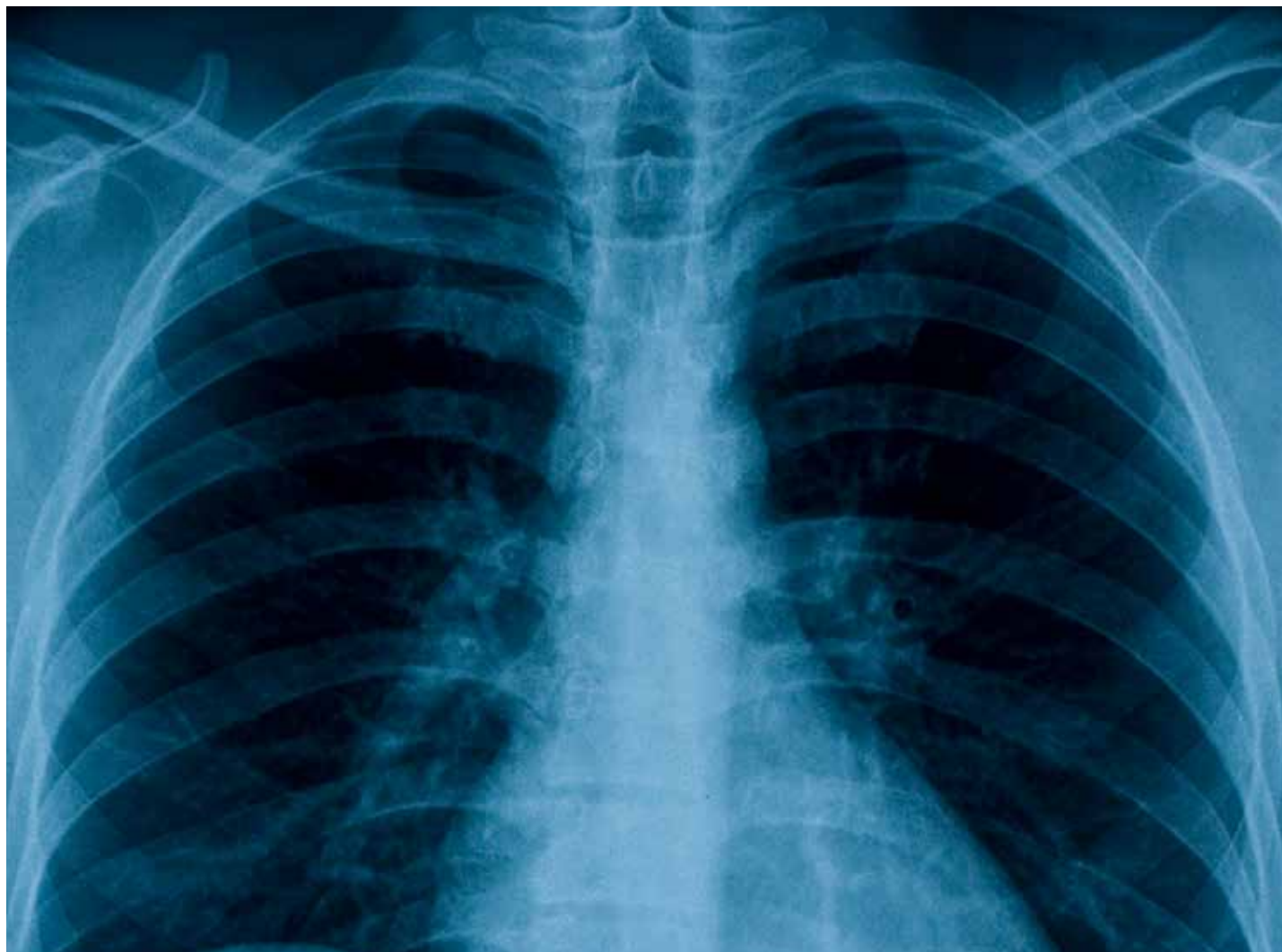


# CASEBOOK

VOLUME 27 | ISSUE 1 | MAY 2019

NEW ZEALAND



## 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



### Welcome

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



### Over to you

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

## Case reports



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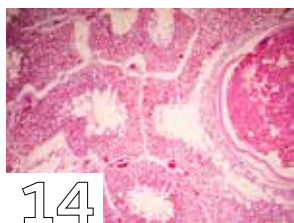
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ISSN 1366 4409

*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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Cover:

@yumiyum@Gettyimages.co.uk

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# Welcome

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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](mailto:casebook@medicalprotection.org).

**Dr Marika Davies**  
Editor-in-Chief

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## Claim

# A retained swab



DR SAM DRESNER, GENERAL SURGEON

**M**iss Y, 37 years old, was known to have bilateral ovarian endometrial cysts, which were treated at the time of a laparotomy by Mr D, consultant gynaecologist. For several years she had been regularly followed up and repeat scans had showed recurrence of her cysts, which were managed with a synthetic progesterone.

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

Mr D performed a further laparotomy and found recurrent bilateral ovarian cysts stuck down in the pouch of Douglas and adherent to the back of the broad ligament. Both 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.

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 continued to complain of a foul 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 was washed with more betadine. Some oestrogen cream was inserted and she was put on further antibiotics. The patient subsequently made a full recovery.

The patient initiated proceedings against Mr D, citing negligence in failing to remove the swab during the operation. A further complaint was also made that Mr D failed to suspect or locate the swab 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 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](http://www.who.int) for more information.

### NOTE FOR NZ MEMBERS

In New Zealand a similar complaint would be dealt with by the Office of the Health and Disability Commissioner.<sup>1</sup> Most, if not all, organisations would treat this as a sentinel event and also instigate their own review.

### REFERENCES

1. For example, see decision 99HDC12195, [www.hdc.org.nz/decisions/search-decisions/2001/99hdc12195/](http://www.hdc.org.nz/decisions/search-decisions/2001/99hdc12195/)



# Clozapine induced constipation, not a trivial concern

Although agranulocytosis is the most well-known serious adverse effect with clozapine, requiring full blood count (FBC) monitoring, undetected constipation is less recognised yet equally potentially harmful. *Dr Mark Burns, Medical Adviser at Medical Protection, looks at some of the issues associated with this*

## CLOZAPINE: THE BACKGROUND

**C**lozapine is an atypical antipsychotic medication used for treatment-resistant schizophrenia. Although having been around since the 1960s, clozapine was withdrawn from the market after deaths associated with agranulocytosis. It has become available again since the 1990s after it was demonstrated as a useful treatment for those who were unresponsive to other antipsychotic medications. Up to two thirds of people unresponsive to other antipsychotics will respond to clozapine. Due to the risk of agranulocytosis, it is only prescribed under strict guidelines with regular monitoring of FBC.

Clozapine treatment needs to be initiated by a psychiatrist; however, an increasing number of DHBs are discharging stable patients on clozapine back to primary care since MEDSAFE changed the prescribing conditions in 2010 to allow this. Accordingly, GPs are increasingly being required to manage the adverse effects of clozapine, which are many in number, ranging from relatively trivial to potentially life-threatening.

Clozapine is frequently associated with constipation, hypersalivation, orthostatic hypotension, sedation and weight gain with metabolic risks of dyslipidaemia and hyperglycaemia.

There are also well-recognised, potentially serious, adverse effects including neutropenia/agranulocytosis, myocarditis, cardiomyopathy, QT prolongation and increased risk of seizures at higher doses.

Clozapine causing constipation is increasingly acknowledged as a further potential serious adverse effect. It is caused by gastrointestinal hypomotility due to clozapine's anticholinergic and antiserotonergic effects. More deaths with clozapine are now caused by fatal constipation than due to agranulocytosis.

Risk factors for developing constipation with clozapine include higher doses of clozapine, smoking cessation, comorbid medical conditions with fever inhibiting clozapine metabolism – thereby increasing serum levels – and the first four months of treatment.

The following fictional case study underlines some of the risks and the need for caution amongst clinicians.

## CASE STUDY

Ms C is a 46-year-old woman with chronic treatment-resistant schizophrenia. She lived with her elderly parents and was a beneficiary. She had a tumultuous psychiatric course through her early 20s, with psychotic symptoms that were difficult to treat, and multiple psychiatric hospital admissions. She was commenced on clozapine on one hospital admission and, subsequently, for most of her 30s was in a much more stable mental health, and avoided further psychiatric hospitalisation. She had ongoing negative symptoms of schizophrenia, including amotivation and alogia (poverty of speech), which impacted upon her functional recovery. Although somewhat socially isolated, she attended a community drop-in centre once a week and got out socially with her parents.

She was under the care of Dr Z at the District Health Board (DHB) community mental health centre, and, after a long period of stability, was discharged to her GP, Dr A, to follow-up on clozapine, 500mg per day. She was also prescribed the laxative coloxyl with senna, which was commenced at the initiation of the clozapine, and achieved reasonably regular bowel function thereafter. Ms C took this regularly at night with her clozapine.

Ms C attended the GP practice every six months for a review with Dr A, and would get a three-month repeat prescription in between. She was not really forthcoming at these reviews, but usually had no particular complaints. Ms C was not especially active and had gained weight over the years, and Dr A was monitoring her markers for metabolic syndrome including fasting glucose, HbA1c and lipid profile. Ms A had established a good routine of having her monthly FBC as part of the haematological monitoring. She had previously been a moderately heavy, regular smoker, but as part of managing her cardiovascular risk she had recently successfully stopped smoking. She had never been a coffee drinker.

Ms C fell at home one day, severely twisting her right knee. She saw Dr A, who diagnosed a strained medial meniscus. As Ms C struggled to weight bear, she was advised to mobilise with the help of crutches and prescribed tramadol 100mg tds for the pain.

Approximately a month later, Ms C complained of abdominal pain and her parents took her to the Emergency Department; where the doctor was made aware that she had not had a bowel motion in more than seven days. She was admitted, but her condition deteriorated, and she was considered to have toxic megacolon as a consequence of the severe constipation.

Ms C's parents complained to the Health and Disability Commissioner (HDC) on her behalf regarding the care provided by Dr A. Dr A made a very brief response without Medical Protection assistance.

The HDC obtained a GP expert opinion, which criticised Dr A for not screening for adverse effects following the cessation of smoking, for not considering a review of her clozapine level, for not better conveying the risk of constipation and for not enquiring regularly about Ms C's bowel function. The expert considered it a moderate departure from the expected standard of care that Dr A had not managed her bowel function more assertively, having prescribed the opioid that likely exacerbated the constipation. The HDC opened an investigation and widened the scope to include the communication between Dr Z, the psychiatrist, and Dr A, the GP.

Dr A then contacted Medical Protection seeking assistance. Dr A was given guidance on how to provide a more thorough response, responding to each of the issues raised by the expert opinion. He was able to consult his notes that indicated that he generally did enquire about her bowel habit and had followed the guidance provided by the DHB at the time of her discharge, including their protocol for prescribing of clozapine in primary care. However, Dr A acknowledged that he had not been mindful that her smoking cessation may have increased her clozapine level and, moreover, he did not recall having drawn Ms C's attention to the new risk of tramadol exacerbating the constipation, nor did his notes document this. The HDC subsequently found Dr A in breach of the *Code of Health and Disability Services Consumers' Rights*, in particular the right to services of an appropriate standard and the right to be fully informed.

## LEARNING POINTS

- In addition to the well-known risk of neutropenia/agranulocytosis and cardiac toxicity, constipation is an under-recognised, potentially serious and frequently-occurring adverse effect of clozapine.
- Although the greatest risk of constipation is at the time of initiation, concomitant use of other medications that increase the risk of constipation should be used with care, including opioids and those with anticholinergic properties (tricyclic antidepressants and benzotropine).
- Bowel function and constipation should be enquired about at all consultations with patients on clozapine and managed assertively using an approach such as the Porirua protocol.<sup>1</sup> Patients should not necessarily be relied upon to volunteer unprompted that they are experiencing adverse effects such as constipation.
- Cessation of cigarette smoking can cause a significant increase in plasma clozapine levels. High levels of caffeine consumption can also increase plasma clozapine levels. Such lifestyle changes may require an alteration in clozapine dose. Higher clozapine levels are associated with increased risk of adverse effects such as constipation.
- Good communication between services is essential, especially guidance to GPs when patients are leaving specialist services and returning to primary care.

“ Clozapine is frequently associated with constipation, hypersalivation, orthostatic hypotension, sedation and weight gain with metabolic risks of dyslipidaemia and hyperglycaemia. ”

## REFERENCES

1. [bpac.org.nz/2017/clozapine.aspx#prescribing](http://bpac.org.nz/2017/clozapine.aspx#prescribing)





## Regulatory

# Sharing evaluative material with patients



DR ANDREW **STACEY**, MEDICAL ADVISER, MEDICAL PROTECTION

**A** patient, Mr Q, made a request to a health organisation for the personal health information they held about him. Four days later, the organisation made two documents available to him. Mr Q then contacted the organisation again, advising that the information did not match his expectations of what he would receive, and he reiterated his request.

Just under a month later, Mr Q contacted the organisation again, complaining that he had still not received all the information he had requested. He was advised during this call that the organisation had more information regarding his healthcare, but they were withholding this information from him.

Mr Q again requested all the information regarding his healthcare including, but not limited to, copies of emails between the organisation and ACC, and alerted the organisation to the fact that he had also requested from ACC a summary of the voice conversations with ACC relating to his claim. Mr Q further requested that the organisation provide him with all his information, including documents that related to his injury claim.



Two days later the organisation wrote to Mr Q advising that:

1. It was not their practice to collect information on every voice conversation that may occur in the course of delivering a clinical service, particularly where collection of that information did not add further to the record of health status, or document the care or treatment provided.
2. They did not have provision for an 'IT sweep' but would ask staff to search their email systems for any held emails related to the service provided, which had not already been uploaded into the clinical record.
3. They would provide him with a copy of all information collected in the course of the management of his referral to the organisation, with the exception of the neuropsychology test materials used and a copy of the raw data. It was explained that these were not health or personal information and that the test material was protected by copyright. It was pointed out that:

*"...psychologists are required to protect the physical security and integrity of assessment instruments and ensure that they are not used inappropriately. Maintaining test security is critical because if the tests were known beyond those performing neuropsychology, the results would be severely diminished, and result in inappropriate usage of the same."*

Three months later, Mr Q complained to the Office of the Privacy Commissioner and asked them to review the organisation's response to his request.

Medical Protection assisted the organisation with their response to the Office of the Privacy Commissioner. The organisation explained that they had given the patient all the information that they held, with the exception of the raw test data and test materials, which had been withheld as:

*"...raw data can undermine the integrity and security of neuropsychological testing instruments, and raw test data are vulnerable to misinterpretation. In particular, the practice of neuropsychological assessment assumes the client is naïve to the test material, and has not had the opportunity to learn or be schooled in the required responses. Without this, neuropsychological data are likely to be invalid as an accurate representation of the client's actual ability and the practice of neuropsychological [testing] is of limited clinical utility. To this end, most tests used, and their scoring and interpretation manuals, can only be purchased by appropriately qualified psychologists, and are copyrighted. Most tests are published after extensive peer-reviewed*

*assessment to establish appropriate norms, and cannot be quickly replaced if the material becomes widely distributed."*

The organisation argued that they had the right to withhold this information under section 28 of the Privacy Act 1993 – Trade Secrets. They referenced a prior decision of the Privacy Commissioner, which had elucidated the following principles from judicial decisions:

- Matters of public knowledge or of general knowledge in an industry cannot be considered to be true trade secrets.
- The element of secrecy derives from the information only being known in the particular business in which it is used. However, mere assertion that something is a trade secret does not automatically make it so.
- Whether information is or is not a trade secret has to be determined objectively on the facts and circumstances of each case.

They surmised that it was their understanding that section 28 of the Privacy Act related to the ability of professions and commercial businesses to protect trade secrets. The way in which neuropsychologists used the tests that were the subject of this request, and their ethical obligations in preserving the security of this testing, would in their view mean that the use of the tests fall within the definition of trade secrets. They also noted that in the past, the Commissioner had withheld information such as examination scripts on the basis that the questions themselves were not information about the candidate. Similarly, they did not believe that the requested information fell within the definition of personal information.

**“ ”**  
*The organisation argued that they had the right to withhold this information under section 28 of the Privacy Act 1993 – Trade Secrets.*

## OUTCOME

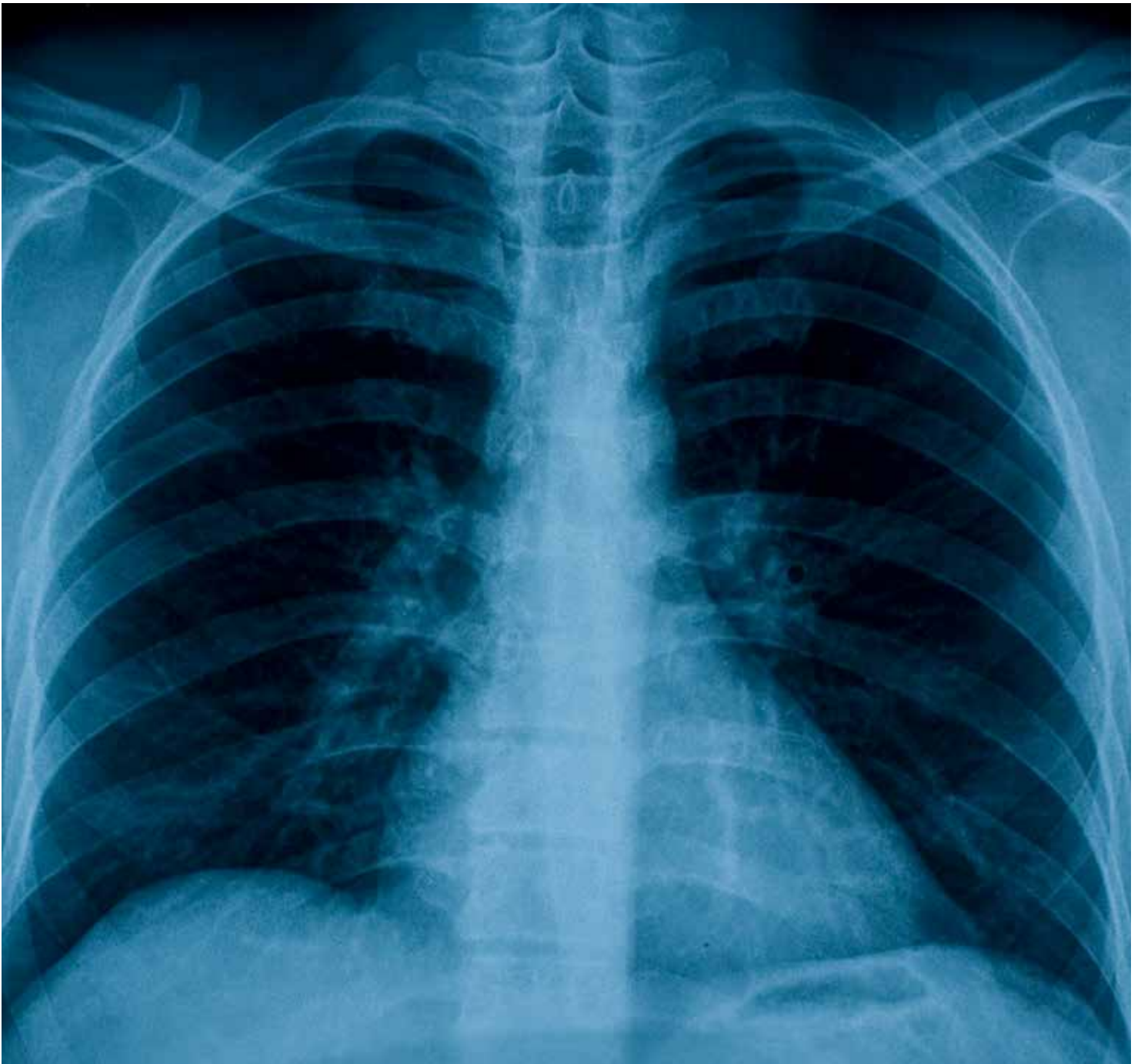
The Office of the Privacy Commissioner formed the preliminary view that the evaluative material (raw test data and test materials) could be considered and withheld under section 28 (trade secrets), but advised that they wanted to confirm the steps the organisation had taken to locate the correspondence relating to the patient.

The Office of the Privacy Commissioner later came back to the organisation and advised that while they were satisfied that the organisation had taken appropriate steps to locate the other requested information, in order to withhold the test information it would be necessary for the organisation to prove that release of that information would likely prejudice its commercial position. They acknowledged that they were aware that the test answers were recorded within questions and therefore the copyrighted information would be hard to redact. In light of the organisation's concern that this information would be used or could be disseminated without their knowledge and/or interpreted incorrectly, the suggestion was made that Mr Q could view the information at the organisation, rather than receiving a copy of the information.

Mr Q did not take up this opportunity, instead being more concerned about the correspondence with ACC.

## LEARNING POINTS

- What is “health information” is broader than just the clinical notes. This complaint demonstrates the extent to which some patients will go to request their health information; particularly in cases where a third party has made a disadvantageous decision concerning them.
- Access to health information is seen as a fundamental right under the Health Information Privacy Code. Health agencies must provide access to requested information unless they have a reason for withholding that information under the Privacy Act. You should contact Medical Protection for advice, if you are considering withholding information.
- Many psychologists feel they have ethical and professional obligations not to disclose test materials. While these obligations do not appear to outweigh patients' rights to access their health information, the Privacy Commissioner is prepared to place constraints on how patients access their information in order to protect, to some extent, the integrity of the assessment instruments.



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.

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.*

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.
- In New Zealand, this scenario might have been considered by ACC as a treatment injury (delay in diagnosis) or by the HDC as a complaint. The key question to consider is whether the management was reasonable, given the history, symptoms and signs at the time of Dr N's assessment. There was no history of cough or fever, but she did have pain on breathing and felt tired. Dr N clearly considered chest pathology as a possibility, and recorded respiratory rate, oxygen saturations and listened to the chest. These were all normal. In addition, she had muscle tenderness consistent with muscular pain. The GP expert's assessment is consistent with the facts. The respiratory medicine expert's opinion contains conjecture that is not relevant to the question of whether the management was reasonable.





## Claim

# Accidental anaesthetic awareness



DR HEIDI MOUNSEY, MEDICOLEGAL CONSULTANT,  
MEDICAL PROTECTION

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**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 remifentanyl 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 remifentanyl 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 remifentanyl 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 remifentanyl 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 available to be 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. Target-controlled infusion pumps are widely available and some consideration should be given to justifying the use of total intravenous anaesthesia without an appropriate infusion pump.
- 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.
- If this case had been an HDC complaint in New Zealand, Dr T may have been vulnerable to criticism for not using an appropriate target-controlled infusion pump, especially if one was available. The lack of use of depth of anaesthesia monitoring when a muscle relaxant is administered, as well as not keeping contemporaneous records, may also lead to criticism.
- The HDC may then have a number of recommendations if Dr T is found to be in breach of the Patient Code of Rights. These may include: referral of Dr T to the MCNZ for assessment of his competence in the practice of anaesthesia, apologising to the patient, and upskilling and reviewing his practice in the use of total intravenous anaesthesia and record keeping.





## Claim

# A routine referral?



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

**M**rs 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 and a respiratory medicine expert.

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.

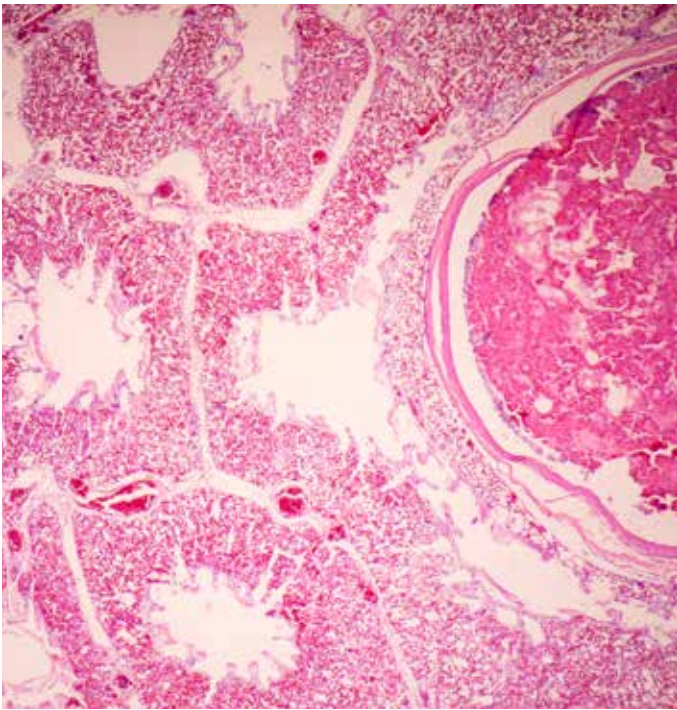
### OUTCOME

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 owners 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 that later proves to be significant.
- In New Zealand, if the delay in diagnosis led to a worse long-term outcome, the patient would be entitled to make a claim under ACC for a treatment injury. However, in this case, a claim may not be successful if the injury was thought to be substantially caused by the underlying health condition or attributable to a resource allocation decision.



## Claim

# Delayed diagnosis of lung cancer



DR HEIDI MOUNSEY, MEDICOLEGAL CONSULTANT,  
MEDICAL PROTECTION

**M**r 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 New Zealand, it would usually be expected that the clinician requesting the investigation would also review the results.
- Adequate handovers of patients should take place between clinicians in order to highlight which investigations have been requested, and any results which are outstanding.
- In New Zealand, it is very likely that all doctors involved – certainly Dr F and most likely Dr B – would be at least severely criticised by the HDC, as would the DHB if appropriate protocols and systems for following up on investigation results were not in place.



## Claim

# Forgotten blood test results: forgotten patient



DR SOPHIE HAROON, MEDICAL CLAIMS ADVISER,  
MEDICAL PROTECTION

**B**aby 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 opinion 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.

In New Zealand we very rarely see claims. In cases such as this, a common avenue for patients is to make a complaint through the Health and Disability Commissioner or the Medical Council of New Zealand (MCNZ). In addition, patients may make a treatment injury application through the Accident Compensation Corporation (ACC). ACC will assess the application, and if they believe that a doctor poses a risk of harm to the public they will make a notification to the MCNZ.

### LEARNING POINTS

- Clinicians can deal with hundreds of blood test results every day. Having a robust system to manage results is crucial, to ensure that results are dealt with in a timely manner and that patients don't fall through the cracks.
- Patients should be informed about how and when they will be notified about results. This plan should also be documented in the medical records.
- It is common practice in general practice to only contact the patient if results are abnormal, which is considered acceptable. However, for results that you consider to be very clinically significant, such as in this case, it is advisable to have added layers of safety. You might advise the patient that they will receive the result regardless of it being normal or not; set yourself a tracking task and/or advise the patient to contact the surgery if they have not heard from the practice within a reasonable timeframe.





## Claim

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



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

**M**rs 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, gender and 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.
- In New Zealand, the doctor could assist the patient to complete an application for an ACC treatment injury claim. ACC would decide if there was a treatment injury. If there was a satisfactory claim then ACC may provide compensation for costs incurred.
- In NZ the patient can also raise a complaint with the Health and Disability Commissioner. Clinical expert opinion would be provided to assist the HDC decision but the HDC would also obtain their independent 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*





# 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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