

# CASEBOOK

## PHYSICIAN, HEAL THYSELF

TREATING YOURSELF, FAMILY  
MEMBERS OR FRIENDS  
– WHAT SHOULD YOU DO?

PAGE 6

From the case files.....

### ANTIBIOTIC ALLEGATIONS

Was a GP negligent for not prescribing antibiotics?

### A DELAYED DIAGNOSIS

Persistent abdominal symptoms but what was missed?

### AN ELUSIVE FOREIGN BODY

A child, a plastic toy – and pneumonia?





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# WHAT'S INSIDE...



## FEATURE

### 06 Physician, heal thyself

Treating yourself, family members or friends is a medicolegal minefield, yet the temptation is all too real. Dr Rob Hendry, medical director at Medical Protection, recently met with the MCNZ to clarify the key points.

## CASE REPORTS

### 08 An elusive foreign body

A child suffers recurrent episodes of pneumonia following the inhalation of a plastic toy.

### 09 Living up to expectations

A surgeon fails to inform a patient about a complication that may have occurred.

### 10 Problematic pacemaker placement

A patient undergoes multiple procedures due to problems with their pacemaker placement.

### 11 Delayed diagnosis

A patient repeatedly attends over the years with persistent abdominal symptoms.

### 12 Antibiotic allegations

A patient alleges her GP was negligent for failing to prescribe antibiotics.

### 13 A case of mistaken haemorrhoids

A patient presents with symptoms of haemorrhoids but is it something more sinister?

### 14 A pain in the knee

An 11-year-old girl repeatedly attends her GP complaining of knee pain.

### 15 Caught by consent

A private neurosurgeon faces questions regarding consent.

### 16 Complications of nitrofurantoin

A patient on long-term medication begins to feel short of breath.

### 17 Chain reaction

A patient presents with a sore wrist after a fall.

## EVERY ISSUE...

### 04 Welcome

Dr Marika Davies, Editor-in-Chief of Casebook, welcomes you to this edition and comments on some topical issues.

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ISSN 2056 4449

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.

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### 05 Noticeboard

News and updates from the Casebook team.

### 18 Over to you

What did you think about the last issue of Casebook? All comments and suggestions welcome.

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## EDITORIAL TEAM

**Dr Marika Davies**  
EDITOR-IN-CHIEF



**Gareth Gillespie**  
EDITOR



**Rebecca Imrie**  
EDITORIAL CONSULTANT



## PRODUCTION

**Philip Walker** Production Manager

**Emma Senior** Corporate Design Manager

**TU Ink** Print

## CASE REPORT WRITERS

**Dr Rachel Birch**



**Dr Clare Devlin**



**Dr Anna Fox**



**Dr Emma Green**



**Dr Monica Lalanda**



**Dr Janet Page**



**Dr Rafael Sadaba**



**Dr Ellen Welch**



**Dr Philip White**



Please address all correspondence to:

Casebook Editor  
Medical Protection  
Victoria House  
2 Victoria Place  
Leeds LS11 5AE  
United Kingdom

[casebook@medicalprotection.org](mailto:casebook@medicalprotection.org)



# WELCOME

**Dr Marika Davies**  
EDITOR-IN-CHIEF



**T**here are many emotional dilemmas and sensitive areas of clinical practice, but one issue that stands out is treating yourself, friends and your family. It is understandably hugely tempting to do this, given that you are qualified for the job and clearly equipped with the knowledge and experience to do so.

However, apart from exceptional circumstances, the accepted advice is to avoid treating yourself or anyone close to you. A clear, informed decision on treatments for any patient must be an objective one, and it goes without saying that objectivity is not possible when you are emotionally involved in the patient's wellbeing. Doctors make notoriously bad patients, and it is always surprising to hear how many are not registered with a GP, and if they are they are reticent to seek treatment when unwell.

MCNZ guidance is no different in its stipulations, and in this edition of *Casebook* our medical director Dr Rob Hendry provides a summary of the do's and don'ts – while also reflecting on a meeting with the MCNZ on the issue.

Advice calls from members are a large part of the workload of our medicolegal advice team, as is the management of all types of cases that many members become involved in. This wide variety of cases isn't always reflected in *Casebook*, where traditionally we have devoted much of the focus to clinical negligence claims, perhaps because of the sheer costs that are often associated with them.

However, due to the ACC, the vast majority of our work in New Zealand does not involve clinical negligence claims, but instead involves providing advice and assistance with report writing, complaints, MCNZ procedures, inquests, employer disciplinarys and police investigations. From this edition on, the *Casebook* team will be working hard to bring you case reports from these different areas of medicolegal jeopardy, painting a more complete picture of the modern landscape in which you practise and the range of services available to you as a Medical Protection member.

We've started things off in this edition with a case that describes how we helped a GP respond to a patient complaint about an alleged delay in diagnosing a scaphoid fracture. The quick and thorough way with which the complaint was subsequently dealt helped stave off any possible escalation into an MCNZ referral.

I hope you enjoy these new case reports and the rest of this edition – please do get in touch with your views and comments.

**Dr Marika Davies**  
Editor-in-Chief  
[marika.davies@medicalprotection.org](mailto:marika.davies@medicalprotection.org)

## NEW ANNUAL REPORT FROM MPS

MPS's 2016 Annual Report is now available on our website.

The report contains MPS's full financial statements, together with our strategic report, report of the Council and statements by Kay-tee Khaw (Chairman of the Council), Simon Kayll (Chief Executive) and Howard Kew (Executive Director – Finance and Risk).

In previous years, MPS has posted a summary version of our Annual Report to all members worldwide. Following feedback from members, the report will no longer be posted out and, instead, will be published in full on our website each year, representing a cost saving for members.

To view the 2016 Annual Report, please visit the About section of [www.medicalprotection.org](http://www.medicalprotection.org).

## AMENDMENT TO THREE PRIVACY CODES

New Zealand's Privacy Commissioner has amended the Health Information Privacy Code 1994 (Amendment No 9), the Telecommunications Information Privacy Code 2003 (Amendment No 6), and the Credit Reporting Privacy Code 2004 (Amendment No 11), in light of reforms made by the Intelligence and Security Act 2017.

## SNAPSHOT OF HEALTHCARE QUALITY

*A Window on the Quality of New Zealand's Health Care 2017* is a report released by the Health Quality & Safety Commission (HQSC), giving a snapshot of the quality of New Zealand's healthcare. It shows continuing improvements, but also highlights ongoing inequity in treatment. The report can be found on the HQSC website at [www.hqsc.govt.nz](http://www.hqsc.govt.nz).

## ALERT – PRESCRIBING ERROR

The HQSC has published an Open Book, *ALERT: Prescribing error – dabigatran and enoxaparin*, to alert providers to adverse event cases. Visit [www.hqsc.govt.nz](http://www.hqsc.govt.nz) to see more.

## NZ DOCTOR AMENDS HIPPOCRATIC OATH

A New Zealand doctor's amendment to the modern Hippocratic Oath sworn by all doctors has been ratified unanimously by the World Medical Association (WMA).

Queenstown doctor Sam Hazledine's change allows doctors to prioritise their own health as well as that of their patient. The Physician's Oath, first adopted in 1948, is a modern version of the ancient Hippocratic Oath and is the vow read out by doctors when they qualify.

The amendment adds the clause: "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard." Until now, the declaration has had no provision relating to self-care.

Dr Hazledine said the motion passed unanimously and received a standing ovation. He said he pressed for the change after becoming concerned about burnout in the profession, including the fact that suicide rates among doctors are climbing. Half of all New Zealand GPs have said in surveys they are either burntout or approaching it.

The amendment happened after Dr Hazledine presented a petition requesting a change to the WMA a year ago, signed by 4,500 Australasian doctors.

The New Zealand College of General Practitioners said the amendment was much needed. College medical director Richard Medicott said, traditionally, New Zealand doctors have put their own health on the back burner. They worked hard, expected perfection from themselves and the stress caused burnout, he said.

# PHYSICIAN, HEAL THYSELF

Treating yourself, family members or friends is a medicolegal minefield, yet the temptation is all too real. *Dr Rob Hendry*, medical director at Medical Protection, recently met with the MCNZ to clarify the key points

## READ THIS ARTICLE TO:



- ✓ Understand the risks of treating yourself or those close to you
- ✓ Discover your obligations in a number of scenarios

**F**ollowing our recent article (“A family matter”, *Casebook* 24(1), May 2016) on the subject of treating yourself, friends and family, we received a number of letters and comments from members on what were seen as overly restrictive guidelines (*Statement on providing care to yourself and those close to you*) from the MCNZ.

Along with other members of the Medical Protection team, I met with senior members of the MCNZ to raise these concerns. In a very productive discussion with Andrew Connelly and Philip Pigou, we explored members’ concerns – particularly those raised by doctors who were concerned they might end up in front of their regulator for prescribing over-the-counter medication for themselves, or their family.

Following this meeting, we all agreed it is important to clarify the aims of the guidance. Any patient that requires treatment by a physician has to have an opportunity to consult an objective, independent professional who makes the patient’s care their prime concern. This objectivity will inevitably be lost when close personal or family bonds exist.

## TO SELF-CARE OR NOT?

The human condition is beset with ailments; it is helpful to think of them and treatments as sitting on a continuous spectrum. At one end there are the trivial, self-limiting conditions such as colds, insect bites and aches and pains, where we expect all reasonably competent adults to treat themselves with 'over the counter' medications.

Setting aside serious emergency conditions that require urgent intervention, such as myocardial infarction, septicaemia and major trauma, we find at the far end of the spectrum chronic serious conditions that can impact the quality and expectancy of life. Depression, hypertension, diabetes, epilepsy would fall into this category. You may be tempted to manage such conditions in yourself or someone close to you, especially in the early stages or where the situation is poorly defined.

The spectrum passes from situations where people can treat themselves, through where it may be reasonable for qualified healthcare professionals to treat those close to them, to an area where such involvement is increasingly inappropriate.

The question is, where do we draw the line?

## WHEN SELF-CARE IS OK

The first line that needs to be drawn is the point where the 'man or woman in the street' can no longer self-prescribe, since that in effect is what they do when they purchase medicines from a pharmacy or supermarket. The manufacturers produce guidance leaflets that are included in the packaging, but whether this is heeded is largely left up to individuals themselves.

Pharmacists can give some advice, and an increasing array of paramedical specialists also step into this space of advising and prescribing without recourse to a registered doctor. I think this is appropriate, albeit that the advice is to see a doctor for further investigation.

## FIND OUT MORE

- As a Medical Protection member, you have access to a range of free workshops that offer practical advice on reducing your risk. Visit [medicalprotection.org](https://www.medicalprotection.org) to find out more.
- If you have any further queries on this or any other medicolegal issue, call our medicolegal advice line on **0800 225 5677**.

## STEPPING OVER THE LINE

Then there is the line over which a doctor steps at their peril. When asked to treat someone close to you, it is wise to stand back and relate the situation to where on the spectrum the individual's health issue sits.

There are clearly times where it might be reasonable to prescribe, for example prescribing a salbutamol inhaler for your asthmatic child on holiday when they have forgotten to bring their regular supply with them. However, it would not be reasonable to manage your child's respiratory condition on a continuing basis.

One way to avoid such dilemmas is for all doctors to ensure that both themselves and their families are registered with a GP. The MCNZ acknowledges this may present problems in remote communities, but with the support of professional peer groups and new technologies, many doctors have found ways of overcoming geographical constraints.

## 'NO, NOT EVER'

Then there are those situations where we are all agreed that doctors must not treat themselves, their families, or those close to them. The guidance sets out a list of situations which includes prescribing or administering controlled drugs and those with a risk of addiction or misuse, prescribing psychotropic medication, undertaking psychotherapy or performing invasive procedures. Doctors should also avoid issuing certificates or undertaking medical assessments for third parties.

## YOU ARE ACCOUNTABLE

Ultimately, it will be for the professional to account for their decisions and actions. It is important that the current guidance is understood and borne in mind when deciding whether or not to give advice or offer treatment.

Where you do decide to prescribe or treat someone close to you, it is absolutely vital that you document what has been done and why, and that you notify the individual's GP as soon as reasonably possible. Should the decision be called into question, good record-keeping and communication will greatly assist in justifying your actions.



# AN ELUSIVE FOREIGN BODY

A child suffers recurrent episodes of pneumonia following the inhalation of a plastic toy

Author: Dr Mónica Lalanda

**C**hild H, a three-year-old boy, was brought into the Emergency Department (ED) of a private hospital by his mother, having inhaled or swallowed a small plastic building block. They brought a similar piece with them. Child H was seen by Dr W, who documented that he appeared well, with no signs of respiratory distress and a normal auscultation. Dr W arranged for him to have a chest x-ray, which both Dr W and a radiologist considered normal.

Two months later, Child H became unwell with a cough and a high temperature. His mother brought him to the ED where, following a chest x-ray, he was diagnosed with right lower lobe pneumonia. Child H's mother mentioned to Dr F – the doctor who saw them – that they had been to the ED not long ago after Child H “swallowed” a little toy. All this was documented.

During the next two years, Child H suffered recurrent episodes of pneumonia and attended the ED five times. He saw a different doctor on every occasion and had five more chest x-rays. All of them were reported as “right lower lobe pneumonia with collapse and some pleural fluid”. There were no indications in the ED notes to suggest that previous notes or x-rays were looked at.

In view of the recurrent chest infections, Child H's GP, Dr W, referred him to the paediatric team for further investigations. Paediatric consultant Dr Q saw Child H in clinic, looked at all the x-rays and became suspicious of the presence of a foreign body. An urgent bronchoscopy was organised and a large piece of plastic removed. Child H required further surgery as the foreign body had caused fibrosis of the pulmonary parenchyma, which required excision.

Child H's mother made a claim against the private hospital and all the hospital doctors involved during those two years.

## EXPERT OPINION

The experts commented that “a case of a possible inhaled foreign body has to be followed up closely and even without a clear history of inhalation of a foreign body, this should be considered a possibility in cases of recurrent pneumonia in children with persistent x-ray changes”.

The case was deemed to be indefensible and was settled for a moderate amount.

## Learning points

- Taking a good history can save a lot of mishaps in clinical practice; it is important to listen. Digging into the details of what happened to this child could have made it clear whether the foreign body was swallowed or inhaled. The sudden onset of respiratory difficulty, with coughing, stridor or wheezing, needs to be specifically investigated. If inhalation is suspected, careful follow-up is required to determine the need for a bronchoscopy.
- Many types of plastic are radiolucent and will not show up on an x-ray.
- Asking the radiographers to place an example of a foreign body, if brought in by the parents, next to the patient they are going to x-ray will easily determine whether it is a radio-opaque object or a radiolucent one.
- Previous attendances to the ED by children might be relevant in a significant number of cases. Hospital note-gathering systems may be helpful in picking up previous ED attendances. Reviewing old notes is therefore always important and might offer unexpected background to a new presentation.
- With modern computerised radiographic storing systems, there is little excuse not to look at previous x-rays. Both clinician and radiologist would have been alerted to the fact that the changes in the chest x-ray were chronic and would therefore be suspicious of a foreign body being present.
- In the New Zealand environment, it would be exceedingly rare for there to be a claim of negligence made against the doctors – but they may have been vulnerable to a complaint to the HDC.



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# LIVING UP TO EXPECTATIONS

A surgeon fails to inform a patient about a complication that may have occurred

Author: Dr Rafael Sadaba

**M**r G was a 62-year-old office worker; he was overweight (BMI 29) and suffered from exercise-related angina. Mr G had several risk factors for ischaemic heart disease including smoking, diabetes mellitus and hypercholesterolaemia. Following a positive exercise test, a coronary angiography confirmed triple vessel coronary artery disease with a left ventricular ejection fraction of 45%. He was referred to Mr F, a consultant cardiothoracic surgeon, for consideration of coronary artery bypass graft (CABG) surgery.

Based on his symptoms and the severity of his coronary artery disease, Mr F strongly advised Mr G to undergo surgery on both prognostic and symptomatic grounds. He also explained the risks of the operation, stating that the risk of death was below 3%. In view of the seriousness of his condition, Mr G accepted to be put on the waiting list for CABG. He was strongly advised by Mr F to stop smoking and lose weight before the operation.

Mr G underwent an uneventful triple bypass. Mr F documented the use of bilateral internal mammary artery and saphenous vein grafts. Following surgery, Mr G made a good recovery, although a control chest x-ray showed an elevation of the right hemidiaphragm. Mr F and his team decided not to share this finding with Mr G in order to avoid giving him unnecessary reasons for concern. Mr G was eventually discharged home on the seventh postoperative day, having made a good recovery.

Six weeks later, Mr G attended clinic for a postoperative surgical review. He mentioned that he was angina-free but complained of dyspnoea on moderate exertion. Mr F put this down to the fact that Mr G was still recovering from the operation and said that "things would get better soon". Mr G was discharged from the clinic back to the care of his own GP.

The shortness of breath persisted during the next few months and Mr G mentioned this to his cardiologist, Dr T. Dr T reviewed the chest x-rays and arranged an echocardiogram, which showed a poor left ventricular function with significant dyskinesia in the inferior and lateral walls of the left ventricle. Pulmonary function test showed a mild reduction in total lung capacity. A chest fluoroscopy test revealed paralysis of the right hemidiaphragm. The final diagnosis was right phrenic nerve palsy secondary to surgical damage.

Mr G made a claim against Mr F because of the damage to his right phrenic nerve during the operation. The case was defended successfully, based on the facts that damage to the right phrenic nerve is a rare, but known, complication of right mammary artery harvesting and that his deteriorated heart function, rather than the paralysed diaphragm, was the likely cause of his breathlessness.

## Learning points

- Mr F was not open about the complication; he should have warned Mr G as soon as it happened, as part of the ongoing consenting process. If he had disclosed the complication and explained why it had occurred, the complaint may never have arisen.
- *Cole's Medical Practice in New Zealand* states you must be open and honest with patients if things go wrong. Open disclosure is important and would have also allowed monitoring of the patient's ongoing dyspnea and the potential causes for this.
- Patients should not be given false expectations. Surgical procedures do not always result in a complete cure, but can slow down deterioration and reduce the risks of serious complications. In this case, Mr G was led to believe that the operation would rid him of all his angina and dyspnoea.
- Surgical complications are not necessarily a result of medical negligence. However, when these do occur, giving an open clear explanation to the patient of the possible causes and consequences decreases the likelihood of complaints.



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# PROBLEMATIC PACEMAKER PLACEMENT

A patient undergoes multiple procedures due to problems with their pacemaker placement

Author: Dr Rachel Birch, medicolegal adviser at Medical Protection



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**M**r U, a 29-year-old teacher, was referred to Dr N, a consultant cardiologist, with a history of several episodes of dizziness, perspiration and palpitations. A 24-hour ECG had shown episodes of tachycardia and bradycardia, and second-degree Mobitz type II heart block was demonstrated when symptomatic.

Dr N recommended a procedure to insert a permanent pacemaker, to which Mr U consented. The procedure was straightforward, with the post-procedure chest x-ray and pacemaker check both recorded as satisfactory. Mr U was discharged home.

Six weeks later, a routine pacemaker check demonstrated a high threshold in the ventricular lead (which could signify potential pacemaker failure), despite satisfactory positions on the chest x-ray. Dr N prescribed a short course of steroids.

The following month, Mr U was admitted to hospital with left-sided chest pain and episodes of tachycardia and bradycardia. Dr N undertook an exploration of the pacemaker system and replaced the ventricular lead. Dr N reviewed the post-intervention chest x-ray and felt it was satisfactory; the patient was discharged.

Mr U was readmitted by ambulance late that evening: a pacemaker check demonstrated that the ventricular lead did not capture the ventricle.

The following day Dr N re-sited the ventricular lead and re-advanced the atrial lead. Again, the post-procedure chest x-ray and pacemaker check were felt by Dr N to be satisfactory. Mr U was kept under observation for two days and advised to keep his arms still. Dr N's notes stated that he suspected Twiddler's Syndrome, which occurs when a patient manipulates the pacemaker's pulse generator and dislodges the leads from their intended location.

A week later, another pacemaker check demonstrated a failure of the pacemaker and the ventricular lead. Mr U, unhappy with his care so far, asked to see a second cardiologist.

He was referred to Dr B, who undertook a revision of the pacemaker. She found the suture sleeves to be loose and that both leads were mobile. Following the procedure, a pacemaker check and chest x-ray were both satisfactory and Mr U was discharged home. He had no further problems with his pacemaker following Dr B's intervention.

Mr U made a clinical negligence claim against Dr N, alleging that, in the second and third procedures, he had failed to secure the leads to prevent them from moving, and that he had failed to check appropriate lead positioning during and after the procedures.

## EXPERT OPINION

Medical Protection sought expert opinion from a consultant cardiologist. The expert was critical of several aspects of the care provided by Dr N.

First, the expert cited that the post-procedure chest x-rays from the second and third procedures showed unsatisfactory lead positions, which would have made lead dislodgement likely. Also, she could find no evidence of Twiddler's Syndrome on any chest x-ray.

The expert also noted that, in the fourth procedure, Dr B could not find evidence of lead sutures, suggesting that the leads were not secured adequately.

Based on the expert opinion, the case was deemed indefensible and was settled for a moderate sum.

## Learning points

- It is important to take extra care suturing the leads during a revision procedure, especially if there has already been an episode of lead migration.
- Twiddler's Syndrome is a well-known but infrequent cause of pacemaker malfunction. A chest x-ray would usually show the two leads migrated to the same degree and rotation of the pulse generator, so making the diagnosis.

# DELAYED DIAGNOSIS

A patient repeatedly attends the surgery over a number of years, with persistent abdominal symptoms

Author: Dr Ellen Welch, GP

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**M**rs F, a 30-year-old housewife, visited her GP, Dr O, with a four-week history of diarrhoea. Dr O arranged a stool sample for microscopy and culture (which was negative) and prescribed codeine. Four months later, Mrs F was still having diarrhoea, especially after meals, and she had started to notice some weight loss. She returned to the surgery and this time saw Dr P, who examined her and found nothing remarkable, but decided to refer her to gastroenterology in view of her persistent symptoms.

Mrs F was seen four months later by the outpatient gastroenterology team, who attributed her symptoms to irritable bowel syndrome (IBS). She underwent a sigmoidoscopy, which revealed no changes, and was diagnosed with functional bowel disease.

Four years later, Mrs F developed difficulty passing stools after the birth of her second child. She was referred to the colorectal team and underwent a further sigmoidoscopy, which revealed no abnormalities. She was referred for pelvic floor physiotherapy.

Two years later, Mrs F returned to her GP and consulted Dr G with the sensation of a lump in her rectum preventing her from defecating. She reported incomplete bowel emptying and the need to manually evacuate. She was referred back to the colorectal surgeons, who arranged a barium enema, which was reported as normal.

Three months later, Mrs F visited the practice again with a two-week history of diarrhoea and abdominal cramps. Dr B saw her on this occasion and diagnosed her with possible gastroenteritis. He arranged a stool culture, coeliac screen and routine bloods.

Mrs F returned a week later for follow-up with Dr Y, reporting ongoing diarrhoea with no rectal bleeding. Dr Y noted the recent normal barium enema and sigmoidoscopy and normal stool culture. The blood tests remained pending so Dr Y sent Mrs F to hospital to get them done. The results for the coeliac screen were normal.

Another three months later, Mrs F was still symptomatic and attended Dr P with diarrhoea and bloating. No abnormalities were found on abdominal and PR examination. Dr P diagnosed IBS and prescribed amitriptyline.

Over the next three weeks, frustrated at the lack of resolution of her symptoms, Mrs F had several GP appointments with Dr G, Dr P, Dr O, Dr B and Dr Y. She was referred for a colonoscopy and pelvic ultrasound – all of which were normal. She was re-referred to the colorectal surgeons and a family history of pancreatic insufficiency was discussed during the outpatient appointment. Faecal elastase confirmed pancreatic insufficiency and a CT abdomen revealed obstructing pancreatic duct calculi. She underwent ERCP and Frey's procedure, which failed to resolve her symptoms and, at the time of the claim, Mrs F was considering a total pancreatectomy.

A claim was brought against Dr P, Dr Y and Dr O, for failing to take into account Mrs F's family history of chronic pancreatitis and arranging a specialist referral and follow-up.

## EXPERT OPINION

On the basis of the medical records and the evidence provided by the doctors involved, the GP expert was supportive of Dr P, Dr Y and Dr O. Given that Mrs F did not mention her family history of chronic pancreatitis, there was no reason to suspect pancreatic insufficiency as a cause for her symptoms. The claim subsequently discontinued.

## Learning points

- Where patients are repeat attenders with ongoing symptoms, it is important to consider alternative causes for their symptoms.
- Careful documentation of consultations is imperative and greatly assists when responding to complaints.
- Where patients are repeat attenders, it is important to consider all past consultations, particularly if patients do not see the same practitioner each time, to ensure that continuity of care is not impacted.
- It would be helpful for there to be evidence in the notes that details of family history had been obtained, and ideally updated from time to time.

# ANTIBIOTIC ALLEGATIONS

A patient alleges her GP was negligent for failing to prescribe antibiotics

Author: Dr Clare Devlin, medical claims adviser at Medical Protection

**M**iss G, 23, presented to GP Dr Q with a four-day history of fever, cough and green/brown phlegm. On examination, she was afebrile with no chest signs except expiratory wheeze.

Dr Q's clinical impression was of a viral infection. The clinical findings were supported by the fact that Miss G was on day four of a five-day course of amoxicillin, prescribed by her dentist, which had not produced an improvement in her symptoms.

Given the history and examination findings, Dr Q did not feel Miss G required a further course of antibiotics; in any event, Miss G was already receiving the correct antibiotic and course duration, as set out in the NICE guidelines for empirical cover of low risk community-acquired pneumonia.

Dr Q advised Miss G about viral infection, and performed appropriate safety-netting with instructions in the event of the symptoms worsening, new symptoms developing or a failure to improve.

Miss G did not re-present to Dr Q, but did see other doctors when her cough failed to improve, and she received further courses of antibiotics at this point. She later fractured a rib during a bout of coughing, but made a full recovery.

Miss G made a claim against Dr Q, alleging a failure to prescribe any or an adequate dosage of antibiotics to treat the symptoms of fever and productive cough. She also alleged there was a failure to advise against continuing amoxicillin, which allegedly had not been prescribed for Miss G's symptoms and which had only one more day left of the course, and finally alleged that her chronic cough led to her rib fracture.

## EXPERT OPINION

In this case, Medical Protection was able to serve a robust letter of response denying liability, based on our legal team's assessment and the quality of Dr Q's medical records, supplemented by a helpful detailed account provided by Dr Q.

This approach by Medical Protection enabled the claim to be dealt with rapidly, without the need to instruct an independent expert witness or generate expenditure on an expert report.

The letter of response served by Medical Protection highlighted the appropriate history and examination performed by Dr Q and the lack of clinical indication for antibiotics. It also explained that Miss G was already on first-line empirical antibiotic treatment, started by another clinician for a different problem, and it would be inappropriate to interfere with that clinician's recommendation.

Miss G's solicitors discontinued the claim after receiving the firm letter of response from Medical Protection.

## Learning points

- On receiving a complaint, members may be shocked and aggrieved to see allegations that are factually incorrect and may in addition be medically misconceived. In this case, we see contradictory allegations, where Dr Q is simultaneously being criticised for failing to stop an antibiotic and for failure to prescribe an antibiotic.
- Medical Protection is accustomed to allegations of this nature and takes care to address them fully, with a comprehensive rebuttal of all factual and clinical inaccuracies. In this we are greatly assisted by thorough accounts of incidents from our members, and especially quality documentation in the form of contemporaneous medical records.
- The Choose Wisely resource ([choosingwisely.org.nz/professional-resource/asid/](http://choosingwisely.org.nz/professional-resource/asid/)) provides evidence to support not prescribing antibiotics for uncomplicated URTIs.



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# A CASE OF MISTAKEN HAEMORRHOIDS

A patient presents with symptoms of haemorrhoids but is it something more sinister?

Author: Dr Emma Green, medical claims adviser at Medical Protection

**M**r F, a 33-year-old policeman, attended his GP, Dr B, with a six-month history of abdominal pain and rectal bleeding. The abdominal pain had become more constant over the preceding few weeks and laxatives reportedly eased the pain; the pain had eased on the day of the consultation. The blood was bright red in the toilet bowl and on the stool and paper, there was no mucus in the stool and no family history of cancer. Dr B documented no weight loss or joint pains. A telephone consultation earlier the same day, with another GP, had referred to Mr F “straining” to pass his stool.

The examination revealed a soft abdomen with slight lower abdominal tenderness. There were no masses and no organomegaly, and a rectal examination revealed an empty rectum with no masses.

Given the age of the patient and the description of the blood, Dr B felt this was most likely haemorrhoids secondary to constipation, which was being eased by the laxatives. He advised further laxatives, blood tests to look for inflammatory bowel disease and for Mr F to return in four weeks, if no better.

Mr F did not attend for blood tests nor did he return to see Dr B. One year later he was admitted to hospital and diagnosed with metastatic colorectal cancer, from which he died within a year.

A claim was made against Dr B by Mr F’s family, alleging he was negligent in diagnosing haemorrhoids when these were not visualised, instead of referring to secondary care for further assessment. It was alleged that these failures resulted in a 12-month delay in diagnosis and a nine-month reduction in life expectancy.

## EXPERT OPINION

A GP expert considered that the history of straining with fresh red blood on defecation would be consistent with a diagnosis of haemorrhoids. The recorded history in the records was felt to be detailed enough to support Dr B, and his logical reasoning that constipation was the most likely cause of the abdominal pain, the improvement with laxatives and the straining to pass stool. The blood tests and safety netting were also considered appropriate and it was felt there was no breach of duty. In addition, the expert was supportive of the diagnosis of haemorrhoids in the absence of visualisation, noting that haemorrhoids are frequently not palpated but diagnosed following a history consistent with them that lacks features suggesting something more sinister.

An expert oncologist instructed in the case did not support the claim that Mr F would have survived for a further nine months, had the tumour been diagnosed earlier.

Medical Protection served a robust letter of response, denying both breach of duty and causation and the claim was discontinued against Dr B.

## Learning points

- Record-keeping was the most important aspect in defending this case. Important positive findings and relevant negatives should be recorded to enable a clear logical reasoning to be followed.
- Rectal examination should always be performed in patients presenting with rectal bleeding. When a patient declines this examination, it should be clearly documented that they are aware of the implications this could have on diagnosis.
- Although uncommon, malignancy can be a cause of rectal bleeding in younger patient groups.



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# A PAIN IN THE KNEE

An 11-year-old girl repeatedly attends her GP complaining of knee pain

Author: Dr Janet Page, medical claims adviser at Medical Protection



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**M**iss F, an overweight 11-year-old, attended her GP, Dr A, complaining of knee pain and clicking for two months following a twisting injury whilst playing football.

Examination was unremarkable, with straight-leg raising to 90 degrees and a full range of movement in the knee. Dr A treated with simple analgesia and arranged for an x-ray of the knee the following week. The x-ray was normal and Miss F was advised to see her GP for review.

Miss F next attended the practice seven weeks later, when she was seen by Dr B. She was complaining of pain in the right groin, which was worse on walking or standing. Dr B recorded in her notes that it was “probably muscle strain or too much pressure on hip joint because of her weight”. She prescribed diclofenac.

Five days later, Miss F attended the emergency department (ED) at the local hospital complaining of a painful right hip with difficulty walking. A diagnosis of ligament sprain was made.

Two days later, Miss F again attended the practice and was seen by Dr C. Examination revealed reduced range of movement in the right hip. Dr C arranged a routine appointment for a hip x-ray for the following week.

The day before the appointment, Miss F attended the ED in severe pain. Hip movements, particularly flexion and internal rotation, were noted to be limited. The diagnosis of slipped femoral capital epiphysis was confirmed on x-ray and classified as “mild” (less than 30 degrees). Miss F subsequently underwent pinning of the epiphysis.

Over the course of the next few years, Miss F attended her GP and the hospital on multiple occasions, complaining of intermittent hip pain. Her weight continued to rise and at age 15 her BMI was 41.4. MRI of the hip three years later showed deformity of the right hip with a CAM abnormality (bony deformity of femoral head resulting in femoro-acetabular impingement) and degenerative changes. The features were reported as being consistent with an angle of displacement of 50 degrees (severe slippage).

A claim was brought against Dr A alone, alleging a failure to recognise or appreciate that pain in the knee could be referred pain from the hip, failure to examine the hip and failure to refer for x-ray of the hip. It was additionally alleged that, because of Dr A’s failures, Miss F suffered premature osteoarthritis and was likely to require a primary hip replacement in her late 30s, and two further revisions in her lifetime.

### EXPERT OPINION

Medical Protection sought opinion from a GP expert. The expert was critical of Dr A, stating that a reasonably competent general practitioner would know that a slipped upper femoral capital epiphysis is more common in adolescents who are overweight. He also opined that a reasonably competent GP being presented with an overweight adolescent complaining of knee pain should have been aware that this may have been referred pain from the hip. In these circumstances the GP should have carried out an examination of the hip and, if any abnormality had been found, should have considered the possibility of slipped upper femoral capital epiphysis and referred the claimant for an x-ray.

The expert said that there was also a failure by Dr A, and subsequently Dr B, to consider the diagnosis and to carry out an appropriate examination of the hip. For the same reason, the expert was also critical of the care provided by the ED doctors and of Dr C for failing to make an urgent referral to hospital the same day.

Based on the critical expert opinion, the case was deemed indefensible and was settled on behalf of Dr A for a moderate sum, with a contribution from Dr B and the hospital.

### Learning points

- SUFE is more common in obese adolescents (particularly boys) and may present following an acute, minor injury.
- Pain may be poorly localised. Pathology in the hip can present as referred pain to the knee; hence a full assessment of the joints on either side of the affected joint should be undertaken.
- There may be an associated limp with out-toeing of the affected limb.
- Diagnosis is confirmed on x-ray, which may require a “frog lateral” view for confirmation.
- In the New Zealand environment, it would be exceedingly rare for there to be a claim of negligence made against the doctors, but they may have been vulnerable to a complaint to the HDC.

# CAUGHT BY CONSENT

A private neurosurgeon faces questions regarding consent

Author: Dr Philip White, medical claims adviser at Medical Protection

**M**rs P, a 40-year-old nurse, attended her GP complaining of back pain and was prescribed simple analgesia. After a month, the pain was no better so she consulted a private neurosurgeon, Mr S, who advised conservative measures.

One month later, Mrs P phoned Mr S to tell him her back pain had not improved and that she now had left-sided sciatica. This was confirmed by her GP, who arranged an MRI scan, which showed the disc bulge responsible for it. Overall, her condition was worse and she had been off work for over a month.

As Mrs P now had sciatica, Mr S felt that a microdiscectomy was a reasonable approach. He discussed the options with her over the phone, and explained the operation and its pros and cons. Mr S did record the phone call in the medical records, but did not state exactly what was discussed. Mrs P was happy to proceed and so the operation was arranged. Mr S wrote a letter to the GP informing him of the plan.

Mr S next saw Mrs P on the day of the operation as she was brought in to be anaesthetised. He had a brief conversation with her, confirming that she was happy to go ahead and that she had no questions. She then signed the consent form, which listed none of the pros and cons of the operation.

The operation was straightforward and there were no observed complications. However, two months after the operation Mrs P felt that her pain was worse, and she had genital numbness and urinary symptoms. Her urodynamic investigations were normal but she was numb in the S3 dermatome.

Mrs P brought a complaint against Mr S, alleging that he had taken inadequate consent and had not informed her that the operation could make her pain worse. She also alleged that the operation had been negligently performed, damaging the left L5 root and the S2 and S3 roots bilaterally.

## EXPERT OPINION

Medical Protection sought expert opinion from a consultant neurosurgeon. The expert advised that although the consent form was inadequate, the overall consenting process, including the phone consultation and the brief discussion on the day of the operation, was just about acceptable.

The expert also opined that it was very unlikely that an experienced neurosurgeon, such as Mr S, would have damaged the nerves without noticing and recording it. He noted that there was no suggestion of nerve damage in the immediate postoperative period and suggested that deterioration occurring two months after the operation was more suggestive of a chronic pain syndrome.

The case was deemed defensible. The HDC concluded that there had been no negligence during the operation, but that Mr S had taken inadequate consent. The ruling stated that Mrs P had not been warned of a 5% risk that the surgery could make her back pain worse and, if she had been, she would not have gone ahead. Mr S was found in breach of the Code of Health and Disability Services Consumers' Rights.<sup>1</sup>

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## 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.
- In deciding whether a risk is material, doctors should consider whether a reasonable person in the patient's position would be likely to attach significance to the risk. Right 6 of the Code states that every consumer has "the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive".
- It is important to make a record of the consent discussion in the patient's notes, including key points raised and hard copies or web links of any further information provided. This is in addition to the consent form.

## REFERENCES

1. The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

## Further reading

Medical Council of New Zealand, *Information, choice of treatment and informed consent*

# COMPLICATIONS OF NITROFURANTOIN

A patient on long-term medication begins to feel short of breath

Author: Dr Anna Fox, GP



@brauns/gettyimages.co.uk

**M**rs D was a 70-year-old retired teacher who had struggled with recurrent UTIs. Urologists had advised her to take antibiotics in the long term as a prophylactic measure and advised alternating between trimethoprim and nitrofurantoin.

Sixteen months after commencing nitrofurantoin, Mrs D began to feel short of breath, especially when she was walking her dog. She was also feeling tired and generally unwell so she visited Dr W, her GP. Dr W documented a detailed history, noting that there was no orthopnoea, ankle swelling or palpitations. He also noted the absence of cough, wheeze or fever. Dr W referred back to a recent echocardiogram that was normal and mentioned that Mrs D was an ex-smoker. He conducted a thorough examination including satisfactory BP, pulse and oxygen saturation, and commented in the notes that Mrs D's chest had bilateral air entry with no crackles or wheeze and no dullness on percussion. Dr W stated that her heart sounds were normal and that there was no pitting oedema. He organised a CXR initially.

The CXR reported patchy peribronchial wall thickening and suggested a degree of heart failure. Dr W advised a trial of diuretics, which made no difference. Mrs D continued to feel short of breath and drained over the next few weeks. Gradually her breathlessness got worse and she noticed it even when she was sitting reading.

Four months later, Mrs D was admitted to hospital in respiratory failure. A high-resolution CT scan showed pulmonary fibrosis, with the likely diagnosis being subacute pneumonitis secondary to treatment with nitrofurantoin.

Within a month of withdrawal of nitrofurantoin she improved clinically, becoming less breathless, and her respiratory failure resolved. At a respiratory follow-up ten months later, she was found to be breathless after about 400 yards of walking and quite fatigued but able to do all her daily activities, including walking her dog.

Mrs D made a claim against Dr W. She alleged that he had failed to consider that the long-term use of nitrofurantoin may have caused her symptoms.

## EXPERT OPINION

Medical Protection sought expert opinion from a clinical pharmacologist and a GP. The clinical pharmacologist referred to the relevant edition of the *BNF*, which stated on nitrofurantoin: "Cautions: on long-term therapy, monitor liver function and monitor for pulmonary symptoms especially in the elderly (discontinue if deterioration in lung function)."

She commented that although the *BNF* records the need to monitor periodically, the exact definition of "periodically" is not given. In her view, it should have been every six months.

The expert GP said that many doctors would be unaware of the need for monitoring and that it was probably rarely done in practice. However, he accepted that when prescribing an unfamiliar drug, a GP would need to reference the *BNF*.

Medical Protection served a letter of response rigorously defending Dr W's actions, pointing out that he had seen Mrs D early in her clinical course, had documented a very thorough history and examination and made a reasonable initial management plan. As a result of this, the case against Dr W was dropped. However, the practice partners, who were members of another medical defence organisation, faced a claim regarding the alleged lack of a practice system for monitoring for lung and liver complications in patients on long-term nitrofurantoin. This claim was settled with no contribution sought from Medical Protection.

## Learning points

- Detailed contemporaneous notes assist in defending cases. GPs should document a thorough history and examination, including any negative findings.
- Medical Protection sees a number of claims regarding inadequate monitoring of long-term nitrofurantoin with patients developing hepatic or pulmonary complications. Many claims relate to inadequate practice systems for monitoring.
- Expert opinion sought on these claims advises that *BNF* guidance for monitoring should be followed. The *medsafe* datasheet gives similar advice as the *BNF* and can be viewed at: [medsafe.govt.nz/profs/Datasheet/n/Nifurantab.pdf](https://www.medsafe.govt.nz/profs/Datasheet/n/Nifurantab.pdf)
- To screen for hepatic complications, repeat prescribing of nitrofurantoin should generate liver function tests (LFTs), at least six monthly.
- To screen for pulmonary complications such as pulmonary fibrosis, doctors should advise patients starting on nitrofurantoin to attend urgently if they develop breathing problems. They could be reviewed for respiratory symptoms at the points of taking LFTs at least six monthly, with consideration of more frequent monitoring.
- A case study on prolonged nitrofurantoin usage was published in 2012. Follow this link to read it: [wellsaid.co.nz/wp-content/uploads/2012/12/Nitrofurantoin\\_usage.pdf](https://www.wellsaid.co.nz/wp-content/uploads/2012/12/Nitrofurantoin_usage.pdf)



# CHAIN REACTION

A patient presents with a sore wrist after a fall

Author: Dr Marika Davies, Casebook editor-in-chief

**M**iss P, a 35-year-old teacher, attended her local emergency department (ED) with wrist pain following a fall off her bicycle. She saw Dr A, who examined her and documented that there was some generalised bony tenderness. He arranged an X-ray, which was normal, so reassured the patient and sent her home with analgesia.

The X-ray was later reviewed by a radiologist, who reported it as normal, but recommended follow-up as a scaphoid fracture could not be ruled out. The report was sent to the patient's GP.

Two weeks later Miss P attended her GP, Dr K, complaining of ongoing pain. The radiology report was not in the patient's notes, and the GP relied on the history from the patient that the X-ray had been normal. The notes stated that there was a full range of movement, but there was no record of an examination. Dr K reassured the patient and changed her analgesia.

A few weeks later the patient was still in pain so returned to her GP, who arranged an X-ray. This showed non-union of a fracture of the scaphoid. The patient was referred to an orthopaedic hand surgeon and required bone grafting under anaesthesia.

Miss P made a good recovery, but wrote to Dr K raising concerns about the delay in diagnosing the scaphoid fracture. Dr K took advice from Medical Protection, and was advised to handle the concerns as a complaint using the practice complaints procedure. She was also advised to investigate the event, and to suggest to the patient that her concerns about Dr A were best directed to the hospital.

On investigating the incident the practice found that the radiology report had been received but had been scanned into another patient's records in error, and noted that the two patients had very similar names. A number of flaws in the process for receiving and acting on X-ray reports was noted, so changes were put in place, along with further staff training. Dr K acknowledged that she had not examined the patient or advised her to return if the pain did not resolve.

The hospital contacted the ED doctor and asked for his comments on the complaint. On reviewing the notes, the doctor saw he had not documented the mechanism of injury, whether there was any anatomical snuffbox tenderness, or what advice he had given the patient. As such, there was no evidence that a scaphoid fracture had been considered or the appropriate advice given. The doctor responded to the hospital saying that he had learned from the incident, had reflected upon it, and had discussed it with his clinical supervisor.

Dr A separately contacted Medical Protection for assistance. Medical Protection assisted both Drs A and K to prepare responses, which set out the findings of the separate investigations into the complaint. The letters provided a full explanation for the consultations she had attended, and acknowledged that there had been shortfalls in the care provided, for which they both apologised. Both doctors demonstrated that they had taken her concerns seriously and had taken steps to reduce the risk of similar incidents occurring again. They offered to meet with the patient to discuss any further concerns.

Miss P did not take her complaint further.

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## Learning points

- Maintain a high index of suspicion of scaphoid fractures when treating and reviewing wrist injuries. If symptoms suggest a broken scaphoid, the injury should be treated as one, even if it is not seen on X-ray.
- Document negative findings and advice given to patients - without adequate documentation it is difficult to reconstruct what took place during a consultation some time after the event, and to justify that the patient was managed appropriately.
- Ensure safety nets are in place, and that patients know what symptoms to be concerned about and when to return to see you.
- A full investigation and co-ordinated response are key to providing a complainant with a detailed and thorough explanation.
- Dealing with concerns promptly and swiftly can help to prevent them from escalating. In this case both the hospital and the practice provided a full explanation and apology, and showed that lessons had been learned.

## REPORTED ABUSE

Thank you for the latest edition of *Casebook*. It is always informative, if sobering. I have a comment about one case report: the “Reported abuse” case.

The training that I have received on safeguarding guides me to report incidences of alleged abuse to my local safeguarding team without undertaking investigation or corroboration myself. If the abuse is clear and actual, the report should be direct to the police, or local sexual assault centre (SARC).

The reason for this has been explained as being twofold. Firstly, the safeguarding team is multidisciplinary and is able to undertake a more comprehensive investigation that will be robust in the face of a cross-examination, should it come to that. Secondly, the safeguarding team is privy to a wide range of information, so even small additions may be important.

Notwithstanding the fact that Mrs X told her GP that she had reported the allegation to the police, in this circumstance, as a GP I would have also reported the allegation to my local safeguarding team, informing Mrs X of this action, of course. I should have expected the teacher and Dr B to have done the same thing. I would not have checked with the school myself.

The expert for Mr X reported that Dr B failed to corroborate the allegation with the school. My training would suggest that the expert was wrong in making that comment. Perhaps an example of an expert opining beyond her/his area of expertise as considered in “A complicated claim”.

Whilst this is slightly outside the case, and you do make a general comment about our duty to act in the third learning point, I feel it is important to emphasise the critical nature of collaborative and consistent team working when it comes to safeguarding. All the investigations into failed cases have come to that conclusion. It needs to be reiterated until it is a reflex action across all of health and social care.

Dr Michael Innes

## Response



Thank you for your correspondence – we are always pleased to hear from readers and welcome your comments on this case.

Our case reports are taken from different countries around the world where we represent members, and so local practices and policies can differ. However, I agree entirely with your comments on the importance of collaboration and team-working in these cases, as well as liaison with the safeguarding team where appropriate, which are valuable learning points.

## NO NEWS IS NOT ALWAYS GOOD NEWS

The article on missed hip dysplasia states that Dr R was alleged to have failed to ensure the report made it to clinic. May I be clear? Is this a system error or is there a duty for Dr R to have phoned the abnormal result?

Incidentally, I don't think it is great journalism to illustrate a case of hip dysplasia with a radiograph of a normal hip.

Dr Jules Dyer

## Response



Thank you for your email regarding the case report “No news is not always good news”, in the latest edition of *Casebook*.

The allegation that Dr R (the radiologist) failed to ensure that the report made it safely to the clinic was an allegation brought by the claimant (the parents) in this case. The claim was investigated and the hospital accepted that there had been “a clear administrative error” that allowed the system to file the report without it being sent to the clinical team for action. It would be a matter for an expert radiologist to comment on whether Dr R should have phoned the result or taken any other action. This wasn't explored in this particular case given the hospital's acceptance that there had been an administrative error.

I note your comment on the radiograph used to illustrate the case report. The pictures we use in *Casebook* are for illustrative purposes only and are not intended to be actual representations of the individual cases, and I do hope it did not detract from your learning or enjoyment of this case.



**We welcome all contributions to Over to you.  
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**Please address correspondence to:  
Casebook Editor, Medical Protection, Victoria  
House, 2 Victoria Place, Leeds LS11 5AE, UK.  
Email: [casebook@medicalprotection.org](mailto:casebook@medicalprotection.org)**



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[advice@mps.org.nz](mailto:advice@mps.org.nz)

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