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Medical Protection

CASEBOOK

VOLUME 27 | ISSUE 1 | MAY 2019

ASIA

A missed diagnosis of pneumonia?

We defend a claim, aided by strong record-keeping

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From the case files

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A claim follows intraoperative accidental awareness

DELAYED DIAGNOSIS OF LUNG CANCER
A hernia repair uncovers something potentially worse

A ROUTINE REFERRAL
Why you should beware of "Oh, and by the way..."

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Every issue

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Over to you
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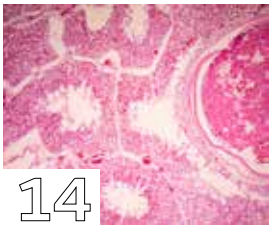

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Casebook is designed and produced twice a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

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

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Welcome

DR MARIKA **DAVIES**
EDITOR-IN-CHIEF

Over the years we have frequently spoken about the value that Medical Protection's global presence brings to our level of medicolegal expertise. With a worldwide membership, we have the advantage of having an international perspective on medicolegal risks and trends in different countries, putting us in a unique position to anticipate, and prepare members for, new and emerging challenges.

All this means you, as members of Medical Protection, benefit from the diverse skillsets acquired over the years across a diverse range of cases and medicolegal scenarios. In this edition of *Casebook* we have decided to reflect this global experience by showcasing a selection of cases that are distinctive to their country of origin.

While the educational learning points across the cases are generally applicable to everyone, it is interesting to see the variety of situations faced by members around the world, and the level of knowledge, experience and understanding required by the multidisciplinary teams within Medical Protection.

Each case is handled on behalf of members with the utmost precision and attention to detail, and there can be no shortcuts when it comes to appreciating the nuances and navigating the complex array of hearings, inquiries, court cases and claims that can affect Medical Protection members around the world.

As with every edition of *Casebook*, we present a balance of cases that we have successfully defended and some that have unavoidably drawn criticism for the member. However, there are learning opportunities throughout – even those cases that have come to a successful conclusion contain valuable risk management points, and we can all learn from the best practice that is often on display in these cases.

There were a number of talking points from the last edition of *Casebook*, and we have captured many of your views in this edition's "Over to you" section.

Please do continue to share your views on *Casebook* or any other issue with me, via my email address below or at **casebook@medicalprotection.org**.

Dr Marika Davies
Editor-in-Chief

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Claim

Paraplegia follows epidural

DR AIDAN **O'DONNELL**, ANAESTHETIST

Mrs M, a 70-year-old woman, was admitted to the local hospital's cardiac surgery unit. Six years ago, a triple coronary artery bypass graft had given her a new lease of life, but since then the grafts had gradually become blocked, and she could no longer exercise. As a result, she had put on weight and was now obese. She had always been hypertensive. Angiography showed diffuse disease in the grafts, which was not amenable to stenting, and she was offered revision surgery.

Dr E, a consultant anaesthetist, went to assess Mrs M prior to the surgery. Dr E told her that as part of his anaesthetic technique, he often inserted a thoracic epidural to provide good postoperative analgesia and support weaning from the ventilator. Mrs M was uncertain about the epidural, but Dr E reassured her it was a very effective analgesic technique. However, he made no specific mention of any risks of the epidural.

The following day, the epidural was placed uneventfully, and general anaesthesia was induced in the routine manner. As is routine for cardiac surgery, a large dose of heparin (300 units/kg, a total of 24,000 units) was given intravenously after induction to facilitate cardiopulmonary bypass. The operation took place without incident and three new vein grafts were inserted. Mrs M came off bypass readily, and the heparin was reversed as normal with protamine. She was transferred to the intensive care unit. An epidural infusion was commenced as planned, and she had a stable night.

The next morning, as the sedation was reduced, the nurse noted that Mrs M was moving her arms, but not her legs. The nurse documented that Mrs M could not feel or move her legs. However, as Mrs M seemed comfortable, she put it down to the normal effects of the epidural and did not call for medical review.

Mrs M was extubated without difficulty mid-morning. At lunchtime, she complained to the nurse that she was still unable to move her legs. The nurse called Dr E for advice. Dr E was in theatre and unable to attend. He asked that the epidural infusion be stopped and the catheter removed. He also sent for his registrar, Dr T, who arrived an hour later. Dr T examined Mrs M and found a dense motor and sensory block with a level at T6 bilaterally. Dr T reported her findings to Dr E, who arranged an emergency CT scan of Mrs M's spine. The scan showed a large haematoma in the epidural space in the mid thoracic spine, compressing the cord. Later that evening, the neurosurgical team performed an emergency laminectomy and evacuation of the haematoma.

Although she recovered from both operations, Mrs M remained paraplegic. She insisted that she had never been warned that this complication might arise, and brought a claim against Dr E.

Dr E contacted Medical Protection and a consultant anaesthetist was instructed to provide an expert report.

The expert's report was critical of several points. The ICU records were poorly kept, and observations were incompletely recorded. It was also critical of the nursing staff for failing to appreciate the significance of a patient who was unable to move her legs. Neither Dr E nor the cardiac surgeon performed a postoperative review. The report also concluded that there were unnecessary delays in recognising the problem, arranging the appropriate scan and carrying out the evacuation. Finally, it questioned the wisdom of Dr E's instruction to remove the epidural catheter prior to the scan.

On the basis of the evidence from Dr E, and the view of the anaesthesia expert, Medical Protection settled the claim for a high sum.

LEARNING POINTS

- Doctors must take reasonable steps to ensure that patients are aware of any risks that are material to them and of any reasonable alternative or variant treatments.
- Good documentation is essential for a good legal defence. In this case, although both the surgeon and Dr E said they had visited Mrs M after the operation, there was no record of her having been seen by a doctor for a period of more than 12 hours.
- It is the doctor's responsibility to give clear instructions to the nursing staff when delegating a task. Instructions should include what adverse signs to look for, and when to ask for help if things go wrong.

Claim

Too close to home

DR STEPHEN **GINN**, PSYCHIATRIST

Ms N, a 32-year-old psychiatric nurse specialist, had been off work for several weeks following an argument with another member of her team. She self-referred to see Dr B, a psychiatrist, with whom she worked closely within the same multidisciplinary team. She explained to Dr B that her alcohol intake had recently increased and she had become unusually restless, with a reduced need for sleep. She had also been spending more money than usual and had been getting into fights with her partner and sometimes with strangers.

At the consultation she said that in the past she had experienced similar episodes of increased activity and also reported periods of low mood. She had described herself as "moody", but had never considered this sufficiently serious to seek referral to a psychiatrist. Dr B made a diagnosis of bipolar disorder, currently hypomanic. Ms N agreed to start pharmacological treatment.

Ms N and Dr B had a long conversation about the treatment of bipolar disorder, and Ms N was prescribed sodium valproate, a mood stabilizer. At the next consultation her sleep was improving and her hypomania appeared to be reducing. However she soon started to complain of low mood and Dr B decided to prescribe lamotrigine, in addition to her valproate, as a treatment for bipolar depression. Ms N was familiar with both sodium valporate and lamotrigine as treatments for bipolar disorder and was taking precautions to avoid pregnancy as valproate is a known teratogen.

The symptoms of Ms N's depression persisted and she had still not returned to work. As a result, Dr B suggested that they should increase the dose of lamotrigine. Ms N was concerned about the impact a history of psychiatric disorder would have on her employment. So she sought to put pressure on Dr B to limit what was documented in her records.

Unfortunately, as a result of the increase in the dose of lamotrigine, Ms N developed a severe form of Stevens-Johnson syndrome and spent some time seriously ill in ICU.

The conversation about the increase of lamotrigine dose, and any discussion of possible side effects, was poorly recorded. It is unclear whether the possibility of developing Stevens-Johnson syndrome was touched upon; Dr B had some recollection of the exchange but had not committed this to writing. She remembered thinking that she didn't want to sound patronising to Ms N, as she thought Ms N was usually extremely competent at her nursing job.

Following her time in ICU, Ms N was unable to return to work and she made a claim against Dr B.

Dr B contacted Medical Protection for assistance and the legal team instructed a psychiatry expert to examine the case. The expert was critical of Dr B's management of Ms N's drug regime, as there is a known high risk of developing Stevens-Johnson syndrome when sodium valproate and lamotrigine are combined – a risk that increases with dose.

Because of the critical expert report, it was felt that the claim could not be defended. It was settled for a high sum.

LEARNING POINTS

- It is good practice not to treat people close to you, either relatives or colleagues.
- Patients should receive assurance about confidentiality and, if they are unsatisfied, alternative arrangements can be made. The best patient care is normally achieved through multi-disciplinary teamworking and appropriate sharing of information between professionals.
- Good record-keeping is essential in all medical specialties. Documenting relevant conversations is always good practice and can make a difference at the time of defending a case.
- Taking knowledge for granted with any patient poses potential risks and, when ill, even the most expert person becomes vulnerable. It is safer to assume no prior understanding, even with patients whom one might expect to be well-informed.
- Many medications have serious untoward effects, especially when used in combination. Patients need to be fully informed of possible side effects and adequately supervised.
- There is a known risk when combining sodium valproate and lamotrigine (see relevant prescribing guidance).

Claim

Treating asthma over the phone

DR ANNA **FOX**, GP

Mr P was a 35-year-old mechanic with a wife and a young child. He had suffered from asthma since he was a boy and his asthma was poorly controlled. He had been admitted to hospital several times over his life with exacerbations of his asthma. During one of these admissions, he had been so unwell he had needed a stay on the high dependency unit. Over the last year he had had to take considerable time off work, particularly when his breathing was bad in the mornings.

Mr P had been registered with his single-handed GP practice all his life and had attended many times about his asthma. However, there was no record in his notes that his inhaler technique had ever been checked or that his peak flow had been measured.

Mr P developed a cough with green sputum and his breathing became more difficult than usual. He felt tight-chested and wheezy and his salbutamol inhaler did not help. He rang his GP, Dr T, and asked for advice. Dr T took a brief history over the phone and left him a prescription for some antibiotics.

By the next day, Mr P's chest felt tighter so he rang Dr T again. Dr T advised him that the antibiotics may need a few days to start working and to see how things progressed. Mr P had a very disturbed night with a great deal of coughing. He noticed that he was out of breath walking around his house and had called in sick at work.

Dr T admitted that he had panicked at the time of Mr P's collapse

He allowed another two days to see if the antibiotics would take effect, but then rang his GP again. Dr T left a prescription for some steroids to collect, but again did not ask Mr P to come to the surgery to be examined. Dr T had not taken a complete history of Mr P's asthma and was thus unaware that his usual control was poor or that he had attended the Emergency Department (ED) twice over the last year, resulting in admission. He was also unaware that one of those admissions had necessitated a stay on the high dependency unit and there was no hospital follow-up.

Mr P contacted the surgery again in the same week, worried that his breathing seemed to be deteriorating rather than improving. Despite him sounding short of breath on the phone while speaking to the GP, he was still not offered an appointment at the surgery. His wife became concerned because he was having difficulty speaking in full sentences without becoming short of breath, so she booked him an emergency appointment at the surgery.

Mr P was exhausted, but attended the emergency appointment the same day. He became extremely short of breath and collapsed in the surgery with a respiratory arrest. Dr T contacted the emergency services for an ambulance and attempted resuscitation, which was unsuccessful and caused Dr T to panic. Mr P was declared dead after 45 minutes of attempted resuscitation by paramedics and ED doctors.

Dr T admitted that he had panicked at the time of Mr P's collapse because he felt de-skilled in his resuscitation knowledge.

Mr P's wife was devastated and made a claim about the long-term management of Mr P's asthma and the acute incident.

Dr T contacted Medical Protection and requested assistance.

An independent investigation was highly critical of the long-term and acute management of the asthma and of the de-skilling, lack of equipment and of practice management. Based on the medical records, the independent investigation and the evidence of Dr T, the claim was settled for a substantial sum.

LEARNING POINTS

- Badly controlled asthma patients need to be carefully assessed to find out the real reasons for this. Could this be due to poor compliance? Is there an occupational trigger? What are the psychosocial aspects affecting this patient's asthma control?
- It is important to keep up-to-date with basic life support skills, particularly when not regularly used, making sure you comply with requirements in the jurisdiction in which you are working.
- In circumstances where a doctor has assessed and provided treatment over the phone, a low threshold for face to face review should be maintained if there is little or no improvement in symptoms.

Inquest

An uncollected prescription

RACHEL **DIGGINS**, CASE MANAGER, MEDICAL PROTECTION

This inquest case took place in the United Kingdom, and refers to some processes of local relevance

Mr A, who was 77 years old, had a history of dementia, diabetes mellitus, hypertension, ischaemic heart disease and severe chronic obstructive airways disease (COPD), for which he was on long-term oxygen therapy. He was a resident in a care home.

Mr A was seen by Dr P, a GP, and presented with fever and a cough that was productive of green sputum. Dr P diagnosed an infective exacerbation of COPD and prescribed antibiotics. He advised the care home staff that the practice would contact them when the prescription was ready to collect later that day. Dr P generated the prescription when he returned to the practice and the reception staff called the care home that afternoon.

The prescription was never collected and Mr A died four days later. The cause of death was identified as bronchopneumonia due to COPD.

INQUEST

An investigation began into the death of Mr A, and the coroner obtained statements from a pathologist, Dr P, the care home manager, the daughter of Mr A, and a healthcare support worker. The statements highlighted a conflict between the GP surgery and the care home staff, in relation to whether the care home was notified that the prescription was ready for collection.

In light of the concerns surrounding the issuing and collection of the antibiotics and its impact on Mr A's death, the coroner decided to hold an inquest. Both the GP practice and the care home were identified as interested persons, and two witnesses were called: Dr P and the care home manager.

Through Dr P's oral evidence, it was clear that the practice had appropriately issued the prescription. There was a note in the medical records that reception staff had contacted the care home to notify them that the prescription was ready for collection at 14.15. However, there was no record of which member of the care home staff they spoke to.

The care home manager conducted an investigation in relation to this. They were unable to identify from those working that afternoon who the practice had spoken to, as there was no record of the telephone call.

As a result of the incident, the practice conducted a significant event analysis (SEA) investigation. Through this, they implemented changes in how they communicated with care homes and how they dealt with uncollected prescriptions.

OUTCOME

The coroner returned a conclusion of natural causes. In his summing up, he determined that although earlier administration of antibiotics may have lessened Mr A's symptoms, it was unlikely – given the severity of his COPD and other comorbidities – to have prevented Mr A's death.

As the practice had already carried out an SEA and made improvements to the practice systems, the coroner did not issue a Regulation 28 report.[1] He recommended that the care home review its systems in relation to the collection of prescriptions for residents.

HOW MEDICAL PROTECTION HELPED

Dr P was a member of Medical Protection and made contact when he received the request from the coroner for a statement. Medical Protection helped Dr P to draft his statement and recommended that the practice carry out an SEA investigation.

When the practice was confirmed as an interested person, Medical Protection instructed legal representation to represent Dr P's interests at the hearing, obtained disclosure of relevant documents from the coroner and prepared Dr P for giving evidence. He had not given evidence at an inquest before so found the prospect of attending quite daunting.

Dr P's clear and detailed statement assisted him during his oral evidence, and demonstrated to the coroner and the family that the appropriate steps had been taken to prevent a similar incident in the future.

Dr P felt reassured and supported by Medical Protection, which gave him confidence during his oral evidence. Dr P was not criticised by the coroner, avoiding the need to self-refer to his regulatory Medical Council.

REFERENCES

1. In the UK, a Regulation 28 report sets out the concerns raised in a coroner's investigation and requests that action should be taken. All Regulation 28 reports and the responses are sent to the chief coroner.

Claim

A retained swab

DR SAM **DRESNER**, GENERAL SURGEON

Miss Y, 37 years old, was known to have bilateral ovarian endometrial cysts, which were treated surgically by Mr D, a consultant gynaecologist. Repeat scans after surgery showed recurrence of the cysts, which were subsequently managed with dydrogesterone.

She subsequently presented as an emergency, complaining of severe dysmenorrhoea for three days. Bilateral ovarian cysts were again confirmed on a trans-vaginal ultrasound scan and a decision was made for her to undergo further surgery.

Mr D performed a laparotomy and found recurrent bilateral ovarian cysts stuck down in the pouch of Douglas and adherent to the back of the broad ligament. Both fallopian tubes were dilated but otherwise normal. Mr D recorded that the right ovary was freed and chocolate coloured material aspirated.

The left ovary was drained in situ, but no attempt was made to free it. Before the operation, Mr D inserted a small pack into the posterior fornix in an attempt to keep the uterus and ovaries elevated. Miss Y had never been sexually active.

Miss Y made an uneventful recovery and was discharged from hospital on day four. Three weeks later she was referred back to the gynaecology department with increasing pain and urinary incontinence. Clinical examination demonstrated left iliac fossa tenderness but an ultrasound scan was negative.

Miss Y made an uneventful recovery and was discharged from hospital on day four. Three weeks later she was referred back to the gynaecology department

A diagnosis of dysmenorrhoea, secondary to endometriosis, was made as the patient had begun menstruating two days earlier. The patient declined admission to hospital as she was anxious to go home. Mefenamic acid was prescribed and she was reviewed by Mr D two weeks later.

At this stage she complained of a foul smelling vaginal discharge although her pain and urinary symptoms had settled. A high vaginal swab was taken and the patient was given continuous progesterone for three months and doxycycline for ten days. At a further review two weeks later the patient was well with no evidence of discharge, but an offensive odour was detected.

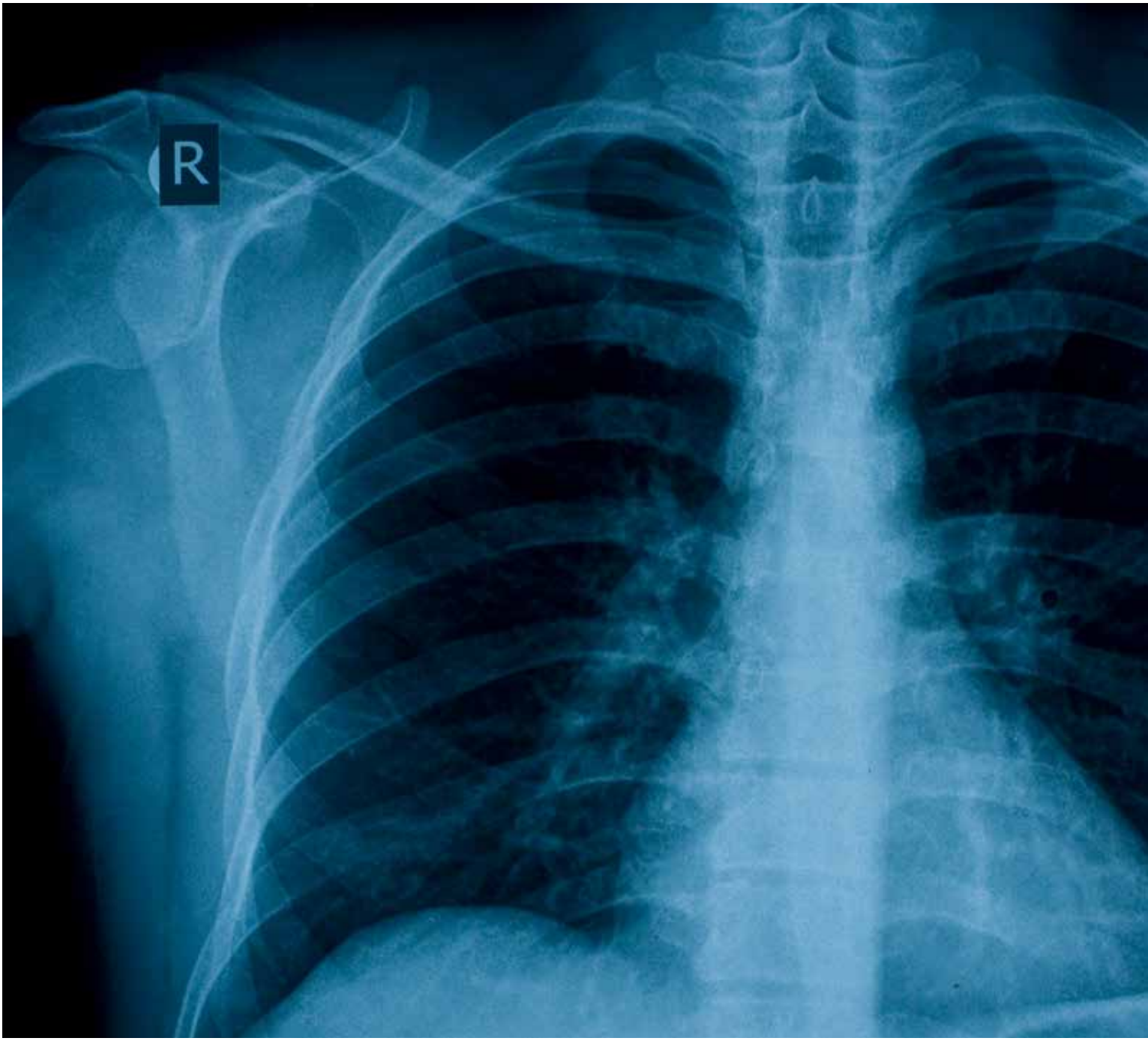
Betadine vaginal pessaries were prescribed and Miss Y was asked to reattend in three weeks. Upon reattendance, it was found that the foul smelling discharge had resumed. Further swabs revealed the presence of faecal organisms and the betadine pessaries were continued.

The patient's problems persisted. Eight months after the original operation she was reviewed again by Mr D who performed a speculum examination. This revealed the pack in the posterior fornix, which was removed, and the vagina washed with betadine. In addition, antibiotics were prescribed. The patient subsequently made a full recovery.

The patient initiated proceedings against Mr D, citing negligence in failing to remove the pack during the operation. A further complaint was also made that Mr D failed to suspect or locate the pack after surgery by not taking reasonable steps to heed or investigate her complaints. Responsibility for not removing the pack and failing to diagnose its presence for several months was accepted and the claim was settled for a moderate sum.

LEARNING POINTS

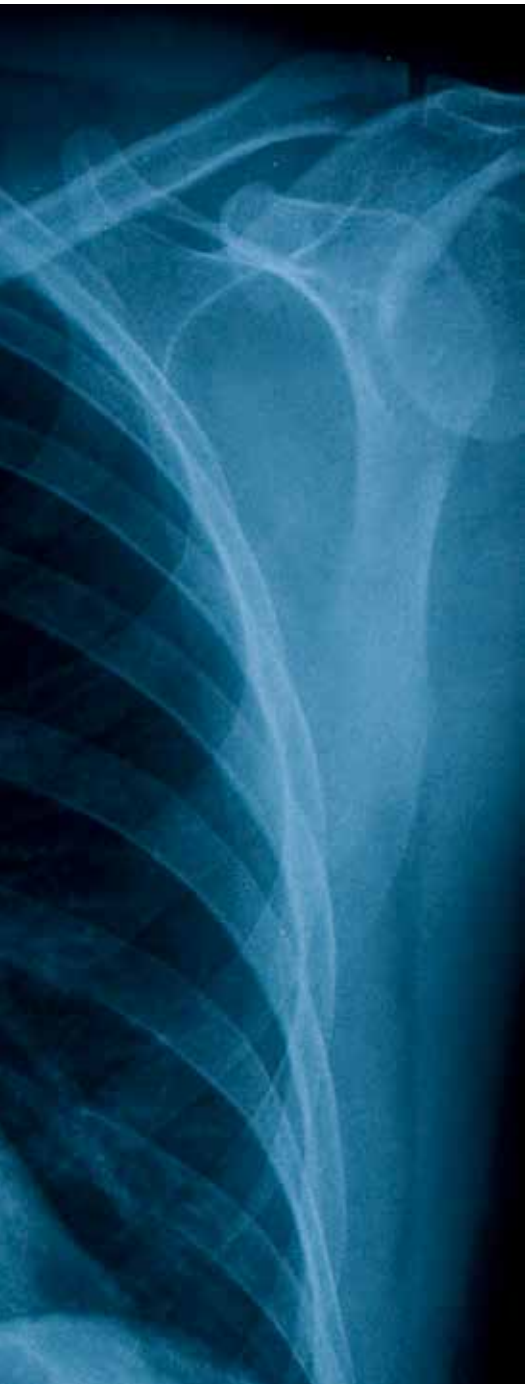
Such incidents as described in this case report continue to occur after operative procedures with variable degrees of subsequent harm. Each organisation and individual surgical team need to implement safety checks and take responsibility for ensuring that all surgical instruments and packs or swabs used in an operation are counted in and counted out. The World Health Organisation Surgical Safety Checklist has been widely implemented and has specific elements to help reduce the risk of such events. See *www.who.int* for more information.



Claim

A missed diagnosis of pneumonia?

DR HEIDI **MOUNSEY**, MEDICOLEGAL CONSULTANT, MEDICAL PROTECTION



A 41-year-old estate agent, Mrs P, attended the emergency department by ambulance complaining of pain to her upper chest and left shoulder, which had started the same day. On examination, her chest was clear and ECG and temperature were normal, and she was discharged with a diagnosis of muscle spasm.

She presented to her GP, Dr N, three days later complaining of ongoing pain to her upper back, chest and both shoulders. Dr N recorded that Mrs P said her chest hurt when she breathed and she felt tired. Dr N was aware of Mrs P's attendance to the emergency department, and in his consultation sought to establish if there was an alternative, perhaps more serious, diagnosis than muscle spasm.

> *Mrs P remained in intensive care for ten days, and was discharged from hospital a month after she was originally admitted.*

On examination, Mrs P had a respiratory rate of 16 breaths per minute, normal auscultation of the chest, and an oxygen saturation of 98%. She was tender on palpation of her upper back, chest and shoulders. Dr N did not check Mrs P's temperature and she did not complain of feeling feverish. Following a thorough history and examination, Dr N concurred with the emergency department's diagnosis of muscular pain, and prescribed analgesia. He advised Mrs P to return if there was no improvement within a couple of days, or to return urgently or attend the emergency department if she felt matters were deteriorating.

Mrs P contacted the practice again two days later, this time speaking to Dr R, to say she felt no better and now also had a cough. Dr R arranged a home visit and found Mrs P to be very short of breath at rest, with a heart rate of 120 beats per minute, a respiratory rate of 26 breaths per minute, and oxygen saturation of 93%. Coarse crackles were heard bilaterally on examination of the chest.

Dr R was concerned that Mrs P may be suffering from pneumonia, and arranged hospital admission. Shortly after arriving at hospital, Mrs P deteriorated and required intubation and ventilation, with admission to intensive care. Microbiology investigations were positive for *Streptococcus pneumoniae*.

Mrs P remained in intensive care for ten days, and was discharged from hospital a month after she was originally admitted.

A claim was brought against Dr N, alleging that he negligently failed to perform a proper clinical examination, to include temperature measurement, and failed to exclude pneumonia as a diagnosis. It was further claimed that at the time of the consultation with Dr N, Mrs P had been unable to walk without assistance and was struggling to breathe.

It was alleged that antibiotics should have been commenced and/or referral to hospital for further investigation should have taken place, and had this been done Mrs P's lengthy hospital admission would have been avoided, and she would not now be suffering from ongoing fatigue that prevented her from returning to work.

EXPERT OPINION

Medical Protection instructed a GP expert and a respiratory medicine expert.

The GP expert considered that although there was a factual dispute about how unwell Mrs P appeared to be at the time of the consultation with Dr N, the medical records demonstrated no evidence that there were clinical signs of pneumonia, and there was no requirement for Dr N to have prescribed antibiotics or made a referral to hospital in view of the normal respiratory rate, normal oxygen saturation and no abnormal chest signs on auscultation. The muscle tenderness elicited on palpation would not be consistent with pneumonia and would not necessitate antibiotic treatment. The GP expert concluded that Dr N's management was appropriate and of the standard of a responsible body of GPs.

The respiratory medicine expert considered that, on balance, even had Mrs P's temperature been taken by Dr N, this likely would have been normal in the absence of any description of fever by Mrs P and the fact that a normal temperature was recorded on her admission to hospital. Had Dr N referred Mrs P to hospital and a chest x-ray obtained, this is likely to have shown features of pneumonia. Had broad spectrum oral antibiotics been commenced by Dr N or by the hospital, then it is likely progression to severe pneumonia would have been prevented, thus avoiding the need for hospital admission and intensive care. Complete recovery would have been achieved after approximately six weeks.

On the basis of the medical records, the evidence of Dr N and the views of the experts, especially that of the GP expert, Medical Protection defended Dr N's actions and the claim was subsequently discontinued.

LEARNING POINTS

- Do not assume that a diagnosis made by a previous clinician is always accurate – consider alternatives and seek to establish if there could be serious or sinister causes for symptoms.
- Good clinical record keeping is vital, including documentation of observations. In the context of a claim, a factual dispute between the claimant and the clinician may arise, and thorough notes help to prevent or resolve such issues.
- It is important to provide safety netting, including advising a patient to return if there is no improvement within a specified time frame, as well as advising on action to take if symptoms deteriorate.

Claim

Accidental anaesthetic awareness

DR HEIDI **MOUNSEY**, MEDICOLEGAL CONSULTANT, MEDICAL PROTECTION

A 41-year-old project manager, Mrs F, underwent breast uplift surgery, performed on a private basis.

Induction of anaesthesia was performed by Dr T using propofol and fentanyl, and a laryngeal mask airway was inserted. A muscle relaxant was also administered. Anaesthesia was maintained with a propofol infusion, and a remifentanil infusion was also used.

Shortly after Mrs F had been transferred from the anaesthetic room to theatre, it was noted her heart rate significantly increased, as did her blood pressure. Although this change was recorded on the anaesthetic monitoring printout, it was not recorded in the handwritten anaesthetic chart.

Dr T noted the changes and considered the increase in heart rate and blood pressure indicated the level of anaesthesia was light, and so the rate of infusion of both propofol and remifentanil were increased, and midazolam was also given.

Dr T did not record on the anaesthetic chart why these measures had been taken.

The surgery proceeded uneventfully, but on recovering from anaesthesia Mrs F stated to ward staff that she had "woken up" during the operation and could hear the surgeon talking and feel tugging and pushing. She tried to scream and move away, but could not.

She later brought a claim against Dr T for intraoperative accidental awareness resulting in psychiatric injury.

EXPERT OPINION

Dr T contacted Medical Protection, who instructed a consultant anaesthetist to provide an expert report.

The expert concluded that Dr T did not use a target controlled infusion pump (which would have used mathematical modelling to calculate and adjust the dose), and also failed to perform any calculation or refer to an infusion regime about the rate of propofol infusion that would be required to keep Mrs F adequately anaesthetised.

The expert calculated that the rate per hour at which the propofol was administered was around half of the rate that would be recommended for Mrs F, based on her weight. The infusion rate of remifentanil was also around half of what would be recommended.

The expert further considered that there was no surgical or anaesthetic requirement for muscle relaxation to be used in this particular case, and the use of a muscle relaxant contributed to the occurrence of awareness, as did the failure to monitor the depth of anaesthesia (although such monitoring would not be mandatory).

The expert held the view that it was appropriate for Dr T to have given midazolam and to increase the rate of infusion of propofol and remifentanil when Mrs F's heart rate and blood pressure increased, and anaesthesia was suspected to be light. However, criticism was given with respect to the failure to clearly document this event on the anaesthetic chart.

OUTCOME

On the basis of the medical records and the expert report, it was considered the claim could not be defended and it was settled for a low sum.

LEARNING POINTS

- If a target-controlled infusion pump is not used to administer total intravenous anaesthesia, then careful consideration and calculation of the rate to be infused must be performed. A number of infusion regimes have been described for use when manually adjusting infusion rates of propofol.
- The risk of anaesthetic awareness is increased when a patient is paralysed, and thought should be given on whether use of a muscle relaxant is necessary for the particular procedure being performed.
- Consider using a depth of anaesthesia monitor when administering total intravenous anaesthesia, especially when a muscle relaxant is also administered.
- Contemporaneous record keeping should be accurate and reflect the events that have occurred.

Claim

A routine referral?

DR HEIDI **MOUNSEY**, MEDICOLEGAL CONSULTANT, MEDICAL PROTECTION

Mrs F, a 48-year-old office worker, attended her GP, Dr A, complaining of unilateral headache in conjunction with double vision and nausea. Dr A considered the symptoms may be due to migraine but, as examination elicited nystagmus on looking to the right, an urgent referral to neurology was made. The remainder of the neurological examination, including fundoscopy, was normal.

Mrs F was offered a neurology appointment for a date approximately three weeks later, but failed to attend. She was therefore discharged and sent a letter to say that if she wished to have a further appointment, she needed to be re-referred by her GP.

Two weeks after the missed appointment she attended the GP practice again, this time seeing Dr T. She complained of several non-neurological symptoms, and at the end of the consultation mentioned in passing that she had missed the neurology appointment and needed another referral.

Dr T requested that the practice administrative staff forward the original referral, which they duly did; however, this time the referral was inadvertently marked routine rather than urgent. An appointment was therefore offered for a date approximately five months later.

During the wait to see the neurologist, Mrs F attended the GP practice on a number of other occasions to complain of headaches with flashing lights and occasional double vision. Migraine continued to be the working diagnosis. Dr T performed another neurological examination, which was documented to be normal. Dr T also performed fundoscopy as part of the examination, but as this was normal she did not specifically document it.

Mrs F was reviewed in the neurology clinic a month after this appointment, and again a normal cranial nerve examination was documented, along with specific documentation that fundoscopy was normal. A diagnosis of migraine was made, and amitriptyline was offered.

Six weeks later, Mrs F attended for a routine optician appointment, where papilloedema was identified – and she was referred to the emergency department for further review. Magnetic resonance imaging identified a right-sided acoustic neuroma and Mrs F went on to have this surgically removed.

A claim was brought against Dr T, alleging that the repeat referral letter should have been marked urgent, and that the neurological examination at the second consultation with Dr T should have included fundoscopy, or documentation of the same if it had been performed.

It was alleged that had papilloedema been identified at an earlier time, imaging would have been performed sooner and the acoustic neuroma would have been removed when it was smaller, reducing the severity of Mrs F's postoperative disability, which included a facial palsy, balance impairment and right-sided deafness.

EXPERT OPINION

Medical Protection instructed a GP expert to review the claim.

The GP expert considered that Dr T had performed an appropriate assessment of Mrs F's symptoms, and was not critical of a failure to specifically record that fundoscopy was normal when it was performed as part of a neurological examination.

However, the expert was somewhat critical that the copy of the referral letter was marked routine rather than urgent, despite the subsequent neurological examinations of Mrs F being normal.

In addition, subsequent fundoscopy performed on Mrs F, including by the neurologist, was normal – meaning that it was unlikely to have been present at an earlier time, and therefore would not have been identified earlier than it was.

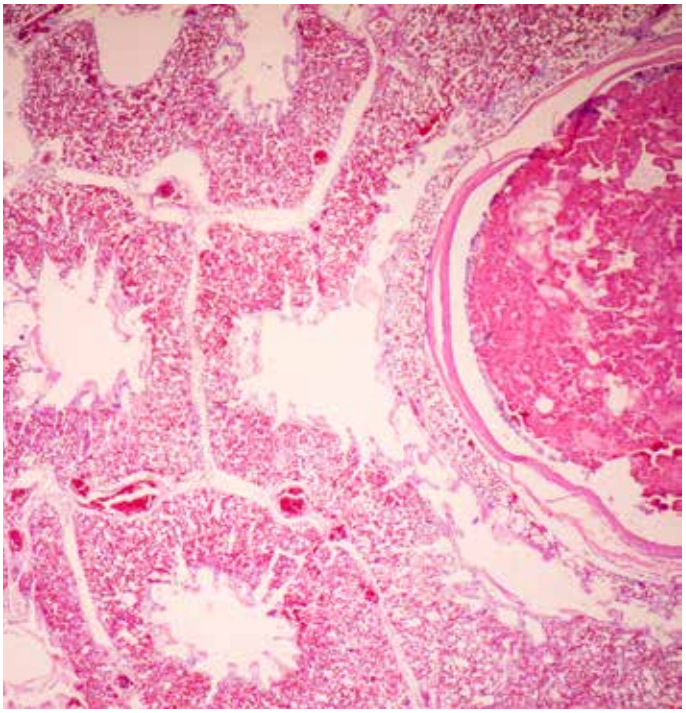
OUTCOME

On the basis of the GP expert report, medical records and the evidence of Dr T, Medical Protection argued that the actions of Dr T were appropriate and that papilloedema would not have been identified at an earlier time, thus the outcome for Mrs F would have been no different.

The claim was subsequently discontinued.

LEARNING POINTS

- Consider documenting in the records that a specific examination, such as fundoscopy, has been performed, even if the findings are normal. This will help to avoid any future allegations that the examination has not been conducted.
- Take care when delegating tasks to non-clinical staff and give clear instructions about the urgency of any referrals, where appropriate. GP partners can be held liable for the actions of their administrative staff.
- Beware "Oh, and by the way..." comments at the end of a consultation – on a busy day, it may be easy to miss a matter of importance to the patient.



Claim

Delayed diagnosis of lung cancer

DR HEIDI **MOUNSEY**, MEDICOLEGAL CONSULTANT, MEDICAL PROTECTION

Mr U, a 60-year-old businessman, was admitted to hospital for repair of an inguinal hernia. A chest x-ray was requested by Dr F on admission as part of the routine preoperative investigations.

The x-ray showed an incidental finding of a well-circumscribed mass in Mr U's left upper lobe of the lung, and the reporting radiologist recommended further evaluation by CT scan. However, Dr F did not review the chest x-ray or the report prior to surgery. He was not the operating surgeon who ultimately undertook the procedure, and the operating surgeon was not aware that the investigation had been requested. Postoperatively the care of Mr U was handed over to yet another surgeon, Dr B, who discharged Mr U the same day, again without having reviewed the chest x-ray.

Seven years later, Mr U was admitted to hospital for sudden onset shortness of breath and chest pain. Bronchoscopy and a CT scan were carried out, confirming Mr U had small cell carcinoma of the lung.

Mr U made a claim against Drs F and B, both Medical Protection members, and the hospital, alleging missed diagnosis of early lung cancer at the time of his hernia repair, resulting in a poorer prognosis from the disease.

EXPERT OPINION

Medical Protection instructed an expert, who considered that the lesion identified on the original x-ray likely grew to become the cancer that was later diagnosed, and that Mr U's prognosis would have been better with earlier detection and treatment.

The expert considered that Dr F's involvement was to order the investigations on behalf of the operating surgeon, and Dr B's involvement was reviewing and discharging Mr U postoperatively (when it would be expected that abnormal preoperative findings would have already been acted on or flagged for future action). The expert was critical that no clinician involved had reviewed the x-ray despite several opportunities to do so, including in an outpatient follow up clinic held by Dr F shortly after the surgery.

The expert also commented that there were systems failures on the part of the hospital, for example there was no system in place for clinicians to note whether or not an investigation had been reviewed and acted on, and ultimately concluded that these factors were the main cause of the delay in identifying the lesion.

OUTCOME

The claim was settled by the hospital with a contribution from Medical Protection, in view of the expert's criticisms.

Bronchoscopy and a CT scan were carried out, confirming Mr U had small cell carcinoma of the lung.

LEARNING POINTS

- Although the expert considered there to be significant system failings on the part of the hospital in this case, a clinician should not assume that others will review and act on investigation results. In a hospital setting, it would usually be expected that the clinician requesting the investigation would also review the results.
- If the requesting clinician is aware they will not be the one to review the results, adequate handovers of patients should take place in order to highlight which investigations have been requested, and any results which are outstanding.

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Claim

Forgotten blood test results: forgotten patient

DR SOPHIE **HAROON**, MEDICAL CLAIMS ADVISER, MEDICAL PROTECTION

Baby L, a term baby with an unremarkable antenatal history, was brought to Dr W for a hepatitis B vaccination at around four weeks of age. The baby was noted to be mildly jaundiced.

On further questioning, the mother stated that the baby's stools were pale. Blood tests were taken, including a total bilirubin level and conjugated bilirubin level. Dr W advised the mother that she would be called if the blood test results were abnormal. Unfortunately, following a busy clinic, Dr W misplaced Baby L's details, so was unable to trace the results.

The results showed a total bilirubin of 110 micromol/l and a conjugated bilirubin of 55 micromol/l. When the results were received at the surgery, Dr W happened to accidentally mark them as normal, so they were automatically filed in Baby L's record without any further action being undertaken.

One month later, the baby's mother attended the surgery with her other child and asked about Baby L's results. The abnormal bilirubin levels from four weeks ago were identified at this point. Bilirubin levels repeated that day showed a total of 124 micromol/l and a conjugated level of 70 micromol/l.

Baby L was urgently referred to the local paediatric department for further assessment and management. He was diagnosed with biliary atresia and underwent a Kasai procedure four days later. The baby was 70 days old at the time. He made an initial good recovery but two months later deteriorated and needed a liver transplant. He remained on immunosuppressants with an optimistic ten-year prognosis.

The parents of Baby L brought a claim against Dr W, alleging a failure to follow up and act on the first set of abnormal bilirubin results, leading to delayed diagnosis and management of biliary atresia. They claimed that as a result of the delay, the Kasai procedure had a suboptimal outcome and so led to the need for a liver transplant.

Dr W contacted Medical Protection and requested assistance.

EXPERT OPINION

The expert instructed by Medical Protection was critical of Dr W's management, citing his loss of the baby's details, which meant he could not follow up the blood test results – despite the advice he had provided to the mother – and then he signed off an abnormal set of results. These errors led to a delay in diagnosis, which was only circumvented by the mother asking about the results whilst in attendance at the practice for another reason. Expert opinion also said that a full liver panel should have been requested at the time of the original testing.

Expert opinion on causation concluded that the delayed diagnosis did not cause the need for a Kasai procedure, but the consensus was that early surgery (within the first eight weeks of life – some even say the first four weeks) would have led to a better outcome. In addition, they noted that although a Kasai procedure can address biliary atresia in the short term (and eliminate the need for a transplant in up to 25% of patients), by the age of 20, some 70-80% of patients would need a liver transplant regardless. Thus on balance, they concluded that Baby L was more likely than not to have always needed a liver transplant at some point in his life. However, the early failure of the Kasai procedure had expedited this need and prolonged the time he would spend on immunosuppressants.

OUTCOME

Medical Protection settled the claim for a moderate amount, while continuing to monitor Baby L for an updated prognosis and potential further payments.

LEARNING POINTS

- Clinicians can deal with hundreds of blood test results every day. Having a plan about which ones to follow up, and how these results might be communicated to the patient, are crucial.
- Clear messages to patients about whether they will or will not hear about results is important. This plan should also be documented in the medical records.
- A plan on handling normal and abnormal results is needed. Even normal results may lead to further action, let alone abnormal ones.

Claim

Fifteen years of urinary tract infections – what's the cause?

DR CLARE **DEVLIN**, MEDICOLEGAL CONSULTANT, MEDICAL PROTECTION

Mrs Q had undergone a kidney transplant and, after surgery, re-presented with urinary tract infections on a number of occasions over a 15-year period. It was later found that Mrs Q had a retained ureteric stent from her transplant, and she brought a claim against Dr X, the genitourinary consultant who provided follow-up care.

Dr X contacted Medical Protection and requested assistance. When discussing the case with our medicolegal consultant, he explained that imaging of Mrs Q's urinary system was not clinically indicated during the periods of urinary symptoms because there was no indication of a structural or obstructive abnormality to warrant imaging studies. He also said Mrs Q was predisposed to urinary tract symptoms and infections because of her history of kidney transplant and chronic immunosuppression, her gender, age, and the menopause.

EXPERT OPINION

The expert instructed by Medical Protection was supportive of Dr X's approach, including his decision to prescribe prophylactic antibiotics instead of ordering an ultrasound scan during the second cluster of urinary symptoms.

In addition, the expert also highlighted that Mrs Q failed to attend various follow-up consultations and was often non-compliant with the medical therapy for her chronic kidney disease, hyperlipidemia, gout and arthritis, which may have contributed to the symptoms she complained of. In particular, Mrs Q's non-compliance with allopurinol treatment may have caused more frequent flares of her gouty arthritis, and failure to follow up with gynaecology caused persistence of her vaginal symptoms.

Medical Protection successfully defended the claim and it was discontinued by Mrs Q.

LEARNING POINTS

- The experts we instruct will examine a case carefully to understand and reconstruct the information that was reasonably available to the treating doctor at the relevant time. For example, in this case, there was no reason for Dr X to suspect a retained ureteric stent, as the operating surgeon had made no record of stent insertion.
- Experts also analyse and comment on the impact of a patient's non-compliance with treatment and non-attendance at follow-up appointments, and provide an opinion on the consequences for the patient's clinical course and symptoms.

> *The expert instructed by Medical Protection was supportive of Dr X's approach, including his decision to prescribe prophylactic antibiotics instead of ordering an ultrasound scan*

Over to you

Medicine – not an exact science

Though I retired from practice many years ago, I find your journal compulsive reading – mainly because, looking back, I often reflect that there, but for the grace of God, went I.

Clinical medicine is not yet a science, but an art that uses science, and while an educated (not trained) professional physician is more to be trusted than a quack, patients cannot in retrospect expect perfection in their medical advisers, much as we would like to attain it day in day out, especially when not only skill and learning is involved in every consultation, but what the patient perceives as humanity.

Those reflections lead me to have serious doubts about the way the GMC goes about its business – on the one hand failing to check the qualifications of a doctor on registration, on the other, failing to appreciate what is involved in dealing with the presentations of illness in stressful situations. I am thinking in particular about the case of Dr Bawa Garba in which, in my view, not she, but those who sat in judgment of her, should have been struck off the register and/or prosecuted.

As I understand it, the GMC was set up to supervise the moral and professional conduct of doctors and is not properly constituted to judge their conduct in coping with illness – their choice of experts requiring an appreciation of what constitutes claims to authority in a particular field. In the case quoted, to state that it concerned what he (or she) called a "barn door case of sepsis" on the strength of Dr Bawa Garba's own notes betrays both arrogance and ignorance. (What is 'sepsis'? A term not in use in my time but presumably referring to overwhelming infection.)

Professor John A Davis

A wrong diagnosis but no criticism

I read the account of the case entitled "A wrong diagnosis but no criticism" with an increasing sense of foreboding from paragraph 3. It was at this point that the 28-year-old patient's past history of anxiety for which he had received counselling was revealed, and my fear – that whatever happened next would be put down to anxiety – was sadly realised. The symptoms of rapid breathing and tingling in his fingers were taken as indicating a panic attack, and it seems that from then on until his collapse into unconsciousness from intra-abdominal bleeding secondary to splenic rupture, that the door was closed to the possibility of any other diagnosis – even for a young man being observed in the resuscitation area following a major RTA.

Not only did the coroner miss an opportunity to flag up a clear case of 'diagnostic overshadowing', but so too have Medical Protection. The learning point does not emphasise enough that patients who happen to have a history of mental illness are repeatedly harmed both in acute situations and in the management of established co-morbid physical illness, by medical staff who ascribe physical symptoms to mental illness without investigating and managing appropriately. The question for all in the case of G is how would he have been managed if he hadn't had a previous history of anxiety?

Dr Moira Connolly
Consultant psychiatrist

Negligent assessment and system failures

I read this article in the November 2018 edition of *Casebook*. The learning points and parts of the description of the case are quite misleading. The National Patient Safety Agency (NPSA) safety practice notice 16 is very clear on placing the burden of responsibility for acting on radiological reports on the referrer. It states: "Ensure systems are in place to provide assurance that requested images are obtained...and that the results of these are viewed, acted upon and recorded. It is the referring health professional's responsibility to ensure that this is followed."

In this case the radiologist both reported the abnormality and recommended follow-up but the referrer either did not read the report or ignored it. You state that "the report was not flagged as abnormal to the ED", but it did of course describe the abnormality entirely correctly and give the required advice on management. Reports do not need to be "flagged to the ED", but rather the ED needs to read all reports and act upon them, as do all referrers. The message is very clear here, or should be: every report of an investigation must be read by the referrer and acted upon appropriately, as required under the NPSA safety notice. Any additional alert placed by radiology on certain reports may be helpful but is not a substitute for what should be normal practice on the part of all referrers.

A great many tests contain abnormalities and if departments place additional alerts on hundreds of reports each day, they soon lose any impact they might have. A normal report can be just as important as an abnormal one, since if the test is normal presumably no explanation for symptoms has been discovered and further investigation may well be required. All reports need to be read. If referrers choose to delegate the responsibility to other staff they remain culpable should an error occur. This is a wake-up call to all professionals who request imaging tests of any sort to examine their processes and ensure that they read and act upon each and every one, not to assume that somebody else will give them a nudge about the ones that 'really' need looking at and that they can ignore the rest.

Richard Orme
Consultant radiologist

Thank you for your email pointing out your concerns about this case report. I would just point out that the learning points stated: "Failsafe systems are a 'safety net' and do not remove responsibility from the referring clinician to ensure that all reports of requested examinations are reviewed and acted upon."

Radiological investigations

In your *Casebook*, you frequently state that radiological investigations are "ordered" but they are in fact "requested". A request for a radiological investigation is a referral from one specialty to another for a radiological opinion, not an order for a test. The request has to be approved under radiation law.

Marc Williams
Consultant radiologist

Correcting semantics

I always read *Casebook* with great interest. Known by some as the horror comic. What is often described as indefensible is frequent practice (eg not sending sebaceous cysts for histological assessment).

I am writing to correct semantics. In "Negligent assessment" on page 9, radiographers and radiologists are done disservices. The respiratory physician did not "repeat the chest X-ray". They presumably requested that a radiographer repeat one. Dr P did not "order a chest X-ray", they requested one. The GP did not order a CT scan; they requested one. These requests should have been seen and optimised by a radiologist. If such a relationship between consultant radiologists and their colleagues does not exist, communication may reach such a poor level that errors like this are more likely.

Jules Dyer
Consultant radiologist

A sight for sore eyes

In "A sight for sore eyes", *Casebook* volume 26(2), it is stated that "doctors who have had a negligence claim are more likely to face litigation again even if the medical care they provide is no different from their peers".

Would it be possible to share the reference from which this assertion was drawn? It is a most interesting notion; the opportunity to peruse the study would be appreciated.

Dr John McGough

Thank-you for getting in touch. The reference in question is Studdert DM, Prevalence and Characteristics of Physicians Prone to Malpractice Claims, N Engl J Med 2016; 374:354-362

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