colleague once a fortnight to have case-based discussions. The supervisor also submitted supervision reports regarding Dr X until such time NHSE were reassured she was safe to practise without ongoing conditions.

Almost 18 months after the initial telephone call suspending her, Dr X had all conditions lifted and was able to resume practice as an independent GP.

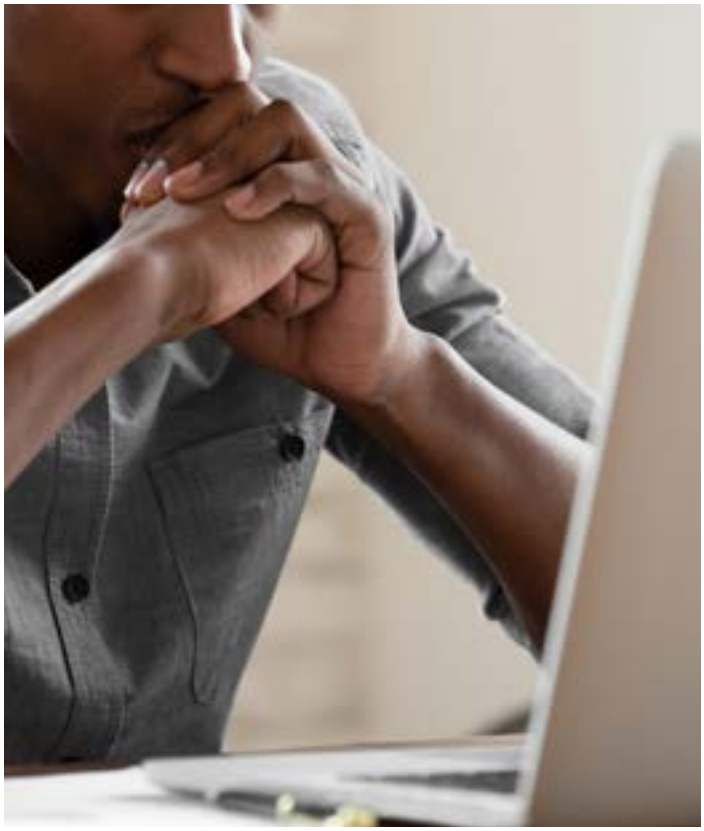
Learning points and discussion

The initial reaction to news of a suspension is understandably to challenge this. However, doctors have a professional obligation to ensure their clinical performance is maintained at a satisfactory level and not adversely affected by their health. Immediate contact with Medical Protection ensured Dr X did not harm her position further by seeking to object to the suspension, demonstrating a lack of insight into her clinical deficiencies. Her close contact with her MLC ensured she was supported throughout a difficult disciplinary process to achieve a satisfactory conclusion and appropriately signposted to assistance for her health and partnership difficulties.

This case occurred before the COVID-19 pandemic. In line with restrictions around the world, Medical Protection teams are not currently able to provide face-to-face assistance to members in person, as demonstrated in this case, but we are committed to continuing the same levels of support and reassurance via virtual means. Many members have already commented positively on this approach, which has saved on the time and disruption caused by lengthy travel.

Managing unwelcome attention from a patient

By Kate **Cowan**, *Case Manager, Medical Protection*



A female patient, Miss Y, who had a past history of mental health issues, had asked GP Dr C to become friends outside their normal doctor–patient relationship. She had also informed Dr C that she had followed him on Facebook, and she also gave him copies of her diary, which had inappropriate comments regarding her feelings towards Dr C.

Dr C explained to Miss Y that their relationship could only be that of a doctor–patient relationship and if she felt she couldn't consult with them in this capacity only, it may be more appropriate for her to see a different GP at the surgery. Miss Y was very upset by this and, as she had previously had thoughts of suicide, Dr C arranged to see her again and requested advice from Medical Protection on how to proceed if this behaviour continued.

How Medical Protection assisted

A Medical Protection case manager handled Dr C's query and began by running through the official local guidance on maintaining professional boundaries between doctors and patients. As Miss Y had a past history of mental health issues, the case manager asked if she was currently under the care of the mental health team. She also explained that if Miss Y continued with the behaviour, a professional boundary should be established and, if needs would be better met by referral to a GP colleague or the community mental health team, then this should be arranged.

The copy of Miss Y's diary should only be documented in the medical records if Dr C felt it was an example of the patient's mental health illness, as this would be a justifiable reason to record the details. The case manager suggested that Dr C could also request consent to share the document with the mental health team – if they were involved – as this could be an insight into Miss Y's current thoughts and feelings. If Dr C did not think it was justifiable to keep the diary entries in the notes, then he needed to ask Miss Y whether she wanted the document back or if it could be destroyed.

Dr C was also advised to update his security settings on his Facebook account and to get back in touch if the matter escalated. Some time later, Dr C did get back in touch with Medical Protection to say that Miss Y had sent him a Valentine's card. He was by now very keen to end the doctor–patient relationship and had drafted a letter to Miss Y to explain this, adding that a different GP at the practice would now be taking over her care – although if he was the only GP at the practice and it was an emergency situation, he would still see Miss Y. The Medical Protection case manager reviewed the letter for tone and content before it was sent to Miss Y.

Unfortunately, Miss Y then sent a complaint to the regulator and numerous letters to the practice. The practice and Dr C were feeling harassed by Miss Y and this was starting to cause anxiety. We assisted Dr C in preparing a response to the complaint, which was sent to the regulator, and we then asked Dr C to send us all the further documents sent by Miss Y so we could advise on next steps.

The regulator suggested a meeting between their complaints officer, the practice manager and all the GPs at the practice to discuss the matter further, which Dr C agreed to attend. We advised Dr C to attend so he could explain the impact the issue was having on him and the practice. He took with him the documents previously received by Miss Y to illustrate the issue.

Outcome

Miss Y was removed from the practice list. Dr C received one more card from her but then nothing further.

Learning points and discussion

- **Dr C did have good security on his social media accounts, but this case is a reminder that social media accounts should be kept private.**
- **If a patient develops an emotional attachment, explore the reasons behind this and discuss with the patient professional doctor–patient relationship boundaries. In this case, Dr C had done this impeccably but sometimes a patient can carry on with an emotional attachment and then further steps need to be taken.**
- **It is important to share concerns about patients crossing boundaries with colleagues rather than keeping this information to yourself. Should things turn sour, it can be helpful to have the history of the issues documented with colleagues.**

Alleged failure to investigate chest pain

*By Dr Sophie **Haroon**, Medicolegal Consultant, Medical Protection*

Mr O was a 55-year-old, self-employed man who smoked ten cigarettes a day. He saw his GP, Dr H, complaining of "not feeling right" for one year. He had headaches, tingling in his throat, nausea, brief losses of vision and tiredness. On examination his eyes appeared normal, his BP was 142/95, his pulse was regular at 56, and there was no anaemia or jaundice. Blood tests were planned – which came back as normal – and Mr O was advised to see an optician.

Two weeks later Mr O saw another GP, Dr J. He was still getting intermittent headaches but there was no pattern to them. Cranial nerve examination was normal, as was his BP. He was again encouraged to see an optician as he had not yet done so, and "watchful waiting" was advised.

An optometrist reviewed Mr O the next day and found slightly raised intraocular pressures but not enough to cause symptoms and short sightedness.

Two weeks after seeing Dr J, Mr O returned to see him again. This time he complained that his original symptoms, as reported to Dr H, were becoming more frequent, lasting longer and that he was very fatigued by them. He thought he might have some possible indigestion. There were no exertional symptoms and he was well in between. Blood tests, ECG and COR were arranged and omeprazole was started, with a planned review in one month.

The practice managed to perform Mr O's ECG the next day. This showed a sinus bradycardia and an established inferior myocardial infarction (MI). An ambulance was called and he was admitted to hospital.

Cardiac intervention was attempted but it was not possible to open the thrombotically occluded right coronary artery so this had to be abandoned.

After the operation Mr O ended up back in hospital due to a post-MI inflammatory reaction. A cardiac multidisciplinary team meeting decided that percutaneous coronary intervention would be attempted if symptoms were significant. This was done five months after the first attempt – again with limited success.

By the end of the year, Mr O could not work due to his health, and was getting throat pain and sweating on minimal exertion. Further attempts at stent insertion also failed. Two years after the MI, Mr O claimed he had not made a full recovery, was unable to work and was still symptomatic.

The patient makes a claim

Mr O brought a claim against Dr H and Dr J. He alleged that there was a failure to undertake cardiac-related investigations when he first presented, review him again when the optometrist found no cause for his symptoms, consider a cardiac diagnosis, administer GTN and aspirin, and refer him to the local cardiology service or, particularly at the last consultation, refer him to hospital as an emergency.

It followed that because of these breaches in duty, his diagnosis of coronary artery disease was delayed, as was its management; if diagnosed earlier, intervention would have been successful and circumvented the eventual MI he had, and all the subsequent long-term symptoms and failed procedures he ended up with.

As the claim progressed, it came to light that Mr O alleged he had told Dr H that he had had chest pain and that he had told Dr J at his first consult that he was having "funny turns". Neither of these reports were noted in the records.

> *Initially it appeared this was a claim capable of being partially defended. However, there were some difficulties.*

How Medical Protection assisted

Medical Protection was contacted for assistance. We obtained expert GP evidence and this deemed that Dr H's actions were reasonable if it was accepted that Mr O had not mentioned chest pain at this consult and only the headaches and visual issues. The expert was more critical of Dr J in failing to act on the report of "funny turns" as although not recorded and possibly a factual dispute, on balance it was deemed more likely that Mr O had reported these symptoms, as the optometrist who subsequently saw Mr O recorded the same.

Expert cardiology evidence was also obtained. This concluded that Mr O's presenting symptoms were complex, unusual and certainly not typical of angina or any other manifestation of coronary artery disease. It was thought that Mr O had an unrecognised and incomplete inferior infarction caused by occlusion of the right coronary artery, most probably when he began to experience chest pains three or four months before he ever presented.

Furthermore, given that this was thought to be a chronic total occlusion, any treatment, even if before Mr O was admitted to hospital, would not have been successful and would not have made a difference to his outcome in terms of persistent angina and his other impairments. However, it was thought that Mr O had, on balance, had a second MI when he presented for the final time to his GP. This in itself could have been avoided with earlier referral and because of it, life expectancy was reduced by one to four years.

Outcome

Initially it appeared this was a claim capable of being partially defended. However, there were some difficulties. Firstly, Mr O claimed he had reported chest pain to his GPs on two occasions. This was his recollection but for the GPs they were having to rely on their memory of their consultations from many years ago. Unfortunately the contemporaneous records had been summarised when Mr O had changed practices and did not reflect what was documented at the material time so were not useful in substantiating what did or did not happen.

Secondly, GP experts for Dr H and Dr J both concluded no breach of duty for Dr H but only if chest pain was not complained of. If it was, then there was a breach. Causation could be defended to a certain extent, albeit there was the issue of reduced life expectancy and some minor pain, suffering and loss of amenity.

It was considered that if this proceeded to trial, there were risks for the GPs. On balance, Mr O's version of events would be more likely to be believed and could not be refuted comfortably for lack of clear recollection and records. There was then the issue of causation; most but not all could be refuted. In light of this, an offer to settle early was put to the solicitors. Unfortunately they refused.

There then followed a protracted course of events over a couple of years. Medical Protection collaborated with the other medical defence organisation involved, pooling resources and expertise in terms of the experts and panel solicitors used. This was a cost effective strategy. Various complications arose from Mr O's side, including problems with attending for a medical examination to assess Mr O's current condition and prognosis, disclosure of various other records, expert opinion changing, and questions arising over the fitness of Mr O to return to work.

The original claim for damages was a fairly low sum but rose through the life of the claim to something substantial. Given the weaknesses in the defence, success at a trial was not deemed likely. However, given the developments from Mr O's side, there was certainly room for manoeuvre on the damages claimed. Mediation was sought. This successfully brought the case to a conclusion with damages paid out being reduced by 80%, shared equally between the two defence organisations involved.

Learning points

From a strategic, cost effective, and time management perspective, pooling of experts and panel solicitor firms can be an efficient and effective use of resources when managing a claim.

Mediation is a form of alternative dispute resolution. It is much less formal (though it follows a structured process) and much less costly than going to court. The primary goal is for all parties to work out a solution they can live with and trust. In addition to being more cost beneficial, mediation is strictly confidential, increases the control parties have over resolution, and usually has high compliance with the agreement reached. Medical Protection uses mediation where possible when it is in the best interests of the member and the wider membership fund.

Care should be taken when summarising patient records if a patient decides to change practice. With paper records in particular, it is easy to lose granular details.

For more advice on good record-keeping, read our factsheets on the Medical Protection website, or alternatively log in to the e-learning platform PRISM.

Over to you

Surgical emphysema in the neck

I refer to the report of "Surgical Emphysema in the Neck" (which later spread to the face and chest) in *Casebook* May 2020.

Firstly I'd like to applaud the Medical Protection legal team for robustly defending this claim. Beyond saying that, I note that this complication of surgical emphysema was considered "rare and unexpected". Also this complication was accompanied by hoarseness and change in voice over the months, which affected the patient's participation in a choir group.

The patient had legal counsel and was advised by medical experts. I am wondering why the patient did not invoke the legal doctrine of "res ipsa loquitor" (let the thing speak for itself). [1]

Here the surgical emphysema, which was extensive, was considered to be "rare and unexpected", and this would have shifted the burden of proof of injury from the patient to the defendant. The accompanying change of voice of a few months would have raised the bar even further to denying liability on the part of the defendant.

This doctrine can only be invoked when the injury is totally under the control of the defendant. Moreover, the defendant will not be held liable if he can show he has exercised all reasonable care to prevent injury. [2]

Dr Lim Ee Koon, Anaesthetist, London

We always like to hear from our readers, particularly someone such as yourself who clearly has an interest in the area of medical law. You wondered why the argument of 'res ipsa loquitor' was not deployed by the claimant in this case. I am not sure this approach does apply here, as it would suggest that every case of surgical emphysema is negligently caused. In fact, our experts were of the opinion that this injury was not caused by a gross error of needling whilst administering an interscalene block, but rather was a recognised (albeit rare) and non-negligent complication of intubation. It is, of course, impossible to know what legal advice the patient actually received. We are quite sure that their expert evidence would not have stood up to logical analysis if the case had proceeded to trial. Thank you for the case references and your interest in this case.

1. (1) Scott v London and St Catherine Docks Co (1895)
2. (2) J v North Lincolnshire County Council (2000)

A risk of harm

I read this collection of cases, as ever, with interest.

"A risk of harm" showcases a common problem, specifically that of "please do NOT request one to one nursing" for any patient. This lack of resources for whatever reason tends to be a recurring theme for both NCHDs and consultants alike, across the specialties. Perhaps there should be a more robust take-home message to send to the hospital managers and directors of nursing when they advocate "please do not request one to one nursing " from Medical Protection.

I was often faced with this request on call at night for newly admitted vulnerable patients (and I am sure I am not alone) and it generally boils down to senior staff members pulling rank or asking another colleague to override such a request (in circumstances in which such staff members may not be part of the team looking after and responsible for the index patient). I suspect documenting such memos in patient clinical records may assist defending medicolegal cases without addressing and rectifying the root problem.

I would also echo the sentiments raised on page 18 by Peter McIntyre, that perhaps it might be more beneficial to highlight relevant clinical learning points (particularly elements of poor or excellent clinical practice) in addition to the medicolegal concerns flagged by Medical Protection cases in *Casebook*, which would serve as an extremely valuable teaching tool.

Dr Nicole Farrell

I think you identify a really important issue relating to the lack of resources compromising doctors' management of their patients. This issue has been particularly relevant during the current crisis and it may well be one we should discuss in more detail in the future. I concur with Peter McIntyre's comments and as a potential patient myself, would be more interested in the excellence of the care provided rather than the documentation of it.

Some advice for on calls

As always, I thoroughly enjoyed reading this frightening and enlightening journal and look forward to future editions.

On this note, I feel it would be highly beneficial for a case study and subsequent guidance concerning clinicians performing on calls from home, as may be the case for consultants and middle grades in surgical specialties like urology. I often fear that although my clinical recommendations given over the phone at 4am are sound, perhaps the ED doctor may not record my advice accurately or forget parts of a plan. Come the morning, perhaps I too will not accurately remember the case.

Similarly, when giving advice over the phone, it can be particularly difficult when the history and exam are insufficient to enable me to give the level of advice I normally would. I would be grateful for pointers to this effect. Perhaps it may be sufficiently interesting to be included in the next edition of *Casebook*?

Daniel Beder, Senior Clinical Fellow in Urology

Your comments about giving advice remotely are very apposite, particularly at the present time with more advice being given remotely than ever before. I am certain that we will pick up this theme in future articles.

Contacts

You can contact Medical Protection for assistance

Medicolegal advice

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Phone 0800 225 677

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mps@samedical.org

Calls to Membership Services may be recorded for monitoring and training purposes.

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

medicalprotection.org

Medical Protection

Who's looking out for you?

The COVID-19 pandemic has drastically changed the way you practise medicine, so our flexible protection is here to look out for you.

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