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Medical Protection

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AUGUST 2017

CASEBOOK

THE COST OF RISING CLAIMS AND COMPLAINTS

The number of complaints and the rising value of claims is a growing concern. We analyse statistics which demonstrate these changes

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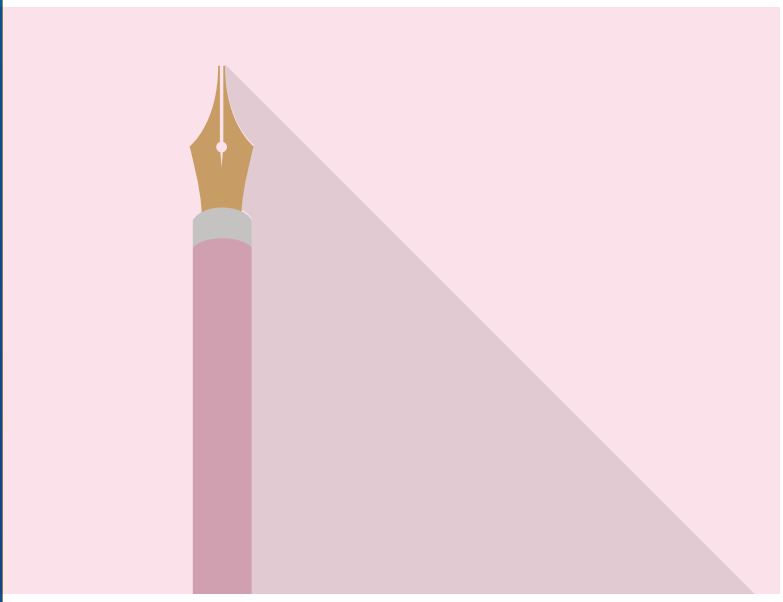

FEATURES

CASE REPORTS

EVERY ISSUE...

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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF

This year marks two significant anniversaries for Medical Protection – firstly, we celebrate 125 years of supporting members. We were founded in 1892 as a mutual organisation to provide members with expert advice, support and protection in their professional practice.

Though our purpose remains the same as it always has, the world around us has changed dramatically. Life is faster and more complex, presenting healthcare professionals with even greater opportunities and challenges.

The breadth of specialist advice and support, and the education and training we provide, has expanded exponentially not only to keep pace with advances in medicine, but to stay ahead of the curve – anticipating challenges and risks before they emerge.

Secondly, we celebrate 60 years of providing support to members in South Africa. We began to protect members in 1957, with nearly 650 members joining in the first year. Today we're proud to support more than 30,000 South African members. We're always working hard, often behind the scenes, to make the medicolegal environment in which you work safer and more secure.

You are part of a member-owned, not-for-profit organisation, whose sole focus is on supporting and protecting members throughout their careers. Whether you work in the public or private sector, or both, you can request legal assistance on a range of issues arising from your professional practice.

In this edition, our main story is an interview with the chairman of MacRobert Incorporated Attorneys, Leon Kelbrick. Leon has supported Medical Protection members for over 35 years. He talks to us about the biggest medicolegal challenges that doctors face, including the increase in claims and complaints, patient expectations and the current litigation environment.

As always, we welcome your feedback. Please contact us with any questions or comments on the articles and case reports.

I hope you enjoy this edition.

Dr Marika Davies
Editor-in-Chief
marika.davies@medicalprotection.org

RISKALERT

AN INCREASE IN WRONGFUL BIRTH CLAIMS

Dr Graham Howarth, Head of Medical Services for Southern Africa, examines the common risks associated with wrongful birth claims that make up a third of high-value obstetric claims

READ THIS ARTICLE TO:

- **Learn more about wrongful birth claims**
- **Discover where common issues arise**
- **Reflect on a relevant case study**

In an ideal world, every pregnancy would progress normally, every delivery would be uncomplicated, and every baby would be normal and healthy. Unfortunately, this is not always the case. However, due to our increased understanding of genetics and developments in technology, it is now possible to identify far more pregnancies where the foetus has a major structural or genetic abnormality.

A wrongful birth claim is where a major structural or genetic abnormality is missed, and the parents claim that had they been made aware of the problem, they would have terminated the pregnancy. The healthcare worker is then sued for the costs of raising the injured child.

Classically, obstetric risk and litigation has been birth-related, with a focus on either birth injuries or cerebral palsy claims. However, recent Medical Protection obstetric claims experience reveals that about a third of obstetric multimillion rand claims are now related to a missed structural or genetic abnormality, and the alleged negligence is not birth-related but occurs far earlier in pregnancy.

ISSUES ARISE WHEN:

- screening is not offered
- there is paternalistic decision making, where the doctor decides not to tell the patient about the possibility of screening as there is a perception that the patient cannot afford the tests, or alternatively would never consent to a termination of pregnancy
- ultrasound screening is not performed correctly
- patients do not understand the limitations of screening tests and have unrealistic expectations
- a screening test reports a relatively low risk of an abnormality and the patient is informed that the test is negative.

CASE STUDY

Dr A was responsible for the care of Ms S, a 15-year-old girl who was pregnant. Dr A saw her early in the pregnancy and advised her of the possibility of a termination of pregnancy on social grounds, but she declined.

Given her age and her financial circumstances, Dr A was unsure if Ms S would be interested in genetic screening due to the cost, but he decided to offer it anyway. Ms S told him that she would like to go ahead with the screening, as the one thing she did not want was a disabled child.

Dr A explained the screening tests and pointed out that the definitive test, an amniocentesis, was not without its risk. The consent, as well as her thoughts on a disabled child, was well documented by Dr A. He also noted that Ms S borrowed money from her uncle to pay for the screening.

Once the blood results became available, the chance of Trisomy 21 was reported as 1:350. Dr A initially reviewed the blood results in the absence of the patient and wrote "low risk" on the laboratory report. He asked his receptionist to inform the patient of the result.

The baby was delivered by a colleague as Dr A was away on holiday. When he returned, he was saddened to hear that the baby had been diagnosed as having Trisomy 21, but on checking his notes, he was reassured.

Two years later, he was distressed to receive a summons accusing him of negligently missing Trisomy 21. One of the allegations was that he had never discussed the results of the screening tests with Ms S and that his receptionist had informed the patient that she did not need an amniocentesis, as the screening test was negative.

The claim was settled for a high sum, to reflect the future care needs of the child.

LEARNING POINTS

- **Do not make paternalistic decisions on behalf of patients, such as what they can afford.**
- **The National Health Act is very clear on a practitioner's responsibilities regarding consent.**
- **When a screening test gives a risk, and a definitive test also has a risk, you need to explain the risks to the patient and assist them in balancing risks.**
- **Even if a risk is low beware of totally discounting it.**
- **Remember, it is the patient and not the doctor who is taking the risks and the patient has to balance them.**
- **The test result would have been better delivered by Dr A so that he could fully explain what the result meant, and what risks still remained.**
- **The majority of Trisomy 21 deliveries occur in younger mothers, as there are far more pregnancies in younger than older mothers.**

MORE SUPPORT FROM MEDICAL PROTECTION

If you need advice, contact a medicolegal adviser at **medical.rsa@medicalprotection.org** or **0800 982 766.**

The case in this article is fictional but is an example of a common scenario that might occur in medical practice.

THE COST

OF RISING CLAIMS AND COMPLAINTS

The prevalence of HPCSA complaints, claims and the rising value of claims is a growing concern. We analyse statistics which demonstrate these changes, and speak to Leon Kelbrick, Chairman at MacRobert Attorneys, who reflects on the reasons for this growth

READ THIS ARTICLE TO:

- **Learn more about the rise in complaints and claims in South Africa**
- **Discover why the value of claims is also rising**
- **Find out about the medicolegal challenges facing healthcare professionals in the country**

Doctors are practising in an increasingly litigious environment in which claims and complaints are now becoming more common. Our data indicates that over the six-year period from 2011 to 2016, there was a 35% increase in the number of claims being made against healthcare professionals in South Africa. Large claims in particular are on the rise. MPS has seen an increase of 121% in medical and dental claims valued at over R1 million.

In addition to Medical Protection seeing a growth in the amount and value of claims, the HPCSA has also seen the number of complaints rise. Over 10 years, from 2006 to 2016, the HPCSA has seen a 100% increase in the total number of complaints, with a peak in 2014 (see Figure 1).[1]

Patients can submit a complaint to the HPCSA when they feel that the healthcare services they receive either violate their rights to good health or breach ethical standards. The HPCSA has the power to institute disciplinary proceedings regarding any complaint, charge or allegation of unprofessional conduct against any person registered with the council.

A number of interrelated factors have led to the current claims environment. We spoke to Leon Kelbrick, Chairman at MacRobert Attorneys, to discuss why we have seen this growth. Medical Protection has instructed MacRobert Attorneys in South Africa for 50 years and Leon has assisted with Medical Protection cases for over 35 years.

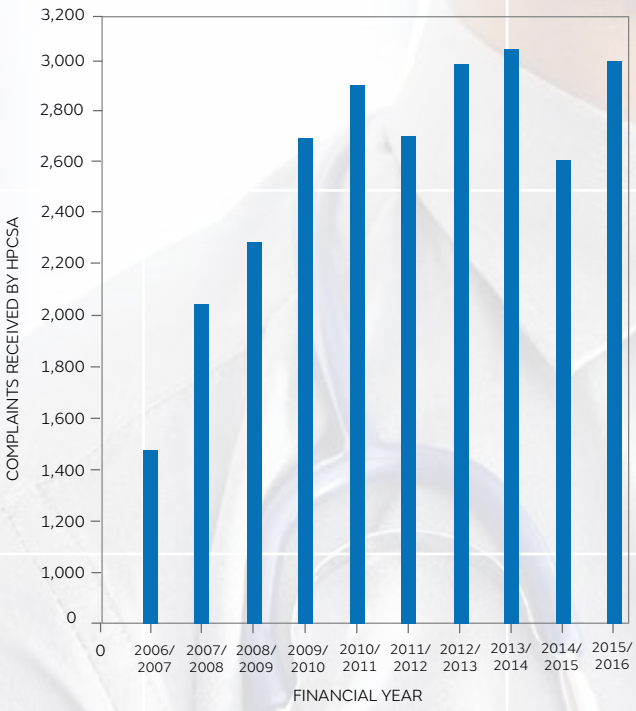


Figure 1 - Number of complaints received by the HPCSA over the last 10 years

©MartinPrescott/GettyImages

Leon Kelbrick
Leon obtained the degrees BA and LLB from the University of Pretoria. After his admission as an attorney in 1979, he joined MacRobert Attorneys where he has practised in the field of medical negligence. Leon was appointed Chairman of the Board of Directors of MacRobert Inc in 2014. He has also been a part-time lecturer in Forensic Medicine at the University of Pretoria, where he presented on subjects relating to medical law.

WHAT HAS CONTRIBUTED TO THE INCREASED VOLUME OF CLAIMS AND COMPLAINTS?

The long-term increase in the number of claims and complaints is deeply concerning. I think that the changes in compensation provided by the Road Accident Fund have had a significant effect on the growth of claims, as personal injury lawyers who sought alternatives following the changes, turned to medical professional indemnity claims instead.

Additionally, the increase in complaints to the HPCSA has largely come about by patient awareness and through the council's policy of inviting complaints, which saw the council distribute pamphlets inviting patients to do so. The HPCSA now receives in excess of 2,500 complaints a year – this is not just against doctors, but dentists and associated healthcare professionals too.

In addition to the HPCSA canvassing complaints, patients are now more informed and aware of their human rights. Their expectations are increasing. This is one of the biggest medicolegal challenges that doctors have to adapt to.

WHAT HAS CAUSED THE VALUE OF CLAIMS TO RISE?

At the start of my career, a claim of R200,000 was considered a large claim, but now it's not unusual to see claims in excess of R20 million – the highest claim I have settled was in excess of R34 million.

Changes in the nature of claims have contributed to the increase in claim value. Patients used to claim for obvious things – a retained swab, an operation on an incorrect leg or an operation on an incorrect patient. With the passage of time claims have expanded, and now multiple experts are frequently involved in each investigation. In addition, the cost of long-term care of patients has increased as improved technologies have become available improving both the quality of care and life expectancy.

Over the years claims have also become more complicated. In addition to the obvious claims, we now see wrongful life claims, wrongful birth claims and other catastrophic claims, including cerebral palsy, Down Syndrome, and birth defect claims. The earlier high-value claims used to be based on neurological damage. We now find the very high-value claims are concerned with obstetrics and neonatology.

The introduction of contingency fees for attorneys has also contributed to the increase in the number and value of claims. Attorneys now often have a financial interest in the claim and this has led to the value of claims increasing. In addition, claimants' attorneys are beginning to feel increasingly vulnerable – if a claim is undersettled, the attorney may find themselves being sued for not having recovered adequate compensation for the claimant.

HOW DOES THE CURRENT MEDICOLEGAL CLIMATE AFFECT DOCTORS AND WHAT CHALLENGES DO THEY FACE IN THE FUTURE?

The medicolegal climate is very uncomfortable for doctors now. They are subject to increasing numbers of claims, and the claims environment discourages doctors from entering particular fields of practice, such as obstetrics. No one wishes to practise medicine in a field where they are more likely to be sued.

As I mentioned earlier, patients are better informed and their awareness and expectations are rising, and the introduction of contingency fees has led to claims being pursued more persistently. I think the current litigation environment is particularly daunting for the medical profession.

The ability of medical aid funds to process large quantities of data has led to them being able to challenge doctors' billing. The medical aid funds are becoming more powerful because of the access to more information. Doctors' accounts are open to review and challenge, in some instances, years after the submission of the account.

DO YOU THINK THE GOVERNMENT WILL IMPLEMENT ANY REGULATORY CHANGES TO MEDICAL INDEMNITY?

I think that the main issue on the horizon is the potential limitation of damages which are payable to patients. The state appears to be anxious to limit payable damages and encourage mediation.

Previously, the state successfully capped the damages payable to claimants by the Road Accident Fund. It has been suggested that the state should be doing the same in medical cases. It remains to be seen whether, if implemented, this will affect state hospitals only, or whether private hospitals and medical practitioners will benefit as well.

MORE SUPPORT FROM MEDICAL PROTECTION

In 2015, MPS launched a campaign to tackle the increasing costs of clinical negligence called 'Challenging the Costs of Clinical Negligence: The Case for Reform'. MPS's recommendations included a centralised complaints system to avoid claims and complaints to the HPCSA, and mediation to encourage early resolution.

To read our policy paper, visit **medicalprotection.org** and click on the 'About' tab.

If you need advice, contact a medicolegal adviser at **medical.rsa@medicalprotection.org** or **0800 982 766**.

FOOTNOTES

1. Collated from HPCSA annual reports (2006-2016): http://www.hpcsa.co.za/Publications/Reports

IMPLICATIONS OF COMPLETING FORMS AND WRITING REPORTS

Medical Protection receives numerous requests from members for advice and assistance with completing forms and writing medical reports. Dr Volker Hitzeroth, Medicolegal Adviser at Medical Protection, advises on best practice

READ THIS ARTICLE TO:

- **Learn what steps to take when you receive a request to complete forms or write medical reports**
- **Discover the medicolegal risks associated with this process**

Healthcare practitioners may be experts at the diagnosis and treatment of medical conditions, but they usually have no formal training or experience in performing administrative tasks such as completing forms and questionnaires or writing medical reports. However, the daily workload of most healthcare professionals includes numerous requests from patients, their family or a third party to complete a form or write a report. Such requests are often viewed as an unwelcome burden that distracts from the clinical work that healthcare workers have been trained to do. Yet, such administrative forms and reports constitute an important part of the modern world and are often critical to patients' or their families' welfare.

Completing relevant forms and writing appropriate reports has become pivotal to a healthcare professional's practice. Forms and reports are also an important part of a patient's healthcare journey (for example, medical aid related documents), medical condition (for instance, J88 forms), income (such as insurance and disability forms) or employment (for example, sick certificates).

STEPS TO CONSIDER WHEN YOU RECEIVE A REQUEST

The HPCSA advises that any healthcare practitioner is obliged to issue a brief, factual report to a patient, where such a patient requires information concerning him or herself.[1]

It is usually best to get any request for forms or reports in writing from the patient, their family or the requesting third party. This is important as it establishes who the requesting party is, and for what purpose they are requesting the medical information. If you can, you should then make contact with the patient and discuss the details with them.

OBTAINING CONSENT FROM THE PATIENT

When dealing with a third party request, ensure that the patient fully understands what information is requested and what the implications of the information disclosure entails. This informed consent process should be documented in the medical records.

If the patient consents to such information being shared with the party concerned, ensure your handwriting is clear or typeset on the form or report.

WHAT TO THINK ABOUT WHEN DISCLOSING THE INFORMATION

The HPCSA advises that:[2]

- You should be satisfied that the patient has been told at the earliest opportunity about the purpose of the examination or disclosure.
- The patient should also be informed of the extent of the information to be disclosed and the fact that relevant information cannot be concealed or withheld.

- Doctors should show the initial request for information to the patient in order to ensure that the patient understands the scope of the information requested and the information to be disclosed.
- A doctor should obtain, or have seen, the written informed consent to the disclosure from the patient or a person properly authorised to act on the patient's behalf.
- Only factual information that the practitioner feels comfortable to substantiate should be disclosed. This should be presented in an unbiased manner.
- If a patient requests you to limit the information to be disclosed (such as a sensitive diagnosis or embarrassing history) he or she should be reminded that relevant and necessary information cannot be concealed or withheld. Such a situation should be handled sensitively and should be satisfactorily resolved prior to information being disclosed.

PRACTICAL TIPS WHEN COMPLETING A FORM OR REPORT

- Be clear as to whether your information is based on a specific personal examination, your medical records or on the patient's, or a third party's, reported version of events.
- Complete only the relevant sections and disclose only the necessary information. Do not withhold any important or necessary information either. Always be open and honest.
- Prior to submitting the report, review it to satisfy yourself of the facts and to ensure you cannot be accused of trying to mislead.
- Clearly delete any errors or unnecessary sections with a single line which should be dated and signed.
- Always sign and date the document. It is wise to make copies, which you should keep in the patient's medical records.

CAN THE PATIENT SEE THE REPORT?

In all circumstances, the healthcare practitioner should check and confirm whether patients wish to see their reports. Patients may wish to see the completed report or form before this is disclosed to the requesting third party. Unless patients have clearly and specifically stated that they do not wish to do so, it would be prudent to share the completed report or form with the patient.[3]

CHARGING FOR A REQUEST FOR INFORMATION

A doctor may charge a reasonable fee for the time spent in managing a request for information, the completion of forms and the writing of reports. In some instances, such forms and reports might have a standard remuneration fee attached to them. This fee might be claimed from a third party such as an insurer or medical aid.

Ensure that the correct amount and reference code or billing code is used when remuneration is sought. If the remuneration fee is not prescribed by the requesting party, a healthcare practitioner should ensure that the patient is fully informed of the exact amount to be charged for the service in rands and cents. A documented quote would be appropriate and helpful.

This discussion should be documented and a copy of the signed cost estimate should be placed in the file. The amount to be billed to the patient should be reasonable and justifiable. If the amount is calculated based on the time spent in completing the form or writing the report, the beginning and end times should also be documented in the clinical records. The bill should be presented to the patient in the format of an appropriately laid out and legal account.

DIFFICULT DILEMMAS

It is likely that, on occasion, some challenging situations may arise. The HPCSA advises that healthcare professionals uphold a number of core ethical values and standards.

These include, but are not limited to:

- respect for persons
- the patient's best interests
- truthfulness
- confidentiality.[4]

Furthermore, the HPCSA suggests that healthcare professionals have a number of duties which include, but are not limited to a duty to:

- their patients
- their colleagues
- society
- the healthcare profession.

In the event of a particularly challenging and difficult situation arising, doctors should balance these values and duties against each other and make a reasoned decision on how to proceed in the matter.[5] The HPCSA provides guidance on how to approach and resolve such ethical dilemmas.[6]

Sometimes you may have dual responsibilities towards your patient and a third party, such as a company or organisation. This might arise if you are requested to complete occupational health forms or insurance documents, or you work in forensic medicine, the armed forces or the correctional services.[7]

If you find yourself in any of the situations above, seek appropriate medicolegal advice.

MORE SUPPORT FROM MEDICAL PROTECTION

To read our factsheet on this topic, visit medicalprotection.org and click on the '*Casebook* & Resources' link.

If you need advice, contact a medicolegal adviser at medical.rsa@medicalprotection.org or **0800 982 766.**

FOOTNOTES

1. HPCSA. *Guidelines for Good Practice in the Health Care Professions Booklet 2: Ethical and Professional Rules of the Health Professions Council of South Africa. Pretoria:* 2008.
2. HPCSA. *Guidelines for Good Practice in the Health Care Professions Booklet 5: Confidentiality – Protecting and Providing Information. Pretoria:* 2008.
3. Ibid
4. HPCSA. *Guidelines for Good Practice in the Health Care Professions Booklet 1: General Ethical Guidelines for the Healthcare Professions. Pretoria:* 2008.
5. Ibid
6. Ibid
7. HPCSA. *Guidelines for Good Practice in the Health Care Professions Booklet 5: Confidentiality – Protecting and Providing Information. Pretoria:* 2008.

ETHICS FOR ALL

OUR ANNUAL ETHICS EVENT

Navigate your way through ethical risks and challenges

Medical Protection is proud to provide education and risk management events to healthcare professionals to help them improve their knowledge and skills, thereby reducing the risk of litigation and complaints

Medical Protection is pleased to be hosting our annual ethics event – Ethics For All – for healthcare professionals in October, in Johannesburg, Durban and Cape Town. We are also delighted to announce that we are adding a fourth location in 2017 and will be bringing Ethics For All to Port Elizabeth for the first time.

Ethics For All brings together highly respected local and international speakers from the healthcare profession and beyond, to provide guidance to help you practise safely and ethically. The event provides an opportunity for members to examine ethical challenges and obtain CME ethics, human rights and medical law units for the ethical component of your professional development.

Dr Graham Howarth, Head of Medical Services for Southern Africa, states: "Set against the backdrop of increasing complaints and rising patient expectations, providing support and guidance to doctors and dentists about ethical issues fulfils a key educational need. It is important that doctors and healthcare professionals receive straightforward and effective advice about how to avoid adverse outcomes.

"We know that issues surrounding ethics and professionalism can be challenging for healthcare professionals to navigate and, although we're here for members when things go wrong, we very much want to help them get it right in the first place. It's about preventing unnecessary pain for healthcare professionals and their patients."

Ethics For All will cover some key ethical issues including behavioural ethics in healthcare – which will focus on the importance, value and impact of trust between the provider and patient, whilst considering the medicolegal and ethical consequences that stem from the loss of trust and ineffective communication.

We will also explore the complexities of breaking bad news to patients and families, how to manage expectations, and improve patient satisfaction and healthcare quality.

The event is free of charge for Medical Protection members as a benefit of membership and a full copy of the conference programme can be found online at: **medicalprotection.org/ethicsforall**

Don't miss this opportunity to debate key medicolegal and ethical issues with your peers and hear from leading experts on ethics.

PORT ELIZABETH

Date: Thursday 12 October 2017
Venue: Boardwalk Hotel and International Convention Centre
Time: 1730 for an 1830 start – 2130 close

JOHANNESBURG

Date: Saturday 14 October 2017
Venue: The Wanderers Club
Time: 0830 for a 0930 start – 1300 close, followed by lunch to 1400

DURBAN

Date: Sunday 15 October 2017
Venue: Southern Sun Elangeni and Maharaj Hotel
Time: 0830 for a 0930 start – 1300 close, followed by lunch to 1400

CAPE TOWN

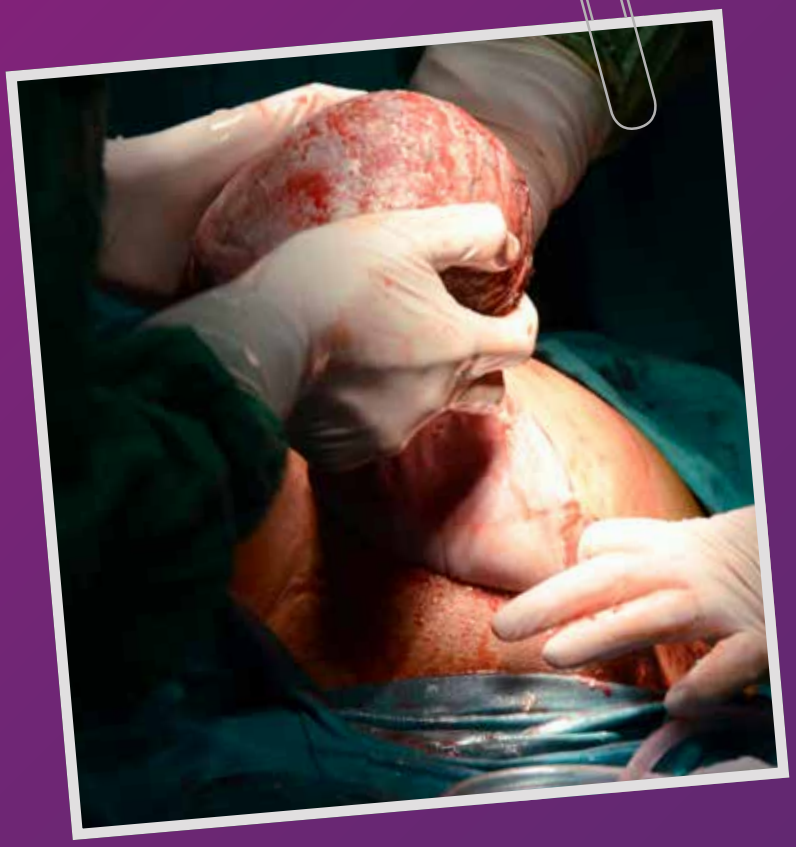
Date: Wednesday 18 October 2017
Venue: Cape Town International Convention Centre
Time: 1730 for an 1830 start – 2130 close

For more information and to register, visit **medicalprotection.org/ethicsforall**

TOO MUCH OXYGEN

A baby loses vision due to excessive oxygen administration

Author: Dr Mike Greenberg, Specialist Paediatrician



A baby was born by caesarean section at 27 weeks gestation with a birth weight of 980grams. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first four hours of life, the baby's oxygen saturations were recorded as ranging between 90-97%. A blood gas taken five hours after delivery showed a pH of 7.68 (normal 7.3-7.4), a PaCO2 of 1.91kPa (normal 4.5-6.0), a PaO2 of 35.84kPa (normal 5-8) and a bicarbonate level of 24.6mmol/L (normal 18-24). This demonstrated the baby was being over-ventilated.

The baby was ventilated for three days, placed on continuous positive airway pressure (CPAP), and then placed on 0.5L nasal cannula oxygen due to recurrent apnoeic spells. Overall the baby received 204 hours of oxygen with oxygen saturation levels of 96-100% throughout.

The baby was not referred at four to six weeks of age for retinopathy of prematurity (ROP) screening, and was first seen by an ophthalmologist at the age of seven months when a diagnosis of inoperable Grade 5 ROP, causing blindness, was made.

The baby's parents made a claim against the specialist paediatrician who handled the baby's care.

EXPERT OPINION

The baby had inappropriately high transcutaneous oxygen saturation levels and PaO2 levels for a period of 204 hours. During oxygen administration to premature infants, very high blood oxygen levels can develop if saturation levels rise above 96%. Weaning of the Fraction of Inspired Oxygen (FiO2) seldom occurred despite oxygen saturation levels of between 96% and 100%, indicating that the nursing staff had no protocol for weaning of oxygen according to oxygen saturation.

There was no record that an ophthalmological appointment for the screening of ROP was made at the recommended four to six weeks of age. The baby developed severe ROP and blindness due to excessive oxygen administration. The opportunity to limit the condition and save the infant's vision was missed due to the fact that the child was not referred for screening for ROP. There was negligence on the part of the paediatrician and nursing staff, in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a four-day period, and for not referring the child at the appropriate time for an eye examination.

The case was settled for a substantial sum.

Learning points

- Neonatal units should have written guidelines for oxygen saturation levels during the administration of oxygen to very low birth weight premature infants, and these must be adhered to.
- Attention should be paid to weaning oxygen when the saturation levels are more than 95%. The recommended safe levels of oxygen saturation in very premature, low birth weight infants are between 86%-92%. Unrestricted and prolonged oxygen exposure in very low birth weight infants is significantly associated with severe grades of ROP.
- ROP is a retinal disease that affects premature infants, and can be limited by adhering to the specific guidelines for oxygen administration and by screening of premature infants at four to seven weeks of age by an ophthalmologist experienced in the identification and treatment of ROP.

BACK TO BASICS

A patient repeatedly attends his GP with worsening back pain

Author: Dr Philip White, Medical Claims Adviser at Medical Protection

Mr B, a 42-year-old builder, attended his GP, Dr S, with a three-week history of back pain and left sided sciatica. Dr S found nothing of concern on further questioning or examination, so made a referral for physiotherapy and recommended ibuprofen. Over the next few weeks the pain increased and the patient required diclofenac and cocodamol to control his symptoms.

One month later, the pain got so bad that Mr B called an ambulance and was taken to the Emergency Department (ED), where he was found to have a slight left foot drop and bilateral straight leg raising of 45 degrees. Mr B's neurology was not examined. The ED doctor thought that this was not sciatica, but simple back pain made worse by moving Mr B's legs. Mr B was sent home with diazepam.

One week later, the pain was even worse and there was now intermittent numbness in both buttocks. Mr B attended another ED, as his GP was away, and was seen by Dr T. He told Dr T that he was able to pass small amounts of urine, and Dr T also recorded "no saddle anaesthesia". Dr T carried out a very brief examination of the legs which was unremarkable, started tramadol, and advised Mr B to keep active and see his own GP the following day.

Mr B was reviewed by Dr S the next day, who again recorded in the notes: "No red flags, no loss of bowel or bladder function. No saddle anaesthesia."

Dr S gave Mr B a diclofenac injection and arranged an MRI scan. He too only carried out a very brief examination of the back and legs.

Two days later, due to intolerable pain, Mr B was on his way to the ED again when he suffered urinary incontinence in the ambulance. On admission, he had an MRI scan that showed a large L4/5 central disc pressing on the cauda equina.

Mr B underwent surgical decompression the next day but was left with bowel, bladder and sexual dysfunction, and bilateral foot drop requiring the use of a wheelchair.

Mr B brought a claim against all the doctors involved in his care. He alleged that they had failed to take a proper history and perform an adequate examination, including assessment of perineal sensation and anal tone. The claim also alleged that they did not give proper regard to bilateral and worsening pain and buttock numbness, and did not refer for urgent assessment.

EXPERT OPINION

Medical Protection instructed an expert GP who was critical of the care provided by both general practitioners. She opined that Dr T did not carry out an adequate assessment after the report of intermittent buttock numbness, and that Dr S conducted a "very severely substandard" examination the next day.

Emergency medicine and orthopaedic experts concluded that the ED doctor's assessment had been inadequate and were critical of the delay before decompression. They also stated that if Dr S or Dr T had assessed Mr B more thoroughly, they would likely have found perineal numbness and/or urinary retention, and the resulting emergency decompression would have left Mr B in a much better condition.

On the basis of the expert opinion, the case was deemed indefensible and was settled for a high sum, shared equally between the hospital, Dr S and Dr T.

Learning points

- Even when referral to physiotherapy has already been made, keep a low threshold for reassessment if things change.
- Issuing analgesia, especially increasing the strength, is an opportunity for reassessment.
- Do not assume that the doctor who saw the patient before you has carried out an adequate assessment, even though nothing might have changed.
- If you ask a patient if they have saddle anaesthesia, make sure they know exactly what that is. It might be useful to ask about rectal function, numbness between the legs or around genitals and anus, and if they have any difficulty getting an erection.
- Any suggestion of perineal numbness or urinary symptoms mandates a thorough assessment of both. Don't forget that urinary tract infections can be caused by retention.
- Giving patients information about the red flags for cauda equina in writing can improve safety netting. However it is no substitute for discussing them with the patient and explaining how the different red flags can present and what the symptoms may mean.

REPORTED ABUSE

A child makes an allegation of abuse

Author: Dr Clare Redmond, Medicolegal Adviser at Medical Protection

Mrs X asked her GP to refer her eight-year-old daughter, Child F, to be assessed by a specialist psychiatrist in child and adolescent mental health. The GP referral letter stated that Child F had reported to her teacher that her father frequently touched her genitalia. The child's parents had recently separated acrimoniously and the mother had reported the matter to the police.

The specialist psychiatrist, Dr B, obtained a history from Mrs X, who confirmed these details. She then took a history from Child F and wrote a report based on these discussions. The report detailed that Child F had reported numerous incidents of touching by her father, and the descriptions provided by the child indicated the father was sexually abusing his daughter.

The police investigated the allegations but no charges were brought against the father, Mr X. However Dr B's report was used by the mother in custody proceedings, and the mother gained sole custody of Child F.

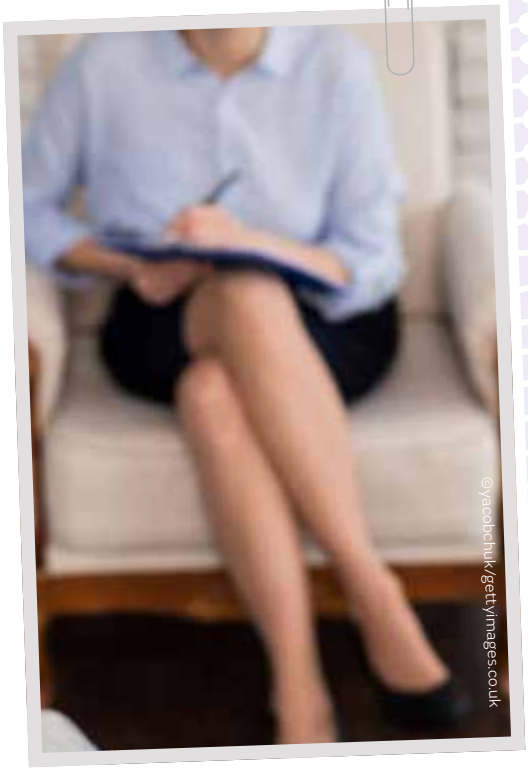
In the course of the proceedings, Mr X obtained his own expert psychiatric report. Mr X's expert concluded that Dr B had obtained an inadequate history in three areas. The expert said that Dr B had failed to confirm the history with the school directly, had failed to seek an explanation from Mr X, and had failed to consider that Mrs X may have coached Child F in giving her answers. This expert was less certain that this was a case of sexual abuse, but deemed the child was best placed with her mother, with supervised contact with her father.

Mr X brought a claim for negligence against Dr B, alleging a failure to take an adequate history from a range of sources to evidence her conclusion of sexual abuse.

EXPERT OPINION

Medical Protection obtained further expert opinion from a psychiatrist. This expert concluded that Dr B carried out her interview with Child F appropriately, and that there was no evidence of pressure or undue influence by the mother. She concluded that there may have been some shortcomings in failing to obtain collateral history from the school and Mr X, but that the activity that Child F had described to Dr B, if true, would unequivocally amount to child sexual abuse and that Dr B's conclusions to that effect were reasonable.

Medical Protection successfully defended the claim.



Learning points

- When writing a professional report, you should take reasonable steps to check the information provided, to ensure it is not false or misleading. A report should make clear where a patient has provided information about events or another party, and this should not be recorded as fact. You must not deliberately leave out relevant information even if requested to do so.
- When writing a professional report, you should set out the facts of the case and clarify when you are providing an opinion. Do not be tempted to comment on matters that do not fall within your area of expertise. In this case, Dr B was assisted by her clear and robust report-writing.
- All doctors have a duty to act on concerns about the welfare of children, and child protection work is recognised as challenging and emotionally difficult. All doctors should have confidence to act if they believe a child or young person may be abused or neglected. As long as their concerns are 'honestly held and reasonable' and they take appropriate action, doctors should not face criticism even if the allegations prove unfounded.

Further Reading

Medical Protection factsheet, *Notes on writing witness statements and reports*
medicalprotection.org/southafrica/casebook-and-resources/factsheets

NO NEWS IS NOT ALWAYS GOOD NEWS

A newborn is referred with a clicking hip

Author: Dr Mónica Lalanda, Emergency Medicine Physician and Medical Writer

Child J, a one-week-old baby girl, was noticed to have a clicking right hip when she was seen by the GP. A referral to an orthopaedic surgeon was made and Child J was reviewed by Dr M later that week. Dr M confirmed that there was no relevant family history and examined Child J. Dr M documented that there was no clicking of the hips, and Ortolani and Barlow tests for assessing hip stability were negative. Dr M discharged the baby back to the care of her GP.

During a routine check-up at eight months, Child J's GP, Dr X, found she had limited rotation of her right leg and immediately arranged for her to have an x-ray. Two days later, following the x-ray, specialist radiologist Dr R described the results as follows: "The left hip is normal. The right hip appears dislocated with associated moderate acetabular dysplasia."

However, due to a failure in the system, the report was simply filed by Dr X's staff and Dr X did not receive a copy.

Three weeks later Child J's mother brought her in with a minor cold and asked about the x-ray results. Dr X reassured her that he had not heard anything so it was a case of "no news is good news" but he promised to check up on it. Unfortunately, the practice was very busy and he forgot to look into it.

Child J was reviewed at 16 months, when her mother complained that she "walked funny". Child J had an obvious limp, and on examination her right hip was clearly abnormal. Dr X made an urgent referral to an orthopaedic surgeon, Dr B, who confirmed the diagnosis of developmental dysplasia of the hip.

Child J was initially treated with a closed reduction and immobilisation with hip spica, but on follow up at three months, the hip appeared dislocated again. An osteotomy was performed and appropriate immobilisation applied, but unfortunately, months later, the dislocation reoccurred and the dysplasia also seemed to have deteriorated. Child J was referred to Dr P, an orthopaedic specialist in hip dysplasia. Dr P arranged for Child J to have specialised physical therapy and explained to her parents that it was likely that Child J would require further surgery within the next few years, although it was still too early to predict when and what kind of surgery Child J would need.

Child J's parents brought a claim against all the doctors involved in the management of their daughter's care. They alleged that Dr M should have requested an x-ray to exclude the dislocation on the initial visit. They also alleged that Dr R failed to ensure that the report made it safely to Dr X, and that Dr X had not checked the x-ray but had dismissed their concern. The parents also claimed against the orthopaedic surgeon, Dr B, for failing to treat their daughter's hip appropriately.

EXPERT OPINION

Medical Protection sought expert opinion from an orthopaedic surgeon with paediatric expertise.

The orthopaedic expert considered that Dr M had demonstrated an acceptable standard of care. The examination of the baby was normal, with no suggestion of a dislocated hip, and was well documented. There was no family history to suggest higher risk, therefore an x-ray was not indicated at that time.

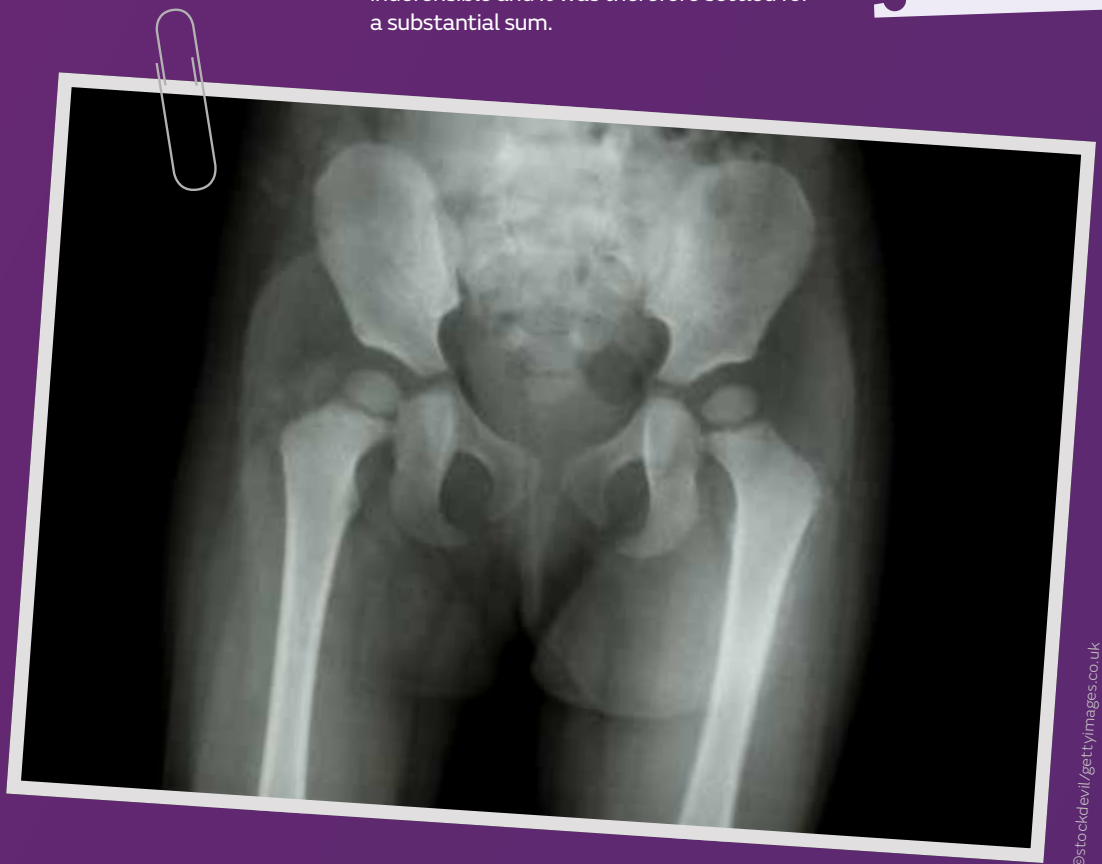
The expert opinion on the care provided by Dr X stated that the standard of care was below a reasonable standard, since he failed to follow up the investigation that he had rightly requested. The expert expressed sympathy for Dr X, who had diagnosed the abnormality appropriately, but then failed to follow up on the investigation. If the mother's account of the next consultation was correct, he missed a second opportunity to review the x-ray report. All this translated into a long delay of several months in the surgical treatment of Child J's hip.

The orthopaedic expert commented that the surgical treatment by Dr B was in keeping with acceptable practice and that the failure was caused by the advanced state of the dysplasia that made the hip very unstable.

The supportive orthopaedic expert's report enabled Medical Protection to extricate Dr M and Dr B from this action. The other failings in this case meant it was considered indefensible and it was therefore settled for a substantial sum.

Learning points

- Good history-taking and careful documentation of physical examination can make a huge difference if a patient makes a claim against you, which can often be many years after the event.
- When you request a test, you are responsible for ensuring the results are checked and acted upon.
- All systems need a safety net where results are checked so that abnormal results are not missed. It is vital to ensure you have a robust system for acting on tasks that arise from a consultation.
- Poor outcomes are not necessarily the result of negligent medical management. Sometimes poor outcomes are a result of the particular condition. You can help protect yourself from criticism by always ensuring your records outline the rationale for any decision you have taken.



A COMPLICATED CLAIM

A surgeon's experience is questioned when he acts as an expert witness

Author: Dr Janet Page, Medical Claims Adviser at Medical Protection

Dr A, an orthopaedic surgeon, was approached by a patient's attorney to provide an expert report on behalf of their client. He was advised that the claim, against the state, related to alleged negligence in the conduct of an L4/5 spinal decompression and fusion with malposition of the pedicle screws, following which the claimant developed right S1 nerve root damage, causing right foot drop. Dr A sent the attorney his CV – which set out his area of practice – as evidence of his suitability for the role, and agreed to provide the requested report.

In his report, Dr A criticised the conduct of the surgeon. His opinion was that the hospital inappropriately allowed a specialist registrar to perform the operation unsupervised, that there was a failure to use an image intensifier and a failure to check the position of pedicle screws immediately postoperatively, resulting in delayed diagnosis of the malposition of the screws and permanent foot drop. A Letter of Claim was served on the hospital based on Dr A's expert opinion.

In their plea, the hospital's attorney denied liability. They commented that Dr A "does not claim to have expertise in spinal surgery". They advised that a newly appointed specialist had performed the operation, an image intensifier was used, and that foot drop is a recognised complication of spinal decompression and fusion, about which the claimant was warned preoperatively.

Proceedings were nevertheless commenced by the patient's attorney. In response, the hospital's attorney submitted questions to clarify Dr A's expertise in spinal surgery. When answering the questions, Dr A confirmed that he had never held a specialist post in the public sector, that he had last performed spinal surgery 15 years earlier, and that he had not operated at all in three years. He also stated that he had never performed complex spinal surgery and that he had not personally performed the operation in question, because of the high risks associated with it.

Following this, the patient's attorney instructed a new expert. She agreed with Dr A's original opinion that there was a failure to check the position of the pedicle screw immediately postoperatively and that there was a delay in making the diagnosis of foot drop. However, the expert also identified new areas of concern, namely that there was a failure to check the neurovascular status of the limb during the procedure, and that there were deficiencies in the consent that had been taken.

She concluded that, on the balance of probabilities, the neurological damage sustained would have been less severe with earlier diagnosis of the foot drop and subsequent correction of the underlying cause (malposition of the screws).

The patient's attorney sought financial redress from Dr A for the increased costs incurred by their client in instructing a second expert and revising their claim. They alleged that Dr A was wrong to maintain that he had sufficient expertise in the field of spinal surgery, and to comment on the current public sector standards and operational procedures on the facts of this case. They pointed out that the hospital's attorney was quick to notice this weakness, as a result of which their client faced an Adverse Costs Order against him.

EXPERT OPINION

Dr A remained of the view that he had the appropriate expertise to report on the case, relying on the elements of spinal surgery in his training in general orthopaedic surgery and his efforts to keep up to date with developments in this area.

Medical Protection advised that he should seek to settle on the basis that whilst there was no suggestion that Dr A deliberately misrepresented his expertise, he did not make explicitly clear the limits of his knowledge and personal experience. Additionally, although he clearly stated an interest in spinal surgery outcomes, he did not advise that he had not carried out a spinal decompression in 15 years, nor did he advise that he had never carried out the decompression and fusion that was the subject of the original claim.

The matter was settled with Dr A's agreement for a low sum and without admission of liability.

Learning points

- Be clear and explicit about the limits of your expertise to avoid misunderstandings.
- Your credibility is likely to be undermined if you are providing an opinion about an area of practice in which you have no (or no recent) practical experience.
- This case highlights the importance of having understanding and experience appropriate to the location of a claim (for example, private or public sector) in order to avoid making incorrect assumptions about personnel or protocols.

A FRIEND IN NEED

A patient suffers complications during spinal surgery

Author: Dr Ian Stephen, Specialist Orthopaedic Surgeon

Ms N, a 33-year-old female accountant, presented to Dr X, a specialist orthopaedic surgeon, with severe lower back pain radiating to both legs. A clinical diagnosis of a central disc protrusion at L4/5 was confirmed on MRI scan. Dr X advised laminectomy with discectomy, to which Ms N consented. Dr X did not record the details of the consent process, but has since stated that he would have warned of potential complications.

Dr X recorded the operation as uneventful, but Ms N rapidly became hypotensive postoperatively and an ultrasound scan revealed a large retroperitoneal haemorrhage. Dr X requested an opinion from Dr Y, a specialist general surgeon, who assessed the patient and advised an emergency laparotomy.

During the laparotomy by Dr Y, retrocolic exploration revealed a clot adjacent to the abdominal aorta. Removal of this clot caused a gush of blood and haemodynamic collapse. The aorta was found to have been transected just below the left renal artery. Dr Y clamped the aorta above the renal artery which controlled the bleeding, and the patient's condition then improved.

Dr Y then attempted to perform an end-to-end anastomosis of the aorta, but this failed. There was bleeding from the left kidney, which proved uncontrollable, so Dr Y took the decision to remove the kidney. Dr Z, a specialist vascular surgeon, was called in and successfully repaired the aorta with a synthetic graft.

Ms N subsequently made a good recovery. She later brought a claim against the orthopaedic surgeon, Dr X, alleging that there had been an indisputable act of negligence in damaging the aorta and in causing the left kidney to be removed.

EXPERT OPINION

Medical Protection's medicolegal experts considered the case carefully and concluded that it would be difficult to defend the fact that the aorta was transected during an otherwise straightforward laminectomy procedure.

The case was therefore settled on behalf of Dr X for a substantial sum.

Learning points

- Work within the limits of your competence. In line with HPCSA guidance, doctors must recognise and work within the limits of their competence and refer a patient to another practitioner when this serves the patient's needs. If an emergency arises in a clinical setting, you must take into account your competence and the availability of other options for care. Specialist input was sought in this case, which helped to avoid a more serious outcome for the patient.
- Make clear and detailed notes. When things go wrong during a surgical procedure, the absence of any documentation of the consent process makes a claim very difficult to defend.
- Patients must be given clear, accurate information about the risks of any proposed treatment, and this must be clearly documented in the medical records.
- Vascular and visceral injuries are a recognised complication of surgery for herniated lumbar disc disease, and frequently result in the death of the patient.
- In this case there were clear vulnerabilities and it was considered unlikely that it would be possible to successfully defend the claim.

UNFORESEEABLE COMPLICATIONS?

A patient undergoes corneal graft surgery for deteriorating keratoconus

Author: Dr Anusha Kailasanathan, Ophthalmologist

Mr M, a 45-year-old lawyer with a substantial income, consulted Dr L, an ophthalmologist, for the management of deteriorating keratoconus. He had become intolerant of contact lenses and was experiencing visual difficulties. His right eye had a corneal scar secondary to severe keratoconus, and he had keratoconus forme fruste in his left eye. Visual acuity was 6/20 in the right eye and 6/12 in the left eye.

Dr L offered Mr M corneal graft surgery in order to improve his symptom of deteriorating vision. He was advised regarding complications, specifically that eye infections were a possibility, but he was not told about the rare risk of loss of the eye. Dr L performed uncomplicated corneal graft surgery on the right eye, and before discharging Mr M, provided him with his mobile phone number and a postoperative information leaflet, which informed patients that they should contact him immediately if they experienced any pain or poor vision.

Written records show that Dr L reviewed Mr M on the first day post-surgery. He was satisfied with the eye and prescribed a topical corticosteroid and a topical antibiotic. On the morning of the second day following the surgery, written and telephonic records show that Dr L gave Mr M a courtesy call and that Mr M did not inform Dr L of any pain during this conversation. Twenty-four hours later, Mr M called Dr L and complained of severe, worsening pain in the right eye, that started shortly after Dr L's phone call the previous day. Dr L saw Mr M immediately and observed a fulminant endophthalmitis.

Mr M was referred to Dr G, another ophthalmologist with experience in vitreo-retinal surgery, who arranged immediate treatment with intra-vitreal and systemic antibiotics. A posterior vitrectomy and lensectomy were performed, but B-scan ultrasonography later showed a retinal detachment. Bacterial culture of the vitreous revealed a serratia marcescens infection, sensitive to the antibiotics being used. As a result of the retinal detachment Mr M lost all vision in the right eye. His corrected visual acuity in the left eye was 6/36.

Mr M made a claim against Dr L, alleging that he had failed to inform him of the risks of corneal graft surgery or of the significance of pain postoperatively. He further alleged inadequate postoperative care, which led to Mr M developing an uncontrolled infection and subsequent blindness in that eye.

EXPERT OPINION

Medical Protection sought expert opinion from an ophthalmologist. She was supportive of the care provided by Dr L and concluded that the postoperative patient information leaflet had sufficient information about warning signs. She also noted that Dr L did warn that eye infections were a possible complication and opined that loss of vision due to an infection was such a rare complication that the patient did not need to be warned specifically about the risk.

The expert made the additional point that, in Mr M's case, there was a real risk that the natural course of the disease may have led to blindness through the complications of keratoconus itself, in the long term.

The case was considered to be defensible and was taken to trial. The court was satisfied that Dr L's management was appropriate and that there was no evidence of a failure to provide adequate informed consent or negligent after care. Judgment was made in favour of Dr L.

Learning points

- The National Health Act (2003) states that every healthcare provider must inform a patient of:
  - the patient's health status except in circumstances where there is substantial evidence that the disclosure of the patient's health status would be contrary to the best interests of the patient
  - the range of diagnostic procedures and treatment options generally available to the patient
  - the benefits, risks, costs and consequences generally associated with each option
  - the patient's right to refuse health services and explain the implications, risks, obligations of such refusal.
- When providing important information in a written format, the patient must be made aware of its importance. Consider providing verbal information as well as written information for important matters. When giving written information to sight-impaired patients, the format and font should be suitable for their visual ability. When applicable, consider adjunctive methods to deliver information such as audio or video formats. Document that the material was given to the patient.
- Although the primary purpose of medical records is to ensure continuity of patient care, medical records are used as evidence of care when dealing with complaints and medicolegal claims. Therefore, clear and detailed medical records are in both the patient's and the doctor's best interest.

CPD QUESTIONNAIRE

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

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

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

Accreditation number: **MDB015/560/06/2017**

INSTRUCTIONS

1. In the case of Ms S, the chance of Trisomy 21 was reported as:
   a. 1:270
   b. 1:350
   c. 1:940

2. Over the six-year period from 2011 to 2016, MPS has seen large claims (over R1 million) increase by what percentage?
   a. 14%
   b. 37%
   c. 121%
   d. 152%

3. What is the percentage increase in the total number of complaints against doctors received by the HPCSA from 2006 – 2016?
   a. 25%
   b. 50%
   c. 75%
   d. 100%

4. Which one of the following statements is NOT true when charging for a request for information?
   a. The signed cost estimate should be placed in the file.
   b. If the amount is calculated based on time spent in completing the form or writing the report, you do not need to document the beginning and end times in the clinical record.
   c. The amount billed should be reasonable and justifiable.
   d. The bill should be presented to the patient in the format of an appropriately laid out and legal account

5. When a test or investigation is requested for a patient, who is responsible for ensuring the results are checked and acted upon?
   a. The patient who is having the test.
   b. The person conducting the test or investigation.
   c. The doctor who requested the test or investigation.

6. In the case where Mr B, a 42-year-old builder, attended his GP with worsening back pain, what were the allegations?
   a. Failure to take a proper history and perform an adequate examination.
   b. Failure to inform the patient of the possible risks.
   c. Failure to obtain and document adequate consent to treatment.

7. The National Health Act (2003) states that
   a. Healthcare providers must inform a patient of their health status except in circumstances where there is substantial evidence that the disclosure of the patient's health status would be contrary to the best interests of the patient.
   b. Healthcare providers need only give their patients the information they ask for.
   c. Healthcare providers should only give their patients the basic information they think the patient needs.

8. In the case where Dr A was approached to provide an expert report, why did the patient's attorney subsequently instruct a new expert?
   a. Dr A had never performed spinal surgery.
   b. Dr A was not explicit about the limits of his experience.
   c. Dr A's opinion that there was failure to check the position of the pedicle screw was incorrect.

9. Regarding the consent process with a patient, which of the following is true?
   a. Patients must be given clear, accurate information about the risks of any proposed treatment, and this must be clearly documented in the medical records.
   b. Patients must be given clear, accurate information about the risks of any proposed treatment but there is no need to document this in their records.
   c. Patients must only be informed about the risks of any proposed treatment if they ask.

10. When providing information to a patient about their condition, its treatment and prognosis, it should be provided:
    a. Verbally.
    b. In a way that the patient can best understand.
    c. Written down.

How to contact us

MEDICAL PROTECTION

info@medicalprotection.org

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

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