Casebook

Professional support and expert advice from your leading medicolegal journal

MPS

Putting members **first**

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On deadly ground

Explore the pitfalls of practice as we look at problems beyond claims

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www.mps.org.uk

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MPS

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Welcome

Dr Stephanie Bown – Editor-in-chief
MPS Director of Policy and Communications

There has been a lot of talk about the rising cost of clinical negligence: the increasing number of claims, and the increasing levels of awards. We also hear the rhetoric that the fear of litigation drives doctors to practise defensive medicine. But I hear members tell me that it is the dread of a complaint to the Medical Council, and the risk of a public hearing, trial by media and reputational damage that concern them much more than a claim.

That is not to disregard the stress of litigation – but, generally speaking, the fact that your indemnity arrangements will step in to meet the financial costs of a claim makes it a less personally traumatic experience than the sanctions you might face at, for example, the hands of your employer, regulator or even the police.

Although the cost of claims is far and away the largest call on members' funds at MPS, they only represent about 20% of the cases we handle worldwide – the rest are complaints, inquests, disciplinary cases and other medicolegal challenges to a member's professional practice. Our feature on page 6 illustrates just some of the wide-ranging problems that members contact us for advice on.

It is also possible for a single incident to take a member through a series of procedures. For example, a perinatal death might give rise to complaint, claim, inquiry, inquest, disciplinary and regulatory investigations. And doctors who rely solely on employers' indemnity have no entitlement to ask for assistance with anything other than the claim for compensation – so you might want to have a word in the ear of a colleague who could unwittingly be leaving themselves exposed to a range of sanctions.

Finally, I hope you enjoy reading the case reports – in this edition we share learning from both settled claims and also some very successful defences.

As always, I welcome your feedback – whether in response to content within *Casebook* or to share your own experiences.

Under the influence

MPS Medical Director *Dr Rob Hendry* reminds doctors of their unique opportunities to influence and inspire those working around them

Doctors are often surprised how influential they are within their teams and organisations. The things they do and say and the way they conduct themselves is increasingly being recognised as central to effective healthcare.

Most medical care is now delivered by teams rather than by individual healthcare professionals working in isolation. When teams work well the results can be spectacular, but when teams are dysfunctional, patient care can suffer. Stories in the press about "failing hospitals" are, in fact, often actually about failing teams.

Sadly at MPS we frequently see members getting into difficulties with their employers and their regulators, not because of their lack of specialist knowledge or poor technical skills, but because of the way they interact with their colleagues.

When relationships break down in healthcare teams not only do things go wrong more often, but when they do the impact on everyone involved is usually much greater.

One of the characteristics of being a professional is taking responsibility for one's actions. Often, choosing to turn a blind eye to problems within a team can lead to problems becoming magnified and intractable.

Product liability and MPS

Issues with product liability have made the headlines in a number of countries around the world recently – notably the DePuy metal on metal hips in South Africa and Ireland, and the PiP breast implants in the UK.

These issues arose from faulty products, where normally responsibility lies with the manufacturer or supplier of the product.

However, in both cases, attempts were made by claimants to include surgeons in the claims – in the DePuy hips case, the justification given was that the surgeons had failed to properly fit the prostheses; with the PiP implants, the insolvency of the manufacturer was the motivation for involving the surgeons in the claims.

In both situations, whilst MPS is not providing an indemnity for product liability, MPS is supporting members with these cases by doing whatever is possible to prevent the development of litigation targeting clinicians, when other more appropriate sources of compensation (the manufacturer or supplier) are no longer available.

In the meantime, members can take steps to protect themselves in the event of a claim for product liability, by retaining documentation relating to:

- Evidence of purchase.
- Where possible, the serial number of the item in question – it can be used as evidence of the batch of goods obtained.
- Terms and conditions.
- Express warranties and guarantees.
- Instructions and packaging.
- Correspondence regarding product specification and any alteration.
- Where whole goods are transported by an external logistics company, relevant contracts/terms/correspondence.
- Complaints history relating to product and similar products (if relevant).
- Order forms, emails, faxes.

Clinicians should also take care regarding any verbal statements made to patients regarding a product. Statements that erroneously imply a lifetime guarantee, for example, can make a clinician liable in the event of a related allegation or claim.

NICE GUIDANCEWATCH

Note: These anticipated publication dates are subject to change. To keep up-to-date visit www.nice.org.uk/GP or follow NICE on Twitter (@NICEComms)

September

Clinical guideline
- Urinary incontinence

Technology appraisal
- Lung cancer (non-small-cell, anaplastic lymphoma kinase fusion gene, previously treated) - crizotinib [ID499]

Diagnostics guidance
- Epidermal growth factor receptor tyrosine kinase (EGFR-TK) mutation testing in adults with locally advanced or metastatic non-small-cell lung cancer
- Gene expression profiling and expanded immunohistochemistry tests to guide the use of adjuvant chemotherapy in early breast cancer management: MammaPrint, Oncotype DX, IHC4 and Mammostrat

Quality standard
- Atopic eczema in children
- Depression in children and young people
- Heavy menstrual bleeding
- Lower urinary tract symptoms
- Multiple pregnancy

Interventional procedures guidance
- Insertion of endobronchial valves for lung volume reduction in emphysema
- Photochemical corneal cross-linkage using riboflavin and ultraviolet A for keratoconus and keratectasia
- Endoscopic bipolar radiofrequency ablation for the treatment of malignant biliary obstructions from cholangiocarcinoma or pancreatic adenocarcinoma
- Negative pressure wound therapy for the open abdomen

October

Clinical guideline
- Neuropathic pain – pharmacological management

Public health guidance
- Overweight and obese children and young people – lifestyle weight management services

Technology appraisal
- Colorectal cancer (metastatic) – aflibercept [ID514]
- Hepatic encephalopathy (maintenance treatment) – rifaximin [ID496]
- Vitreomacular traction – ocriplasmin [ID544]

Diagnostics guidance
- Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel

Quality standard
- Surgical site infection

EDUCATION UPDATE

The risk of working with others

Dr Mark O'Brien looks at reducing risk from professional interactions

While poor patient communication has long been established as a major risk factor for complaints or claims, Dr Priya Singh, Executive Director, Professional Services, MPS, notes: "It is important members know that ensuring high quality verbal and written communication between doctors has been identified by MPS as an important strategy to reduce the risk of patient harm and action against members."

MPS has increasingly identified communication between doctors as a significant source of risk in two critical areas.

Referrals and handovers

Patient care is often passed between doctors, whether in the form of a referral or a handover. In these instances, poor communication can lead to:
- Abnormal investigations not acted on
- Wrong diagnosis made or wrong investigation and treatment undertaken
- High risk treatments not effectively monitored
- Predictable complications not recognised
- Significant co-morbidities not taken into account
- Unnecessary investigation and treatment.

Disagreements between colleagues

Disagreements between clinicians are common and poor communication between doctors in this situation can contribute to patients believing they've received poor care. Hickson found doctors urging patients to sue was a factor in one third of litigation cases.[1]

Helping you to reduce your exposure to these risks

These challenging situations are explored in MPS's Mastering Professional Interactions workshop. This half-day workshop is offered free of charge to members, as a benefit of membership.

Mastering Professional Interactions is run in locations across the UK. For more information, including forthcoming dates, locations and online booking, please visit: **www.mps.org.uk/workshops**.

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1. Hickson GB et al, Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care, *JAMA* 272: 1583-1587 (1994)

Australia: ruling sets boundaries for duty of care

An interesting case in Australia has concluded, which raises pertinent questions over the degree to which patients should be responsible for aspects of their own care.

The case, *Varipatis v Almario [2013] NSWCA 76*, saw the New South Wales Court of Appeal overturn a Supreme Court decision, which found a GP who failed to re-refer a morbidly obese patient to an obesity clinic had breached his duty of care.

The claimant, Mr Almario, attended Dr Varipatis, from August 1997 to February 2011, during which time he suffered from various illnesses including morbid obesity, elevated liver function test results and liver disease. Mr Almario was told that he needed to lose weight to prevent the liver disease progressing to cirrhosis of the liver.

Dr Varipatis referred Mr Almario to another physician, who in turn referred him to an obesity clinic. Both doctors counselled Mr Almario of the importance of losing weight – advice that Mr Almario ignored, saying he had previously lost 30kg attending the clinic which, in his opinion, had not improved his health. Mr Almario developed cirrhosis in June 2001 and liver cancer in 2011.

Mr Almario won original claim for damages, arguing that Dr Varipatis failed to take steps to treat his morbid obesity and prevent his liver cancer, and was awarded over $350,000. On appeal, this was overturned – there was overwhelming evidence by numerous doctors that Mr Almario had been advised of the need to lose weight in order to prevent further liver damage, but chose to ignore this advice.

On deadly ground

It is a harsh reality of medicine that doctors face multiple avenues of complaint related to their practice. In *Casebook* we often focus on the learning points afforded when a doctor is sued for clinical negligence, but members come to MPS requesting assistance with a wide range of other matters, such as ethical queries, complaints and regulatory body investigations.

Here we present six diverse cases from MPS's files, listed by theme and not involving claims. They are drawn from incidents around the world (regulatory bodies will be generically referred to as "Medical Council") and some facts have been altered to preserve confidentiality.

SOCIAL MEDIA

Dr P was working as a junior doctor in general practice. Three months into her new post she received a "friend request" on Facebook from a former patient, Mr T. She had got to know him whilst doing her medical school psychiatry attachment as he had been an inpatient for a brief period of time.

Mr T told her that he was doing really well and was off all his medication. He had started an arts course at the local college. Dr P accepted his friend request. Initially she enjoyed reading Mr T's posts, but gradually she noticed his comments were becoming more bizarre, culminating in the statement that he felt he was being followed by the CIA. She recognised this as being a symptom of his mental illness and sent him a personal message urging him to go and see his GP.

Mr T replied stating that he didn't trust his GP. He asked to meet up with Dr P. She told him that she couldn't do so and suggested she speak to his GP on his behalf. He became angry and upset. Dr P was concerned about Mr T so she contacted his consultant psychiatrist who arranged to review him later that week. Mr T 'de-friended' Dr P a few days later.

A month later Mr T complained to the senior partner at Dr P's practice. He was unhappy that Dr P had declined to meet him as he had felt that they were friends. He was disappointed that she had contacted his psychiatrist, although he admitted that he was feeling a lot better and back on his medication.

The senior partner and Dr P met with Mr T to discuss his concerns. Dr P apologised to Mr T and stated that she should never have accepted his friend request. She told him that she had been concerned about him and had felt she had to contact his psychiatrist to try to access help for him.

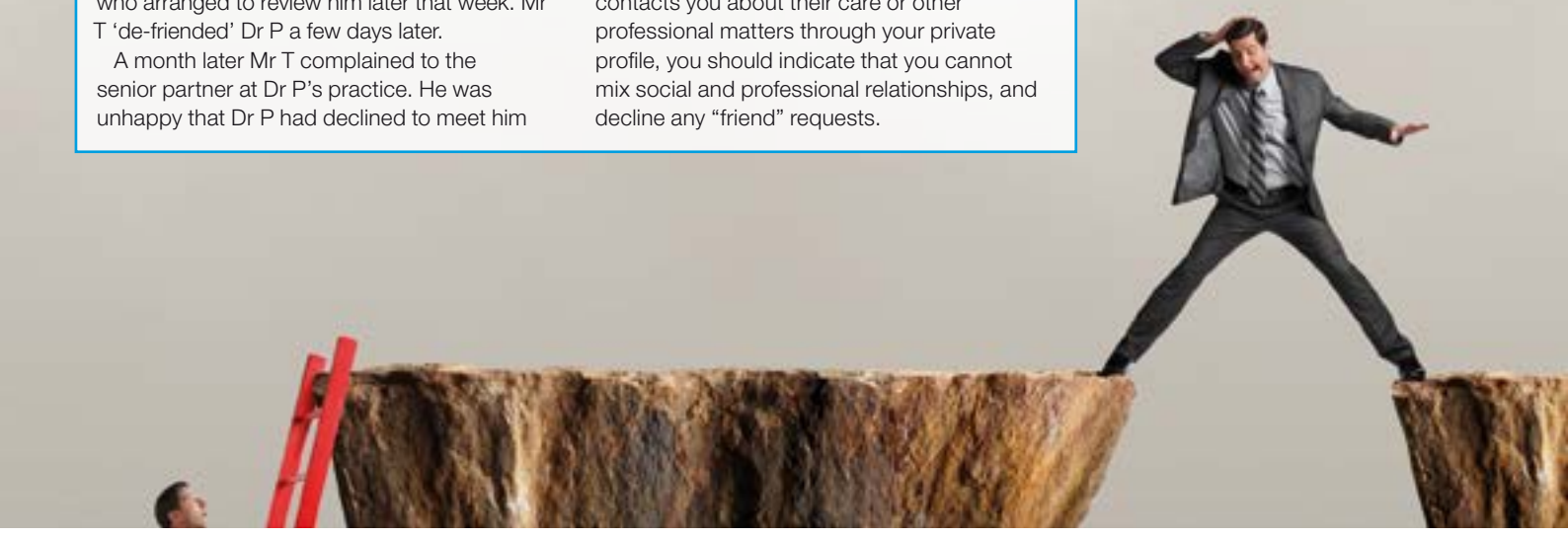
Mr T accepted Dr P's apology. He asked her to share the experience, anonymously, with her colleagues, so that they could all learn from this incident.

Learning points

Doctors should ensure that their conduct justifies patient and public trust in themselves and the profession as a whole. This applies equally online as it does in the consultation room.

Using social media creates new risks, particularly where social and professional boundaries become unclear. If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships, and decline any "friend" requests.

Doctors should ensure that their conduct justifies patient and public trust in themselves and the profession as a whole. This applies equally online as it does in the consultation room



RAISING CONCERNS ABOUT COLLEAGUES

Dr H visited his local pharmacy with a private prescription for a benzodiazepine; he had a fear of flying and was due to undertake a long-distance flight for a holiday. The pharmacist had concerns that Dr H might be self-medicating for a more serious psychiatric condition, with potential implications for his ability to practise. Dr H was reported to his Medical Council, who invited him to undergo a full health assessment. He contacted MPS for assistance.

Dr H was angry and embarrassed at this turn of events. He felt that he was facing castigation for an innocuous incident. Dr H was very uncomfortable with the prospect of a health assessment and was also concerned about the potential of being referred to a full panel hearing to assess his fitness to practise. While MPS's medicolegal adviser advised Dr H on the full range of options open to him, he opted for voluntary erasure, which was accepted by the Medical Council. Dr H was close to retirement and explained that he found voluntary erasure more appealing than a health assessment.

Learning points

Many doctors feel it is their right to prescribe as they see fit, but they risk referral to the Medical Council. In other similar MPS cases, members have undergone health assessments and MPS has advised them to apologise, demonstrate greater awareness of prescribing guidance and undertake only to self-prescribe in emergency situations in future.

The temptation to self-prescribe in order to patch yourself up, and avoid taking sick leave, is understandable; however, doctors who do this might be presenting a risk to patients in not having had their condition reviewed independently. Guidance states that doctors should be registered with a GP, to ensure treatment of an independent, objective nature. Furthermore, your clinical judgment could be impaired if you are genuinely unwell.

In particular, you must avoid self-prescribing controlled drugs unless there is no-one else available with the legal right to prescribe without a delay that would cause great pain or distress, or a risk to your life. Any decision to self-prescribe should be recorded and your own GP should be notified as soon as possible.

CHAPERONES

Dr V was carrying out a routine doctor's round in the segregation unit at a women's prison. She was accompanied by a healthcare assistant. During the round she was asked by a prisoner, Ms J, for medication for anxiety; Dr V declined. Ms J then made a further request for opiate analgesics for hip pain; Dr V decided to examine her and took the appropriate consent. Dr V discovered a small abscess in the left groin area and prescribed anti-inflammatories and antibiotics. However, Ms J reiterated her original medication request and threatened to report Dr V to the Medical Council.

Ms J carried out her threat, alleging that Dr V's clinical decision-making was unsound and also that she had been rude and abusive – in particular using racist terms to subdue Ms J. Ms J also alleged that Dr V spoke about her condition in a loud voice, which breached patient confidentiality.

The Medical Council concluded its investigation with no further action necessary. Dr V's excellent record-keeping ensured a comprehensive account of her clinical decisions and this allegation was rebutted at an early stage.

Dr V had been accompanied by her assistant throughout her doctor's round, and had also been observed at a distance by a member of the prison staff. Both were reliable witnesses and since no concerns were raised by them, Dr V was able to refute Ms J's allegations of a confidentiality breach and Dr V's abusive manner.

Learning points

Here the Medical Council was not concerned about the medical care provided, since Dr V had kept a comprehensive and contemporaneous clinical record, but by Dr V's conduct. The allegations made, if proven, would be serious and might demonstrate impairment of Dr V's fitness to practise. It should be remembered that the veracity of the allegations need only be demonstrated "on the balance of probabilities".

In this situation the importance of a chaperone was paramount. Every patient must be afforded dignity and privacy, and this typically means offering a chaperone for an intimate examination. However, this is not the only time when a chaperone should, or can, be offered. It should be remembered that a chaperone also protects the doctor from unfounded allegations, as demonstrated in this case, and if the patient refuses the presence of a chaperone then you may wish to defer the examination or refer the patient on to a colleague who would be willing to conduct the examination, so long as there is not unreasonable delay and the clinical situation does not demand urgent assessment.

CONTINUED OVERLEAF

CONFIDENTIALITY

GP Dr W was visited by 50-year-old patient Mrs B with a history of drug dependency, alongside her daughter V. During the consultation, Dr W inadvertently made reference to the fact that Mrs B was HIV positive; V was not aware of this. Dr W immediately apologised for this disclosure. He wrote to Mrs B that evening acknowledging the breach of confidentiality and again apologising for it.

Mrs B was very angry and complained to the Medical Council, forwarding Dr W's letter, making reference to other concerns about the care she had received. The Medical Council wrote to Dr W indicating that they would not be investigating the matter, but asking him to provide details of his employers.

Learning points

Dr W should not have assumed that the daughter was aware of her mother's HIV status. At the start of the consultation he should have asked Mrs B whether she was happy for her daughter to stay and should not have mentioned anything the patient or daughter had not brought up themselves. If it had been necessary to mention Mrs B's HIV status he should have asked the daughter to leave as he had a potentially sensitive matter to explore with her mother.

The Medical Council accepted that the breach was inadvertent and that Dr W had reflected appropriately; however, it was usual for the Medical Council to inform employers to establish whether this was part of a pattern of concerns. Dr W was also advised that the patient had raised additional concerns, which needed to be investigated and responded to in accordance with local complaints procedures. MPS reviewed his letter to the patient and advised on tone and content.

CAPACITY

Mrs G, an elderly patient with type 2 diabetes, respiratory disease and dementia, fell during the night in the care home where she lived. Her care home called an ambulance immediately as Mrs G was in a lot of pain and was distressed by the fall.

When Mrs G arrived at the hospital she was assessed by the staff in the Emergency Department and an X-ray revealed a fractured neck of femur. Mr L, an orthopaedic surgeon, examined her, and was of the opinion that Mrs G needed surgery. Mrs G was distressed and confused, and Mr L believed that she lacked capacity to consent to surgery. He attempted to contact her next of kin, but he was unable to do so as they were in Greece. As Mrs G lacked capacity to consent to the proposed treatment, Mr L was not sure how to proceed, so he called MPS.

Learning points

This query related to an incident in the United Kingdom; the Mental Capacity Act 2005 provides the legal framework for making decisions on behalf of adults who lack mental capacity to make decisions for themselves. Unless there is a personal welfare lasting power of attorney in place, no-one else can provide consent on behalf of another adult. In addition, the Court of Protection can settle disputes over the healthcare and treatment of a person lacking capacity. Any proposed treatment must be in the patient's best interests.

Mr L was reminded of the factors to take into consideration when assessing mental capacity, as set out in the Mental Capacity Act. It should not be assumed that the patient lacks capacity simply because she has a diagnosis of dementia. In this instance, Mrs G's immediate family were on holiday and were not contactable.

MPS advised Mr L to gather as much information as possible in order to arrive at a 'best interests' decision regarding further treatment if Mrs G was unlikely to regain the capacity to consent. The extent of Mr L's enquiries depended on the urgency of the treatment. If the proposed treatment was non-urgent Mr L should continue to attempt to contact Mrs G's family, and gather information from other sources (such as staff at the care home and the GP).

The member of staff who ultimately delivers the treatment is the decision maker, and assessments of capacity and best interests had to be carefully documented in Mrs G's records.

PROBITY

Dr M was employed by a university to undertake a research project, which was funded by a charity, for two years. After his employment ended, the university's faculty of medicine agreed that Dr M could continue aspects of his project work, supported by his grant; at the same time Dr M was also beginning specialty training in general medicine.

After a period of around eight months, Dr M's supervisor at the university raised concerns over a number of purchases made by her department, credited to the research grant. These included an expensive piece of specialist equipment and costly travel and accommodation expenses for two overseas conferences. The supervisor discovered that the purchases had been made without her authorisation, or that of the charity providing the funding. Dr M was questioned about this and claimed to have indeed received the necessary authorisation.

It was later found that Dr M had made numerous fraudulent attempts to demonstrate this authorisation, including retrospectively amending travel booking details and forging approval letters.

Dr M was eventually reported to the Medical Council, where a panel hearing assessed his fitness to practise. It was found that Dr M's fitness to practise was severely impaired by his lack of honesty, integrity and probity – the basic attributes of being a good doctor. His attempts at deception and manipulation of colleagues exacerbated his original dishonest acts.

Dr M admitted to the charges but revealed that he had been under severe stress due to the recent death of his sister; further psychiatric examination led to Dr M being diagnosed with a major depressive disorder, which the Medical Council accepted as having contributed to his original actions.

The panel concluded that despite his mental health issues, Dr M's conduct was unacceptable for a doctor and and brought the profession into disrepute, undermining public confidence in the profession. A three-year set of conditions was imposed on Dr M's practice, including notifying the Medical Council of any post he accepted which required Medical Council registration; agreeing to the appointment of a workplace reporter, as approved by the Medical Council; and informing the Medical Council of any further formal disciplinary proceedings. Dr M was also placed under the supervision of a medical supervisor, nominated by the Medical Council.

Learning points

Honesty and integrity are central to the role of a doctor, principally because of the extent to which the doctor–patient relationship depends on trust. Doctors have a responsibility to the reputation of the profession to be trustworthy in all aspects of their work, including signing forms, reports and other documents, and in any financial arrangements with patients and employers, insurers and other organisations or individuals. Any doubt surrounding the probity of a doctor can be extremely damaging to the trust invested in the profession by patients.

Doctors are notoriously bad at looking after their own health. Stress and anxiety can affect a doctor's ability to practise safely, and an impaired practitioner is a significant medicolegal risk. There are usually local support networks for doctors affected by mental health issues, and any concerns about your own health should be raised with senior colleagues. MPS also has a worldwide counselling service available to members.

How can MPS help?

Members sometimes come up against problems that are out of the ordinary. MPS considers borderline requests for assistance on the merits, balancing the individual member's needs against the responsibility to use members' funds wisely and in the interests of the membership as a whole. The following are examples of problems where detailed consideration of the exercising of discretion to assist may be warranted.

Criminal proceedings arising from non-clinical practice

We can exercise our discretion to assist with criminal allegations, but this does not usually extend to allegations of fraud or theft, on the basis that these offences arise from the business aspects of practice.

Allegations of fraud

It is unlikely that we would provide assistance in connection with allegations of fraud arising from business dealings. Occasionally, allegations of fraud may have arisen from professional life, for example, errors on a CV, or in research. Such cases are considered on their individual merits.

Defamation

If a member is the named defendant in a defamation claim, we may assist if the alleged defamation stems from their professional practice and their professional reputation is likely to suffer serious harm.

Other employment and disciplinary issues

MPS is unlikely to assist where a member faces a disciplinary investigation or hearing arising from:

- Employment or contractual issues
- Working relationships with colleagues
- The business of practice.

Personal conduct

Assistance is very unlikely to be offered with complaints or claims arising from a member's conduct that is of a wholly personal nature clearly unrelated to professional practice, or only loosely related to the practice of medicine (for example, by virtue of having been committed at the work/practice premises, or because they happened to involve an employee or working colleague).

Taken from MPS cases handled between June 2012 and May 2013. Words by Gareth Gillespie and Sara Williams

A conversation with... David Pearl

His Honour *Judge David Pearl* has been Chair of the Medical Practitioners Tribunal Service (MPTS) since June 2012. The MPTS took over the adjudication of doctors' fitness to practise from the GMC in order to create a system independent of the investigation process. Judge Pearl recently met with *Gareth Gillespie* to reflect on the first year of the MPTS and what further plans he has in store for the organisation.

The model of adjudication we have adopted is that of being operationally separate from the GMC, but still within the GMC family – the decision-making process is entirely separate and independent of the GMC

You have emphasised your model of adjudication as being one that ensures total independence from the investigatory process. What are the advantages of an adjudication process that is independent from the regulator?

Everyone has the confidence – the medical profession, patients (and we are all patients), the medical defence organisations, etc – that decisions taken are totally independent of the GMC, in a separate function, with all training and selection of panel members down to the MPTS.

We have a quality assurance group, which I chair, and which looks at the vast proportion of our decisions to quality assure them and pick up any learning issues. I ensure these go back into training requirements. Rather than us questioning panel decisions, our focus is on assessing whether the reasons given for the decision are clear enough in the written determination.

Previously, the GMC had a similar review group – but this meant the GMC was the prosecutor and then reviewed its own decisions, and that was clearly wrong. Investigation and adjudication should be entirely separate, rather like the criminal courts – the Crown Prosecution Service makes a decision on whether to prosecute and the courts decide whether they are guilty or not. The GMC gets the complaint, investigates, and makes a decision whether they are going to refer the matter for adjudication; we take over and make a decision based on whether the facts are as proved, whether there is impairment, whether there should be a sanction – and that's all up to us; the GMC plays no part at all.

What are your views on other models of adjudication?

Our model certainly fits into this kind of disciplinary process – I believe you need a panel, rather than one person making the decisions, and that the panel should be a mixture of medical and lay members. I do know, for example, that pharmacists have a different model of adjudication – the chairs of their panels are legally qualified and therefore they do not use legal assessors. As a model I think ours is the right one, especially when we make the changes that I feel are necessary.

Have there been any criticisms of this model?

When I have spoken at conferences I have been asked: "How can you call yourself independent when the GMC control your budget, and your salaries are paid by the GMC?" The model that has been worked on and agreed is that we are part of the wider GMC family; in the context of the regulation of the profession, that is the right model. It is the best model for disputes, in my view, between the registrant and the regulator.

As the adjudicator for all doctors in the UK, the MPTS has an enormous responsibility to protect the public by ensuring standards are maintained across the medical profession. Chairing such an organisation must be extremely demanding – what has best equipped you for this role?

I started out in academic teaching but 20 years ago I became a judge – and what is probably the most relevant role to my current one at the MPTS is my time as President of what was then the Care Standards Tribunal. Sponsored by the Department of Health, the tribunal heard appeals stemming from decisions made by regulators in relation to children's homes and child minders. We would also deal with matters involving social workers who may have been suspended from work, or who felt they were being restricted in the way they work. Appeals were heard on a range of matters; one example was a frontline social worker involved in the Victoria Climbie case, who felt she was being used as a scapegoat.[1]

I also have experience in establishing a tribunal – which is what I did with the Care Standards Tribunal. I also had six years as a Commissioner

1. www.bailii.org/ew/cases/EWCST/2005/268(PC).html

at the Judicial Appointments Commission, overseeing such appointments from the High Court down, and spent two years at the Judicial Studies Board – now the Judicial College – where I was responsible for training all judges. My principal responsibility was preparing judges for the Human Rights Act, which at the time was bringing the European Convention on Human Rights into UK law.

When the position at the MPTS came up, I thought it sounded very interesting and was something to which I had a lot to offer.

You have been in the position for just over a year – what are the main challenges you have seen so far?

Reducing the amount of time that hearings take – at the moment, the rules we have inherited are rules that do not have any real case management built into them. It's certainly my view and one we all share. Better case management means more work is done in advance of a hearing, in terms of making sure all documents have been provided to both parties, ensuring all witness statements have been submitted, and resolving all preliminary legal arguments – if there are any – at an earlier stage.

It must be in the interests of everyone – it certainly is for doctors and the GMC – that cases are heard and decisions are made efficiently. Case management really is the key in ensuring hearings can get straight to the evidence and into hearing the witnesses, rather than days being taken up with matters that really should have been addressed at the pre-hearing stage.

Another area I have been keen to deal with is the decision-making by the panels. When they reach their decisions, we want to make their reasons clear and easy to understand. Decisions are essentially comprised of three things: firstly, the panel has to make a decision based on fact; secondly, they must decide – based on the facts – whether there has been misconduct and, if so, if it is of the kind to warrant a finding of impairment; and thirdly, what is the sanction? These decisions must be reasoned – for example, the GMC may have asked for erasure of a particular doctor, but the MPTS panel has decided on another route: this decision must be explained in full. Annual training sessions have now been put in place for our existing panel members, with induction training for new members.

What is the timescale for achieving the level of change you wish to see at the MPTS – and what else is on the agenda?

Over the next 12 months we will be working hard to make these changes happen. We have also introduced a set of amendments to our 2004 set of rules, many of which are of a technical nature but are primarily designed to make hearings more efficient.

The Department of Health will be consulting on some other new changes – which will need amendments to the Medical Act – at the end of the year, but they are broadly split into four areas:

- **Cost sanctions**
  We want to ensure that case management has some teeth to it – and the best way of doing that is to introduce a cost sanction. If the case manager says that your document must be available by a certain date, and it's not, and this then involves an adjournment while the document is produced, then there is a considerable cost incurred – and of course it's a cost to the medical profession, because the GMC is a charity whose money comes from the registrants; it's the registrants' money that is being wasted.
  To have a cost sanction, which I don't envisage we'd use very often – but it'd be there – is to remind everyone that if they don't do what the case manager has instructed they will find that there is a cost implication to that, which could be substantial. Other tribunals have this approach. The GMC would be subject to the same sanction, as well as doctors' representatives.
- **GMC's right to appeal**
  The model of adjudication we have adopted is that of being operationally separate from the GMC, but still within the GMC family – the decision-making process is entirely separate and independent of the GMC. We are seeking to underline this independence by providing the GMC with a right to appeal – at the moment doctors have this, but the GMC doesn't, and they ought to be able to appeal a decision they don't agree with.
- **Legal assessors**
  Legal assessors play a very important role but in some cases they are not really necessary – for example, it might be a review case or an interim order panel, where there isn't much law involved. All you really need is a well trained chair. What I would like to move towards is discretion – where they are only appointed in cases where they are needed. At the moment legal assessors are mandatory.
- **A statutory base**
  At the moment, we don't exist in statute – we are essentially a creation of the GMC. It is very important that we are given a statutory base, and work is being done to make us directly accountable to parliament.

Do you have any advice for MPS members who are unfortunate enough to face an MPTS hearing?

Preparation is the key for any doctor who finds him/herself in front of the panel. The witness statement is the key – this should be made as comprehensive a document as possible, covering all the issues to be discussed by the panel. Our new rules will provide an opportunity to the doctor to present his case in writing, in advance of the hearing.

We are fully aware it is not an easy time; facing a fitness-to-practise panel or interim order panel is difficult, and it may be the first time a doctor has faced any formal body of any kind. We do our best to ensure that everyone involved is as comfortable as possible, such as making sure breaks are given if the doctor needs it during sessions.

mpts
medical practitioners tribunal service

At a glance:

David Pearl and the MPTS

His Honour David Pearl became Chair of the Medical Practitioners Tribunal Service on 11 June 2012.

Judge Pearl has held a range of senior judicial appointments throughout his career.

He is now responsible for managing all fitness to practise hearings for doctors registered in the UK.

Judge Pearl, 68, began his career in academia as a Lecturer in Law at the University of Cambridge. He was called to the Bar in 1968 and became a circuit judge in 1994.

He was President of the Immigration Appeal Tribunal from 1997 to 1999 and spent eight years as President of the Care Standards Tribunal.

Before joining the MPTS, Judge Pearl sat as a Commissioner of the Judicial Appointments Commission and Director of Studies at the Judicial Studies Board.

The Medical Practitioners Tribunal Service runs all doctors' fitness to practise hearings and interim order panel hearings. It sits in the St James's Building, Oxford Street, Manchester.

The MPTS is part of the GMC, but it is operationally separate.

Since June 2012, the MPTS has adjudicated in a number of very high profile cases.

A number of efficiency savings have been made. For example, shorthand writers have been replaced with digital recording in hearing rooms.

The changing face of cosmetic interventions

In the wake of the PiP implant scandal, the scrutiny of how the cosmetic interventions industry is regulated has become as meticulous as society's scrutiny of fine lines and wrinkles. *Sarah Whitehouse* looks at what steps are being taken in the UK and Ireland to try to reduce the risks

The cosmetic interventions industry in the UK is big business. Worth £2.3 billion in 2010 and estimated to rise to £3.6 billion by 2015, it has expanded at such a rate that existing regulatory frameworks are now glaringly inadequate. The chances of a patient encountering poor quality products, poor quality treatment, and poor quality aftercare is surprisingly high – and for non-surgical procedures, there is no guarantee of redress.

On the surgical side – for procedures such as facelifts, liposuction, or breast implants – surgery is performed by cosmetic surgeons: experts in the field. But on the non-surgical side – for procedures such as dermal fillers, Botox, or intense pulsed light (IPL) treatments – anyone can carry out cosmetic interventions, even if they are not medically trained. An example of this is in beauty clinics.

The majority of the market growth has been seen in the non-surgical interventions sector. In a recent MPS survey of members in the UK and Ireland, 16% of non-plastic surgeon practitioners said they carry out cosmetic interventions. Of those, 53% carry out Botox injections always or often, and 40% perform dermal fillers with the same degree of frequency. Forty per cent of doctors carrying out these procedures are GPs.

Regulating the industry

In both the UK and Ireland, steps are being taken to clamp down on cosmetic interventions carried out by doctors, nurses, and others, who are not appropriately qualified or indemnified to do so safely and skilfully. In April, the UK's Department of Health published its final report into the *Review of Regulation on Cosmetic Interventions*. Some of the key recommendations include:

- A register of everyone who performs surgical or non-surgical cosmetic interventions
- Classifying dermal fillers as a prescription only medical device
- Ensuring all practitioners are properly qualified for all the procedures they offer
- All non-surgical procedures must be performed under the responsibility of a clinical professional who has gained the accredited qualification to prescribe, administer and supervise aesthetic procedures
- A ban on special financial offers for surgery
- An advertising code of conduct with mandatory compliance for practitioners
- Compulsory professional indemnity in case things go wrong
- An ombudsman to oversee all private healthcare, including cosmetic procedures, to help those who have been treated poorly.

In the view of the Royal College of Surgeons in England, their guidelines, *Professional Standards for Cosmetic Practice*, state that only licensed doctors, registered dentists and registered nurses should provide any cosmetic treatments (including laser treatments and injectable cosmetic treatments).

In both the UK and Ireland, legislation is pending that will make indemnity or insurance for all practitioners become obligatory, and the Medical Council would be able to stop a practitioner from practising if he or she did not have adequate cover. This would make sure patients could access compensation.

When things go wrong in healthcare, it is important to investigate, explain and apologise. Dr Nick Clements, Head of Medical Services at MPS, says: "MPS strongly believes that practitioners should have appropriate indemnity arrangements to ensure that no patient who suffers avoidable harm is left uncompensated. There is a

> *"A person having a non-surgical cosmetic intervention has no more protection and redress than someone buying a ballpoint pen."*
>
> Professor Sir Bruce Keogh

need for clarity on who is responsible for ensuring appropriate indemnity arrangements are in place." Both the UK and Irish suggestions regarding the regulation of the cosmetic interventions section recognise the importance of adequate and appropriate indemnity.

But will the proposed changes be far-reaching enough to regulate the cosmetic interventions industry? Fifty eight per cent of MPS members surveyed are not sure. Clearly, the changes needed to the industry are far from cosmetic – real strides need to be made in terms of keeping a register of qualified practitioners and ensuring accountability. Proposed European Union standards could end free consultations for cosmetic procedures, help cut out 'pressure selling' of cosmetic procedures and help to safeguard patients. The Irish Association of Plastic Surgeons supports these proposals and has also launched its own patient information website, **www.plasticsurgery.ie**, providing a register of qualified plastic surgeons.

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A risky business

One of the main areas of risk for cosmetic interventions is a lack of informed consent. Dr Clements says: "For consent to be valid, the patient must be competent, the patient must have sufficient information to make a choice, and the patient must be able to give their consent freely. Patients should, where possible, be given time to consider their options before deciding to proceed with a proposed treatment."

It is clear that what patients do not need is to feel hurried into making a decision because of time-limited deals, or financial inducements, as is often the case with cosmetic interventions. The UK Department of Health's report recommends that the following "socially irresponsible" advertising practices for cosmetic interventions should be prohibited:

- Time-limited deals
- Financial inducements
- Package deals, such as 'buy one get one free'
- Offering cosmetic procedures as competition prizes.

In Ireland, the Medical Council already puts constraints on the use of misleading photography in advertising. Doctors are warned against using photographic or other illustrations of the human body to promote cosmetic or plastic surgery procedures, as they may raise unrealistic expectations amongst potential patients.

Dr Paul Heslin, a GP based in Dublin, Ireland, agrees with the importance of informed consent: "Consent should involve someone neutral, external to the selling of the procedure, as well as the selling clinic, but with the appropriate knowledge." He also believes it is important to discuss the potential for complications openly: "The patient should see a few photos of the worst-case outcomes – like an anti-smoking programme – because this area is lucrative and there is a tendency to oversell the benefits."

Managing expectations

When taking informed consent, managing often unrealistic patient expectations can throw up another challenge for practitioners. Unregulated advertising can compound the problems. Asking the patient what would be a "good outcome" for them if they undergo a procedure can help identify whether their expectations are realistic and achievable. Both the practitioner and the patient must agree on the intended outcome.

Patients who have been closely involved in discussions about the options available, the potential solutions, and the risks involved, are less likely to take legal action should an unsatisfactory result occur, particularly if these discussions are well documented. Although patients considering cosmetic interventions should satisfy themselves that they are aware of the potential risks, doctors carrying out the procedure should take responsibility for ensuring that careful screening of the patient is conducted, including assessment of their psychological profile, and any vulnerability they may have.

There is, with all regulation, a fine line between ensuring adequate regulation and introducing a further layer of bureaucracy. The aim of both sets of suggestions so far is to protect patients against rogue practitioners and unsafe practice, whilst not preventing qualified GPs and specialists from carrying out similar procedures for non-cosmetic reasons.

Given the growth and range of procedures carried out by disparate practitioners – some of whom aren't even regulated, such as beauty clinics – it is more important than ever to ensure there is accountability for quality of care in cosmetic interventions. The proposed suggestions for regulation go some way to address accountability and the need for appropriate indemnity, but more work needs to be done – and quickly – to change the face of this rapidly expanding industry.

One of the main challenges is to bring cosmetic interventions in line with other specialties. Speaking of a lack of regulation and checks on qualifications, one MPS member surveyed states: "There would be public outrage if this was happening in specialties such as neurosurgery or cardiac surgery. Why should this be allowed to happen to patients who are vulnerable to manipulative advertising?"

MPS indemnity doesn't extend to product liability

MPS sets its subscriptions based on the risks associated with negligence, rather than risks associated with product liability.

If a doctor has a claim brought against them purely for product liability, MPS indemnity would not usually cover this.

From the case files

Dr Alison Metcalfe, Head of Medical Services, introduces this issue's round-up of case reports

All doctors are aware of the need to keep accurate and comprehensive medical records. But in busy clinical practice, standards can sometimes slip as a result of the need to meet ever increasing service demands. In many of the claims MPS handles, we come across examples of patient notes where there is no record of informed consent being taken; there is no record of discussions around potential postoperative complications; or there is no record of tests being ordered or results being followed up. This can make defending a clinical negligence claim very difficult indeed.

No matter how busy you are, it is important not to underestimate the value of detailed notes. Not only do they help if a clinical negligence claim is brought against you, they are fundamental to good patient care – leading to better communication between colleagues and smoother handovers.

In "Penetrating the eyeball" on page 15, Dr R's records showed no evidence of discussion of indication, risks or alternatives for Ms J's periocular injections. Additionally no written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. The case was indefensible and settled for a substantial sum.

Good record-keeping means not only recording consent taken and treatments offered, but doing so contemporaneously. In "Rash decisions" on page 16, Dr P made notes retrospectively after Mr M rang the surgery with swelling, throat discomfort and difficulty breathing after he had been taking allopurinol and steroids for severe foot pain. Remember that alteration of records is a probity issue. Any alterations or retrospective entries should be clearly marked and dated according to when they are entered in the record.

Good record-keeping also means recording accurately the results of observation and monitoring. In "A brain-damaged baby" on page 16, experts were critical of the monitoring of the fetal heart rate both during Mrs N's induction phase with prostaglandin, as well as during labour. Poor monitoring and incorrect interpretation of the CTGs, compounded by poor documentation on the CTGs, with a failure to record the date and time, meant that labour was allowed to continue in place of a caesarean section, resulting in intrapartum asphyxia. The case could not be defended.

CASE REPORTS

Casebook aims to promote safer practice by sharing experiences that we hope you will find helpful. MPS publishes medicolegal reports as an educational aid to MPS members and as a risk management tool.

The case reports are based on MPS experience from around the world and are anonymised to preserve the confidentiality of those involved.

The cases described are historic and the expert opinions that follow in specific cases reflect accepted practice at the time. The learning points are applicable today.

If you would like to comment on a case, please email casebook@mps.org.uk.

CASE REPORT INDEX

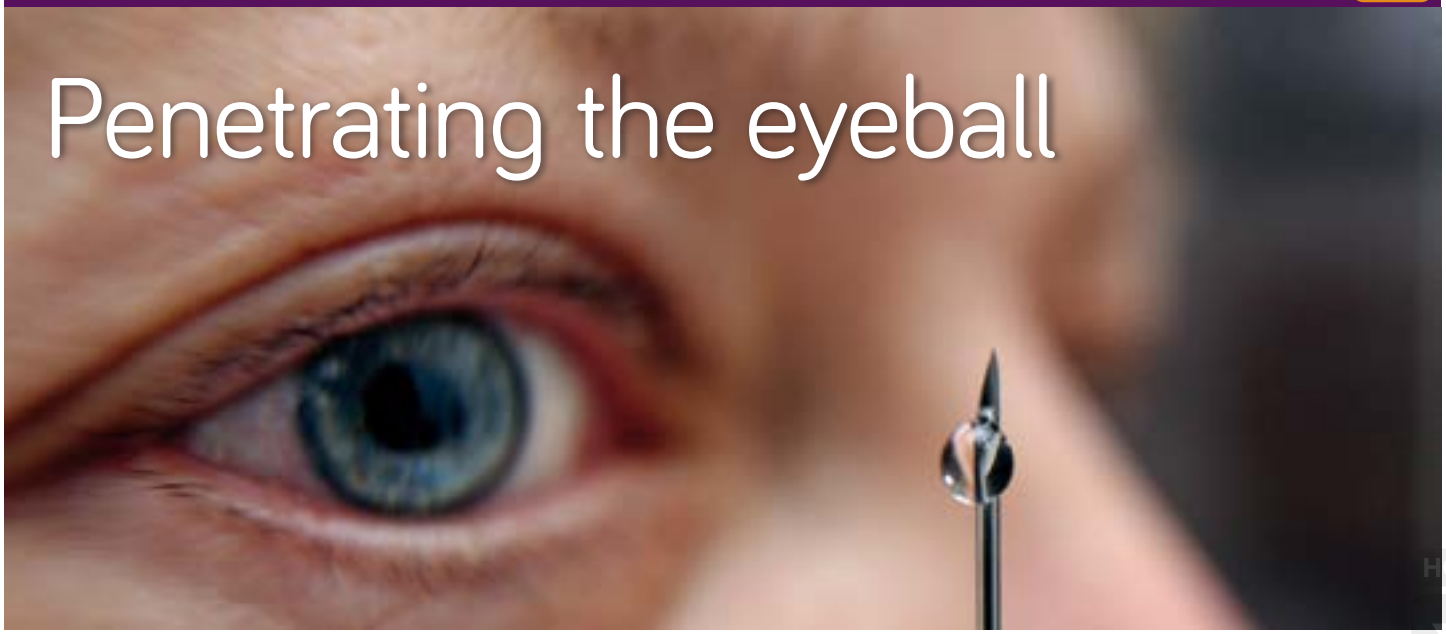
WHAT'S IT WORTH?

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

High £1,000,000+
Substantial £100,000+
Moderate £10,000+
Low £1,000+
Negligible <£1,000

SPECIALTY OPHTHALMOLOGY **THEME** CONSENT/INTERVENTION AND MANAGEMENT **SUBSTANTIAL** £100,000+

Penetrating the eyeball



Ms J, a 36-year-old banker with myopia, consulted Mr R, an ophthalmologist, with a one-week history of pain and blurring of vision in the left eye. Mr R diagnosed anterior uveitis and prescribed corticosteroid eye drops, and proceeded to give a sub-tenon's injection of 0.5ml depomedrol under local anesthesia in the lower outer corner of the left eye. The patient felt minor pain with the local anaesthetic injection but felt excruciating pain with the depomedrol injection. Within seconds a black spot blocked the central vision in the left eye. The spot expanded rapidly until the vision was completely lost. Mr R continued injecting till the full dose was given. On examining the left eye Mr R found that the eye was filled with fluid – he arranged a follow-up consultation the next day.

Ms J called later that afternoon to ask if she could see Mr R immediately but was advised to return the next day. Ms J chose to see another ophthalmologist who diagnosed a localised retinal detachment and referred her to a retinal surgeon, who performed surgery eight hours later. The retinal detachment was caused by two needle punctures penetrating the eyeball and injecting depomedrol into the eye instead of the intended sub-tenon's space. She underwent surgery to repair the retinal detachment and remove the intraocular drug but complete removal of the steroid was not possible.

Postoperatively, the retina was flat, but scattered retinal hemorrhage and macular nerve fibre layer oedema was noted. About three weeks later, Ms J developed an inferior retinal detachment, epiretinal membrane and retinal necrosis. She underwent further surgery to remove the epiretinal scar membrane and correct the retinal detachment. Her intraocular pressure was raised postoperatively but was controlled with medical treatment.

The iritis subsided, the intraocular pressure normalised and the remaining subretinal steroid dissipated completely within three months. Her final visual acuity was hand movement in the left eye and 6/6 in the right eye. The left eye remained painful and uncomfortable. Ms J had difficulty with near work and computer work, suffered eye strain and easy fatigue in the right eye and experienced frequent headaches and imbalance when walking downstairs.

She was assessed as having 20% impairment of vision and 20% impairment of the whole person, with 50% loss of capacity. She also developed depression and was under the care of a psychiatrist. She returned to work six months later but, due to mental distress and intense eye pain, she had to work part-time in a less intense position, and with a lower salary.

Ms J made a complaint and a civil claim. The claim was indefensible and was settled for a substantial sum.

AK

Learning points

- Ample guidance is available through professional bodies and the scientific literature on the management of common eye conditions. Periocular corticosteroid is not indicated for uncomplicated anterior uveitis. Where topical corticosteroids are ineffective, a sub-conjunctival injection of a short acting corticosteroid may be considered. Mr R chose the wrong primary method of treatment, the wrong injectable drug and the wrong route of injecting the drug.
- Periocular injections carry a risk of globe penetration that is much higher in myopic eyes. The records showed no evidence of discussion of indication, risks or alternatives. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. Guidance on the principles of taking informed consent is available in a number of different countries.
- Mr R failed to discontinue the injection when the patient had severe pain and loss of vision. Even though the globe had been injured, the extent of damage may have been reduced had he stopped immediately. Immediate exclusion of a penetration either by ultrasound or by clinical examination is mandatory when patient symptoms suggest globe penetration. Failure to do this established a breach in the duty of care. Early diagnosis and referral for emergency intervention may have reduced the extent of the irreversible damage.
- Adverse outcomes and complications are part of a doctor's working life. Responding to these events in a timely manner, showing respect, being open and communicating honestly help to reduce the impact of these events on both the patient's wellbeing as well as the doctor's professionalism.
- A patient can withdraw consent at any time during the procedure. When pain is not what you expect, it is good practice to stop and reconsider your treatment.

SPECIALTY GENERAL PRACTICE **THEME** DIAGNOSIS/RECORD-KEEPING

MODERATE £10,000+

Rash decisions

Mr M, a 56-year-old clerical worker, developed severe pain in his left foot and made an appointment to see his usual GP, Dr P. Dr P knew him well, having diagnosed Mr M with chronic kidney disease several years earlier, and supported him when he suffered a stroke. Dr P suspected he was suffering from gout on this occasion and prescribed diclofenac, with omeprazole cover, since he was also taking aspirin.

Less than a month later, Mr M's symptoms deteriorated and he requested a telephone consultation with his doctor. Dr P arranged for him to have a further prescription issued for diclofenac and omeprazole, and organised blood testing with the nurse to monitor his renal function.

A further month after attending for bloods, Mr M attended his follow-up appointment with Dr P, where he was advised that the blood tests had confirmed gout, alongside the ongoing chronic kidney disease. He was commenced on allopurinol, with the advice that he should double the dose of this after ten days of treatment.

A fortnight after commencing the new medication, with Mr M now on 200mg of allopurinol, Mr M started to feel unwell. He initially reported nausea and a small itchy area on his torso. Over the next few weeks, a similar rash began to appear on his face. He used calamine lotion without success, and eventually returned to see Dr P for advice.

Dr P concluded that the rash was likely to be secondary to a viral illness, and antihistamines were prescribed. That night, the rash seemed to be getting worse, so Mr M consulted with Dr P again the very next day, and a course of prednisolone was commenced. The allopurinol was briefly discussed, and the patient was advised to continue taking it at a dose of 200mg daily.

The situation continued to deteriorate and Mr M had two further appointments with Dr P over the course of the next week. His steroids were initially increased, and when this failed to improve symptoms, Dr P suggested the allopurinol should be discontinued. To complicate matters further, Dr P forgot to document the second consultation since he had a busy surgery. Three days later, Mr M developed generalised swelling, throat discomfort and difficulty breathing. Dr P spoke to the patient over the telephone and advised he was likely to be suffering from thrush.

Dr P realised at this stage he had failed to document his previous consultations so made some brief notes, without indicating he was doing this retrospectively. The next day Mr M was admitted to hospital by ambulance and diagnosed with Stevens-Johnson syndrome. He spent a week being treated in ICU with septicaemia and renal failure, but unfortunately died as a result of these conditions.

Causation reports concluded that on the balance of probabilities, the patient developed Stevens-Johnson syndrome due to allopurinol, and experts were critical of Dr P's decision to initiate the treatment after just one attack of gout, and at an increasing dose.

Experts agreed in this case that Dr P had ample opportunity to make the connection between the rash and the allopurinol, and furthermore, the steroid treatment, which is likely to have contributed towards the ulceration, could have been avoided. The case was indefensible and was settled for a moderate sum.

EW

Learning points

- The basics can sometimes be overlooked – an apparently trivial rash, as in this case, can herald a more serious condition, which reflects the need for joined up thinking.
- Clear and contemporaneous note-keeping is essential and this case highlights the importance of adequate documentation. Clinical notes are legal documents and any alterations or retrospective entries should be clearly marked and dated. GMC guidance states that doctors should "keep clear, accurate and legible records". Alteration of medical records is a probity issue.

Further information:

- Stevens-Johnson syndrome – **www.patient.co.uk/doctor/stevens-johnson-syndrome**
- Management of gout – **www.arthritisresearchuk.org/shop/products/publications/patient-information/conditions/gout.aspx**
- GMC, *Good Medical Practice* (2013) – **www.gmc-uk.org/guidance/good_medical_practice.asp**

SPECIALTY OBSTETRICS AND GYNAECOLOGY **THEME** INTERV

A brain-damaged baby

Mrs N was admitted for induction of labour at a gestation of 38 weeks. Mrs N had requested induction as she was feeling very tired. Antenatally, there had been no concerns over mother or baby. A cardiotocograph (CTG) was normal. As the cervix was unfavourable, Dr L inserted 1mg prostaglandin gel into the vagina. Dr L asked the midwife to commence continuous fetal heart rate monitoring. However recordings were not documented at regular or consistent intervals.

Six hours later, Mrs N was not in labour and the cervix was still unfavourable. Dr L inserted a second prostaglandin gel. Two hours later, Mrs N was in labour with the cervix 3cm dilated. The membranes were artificially ruptured after five hours, after which labour progressed rapidly, resulting in a normal delivery within two hours. During the induction process and labour, the fetal heart was monitored electronically using a CTG.

The baby was born in poor condition with low Apgar scores and transferred to the neonatal intensive care unit.

Mrs N developed a primary postpartum haemorrhage due to an atonic uterus, which failed to respond to medical intervention. The bleeding was so severe that Mrs N needed a laparotomy and ligation of the internal iliac arteries, which successfully arrested the uterine bleeding.

Analysis of the baby's blood shortly after birth revealed metabolic acidosis consistent with intrapartum hypoxia. Unfortunately, the baby developed seizures and investigations revealed hypoxic ischaemic encephalopathy. The child now has severe spastic cerebral palsy.

A claim was brought by Mrs N. The experts were critical of the monitoring of the fetal heart rate both during the induction phase with prostaglandin, as well as during labour. There was a combination of inadequate fetal heart rate documentation and inaccurate interpretation by the midwife. The CTGs were incorrectly interpreted as normal when they were actually pathological. Allowing labour to continue, rather than performing a caesarean section, led to intrapartum asphyxia and the resultant brain injury. The obstetric expert was also critical of the poor documentation on the CTGs, with a failure to record the date and time, or contractions in some instances.

There was no criticism of the management of the postpartum haemorrhage.

The case was settled for a high sum.

GM

ENTION AND MANAGEMENT **HIGH** £1,000,000+

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Learning points

- It is important to have a valid indication for induction.
- A CTG is a tool to monitor the fetal heart rate both during the antenatal period and during labour. In labour it is also used to monitor uterine contractions. The fetal heart rate (FHR) has a number of features that must be examined to allow proper interpretation. There are different levels of abnormality of the FHR. An intrapartum CTG classified as pathological requires urgent intervention.
- Training in CTG interpretation and regular updates should be mandatory for all healthcare professionals working in obstetric units.
- Misinterpretation of CTGs and failure to act on abnormal CTGs are cited as major factors in maternity claims in the United Kingdom. Between 2000 and 2010, "CTG interpretation" was the second most expensive category in terms of claims by value at over £466 million – *Ten Years of Maternity Claims – An Analysis of the NHS Litigation Authority Data* (October 2012).
- The NICE *Clinical Guideline on induction of labour*, published in 2008, recommends continuous CTG monitoring of labour which, if normal, can be reduced to intermittent monitoring: **http://publications.nice.org.uk/induction-of-labour-cg70**.

SPECIALTY NEUROSURGERY **THEME** CONSENT/INTERVENTION AND MANAGEMENT

SUBSTANTIAL £100,000+

Paraplegia after spinal surgery

Mr A, a 50-year-old engineer, was referred to Mr Z, consultant neurosurgeon, with increasingly severe back pain and additionally pain and weakness in his right thigh. Mr A had required high doses of opiate analgesia for pain relief and had been unable to work for several months prior to the consultation.

An MRI scan was organised, which demonstrated severe spinal stenosis at the level of T11/T12. Mr Z advised the patient that the spinal stenosis should be decompressed and that the symptoms in his right leg were related to meralgia paraesthetica, which could be dealt with at the same operation. Mr A underwent posterior discectomy of T11/T12 and decompression of the right lateral cutaneous nerve of the thigh.

Postoperatively Mr A complained of pain and weakness in the left leg and thigh and loss of movement in the right leg. A further MRI scan demonstrated a haematoma at the level of T12. Despite further emergency surgery by Mr Z, there was no improvement in Mr A's lower limbs and three weeks later he was transferred to a long-term rehabilitation unit. After a further three months Mr A was eventually able to return home. He had control of his bladder and bowel, could stand with help but was unable to walk and was no longer able to work.

Mr A commenced legal proceedings against Mr Z, citing inadequacies in informed consent: specifically that Mr Z failed to warn him that the procedure carried the potential risks of severe neurological complications. It was also alleged that Mr Z was negligent in carrying out the thoracic spinal decompression, with particular regard to the posterior transdural approach that he used.

It was evident from the notes and consent form that there was no documented discussion regarding any risk of neurological deficit relating to the operation and Mr Z acknowledged that he had not discussed such potential complications with the patient. A series of up-to-date independent neurological examinations and tests on Mr A demonstrated features entirely consistent with a spinal cord injury at the level of T12, in keeping with surgical trauma from the operation carried out by Mr Z.

Several expert neurosurgeons, commenting on the case, agreed that the posterior transdural approach employed by Mr Z for removal of a central thoracic disc protrusion had a much higher risk of spinal cord injury compared to the preferred anterior approach, as this would have posed less risk of serious neurological injury. They concluded that Mr Z's procedure was not supported by the modern neurosurgical literature, was not the standard surgical approach and fell short of what would be considered reasonable spinal surgical practice. The case was not defensible and settled for a substantial sum.

SD

Learning points

- With any operation it is important to have a detailed discussion with patients regarding the potential for complications, so that they can make a balanced decision as to whether they wish to go ahead with the procedure. The discussion should include common/minor side effects as well as rarer, serious adverse outcomes that can produce permanent disability or death.
- Discussions with patients should always be thoroughly documented. Statistically, decompressive surgery of the thoracic spine has the highest risk of neurological complications, compared to decompressive surgery of the cervical and lumbar spine, given the size of the spinal canal relative to the spinal cord and the spinal cord's relatively poor blood supply in the thoracic spinal canal. It would be expected from the reasonable spinal surgeon to mention the risk of a significant neurological deficit from surgery in this region.
- Clinicians are obliged to keep up-to-date in their field and undertake procedures that are recognised as standard by their peers with acceptable outcomes. Clinicians additionally need to demonstrate evidence of continuing professional education as part of their appraisal and revalidation processes.

SPECIALTY ANAESTHETICS AND ORTHOPAEDICS **THEME** CONSENT/INTERVENTION AND MANAGEMENT **SUBSTANTIAL** £100,000+

Stumbling block

Mr G was a 52-year-old school headmaster. His lifelong enjoyment of sports was becoming more difficult due to increasing pain from his left knee, although there was no injury or trauma to account for it. His GP, Dr M, initially referred him to a physiotherapist with only temporary improvement. Eventually Mr G asked to be referred privately to a specialist and was referred to Ms S.

Ms S assessed the knee thoroughly. The pain originated in the anterior aspect of the knee around the patellar tendon. There was no history of locking, swelling, or giving way. On examination, the only abnormal finding was mild tenderness along the medial joint line. X-rays revealed small osteophytes around the patella, but normal joint architecture and no other abnormality. An MRI scan of the knee revealed mild degenerative change of the medial meniscus, with no tears, and mild arthritis of the patellofemoral joint.

Mr G was keen to have this treated, so Ms S offered him an arthroscopic assessment and lateral release of the patella. This was performed under general anaesthesia, which was administered by Dr H. After induction, but prior to surgery, Dr H placed a femoral nerve block to provide postoperative pain relief. Dr H did not document any discussion about the block beforehand, nor Mr G's consent.

Mr G seemed to recover well and was discharged home the following day. At his ten-day follow-up visit to Ms S, he complained of pain in his heel. Ms S recommended physiotherapy and made a plan to follow Mr G up in two weeks. At this visit, the heel pain had settled, but Mr G was experiencing giving way and locking of the knee, as well as numbness and burning pain in his thigh. Ms S noted marked wasting of Mr G's left quadriceps, and documented he was barely able to perform a straight leg raise. She referred him for electromyography, and commented that she could not think of any reason why a knee arthroscopy would be associated with quadriceps wasting.

Neurophysiologist Dr R performed EMG studies of Mr G's lower limbs, which revealed an isolated left femoral nerve lesion. Dr R commented that she could not initially identify a cause for the lesion, but speculated that a femoral nerve block might be responsible. She found documentation of Dr H's block in the anaesthesia chart, and ascribed the nerve damage to the block.

Twelve months later, Mr G had no recovery from his injury. He had almost complete loss of function of the femoral nerve, and experienced difficulty climbing stairs, rising from a sitting position, and walking even short distances. He was required to use a lockable knee brace. As a result of his symptoms, he had been unable to continue working.

Mr G brought a claim against Dr H, in which he alleged that Dr H had not discussed the femoral nerve block with him, and had not sought his consent. Mr G said that he would not have agreed to undergo the block. Ms S had not known at the time of surgery that a block had been performed, and did not see it being placed.

Dr H's technique was also criticised. He had used a 25mm blue needle to perform "fan infiltration lateral to the femoral artery using a continuously moving needle technique". Several of the experts concluded that the nerve had been severely injured by this technique.

Dr H's failure to obtain informed consent for the block, and his questionable technique, were considered indefensible. The case was settled for a substantial sum.

AOD

Learning points

- An important point in this case was the informed consent. Dr H asserted that he had discussed the femoral nerve block with Mr G beforehand, but failed to document any discussion. Consent given by the patient for general anaesthesia does not imply consent to undergo other types of anaesthetic intervention while anaesthetised; for example, a regional nerve block. Where extra procedures are required, their specific risks and benefits should be discussed with the patient, and consent obtained to perform them. These discussions need to be documented.
- Dr H was criticised by the experts for his use of an outdated, unsafe technique. There are several readily-available techniques to make regional blockade safer, including performing the block awake, or the use of a regional block needle, a nerve stimulator, or an ultrasound probe. Ultrasound, in particular, has revolutionised the safety and efficacy of therapeutic nerve blockade.
- Dr H also failed to communicate his block to Ms S. Although it did not affect the outcome, had Ms S known about the femoral block, she may have caught on sooner. The surgeon and the anaesthetist should each know broadly what the other is doing at all times. Dr H should have documented more carefully.
- The WHO surgical safety checklist is a useful tool. Visit: **www.who.int/patientsafety/safesurgery/ss_checklist/en**

An unavoidable amputation

Mrs N was a 26-year-old researcher with a four-year-old daughter. She enjoyed dancing and went to a salsa class with her husband each week. Her right knee was slightly painful so she missed a class to see if it improved but it got gradually worse over the next few weeks.

She made an appointment with her GP, Dr B, to discuss her knee pain and seek his opinion on a skiing holiday she had booked. His notes commented on her right knee pain which was "possibly due to dancing". He documented some tenderness over the tibial insertion of the medial collateral ligament. He noted that the joint was stable and that there was no effusion. Dr B prescribed diclofenac and explained that he felt her skiing holiday did not need to be cancelled, but that it may not help matters.

Mrs N enjoyed her holiday but was becoming aggrieved by the knee pain, which was troublesome most of the time and when dancing. She saw Dr B and explained that the pain had been ongoing for four months with no improvement and that she couldn't remember any specific injury. Dr B documented the history and referred her to physiotherapy. His completed musculoskeletal referral form did not highlight any red flags including intractable night pain, weight loss, systemic illness or previous history of cancer.

While she was waiting for her physiotherapy appointment Mrs N rang the surgery again asking for a GP appointment. This was the first appointment she was given with Dr G. Mrs N explained that she had not taken the diclofenac because she was nervous about possible side effects and she felt the pain was getting worse. Dr G's records stated "history as above" and also noted that there was no locking or giving way. His examination notes were thorough. He documented that she was able to weight bear, that there was no swelling and that the knee was stable with a normal range of movement. He noted mild tenderness medially. He encouraged her to take the diclofenac and to rest, ice and elevate the knee. He advised buying a tubigrip to offer some compression to the knee. He gave safety-netting advice: asking her to return if things got worse while waiting for physiotherapy.

Mrs N saw the physiotherapist, Mr Y, who noted her four-month history of gradual onset knee pain. He recalled the patient saying that the pain intermittently flared. His examination noted a limping gait and an inability to extend her right knee fully due to pain. He noted slight swelling and that the knee was very warm to touch. Mcmurray's test was positive. Mr Y's initial thoughts were an injury, mono-arthritis or cartilage damage. He advised a review after two weeks of anti-inflammatories and ice. At the review it was noted that there was swelling most days and the pain was worse. Mr Y was concerned that there was an inflammatory cause and suggested inflammatory marker blood tests through Mrs N's surgery. These were found to be normal but Mr Y referred her to a consultant rheumatologist because her knee was still hot and swollen with no obvious cause.

Mrs N was seen urgently in the rheumatology clinic. Blood-stained fluid was aspirated and an x-ray arranged. The x-ray reported "possible tumour" and a subsequent MRI scan and biopsy confirmed the diagnosis of osteosarcoma of her right tibia.

Mrs N sustained a tibial fracture and was given chemotherapy. She struggled with nausea and fatigue and was devastated when she was told that she needed an above knee amputation because the tumour was aggressive and had not responded to chemotherapy. She later had a prosthesis fitted.

Mrs N was extremely upset and made a claim against Dr G. She felt that there had been a delay in the diagnosis of her tumour and that earlier diagnosis could have saved her leg from amputation. Mrs N claimed that the first time she had seen Dr G, she had complained of severe pain in the day and night and that the knee was hot and swollen at that time.

Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given. It was felt that Dr G's examination was of a good standard and that his actions were reasonable. The decision to wait for the physiotherapy appointment with the safety net of reattending if symptoms worsened was found to be reasonable. No indication could be found to arrange an x-ray, blood tests or referral at Dr G's initial consultation.

Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given

It was noted that Mrs N was still dancing at this point and had just returned from a skiing holiday, which would not raise alarm bells. It was also noted that Mrs N was not taking the diclofenac, so it was reasonable to think that her pain was manageable.

Expert opinions were sought from a consultant orthopaedic surgeon, a professor of medical oncology and a consultant radiologist. It was their agreed view that an amputation would have been needed even with an earlier diagnosis, because of the tumour's poor response to chemotherapy and its aggressive nature.

The case was successfully defended and Dr G was not found to be in breach of duty. MPS took steps to recover their costs.

AF

Learning points

- Although the patient's circumstances were very tragic, this did not equate to negligence.
- This case reflects the importance of strong expert opinion. The successful defence hinged around the experts' opinion.
- Good note-keeping is important for good medical practice and essential in defending a case.
- If a patient attends multiple times with the same problem, alarm bells should start ringing. It is useful to stop and think "what could I be missing?"
- Always try to exclude the worst case scenario. It is useful to document the absence of red flags.

SPECIALTY ENT **THEME** CONSENT/INTERVENTION AND MANAGEMENT **SUBSTANTIAL** £100,000+

HOME

Sinus surgery: damaged vision

Mr P, a 40-year-old office worker, had a long history of sino-nasal problems, and had even had a previous septoplasty operation. Soon after returning from a holiday, he consulted his GP, Dr A, with worsening blockage in the left side of his nose. Dr A saw a polyp on this side and referred Mr P to ENT surgeon Mr E for his opinion.

Soon after this, however, Mr P was admitted to hospital with some breathing problems and sinusitis, and was extensively investigated. These investigations included a CT scan of his sinuses.

During this admission, he was seen by Mr E, who also identified the polyp, and a number of other problems on the scan, which he felt would benefit from some endoscopic sinus surgery.

Mr P was readmitted to the hospital a few weeks later for his elective endoscopic sinus surgery. A standard consent form was signed on the morning of the surgery, (including a general mention of risk to eye or brain damage generally, but there was no discussion about specific complications). Surgery took place later that day. During the operation, Mr E suspected that he had breached the lamina papyracea (the thin bony wall separating orbit from nasal cavity). Immediately postoperatively, Mr P was noted to have a swollen left eyelid, which became more swollen over the next few hours. In addition, he complained of pain and blurring of vision.

Mr P was discharged from hospital and an ophthalmology opinion was arranged for a few days later. This confirmed an orbital haematoma and some limitation of movements, but no evidence of alteration to visual acuity.

A second ophthalmological opinion was requested some months later when the symptoms of double vision did not settle. In addition, Mr P described symptoms of dizziness and discomfort in the affected eye. This limited his ability to drive and rendered him unable to work. Sadly, no curative interventions were available.

Varifocal lenses were suggested to try and help Mr P with his vision, along with the hope that things might improve further with the passage of time. More positively, his chronic sinus problem appeared to have been successfully addressed.

Expert opinion determined that the breach in the lamina papyracea and the subsequent orbital haematoma had been the cause of Mr P's visual problems, by limiting the movements of the superior oblique muscle. This is a rare but well-known complication that can happen even to experienced surgeons.

Expert opinion found a breach in the standard of care around the process of consent. Mr E did not appear to explain that the surgery was for quality of life and therefore not essential, or that ongoing medical treatment was a therapeutic option. Nor did he specifically warn Mr P that orbital damage might result in impairment of vision, including diplopia.

The case was settled for a substantial amount.

AMcC

Learning points

- Informed consent must involve an explanation of the role of medical treatment, or no treatment at all, rather than just surgery, in non-life threatening medical conditions. In this case, Mr P's chronic sinus condition might have been controlled with steroids and antibiotics.
- The consent process must also include details of the consequences of a complication, not just a general mention of possible adverse events.
- This case is a reminder that even in what might be considered simple or straightforward surgery, significant problems or complications can, and still do, occur.
- MPS's free workshop for members, *Mastering Shared Decision Making*, shows how the shared decision making model is an effective way to ensure that patients make appropriate and informed choices about the treatment options available to them. For more information visit the Education section of the MPS website.

It's all about consent

Mr K, a 37-year-old self-employed businessman, consulted his GP, Dr P, requesting sterilisation. Mr K stated that although he had two children, aged 17 and 9, he wished to undergo a vasectomy. Dr P explained to Mr K that the procedure was irreversible, and Mr K stated he still wished to go ahead and to use his private insurance. Hence, Dr P referred Mr K privately to a consultant urologist, Mr S.

The patient saw the urologist and was subsequently listed for a vasectomy. Mr S then carried out the procedure under local anaesthesia, with no immediate complications. A few days following the procedure, Mr K noticed some weeping from one of the wound sites, and attended Dr P, who prescribed him a course of antibiotics. By the end of the seven-day course, the situation had worsened with increasing weeping at the wound site as well as pain both at the wound site and in the testis and groin on that side; Mr K thus attended the Emergency Department (ED).

On assessment there his pain was reported as 10/10 and constant, thus not allowing him to sleep, despite oral paracetamol. He was discharged with co-codamol. Four days later Mr K attended a different ED and a diagnosis of post-vasectomy haematoma was made, and Mr K was again discharged with yet stronger analgesics. The following day the patient saw Dr P again and was advised to take a week off work. Things did not improve and the patient called Dr P the following day to see him at home, and was then subsequently admitted to hospital with a diagnosis of infected hydrocoele/haematoma.

After hospital admission, the wound burst and the patient was taken to the operating theatre where the infected haematoma was drained. Two days later the patient was discharged home, and subsequently reviewed four weeks later in outpatients by Mr W, consultant urologist, who discharged him from further follow-up.

Mr K alleged breach of duty due to lack of informed consent on the part of Mr S. As the complication was handled appropriately and is a recognised complication of vasectomy, no issue of technical incompetence by Mr S was alleged. The claim thus solely related to a lack of informed consent; specifically, Mr K alleged that Mr S did not warn him before he consented about the possible complication he subsequently suffered. Mr K stated that he was uncertain about whether to go ahead with the vasectomy and if he had known about the potential complications, he would not have undergone the surgery.

The signed consent form was the key piece of evidence in this case. Mr K used a standard form of consent, but one in which all complications were not printed, and thus Mr S handwrote the complications of pain, bleeding, bruising, haematoma and infection at the bottom of the form. It was alleged by Mr K that Mr S did this after the claim was filed, and thus that Mr S doctored the consent form days after the procedure. This was proven to be untrue as a copy of the consent form was sent to Dr P with a letter stating these complications had been explained, on the same day as the initial consultation.

Dr P confirmed that Mr S did not have access to Mr K's files after the procedure and thus could not have amended the consent form at a later date as alleged. Also, Mr S had a practice nurse sitting in during the consent procedure and she reiterated the complications to Mr K as well herself after the initial consultation, and this practice nurse confirmed that the consent procedure by Mr S was thorough and complete. The claim was therefore discontinued and costs were recovered from the claimant.

PS

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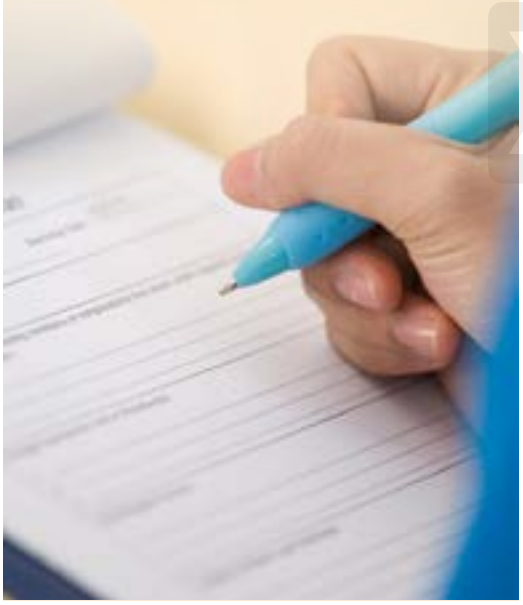
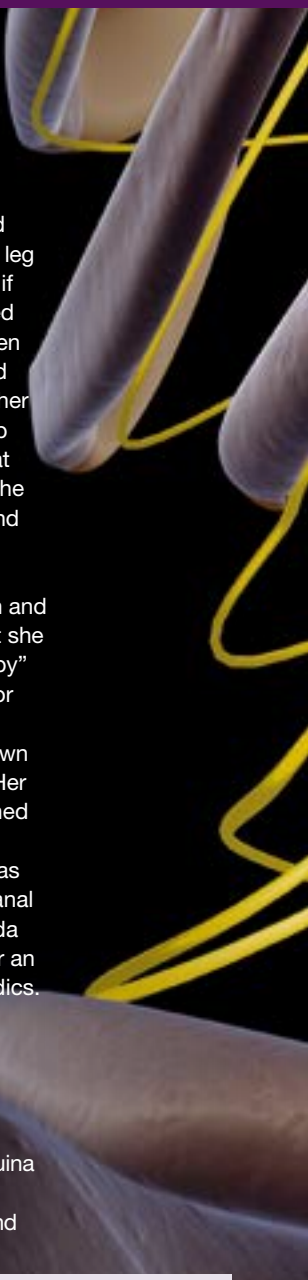


Learning points

- This case illustrates one of the commonest reasons for litigation against doctors, and especially surgeons; that of issues of consent before a procedure. It is not uncommon for a patient to feel happy to proceed for a surgical procedure at the time of the procedure, but then to feel unhappy with that decision to proceed when he suffers a well-accepted complication.
- Vasectomy is one of the most litiginous procedures for urologists, although it is one of the simplest operations within that specialty. The procedure is typically day case and under local anaesthesia, taking an average of 20 minutes. However, the pre-procedure consent process and consultation typically lasts longer than this. Having copies sent to the patient's GP and having a nurse during the consultation further safeguards against litigation.
- When surgeons operate on patients in the private sector and their complications are then managed by different doctors in the public sector, patients can often feel aggrieved at the operating surgeon who is now 'nowhere to be seen'. Good communication between all doctors involved in such situations can facilitate the optimal management of the patient, and thus lessen the risk of future litigation. This case provides a valuable lesson: however straightforward and routine the surgery might be, proper documentation is vital.
- There were two missed opportunities to intervene here. The patient was left unhappy and aggrieved.
- The surgeons should have given their contact details and been responsible for the follow-up arrangements.

SPECIALTY GENERAL PRACTICE **THEME** DIAGNOSIS/RECORD-KEEPING

A weekend of back pain



This case occurred in the United Kingdom and details procedures and organisations specific to the country.

Mrs P was a 42-year-old housewife who lived with her husband, daughter and their first grandchild. She had suffered with chronic lower back pain for many years, which was helped by regular paracetamol. She had struggled with flare-ups over the years, usually after gardening or lifting the shopping. Symptoms always settled within a few days with co-codamol or ibuprofen prescribed by her GP.

Mrs P had been looking after her granddaughter and had lifted her rather awkwardly into the car. This aggravated her back so she took some co-codamol she had at home from the most recent flare-up. When this failed to relieve the pain, she made an appointment with her GP. She was unable to lift her granddaughter because of pain in her lower back. He prescribed ibuprofen and arranged a follow-up appointment in a week. He referred her to physiotherapy because of the frequent exacerbations.

Her pain became more severe through the week. She took the co-codamol and ibuprofen but couldn't manage the pain. By the Friday evening she was in tears and her husband suggested she ring the out-of-hours GP service. She was put through to a triage nurse who noted her history of long-standing back problems and worsening pain. The nurse advised Mrs P to keep mobile and to see her GP again after the weekend but her husband demanded that she saw a doctor that evening. The nurse documented that she "would like to see a doctor for stronger meds" and made her an appointment to see the out of hours GP, Dr M, that evening.

Dr M reviewed the triage nurse's history, in particular the lack of any noted red flags. He documented that she had complained of pain over the coccyx area and that she had claimed she could not sit or lie down due to pain. He therefore examined her standing and noted an absence of spinal tenderness except over the coccyx. He prescribed some dihydrocodeine to help her manage the pain and asked her to ring back if the situation worsened.

On the Sunday, Mrs P became anxious because she felt completely numb at the bottom of her back. She rang the out-of-hours service again and spoke to a triage nurse. She explained that she "felt so numb she couldn't feel the toilet seat beneath her and that she couldn't feel the passing of water". She was also very embarrassed but mentioned that she had been dribbling urine without being aware of it. She explained that despite taking the dihydrocodeine she had developed severe pain at the back of her right leg and near her ankle. She wondered if the dihydrocodeine had constipated her because she was unable to open her bowels. The nurse documented the history and advised her to see her own GP in the morning and to keep the physiotherapy appointment that was pending the following week. She gave her advice on taking senna and lactulose for the constipation.

Mrs P had a dreadful night. She couldn't sleep because of the pain and when she tried to walk to the toilet she noticed that her right leg felt "floppy" and that she could not feel the floor with her right foot properly. Her husband took her straight to her own GP surgery on Monday morning. Her own GP took a history and examined her, documenting an absent ankle reflex, a straight leg raise which was reduced on both sides and weak anal tone. He diagnosed probable cauda equina syndrome and arranged for an urgent assessment with orthopaedics. His referral letter stated that she developed the numbness and the voiding difficulties the day before.

The orthopaedics team saw her the same day, also noting that her symptoms suggestive of cauda equina had started the day before. They catheterised her due to retention and

Learning points

- Doctors should record the particular red flags that are absent – it is important to record both relevant positive and negative findings in the history and examination.
- When a healthcare team experiences such an incident where a patient has suffered a considerable harm as a result of a delay in diagnosis, the team should conduct an SUI – serious untoward incident – review. The team should get together and see what lessons can be learnt to prevent similar incidents happening again. There may be issues, for example, for the out-of-hours (OOH) centre – eg, the triaging by the nurse – was she working to a script? In which case the script might be at fault. If so, it might need reviewing. Nurses/GPs working in OOH needs to be appropriately trained and qualified.
- In such cases, the danger for the patient's registered GP is that with a long-standing back problem he needs professional discipline to ensure that he or she repeatedly checks his patient is also aware of what the red flag symptoms are. It is all too easy with chronic back pain patients to simply focus on analgesia control, rather than what to look out for and contact the doctor urgently about.
- Surveillance is a useful and legitimate tool that MPS can use to strengthen the defence of a claim.
- Doctors should keep clear, accurate, and legible records. It is important to keep contemporaneous notes. The defence in this case was partly based on dates and times of symptoms recorded in the medical notes.
- Remember that referral letters add to consultation notes. They contain important clinical and medicolegal information and should be copied in patients' medical records. This case was defended partly on information written in referral letters.
- Although Dr M was not criticised, it is still a useful reminder that doctors should take and document their own history from a patient and not rely on someone else's account.
- This case illustrates that the claimant also runs a litigation risk when pursuing a claim. The general rule in litigation is that all claimants and all defendants are jointly and severally liable for all costs awarded against them.

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arranged an MRI scan of her lumbar spine. The MRI showed a massive L4/5 disc prolapse causing severe central canal stenosis and also impinging on the traversing right L5 nerve root. Mrs P subsequently had an L4/5 decompression and discectomy and partial L4/L5 laminectomy.

After the surgery, Mrs P was seen in the spinal clinic. She had no true urinary incontinence following the retention although she still had some difficulty in assessing when she had finished passing urine. Fortunately she had full control of her bowels. She was still upset about worsening right leg pain, which was severe.

Mrs P made a claim against the out-of-hours service, firstly against the nurse for failing to triage appropriately and secondly against the GP, Dr M, for failing to recognise and promptly refer her cauda equina syndrome. She claimed that she had had the cauda equina symptoms on the Friday that she consulted Dr M.

MPS sought the opinion of a GP expert who was not critical of Dr M's consultation on the Friday evening. The triage notes did not indicate any problems with new symptomatology, specifically no mention of any development of radiation of the pain, altered sensation or problems with micturition and bowels. It was agreed that the limited examination in the absence of these symptoms was reasonable. It was also considered that Dr M's prescription for stronger analgesia was effective since the patient did not contact a doctor the following day. It was, however, agreed that the triage nurse was in breach of duty on the Sunday when she recorded red flag symptoms and failed to pass the call onto a doctor.

Mrs P's contemporaneous medical records were analysed carefully. It was agreed that the major deterioration in her condition occurred on the Saturday. Dr M's records, the GP's referral letter to orthopaedics and the orthopaedic team's records all contradicted the claimant's account and indicated that she did not have symptoms of cauda equina syndrome at the time of consulting Dr M.

MPS represented the out-of-hours provider and the claim was settled with respect to the triage nurse's breach of duty. Dr M, however, was successfully defended and not found liable.

Mrs P was seeking very substantial damages because she alleged that she could no longer live in her current home and needed to move to a specially-adapted bungalow. She claimed she needed an electric scooter, could not walk unaided, and that she needed constant care both day and night. MPS engaged a surveillance firm to observe the claimant. Over a period of time they assimilated evidence: photographing the claimant carrying a young child, picking up and moving boxes, folding a child's buggy against her leg, walking without any aids, and carrying a basket of heavy shopping with one hand and waving with the other. The claimant's legal costs were being paid by public funding. MPS wrote to the Legal Service Commission regarding the evidence and funding was withdrawn. The claim was originally for damages in excess of £2 million but was settled for a fraction of that amount.

AF

It was agreed that the limited examination in the absence of these symptoms was reasonable. It was also considered that Dr M's prescription for stronger analgesia was effective since the patient did not contact a doctor the following day

Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions.
Please address correspondence to: *Casebook*, MPS, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK. Email: casebook@mps.org.uk

Suspected epilepsy: when to warn

›› It was stated in "Suspected epilepsy: when to warn" (*Casebook* 21(2)) that "there was nothing in the notes to suggest the hospital intended to rule out anything serious, like epilepsy". Yet an EEG was arranged. I cannot conceive of a reason for EEG other than to rule out something serious – like epilepsy. The mere fact that it was arranged – isn't it ample proof?

Moreover, presumably the patient's parents were given the EEG appointment card or information before leaving the hospital; they then chose not to bring the patient for the EEG, without bothering to find out what the test was and what it was for. Don't they bear some responsibility?

Dr Chun How Ooi, Singapore

Response

I agree with you that the statement you quote in your first paragraph is somewhat illogical.

Regarding the parents' responsibility, courts generally are reluctant to hold a patient – or in this case the child's parents – as contributing to the negligent outcome. You can imagine the persuasive power of a parent saying: "Of course if I had been properly informed of what the test was for and why it was important, I would never have knowingly put my child at risk..." And the notes usually do not document the detail of such a conversation.

Many thanks for your interesting and thoughtful comments.

Two cases: one theme

Re: the articles on pages 20 ("A rash oversight") and 21 ("A failure to monitor"), *Casebook* 21(2).

›› Two articles have a common theme. Patients in both cases sued their GP while the healthcare system and government policy neglected to ensure patient safety.

The healthcare industry should take steps to prevent chickenpox in pregnancy. We could have a national immunisation program [here in the UK] like that in the US (www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html). We could also check women for immune status at booking or preconception. As it is we rely on GPs remembering to follow a post-exposure prophylaxis protocol. Murphy's Law applies so patients suffer and doctors pay, via indemnity subscriptions, to help clear up the mess.

Why does the healthcare system have us install a piece of electronics in a man's chest without having a way to monitor it? The GP's notes may have been poor but the responsibility for the device should rest with the company that made it and the clinic that inserted it. A cardiac pacemaker is a 'mission critical' device. If it stops the patient might die. In the case you describe recording the pulse or an ECG wouldn't have given information about its activity over a period longer than a few seconds. There should be systems to ensure that it can't fail without that failure being detectable in

When normal is wrong

›› In the section headed "Learning points", it is written: "The failure rate of vasectomy, either due to failure to remove adequate sections of both vasa or recanalisation, albeit small, is of crucial significance, and must be mentioned and documented."

Unfortunately, this sentence implies that removing an "adequate section" of vas will prevent failure. Evidence from vasectomy randomised studies shows that the best way to prevent failure is to lightly cauterise the lumen of each vas and to separate the ends by a tissue plane. Separating the ends by a tissue plane but without luminal cautery is nearly as good. The older method of removing a long length of vas is associated with a higher complication rate (bleeding and pain) and higher recanalisation rate.

If any vas is removed then it should only be a small section, not an "adequate section", as one has to remove a very long section to prevent end approximation and vasectomy failure. Removing very long sections is associated with an unnecessarily higher complication rate and also makes reversal much more difficult should circumstances change. The ideal vasectomy is minimally invasive, has minimal complications, is 100% effective and 100% reversible. No technique perfectly meets these criteria but the no-scalpel technique with fascial interposition and ideally with luminal cautery is the best we currently have.

Tim Hargreave, Consultant genito-urinary surgeon (retired), Current member, research review panel, human reproduction programme, WHO, Geneva. References have been supplied, and are available on request.

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real time. At the very least there should be a way to interrogate it to determine how it has behaved in the past.

In critical event analysis we should be looking at ways to improve patient safety. A simple measure would be to change the way we record blood pressure. The data entry box for BP using INPS Vision has no facility except free text for recording pulse rate. It would be very simple to add a mandatory field for pulse rate (and reg/irreg to screen for atrial fibrillation).

I want to see MPS analysing cases to identify areas where putting pressure on government health departments and their suppliers to change policy could prevent future disasters, and then applying that pressure.

Dr Ian Quigley, Partner and GP Principal, Western Road Medical Centre, UK

Response

Many thanks for taking the trouble to write in with your response to two of the reports in the last edition of Casebook. *It is useful for us to have feedback like this, and it informs our future publications and lobbying activities. We also plan to share such activities with readers in more detail, in future articles and updates.*

A case of renal failure

» I found "A case of renal failure" (*Casebook* 21(2)) rather worrying. It states that Dr T was criticised for failing to notice that Mrs B's renal function had not been rechecked.

Mrs B had been advised by Dr T to have her bloods rechecked but if she failed to do so, then that is her fault. I see between 36-40 patients a day but do not make a list of which patients have not had the blood tests that I requested them to have.

Is MPS suggesting that this is what we should be doing?

Secondly, the report mentions that the GP should have sent a urine for ACR. My understanding is that an ACR should only be sent for diabetic patients and non-diabetic patients should have a PCR sent instead. Please do let me know if I am wrong in this regard.

Dr Muhammad Shahbaz Sharif, Salaried GP, Leicester, UK

Response

We acknowledge the practical challenges of having a system that will pick up patients who do not return with results of tests that have been ordered – it is a frequent source of debate as to whether a court would invariably hold the patient totally responsible for the consequences; a court might take the view that patients are less likely to act in a way that puts them at risk, if they understand those risks. However, there was no excuse for the GP not to have checked her renal function at subsequent visits, and the results were so significant as to suggest that the GP could not have explained the importance to the patient.

Finally I am advised that most CKD guidelines advise annual ACR checks, on all patients with an eGFR under 60, regardless of underlying aetiology.

I hope that this addresses the issues you raised.

A rash oversight

» I read with interest your case report regarding the patient who was given incorrect medical advice by non-medical staff ("A rash oversight", *Casebook* 21(2)). I notice the doctor involved was criticised for "allowing administrative and nursing staff to provide negligent medical advice". Although not knowing the full case, I assume that the doctor had no knowledge of his administrative staff giving such advice; so I wonder why the doctor is the subject of the claim and not the member of staff involved?

Secondly, with the increasing use of non-medical practitioners to cross-cover several specialties out-of-hours, who would be responsible overall for any errors in a patient's management? One example would be an error made by a member of the Hospital at Night (H@N) team on a surgical ward. The teams are not usually specialty-specific (as medical staff traditionally are) and the consultant responsible for the patient would not line manage the members of the H@N team or be involved in setting out their roles and responsibilities.

With this case report – and the increasing use of non-medical staff – I worry that when I am a consultant I may be deemed responsible for the erroneous actions of a member of staff I do not even know, purely as my name is above the bed.

Dr Callum Kaye, UK

Response

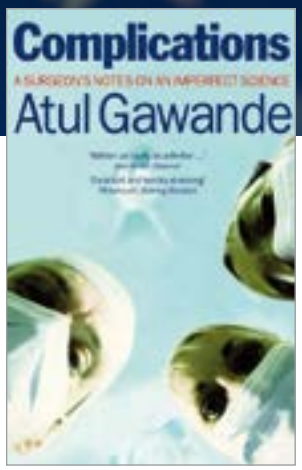
In the first case which took place in general practice, the GPs who employ practice staff are vicariously liable in law for their acts and omissions. And they would be expected as a matter of good practice to have systems and procedures in place regarding the scope of their responsibilities, as a safeguard against people acting outwith the scope of their knowledge. It would be an unsuccessful defence for the GP to argue that they were unaware of what their staff were doing.

In the hospital setting, whilst each individual is personally responsible (as opposed to liable) for their own actions, any claim would be brought against the hospital, which is liable for the acts and omissions of its employed staff, as well as for any deficiencies in policy and procedure.

I hope that this clarifies the different situations.

Reviews

If you would like to suggest an app, website or book for review, or write a review, please email sara.williams@mps.org.uk



Complications: A Surgeon's Notes on an Imperfect Science

by Dr Atul Gawande (£8.99, Profile Books, 2008)
Reviewed by Dr Omar Mukhtar, 'Darzi' Fellow, Health Education South London (UK)

Complications: A Surgeon's Notes on an Imperfect Science is a collection of essays focusing on the fundamentals and imperfections of modern surgery. With many originally written for *The New Yorker* magazine, where Atul Gawande has been a staff writer since 1998, the essays provide an honest insight into the world of modern healthcare that extends beyond the operating theatre and the consulting room – ultimately, affording readers an opportunity to reflect on the human condition itself.

Broadly grouped around three central themes – Fallibility, Mystery and Uncertainty – Gawande's essays slowly dismantle the misconceptions held by the general public whilst challenging the status quo fostered and maintained by the medical hierarchy. He admits freely that medical professionals make mistakes, that much of the knowledge we hold so dear is based on a loose interpretation of facts (often acquired many years ago) and that we do learn 'on the job'. He also acknowledges that there is much about the human body that remains stubbornly mysterious, that good doctors do go 'bad' and that there might be a case for super-specialisation from the outset of medical training.

Written with a clarity often lacking in 'populist' musings on healthcare, Gawande's work draws not only on his experiences as a general/endocrine surgeon at Brigham and Women's Hospital, Boston, Massachusetts, but also on his experiences as a father. Equally, many of the essays make reference to the scientific literature without resorting to a dry recall of facts, in a manner that must be applauded – regardless of whether they relate to the chronic pain of a stranger or the horror of a life-threatening respiratory infection afflicting his youngest child (born prematurely). That said, despite being a Rhodes Scholar who studied PPE at Oxford, Gawande's observations tend towards the superficial cliche – perhaps a consequence of the immediacy required when writing for a periodical that is published 47 times a year.

Despite this, *Complications* has a charm, confidence and humility that you suspect is intrinsic to Gawande himself. The first of three books (the others being *Better: A Surgeon's Notes on Performance* and *The Checklist Manifesto: How to Get Things Right*), you might not be wrong in assuming that it is Gawande's personal testament to a quality and safety agenda that is only now taking root in certain countries – a decade after *Complications* was first published.

Read a review of *The Checklist Manifesto* in the next *Casebook*

The Secret Anatomy of Candles

By Quentin Smith (£8.99, Troubador Publishing LTD, 2012)
Reviewed by Dr Catherine Walton, CT3 Psychiatry, Wales (UK)

Quentin Smith has delivered a promising debut novel. *The Secret Anatomy of Candles* is a medicolegal drama with an ethical dilemma that will hook even the most world-weary of medics, and stir them to discuss the central themes with colleagues over coffee.

The ideas and questions raised by the novel are topical and relevant; for example, one important theme of the book is the MMR vaccine. The week I read the novel was during the time of intense media coverage of the measles outbreak in the Swansea area. So it was immediately relevant.

The world of Jasper Candle, a "ruthless compensation lawyer", is set in the courts, bars and streets of Durham. The description of the city is excellent: Smith shows a flair for this, and it was effortless to conjure up the areas described in my mind's eye.

The man himself, Jasper Candle, is a character of some depth, with the flaws and nuances one would expect of a successful lawyer of his standing. Unfortunately, the character is perhaps rather too typical – the flaws and nuances feel somewhat unoriginal. It is clear that Candle is troubled by a physical ailment, the development and diagnosis of which is essential to the plot. Unfortunately, as a medic reading this novel, the diagnosis became clear rather sooner than I feel the author would have hoped in order to maintain suspense through to the twist at the end.

However, having discussed the plot with family members, I feel that this would not have been so apparent to a non-medical audience. Other characters within the book are somewhat more intriguing. In particular, the investigator Lazlo is perhaps the most interesting. His clothes and 'cheap' piercings put him firmly in the lower class, but he shows understanding and insight into the feelings and motivation of his employer, Candle.

The plot itself is complex and several themes run in parallel. This would be confusing were it not for some skill on Smith's part in keeping the chapters short and succinct. It also had the added benefit of keeping the pages turning. If I had any criticisms of the novel it was the use of cockney rhyming slang to add 'depth' to Candle as a character – it felt unnecessary and at times plain out of place. I also think that sometimes Smith utilised long and challenging words and sentences, which over-complicated the style of the book.

Overall, I felt that this was a great read. The storyline is relevant, up-to-date, and made me think about certain issues from a different perspective; it is certainly one to consider for your next bedtime book.

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